

Training the Next Generation

Advanced Practice Provider (APP)
Postgraduate Training Programs
in Community Health Centers

2ND EDITION



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SPONSORED BY:

The National Health Center Training and Technical Assistance Partners (NTTAP)
on Clinical Workforce Development at Community Health Center, Inc.
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innovation, and quality improvement arm. She serves as the Director Emeritus of the Weitzman Institute. Margaret served as the national co-director of the Robert Wood Johnson Foundation's Primary Care Teams: Learning from Effective Ambulatory Practices (LEAP) project, which is studying exemplar primary care practices across the country. Margaret has led the national development of a model of post-graduate residency training programs for new nurse practitioners and established and serves as the Chair of the Board for the Consortium for Advanced Practice Providers. Margaret is the Co-Principal Investigator for the Health Resources and Services Administration's (HRSA) National Technical Training and Assistance Partners on Clinical Workforce Development. Since 2009, she has co-hosted, along with CHCI's CEO Mark Masselli, a weekly podcast show, "Conversations on Health Care", which connects people with issues of health policy, reform, and innovation, and speaks widely on topics related to primary care transformation. Margaret received her BSN from the University of Connecticut, her MSN from Yale University, and her PhD at the University of Connecticut. She is a Fellow of the American Academy of Nursing and the American Academy of Nurse Practitioners.



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development of curriculum, materials, and presentations. Meaghan is also responsible for coordinating the NTTAP efforts around evaluation, data analysis, and publications. Meaghan received her Bachelors of Arts and Sciences in Communications from Bryant University.



Charise Corsino is the Program Director for CHCI's Nurse Practitioner Residency Training Programs. In this role Charise manages the operations and growth of CHCI's NP Residency Programs which includes training programs for Family, Pediatric, and Psychiatric Mental Health Nurse Practitioners. In addition, Charise also serves an expert faculty on the Health Resources and Services Administration (HRSA) funded National Training and Technical Assistance Partners (NTTAP) on Clinical Workforce Development. In this role, Charise supports organizations in the planning, implementation, and evaluation of new postgraduate NP Residency Programs at federally qualified health centers across the country.

Charise has developed expertise in the development, planning, implementation and operation of postgraduate NP Residency Programs. Charise also serves as a member on CHCI's Emerging Leaders Team as well as Weitzman's Education Programs Leadership team.

Charise earned a Bachelor of Science in Health Care Management from the University of Connecticut's School of Business and a Masters of Arts degree in Health Communication from Emerson College in collaboration with Tufts University School of Medicine.



Dr. Garrett Matlick currently serves in the role of Clinical Program Director for CHCI's Nurse Practitioner (NP) Residency Programs. Dr. Matlick brings a wealth of integrated primary care experience and unique perspective as a dually certified family and psychiatric mental health NP. He received his Master of Science in Nursing and Master of Public Health from Johns Hopkins University and his DNP-PMHNP from Rush University. He joined CHCI's NP Residency program in the 2018-2019 cohort in our Stamford location. Since completing the residency, Dr. Matlick has been practicing in Stamford where he also serves as the On-Site Medical Director. Lastly, Dr. Matlick has been deeply involved in the Consortium

for Advanced Practice Providers as an accreditation site visitor and attendee and presenter at annual conferences. He brings a commitment and passion to postgraduate training for NPs, support for CHCI's program, and the national movement.



Kerry Bamrick is the Executive Director of The Consortium for Advanced Practice Providers ("the Consortium"). In this role, she serves as the key executive leader of the Consortium. Bamrick is responsible for overseeing the services of the Consortium while carrying out the strategic plan of the organization. As the Executive Director, key responsibilities include oversight of the development and implementation of the Accreditation Commission of the organization in accord with the rules governing that Commission. For nearly two decades, she has been directly involved in the growth and development of the organization including moving it from an informal group of five organizations to becoming its own 501c3. In addition,

Bamrick was a member of the accreditation planning committee and contributed to the development of consortium's accreditation standards. She serves as faculty in the online accreditation site visitor-training program.

Bamrick is a recognized leader in the area of postgraduate Nurse Practitioner/Physician Associate training. She has extensive experience in both managing postgraduate nurse practitioner residency training programs and serving as a content expert to organizations interested in implementing postgraduate APP residency and fellowship programs. Prior to becoming the Executive Director, she managed CHCI's remotely hosted nurse practitioner and joint nurse practitioner/physician associate postgraduate training programs in the states of California, Hawaii, Illinois, Indiana, Massachusetts, New York, Oregon, Rhode Island, and Washington. Bamrick also serves an expert faculty on the Health Resources and Services Administration (HRSA) funded National Training and Technical Assistance Partners (NTTAP) on Clinical Workforce Development, and previously served as the Co-Principal Investigator. Her passion and interest in this field is reflected in her work nationally.

Bamrick has an undergraduate degree from Merrimack College and a Master's Degree from Western New England College.



Dr. Nicole Seagriff, APRN, DNP, is Vice President of the Community Health Center Inc.'s Western Region, which includes mobile, school-based and comprehensive primary care centers in Stamford, Norwalk, Danbury, Meriden, Bristol and Waterbury.

She attended Boston College and graduated with a BSN in 2007. Upon graduation, she began work as a Registered Nurse in the Medical Intensive Care Unit at Yale New Haven Hospital while completing her MSN degree at Yale University in 2011. In 2016, she graduated with her Doctor of Nursing Practice degree from Duke University with a focus on genetic testing for breast

cancer mutations in underserved populations. She is board certified as a Family Nurse Practitioner.

While at Yale, she recognized the need for access to primary care services for underserved patients and chose to complete an additional year of training through the nurse practitioner (NP) residency program at the Community Health Center, Inc. (CHCI) based in Middletown, CT. After completion of the NP residency program, she practiced as a primary care provider at CHCI for nearly 12 years where she also served as the On-Site Medical Director of the Norwalk and Stamford locations. In addition to this, and with an ever present appreciation for post graduate training, she was Clinical Program Director of the National Nurse Practitioner Residency Program from 2018–2023.

Nicole is President of The Pink Agenda, a 501(c)(3) dedicated to raising money and awareness among young professionals for breast cancer research and care. Since its inception less than a decade ago, The Pink Agenda has raised nearly \$14 million for life saving research. In 2022, she was named the Yale School of Nursing Decade Award winner.

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The funding provided from 2015 to 2026 enabled us to assist over 100 health centers through intensive training and technical assistance in the development of postgraduate training programs.

In particular, we would like to extend our appreciation to our Project Officer, Tiffany Long, and to David Bates for his exemplary leadership throughout this initiative.

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INTRODUCTION

Welcome to the 2nd edition of *Training the Next Generation*!

To state the obvious, much has changed in the world of health care, workforce training, and Health Centers (HCs) since we launched the 1st edition of this book in December of 2017! Our commitment to ensuring access to healthcare, improving health outcomes, and building healthier communities remains steadfast. Now as then, we know that it is imperative that community health centers play a major role in training the next generation of health professionals who will provide that care. As the Health Resources and Services Administration (HRSA)-funded National Training and Technical Assistance Partners (NTTAP) on Clinical Workforce Development, Community Health Center, Inc. (CHCI) has been honored to play a key role in the design, launch, and expansion of postgraduate training programs for nurse practitioners (NPs) in community health centers since 2015.

Change is a constant in our work. One of the significant changes in this 2nd edition of *Training the Next Generation* reflects the choice by many health centers to open their postgraduate training programs to both NPs and physician associates/assistants (PAs). Thus, our language throughout this book has been modified to be inclusive and reflective of this development by referencing advanced practice providers (APPs) when referring to joint programs. While the 1st edition focused almost exclusively on the training of NPs in the role of primary care provider, health centers have also led in the development of Psychiatric/Mental Health Nurse Practitioner (PMHNP) programs and we have reflected this important development as well.

We have benefited greatly from the work of our colleagues across the country who participated in our NTTAP on Clinical Workforce Development over the years and continually challenged us to evolve, evaluate, and redesign our program to best reflect the need for expert APPs who practice in HCs, the country's largest primary care system. Our quest for rigor and quality in postgraduate training for NPs and PAs has led to the development of formal accreditation programs, which are also described in this 2nd edition for the first time.

With nearly two decades of history, programs in 48 states (as of this edition), and several generations of NP and PA alumni dispersed across the country, the impact of

those who have benefited from postgraduate training in a community health center is being felt both in their delivery of health care as expert primary care and psychiatric/mental health providers, but also by their engagement in research, education, policy, and leadership. We acknowledge each NP and PA who has completed a postgraduate residency or fellowship in a HC and thank them for now being that next generation that is delivering on the promise of excellent primary care for all.

—**Margaret Flinter**, APRN, PhD, c-FNP, FAAN, FAANP;
Co-Principal Investigator, NTTAP on Clinical Workforce Development;
Senior Vice President and Clinical Director,
CHCI and Moses/Weitzman Health System (MWHS)



American Association of Nurse Practitioners (AANP) Annual Conference; Las Vegas, NV; October 2011. Standing, left to right: Caitlin Erickson, Hao Pham, and Sarah Eichenberger. Seated, left to right: Anna Olivier, Martha Trevey, Margaret Flinter, and Kristie Quarles.

CHAPTER 1

Origins and Growth of the Movement for Advanced Practice Provider (APP) Postgraduate Training

In the summer of 2002, I (Margaret Flinter) was driving down Route 9 in Middletown, Connecticut and contemplating the meta-question *“What’s wrong with this picture?”* The picture I had in mind was that of the best and brightest new nurse practitioners (NPs) who came into Community Health Center, Inc. (CHCI) brilliantly educated and burning with passion to serve as primary care providers (PCPs) for the vulnerable populations who are at the core of community health center practice everywhere. For years, I had observed these remarkable individuals, well prepared with the competencies for entry-level practice, confront the complex realities of being a PCP in the setting of community health centers. These new NPs quickly found that our patient population was rarely “uncomplicated” on any level. The range, depth, and often severity of health challenges coupled with and influenced by the weight of adverse life circumstances, such as poverty, chronic physical or mental health conditions, and delayed or foregone preventive health care creates challenges for the most sophisticated and expert PCPs.

With the Connecticut River languidly flowing by under a hot summer haze, I faced the reality that CHCI, the tremendous community health center that I had devoted most of my professional life to help build, had at that time only a handful of NPs in its primary care centers, while the medical staff had grown several times in size. I knew that I was finding it hard to recruit, and even harder to retain NPs after their first or second year into practice—exactly the kind of NPs our patients needed. I had already figured out with the help of two new NPs, that our best chance of success was to create a very intensive, highly structured, individualized “ramp up” for each NP, with dedicated time for individual teaching and feedback. CHCI and the new NPs would need to work together to build confidence and competence across the full range required for primary care practice as an NP, all the while reassuring the new NPs that their feelings of being unprepared for this practice was normal, and to be expected. But was it? And could I do this over and over, one NP at a time? Could my health center colleagues across the country, more than a thousand organizations strong, do this? Was there a better way?



Nurse Practitioner (NP) Residents, faculty, and leadership gather on the first day of orientation for the 19th cohort of the Community Health Center, Inc.'s Postgraduate NP Residency Program.

And why, I further asked, was the experience of other new providers, particularly physicians, often so different from that of new NPs coming to practice in the role of PCPs? Other new to practice providers were also far from expert in the management and care of our CHCI patients across the board, and certainly struggled with the challenges of new clinical systems, as well as the disproportionate representation of behavioral health and substance use disorders. These new providers too required an extended period of “ramping up” as they developed their panels and practices, mastered the electronic health record (EHR), and learned the art of practice in the community health center system. Yet, they had demonstrated a readiness to take on a panel of patients and a confidence about their practice that was clearly different.

I had a lot of questions, and needed to find some answers. In this chapter, we will describe how our questions and answers led us to innovate and create perhaps the first formal Postgraduate NP Residency Training Program for new primary care NPs who aspired to be PCPs. In the process, this launched a movement for postgraduate training for new NPs across the country and in all practice settings. The movement has since expanded to include joint NP-physician associate/assistant (PA) programs and Psychiatric/Mental Health Nurse Practitioner (PMHNP) programs. The PA profession has had a model of postgraduate training primarily specialty focused. As part of the evolution of the model, some programs choose “fellowship” vs. “residency”, but the design, content, and standards for accreditation are generally the same.

Asking the Right Questions



Asking the right questions—and avoiding the wrong ones—is an art when you set off to create an innovation or disrupt a traditional pattern. We asked: ***What do new NPs want and need to be successful at transitioning to clinical practice as PCPs in the safety net setting after completing the educational requirements for licensure and board certification? How can that need be met?*** Our answer: a highly structured, postgraduate year of clinical practice with formal precepting, mentoring, continued didactic learning, and training to a high-performance model of primary care. As we saw it, the problem was neither a shortcoming in educational preparation, nor a shortcoming in the new NP. It was a recognition that the formal residency training that is afforded to physicians, dentists, psychologists and other clinicians following the award of their clinical degree (MD, DO, DDS, PsyD) had not been afforded to NPs, and it is this intensive period of practice in the context of structured residency that was missing. To put it another way, new NPs committed to clinical practice careers as PCPs deserve the opportunity for postgraduate training in a formal residency program.

Was this a good idea? Why hadn’t this been done before? After all, physicians, dentists, and clinical psychologists, to name a few, all had either the mandate or the option for formal residency training. It wasn’t as if nobody had thought about postgraduate residency training for NPs. As I summarized in my first article on this topic, NPs have long advocated for postgraduate training as a bridge between academia and practice to support the transition from entry-level clinical competence to the depth of experience required for practice as an NP and primary care provider. Such training should be available to new NPs who seek it, based on their career goals and intended practice settings (Flinter, 2005).

Further research confirmed the difficult transition that many new NPs underwent and the desire of new NPs to have access to postgraduate training (Brown & Olshansky, 1997; Brown & Olshansky, 1998; Draye & Brown, 2000; Hart & Macnee, 2007). As is so often the case, the answer seemed to lie in policy, practice, and professional considerations. By policy, the generous funding available to training other health professions under federal graduate medical education known as “Graduate Medical Education (GME)” was exclusive, by statute, as it did not reference NP training. By practice, the driving concern of the nursing profession was continuing our long held quest to advance legislatively to independent practice, and educationally, to the doctor of nursing practice, and not postgraduate training. And tied to both, perhaps, was the concern of professional organizations that any indication from the profession that new NPs might need, deserve, and want postgraduate training would be perceived as a deficiency that could weaken the argument for independent practice.

Historical perspective is always interesting. In 2002, when I began pondering this issue, the Affordable Care Act (ACA) was still seven years in the future, and with its signing, the acknowledgement of the nation’s critical need for and shortage of expert PCPs. In 2005, the focus of the nursing profession was on the development of the clinical Doctorate of Nursing Practice (DNP) (Mundinger, 2005). At the same time, in medicine, the focus was on early evidence and standards for something that would soon become a norm of practice in primary care, the *Patient-Centered Medical Home* (Davis, et al., 2005). In community health centers across the country, we were focused on issues of access, growth, and expansion to meet the growing demand to provide care to patients who were typically low income, uninsured, or publicly insured, and disproportionately burdened by chronic health conditions, risk factors, and prior lack of access to preventive care.

The first edition of this book was published in 2017. In 2026, we write from the perspective of having made great progress on many fronts: the movement for postgraduate training for NPs has grown dramatically and joint NP/PA programs are growing

as well. Primary care has been renewed and strengthened through innovations in practice, technology, and science, and artificial intelligence (AI) promises to bring more innovation to our practice. Community health centers have expanded to care for 31 million Americans (Health Resources and Services Administration, 2025). However, challenges abound. The PCP shortage, despite the advent of the Teaching Health Center (THC) program and an unprecedented growth in the number of new medical schools in the United States (U.S.) has not gotten better, it has gotten worse. Changes in federal policy regarding Medicaid eligibility and costs associated with coverage under the ACA marketplace may increase the numbers of uninsured (Milbank, 2025). Clearly, we still have big challenges ahead of us!



Who wants to be a PCP and how can we support them? This stands in contrast to the question we had been asking for decades about why such a small percentage of physicians choose primary care today. My answer was **“NPs do.”** NPs historically and still today overwhelmingly choose primary care as their specialty certification area. According to the American Association of Nurse Practitioners (AANP), 66.4% of new NP graduates from 2023–2024 received primary care certifications, including Family, Adult Gerontology Primary Care, Pediatric Primary Care, Women’s Health) (AANP, 2025). Communities need expert PCPs who are committed to and are passionate about primary care, and who are committed in particular to underserved patients. NPs serving as PCPs in Patient-Centered Medical Homes (PCMH) that are also Health Centers (HCs) are the backbone of the nation’s primary care system. We need to find a way to support their transition to practice and, equally important, retain them as PCPs throughout their career.



Should postgraduate residency training be required for new NPs? Rather than adding a new requirement for practice, the authors focus on continuing to build the infrastructure, support, and access to such training with expanding opportunities to complete an advanced practice provider (APP) postgraduate training program steadily increasing over time. We do believe it is critical to expand the opportunities for APP postgraduate training programs, particularly in primary care and for the role of PCP, and most especially in the nation’s community health centers.



How can we improve access to high quality healthcare? As leaders in a community health center, we have been driven by the question of not just access to health-care, but access to high quality, effective healthcare. The population of patients in community health centers need access to care that is transformational as we seek to improve health and build healthier communities. We want to create access to care that incorporates prevention in every element of care, and that motivates behavioral change, self-care, and healthier lifestyles at the patient level. We want to organize

and implement care that eliminates waits and delays, drives improvement with data, and integrates behavioral health and primary care. We want every patient to have a team that engages with individuals and panels of patients, shares decision making with them, and respects their healthcare preferences.

Thus, postgraduate training for new APPs is equally engaged in training to clinical complexity, and training to a high-performance model of care. From our roots in community-oriented primary care, with its focus on consumer engagement and control, we were and still are in the business of transforming primary care from the ground up.

From Concept to Launch

It so happened that in 2002, I joined the Robert Wood Johnson Foundation (RWJF) Executive Nurse Fellows program, a three year journey that promised to stretch, expand, and challenge its Fellows to take on big leadership challenges. With access to great minds in nursing, healthcare, politics, and beyond, I launched my campaign to learn everything there was to know about what thought leaders had studied, proposed, and recommended in this area. I wanted to learn about the barriers that had been identified in the area of creating NP residency training, how to overcome them and to learn where collaboration and support might lie. I quickly learned that the barriers were abundant; the support was less so.

Reviewing Funding Mechanisms

A legal brief commissioned with some of my RWJF funds quickly confirmed that the statutory language of Medicare GME clearly precluded use of these funds for residency training for nurse practitioners (Direct GME Payments: General Requirements, 2010). Reading the many Council on Graduate Medical Education (COGME) reports to Congress over the years, it was clear that the Council members were aware of the compelling need to promote primary care practice among new physicians as a viable alternative to the growing preference for specialty practice, to revamp training for a new era in healthcare, and to recognize the increased number of healthcare professionals, such as NPs and PAs. Over the subsequent decade, COGME would devote significant attention to questions of revision and reform of GME, but without substantial changes (Institute of Medicine [IOM], 2014). As I reached out to leaders in nursing practice, education, and policy, I encountered a variety of opinions, both supportive and opposed, regarding postgraduate training.

Early Support

I am indebted to leaders, such as the late Dr. Loretta Ford, founder of the NP role; the late Dr. Donna Diers, former Dean of the Yale School of Nursing; and Dr. Margaret Fitzgerald, legendary NP leader and educator, for their interest and support. Along with a team of colleagues at CHCI, I began to lay out a conceptual framework for a postgraduate NP residency training program, specifically designed to prepare new primary care NPs for practice in the safety net settings. As a senior executive leader in a large healthcare organization, I have influence over what we choose to invest our margin in—staff, services, programs, facilities, and innovations. But the truth is, it's hardest to make the decision to invest in something which also happens to be your particular passion, when there are so many needs and promising ideas for innovations. Fortunately, CHCI's Founder, President and Chief Executive Officer (CEO) of CHCI, Mark Masselli, and the CHCI Board of Directors, were early advocates of proceeding with the design and launch of the NP Residency program and have provided unwavering support over the years. In 2006, with no funding on the horizon, but the structure of the model designed, we decided it was time to move from concept to pilot so that we could test and evaluate the effectiveness of our design.

Initial Cohort

In 2007, with the help of a very talented Yale University School of Public Health recent graduate and young entrepreneur, Ming Cheung, we defined the essential and core elements of a new postgraduate NP program with a single focus on family NPs, which would later expand to multiple tracks. We identified qualifications, a strategy for recruiting and selecting candidates, and a plan to recruit internal and external preceptors and master lecturers. In addition to the CEO and Board, we had the enthusiastic support of the key clinical and business leaders in the organization. Recognizing the time it takes after graduation to sit for certifying exams and become licensed as an advanced practice registered nurse (APRN), we set a yearly calendar for the program, starting the day after the Labor Day holiday and ending on August 31st of the following year. We accepted four individuals for the initial cohort; we educated colleagues within and outside of CHCI about the initiative; and we even had a bill passed by the Connecticut legislature applauding the creation of the program (Pub. Act No. 07-219, 2007). Rachel Demarco, a member of the inaugural cohort and still on staff at CHCI 20 years later, joined us for the bill signing, and read from her application essay her reasons for applying to the program.



Ming Cheung (far left) and Dr. Nwando Olayiwola (center) with the initial CHCI NP resident cohort.

From the 1st edition of *Training the Next Generation: Residency and Fellowship Programs for Nurse Practitioners in Community Health Centers*

"Growing up in a family of Traditional Chinese Medicine (TCM) practitioners in NYC's China Town has taught me so much in terms of community health and care coordination across various disciplines and cultural settings. But my first formal community health project in Connecticut was when I was a student at Yale University's Masters in Public Health program doing assessment on unmet behavioral health for the children in the state. This was when I first realized the shortage of community health providers has caused an inefficient healthcare model and poor quality of care.

When Margaret first introduced me to the concept of an NP residency program, I was troubled by the fact that such an important component of community healthcare providers, especially Family Practice NPs, did not have the systematic practical training available to them. To embark on such a program as a private institution we faced many challenges such as training operating costs, trainee and preceptor's productivity measures, and evaluation of quality of rotations and didactics. All of the challenges we faced didn't have a source of reference because we were the first ones to do such a thing. Under Margaret's support and guidance, we eventually came up with the rotations, didactics, calculated the proper teaching time-adjusted performance measurements, and even created an online evaluation tool for feedback and evaluations. As the person who managed the first year of the program, I felt indebted to all the people who had made sacrifices to support the program. There are a few components that we couldn't do without:

- 1. CHCI at the time had a very diversified group of specialists to support the program and a pool of preceptors from whom we could choose.**
- 2. CHCI had various sites and community programs (homeless outreach, school-based health centers, mobile health vans) to provide various settings for the NP training. We only had to seek outside CHCI for two rotations: the community hospital for rounding in the newborn nursery, and a senior-living facility for geriatric care.**
- 3. Leadership's commitment was absolutely important. Mark, Margaret, the clinical site directors, and medical directors, all believed in this vision."**

—Ming Cheung, President/CEO
Shanghai Pu Kang Health Management Limited, China Primary Care Co., Ltd

"I knew from a young age that my career would focus on helping those in need. My passion lies in providing high quality healthcare for underprivileged populations. I became a family nurse practitioner because I believe that in caring for patients from birth to death I will form strong bonds and serve a diverse community. In building my patient panel post-residency as a full-time practitioner in the community, I am eager to establish and nurture meaningful and trusting relationships with my clients, and to become immersed in care at the essential level of the patient-provider relationship. It is this personal and respectful dialogue that is the heart of nursing and provides the foundation for patient trust, compliance, and improved clinical outcomes.

The residency is an ideal opportunity to collaborate with experienced clinicians, build and refine skill base, hone clinical judgment. Mentoring and support has prepared me to be a leader among APRNs in the community and in larger professional organizations.

I have a hunger for evolving clinical information, a continual drive to improve my abilities, and a high level of responsiveness to preceptor feedback."

—Rachel (Gollnick) Demarco



The ceremonial bill signing on July 3, 2007. Standing behind Governor M. Jodi Rell are (left to right): Dr. Robert Galvin, Commissioner of the Department of Public Health; Rachel Gollnick, member of the inaugural NP residency class; Angela Anthony, Board member of CHCI; Margaret Flinter, Senior Vice President and Clinical Director at CHCI; Daren Anderson, MD, Chief Medical Officer at CHCI; Mike Starkowski, Commission of the Department of Social Services; State Senator John Kissel; and State Representative Faith McMahon.

That first cohort took a giant leap of faith born of nothing but their fierce and unrelenting desire to provide the best and most effective primary care to people who needed it most, to do that in the context of family and community, and to diminish however possible the impact of poverty on health. Their love of nursing, of community, of the science and art of healthcare coupled with their clear-eyed assessment of the gap between their readiness to practice as PCPs and the needs of their patients led them to be part of this brand new innovation. We saluted that first cohort for their commitment and every one of the twenty cohorts since.

The experience and evaluation data from that first year strengthened our working hypothesis that postgraduate NP residency training was the bridge between entry to practice and the advanced competencies required to care for patients with complex and often multi-co-morbid conditions. We witnessed the impact of the support of dedicated preceptors, mentors, and experiences as facilitating factors in mitigating the distress common among new NPs, and observed that distress gradually gave way to sustained progress towards confidence and mastery of the role of PCP. This transition was very consistent with the transition theory advanced by Dr. Afaf Meleis, which shows that the hallmarks of a successful transition are mastery of new skills and development of a fluid yet integrative identity (Meleis, Sawyer, Im, Messias, & Schumacher, 2000).

CHCI NP Residents have submitted weekly reflective journals since the beginning of the Postgraduate NP Residency Training Program. These journals became a cornerstone of the program, yielding rich insights into the NP Residents' experience over time. They illuminated a journey towards competence, mastery, and confidence in being an NP in the role of a PCP. A rigorous qualitative analysis of 1,200 journal entries submitted by 24 CHCI NP Residents over a five year period provided primary scholarly confirmation of successful transition experience (Flinter & Hart, 2016).

Figure 1.1 (shown on page 24) illustrates the results of that study. Study authors, Flinter and Hart (2016), were able to capture an overarching sequence of thoughts and emotions during the NP Residents' transition to providing care to complex patients in a safety net setting. In the first three months, the NP Residents transitioned from "gratitude" for the opportunity to be in the residency to "shock and awe", followed by "exhaustion", and then a feeling of having their "heads above water" by the middle of the residency year. As NP Residents began the second half of their year, they began to "manage complexity" well enough to have an "awareness of emerging competence." By the end of the year, they reflect the confidence, competence, and mastery that will position them for success as PCPs in community health centers.

The pace and milestones of the transition experience will be different for each resident as they progress through the program year, and this ongoing, real-time feedback provides a valuable perspective on what each individual needs to maximize their progress.

A Year in the Nurse Practitioner Residency Program

Based on Analysis of 1,200 Journal Entries from 2008 through 2013



Figure 1.1: A Year in the Nurse Practitioner Residency Program

Building and Seeking Federal Support

We continued to innovate and advance the model locally, as well as nationally, learning from and collaborating with other organizations in developing programs, outreach or support, and education with our congressional offices, and continuing the dialogue with our healthcare colleagues and organizations. As we were preparing to welcome the third cohort (2009–2010), and as the country began its journey towards passage

of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010), we were invited to host a briefing on Capitol Hill attended by congressional staffers, policy makers, representatives of HRSA and the National Health Services Corps (NHSC), and representatives of professional organizations and academia. Monica O'Reilly (now Dr. O'Reilly-Jacob and a prominent health policy researcher) of the initial cohort joined us and spoke of the impact of CHCI's Postgraduate NP Residency Training Program on her development as a primary care provider.

From the 1st edition of *Training the Next Generation: Residency and Fellowship Programs for Nurse Practitioners in Community Health Centers*



Monica O'Reilly-Jacob, PhD, APRN, FNP-BC, FAAN, a graduate of CHCI's inaugural NP residency class, speaking at the Nurse Practitioner Residency Briefing on May 28, 2008. Seated at the table are (left) Kandree Hicks, an incoming resident to the 2009–2010 cohort, and Nwando Olayiwola, MD, Chief Medical Officer at CHCI.

"With only one year of extra support and mentorship, we can prepare nurse practitioners to thrive in community health centers. As we all know there is a shortage of primary care providers in this country. Nurse practitioners bring a unique philosophy and tradition to the front lines of community health. We excel in disease prevention and health promotion, empowering our patients to make lifestyle changes before the development of chronic diseases that expend an enormous amount of healthcare dollars. Founded in holism and compassion, we approach our patients with a special kind of care...a nurse's care...one that addresses the human experience of illness...one that understands the profound impact of poverty on wellness. People like and trust nurses...we are an invaluable and complementary asset to the world of primary care.

We need to provide the tools and skills to new nurse practitioners who desire to serve in community health, but are thwarted by fear of patient complexity and inadequacy. A year of extra training to these committed NPs, may yield decades of high quality care in an underserved area. It was an honor to be part of the first residency class...through the program I established a solid foundation of skills that remain the backbone of my clinical practice. My continued commitment to community health and my sense of professional confidence and fulfillment speak to the value of this program...and the role it could serve in nurse practitioner education and improved access to healthcare. I am a primary care provider and I love it."

—Monica O'Reilly-Jacob, PHD, APRN, FNP-BC, FAAN

The discussion that day led to support from the late Senator Daniel Inouye and Senator Christopher Dodd, and inclusion of Section 5316, *An Act Authorizing Nurse Practitioner Training Programs* in the final version of the Affordable Care Act, 42 U.S.C. § 296j-1 (2010), which authorized a three year funding program establishing NP training programs in HCs and Nurse Managed Health Centers. Although never appropriated, Section 5316 stands as the first congressional legislative support for postgraduate nurse practitioner training programs.

Growth and Spread of the Model

With the proof of concept established, CHCI continued its focus on its own program development along with national replication and spread. From the very beginning, CHCI's intent had been to build a model for the country and the health center movement. Even as we have tripled the size of the CHCI program, increasing the number of family NP Residents per year and expanding to include pediatric and PMHNPs, we were strategizing about a model of scalability beyond CHCI.

We found our inspiration for that scalability in the work of the Lutheran Medical Center, now NYU Langone Health, and their national dental residency program. The team at NYU Langone had also looked at the issue of clinical preparation for dentists in the safety net setting and opportunities to train new dentists in this setting. Like NPs, there was no requirement for postgraduate residency training for dentists. However, unlike NPs, GME provides funding for dentists. The brilliance of the Lutheran model is that they could centralize and remotely support the service delivery and training sites with the expert training support and infrastructure.

In 2018, more than a decade after CHCI launched its initial program, HRSA, through its Bureau of Health Workforce (BHW), released a notice of funding opportunity under Title VII inviting proposals to plan and implement Postgraduate NP Residency Training Programs. The structure and function of these programs were closely aligned with the legislative language of the Patient Protection and Affordable Care Act (PPACA) of 2009, which authorized funding for NP residency programs, and expanded on the original model by calling for the development of academic partnerships. HRSA awarded 20 grants under the Advanced Nursing Education Nurse Practitioner Residency (ANE-NPR) Program to establish or expand existing programs, and required that the successful applicants would be accredited or in the process of accreditation (HRSA, n.d.). This funding fueled further growth and depth of the movement. The Title VII funding was notable in many ways, including that HRSA designated PMHNPs as a primary care specialty eligible for funding under the

ANE-NPR program. This has been extremely successful in supporting health centers who launched NP residency programs focused on adult, family, pediatric, or women's health postgraduate residency programs to add PMHNPs programs as well; some grantees have exclusively pursued PMHNPs programs and made significant contributions to their organization's pipeline for critically needed PMHNPs.

At the same time, the U.S. Department of Veteran Affairs (VA), has done exceptional work in building a national program of Postgraduate NP Residents in primary care and PMHNPs along with contributing substantially to the research concerning postgraduate training. Through the Office of Academic Affiliations (OAA), the VA offers four nurse residency programs throughout the U.S.: Geriatrics and Extended Care, Mental Health, Primary Care Nurse Practitioner, and Post-Baccalaureate Registered Nurse. Additionally, in 2025, the VA launched Postgraduate PA Residency Programs in primary care and psychiatry/mental health. To learn more, please visit: <https://department.va.gov/academic-affiliations/nursing-education/>.

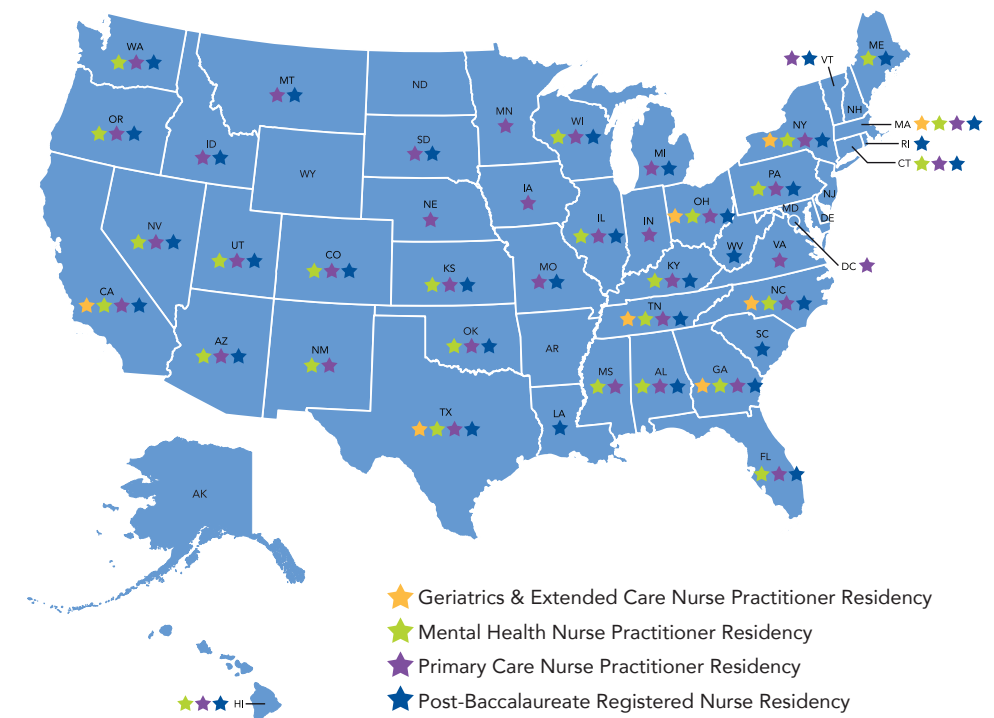


Figure 1.2: U.S. Department of Veteran Affairs (VA) Residency Programs.
Retrieved from <https://department.va.gov/academic-affiliations/nursing-education/>

Across the U.S., we have seen a steady march forward of this movement. Our initial vision of building a replicable model that could make a major contribution to the future of health and healthcare in this country, particularly in primary care, is being realized. Growth has accelerated nationally, with new NP and PA postgraduate training programs established in specialties, such as psychiatry, emergency medicine, critical care, oncology, and surgery. Hospitals, health systems, and academic medical centers have begun to integrate APP postgraduate programs into workforce pipelines. This national growth can be explored here: <https://www.app-postgradtraining.com/postgraduate-training/>.

We are inspired now both by the incredible new APPs choosing to undertake postgraduate NP residency programs, but also by the career trajectories of the alums of these programs—first and foremost in practice, particularly in safety net settings, but also in education, research, policy—and as program directors of postgraduate training programs across the country. We have continued to answer the question: **Who wants to be a primary care provider and how can we support them?** With a fact, no longer an opinion: **APPs do, and postgraduate residency training programs, particularly in HCs, are a key strategy to support them.**



Community Health Center, Inc.'s 2016–2017 Postgraduate Nurse Practitioner Residency Class.

Primary Care Postgraduate NP Training Programs

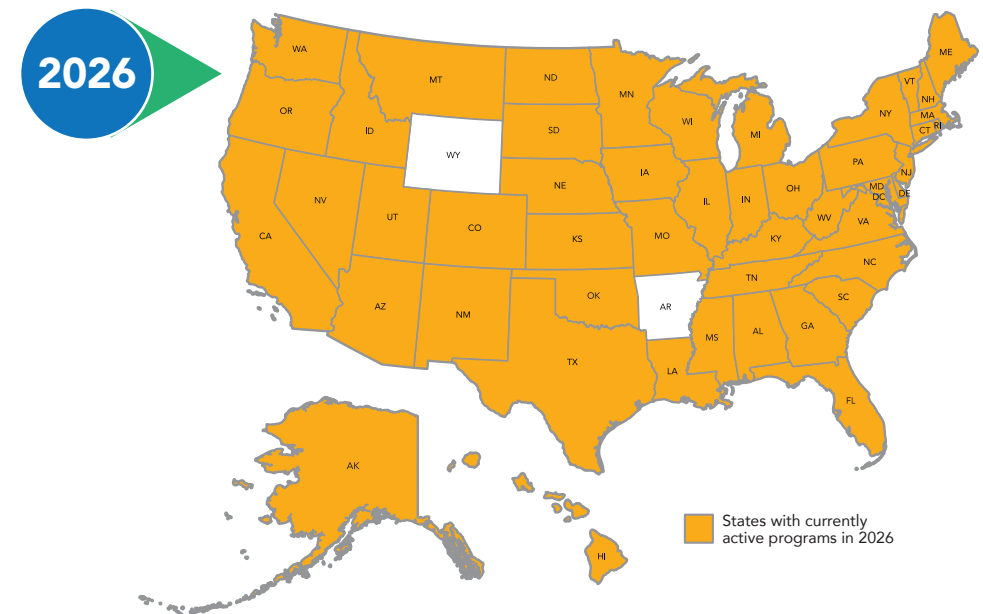
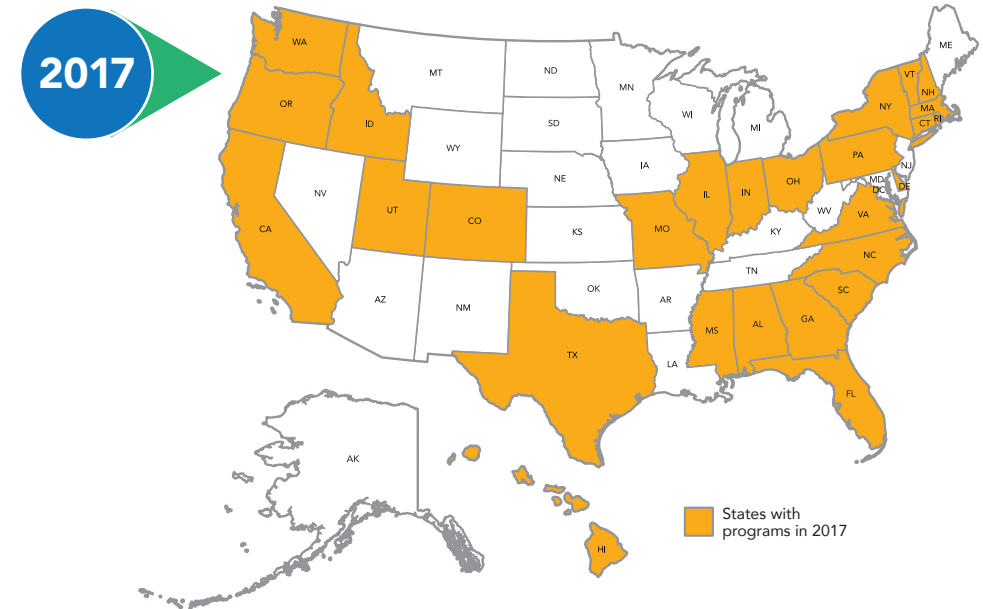


Figure 1.3: Consortium Maps—2017 vs 2026

To explore more, visit: https://www.apppostgradtraining.com/wp-content/uploads/2026/07/CAPP_NPPCProgSheet_withVAwithLC_R0726_R2.pdf

Box 1.1: Recent Literature

Below is a comprehensive collection of recent resources and research to support the ongoing education and professional development of our community. To explore more resources, please visit the repository regularly updated by the Consortium for Advanced Practice Providers (CAPP): <https://www.apppostgradtraining.com/resources/research-and-publications/>

Angers M, Mishra M, Schiessl A, et al. [Evaluation of a Learning Collaborative to Implement Postgraduate Nurse Practitioner \(NP\) and/or Physician Associate \(PA\) Residency or Fellowship Programs in a Community Health Center](#). *Journal of Primary Care & Community Health*. 2025;16.

Barnes H, Faraz Covelli A, Rubright J. [Development of the Novice Nurse Practitioner Role Transition Scale: An Exploratory Factor Analysis](#). *Journal of the American Association of Nurse Practitioners*. March 2020.

Crogan J, Smith R, Moore E. [Development and Accreditation of an Advanced Practice Provider Fellowship at an Acute Care Pediatric Hospital](#). *Science Direct*. 2024;20(3).

Kidd VD, Horstmann JL, Felder S, Bamrick K. [An Analysis of Trainee Salaries Offered in Nurse Practitioner and Physician Assistant/Associate Postgraduate Residency and Fellowship Programs in the United States](#). *Cureus*. 2024 Jul 12;16(7):e64434. doi: 10.7759/cureus.64434. PMID: 39007022; PMCID: PMC11245340.

Kidd VD, Horstmann JL, Felder S, et al. [National Survey on Support for Nurse Practitioner and Physician Assistant/Associate Postgraduate Fellowship/Residency Programs and Director Compensation](#). *Cureus*. April 09, 2024; 16(4): e57919. doi:10.7759/cureus.57919.

Kidd VD, Hooker RS. [Postgraduate Programs in Orthopaedic Surgery for Physician Assistants and Nurse Practitioners](#). 2021.

Kidd VD, Spisak JM, Vanderlinden S. [An Analysis of the Selection Criteria for Postgraduate Physician Assistant Residency and Fellowship Programs in the United States](#). 2021.

Kidd VD, Spisak JM, Vanderlinden S, Kayingo G. [A Survey of Implicit Bias Training in Physician Assistant and Nurse Practitioner Postgraduate Fellowship/Residency Programs](#). 2022.

Kidd VD. [Exploring Motivations and Barriers to Accreditation Adoption Among Physician Assistant and Nurse Practitioner Emergency Medicine and Orthopedic Surgery Residency and Fellowship Programs](#). *Cureus*. March 21, 2023; 15(3). doi:10.7759/cureus.36490.

Kidd VD. [Optimal Use of Advanced Practice Providers at an Academic Medical Center: A First-Year Retrospective Review](#). 2023.

Kidd VD, Vanderlinden S, Hooker R. [A National Survey of postgraduate physician assistant fellowship and residency programs](#). 2021.

Morris A, Bosque E. [Do We Nurture Our Young? Qualitative Conceptual Analysis of Worst and Best Mentorship Experiences Among Neonatal Advanced Practice Providers](#). 2021.

Morris A, Smith R, Fitzgerald S, Bosque E. [Growing Neonatal Advanced Practice Providers via Mentorship Can Fill the Need](#). 2021.

O'Reilly-Jacob M, Chapman J, Subbiah SV, Perloff J. [Estimating the Primary Care Workforce for Medicare Beneficiaries Using an Activity-Based Approach](#). *J Gen Intern Med*. April 20, 2023. doi:10.1007/s11606-023-08206-3.

Park J, Faraz Covelli A, Pittman P. [Effects of Completing a Postgraduate Residency or Fellowship Program on Primary Care Nurse Practitioners' Transition to Practice](#). *Journal of the American Association of Nurse Practitioners*. 2021. DOI# 10.1097/JXX.0000000000000563.

Smith M, Bosque E. [Neonatal Care Provider Tasks for Hospitalized Well Newborns](#). *Adv Neonatal Care*. 2022 Dec 1;22(6):523-530.

Smith M, Bosque E. [Neonatal Care Provider Tasks in the NICU and Delivery Room](#). *Adv Neonatal Care*. 2022 Jun 1;22(3):215-222.

Stangl J. [The Ultimate Guide to Physician Assistant & Nurse Practitioner Residency & Fellowship Programs: Get Accepted and Succeed in Your Dream Program](#). September 2022.

Torrens C, Campbell P, Hoskins G, Strachan H, Wells M, Cunningham M, Bottone H, Polson R, Maxwell M. [Barriers and Facilitators to the Implementation of the Advanced Nurse Practitioner Role in Primary Care Settings: A Scoping Review](#). *International Journal of Nursing Studies*. 2020;104:103443.

Penobscot Community Health Care (PCHC) Nurse Practitioner Residency Program (Bangor, Maine)



Penobscot Community Health Care (PCHC) established one of the first Nurse Practitioner (NP) Residency Programs in the United States in 2011 with support from a three-year Health Resources and Services Administration (HRSA) grant. The program was paused in 2014 after the initial 1:1 provider-to-preceptor and single practice/site model proved unsustainable due to the intensive level of direct oversight required from preceptors and impact to the designated practice's overall sustainability. This pause created a significant gap in PCHC's workforce pipeline for preparing advanced practice providers to transition from education to independent clinical practice.

Following a comprehensive review of the initial program and identification of factors contributing to its unsustainability, the residency was re-established in 2019 with support for program development and implementation from a new, four-year HRSA grant. Through continuous evaluation and feedback from Residents and clinical sites' providers and leadership, the program underwent further enhancement in 2024 in preparation for initial accreditation through the Consortium for Advanced Practice Providers (CAPP).

The accreditation self-study process, combined with program history and comprehensive data analysis, guided the development and re-emergence of PCHC's current residency model. In July of 2025, PCHC's revitalized Nurse Practitioner (NP) Residency Program earned initial accreditation from CAPP.

Key elements of the current model include:

- **Dedicated leadership:** An experienced, practicing NP Residency Clinical Director with allocated administrative time to support Residents, preceptors, and program decision-making.
- **Embedded preceptorship with multiple practice locations:** Preceptors are based at the Resident's assigned primary care site and serve as both clinical and organizational resources. Preceptors maintain reduced patient schedules and have protected precepting time to promote intentional mentorship and collaboration.
- **Comprehensive support network:** An embedded program structure ensures collegial support beyond preceptors, including co-Resident peer collaboration, medical assistant partnership, and access to a multidisciplinary team of mental health professionals, primary care registered nurses (RNs), and clinical pharmacists.
- **Gradual ramp-up:** Residents maintain a reduced patient panel with a structured 12-month ramp and dedicated administrative time to support professional growth and prevent burnout.
- **Shared organizational resources:** The program leverages system-wide operations, administrative, and human resources support to sustain program efficiency and alignment with PCHC's mission.
- **Specialty rotations:** One of the defining strengths of our NP Residency Program is the inclusion of specialty rotations that provide focused, hands-on experience under the guidance of expert site mentors, preparing residents to deliver high-quality primary care in rural and underserved communities. A favorite among residents is the rural health immersion experience, a week-long rotation at our 24/7 community health center in Jackman, Maine (on the Maine–Québec border) that integrates rural primary care and emergency medicine. During this rotation, residents gain firsthand experience stabilizing patients who require transport—often over an hour by ground or via airlift—to the nearest hospital for advanced care.

PCHC recognizes that advanced practice providers play a vital role in sustaining the healthcare system and closing gaps in access to high-quality care, particularly in rural and underserved communities. PCHC's NP Residency Program serves as both a recruitment pipeline and a bridge to support new providers in successfully transitioning into practice within a safety-net environment.

—Amanda Willette, M.S.Ed, PCHC Director of Education;
Samara Shiromani, FNP-C, PCHC Nurse Practitioner Residency Clinical Director;
PCHC (Bangor, Maine)

Conclusion

With nearly two decades of data and experience, the value of postgraduate NP residency and fellowship is clear, but we now speak more inclusively of “APP postgraduate training” to embrace joint NP-PA programs, as well as NP-only programs. The goal of securing a sustainable, legislatively mandated funding stream remains a central focus of the movement towards postgraduate NP-PA training.

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Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010)



Nicole Seagriff, now Vice President of the Community Health Center Inc.’s (CHCI) Western Region, examines a young patient as a new nurse practitioner resident in CHCI’s 2011-2012 cohort.

Procedural training and sufficient practice with procedures such as suturing, joint injections, and skin biopsies are highly valued by advanced practice providers.



CHAPTER 2

What Does it Mean to Train to a High-Performance Model of Care?

The original drivers in creating Community Health Center, Inc.'s (CHCI) Postgraduate Nurse Practitioner (NP) Residency Program were almost entirely focused on training new NPs to the clinical complexity of patients cared for in the nation's community health centers. We did not initially appreciate how much new NPs would benefit from additional intensive training to the model of care in practice. Postgraduate training provides an opportunity to **train to a high-performance model of care** that is satisfying to patients and providers alike; one that addresses and removes systemic barriers to providing excellent care to complex patients, leads to quality outcomes, and arms the next generation with the tools and skills available to us from the science of quality improvement. In this way, we will continually improve the practice environment.



What is a high-performance model of care? Dr. Karen Davis is Professor Emerita at Johns Hopkins University, former head of the Commonwealth Fund and served as a federal health economist in the early days of the health center movement. She has focused on identifying and studying high-performance health systems. In a study published in 2005, she identified seven attributes of high-performance, patient-driven primary care that is likely to yield cost and quality outcomes that are valued by patients, providers, and policy makers (Davis, 2005). These include:

- Superb access to care;
- Patient engagement in care;
- Clinical information systems;
- Care coordination;
- Integrated, comprehensive care;
- Ongoing, routine patient feedback; and
- Publicly available information about practices.

In 2026, with another two decades of innovation, research, and policy changes behind us in the United States (U.S.), these attributes of primary care practice are expanded to include:

- **Team-based care in which patients are empaneled with a primary care provider (PCP) and team of individuals with clearly defined roles, skills, and training; and are armed with the data that allow each team member to make their fullest contribution;**
- **Fully integrated behavioral health and primary care, characterized by physical co-location, integrated clinical data, coordination of care, access by “warm hand-offs” for initial contact, a program of both individual and group therapy, co-led medical/behavioral groups to enhance chronic illness care, and access to psychiatric specialty care as needed;**
- **Complex/intensive care management that expands services to the individual and their family during periods of great need, such as transitions in care or at times when healthcare needs are exacerbated or conditions poorly controlled, often working in collaboration with a circle of care involving others in the community to address health-related and clinical needs;**
- **Consultation and collaboration with specialists, through either traditional referral mechanisms or, increasingly, through electronic, asynchronous consults through “eConsults”;**
- **Ongoing training and mastery of new knowledge and skills by primary care teams through strategies, such as Project ECHO® (n.d.) and training and technical assistance developed by the Health Resources and Services Administration (HRSA)-funded National Training and Technical Assistance Partners (NTTAP) on Clinical Workforce Development at CHCI;**
- **Quality improvement support and training for real-time, ongoing process improvement, redesign, and management of change in primary care; and**
- **Opportunity for engagement in one or more elements of education, training, research, innovation, or quality improvement by every member of the team.**
- **Finally, the continued transition to both value-based payment and value-based care is part of the reality of primary care today in the U.S. (Werner, et al., 2021; Horstman & Lewis, 2026).**

The work of defining what we mean by “Team-Based Care” has evolved over a 25 year period, led in large part by the seminal work of Dr. Ed Wagner, the team at the MacColl Center for Health Care Innovation (now the ACT Center), and the national Learning from Effective Ambulatory Practices (LEAP) project (Wagner et al., 2017).

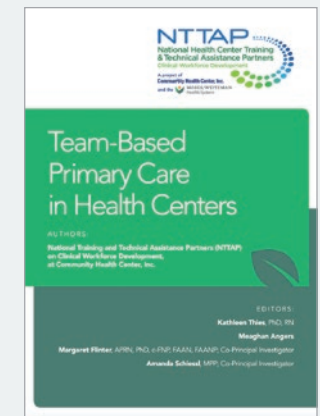


The LEAP project was funded by the RWJF between 2012 and 2017, which significantly added to the body of knowledge of effective team-based care in primary care. This decade’s long work culminated in the National Academies of Sciences, Engineering, and Medicine (NASEM) report, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*, which defined and called for organizing, implementing, and paying for team-based care as a core strategy of primary care in the U.S. (NASEM, 2021).

Additional tools and resources can found at <https://www.improvingprimarycare.org/team>.

Box 2.1: Free Training and Technical Assistance on Team-Based Care

From 2015 through 2026, CHCI served as the Health Resources and Services Administration (HRSA)-funded National Training and Technical Assistance Partners (NTTAP) on Clinical Workforce Development. Through this cooperative agreement, CHCI provided free training and technical assistance to Health Centers (HCs) across the country. A key focus area of the NTTAP on Clinical Workforce Development was team-based care. CHCI developed dozens of webinars on developing and supporting high-performing primary care teams. In 2024, CHCI published [*Team-Based Primary Care in Health Centers*](#), a book highlighting strategies, tools, and lessons learned to develop effective team-based care. To explore free team-based care resources developed by the NTTAP on Clinical Workforce Development, visit <https://www.weitzmaninstitute.org/ncaresources/>.



Elements of a High Performance Model of Care

The following is a brief overview of each element of the model as listed above with additional focus on emerging changes to specific roles. We will describe the roles of team members practicing in a high-performance model of care, and strategies to provide postgraduate trainees, as well as students and trainees of all the health

professions, an opportunity to learn, model, and train in a high-performance model of primary care appropriate to the challenge and complexity of the patient population.

Team-Based Care



What is team-based care? The NASEM report, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*, cites a commonly used definition: “the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care” (NASEM, 2021 p. 182). Many primary care practices consider themselves to be working in teams because they have a staff of medical assistants, nurses, and non-clinical staff working for a primary care provider (PCP), but that is not the whole picture. The structure of an interprofessional primary care team includes core and extended teams with links to community-based health teams to optimize the health of the patient. The composition of the core and extended team will vary by practice. In most primary care practices, the core team consists of the PCP, registered nurse (RN), medical assistant (MA), and front desk staff that work together on a panel of patients. Meanwhile, the extended team includes clinicians and staff who work with multiple teams, including the behavioral health specialist, pharmacist, social worker, dentist, community health worker, care manager, dietitian, and more (NASEM, 2021). For a visual of core and extended teams, see [Figure 2.1](#).

In the NASEM report, the implementation plan includes five objectives to make high-quality primary care available for everyone in the U.S:

1. Pay for primary care teams to care for people, not doctors to deliver services.
2. Ensure that high-quality primary care is available to every individual and family in every community.
3. Train primary care teams where people live and work
4. Design information technology that serves the patient, family, and inter-professional care team.
5. Ensure that high-quality primary care is implemented in the United States.

(NASEM, 2021, p.2)

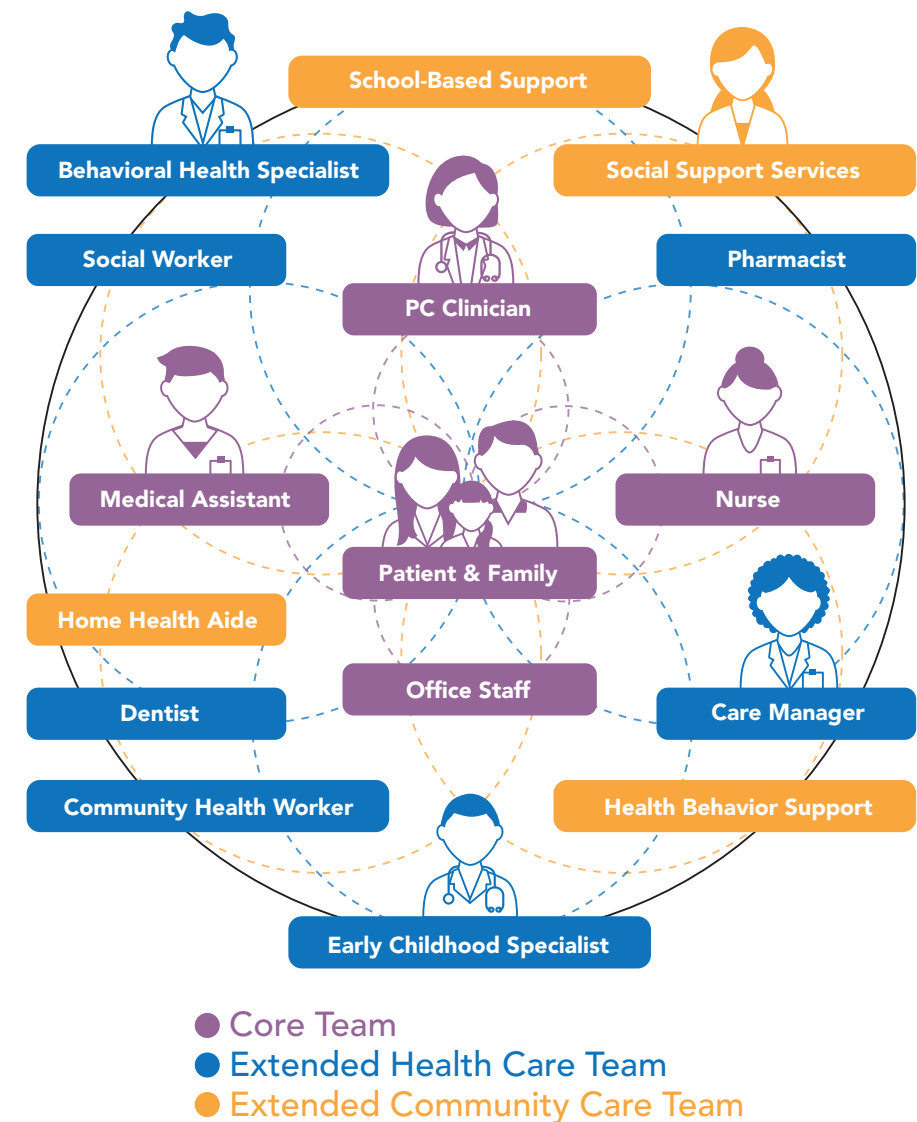


Figure 2.1. Interprofessional Care Teams National Academies of Sciences, Engineering, and Medicine (NASEM, 2021a)



For a comprehensive overview of team-based care, please visit our book, [Team-Based Primary Care in Health Centers](#) (2024).

Practice in the very busy and demanding setting of a Health Center (HC) calls for explicit training in the expectations, communications, workflow, and mutual support that underlies a highly effective team. Therefore, the advanced practice providers

(APP) postgraduate training program should allow time for postgraduate trainees to shadow the medical assistant (MA), the registered nurse (RN), and front desk reception staff, as well as to review policies, protocols, and procedures for their work, and a discussion of the scope of practice and legal authority for both MAs and RNs in their state. If the practice utilizes clinical dashboards or “huddles” to plan the day, provide an opportunity for the postgraduate trainees to see the perspective of team members beyond only the PCPs. Different practices will be at different levels in the advancement of the MA role and the transforming role of the RN in primary care. It is critical to understand these roles, and to work together in partnership for the success of the team and the care of the patient (Bodenheimer, Ghorob, Willard-Grace, & Grumbach, 2014a; Flinter, Hsu, Crompton, Ladden, & Wagner, 2017).

The Role of the Registered Nurse (RN)

It has become increasingly clear that RNs play an important role in high-performing primary care teams. While traditional RN responsibilities, such as telephone and in-person triage, immunizations, and other routine clinical tasks, remain important, these functions alone do not fully leverage RNs’ clinical expertise and may contribute to burnout (Bodenheimer et al., 2015). Team-based primary care models emphasize a broader, more proactive RN role focused on meeting patient needs that PCPs often lack time to address. Best practices for optimizing the role of the RN include:

- Standing Orders;
- Delegated Order Sets;
- Care Coordination and Chronic Care Management;
- Value-Based Care;
- Community Health.

In this expanded role, RNs can support community health management, chronic disease self-management, preventive care, and care transitions, which enhances both access and continuity of care. By fully integrating RNs into these functions, it can strengthen team performance, improve patient outcomes, and allow PCPs to practice at the top of their training.



Additional details regarding the role of the RN within team-based primary care can be found in Chapter 7 of [Team-Based Primary Care in Health Centers](#) (2024).

The Role of the Medical Assistant (MA)

Across the country, MAs are advancing their knowledge, skills, and contributions to primary care. Inspired by the work of Dr. Tom Bodenheimer and colleagues, MAs in some high performing practices are now well-versed in motivational interviewing and the use of clinical dashboards to support adherence to standards for routine prevention, health promotion, and chronic illness monitoring (Bodenheimer, Willard-Grace, & Ghorub, 2014b). In 2017, two health centers, CHCI and Salud Health Center in Colorado, joined efforts to create a national MA training program. The National Institute for Medical Assistant Advancement (NIMAA) (<https://nimaa.edu/>) uses an innovative model that integrates online didactic education with hands-on clinical training in high-performance health centers, preparing new MAs to participate at an advanced level in team-based care. This eight-month program pushes the boundaries of what the MA is capable of and directly parallels ongoing efforts to elevate PCPs through postgraduate training. As such, the relationship between learners in these programs has the potential to transform the primary care landscape and, ultimately, improve outcomes for the patients we serve.



Additional details regarding the role of the MA within team-based primary care can be found in Chapter 8 of [Team-Based Primary Care in Health Centers](#) (2024).

The Role of Integrated Behavioral Health

Health centers are leaders in the implementation of integrated behavioral health and primary care. The core team has expanded to include a master’s or doctoral level behavioral health clinician. Ideally, the behavioral health clinician is there to accept immediate “warm hand-offs” (WHOs) from the PCP, but also to “in-reach” into the panel(s), looking to identify individuals with characteristics that suggest behavioral health intervention might be desired and beneficial. Additionally, since the advent of telehealth services, behavioral health team members across an agency (even those in a multi-site practice) can provide “electronic WHOs (eWHOs)” where an internal message within the electronic health record (EHR) goes to a bin shared by team members to reach out to patients to introduce them to services and help schedule them for an intake (if appropriate), particularly if the connection to behavioral health is not urgent or emergent. Once the patient has established care into the behavioral health team through an intake, the therapist then provides follow-up individually, as well as through group care (where applicable) to patients. Postgraduate trainees learning in a practice that has adapted to this model recognizes the vital role of the behavioral health provider both in the care of the patient and in supporting the work of the entire team.

Integrated Behavioral Health Pilot at Community Health Center, Inc. (CHCI)

In the standard outpatient workflow at CHCI, patients must first complete a behavioral health intake with a therapist before obtaining an intake with psychiatry for medication management—a process that, depending on site volume, can involve wait times of two to six weeks for the initial visit, followed by additional time for a psychiatric appointment. This “sequential” model often leaves Primary Care Providers (PCPs) in a difficult clinical position to manage complex psychotropic regimens—such as those following a hospital discharge—or in finding clarity in a patient’s diagnosis or determining the appropriate medication (perhaps less frequently encountered in primary care) on which to initiate them prior to being transferred to psychiatry.

To mitigate this, CHCI developed a psychiatric consultancy pilot created and led by the Chief Psychiatry Officer and a veteran Psychiatric Mental Health Nurse Practitioner (PMHNP).

This model bypasses traditional administrative bottlenecks, allowing PCPs to receive expert medication guidance or diagnostic consultation within one to two weeks. Feedback is delivered via a streamlined internal message within the Electronic Health Record (EHR), providing the PCP with immediate actionable steps while the patient awaits their formal intake.

By integrating PMHNP residents into this service, postgraduate trainees gain first-hand experience in a robust, integrated structure, learning to navigate the nuances of both the referring and consulting ends of the clinical spectrum.

—Garrett Matlick, DNP, MPH, APRN, FNP-BC, PMHNP-BC,
CHCI (Stamford, Connecticut)

The APP postgraduate training program should include an explicit review of the role, protocols, and scope of the behavioral health provider in the practice. This should include training on the use of WHO, the flow of communication among team members, crisis management, and how to access psychiatrists and/or Psychiatric/Mental Health Nurse Practitioners (PMHNPs) (directly or via telehealth options) for diagnostic support, psychiatric emergencies, and support in managing psychotropic medications as needed. Increasingly, substance use treatment, particularly for opioid

use disorder, is also part of this integration. Assessing the level of the postgraduate trainees’ experience and comfort with medication for opioid use disorder (MOUD) is critical to prepare them for clinical interactions. It is important for the postgraduate trainee not just to understand prescribing and monitoring of these medications but, more importantly, to understand the greater context of substance use within their clinic’s specific patient population.

The team-based care model with behavioral health integration is enhanced by formal case review and discussion, such as in integrated care team meetings, or through regular sharing of updated information. The behavioral health provider(s) can provide invaluable support through these means of communication which amplify and augment medical treatment. They can also provide patients with the robust education, support, and counseling that is challenging for medical providers to deliver in the primary care visit. We strongly encourage that you take advantage of any opportunity for the postgraduate trainee to co-lead or participate in a group with a behavioral health clinician.

Additional details regarding the role of the integrated behavioral health within team-based primary care can be found in Chapter 10 of [Team-Based Primary Care in Health Centers](#) (2024).



Dr. Tichiana Armah (right), Chief Psychiatry Officer, meets with Community Health Center, Inc. and Weitzman Institute staff.

Other Team Members

Beyond the core team members, today's health centers may include a pharmacist, chiropractor, physical therapist, dietitian/nutritionist, diabetes educator, podiatrist, community health worker (CHW), scribe, and more as practices respond to the needs of their patients and local environment. In addition, larger health centers may have on-site specialists to address particularly high-volume specialty needs.



Additional details on the pharmacist's role are provided in Chapter 12, and on the CHW's role in team-based primary care in Chapter 13 of [Team-Based Primary Care in Health Centers](#) (2024).

Training to a Health-Performing Model of Care

At AltaMed Health Services, we view every resident and fellow as an extension of our mission to eliminate poor health outcomes by developing clinicians who deliver empathetic, competent, compassionate, and responsive care. Training within a Health Center (HC) allows learners to train and practice the full scope of their specialty, which is essential in today's environment of limited access to specialists and hospital services. Too often, underserved communities struggle to find providers willing or able to accept lower reimbursement or dedicate the time required to care for those with complex needs.

By training in this setting, our residents learn how to think comprehensively and act with purpose. They gain hands-on experience managing the full continuum of care and are introduced to the principles of value-based care. They ultimately understand how quality, outcomes, and cost are interconnected in improving community health. And how we best use limited resources that are becoming scarcer.

***As Chief Medical Officer (CMO),
I've seen how these programs produce clinicians
who are not only technically excellent but also mission driven.
Investing in workforce development
ensures a sustainable pipeline of providers ready to serve
and lead in the communities that need them most.***

—Cristian Rico, MD, Chief Medical Officer, Senior Vice President,
AltaMed Health Services Corporation (Commerce, California)

Consultation and Referral to Specialist Care

For clinicians new to practice in health centers, it can be a shock to realize how challenging accessing specialty care can be for their patient population based on geography, insurance type, and specialist availability. Although on-site specialist care is not a required service that HCs must provide, all PCPs refer to specialists and have a process for referrals in place. The orientation for the postgraduate trainee should include discussing the availability of specialist care, including by asynchronous eConsults if available, the processes of accessing specialist care, and the bi-directional communication pathway to coordinate that care and follow-up. We encourage, whenever possible, that the APP postgraduate training program seek opportunities to directly connect the postgraduate trainee at the start of the program with community specialists who are either formally or informally the principal specialists serving the practice.

Box 2.2: eConsults

eConsults, or "eReferrals" was originally conceived by Dr. Mitch Katz and colleagues at San Francisco General Hospital and Trauma Center, which is part of the San Francisco County Health Department. This model allowed primary care providers (PCPs) to electronically submit the consult question, along with pertinent data (e.g. recent labs, diagnostic images, and history to a designated specialist for consultation and advice) (Sheridan & Howard, 2013). The asynchronous nature of the eConsult, in which the PCP submits the consult question and relevant data, and the receiving specialist reviews and returns within a mutually agreed upon time period, maximizes flexibility and convenience on the part of both primary care and specialty providers; it also further advances the knowledge of the PCP, allowing them to manage similar instances in the future.

A growing body of evidence demonstrates that using eConsults to provide guidance on clinical care enhances access, improves quality of care, reduces wait times, and reduces costs. Patients benefit by getting rapid access to specialty care they need and might otherwise not be able to obtain, especially those in rural communities (Bifulco, et al., 2023; Anderson, et al., 2022). This model is scalable and replicable, and use of this innovation is spreading. Postgraduate trainees in organizations with access to eConsults should receive training by clinical leadership on when and how to request or create an eConsult, the framing of the consult question, and the protocols for informing the patient of the request, as well as the results.

Ongoing Training to Address New and Emerging High Complexity Challenges

Today's practicing PCPs, including postgraduate trainees, have access to an innovation that collectively advances our ability to secure timely consultation from a team of specialists in a high complexity area, while advancing our knowledge and mastery in caring for patients with complex conditions. At the same time, PCPs become part of a community, learning from other primary care practices. Project ECHO® (n.d.) brings together multiple PCPs with a team of multi-disciplinary specialists with expertise in a particular clinical area.

The creator of the Project ECHO® model, Dr. Sanjeev Arora at the University of New Mexico, defines it as such: "Project ECHO® is a lifelong learning and guided practice model that revolutionizes medical education and exponentially increases workforce capacity to provide best-practice specialty care and improve health outcomes. The heart of the ECHO® model is its hub-and-spoke knowledge-sharing networks, led by expert teams who use multi-point videoconferencing to conduct virtual clinics with community providers. In this way, primary care doctors, nurses, and other clinicians learn to provide excellent specialty care to patients in their own communities" (Arora et al., 2011). Project ECHO® is further discussed in [Chapter 4](#) as part of the program structure and design.



Project ECHO faculty lead a Registered Nurse (RN) Complex Care Management session.

Training to a High-Performing Model of Care: Former Postgraduate NP Resident Perspective



Sarah Knoeckel, DNP, FNP-BC, as a family nurse practitioner resident at Community Health Center, Inc. from 2009-2010.

I participated in the Community Health Center, Inc. (CHCI) Family Nurse Practitioner (FNP) Residency from 2009 to 2010, and I truly believe it was the foundation of my successful career as both a healthcare provider and nursing educator. The residency greatly enhanced my competence and confidence.

As a new FNP graduate, I initially felt insecure about managing complex health problems, but the supervised training and additional education provided by the residency helped me grow into a capable and confident provider.

The program also introduced me to a mentorship-based model of education, which I have come to view as essential for developing nurse practitioners into highly skilled providers. Since completing the residency, my husband and I have relocated several times due to his military service, allowing me to practice in three different states and hold four primary care positions. While Health Center (HC) opportunities were not always available, I consistently sought roles serving underserved populations.

A few years ago, we returned to Southwest Virginia, where I now work as both an Assistant Professor of Nursing and a provider at a HC. In my clinical role, I collaborate with leadership on quality improvement projects and grant applications. As an educator, I draw on my broad clinical experience caring for complex patients to prepare nursing and FNP students for real-world practice. My areas of expertise include women's health, chronic disease management, preventive care, and the use of eConsults to address limited specialist access in rural healthcare settings.

—Sarah Knoeckel, DNP, FNP-BC (Practicing in Virginia)

The Art and Science of Performance and Quality Improvement (QI)

All health professional students learn throughout their academic preparation and in practice that we must be champions of quality and safety, responsible not just to deliver care, but to improve it. The APP postgraduate training year provides an ideal opportunity to teach and practice the science and tools of quality improvement (QI). A high-performance health system is one in which quality improvement knowledge, skills, and activities are prominent, distributed throughout the practice or organization, and brought to bear on issues of interest and concern to the primary care team and practice. We need our providers to have the skills to participate in data-driven performance improvement in a meaningful way; to lead and guide practice teams in identifying areas in need of improvement and systematically addressing them; and to use the concepts of change management and organizational effectiveness to implement tested and verified improved processes and practices. The APP postgraduate training year provides a superb opportunity to accomplish this.

In CHCI's Postgraduate NP Residency Training Program, a highly interactive QI Seminar meets twice a month as part of the yearlong program. In this QI seminar, teams of NP Residents produce a QI project, applying the science and tools learned over the year to identify, address, and hopefully resolve a problem or improve a process or clinical outcome. If possible, the QI Seminar can be hosted interprofessionally with other trainees at your organization, such as PMHNP Residents as it is done at CHCI. In addition, CHCI's NP Residents attend and participate in a variety of organizational Performance Improvement Committee meetings in order to integrate the residents into CHCI's QI infrastructure. The incorporation of QI is also a requirement for accreditation through the Consortium for Advanced Practice Providers (CAPP) under Standard 2: Curriculum (CAPP, 2025). The incorporation of QI is further discussed in [Chapter 4](#) as part of the program structure and design.

Community Health Center, Inc. Nurse Practitioner (NP) Residents attending a quality improvement training.



Training to a High-Performing Model of Care: Former Postgraduate NP Resident Perspective



Lindsay Marmaras (middle), a proud graduate of the 2018–2019 Community Health Center, Inc. (CHCI) Postgraduate Nurse Practitioner (NP) Residency Program, exemplifies the next generation of NPs trained to deliver compassionate, patient-focused care.

I graduated from Yale School of Nursing in 2018 and I completed my Postgraduate Nurse Practitioner (NP) Residency at Community Health Center, Inc. (CHCI) after that. I didn't know that NP residencies even existed until a few months before I finished my graduate program and Dr. Margaret Flintner came to speak to my class about the community health center movement. When I graduated I felt like my academic preparation was pretty strong and solid, but there were some really easily identifiable holes and weak spots simply because of the breadth of primary care. I was graduating with a license to care for people of all ages, but I had never done a hands-on exam with a newborn and had pretty minimal exposure to women's healthcare. My goals for residency were to fill those gaps and become a primary care provider who felt prepared to give really holistic and high-quality healthcare to all people.

Fast forward almost seven years and I am still working at CHCI and now a preceptor of advanced practice registered nurse (APRN) students and CHCI NP Residents, and also running a clinical simulation program with our residents. I care for people of all ages and walks of life and confidently so. I am a self-proclaimed residency fangirl and encourage my NP students to consider residency as a way to dip your toe into the occasionally turbulent waters of primary care with preceptor support and guidance.

Without additional postgraduate education, primary care, especially in the community health space, can be a daunting and unsustainable job.

With the support of my residency program,

I was able to overcome that hurdle and know that I am prepared to serve my patients for the long haul.

—Lindsay Marmaras, MSN, APRN, FNP-C, Nurse Practitioner, CHCI (Clinton, Connecticut)

Conclusion

Every organization is on a path towards higher performance in service to our patients and communities, and as stewards of federal resources invested in the health center program. Progress has been dramatic over the past decade. As of 2024, 77.61% of HCs have achieved Patient-Centered Medical Home (PCMH) designation (HRSA, 2024). APP postgraduate training in health centers gives us an opportunity to train our next generation of APPs to be generational leaders in advancing a model of high-performance healthcare throughout the country.

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Krishna Kothary, NP, during her residency year at Community Health Center, Inc. from 2012-2013.

Below: Community Health Center, Inc. (CHCI) Nurse Practitioner (NP) Resident hones their suturing skills during a hands-on training session, preparing for real-world patient care.



Above left: Joan Christenson Legay leads a didactic session for CHCI and other NP Residency Programs across the country. Right: Erie Family Health Centers APRN Fellows during their continuity clinic.

CHAPTER 3

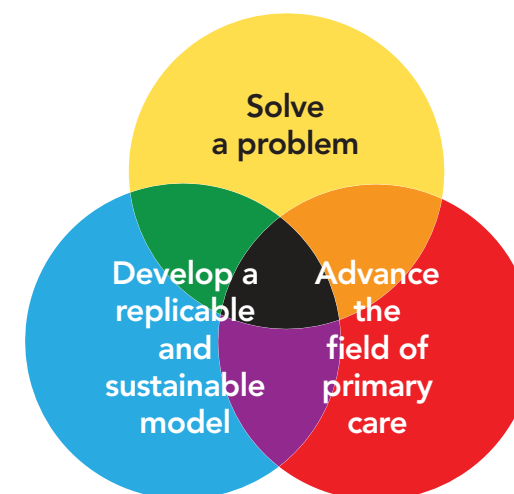
Building the Case for Starting an Advanced Practice Provider (APP) Postgraduate Training Program

NOTE: In Chapters 1 and 2, our focus often referenced the historical underpinnings of postgraduate training, which started with CHCI's Postgraduate Nurse Practitioner (NP) Residency Program, and thus our language and references are NP Residency specific. In Chapter 3 and throughout the remainder of this book, we transition to the use of advanced practice provider (APP) postgraduate training programs, inclusive of those termed residency and fellowship, to refer to either NP, physician associates/assistants (PAs), or joint NP-PA training programs.

The idea of starting a postgraduate training program for new advanced practice providers (APPs) can feel overwhelming. There are many elements to consider: program administration and structure within your organization, financial impact, program curriculum, staff and faculty, and evaluation of both individual trainees and the program as a whole. But first, you need to ask this critical question: **Why should your organization start an APP Postgraduate Training Program?** If you



don't understand the "why," then you can't get to the "how." In this chapter, we will address the crucial first steps to building your case for starting an APP postgraduate training program: identify your drivers and secure support from your organization's leadership and Board of Directors. We will share our experiences at Community Health Center, Inc. (CHCI) and insights from organizations we've worked with through the Health Resources and Services Administration (HRSA)-funded National Training and Technical Assistance Partners (NTTAP) on Clinical Workforce Development, offering guidance on how to build a strong case for your organization.



Program Drivers

It is important for your organization to identify its drivers for implementing an APP postgraduate training program before pitching the idea to your thought leaders/champions. These drivers will ground you and your program as you move forward with developing your case for why such a program would benefit your organization. Our organization may also take a more expansive view of how postgraduate training for new APPs would benefit the larger community or healthcare in general. The drivers will also inform the structure and content of the program itself, because the program should be designed to address your drivers. In the early planning stages for CHCI, we had three main program drivers: (1) Solve a problem; (2) Develop a sustainable, replicable model of postgraduate training for new nurse practitioners (NPs); and (3) Advance the field of primary care, particularly in safety net settings.

Program Driver #1: Solve a Problem

Our first driver was to solve not just one problem, but two problems that we shared with many of our colleagues in community health centers around the country. First, we wanted to address the shortage of primary care providers (PCPs), as true today as it was two decades ago when we launched our model, at both the national and organizational level. In November 2024, the National Center for Health Workforce Analysis (NCHWA) under HRSA released workforce projections through 2037 with the hopes of understanding how changes in population will affect workforce demands within health centers. Nationally, there is a projected shortage of 87,150 full-time equivalent (FTE) primary care physicians. Conversely, these workforce projections also demonstrate a surplus of nurse practitioners (NPs) and physician associates/assistants (PAs) (HRSA, 2024). However, the over-projected NP and PA workforce could mitigate the projected physician shortage in primary care, but only if these APPs are fully prepared for practice in the challenging setting of health centers. We anticipated that providing new NPs with an additional year of intensive postgraduate training as a PCP, with very in-depth and specific structured support, would support the recruitment and retention of NPs in our health center, and in health centers around the country if the intervention model was successful (Milbank, 2025).

Program Driver #2: Develop a Replicable and Sustainable Program

CHCI's goal from the beginning was to develop not just a program, but a model for others to use and build upon. Having identified the problem, our second driver was to develop a program model that was sustainable for CHCI, but also potentially replicable by other organizations. Our focus on replicability took us in the direction of developing a significant portfolio of materials and making them available to other Health Centers (HCs). We took on the work of informing professional associations, policy leaders, Congress, and other constituencies about the need for and value of postgraduate NP training and our building body of experience gleaned from our program. Whether your organization is interested in tackling this as a national issue, or just addressing your specific organizational goals and needs, is entirely up to you. We have been impressed by the acceleration of development of these programs both in the primary care space and in the specialty space.

CHCI also sought to develop a replicable and sustainable model based on our experience and that of other early program leaders. This led to the formation of the National Nurse Practitioner Residency and Fellowship Training Consortium (NNPRFTC) in 2015. The Board of Directors approved a change in name to Consortium for Advanced Practice Providers (CAPP) in 2023 to reflect the evolution to include joint NP-PA postgraduate training programs, as well as NP and PA standalone programs. CAPP's mission remains focused on strengthening the field through membership, education, advocacy, and accreditation. To learn more about CAPP, visit: www.APPpostgradtraining.com.



Five Founders
Initial Members of
the Consortium

Community Health Center, Inc., Middletown, CT
Family Health Center of Worcester, Worcester, MA
Penobscot Community Health Care, Penobscot, ME
Glide Health Services, San Francisco, CA
Community Health Care, Tacoma, WA

Program Driver #3: Advance the Field of Primary Care

Our third driver was to not only to advance the field of primary care, but to transform it, especially in safety net settings. The transformation of primary care from episodic “sick care” to a more holistic, team-based approach including preventive care, management of chronic illness, and integration of behavioral health has been underway for decades (Bodenheimer, Wagner, and Grumbach 2002a; Bodenheimer, Wagner, and Grumbach 2002b; Bodenheimer and Bauer 2016; Bodenheimer, et al., 2014; Crabtree et al., 2011). We asked: **Can we train the next generation to both a higher level of clinical complexity, but also to practice in a high-performance model of care and health system?** If we embed CHCI NP Residents in pods, where they practice as part of an interdisciplinary/interprofessional team, with access to innovative educational tools and models, as well as actionable data to drive community health and individual health outcomes—might we transform the future of the practice of primary care? At CHCI, we have seen our NP Residents as expert PCPs, but also agents of change and transformation, whether they stay at CHCI or move on to practices across the country.



How to Identify Your Drivers

What are your reasons for starting a postgraduate program?

In dialogue with colleagues across the country, the most frequent program drivers for building an Advanced Practice Provider (APP) Postgraduate Training Program are:

- **Build a workforce to better meet the needs of patients/communities;**
- **Increase access to care;**
- **Reduce attrition, burnout, and distress during the initial postgraduate year;**
- **Improve inter-professional education and practice;**
- **Increase satisfaction and retention of an expert, highly skilled primary care workforce.**

By seeking input on the drivers for your organization to start a postgraduate program, you will lay a foundation for the design and sustained success of your program.

Box 3.1: Program Drivers Example: Umpqua Community Health Center DBA Aviva Health (Roseburg, Oregon)

- 1. Enhance Access to Care in Rural Areas:** By establishing an Advanced Practice Provider (APP) Residency, Aviva Health aims to increase access to healthcare services in underserved rural communities. This program would help meet the growing demand for healthcare providers in the region and improve patient care by expanding the healthcare workforce.
- 2. Support Comprehensive, Patient-Focused Care:** Aviva Health is committed to providing high-quality care to patients. An APP program residency would enhance the organization’s ability to offer diverse healthcare services across specialties like primary care, behavioral health, and women’s health, while allowing APPs to work closely with preceptors.
- 3. Foster Professional Development and Retention:** Aviva Health values professional growth and seeks to cultivate a pipeline of highly skilled APPs. By creating an APP program, the organization aims to provide educational opportunities for new graduates, encouraging long-term retention and strengthening its workforce to deliver consistent, quality care.

Asking the Right Questions

As we discussed in [Chapter 1](#), innovation often starts not with a new idea, but by asking the right questions. This helps you to frame the specific problems you want to solve so that you can develop solutions tailored to those problems. Your answers may be different from those of other organizations; but then, you need to build the right program for you. Your organization can start by asking the following questions:



Who are we and why are we here? Start with your organization’s mission statement. For HCs, the mission will likely include a focus on meeting the needs of the underserved, creating access to primary care, and improving health and healthcare—all consistent with developing a postgraduate training program. Your organization’s mission statement will be the critical foundation for your APP postgraduate training program because achieving your postgraduate training programmatic outcomes will support the mission of your organization.



Who are our patients? Understanding your patient population is a key driver of the curriculum of your APP postgraduate training program. You want to train your APPs to provide the highest standard of care to your patient population(s). Is your organization focused on key populations such as the homeless, migratory and seasonal

agricultural workers (MSAWs), or patients living with HIV? Is it weighted towards pediatrics, adult, or family practice? Review the demographics of your patient population, the most common diagnoses, and the outcomes that you measure. An excellent starting place for HCs is your own organization's annual Uniform Data System (UDS) report where organizations report on their service, utilization, financial, and clinical quality performance measures to HRSA annually. However, in today's primary care practices, community health and quality data may go far beyond the UDS data in providing valuable information.



Do we have the current and future staff that we need? Review your organizational data relative to current workforce needs, recruitment and retention, and your current and projected ability to meet the demand for care. Do you have enough providers to meet the demand? What is your experience with recruiting and retaining providers by provider type? What are the contributors to retention and turnover? Will an APP postgraduate training program provide you with a recruitment pipeline? And equally importantly: Are we prepared to invest precious resources into training individuals who choose to practice elsewhere upon completion of training?



Are our clinical outcomes on track? Contributing factors to strong clinical outcomes include a balance between demand and access, robust quality improvement and community health data, meaningful use of data, well trained staff, strong clinical leadership, and well-defined roles for all team members. An APP postgraduate training program may provide you with an opportunity to train these new providers to the high-performance model of care we outlined in [Chapter 2](#).



What is the strategic value to our organization of having a postgraduate training program for APPs? Consider how adding an APP postgraduate training program complements the strategic plan of your organization. Does it give you a competitive edge in the marketplace? Does it create a career opportunity as faculty for current senior staff? Does it support both recruitment and retention of new providers? Does it provide current clinical staff with opportunities for teaching and mentoring that supports their career satisfaction?

Stakeholders

The interests and commitment of stakeholders will be critical to the success of your NP postgraduate training program. Without them, you cannot move forward. A Stakeholder Analysis ([Figure 3.2](#) on page 63) helps you to assess the groups or individuals that will be affected by the program, and group them according to the impact the program will have on them.

Building the Case for a Postgraduate NP Residency Training Program at DePaul Community Health Services of New Orleans (New Orleans, Louisiana)



DePaul Community Health Services of New Orleans 2025–2026 Cohort.

While I was in nursing school, I met folks from Community Health Center, Inc. (CHCI) who had completed their Postgraduate Nurse Practitioner (NP) Residency Training Program in order to ground their practice in clinical excellence, quality improvement, and patient advocacy. I wanted to be a high-quality primary care clinician in community health, and I wanted longevity in this work. As a new provider, fresh out of my own Family Nurse Practitioner (FNP) residency with CHCI (2016–2017), I was recommended to DePaul Community Health Services of New Orleans (then Daughters of Charity) for its robust quality improvement efforts. Here, I found a small group of committed people making big strides in a place where it is hard for folks to achieve health.

The enthusiasm behind these quality efforts laid the groundwork with our administration to launch another innovative idea, becoming the host for the first Primary Care NP Residency Program in the state of Louisiana.

I knew well the transformative arc made possible in the span of a residency year and I believed that if we train folks in our setting with our providers, we could help new providers see their own potential to deliver excellent care and stay in practice. It turns out that curiosity and enthusiasm are contagious! We are a young program, but our application numbers are growing and more than half of our graduates continue to work as primary care providers at DePaul Community Health Centers in New Orleans!

—Tanya Theriault, MSN, FNP-BC, FNP Residency Program Director,
DePaul Community Health Services of New Orleans (New Orleans, Louisiana)

Begin by Identifying Your Stakeholders

Stakeholders include your Board of Directors, executive leadership team, clinical leadership, and the key operational departments whose support is essential: Human Resources (HR), Information Technology (IT)/Business Intelligence, Finance, Quality/Community Health, as well as the PCPs and other clinical staff who will serve as faculty. It is also critical to engage the front-line staff who work in teams with the postgraduate trainees and will have a profound impact on their experience. Stakeholders may also include your community, such as academic institutions that offer NP and/or PA programs, community partners, and other healthcare or professional organizations. Other stakeholders might include your local, regional, or statewide legislative supporters and foundations.

You will use information from your stakeholder analysis in different ways. It will help build your case for an APP postgraduate training program by identifying the relationship of stakeholders to the program's drivers and the program's mission (Figure 3.1). You will also use this information when you develop your program: stakeholders typically have access to the information and resources that you will need. Finally, this information allows you to develop your communication strategy about the value and advantages of an APP postgraduate training program for your organization that will support your case for developing one. Stakeholders are an invaluable source of support, both internally and externally.

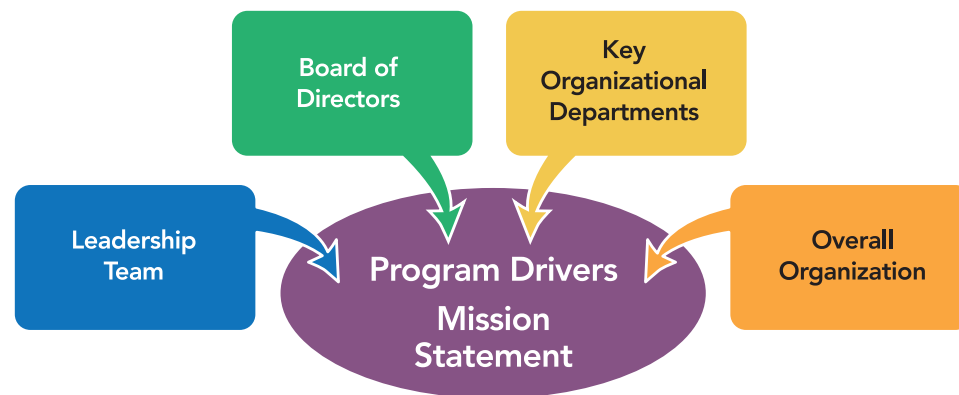


Figure 3.1: Relationship of Stakeholders to Program Drivers and Program Mission

Power and Interest

Once you have made a list of your stakeholders, consider sorting them into spheres of influence to clarify your communication strategy. Figure 3.2 shows a grid with two axes: power and interest. **Power** refers to the influence a stakeholder has in the organization and to what degree that stakeholder can help achieve or hinder the desired change. **Interest** refers to the degree the stakeholder is likely to be impacted by the project, and that stakeholder's level of engagement in and concerns about it.

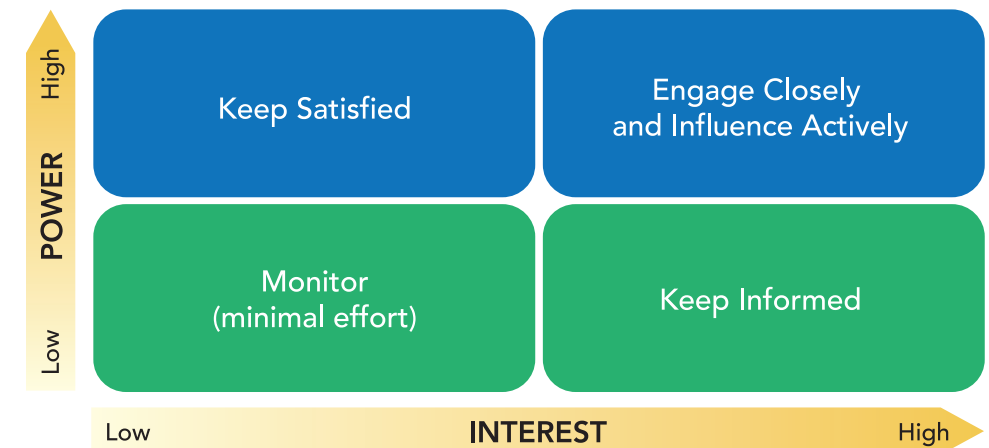


Figure 3.2: Stakeholder Analysis. Adapted from Mendelow's Stakeholder Power-Interest Matrix (1991)

Stakeholders with high power and high interest are your leadership. They need to be fully engaged and actively influenced. Communicate with them early and often. High power, low interest people need to know enough about the program to keep them satisfied. Keep them in the loop, but don't wear out your welcome. Low power, high interest people will want to be adequately informed. They can often be very helpful with the details in which they have expertise. Providers may fall into this category. Low power, low interest people need some monitoring, but do not tax them with excessive communication.

Consider how your stakeholders will react to a proposal for an APP postgraduate training program. What they think they stand to gain or lose will have a powerful bearing on whether you launch the program, as well as how successful it will be.



What motivates your stakeholders? What has been your relationship with them on other projects? Who influences them? Anticipate their questions and how you will answer them. Then develop your communication strategy based on your overall assessment of stakeholders.

Communication Strategy

As George Bernard Shaw stated: “The single biggest problem in communication is the illusion that it has taken place”. An APP postgraduate training program will represent a change in your organization, and will introduce new structures and processes. There will be questions about finances, clinical responsibilities, and administrative resources. In order to have a successful program you will need the support and buy-in at all levels in your organization, top to bottom. Therefore, you need a communication plan that will provide all stakeholders with a common, consistent and clear message about the program that can be linked to your program drivers, your organization’s mission and the mission of the program itself. Think about it this way: **You are not only asking the organization for buy-in: you are asking the organization to build it as well.**

Program Vision and Mission

Before you can secure organizational support, you need to be clear about your vision for and the mission of an APP postgraduate training program. Once you and a small team have identified your program drivers and completed your stakeholder analysis, you should prepare your case for implementing an APP postgraduate training program in writing and/or a formal presentation. This document or presentation should address the problem you are trying to solve, the program drivers for starting a program, and any data to support your proposal. This can also be used for future use, such as a presentation to your leadership and Board of Directors. In addition, you need to establish your mission and vision statements. These will help when you develop your program’s goals. More importantly, they will become the messaging that you will use in securing the support of your organization.



Community Health Center, Inc. celebrated its 2024–2025 cohort of nurse practitioner residents with a graduation luncheon.



Mission statement for the program. The mission statement for the program is what you want it to accomplish for your organization. Therefore, it should align with the mission of your organization. Below are two mission statements developed by participants in the 6-month training led by the HRSA-funded NTTAP on Clinical Workforce Development:

- *“To transform new advanced practice providers to confident and skilled providers in Primary Care. The program will help develop, advance, and educate new APPs to provide evidence-based care and enhance clinical decision-making skills to excel in caring for the needs of our communities.”*

—Blue Ridge Community Health Services, Inc., North Carolina

- *“The mission of the Shasta Community Health Center NP/PA Postgraduate Fellowship in Primary care is to provide the new NP and PA graduate an in-depth and intense primary care training program that safely prepares them for the complexity and challenges of caring for a diverse patient population within the community health care setting. In addition, its mission is to develop within these clinicians the competence and confidence that would result in improvement of individual health care outcomes, as well as the enhancement and furthering of Shasta Community Health Center’s overall organizational mission.”*

—Shasta Community Health Center, California



Vision statement for the program. Your vision statement reflects your ideal future. Perhaps your organization wants to be known for its innovative approach to professional education and training or be the “go to” site for recent graduates of NP and PA education programs. Below are two vision statements developed by participants in the 6-month training led by the HRSA-funded NTTAP on Clinical Workforce Development:

- *“Primary Health Network’s Nurse Practitioner Residency training program envisions future generations of nurse practitioners and clinical leaders at Health Centers who ensure that all patients have access to high quality, evidence-based care.”*

—Primary Health Network, Pennsylvania

- *“Our vision is to grow the next generation of nurse practitioners who are deeply rooted in community health and driven by a shared purpose—to ensure that every person, regardless of income, language, or background, can access high-quality, dignified care. We aim to be a model for workforce development that strengthens both our providers and the communities they serve.”*

—DotHouse Health, Massachusetts

Develop a Communication Plan

For all of your communication you might consider using the guiding principles in **Figure 3.3** to inform your key stakeholders as they are the top three questions most people will have. You will want to communicate a consistent message across the board. However, further conversations and presentations should be adapted for each stakeholder.

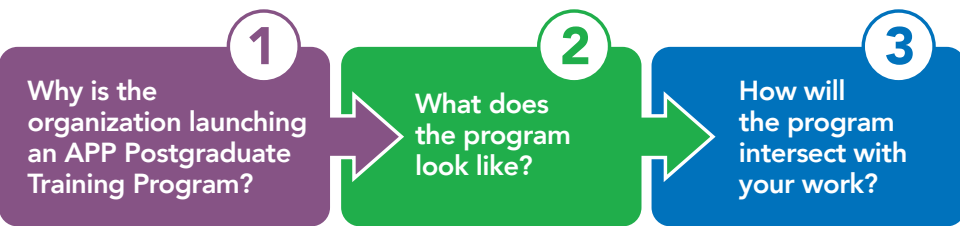


Figure 3.3: Guiding Principles for Communication

Develop a communication plan modeled on **Figure 3.4** for who will deliver what message to which stakeholders and when. Start with your leadership first.



- *What are your objectives in communicating with them about the project?*
- *What are the key messages you want to communicate?*
- *How will it be communicated?*
- *When and how often will you communicate?*

Communication Plan					
Stakeholder	Objectives	Message(s)	Media & Methods	Timing & Frequency	Who/When/Where

Figure 3.4: Stakeholder Communication Plan

What Your Leadership and Board of Directors Want to Know

Start your communication plan by focusing on decision-makers in your organization. If you are not part of your organization’s formal leadership, get their support first. If you are a leader in your organization, be sure to engage other members of the leadership team. Once leaders are on board, work together to plan a presentation to the Board of Directors. If your Board of Directors will need to approve the program, communicate with them early and often so that they understand the APP postgraduate training program, and what it can accomplish for the organization. This is what your leadership and Board of Directors will likely want to know:

Program Drivers and Mission and Vision Statements. Make the case for what an APP postgraduate training program would contribute to the organization. This includes data that support your program’s drivers, such as current number of open positions, number of staff who have expressed a desire to teach, and more.

National Landscape. Explain what the national landscape looks like for APP postgraduate training programs, as well as for postgraduate professional training in other disciplines. This includes the history, growth, and future opportunities. The Consortium for Advanced Practice Providers (CAPP) maintains up to date data on the number and types of APP postgraduate training programs and includes information by state and specialty. To learn more, please visit: www.APPpostgradtraining.com.

Outcomes. Current research demonstrates the impact and effectiveness of existing programs. Success outcomes can include improvements in retention of staff and clinical outcomes of patients, an increase in patient visits and well-being, and revenue from improved access to care.

Program Structure. Details about program structure and curriculum will be addressed in the remaining chapters. Your leadership and Board of Directors will have many questions. How will the APP postgraduate training program fit within your organizational structure? Who is accountable for the program and the postgraduate trainees? Where will the postgraduate trainees get their clinical training?

Resource Assessment. The Programmatic Resource Assessment Tool will be discussed in detail in [Chapter 6](#). When conducting a resource assessment, consider asking the following questions:

1. **Patients:** Do you have a sufficient, ongoing demand for care from new patients to support the development of panels by the postgraduate trainees?
2. **Faculty:** Do you have expert PCPs (NPs, MDs, DOs and/or PAs) who are qualified and willing to become faculty for the program and both precept and mentor the postgraduate trainees?
3. **Specialty Rotations:** Do you have access, internally or externally, to specialty training in the areas identified as necessary and desirable for APPs in a HC?
4. **Space and Equipment:** To train to a high-performance model of care, the postgraduate trainees need access to the same resources as other PCPs on the team: hardware, software, exam rooms, conference space, and space within the pod/team.
5. **Program Leadership:** Even a small program requires program leadership and direction. Ideally, this will be an NP or PA who can guide curriculum, program design, and evaluation and who has the ability to network effectively within the organization to assure the smooth functioning of a complex program. You will want to identify an NP or PA to serve in a leadership capacity, particularly if you will be pursuing accreditation. Based on the size of your program, this individual may be able to combine this role with other responsibilities. They should, in either singular or combined capacities, have adequate administrative time integrated into their overall position at the institution. Particularly in a larger program or a program with multiple tracts, an operational program leader is also desirable.
6. **Finances:** An APP postgraduate training program has specific direct and indirect costs, and transparency in identifying those costs for your stakeholders is important. Equally important is to make transparent the return on investment. It is essential that the Board of Directors have a very realistic understanding of the costs, potential risks, and potential return on the investment. It will be helpful for stakeholders to know what potential external program funding opportunities exist, but stress there is no guarantee on such funding. We will further discuss finances in [Chapter 6](#).

Family Nurse Practitioner (FNP) Residency Program: Leadership Perspective



As a practicing primary care provider (PCP) and now Chief Executive Officer (CEO) of a Health Center (HC), I have seen the transformation brought about by our Family Nurse Practitioner (FNP) Residency Program. Before we had our own FNP Residency Program, I observed too many times how talented and well-intentioned new nurse practitioners struggled with the complex needs of our patient population. As a result, despite their best efforts, many became overwhelmed and ultimately left. Our organization lacked the necessary structural support for new nurse practitioners to succeed in the demanding environment of community health centers.

But everything changed after we launched our FNP Residency Program.

***The program offered structured mentorship,
clinical guidance, and the overall support needed to give
our new family nurse practitioners the confidence and skills
to succeed and thrive.***

***As a result, many of those practitioners have become
permanent team members,
and our community is stronger because of it.***

***We also noticed an impact on our providers,
who report increased job satisfaction from serving as mentors and preceptors.
Our FNP Residency Program has helped create a stronger,
more diverse, and balanced workforce that reflects our communities
and improves how we serve them.***

We are facing a shortage of PCPs for various reasons, and we take pride in contributing to the solution. This program enables us to train and support the next generation of FNPs who will carry our mission's torch: "To provide quality comprehensive health care for our communities" into the future.

—Alejandro Esparza Perez, MD, Chief Executive Officer,
Holyoke Health Center, Inc. (Holyoke, Massachusetts)

What Key Departments and Clinical Staff Want to Know

Key organizational departments, such as Finance, HR, IT, as well as clinical departments and operations staff, will need to understand how this program will intersect with their work, and what support, resources, and services the APP postgraduate training program will need from them. We also recommend discussing with the key departments the ways in which the training program can provide support or help to their team. Using the communication guiding principles, you will want to tell them **why, what, and how**. Identify leaders in each department that your team will work with to implement key program components, as well as to develop or revise any policies and procedures that address how the program and residents will function.

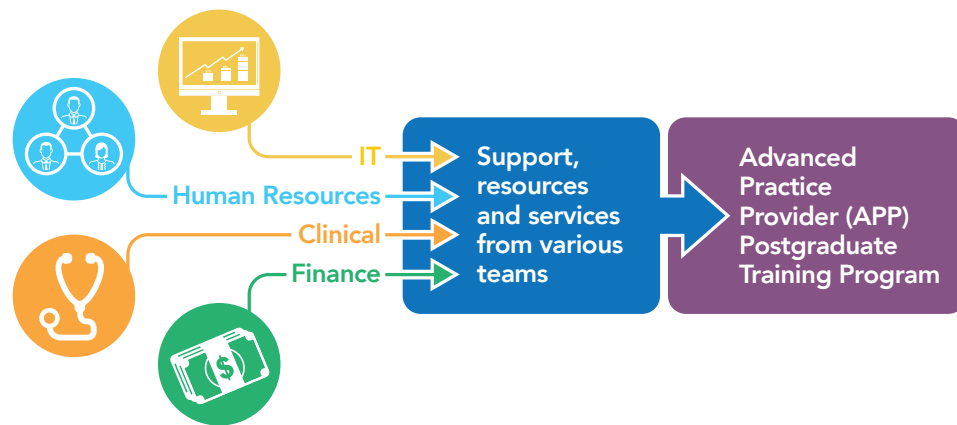


Figure 3.5: Key Organizational Departments for your Advanced Practice Provider (APP) Postgraduate Training Program

Communicate, Communicate, Communicate ...and Listen

You can communicate with these groups in a variety of ways, such as small group meetings, all staff meetings, grand rounds, or formal and informal presentations. Using your common message, you will want everyone to understand why the organization is starting the program and what it will look like so that they can fully engage with and support the postgraduate trainees and program. Also, make sure that you listen and respond to the concerns, suggestions, and opinions of your stakeholders. In our experience, you can never communicate too early or too often, particularly in the early, formative years of a program.

Psychiatric Mental Health Nurse Practitioner (PMHNP) Residency Program: Resident Perspective



I can remember it vividly—the fear I felt as I opened my filing drawer and saw a dense rainbow of filing folders hanging one after the other. One folder for each patient. How was I going to care for them all?

I was in my first few months as a psychiatric provider at a behavioral health clinic with no other psychiatry staff. I had a dozen therapy colleagues, but no one else was providing psychiatric care. I received one hour of supervision from a psychiatrist by phone, but I rarely saw her in person, and she didn't know the culture of care at my clinic. I felt alone, and I began questioning whether I had chosen the wrong career path.

It was around this time that I learned that the Community Health Center, Inc. (CHCI) was starting a Psychiatric Mental Health Nurse Practitioner (PMHNP) Residency Program. This was new. In the past they had only offered a Primary Care Nurse Practitioner Residency. I had many friends go through it and I heard wonderful things. I decided to apply, and it was the best decision I could have made. I started the PMHNP Residency in 2015 as the health center's first PMHNP resident and I remain at the health center today.

Transitioning from that siloed role to a structured residency program, provided me the support, mentorship and structure that I was wanting. I went from being isolated and feeling alone, to being surrounded by a full team of seasoned psychiatry providers, both psychiatrists and psychiatric nurse practitioners, who could mentor me.

And not only were they experienced in outpatient psychiatry; they were also passionate about serving those who are most vulnerable. In terms of the week-to-week schedule, there were regular didactics and supervision meetings along with the direct clinical time, which enhanced my learning and helped me to avoid burnout.

My year of residency provided me with a strong foundation and allowed me to build a sustainable and rewarding practice. In addition to my clinical work, I have also remained engaged with CHCI's PMHNP Residency Program first as a preceptor, then as a supervisor and clinical lead and now as the program's Clinical Director. Supporting new PMHNPs as they launch into their roles and build the confidence and skillset to do so joyfully and sustainably is an absolute privilege.

—**Sarah Freiberg**, APRN, PMHNP, Clinical Program Director,
Psychiatric Mental Health Nurse Practitioner Residency Program,
CHCI (Middletown, Connecticut)

Conclusion

To summarize, each program has its own story. At CHCI, we sought to increase and strengthen our primary care workforce so that our patients would receive the highest quality of care from their providers.

To build your case for starting an APP postgraduate training program, you need to do the following:

1. Identify your program drivers.
2. Complete a stakeholder analysis.
3. Develop mission and vision statements for the program that align with and enhance the mission of your organization.
4. Develop a communication plan addressing the following questions:
 - Why develop a program?
 - What does it look like?
 - How will it affect stakeholders?
5. Engage with your leadership early. Once they are on board, work together to plan a presentation to the Board of Directors.
6. Communicate the message to key departments and clinical staff in multiple forums, multiple times. Listen to what they have to say.

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Advanced Practice Registered Nurse (APRN) fellows from Erie Family Health Centers celebrate Nurses Day at the Capitol, coming together to honor the profession and champion for healthcare policy.

Below: A Community Health Center, Inc. (CHCI) Nurse Practitioner (NP) Resident administers a vaccine during the Connecticut Department of Veterans Affairs (DVA) annual Stand Down event.



Above left: CHCI NP Residents work under the guidance of their preceptor during a patient examination. Right: El Rio Health Advanced Practice Registered Nurse (APRN) Residents volunteer to promote child safety by distributing car seats and educational materials at the 'Be Safe Saturday' event, helping families keep little ones protected on the road.

Advanced Practice Provider (APP) Postgraduate Training Program Structure and Design

Advanced Practice Provider (APP) postgraduate training is a formal, highly structured period of intense clinical practice with continuing didactic education specific to the chosen specialty area of a new APP or one who is transitioning specialty practice area. The goal of postgraduate training is for new APPs to acquire a depth of clinical experience and training with the support of expert preceptors and structured progressive clinical experiences that lead to the mastery, competence, confidence, and well-being that positions the APP for successful practice. This goal needs to be clearly articulated so that it has real meaning in the setting to which it applies, and it should be readily identifiable when it has been achieved.

The elements of the APP postgraduate training program are designed to achieve that goal. Developing the APP postgraduate training program requires a systematic approach, clarity of purpose, a deliberate structure, and achievable results that can be measured at the level of the individual postgraduate trainee and for the program as a whole. These results are then used to evaluate and improve the program further.

In this chapter, we will present the program structure and design of the APP postgraduate training program that was originally developed for new family nurse practitioners (FNPs) at the Community Health Center, Inc. (CHCI) in Connecticut and has been used as a model for the development of many other programs around the country. From 2015 to 2026, CHCI served as the Health Resources and Services Administration (HRSA) funded National Training and Technical Assistance Partners (NTTAP) on Clinical Workforce Development. This is the model that has been used by CHCI's NTTAP as the basis for webinars and intensive 6-month community of practice (CoP) on starting such postgraduate training programs. The model can be tailored to other specialty areas, such as adult, pediatrics, and psychiatric/mental health specialties.

In this chapter, we will discuss the program's structure and design, including the direct and non-patient facing clinical activities. To support the program structure and design, [Chapter 5](#) will discuss the curriculum development. Additionally, [Chapter 6](#) will discuss the clinical and financial resources, while [Chapter 7](#) will

address the operational and administrative supports needed for both direct and non-patient facing clinical activities. Finally, [Chapter 8](#) will explore how all components of the APP postgraduate training program are evaluated.

Structure of the APP Postgraduate Training Program: Direct and Non-Patient Facing Clinical Activities

CHCI’s Postgraduate Nurse Practitioner (NP) Residency Training Program, which now includes family, pediatric, and psychiatric/mental health NP tracks, is a 12-month program beginning in September of each year, during which the NP Residents are full-time employees and are fully integrated into all aspects of the organization. It starts with an intensive orientation to the residency training program, to the organization, and the community (see [Chapter 7](#) for a detailed description of the orientation). Each NP Resident is assigned to a clinical site of CHCI as their “home base.” At this site, the NP Resident is assigned to and immersed in a primary care team or “pod” with whom the NP Resident will work when not engaged in other program activities. **Table 4.1** lists the components and structure of CHCI’s Postgraduate NP Residency Training Program.

Direct Clinical Activities	Non-Patient Facing Clinical Activities	Staff	Resources	Community and Professional Development
● Precepted clinic ● Mentored clinic ● Specialty rotations ● Procedures training ● On-call	● Didactic sessions ● QI seminar ● Project ECHO ● Quality Committees	● Preceptors ● Mentors ● Faculty for presentations ● Primary care team ● Clinical leaders ● Administrative Staff	● Home base clinic ● Patients ● Physical space ● Equipment ● Technology ● Alumni of APP Postgraduate Training Programs	● Professional meetings ● Legislative activities ● Community service ● Social/recreational activities ● Social networking with peers

Table 4.1: NP Residency Program Structure

Direct Clinical-Based Practice Experiences

At CHCI, there are three types of direct clinical experiences, which make up a total of 80% of the NP Residents’ time: 40% for precepted continuity clinics, 20% mentored clinics, 20% specialty rotations. The remaining 20% of time is spent in formal educational, non-direct clinical activities, including didactic education sessions and quality improvement training. **Figure 4.1** illustrates the distribution of time spent by NP Residents at CHCI throughout the program. A description of each type of experience is below, and summarized in [Table 4.2](#). At CHCI, our Postgraduate NP Residency Training Program does not track clinical hours. Rather, we schedule residents for clinical sessions. A session is defined as a four-hour block of time, which generally equates to a half a day of a regular eight-hour workday. For example, one clinic session may be from 8 a.m.–12 noon. [Table 4.3](#) shows a sample schedule based on CHCI’s Postgraduate NP Residency Training Program:

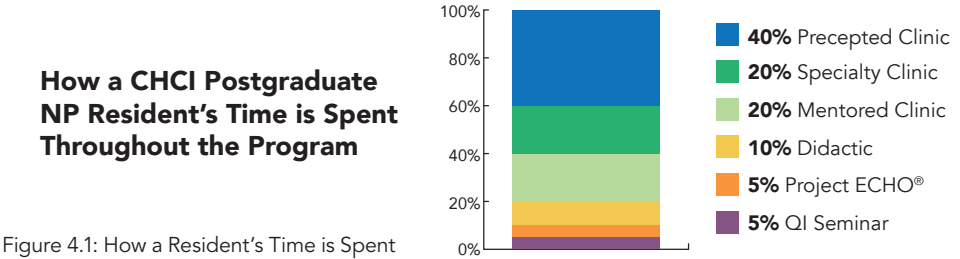


Figure 4.1: How a Resident's Time is Spent

Precepted Continuity Clinics (40%). Precepted continuity clinics are the cornerstone of the APP postgraduate training program focused on primary care providers (PCPs). These precepted continuity clinics account for a minimum of 40% of the entire curriculum, or about four sessions each week at the start of the program. This can be accomplished in two full-day schedules or spread across the week, dependent on program needs and resources. Additionally, it may be beneficial as each cohort progresses throughout the post-graduate year, likely at some point after the half-way mark, to add an additional session to become more accustomed to the typical week’s patient load. At CHCI, we have recently begun adding in a half-day session in May and June followed by an additional half-day session in July for a total of three full days of continuity clinic in the final two months of the program. This clinic experience is critical to the postgraduate trainees’ growth and development as a primary care provider, which includes being accountable to a panel of patients. In precepted continuity clinics, the postgraduate trainees develop their own patient panels while being precepted by a primary care provider (PCP), who may be an expert physician, NP, or physician associate/assistant (PA). One preceptor may work with up to three

postgraduate trainees at a time. The ratio will vary among different APP postgraduate training programs. In [Chapter 6](#), we will discuss the financial breakdown of one preceptor assigned to two vs three postgraduate trainees. This model may be adjusted by track, as the optimal structure for precepting in the psychiatric/mental health track may differ from that in the Family Nurse Practitioner (FNP) track.

Preceptors with more than one assigned postgraduate trainee have no other assigned responsibilities during this time. That is, preceptors are NOT scheduled to see their own patients while simultaneously precepting the postgraduate trainees, which provides the opportunity to teach, provide critical feedback, verify findings and assessments, and teach specific procedures if the need arises. If the ratio is one to one, a partial template can be opened for the preceptor in consideration of productivity. However, volume should not exceed more than 50% of the provider's typical template and should always be weighed against the quality of precepting; ongoing evaluation and feedback is critical. The postgraduate trainee is responsible for documentation in the electronic health record (EHR) under their own license, including closing and locking the note, which will be billed in the licensed and credentialed postgraduate trainee's name. Preceptors also provide additional support on documentation by adding an addendum to notes signing off that they were the preceptor for that patient visit, and adding any educational comments they think helpful. In CHCI's Postgraduate NP Residency Training Program, each residency site often chooses a primary medical assistant (MA) and/or registered nurse (RN) to be assigned support staff to the residents during precepted continuity clinics, and to the growing panels of the NP Residents. Having these assigned roles helps residents experience team-based care and communication that underlies primary care practice as a PCP. Depending on staffing needs on any given day, other MA or RN staff may support the precepted sessions, but the NP Residents' assigned as support staff will remain constant for the purpose of communication and care planning for their patient panel. For more information on the evolving role of RNs in primary care, and the evolving evidence for team-based care, there are several articles that we suggest you review (Flinter, Hsu, Crompt, Ladden, & Wagner, 2017; Wagner et al., 2017). Additional details regarding the role the RN within team-based primary care can be found in Chapter 8 of *Team-Based Primary Care in Health Centers* (2024): <https://www.weitzmaninstitute.org/wp-content/uploads/2024/09/Team-BasedPrimaryCareinHealthCenters.pdf>.



At CHCI, NP Residents begin seeing patients in precepted continuity clinic after an intensive orientation to the organization, the community, and to the Postgraduate NP Residency Training Program, including intensive training on the use of health information technology (HIT) and communications. At week 4 of the program, the

NP Resident starts with one scheduled patient per hour, gradually increasing over time. See **Box 4.1** for CHCI's "Stepwise Increase of NP Resident Clinical Scheduling Policy", which describes the ramp up process. It is important to note that the ramp up schedule should be designed to replicate the visit expectation of the postgraduate trainee over the course of the year. The goal is a slow and progressive ramp up to a full time provider schedule over the program year.

CHCI's Policy and Procedure: Stepwise Increase of APRN Resident Clinical Scheduling

At CHCI, the NP Residents' schedule is designed as follows with incremental increases happening each month. Templates will be updated by a central administrator to help with scheduling consistency.

Current Ramp Up Policy:

- **October: 1 patient per hour (7/day); all mixed appointment (apt) types including 24 hour**
- **November: +1 patient per session; mixed apt type; (9/day)**
- **December: +1 patient per session; mixed apt type; (11/day)**
- **January: +1 patient per hour, mixed apt type; (13/day)**
- **February: +1 patient per session; mixed apt type; (15/day)**
- **March: Same as above; (15/day)**
- **April: +1 patient per hour; mixed apt type; (17/day)**
- **May: +1 patient per hour; mixed apt type; (19/day)**
- **June: 3/hour; (22/day)**
- **July: 3/hour, same as above; (22/day)**
- **August: 3/hour; add one 24 hour overbook per session; (24/day)**

The ramp up schedule should be individualized by the Program Manager based on conversation with the Office Managers, Preceptors, on-site Medical Directors, and the residents themselves. A resident who is consistently running behind in clinical sessions may need to have certain increases delayed based on this feedback. Other residents may be ready to advance more quickly. All residents should be seeing a full schedule by August.

Box 4.1: CHCI's "Stepwise Increase of NP Resident Clinical Scheduling Policy"

	Precepted Continuity Clinic	Specialty Rotations	Mentored Clinic
Percent of Program time	40%	20%	20%
Frequency	4 sessions/week	10 rotations: One day per week for four weeks (one rotation per month). <i>Note: The first and last month of the 12-month program do not have specialty rotations.</i>	2 sessions/week
Type of Patient	Starting with initial visits, then including all visit types.	Several types of patients	Episodic/acute care
Faculty	Preceptor	Preceptor	Mentor
Documentation in the Electronic Health Record (EHR)	Preceptor reviews resident's documentation, then resident closes and locks the note.	Varies by specialty and level of access to EHR. To be determined by program.	Mentor reviews resident's documentation, then Mentor closes and locks the note.

Table 4.2: Summary of CHCI NP Residency Program Clinical Activities

Because the postgraduate trainees are building their panels during the precepted continuity clinic sessions, the patients they are scheduled to see initially are primarily those having their initial visit at CHCI. A postgraduate trainee's panel may include patients whose PCP is or will be moving on from the practice or a subset of patients managed by the previous year's trainees. The focus on seeing new patients ensures that the postgraduate trainees are encountering the typically highly challenging patients who present for the first time at a Health Center (HC), often with unaddressed health challenges, overdue preventive care, and uncontrolled chronic conditions. Behavioral health and substance use disorder (SUD) concerns are not uncommon. This provides tremendous learning opportunities for the postgraduate trainees, much needed care for the patient, and an opportunity to begin building a trusting relationship between both parties—and takes considerable time. At CHCI, after the initial visit, every attempt is made to schedule the patient with their NP Resident. The follow-up visit with that patient will primarily be scheduled during precepted clinic sessions.

In CHCI's family and pediatric NP tracks, patient scheduling during precepted clinic sessions is staggered to allow the preceptor, who is generally precepting two residents, to be actively engaged with patient visits of both residents. For example, Resident A may be scheduled on the hour, 8:00 a.m., 9:00 a.m., etc., and Resident B at 8:20 a.m., 9:20 a.m., etc. If an initial visit cancels or does not show up, a same-day or urgent care patient could be added to the NP Residents' schedules. This can include the preceptor reviewing the schedule for the site itself and communicating with other providers (if they agree) from whom they may be able to transfer patient visits (typically new patients or acute visits) to fill unused slots. The ultimate goal is to see patients and ensure residents are exposed to adequate volume to prepare them for practice. Postgraduate trainees can see a patient even if they are not the PCP of that patient. Precepting days can be flexible based on the needs of the clinic, including optimizing the time when there are the most resources available to the program, such as preceptors, support staff, and exam rooms.

Box 4.2: Community Health Center, Inc. (CHCI) Psychiatric/Mental Health Nurse Practitioners (PMHNP) Residency Program Precepted Clinic

In Precepted Clinic, Psychiatric/Mental Health Nurse Practitioners (PMHNP) Residents develop and manage a panel of psychiatry patients under the direct and dedicated support of a preceptor. Community Health Center, Inc. (CHCI) PMHNP Residency Preceptors are CHCI Psychiatry Providers who have several years of experience in community mental health. Preceptors have been with CHCI anywhere between 5 and 18 years. Our precepting team is passionate about teaching and supporting the next generation of psychiatric providers. Residents have 3 different Precepted Clinic types:

- **Child Psychiatry: 1 day per week**
- **Adult Psychiatry at Fixed Site: 1.5 days per week**
- **Healthcare for the Homeless Psychiatry: Half day every 2 weeks**

Preceptor Perspective



Lauren Reisberg (on right) and her co-resident meet with the Mayor of Valparaiso, Indiana, during their 2016–2017 orientation to the community.

Precepted clinic exists to support the Resident's educational and professional development while ensuring patients receive safe, high-quality care. As a Preceptor, my goal is to model high standards of care, encourage reflective learning, and foster resilience to support the Residency's outcomes of reducing burnout, improving retention, and preparing NPs to meet the complex needs of our patient population. I utilize my personal passion for effective use of the electronic health record (EHR) for accurate and efficient documentation, delivering succinct clinical case presentations, and mastering time management to balance care quality with realistic workload demands.

This is the Resident's time to discover and develop their own practice philosophy while building their clinical skills in an environment that provides structured guidance, constructive feedback, and consistent support to build the clinical competence and professional judgment necessary for independent practice.

It is an invaluable investment in the development of new colleagues, whose diversity of thought and practice strengthens both our organizations and the broader healthcare system by expanding access to high-quality primary care for the varied populations in the communities we serve.

—Lauren Reisberg, Nurse Practitioner and Preceptor, HealthLinc (Valparaiso, Indiana)

Specialty Rotations. Postgraduate trainees spend 20% of their time in specialty rotations. CHCI has identified clinical specialty areas that represent high-volume, high-complexity and/or high-burden health problems and procedures most commonly encountered in our HC. Each specialty rotation consists of one day per week over the course of four weeks, generally equating to one specialty rotation per month. Rotations at CHCI include: Orthopedics; Women's Health; Pediatrics; Newborn Nursery; HIV and Hepatitis care; Adult Psychiatry; Child and Adolescent Psychiatry; Urgent Care; School Based Health; and Healthcare for the Homeless. Specialty rotations may be available within your organization or may warrant developing an agreement with an external partner, as CHCI does for the Newborn Nursery rotation. In addition to the core rotations, CHCI offers residents other rotation opportunities within the organization based on their interests, including podiatry, chiropractic, nutrition, diabetes education, and experience within our migrant/agricultural farms and mobile health unit programs.

While we can accommodate some specialty rotations at CHCI, others occur outside of the organization at other agencies. Documentation for specialty clinics will vary based on whether the rotation is being hosted internally or externally and on the nature of the rotation. If hosted externally, there should be a memorandum of understanding (MOU) between the two organizations that outlines the expectations and responsibilities of each party so that there is clarity around the learning environment and experience. This outline should include an explicit direction to postgraduate trainees about what their role will be (e.g. shadowing vs having direct patient contact) and if there is any needed additional background screenings.



Community Health Center, Inc.'s (CHCI) Mobile Health Unit (MHU) Program brings healthcare directly to people in need, operating in a variety of community settings.

There is flexibility in the selection of specialty rotations and meeting the needs of the clinic and community. There is no required number of specialty rotations that your program must include and you may choose to have rotations last longer than four weeks. Your organization should decide what areas of specialty practice you wish to have your postgraduate trainees experience based on your unique patient population and organizational needs, and the goal of full scope primary care. As always, you should develop clear learning objectives and evaluation criteria for each specialty rotation. A specialty clinic may simply refer to a service area that your organization does not currently provide on-site, such as prenatal care, but which you want to make sure trainees have an opportunity to train in.

Box 4.3: Evolution of the Dermatology Specialty Rotation at Community Health Center, Inc. (CHCI)

Practice changes over time. Dermatology is one of the most common reasons for referral externally, but with the advent of high-resolution dermatoscope devices and the availability of eConsults, CHCI has focused on didactic training internally, mastery of biopsies appropriate to primary care setting, and eConsults with feedback from the eConsultants as optimum strategy for skill development in this area and for assuring access for our patients.

Utilizing eConsults to Bridge Gaps in Patient Care

Over the years, at Community Health Center, Inc. (CHCI), Nurse Practitioner (NP) Residents and former NP Residents have reached out to me on numerous occasions to tell me how informative, educational, and helpful a particular eConsult has been. Just recently, a NP Resident found a surprising finding on a complete blood count (CBC), which also concerned me. Within 24 hours, she had reassurance and a plan from the Pediatric Hematologist. Without that, there would have been an avoidable referral and a lot of alarm on the part of the parents. CHCI has discovered that NP Residents send substantially more eConsults than our other primary care providers (PCPs). At CHCI, we consider the education from eConsults to be an important supplement to the growth of the NP Residents' understanding and abilities. Other preceptors and I have learned from eConsult responses sent by NP Residents we precept.

—**Daniel Wilensky**, MD, NP Residency Program Lead Preceptor for the FNP Tract and CeCN Medical Director, Meriden Medical, CHCI (Middletown, Connecticut)

Utilizing eConsults as a Resident

The Postgraduate Nurse Practitioner (NP) Residency Training Program greatly shaped my career as an NP. The support from my preceptors was essential to building my confidence as I transitioned from an NP student to an NP managing my own patient panel. My preceptors helped me learn how to manage an inbox, how to navigate difficult patient conversations, and how to develop my own style as a practitioner. In residency, I also learned how to utilize resources such as eConsults. In my daily practice, I rely heavily on eConsults to bridge gaps in patient care, particularly when access to specialty appointments may take months. I frequently use dermatology eConsults to submit clinical images for diagnostic confirmation and treatment recommendations. Receiving specialist input within days helps prevent delays in care and allows timely management of skin concerns.

I also utilize eConsults to obtain guidance on diagnostic testing and interim management while a patient awaits an in-person appointment with a specialist. This allows a preliminary workup to be completed which enables the specialist to review existing results and focus on next steps during their visit. My patients appreciate the involvement of the eConsult specialist in their care and the quick turnaround time for the consult results. eConsults have strengthened my clinical practice by providing me with the opportunity to dialogue with specialists on complex patient cases. They have been a valuable learning tool and I often reference past consults to inform my clinical decisions.

—**Kristin Finigan**, Nurse Practitioner, CHCI (Middletown, Connecticut)

Box 4.4: Special Note on Procedures

If your organization plans to provide opportunities for your postgraduate trainees in procedural skills (i.e. IUD/Nexplanon insertion/removal, joint injection, suturing, etc.), it is important to ensure that there are either the program preceptors, other primary care providers (PCPs), or on-site specialists that have the procedural competency and credentialing to supervise the procedure until the postgraduate trainee is deemed competent to do them alone.

The Consortium for Advanced Practice Providers (CAPP) accreditation standards do not set a specific procedures/numbers of procedures to be completed, but states "The Program shall establish a specific target for the number of patients and procedures deemed necessary to achieve the overall goals of the postgraduate NP, PA, or Joint NP/PA Training Program based on the practice setting" (CAPP, 2025, p. 6).

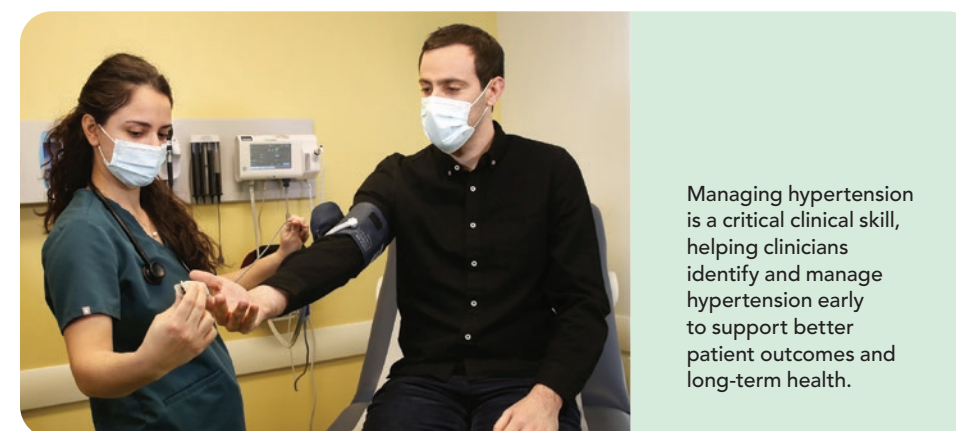
Monthly Schedule					
	Monday	Tuesday	Wednesday	Thursday	Friday
		1	2	3	4
AM		Dermatology	Precepted Clinic	9–11 Admin 11–1 Pain ECHO	Precepted Clinic
PM		Dermatology	Precepted Clinic	2–5 Didactic	Precepted Clinic
	7	8	9	10	11
AM	Mentored Clinic	Dermatology	Precepted Clinic	9–11:30 Admin	Precepted Clinic
PM	Mentored Clinic	Dermatology	Precepted Clinic	12–1:30 QI 2–5 Didactic	Precepted Clinic
	14	15	16	17	18
AM	Mentored Clinic	Dermatology	Precepted Clinic	9–10:30 Monthly Program Meeting 11–1 Pain ECHO	Precepted Clinic
PM	Mentored Clinic	Dermatology	Precepted Clinic	2–5 Didactic	Precepted Clinic
	21	22	23	24	25
AM	Mentored Clinic	Dermatology	Precepted Clinic	9–11:30 Admin	Precepted Clinic
PM	Mentored Clinic	Dermatology	Precepted Clinic	12–1:30 QI 2–5 Didactic	Precepted Clinic
	28	29	30		
AM	Mentored Clinic	Mentored Clinic	Precepted Clinic		
PM	Mentored Clinic	Mentored Clinic	Precepted Clinic		
Dermatology Specialty Rotation—Main Street, Middletown, CT					

Table 4.3: Sample Schedule for One NP Resident for One Month

Mentored Clinics. At CHCI, mentored clinics make up 20% of postgraduate trainees’ time or two sessions each week. During mentored clinics, the postgraduate trainees work alongside a PCP mentor—an experienced physician, NP, Certified Nurse-Midwife (CNM), or PA—with a focus on the practice of episodic and acute care and additional mastery of procedures. The residents generally do not have their own schedule of patients during mentored clinics, but instead see patients at the delegation of the PCP, who remain available for consultations. This is also an opportunity to schedule some follow-up visits for a patient seen during the week in precepted clinic who should be seen again before the next scheduled precepted session; while the resident is in the early phases of the ramp-up period, there are fewer opportunities to schedule those follow-up visits as the residents’ schedules may book well in advance.

During the “huddle” at the beginning of the mentored clinical session, the clinical mentor will select patients from his or her own schedule for the APP postgraduate trainee to see. The postgraduate trainees will see the patient independently and report back to the mentor before the patient leaves. The postgraduate trainees

documents in the EHR, but it is the mentor who reviews, closes, and locks the note since they are the PCP. The goal of the mentored clinic is to provide the postgraduate trainees with an additional supervised clinical experience with a variety of patients. The days of the mentored clinics are determined after the schedule for the precepted clinic sessions, specialty rotations, and non-patient facing clinical learning experiences has been finalized. At CHCI, we learned that assigning mentored clinical schedules in advance works far better than allowing them to develop organically or same-day resident requests for mentorship. When schedules were not assigned, it often led to awkward last-minute negotiations between residents and unexpected additions for providers.



Non-Patient Facing Clinical Activities

The non-patient facing clinical component of the CHCI’s Postgraduate NP Residency Training Program accounts for 20% of the NP Resident’s time, and is divided into four components: Didactic Education Sessions, Quality Improvement (QI) Seminar, Project ECHO® (n.d.) session attendance, and other educational or special experiences selected by the faculty. The Didactic Education Sessions (10%) cover topics relevant to the care of patients, and include group discussions and case presentations to their peers. As described in [Chapter 2](#), postgraduate trainees participate in a QI Seminar (5%) and Project ECHO® (5%). Additionally, they will develop a portfolio that includes their QI project submitted for the QI Seminar and a case presentation for Project ECHO®. The portfolio is discussed further in [Chapter 8](#). Other non-patient facing opportunities might include electrocardiogram (EKG) interpretation, language training, online dermatology trainings, and other learning modules. Like all other program elements, each training should be reviewed by program staff in advance and evaluated by both the postgraduate trainees and the staff at its conclusion.

Didactic Education Sessions (10%). Didactic education sessions generally account for 10% of the postgraduate trainees’ time. Like each other element, there should be clear learning objectives that the presenter or faculty is responsible for providing in advance, and an evaluation to indicate how successful the session was in meeting the objectives. Didactic sessions may range from two to four hours. Multiple shorter topics can be combined into one session. While the topics have likely been covered during the academic program leading to becoming a licensed APP, our experience is that these same topics take on a whole new importance for the trainees when they are now the PCP responsible for a panel of patients where these conditions are regularly seen.

At CHCI, the content is evidence-based, presented in a clear and challenging format, and reflect the patient population served by our organization. The first weeks of the program are “front loaded” with didactics on topics considered essential to safely and effectively start the clinical sessions, such as a refresher on interpreting laboratory values or electrocardiograms (EKGs), either through a formal didactic and other times through online learning modules. These formal learning sessions focus on a variety of complex clinical challenges most commonly encountered in HCs in general, and at CHCI in particular. In addition to clinical topics, didactics may also cover a number of leadership and professional development topics. The content of the presentations is planned to correspond to the NP Resident’s current clinical experiences, and taught by faculty from CHCI, as well as guest faculty from a number of external organizations. The didactic sessions are provided via video conferencing, and all sessions are recorded (audio, video, and content), so that they may be revisited at another time. While not the practice of all programs, CHCI grants formal Continuing Medical Education (CME) credits for NP Residents who complete the session and submit an evaluation. [Box 4.5](#) lists examples of didactic education sessions.



Nurse Practitioner (NP) Residents from Community Health Center, Inc. (CHCI) participate in a didactic education session focused on interrupted suture techniques and clinical procedural education.

Box 4.5: Didactic Topic Examples

These are didactic topic examples your health centers could implement:

Professional Topics

- Presenting a Case to Your Preceptor
- Medical On-Call
- History of the Community Health Center and Nurse Practitioner Movements
- How Not to Mess Up
- Self-Care for New Primary Care Providers
- Managing Difficult Patient Encounters
- Professional Boundaries
- Professional Development and Leadership Training
- Resident Case Presentations

Procedural Didactic Topics

- Long Acting Reversible Contraceptive (LARC) Training
- Suturing
- Biopsies (Punch and Shave)
- Incision and Drainage
- Musculoskeletal Joint Injections
- Prostate Exams

Medical Didactic Topics

- Adult/Pediatric Diabetes*
- Cardiac Ischemia
- Caring for Patients with History of Trauma
- Chronic Heart Failure
- Chronic Kidney Disease
- Chronic Liver Failure
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Pain Management
- Congestive Heart Failure (CHF)
- Dermatology*
- EKG Interpretation*
- Endocrinology
- Focused History, Interviewing, and Documenting
- Health Care for the Homeless
- Medication for Opioid Use Disorder (MOUD)
- Hepatitis B
- Hepatitis C
- HIV/AIDS

- Immunizations of Children and Adults
- Intimate Partner Violence (IPV)
- Laboratory Tests Interpretation
- Managing Neonatal Jaundice and Elevated Bilirubin*
- Motivational Interviewing*
- Myofascial Pain Disorder
- Nutrition Management for Chronic Diseases
- Obesity
- Ophthalmology
- Orthopedics
- Osteoporosis
- Thyroid*
- Pediatric Asthma
- Pediatric Growth and Development
- Pre-Op Physicals
- Polypharmacy*
- Rheumatology
- Sexually Transmitted Disease*
- Tuberculous
- Tobacco Cessation
- Women’s Health I: Preventative Cancer Screening, Reproductive Health*
- Women’s Health II: Bleeding and Pelvic Pain*

Psychiatric Mental Health Topics

- ADHD*
- Biopsychosocial Formulation
- Cultural Formulation
- Risk Assessment
- Motivational Interviewing
- Adult, Child/Adolescent, Geriatric Psychiatry*
- Major Depressive Disorder vs Bipolar Disorder
- Psychosis
- Psychopharmacology
- Psychotherapy
- Vicarious Trauma*
- IEP/504 Plans

*interdisciplinary topics

Healthcare for the Homeless Specialty Rotation



After graduating as a Family Nurse Practitioner (FNP), I learned that family medicine has a way of reshaping you—quietly, insistently—until you begin to see the world with new eyes. But nothing reshaped me quite like the Nurse Practitioner (NP) Residency Program.

As a Latina NP, I carried into the clinic the stories of my family and community—stories of strength braided with struggle, of navigating systems never built for us, of learning to advocate long before we learned the word for it. I thought these experiences had already taught me humility. Then I joined the NP Residency Program Healthcare for the Homeless specialty rotation.

At the Healthcare of the Homeless, the work lives in the in-between places of the town—under highway shadows, alongside shelters, near soup kitchens, sometimes in the back of a mobile van. We meet familiar faces and new ones wherever they are, each carrying not just a medical complaint but an entire landscape of displacement, resilience, humor, trauma, and hope.

One afternoon, I sat with a patient who had been sleeping in his car. He had lost everything in a house fire. His blood pressure was climbing dangerously high, but he kept apologizing for “taking up my time.” I remember pausing, looking into his eyes, and telling him: we are here for you. He looked away, took a deep breath and in that moment, the exam room felt less like a clinic and more like a place where dignity was being quietly rebuilt.

***By the end of the rotation,
I understood that this work is not about saving people—
it’s about walking with them, listening without judgment,
offering care that honors their humanity.***

The Healthcare for the Homeless rotation didn’t just teach me clinical skills; it taught me to be present in a way that feels like both a responsibility and a privilege.

I finished the NP Residency Program different than I began—more grounded, more aware, more committed. As a Latina NP Resident, I found pieces of my own story reflected in my patients’, and in caring for them, I felt myself grow into the kind of provider I had long hoped to become: one who sees the person before the diagnosis, one who believes in the power of connection, and one who understands that healing often begins long before any medication is prescribed.

—Catherine Hinojosa, DNP, FNP-C, AAHIVS, Family Nurse Practitioner,
CHCI (New London, Connecticut)



Weitzman Institute
Quality Improvement
(QI) Seminar, where
Nurse Practitioner (NP)
Residents receive
training on CHCI’s
QI model, using
clinical microsystems
and facilitation as
well as leadership
development.

Quality Improvement (QI) Seminar (5%). Accounting for 5% of the postgraduate trainee’s total time, the QI Seminar meets twice a month for 90 minutes. At CHCI, the QI Seminar provides on-site high-level expertise in theory and methods related to professional and patient education; quality improvement and project management; implementation science; as well as data collection and interpretation. The QI Seminar provides NP Residents the opportunity to develop knowledge and skills to improve care by using quality improvement and systems-based learning. At CHCI, Psychiatric/Mental Health Nurse Practitioners (PMHNPs) Residents also participate in the same QI Seminar curriculum as the NP Residents. However, their projects may differ from those of the NP Residents, and at times they may be joint projects.

The QI model developed by CHCI and its Weitzman Institute is a comprehensive organizational strategy to build an organization of continuous improvement across departments and improve quality in all domains of performance. We have a responsibility to utilize evidence-based standards, and to develop ways to make care safer and more accessible for patients and families. In addition to the agreement that we should improve care, there is broad support for enhancing the learning of health professionals to include topics and experiences that will prepare health professionals to lead the changes that will result in a better health system. CHCI’s Postgraduate NP Residency Training Program leadership and staff believe that NP Residents who are able to demonstrate their knowledge and skills in improving care and changing systems will be highly effective in not just delivering care but improving care, both as clinicians and as organizational leaders in the future. Many alums of the CHCI Postgraduate NP Residency Training Program reflect years later that developing solid QI skills to systematically analyze system breakdowns, improve workflows and processes, and measure improvements might have been the most lasting benefit of the training year. [Table 4.4](#) outlines CHCI’s QI Seminar topics and session goals.

QI Seminar Session Topics and Session Goals

Session Topic	Session Goals
An Overview of Quality Improvement	- Develop a shared understanding of the seminar series - Discuss a framework for improving care - Explore examples of improving care from our sites
Care Observations and Stakeholder Considerations	- Hear about and discuss many of the things you are noticing and wondering about - Review the evidence for the team-based care approach in primary care - Share some examples of team-based care in your setting
Organizing Your Improvement Project	- Briefly review the difference between quality improvement and research - Introduce the Project Charter with focus on three elements of the charter process - Using a structured aim statement - Process analysis using flowcharts - Consideration of changes based on process analysis and information from initial data - Continue consideration of stakeholders for your project topic
Global Aim Statement and Fishbone Diagram	- Formalize the idea you have for a project into a global aim statement - Draft a problem statement related to your global aim - Brainstorm ideas to begin populating your fishbone diagram
Process Mapping (Flowcharts)	- Hear about and discuss the example of a process you chose to explore in detail - Review details of how to approach flowcharting - Share examples of strategies to consider when doing flowcharting
Measurement to Inform Change: Defining Measures and Collecting Data	- Appreciate the value of using balanced measures in quality improvement work - Construct a value compass of measures for a specific clinical condition - Recognize the difference between a conceptual and an operational definition - Develop an operational definition for a measure - Formulate a plan for collecting data for a specific measure and identify potential associated challenges in the data collection
Measurement to Inform Change: Displaying Data Over Time and Run Charts	- Demonstrate the value of displaying data over time - Introduce the distinction between random (common cause) and non-random (special cause) variation - Review a temporal display and analysis method—the run chart - Offer examples in practice of using run chart

Session Topic	Session Goals
An Approach to Testing Change	- Review and learn by sharing your examples - Introduce the Plan-Do-Study-Act (PDSA) cycle as a method for making change - Discuss organizing a PDSA cycle using the PDSA Worksheet - Share examples from existing improvement projects - Practice creating a PDSA using the tool
Communication About Your Improvement Effort	- Strategies for planning a Plan-Do-Study-Act (PDSA) cycle - Share examples of PDSA approaches from your projects - Review tools for communication plans and stakeholder analysis - Practice developing a stakeholder analysis plan
Stakeholder Analysis and Conflict Management	- Learn about input from stakeholders related to a planned change - Discuss strategies for further engaging stakeholders - Develop approaches for managing conflict - Practice using a conflict management approach
Managing Up and Gaining Leadership Buy-In	- Understand common challenges when working with leaders on a QI effort - Review and discuss effective strategies when communicating with leaders - Consider approaches to developing yourself as a leader
Negotiation	- Discuss using a conflict management approach - Review some principles about effective negotiation - Practice an actual negotiation and debrief about what we observed
Negotiation and More About Cycles of Change	- Learn from your application of negotiation skills - Continue and deepen our discussion about PDSA cycles - Look ahead and discuss some upcoming sessions in our seminar series
Sustaining Your Improvement Effort	- Learn and review strategies in order to successfully sustain and spread a proven improvement process - Translate ideas from the strategies to thinking about the spread of your own QI effort - Look ahead and discuss some upcoming sessions in our seminar series
Project Team Presentations	- Share an update of what your team has accomplished thus far in your improvement effort - Practice summarizing and presenting your work in a manner similar to that commonly used in professional meetings

Table 4.4: QI Seminar Session Topics and Session Goals

El Rio Health APRN Residency Program (Tucson, Arizona)



El Rio Health Advanced Practice Registered Nurse (APRN) Residents, Class of 2025, pictured outside the Nancy J. Johnson Building in Tucson, Arizona.

The El Rio Health APRN Residency Program, Arizona's first APRN post-graduate training program, prepares new nurse practitioners to become highly competent, confident primary care clinicians equipped to serve all communities. Based in Tucson, the year-long program centers its mission "to empower the Advanced Practice Registered Nurse with the skill set and support needed to become a competent clinician who is confident to deliver excellent quality care to improve the health of the community and to train the clinician leaders of tomorrow in the Community Health Center movement."

Residents immerse themselves in community health through core continuity clinics in Family Practice and Pediatrics, developing their own patient panels under the guidance of experienced preceptors.

The mentor clinic model deepens learning by placing residents alongside seasoned MDs and NPs for observation, discussion, and shared patient care.

Weekly specialty clinics expand clinical exposure with rotations in dermatology, sports medicine, integrative pain, women's health, and healthcare for the homeless. A commitment to

underserved populations is central to the program, which includes partnerships with three rural Health Centers in Southern Arizona to provide meaningful rural health experiences.

Education extends beyond direct patient care. Weekly didactic sessions offer structured learning on common primary care challenges, while quarterly interprofessional sessions promote collaboration with residents from other disciplines. Residents also gain leadership and systems-thinking experience by completing a data-driven quality improvement project that supports measurable improvements in patient outcomes.



Advanced Practice Registered Nurse (APRN) Residents from El Rio Health participate in volunteer service at the Community Food Bank of Southern Arizona.

With 7 cohorts and 33 graduates to date, the El Rio Health APRN Residency remains committed to developing the next generation of primary care nurse practitioners for Southern Arizona.

—**Jessica Smith**, MSN, RN, FNP-C, Director, El Rio APRN Residency Program;
Alexandra Riley, DNP, RN, FNP-C, Clinical Lead, El Rio APRN Residency Program;
El Rio Health (Tucson, Arizona)

The QI Seminar series is built on the foundational belief that learning to change and improve systems cannot be a passive effort. Such an endeavor requires knowledge and skill, as well as the value of shared accumulated experience. The goal for each QI Seminar session is to incorporate aspects of experiential learning and provide activities that allow residents a chance to practice applying these tools at their sites. Generally, residents will apply these tools at the site where they complete their precepted continuity clinic. As they are practicing as a PCP in that setting, they have a greater ability to assess the practice for needed process improvements. At CHCI, the NP Residents are asked to apply the tools to a specific issue they have encountered at their sites. NP Residents engage in brainstorming sessions with their co-residents at their primary site, workshop ideas with seminar faculty, meet with key stakeholders, and then plan and implement their intended project. They then make a final presentation in the QI Seminar describing their QI effort on which they worked. The goal of the final presentations is to help everyone who participated in the series learn from the experience of others. The QI Seminar is also a requirement for accreditation through the Consortium for Advanced Practice Providers (CAPP) under Standard 2: Curriculum (CAPP, 2025).

Project ECHO®. At CHCI, participation in Project ECHO® (n.d.) sessions every other week accounts for 5% of the NP Resident's time. As discussed in [Chapter 2](#), Project ECHO® is a case-based, virtual education model where providers, including residents, have the opportunity to listen, learn, and present their most challenging cases to an interdisciplinary team of experts. Project ECHO® originated at the University of New Mexico by Dr. Sanjeev Arora as a structured way for a team of specialists to regularly meet via videoconference with a select group of PCPs to discuss Hepatitis C management and treatment over time. Through a combination of lecture, case presentations by the PCPs, and discussion, the PCPs grow in competence and confidence to manage their patients' care with the condition of focus.

The Weitzman Institute of Moses/Weitzman Health System (MWHS) offers Project ECHO® for diabetes and weight management, prenatal and maternal health, complex integrated pediatrics, substance use, key populations, alcohol use disorder, and more. Many are available at no charge thanks to grant funding (<http://weitzmaninstitute.org/project-echo>). Nearly 10,000 healthcare professionals have participated in a Weitzman ECHO since 2012. There are many Project ECHO® "hubs" around the country now in addition to the Weitzman Institute and the University of New Mexico, and we encourage programs to consider joining one or more for the benefit of their NP Residents, as well as other PCPs.

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Nichole Mitchell, Nurse Practitioner Resident at Community Health Center, Inc. (2014–2015), performs a pediatric examination.

Below: In 2019, Dan Wilensky, MD, demonstrates a clinical procedure for Laina Cross, a Nurse Practitioner (NP) Resident at Community Health Center, Inc. (CHCI). Inset: In 2026, Laina Cross now leads a hands-on educational training session for a new generation of CHCI NP Residents.



CHAPTER 5

Advanced Practice Provider (APP) Postgraduate Training Program Curriculum Development

We have given you an overview of the program structure and design of Community Health Center, Inc.'s (CHCI) Postgraduate Nurse Practitioner (NP) Residency Training Program, which has evolved with nearly two decades of experience and evaluation. Knowing what clinical rotations you want to offer and what topics to cover in didactic sessions is necessary, but it is not enough to host an advanced practice provider (APP) postgraduate training program. You need to develop program goals, curricular objectives, and learner outcomes, so that you can evaluate your postgraduate trainees' performance and determine that your program is meeting the needs and achieving the outcomes that you have identified as the rationale for starting a program. In this chapter, we will offer details of the curriculum of CHCI's Postgraduate NP Residency Training Program with particular emphasis on the primary care provider tracks and offer suggestions on how to develop your curriculum. It is important to note that there is no one way to develop a curriculum, a process that often has multiple iterations (both for programs with differing needs and for the same program as it develops and adapts longitudinally). The details of the curriculum for each organization will look different based on your needs, patient populations, and resources.

By "curriculum," we mean the components of a health professions training program as defined by Grant (2010): mission, goals and objectives, direct and non-patient facing clinical activities, the knowledge, skills, and attitudes (KSAs) the postgraduate trainees will achieve, and how these are assessed, measured and evaluated (Grant, 2010). Although this definition does not address competencies per se, its reference to knowledge, skills and attitudes is important for curriculum development. KSAs are the characteristics of a competency-based education framework first developed by Bloom (1956), and relevant today (Anderson & Krathwohl, 2001; Forehand, 2010). Competency-based education/training has been the dominant model in curriculum development in the health professions since the 1970s (Del Bueno, 1978; McGaghie, 1978). This model constituted a shift away from education that used on-the-job training models emphasizing time spent and a list of skills performed. Although

there have been controversies about defining and measuring competence and competency in health professions training (Frank et al., 2010a; Frank et al., 2010b; Pijl-Zieber, Barton, Konkin, Awosoga, & Caine, 2014), it remains the curriculum model used by accrediting bodies, such as the Accreditation Council for Graduate Medical Education (ACGME, n.d.) and the Consortium for Advanced Practice Providers (2025). Competency-based health professions education is learner-centered, and focuses on outcomes and the ability of the learner to demonstrate a level of mastery sufficient for practice (Frank et al., 2010a; Frank et al., 2010b; Cate, 2013).



Therefore, the curriculum design for the APP postgraduate training program begins with the end in mind. After a year of postgraduate training, ask yourself, ***What is it that the new APP knows and can do that is not only more proficient than at the start, but proficient enough that the APP is ready to practice with confidence, competence, mastery, and a sense of well-being?*** When you approach curriculum development from this perspective, your path forward will be clearer.

The most important message for curriculum development is this: ***All of the parts must align, from mission, goals, objectives, and outcomes to evaluation measures.*** This is especially important if you plan to have your APP postgraduate training program accredited. In [Chapter 9](#), we will dive deeper into the accreditation process. One way to think about the alignment of mission, goals, objectives, competencies, and outcomes is to envision them as increasing in specificity as shown in [Figure 5.1](#), with the mission being the broadest and the learner outcomes the most specific and measurable. We will begin our discussion of curriculum development with the APP postgraduate training program's mission and goals, followed by the competencies, program objectives, and learner outcomes.

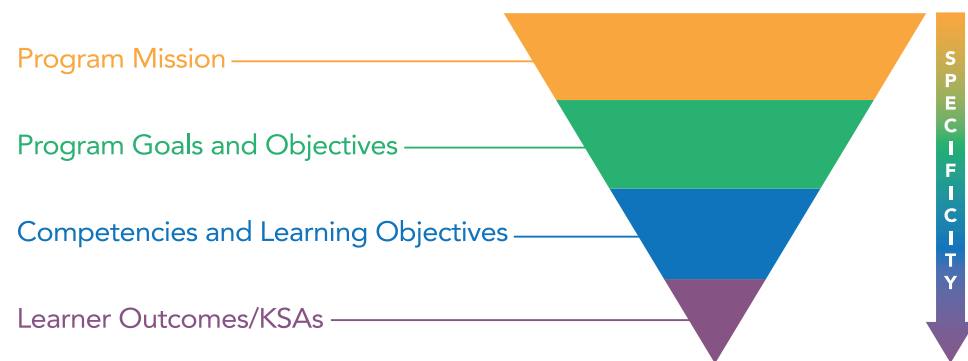


Figure 5.1: Relationship between Mission, Program Goals and Objectives and Competencies and Learner Objectives and Outcomes

Program Mission and Goals and Objectives

CHCI's Postgraduate NP Residency Training Program's mission is firmly grounded in the mission of CHCI, which started with the premise that healthcare is a right, not a privilege, but has expanded to a vision that CHCI is building a world class primary care organization, committed to special medically underserved populations, improving health outcomes, and building healthier communities. Importantly, it is also derived from the program drivers that prompted the development of the Postgraduate NP Residency Training Program as discussed in [Chapter 3](#). The program goals state what we ultimately want to achieve by hosting a program within our organization. The program objectives state how we will achieve those goals.



Mission. As we noted in [Chapter 3](#), the mission of your APP postgraduate training program should align with your organization's mission and program drivers, and paint a broad picture of why you are hosting a program and what that program will accomplish. For example, the mission of CHCI's Postgraduate NP Residency Training Program is "to provide new nurse practitioners with the depth, breadth, and intensity of training to clinical complexity and high-performance primary care in the service delivery setting of a community health center that leads to competence, confidence, and mastery as a primary care provider, and improved health outcomes for the patients they care for and the health system as a whole." We acknowledge the work of Dr. Afaf Meleis and team on the development on the seminal research defining the hallmarks of a successful transition (Meleis, Sawyer, Im, Messias, & Schumacher, 2000).



Program Goals. The program goals are derived from the program's mission statement. The goals tend to be broad, long-term, and identify what the program aims to achieve as its end point. The goals can be helpful with recruitment and marketing materials as well. Because they are broad, the goals are not intended to be measured; however, goals should clearly lead to objectives and outcomes that are measurable. CHCI's Postgraduate NP Residency Program has five broad goals which are a further elaboration of the mission statement and drivers. By hosting the Postgraduate NP Residency Training Program, we aim to achieve the following:

1. **EXPAND** access to quality primary care for underserved and special medically underserved populations, and contribute to primary care clinical workforce development by training new nurse practitioners in a Health Center (HC) residency program.

2. **SUPPORT** the achievement of competence, confidence, and mastery in all domains of primary care that are needed to serve as a full scope, primary care provider in a complex HC setting through a highly structured transition experience that includes the necessary depth, breadth, volume, and intensity of clinical practice.
3. **TRAIN** new nurse practitioners to a model of primary care consistent with the Patient-Centered Medical Home (PCMH) principles, including care that is comprehensive, team-based, patient-driven, coordinated, accessible, high-quality, and safe.
4. **INCREASE** the overall confidence and professional job satisfaction of new NPs who are committed to working in underserved community settings.
5. **CULTIVATE** the leadership qualities and potential of NPs to engage in leadership roles and activities both within their practice setting as well as in the local, state, and federal communities with which they are engaged.



Program Objectives. The term “objectives” is often used broadly. In order to provide consistency, and avoid confusion, we will use definitions found in the Consortium for Advanced Practice Providers (CAPP) accreditation standards (2025). **Program objectives** “specify the efforts, actions, content, and work that the program intends to accomplish, and within specific time frames” (CAPP, 2025, p. 5). Program objectives should not be confused with **learning objectives** in the curriculum, which “guide the postgraduate trainee in the mastery of didactic knowledge and its subsequent application to practice” (CAPP, 2025, p. 6).

That is, program objectives identify how the program’s goals will be accomplished, and so are more specific and measurable **at the program level**. While the program goals should not need frequent revision, the program objectives might be edited as you revise your program. Each program goal will have one or more program objectives. Learning objectives focus on the performance of the resident.

For example, if the first goal of your APP postgraduate training program is to “expand access to quality primary care for underserved and special medically underserved populations, and contribute to primary care clinical workforce development by training new nurse practitioners in a HC-based residency program”, then the associated program objectives explain how that will be done. Note that these are measurable—you will know if you have met your program goals by measuring your program objectives. The program objectives for the first program goal might be as follows:

1. Create capacity for 6 postgraduate trainees, assigned in teams of two, each with a capacity to build and care for a panel of 300 patients/1,000 visits; and
2. About 80% will remain as primary care providers (PCPs) in our health center or another health center following completion of the program.
3. If you are offering tracks in addition to those specific to the role of a primary care provider, such as a Psychiatric/Mental Health Nurse Practitioner (PMHNP) role, be sure that your objectives embrace any specific goals for this role.

Competencies

Increasingly, issues related to system-based practice and quality improvement appear in the competencies. The content in the curriculum falls within these competencies, and reflects the needs of the patient population at CHCI in particular.

1. **Patient Care**
2. **Knowledge for Practice**
3. **Practice-based Learning and Improvement**
4. **Interpersonal and Communication Skills**
5. **Professionalism**
6. **Systems-based Practice**
7. **Interdisciplinary Collaboration**
8. **Personal and Professional Development**
9. **Technology and Telehealth**
10. **Promoting Fairness and Respect in Healthcare**

These competencies are also referred to as “domains” in the CAPP accreditation standards (2025). Each domain has a broad learner/curriculum objective. For example, the objective for the domain **Patient Care** is to “provide patient-centered care that is compassionate, valued, appropriate and effective for the treatment of health problems and the promotion of health” (CAPP, 2025, p. 8). This statement covers a lot of content! Each domain is divided into subdomains that further describes what the domain means, and how you can recognize it when you see it in actual practice. For example, the objective to “provide patient-centered care” in the **Patient Care** domain means to “perform screening assessments, interpret laboratory data,” and so on. As an example, in [Figure 5.2](#) you can find the **Patient Care** domain from the CAPP Program Accreditation Standards (2025), the curriculum objective, and five of the ten associated subdomains. If you pursue accreditation, you will need to demonstrate how the competency domains are integrated into your curriculum.

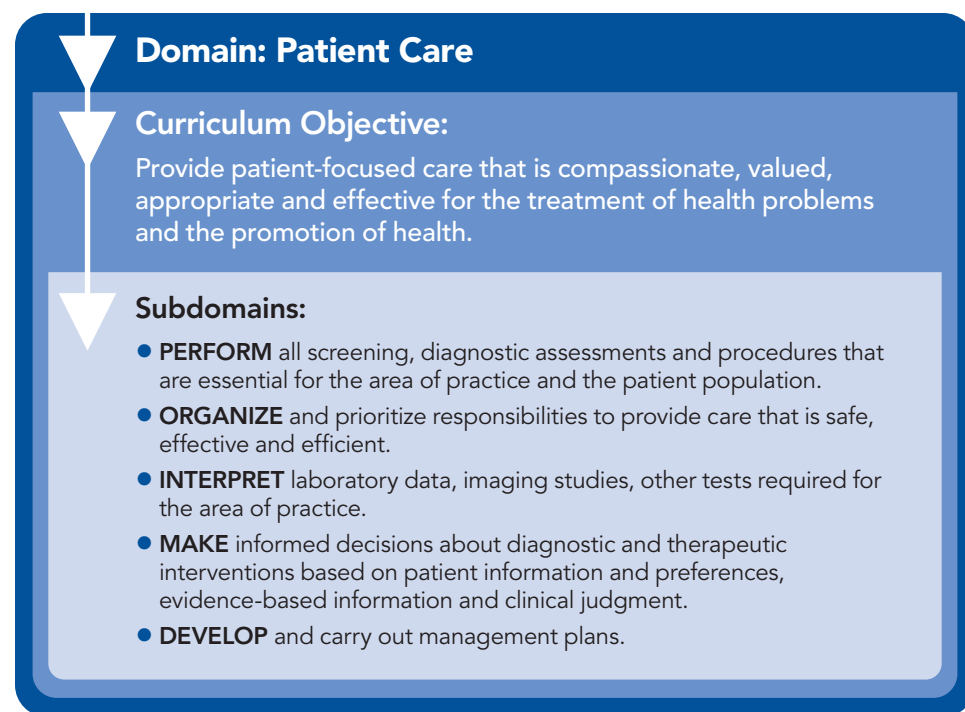


Figure 5.2: Examples of Consortium for Advanced Practice Providers (CAPP) Patient Care Subdomains

Learning/Curriculum Objectives and Learner Outcomes

As we noted above, learning (or learner) objectives in the curriculum state expectations for resident performance based on the competencies. The learner outcomes measure those expectations, and should further elucidate and measure the learning objective in the curriculum. In the example above from the CAPP accreditation standards (2025), the subdomain for **Patient Care** that states “perform screening assessments, interpret laboratory data” can be interpreted as a learner outcome. Learner outcomes articulate the knowledge, skills and attitudes you expect to see in your residents’ performance. Most importantly, the KSAs associated with learner outcomes are measurable; they are the intended results within a curricular domain that can be observed and assessed. They are how you know if your postgraduate trainee is performing as expected. For example, what KSAs are needed to “perform screening assessments”?

In Bloom’s model for competency-based curriculum development, knowledge refers to the cognitive domain of educational activities (Anderson & Krathwohl, 2001; Bloom, 1956; Forehand, 2010). There are six levels of increasing sophistica-

tion demonstrated by the learner that make up learner outcomes in the cognitive domain: 1) knowledge; 2) comprehension; 3) application; 4) analysis; 5) synthesis; and 6) evaluation (See **Figure 5.3**). Skills are the psychomotor domain, the physical and manual skills required for a given task or set of responsibilities. Learner outcomes in the skills domain focus on performance and proficiency. Attitudes are the affective domain, including feelings, values, motivation and behavior. Learner outcomes in the affective domain focus on the demonstration of affective characteristics that can be observed by the person(s) evaluating the learner.

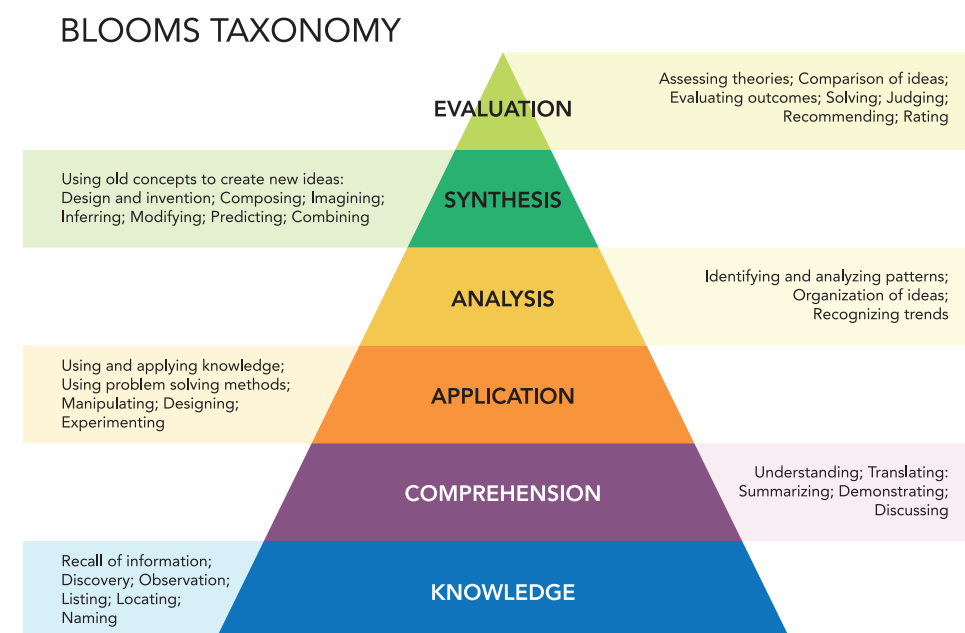


Figure 5.3: Bloom’s Cognitive Domain (Bloom, 1956)

Learner outcomes, especially in the cognitive domain, are usually written using Bloom’s taxonomy. For example, in the CAPP domain **Patient Care**, the first subdomain states “Perform and interpret all screening, diagnostic assessments, and procedures that are essential for area of clinical practice and patient population.” (CAPP, 2025, p. 8). What knowledge should a postgraduate trainee have in order to do this, and at what level of proficiency? As an APP postgraduate training program focuses on application of learning, the learner outcome would address the level of application as a minimum standard. [Table 5.1](#) is a brief example of measurable Learner Outcomes KSAs for the domain **Patient Care** for the population of patients with diabetes. The list in each category for KSAs would continue. [Figure 5.4](#) provides a different view of the same concept.

Domain	Curriculum Objective	Subdomain
Patient Care	Provide patient care that is compassionate, valued.....	Perform all screening, diagnostic assessments and procedures that are essential for the area of practice and the patient population <i>with diabetes</i> .
Subdomain Knowledge	Subdomain Skills	Subdomain Attitudes/Behaviors
Apply knowledge of best practice guidelines for treatment of diabetes	Performs comprehensive medication review and reconciliation	Responsiveness to patient needs that supersedes self-interest
Apply knowledge of screening tests for diabetes	Demonstrate proficiency in performing history and physical	Demonstrate respect for patient
What other knowledge would the resident need?	What other skills would the resident need?	What other attitudes would the resident need to demonstrate?

Table 5.1: Example of Knowledge, Skills, and Attitudes (KSAs) for Curriculum Objective subdomain “Perform all Screening Assessments” for Patients with Diabetes

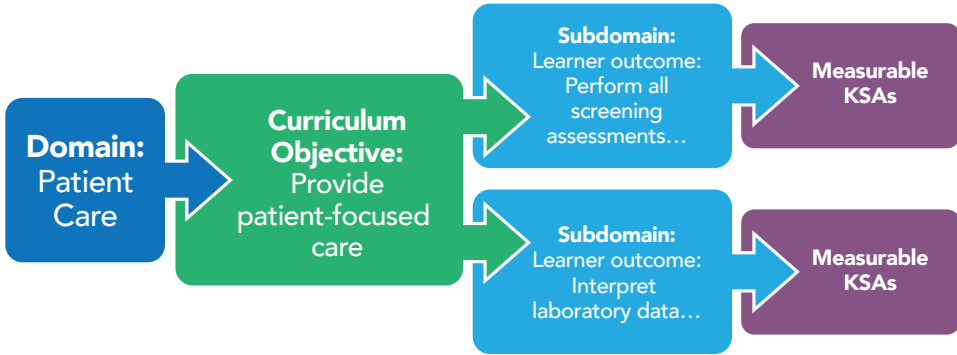


Figure 5.4: Relationship Between Domain, Curriculum Objective, Learner Outcomes and KSAs

As you develop your curriculum, you are not required to use the subdomains in the CAPP accreditation standards (2025) as your learner outcomes. However, they can serve as a helpful guide. While listing all of the KSAs for each subdomain of every curriculum/learning objective can become overwhelming, it is an exercise worth pursuing. It forces you to consider what you need to include in your program and also in the assessment and evaluation of resident performance. You will find that many of the domains and subdomain/curriculum objectives, learner outcomes and KSAs overlap, but you can prune them to avoid redundancies. For example, at CHCI,

we combined the first two domains from the CAPP accreditation guidelines (2025): *Patient Care/Knowledge for Practice*.

Standards of Care in Your Organization

Remember, your APP postgraduate training program should be designed to meet the needs of your organization and your patients. Review the standards of care that your organization has for different populations of patients and/or health conditions. These standards should identify the expectations of all providers for various patient populations and diagnoses. That is, by using your standards of care in curriculum development, much of the work of identifying the content in curriculum development has already been done for you. The terms “knowledge, skills, and attitudes” may not be used explicitly, but your organization’s standards of care can guide the development of your curriculum. Your organization likely has standards for professional conduct as well, that cover ethics, collaboration with peers, communication with patients, and so on.

When and How to Use Curriculum Objectives and Learner Outcomes

Curriculum objectives and learner outcomes are used for any and all learning experiences that contribute to the mission, goals and curriculum objectives of the program and the professional development of the APP postgraduate trainee, and for which you want to assess learner performance. These include:

- Clinical rotations, including specialty rotations, precepted and mentored clinics;
- Clinical procedures;
- Didactic sessions;
- Observation experiences;
- Group discussions; and/or
- Self-reflective journals.

You can think of each clinical rotation as a separate course, but the curriculum/learning objectives for all of these rotations would be similar or even the same, with modifications for the patient population, or the expectations of the resident in those rotations. For example, in an orthopedic rotation, or with patients with behavioral health diagnoses, the postgraduate trainee will need to perform appropriate screenings and interpret associated laboratory data for that group of patients. That is, the curriculum/learning objectives are much the same; the details in the learner outcomes will vary.

As noted earlier, the curriculum/learning objectives will begin to sound repetitive. That is good news. They will provide better consistency and cohesiveness in expectations across clinical rotations. Here is an example of how the Competency/Domain, Curriculum Objectives, and Learner Outcomes might align for a specialty rotation in a diabetes clinic:

I. Competencies/domains: Patient Care/Knowledge for Practice

- A. Curriculum/Learning Objective: **Provide** effective evidence-based patient-focused care for the treatment of health problems and the promotion of health **for patients with diabetes**.
- i. Subdomains/competencies/measurable learner outcomes:
1. **Perform** history and physical **for patients with diabetes**.
 2. **Prescribe** appropriate medications **for patients with diabetes**.

Assessment and Evaluation. The critical reason why you want to align the competencies, learning objectives, and learner outcomes is assessment of the postgraduate trainees' performance and evaluation of the program. **The competencies, learning objectives, and learner outcomes articulate your expectations for the postgraduate trainees' performance, allowing you to use them to assess that performance.** Thus, curriculum development and assessment/evaluation are essentially mirror images. [Table 5.2](#) provides an example of how the competencies, learning objectives, and learner outcomes might work together in a document for a clinical rotation. The Assessment Tool of Resident Performance tool uses a rating scale of novice to expert model published by Dreyfus (2004).



Clinical information is reviewed together in a primary care setting, illustrating collaborative, person-focused care and shared decision-making.

**Building the Next Generation
of Advanced Practice Provider Leaders
at Erie Family Health Centers (Chicago, Illinois)**



Advanced Practice Registered Nurse (APRN) Fellows at Erie Family Health Centers participating in a Saturday Hub clinic.

The Erie Advanced Practice Registered Nurse (APRN) Fellowship Program at Erie Family Health Centers was developed to support newly graduated nurse practitioners in successfully transitioning into community health practice. As an accredited program, Erie's fellowship emphasizes high-quality, team-based care for underserved populations in Chicago and surrounding communities.

We currently offer four primary care fellowship tracks—Family Practice, Women's Health, Pediatrics, and Adult-Gero—each designed to provide focused, immersive training within the Health Center (HC) setting. Our curriculum integrates clinical mentorship, didactic education, and interdisciplinary collaboration to foster confidence, competence, and a lifelong commitment to primary care.

Pursuing accreditation was a natural next step to ensure the program met national standards for advanced practice training, while also reinforcing Erie's commitment to workforce development.

The fellowship has become a vital part of Erie's organizational success, as we retain a significant number of highly trained fellows who continue their careers within our health centers—strengthening continuity of care and leadership within our teams.

Through this fellowship, Erie strengthens its clinical workforce and cultivates a community of compassionate, skilled nurse practitioners (NPs) prepared to serve in high-need communities.

—Kiersten A. Solis, MSN, APRN, FNP-BC, APRN Fellowship Program Director,
Erie Family Health Centers (Chicago, Illinois)

Sample—Assessment Tool of Resident Performance

Competency Domains: 1. Patient Care; 2. Knowledge for Practice						
Curricular Objectives: ● Provide effective evidence-based patient-focused care for the treatment of health problems and the promotion of health. ● Demonstrate knowledge of established and evolving bio-psycho-social, clinical, epidemiological and nursing sciences, for the provision of evidence-based patient care.						
Rating Scale	Competency Rating Score (1–5)					Method of Assessment
1 = Novice 2 = Advance Beginner 3 = Competent 4 = Proficient 5 = Expert 0 = N/A	Resident Self-Assessment Baseline	Preceptor Assessment 6 months	Resident Self-Assessment 6 months	Preceptor Assessment 12 months	Resident Self-Assessment 12 months	List all that apply O = Observed D = Demonstrated C = Chart Audit V = Verbalized T = Tested
Perform comprehensive history and physical exam						
Develop pertinent differential diagnosis						
Order appropriate screening and diagnostic tests						
Order appropriate consults and eConsults						
Order appropriate medications						
Perform comprehensive medication review and reconciliation						
Present case to preceptor in a clear, concise and organized fashion						
Care for acute illness, chronic disease, and health maintenance needs using evidence-based guidelines						
Assess for, diagnose, treat and manage:						
Hypertension						
Diabetes						
Obesity						
Depression						
Chronic Pain						
COPD						
Heart failure						
Asthma						
HIV						

Competency Domains: 1. Patient Care; 2. Knowledge for Practice						
Hepatitis C						
Alcohol Use Disorder						
Substance use						
Women’s Health						
Contraception management						
Perform clinical procedures:						
Electrocardiogram (EKG) Interpretation						
Long-acting reversible contraceptives (LARC) insertion and removal						
Biopsy punch, shave, excisional						
Joint Injection						

Table 5.2: Sample—Assessment Tool of Resident Performance

What you do **NOT** see in this tool is the curricular content and KSAs that are behind it. For example, the learner outcome “Order appropriate screening and diagnostic tests” does not state what those tests are, but you should have clear expectations in your curriculum KSAs about what those tests are in order for a preceptor to determine that the resident has indeed ordered “appropriate” tests. Similarly, the learner outcome “care for acute illness, chronic disease, and health maintenance needs using evidence-based guidelines” is a broad statement. What evidence-based guidelines apply? Again, the standards of care for your organization will likely identify what tests are appropriate for a given health condition in your population. The details will not appear in an evaluation tool, but they should be in your curricular content.

How to Develop Your Curriculum

[Figure 5.5](#) provides a quick overview of the components of your curriculum, and how they fit together. [Figure 5.5](#) is designed to help you to appreciate the importance of alignment in your postgraduate training program as a whole, from mission through learner outcomes, and from learner outcomes back to mission through the process of program evaluation. We have included evaluation of the learner in this figure to emphasize that it flows from the curricular objectives and learner outcomes, but evaluation will be addressed separately in [Chapter 8](#).

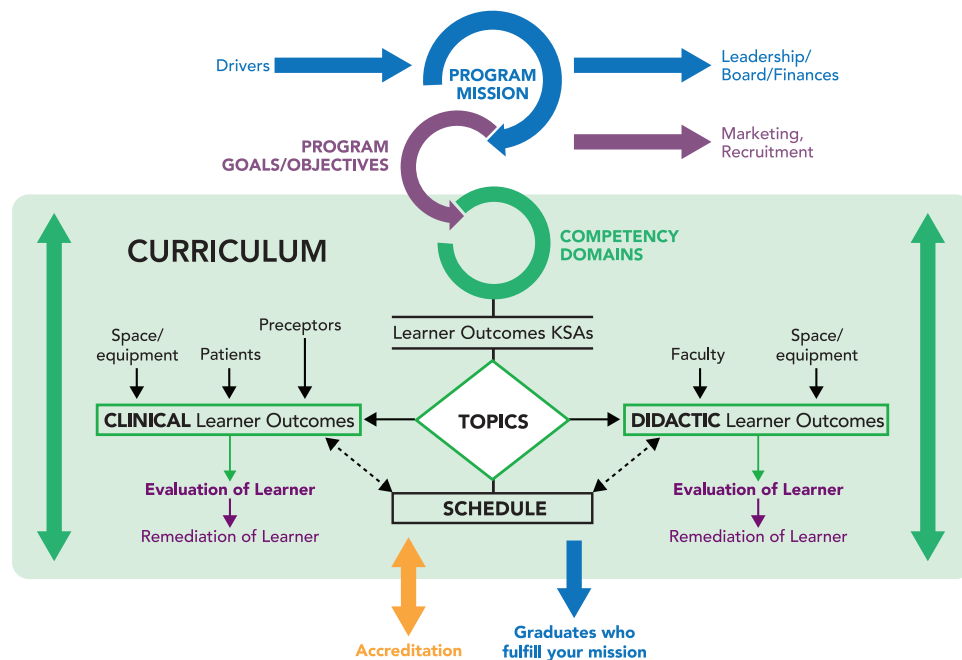


Figure 5.5: Components of the NP Residency Curriculum

Where to Begin

A good place to start is with your organization’s mission, the mission of the APP postgraduate residency training program, your standards of care, professional code of conduct, and an understanding of the patient populations that you serve. With this information, you can make a list of topics, and then sort them into the clinical and/or didactic components of your curriculum. This list would include not just health problems and diagnoses, but also professional issues, such as quality improvement, conflict resolution, or working with your unique population of patients. Working backward from there, you can focus on your learner outcomes and competency domains.

Another place to start is with accreditation guidelines, such as those from CAPP, which will guide you in the development of those learner outcomes and competency domains. As we have noted before, these accreditation guidelines are not designed to be used to develop your curriculum per se, but they may be a helpful resource in your design.

Gaining Tools and Skills



I remember the first day of residency clinic clearly. I was fairly certain my preceptor would quickly discover that I had no business being there. But I also knew that this gnawing worry, this imposter syndrome, only reinforced why I was there in the first place: I cared deeply about getting it right. Patients deserve high-quality, evidence-based care, and I wanted the kind of training that would hold me to that standard.

During residency, I learned, as we all do in community health, from my incredible and complex patients, and the sheer volume of them. But alongside that, I had smart, seasoned, and exceedingly patient preceptors who reviewed every case and showed me the many ways of considering the same questions. I had didactics and readings that pushed my thinking, and rotations that exposed me to networks of care and the ways these networks can break down. Even the quality improvement (QI) project, which I honestly dreaded at the time, turned me into a QI nerd and prepared me to make a positive impact in every place I have worked.

**Looking back, residency didn’t give me all the answers.
It gave me the tools I needed to make an impact
and to advocate for my patients.**

I’ve held various roles in addition to primary care, including directing a nurse practitioner (NP) residency program, co-leading a diabetes prevention program, and currently developing a mobile medicine outreach program. Working in communities where the margin for error is small and the need is great, I’m grateful for these tools.

—**Jessica Horstmann, MSN, FNP-C, Family Nurse Practitioner,**
Native American Community Clinic (Minneapolis, Minnesota)

Conclusion

Curriculum development is an iterative process. There is no one way to start. For the novice, the process can feel overwhelming. This may be an ideal opportunity to reach out to your academic partners and colleagues to collaborate on the development of the curriculum content and objectives. We want to emphasize again that the curriculum for APP postgraduate training is not intended to re-teach what APPs have learned in their formal graduate education. Rather, the intent is to apply what they have learned to your clinical setting with **YOUR** population of patients. As stated earlier, the details of the curriculum for your organization will look different from that of other organizations because your needs, patient populations, and resources will be different. The APP postgraduate training program and its curriculum should meet your needs and the needs of your postgraduate trainees.

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Garrett Matlick, DNP, MPH, APRN, FNP-BC, PMHNP-BC, examines a patient during a clinical visit.

Below: Nurse Practitioner (NP) Residents from Community Health Center, Inc.'s (CHCI) 2016 cohort gather on the rooftop of the organization's Middletown site during their training year.



Above left: Through hands-on training and mentorship, postgraduate trainees build the skills and confidence needed to deliver compassionate care. Right: Sarah Knoeckel, DNP, FNP-BC, as a Family Nurse Practitioner (FNP) Resident at CHCI from 2009–2010.

CHAPTER 6

Clinical and Financial Resources



Where do the clinical and financial resources to establish an advanced practice provider (APP) postgraduate training program come from? In this chapter, we will first address the clinical resources required and then the financial resources. Both are required to establish and maintain a high-quality, effective program in the setting of a healthcare delivery organization, whether a Health Center (HC) or other health care system. We will first describe the support staffing and physical resources needed for APP postgraduate training. These resources include the program and organizational support staff, physical space and equipment, and more. Specifically, this chapter will address the role of clinical preceptors, those seasoned providers who will block a portion of their clinical time to serve as faculty and preceptors in the program for the postgraduate trainees. The second part of this chapter provides details about the financial resources required to start, operate, and maintain an APP postgraduate training program, including a description of how to consider direct and indirect costs. It is important to understand and plan for the full, all-in costs of creating and operating a program, as well as the best and worst case presumptive scenarios of the return on that investment. The chapter will conclude with a section on current and funding strategies for APP postgraduate training.

The **Programmatic Resource Assessment Tool** in [Table 6.1](#) is a good place to start to understand the types of resources you will need in order to implement, maintain, and grow a successful and rigorous program of the highest quality. In [Chapter 7](#), we will review the organizational, operational, and administrative resources for hosting an APP postgraduate training program.

Part I. Clinical Resources

In this section, we will focus specifically on the people, space, and equipment that support the direct and non-patient facing clinical activities described in [Chapter 4](#), including the “home base” clinical assignment, sufficient volume of patients, dedicated workspace and equipment, and space for didactic learning with the requisite technology. We will also describe the role of clinical preceptors and mentors, and specialty providers.

Programmatic Resource Assessment	
PHYSICAL	
1. Have you identified the site that your postgraduate trainees will be assigned?	☐ Y ☐ N
2. Have you identified a dedicated workspace for the postgraduate trainees?	☐ Y ☐ N
3. If Y to question 2, is the space integrated as part of a primary care team?	☐ Y ☐ N
4. Do you have available conference space and video technology for weekly educational programming?	☐ Y ☐ N
FINANCIAL	
1. Have you decided how many postgraduate trainees you will accept?	☐ Y ☐ N
2. Have you established the terms of employment (salary and benefits) for the postgraduate trainees?	☐ Y ☐ N
3. Have you developed a detailed program budget (includes direct and indirect costs including staff, lost revenue, technology, etc.)?	☐ Y ☐ N
HUMAN	
1. Have you identified key program staff (if yes, list positions)?	☐ Y ☐ N
2. Have you identified potential preceptors (MDs/DOs, NPs and PAs) for the program?	☐ Y ☐ N
3. Have you identified potential specialty rotations and faculty for the program?	☐ Y ☐ N
4. Have you identified potential didactics/seminar presenters for the program?	☐ Y ☐ N
ORGANIZATIONAL	
Have you discussed with the following departments about the launch of your postgraduate training program?	
• Board of Directors	☐ Y ☐ N
• Leadership (Administrative and Clinical)—commitment to training program	☐ Y ☐ N
• Human Resources—recruitment, retention, onboarding, credentialing, benefits	☐ Y ☐ N
• IT—hardware, software, electronic health record, conferencing technology	☐ Y ☐ N
• Finance—trainee salaries/benefits, payroll, billing	☐ Y ☐ N
• Operations—scheduling, front desk	☐ Y ☐ N
• Clinical Support staff—support of clinical care for resident patient care experiences	☐ Y ☐ N
If YES, please provide more detail on your answer If NO, please provide initial ideas on addressing the resource	

Table 6.1: Programmatic Resource Assessment Tool

Selecting the “Home Base” Assignment of the APP Postgraduate Trainees

It is important that postgraduate trainees be embedded in a primary care site where they can function as part of a primary care team. At Community Health Center, Inc. (CHCI), Nurse Practitioner (NP) Residents are members of a “pod,” that is, a primary care clinical team, at their assigned site. A typical pod includes two primary care providers (PCPs), their medical assistants (MAs), and a shared registered nurse (RN), along with a behavioral health therapist and may have additional “seats” for students and specialists who support multiple pods. These individuals work together on a regular basis caring for specific panels of patients. Psychiatric/Mental Health Nurse Practitioner (PMHNP) Residents at CHCI are embedded within a site but may support multiple primary care teams.

CHCI makes every effort to assign two residents per primary care site, with the number of sites utilized varying based on the size of the cohort. Other successful programs have assigned three postgraduate trainees per site, with a ratio of one preceptor to three residents. This decision should take into account available exam rooms, support staff, preceptors, and importantly—a sufficient influx of new patients seeking care from which the postgraduate trainees can build a panel. If you have multiple practice sites, as is common for HCs, you will need to choose which site is the best fit for your APP trainees’ assignment.

The following checklist will be used to ensure all appropriate items of site placement are met prior to the start of the training program:

Table with 3 columns: Focus Area, Yes or No?, and Comments. It contains 6 rows of assessment items related to site placement for postgraduate training.

Table 6.2 Clinical Site Assessment



The Clinical Team. At each site where the postgraduate trainees are assigned, there are a number of key individuals who are designated to facilitate the postgraduate trainees' progress in achieving program requirements in conjunction with the program staff. As the postgraduate trainees are members of the clinical team at their site, they have full access to the providers and other clinical support resources as part of their practice. MAs and nursing support is appropriately worked into staffing ratios at the site level to support the postgraduate trainees during their clinical experiences. Postgraduate trainees require support staff assigned to work with them during precepted continuity clinics, so that they can experience working in a truly integrated team-based model of care. The preceptors all play a role in facilitating the postgraduate trainees' progress both in their precepted clinics and also on a daily basis. Whoever the clinical leader is at the site will play an important role in the program and in supporting the postgraduate trainees' progress.

Patients for APP Postgraduate Trainees' Panels. As noted in [Chapter 4](#), in the CHCI model, the NP Residents spend a minimum of 40% of their time embedded in a primary care team at their home base clinical site where they build a panel of approximately 350 to 400 patients over the course of the year, based on a progressive ramp up schedule. The goal for primary care should be at least 1,000 patient visits per year. Therefore, there should be a sufficient volume of patients representing a patient panel based on your clinical setting from which to build that panel.



An orthopedic didactic being led by James J. Lehman, DC, MBA, FACO (center) with CHCI 2010–2011 NP residents (left to right) Anna Olivier, Hao Pham, Kristie Quarles, and Martha Trevey.

In choosing the best site for your postgraduate trainees' assignment, review the data on demand by patients, wait time for an initial appointment, and current size of the existing PCPs' panels to see if there is in fact enough demand to satisfy the need for new and existing patients for the postgraduate trainee. For family nurse practitioners (FNPs), that influx of patients should be inclusive of the full lifespan, from newborns to older adults in order to provide a full learning experience. The questions of panel size and any criteria, such as age range, are important and may vary based on the track, with PMHNP Residents varying from primary care specialties.

Clinical Work Space. You will want to ensure that there are sufficient exam rooms to accommodate the postgraduate trainees during the time they will be seeing patients. At a minimum, each postgraduate trainee should have one room available to them throughout the precepted continuity clinics. The need for available exam rooms may increase over the course of the program to accommodate for the increased capacity of the postgraduate trainees as they implement the progressive patient schedules. Remember, if a preceptor is precepting instead of seeing their own patients, that preceptor's exam rooms may be available for use by the postgraduate trainee.

Non-Clinical Work Space/Station. If at all possible, embed your postgraduate trainees within the same space as the care team to support their training to a team-based model of care. A dedicated workspace for postgraduate trainees supports their experience of being fully embedded in the team at their assigned site. The postgraduate trainees need access to the same physical and technological resources that other providers have access to, such as computers, telephones, printers, and more. Having dedicated space in an integrated clinical setting is paramount in the overall postgraduate training experience.

Space for Didactic Education Sessions. While teaching is continuous and ongoing throughout the program, a major component of the APP postgraduate training program is the regularly scheduled didactic education sessions. You will need to determine how, when, and where these sessions are offered, in addition to what the topics will be. Nevertheless, you want to be sure that your postgraduate trainees have access to the appropriate space and technology to facilitate these educational sessions.

In CHCI's model, we deliver didactic education sessions and other educational content primarily through a video conferencing platform, since both presenters and the NP Residents work in many different physical locations. For this reason, our program has conference space with large screen videoconferencing capacity for larger groups, as well as laptops with camera and microphone capabilities for smaller

groups at each site. We use this technology for all didactic sessions, as well as for the Project ECHO® sessions and the Quality Improvement (QI) Seminars mentioned in [Chapter 4](#). Programs may be flexible in determining when and under what circumstances their postgraduate trainees may participate remotely. This model may be useful if your APP postgraduate training program is hosted across multiple sites.

Human Resources (HR): The People Who Make it Work

New NPs and physician associates/assistants (PAs) seek out APP postgraduate training experiences in large part because of the availability of clinical experts and peers who are not only ready, willing, and able to support their development as new providers, but who also have been given dedicated time to do so. At CHCI, clinical faculty is assigned to precepted and mentored clinics, specialty rotations, didactic education sessions, the QI Seminar, and other components of the curriculum that address organizational development. It is imperative that your program have sufficient capacity to meet these needs with the most qualified clinical program faculty.



Preceptors and Mentors. Expert preceptors and mentors are central to the effectiveness of your APP postgraduate training program. APP postgraduate training in all of the health professions relies on actual clinical experience, as well as expert guidance from clinical preceptors. Preceptors not only teach, but they model the professional role to which the postgraduate trainee aspires (Chen, Rivera, Rotter, Green, & Kools, 2016). At CHCI, preceptors practice the high-performance model of care (as outlined in [Chapter 2](#)) expected of NP Residents when they complete our Postgraduate NP Residency Training Program. Most importantly, preceptors are critical to developing the healthcare workforce (Donley et al., 2014).

The literature on precepting and mentoring in the health professions shows that the relationship between an experienced preceptor and new practitioner is a significant factor in the latter's professional success (Brooks & Niederhauser, 2010; Chen et al., 2016; E. Hayes, 2000; E. F. Hayes, 1999; Lyon & Peach, 2001). Our approach to precepting has, of necessity, paved some new ground. At CHCI, we recognized early on that precepting the NP Residents, already licensed and board-certified healthcare providers, would be very different than precepting health professions students, including NPs, that our clinical staff were accustomed to precepting. There were questions of "how much is too much" involvement on the part of preceptors, reluctance at times on the part of the NP Resident ("I should know this already"), and some discomfort on both sides with giving constructive criticism. The evaluation process, with regular, bi-directional feedback, was immensely helpful in crafting a space of open communication and feedback about the precepting experience that now exists.

In order to ensure that we were attending to the needs of the preceptors, as well as the needs of the NP Residents, CHCI created a "Chief of Preceptors" designation for one senior member of the medical staff who has dedicated time to conduct an annual orientation for all new and existing preceptors and mentors to provide an update on the program, review any new policies or procedures, and provide a forum for preceptors to discuss challenges and successes. This individual rotates once a month at each site to gauge the progress of each resident dyad while providing feedback to them that is also shared with program leadership. Additionally, CHCI created a site-specific preceptor champions group called "Point Preceptors" that meets with the Clinical Program Director to share their day-to-day interactions and experiences with the residents to keep a finger on the pulse within the program both clinically and professionally. This approach achieves both gaining valuable insight (particularly at a multi-site training program), while also providing leadership opportunities for the preceptors. The success of this approach is evidenced by the number of medical staff members, MDs/DOs, PAs, and NPs, who show interest in being a preceptor. The Chief of Preceptors role is further discussed in [Chapter 7](#).

At CHCI, each site may have multiple preceptors; the continuity of care is between the NP Resident and patient, not the preceptor and the patient. Multiple preceptors per site ensures there is always coverage and exposes the NP Residents to different styles of practice. Minimum requirements to serve as a preceptor in the CHCI program include a minimum of one year of practice at CHCI as a PCP, regardless of total years in practice. Interested providers who do not qualify as a preceptor can still participate in mentored clinics, and other curricular activities and special events. All of these areas provide an opportunity for CHCI staff members to engage with the residents outside of being a preceptor.

As stressed throughout this book, the preceptor is blocked from seeing their own patients during precepted sessions so that they are fully available to the postgraduate trainees. The exception to this is if there is a 1:1 ratio of preceptor to the postgraduate trainee. In addition, postgraduate trainees are encouraged to follow-up with the preceptor in between sessions if additional questions arise and follow up is needed, such as results from lab and diagnostic imaging ordered during the session.

Each APP postgraduate training program will determine that best approach to scheduling. The balance between same day/urgent/acute/complex care appointments is unique to each practice, but the program staff will maintain vigilance that the appropriate balance of such visits is supportive of the learning objectives of the program.

Box 6.1: UMass Chan Medical School: New England Nursing Clinical Faculty and Preceptor Academy

The New England Nursing Clinical Faculty and Preceptor Academy (HRSA grant T1QHP47319 awarded to the UMass Chan Tan Chingfen Graduate School of Nursing, Worcester, MA 2022-2026) was developed as a centralized resource to support the skill and knowledge development of clinical faculty and preceptors for nurse learners at all levels and in all settings. The term Preceptors includes clinical faculty, supervisors and other roles that are essential to effective teaching and onboarding of nurses. More than 50 Preceptor Skills Webinars incorporate best practices, principles of adult learning and strategies for audience engagement are organized by the seven core competencies identified by the Association for Nursing Professional Development (ANPD) National Preceptor Practice Study (2021). The webinars also include strategies to support both preceptor and learner wellness. A toolkit provides resources shared by presenters and available from the literature. The webinars with CE, toolkit and resources are free to access. An annual conference, Teaching of Tomorrow teaches foundation skills in a master train-the-trainer approach and podcasts provide a quick introduction to the skills of effective preceptors.

To learn more, please visit: <https://www.umassmed.edu/gsn/preceptor-portal-two/welcome/>



Specialists. You may identify specialty rotation preceptors internally or externally, based on the resources and needs of your organization and program. CHCI's HIV, Women's Health, Healthcare for the Homeless, Pediatrics, and Adult and Child Psychiatry, School-Based Health Centers, and Urgent Care rotations are staffed with faculty from within CHCI, while our Newborn Nursery and Orthopedics rotations are staffed by external specialists. Identifying and recruiting external practices to support and staff specialty rotations for your program can present some challenges with the current high demand for clinical placement sites by health professions students and postgraduate trainees. However, our experience, and that of many APP postgraduate training programs, is that local practices and hospitals are often willing to collaborate and partner. Not only does this provide the program with the desired clinical learning experiences for the APP postgraduate training program, but provides the organization with an opportunity for relationship building and better coordination of patient care. If there is an external partnership established, make certain to have a signed Memorandum of Understanding (MOU) in place between

both organizations to determine the length of the relationship, frequency of review of the relationship, and explicitly note what the trainees can and cannot do at that outside organization.

As noted previously in [Chapter 4](#), programs evolve over time. CHCI initially sent NP Residents to community dermatologists for a specialty rotation. With the advent of high resolution dermatology cameras and access to eConsults, our NP Residents are able to secure expert consultation and enhance this by performing skin biopsies on site as indicated.

Choosing the Right Resources

Choosing the right physical and staff resources for your program comes with challenges. As your program grows, and as your organization grows, you will need to design space to accommodate the APP postgraduate training program and its postgraduate trainees. As CHCI's Postgraduate NP Residency Training Program expanded from beyond 4 residents, we have found that it can be difficult to balance the residents' needs for physical space and equipment with other, equally important priorities for space and resources. You may have a wonderful clinical practice site to which you want to assign postgraduate trainees, with qualified preceptors and plenty of space, but perhaps there isn't sufficient demand by new patients to support both the current providers and the postgraduate trainees in building a panel of new patients; this may also have been a function of the success of the program due to filling staffing roles at the site to capacity. Conversely, you may have another location that has both sufficient patient demand and expert preceptors, but there is simply not enough space without inconveniencing the staff already on site. You should balance all these factors when assessing your resources and in choosing the best location for your postgraduate trainees to train.

We note that some APP postgraduate training programs have designed new dedicated space for training health professionals, including the postgraduate trainees. This is a unique opportunity to design a space that meets your program needs, hopefully in a team-based, interprofessional context, with design features to enhance your training program. Should you decide to create such a space, it is highly recommended that the complexity and acuity do not differ from that of your other clinical staff at other locations in order to allow postgraduate trainees to train to the top of their scope of practice.

Part II.

Financial Resources: Cost, Revenue, and the Return on Investment

A critical responsibility of leadership in organizations seeking to develop APP postgraduate training programs is to assess both the costs and the return on investment. Postgraduate training for NPs and PAs has had federal grant support since 2018 under Title VII Advanced Nurse Education-Nurse Practitioner Residency (ANE-NPR) program, but is subject to changes in federal funding opportunities and funding has not exceeded support for 40 programs. While state-based and philanthropic funding is a possibility, it is essential that organizations realistically assess their capability to invest in and sustain a program. The Board of Directors and leadership of your organization should determine the strategic benefit to the organization when considering whether to invest in the APP postgraduate training program. Our goal is to provide you/your organization with data gleaned from nearly two decades of experience to help guide that assessment.

[Table 6.3](#) serves as a sample Pro Forma Analysis (Cost Calculator) to compare the impact of adjustable factors, such as the number of postgraduate trainees, the number of sites to which they are assigned, and the ratio of preceptors to postgraduate trainees. This model takes a realistic look at the lost revenue resulting from experienced PCPs acting as preceptors assigned to postgraduate trainee teaching, and the resultant reduction of billable visits, particularly in the first several months of the program. A major factor to consider is the unique nature of APP postgraduate training: APP postgraduate trainees are licensed and credentialed PCPs able to bill for their own services.

We will also address the return on the investment (ROI) of a training program by reviewing the financial impact of retaining the postgraduate trainees post-training compared to recruitment of new providers. We will take a look at cost first, then revenue, and finally provide a model for calculating the return on your investment. Many organizations have told us their final decision to proceed was not based on whether they could afford to start a program, but whether they could afford not to.

Costs: Direct, Overhead, and Indirect

In postgraduate clinical training, whether of NPs, PAs, physicians, dentists, or psychologists, there are two major areas of costs: direct and indirect. The best known

example is post-medical school training for resident physicians working in teaching hospitals under the supervision of more senior residents and attending physicians.

The direct and indirect costs of postgraduate medical training are traditionally supported by payments to the hospital from federal Graduate Medical Education (GME) dollars, which has its own unique formula. The Teaching Health Center (THC) program, created and funded under the Affordable Care Act, operates differently with a per capita payment per medical resident, but also recognizes both direct and indirect costs (Department of Health and Human Services, 2011). The THC program supports the training of physicians and dentists trained in community-based ambulatory patient care settings. These community-based settings include, but are not limited to: community mental health centers, rural health clinics, and health centers operated by the Indian Health Service or an Indian tribe or tribal organization, and entities receiving funds under the Public Health Service (PHS) Act.



Calculating Direct Costs. Each program should set its own salary structure for the postgraduate trainees. Generally, salaries are set at a percentage of current market for new NPs or PAs not in a training program, but the percentage set by the organization. Employee benefits are also a direct cost, and for postgraduate trainees are generally on par with other Licensed Independent Practitioner (LIPs) in the organization, although there may be some variations, such as paid time off (PTO) accrual and Continuing Medical Education (CME) allowance. Direct costs also include program personnel and equipment. Depending on the size of your program, the roles of Program Director and Program Coordinator may be a full-time position or allocated as dedicated time from existing positions. Both clinical leadership responsibilities (e.g. curriculum, evaluation, precepting), as well as the operational details (e.g. tracking clinical assignments, arranging didactic sessions, coordinating schedules) have to be managed. Direct costs may also include computers, tablets and phones, electronic health record (EHR) and other licenses, evaluation system licensing fees, mileage reimbursement, and teaching/education aides.

The Pro Forma Analysis (Cost Calculator) in [Table 6.3](#) provides a snapshot of potential expenses and ROI, and is based on assumptions for details that only you can meaningfully provide. In this example, we assume that there are no additional revenue sources such as grant funds, that there are either two or three postgraduate trainees in the initial cohort, and that the organization is using only one site for the program. In this example, there are lines for the Residency Program Director, Residency Program Coordinator, and other staff. Of course, many staff will contribute to the education and training of the postgraduate trainees beyond these individuals.

Advanced Practice Provider (APP) Postgraduate Training Program Pro Forma Financial Analysis/Cost Calculator Sample		2 Residents	3 Residents
YEAR 1			
REVENUE			
Patient Revenue Generated by Residents			
# of Residents		2	3
Visit Expectation per Resident		1,000	1,000
Average Revenue per Patient Visit			
TOTAL REVENUE			
EXPENSES			
Salaries and Fringe Benefits			
# of Residents		2	3
Salary per Resident			
Program Director FTE			
Program Coordinator FTE			
Other Staff FTE			
Total Salaries			
Fringe Benefits (X%)			
Total Salaries and Fringe Benefits			
Other Direct Expenses			
Equipment, Software, EMR Licenses			
Evaluation Software License			
Medical Supplies and Materials			
Total Direct Expenses			
Indirect Expenses (lost patient revenue from preceptors)			
Estimated Lost Visit Revenue for Preceptors (Estimated 45 Weeks of Precepting)			
Average Revenue per Patient Visit			
Total Indirect Expenses			
TOTAL EXPENSES			
Margin—Year 1			

Table 6.3: Sample—Pro Forma Analysis (Cost Calculator) *This assumes there are no additional revenue sources.

The Program Director, usually an NP or PA, is engaged in key elements of the program and responsible for curriculum development and evaluation. The Program Coordinator is responsible for the oversight of the operation of the program and manages the day-to-day implementation and logistics of the program. These responsibilities can be combined with another staff position within your organization. Based on the size of the program, this can look very different in terms of FTE staffing.

YEAR 2 (Post-Residency Year). A consideration that may help offset the costs associated with an APP postgraduate training program is the inclusion of a post-residency service commitment within the postgraduate trainee’s employment contract. During this second year, the postgraduate trainee transitions into a full-time provider role, enabling the organization to recover a portion of the reduced productivity and associated revenue limitations experienced during the training year. In addition to increased clinical productivity, the post-residency year may provide substantial financial benefit through avoided recruitment and onboarding costs associated with hiring external providers. Organizations considering incorporation of a post-residency commitment into employment contracts should evaluate factors such as current recruitment and onboarding costs, workforce needs, and organizational capacity for additional providers. It is also important to consider any planned changes during the post-residency year and making appropriate adjustments, such as changes in site location or increased empanelment.



Calculating Opportunity Costs. The revenue lost when preceptor clinicians are not seeing their own patients, but are exclusively attending to the education and training of the postgraduate trainees, is what we refer to as an opportunity cost of the program. Some organizations encourage preceptors to schedule additional hours, with additional compensation, for precepting to avoid this loss. In that case, the amount of compensation paid for their time spent precepting should be included as a Direct Cost. In most organizations, many clinicians generally welcome the opportunity to serve as preceptors as a respite from their regularly scheduled clinical time and as a satisfying professional opportunity.

We have previously noted that most programs devote 40% of the postgraduate trainees’ time to precepted continuity clinic sessions. Since the postgraduate trainees are licensed independent providers, they are the accountable clinicians of record who bill for the patient visit. This is recorded as revenue and may significantly offset the lost revenue of the preceptor not seeing their own patients and billing for those visits. This “lost revenue” is a function of your practice’s average reimbursement rate



per visit multiplied by the expected number of visits per hour for your precepting providers multiplied by the number of hours spent precepting.

While the number of visits billed by each postgraduate trainee in the first few months of the program is modest, this number steadily increases throughout the year as they become more experienced. The volume of visits and encounters varies across specialties. In our experience, most primary care programs aim for 800 to 1,200 visits per postgraduate trainee over the 12-month program.

Benefits: The Return on Investment (ROI)

It is the potential return on investment (ROI) and business imperative of growing an expert primary care workforce that makes implementing an APP postgraduate training program an attractive investment to a health center. In order to correctly arrive at an ROI for the APP postgraduate training program, the cost analysis of the program has to be calculated over the full life-cycle of the trainees, which is two years. If all of your wonderfully trained, confident, competent APP alums now head off for other health centers and areas of the country, you can take pride in having made a real contribution to clinical workforce development, but that may not be very reassuring to your organization's bottom line. The ROI is realized in retaining a significant number of alumni of the program as PCPs at your organization in year two. Of course, grant and philanthropic funding eases the financial challenge.

Retention by Contract. Some, but not all, organizations require by contract that the postgraduate trainees commit to employment for a period of time, usually one year, post-residency. Our experience at CHCI is that an average of 40%–50% of our NP Residents will choose to remain for at least an additional two years without a contractual obligation. In 2018, CHCI implemented a two-year contract; the first year for the NP residency year and the second year post-residency employment commitment.

Another factor to consider is the additional cost of recruiting a new provider to your organization, rather than retaining a postgraduate trainee. This will vary for each organization based on the time, effort, and fees your organization typically expends in recruiting new providers. See [Box 6.2](#) for a summary of the financial impact of retaining APP postgraduate trainees.

Box 6.2: Financial Impact: Retaining Advanced Practice Providers (APPs) from the Postgraduate Training Program Offers Significant Organizational Benefits

Retaining advance practice providers (APPs) who have completed the postgraduate training program represents clinical, organizational, and financial benefits to the host organization. Staff vacancies due to growth or turnover are costly on many levels, including the high costs of recruitment and lost revenue/interruption of patient care due to position vacancies.

Impact on Healthcare Organizations

- These financial pressures extend beyond hiring budgets. Prolonged vacancies and associated fees strain operating margins—especially in community and rural facilities. Operationally, staffing gaps increase workload for remaining clinicians, heighten burnout risk, and complicate panel management. Ultimately, patients—particularly in underserved regions—experience reduced access to timely, high-quality care.

A Strategic Alternative: Transitioning APP Postgraduate Trainees into Open Positions Following Residency

- Retaining former APP postgraduate trainees as full-time clinical staff offers a cost-effective and sustainable recruitment strategy. This model leverages clinicians already familiar with organizational workflows, supports smoother hand-offs when paired with outgoing providers, and reduces recruitment costs.

Provider Shortages Will Continue

- The Health Resources and Services Administration (HRSA) projects a shortage of 87,150 primary care physicians by 2037 (HRSA, 2024). As shortages persist, recruitment challenges will intensify. Success will depend not on increased spending but on smarter, data-driven, and adaptable hiring strategies, including residency pipelines that meet clinical needs while training the next generation of providers.

The Intangibles: Staff Satisfaction. There are important intangible benefits as well that should be recognized. CHCI and other organizations have witnessed immense satisfaction on the part of clinicians that serve as preceptors. This may contribute to successful efforts to retain expert clinicians.



Partnering With Another Organization

As you plan your program and build your budget, you may want to consider contracting with an external partner for some aspects of the program. An expert partner can manage all or some aspects of the APP postgraduate training program including recruitment and selection of candidates, program design/redesign and implementation, preceptor and staff trainings, distance learning for didactic elements, and program evaluation. Some organizations seek out an academic partner for help specifically with curriculum development and delivery as well as evaluation.

Organizations may find it easier in the initial years to partner with an expert organization to provide support and consultation to the APP postgraduate training program. When thinking about potential partners and collaboration, you will need to identify the services needed for your program and the cost associated with another organization providing those services.

Summary

It is important to remember that starting and operating a postgraduate training program for new NP and PA graduates is a multi-year cycle. It should be clear by now that there are many variables in your financial calculations. The number of postgraduate trainees and program staff, their compensation and benefits, the ratio of preceptor-to-residents, lost productivity of the preceptors, and projected revenue for the postgraduate trainees all are factors to consider in developing your financial projections.

Part III. Future Funding Opportunities

This exercise in calculating your costs and ROI point to an obvious conclusion: some health centers are in a better position than others to start and operate an APP postgraduate training program. Health centers that have a substantial bottom line margin, available operational resources, such as space and equipment, and staff and preceptors that can be deployed to support such a program are better positioned to make the investment in developing an APP postgraduate training program than those health centers that are smaller or more restrained. Yet, these smaller health centers may be able to offer an excellent training experience and

would benefit enormously from attracting talented new NPs and PAs to their area, with the possibility of retaining them as long-term PCPs.

We believe that there is a case for a national investment in APP postgraduate training and have worked diligently over the years since developing this model to educate stakeholders about the growing need for expert PCPs in the U.S., the value of APPs in meeting that need, and the benefit of an additional year of postgraduate training that fully prepares them for the challenges of practice and leadership. We have seen progress in stakeholders' understanding of the clinical workforce issues in primary care, and the need for sustainable funding for APP postgraduate training.

The History of Federal Funding for APP Postgraduate Training Programs:

- The Affordable Care Act (ACA) authorized funding for a 4-year period in 2010, however it was never appropriated.
- The Health Resources and Services Administration (HRSA) and the Bureau of Health Workforce (BHW) initiated a funding opportunity of \$20m in 2018 for postgraduate NP Residency programs, which rose over the years to \$36m. These opportunities have been funded by HRSA's Advanced Nursing Education (ANE) account. This funding has been supplemented by specific direct congressional awards.
 - In June 2023, the HRSA Advanced Nursing Education Nurse Practitioner Residency and Fellowship (ANE-NPRF) awarded 45 grants with an end date of June 30, 2027.
 - Direct appropriation increased to \$7m in language included in the FY 2024 Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act approved by the full House Appropriations Committee which states:

"Provided further, that of the funds made available under this heading, \$7,000,000 shall be available to make grants to establish, expand or maintain optional community based nurse practitioner fellowship programs that are accredited or in the accreditation process, with a preference for those in Federally Qualified Health Centers (FQHCs), for practicing postgraduate NPs in primary care or behavioral health" (U.S. House of Representatives, 2024).

Current sources of funding for physician residency training programs, particularly under Graduate Medical Education (GME) and Teaching Health Center (THC) are limited to physicians and dentists. Continued support at the state and federal level, including Medicare and Medicaid, as well as HRSA, is needed. It is essential that leaders in APP training conduct the rigorous research and evaluation to demonstrate the value of and need for APP postgraduate training.

Private Foundations. Private funding and philanthropy is particularly well suited to the innovation and development phase of a new initiative and as such, foundations may be able to help with implementing and evaluating demonstration APP postgraduate residency training programs, but they cannot be relied upon as a long-term source of funding.

Conclusion

The questions before you, your Board of Directors, and the leadership team in your organization are: **What are the clinical, financial, and strategic drivers for developing an APP postgraduate training program, the impact to your bottom line, and the likely potential return on the investment? And most importantly: What is the cost of NOT moving forward with clinical workforce development in your own organization?** With this in mind, as wise stewards of the resources available to your organization and a commitment to both the short- and long-term healthcare needs of your patients and your organizations, we are confident you will make the right decision for your organization. With or without external funding, we continue to see growth and further development of a model for APP postgraduate training programs.

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The Connecticut Department of Veterans Affairs (DVA) annual Stand Down event is a highlight of Community Health Center, Inc.'s Postgraduate Nurse Practitioner Residency Training Program orientation.

Below: Each year, Community Health Center, Inc. (CHCI) celebrates its Nurse Practitioner (NP) Residents at a graduation ceremony recognizing the completion of their Postgraduate NP Residency Training Program and their professional achievements.



CHAPTER 7

Operations and Administration

In a well-run advanced practice provider (APP) postgraduate training program, it is easy to miss how much is going on behind the scenes to make it a smooth, efficient, and effective operation for the APP postgraduate trainees and the organization. Marketing, recruiting, candidate selection, onboarding, credentialing, orienting, scheduling, and—of course—troubleshooting are all part of the orchestration below the surface.

The operational and administrative activities of the program involve several departments across the organization, which is why it is important to involve them from the very beginning. They include: Human Resources (HR), Information Technology (IT), Business Intelligence (BI), Marketing and Communications, Finance, Facilities, and Credentialing. The program itself also requires administrative staff with time dedicated to planning, implementing, and evaluating the APP postgraduate training program to ensure that it is of the highest quality. In this chapter, we will describe the operational activities and organizational resources underpinning the model of APP postgraduate training as has been presented through Community Health Center, Inc.'s (CHCI) Health Resources and Services Administration (HRSA)-funded National Training and Technical Assistance Partners (NTTAP) on Clinical Workforce Development.

Organizational Resources: Achieving Top-to-Bottom Support

One thing is certain: you can't run an effective APP postgraduate training program in a silo. Successful programs benefit from widespread understanding and support of the program and its implementation. Your implementation plan should include clear and focused communications with key departments in order for them to have the information they need to support the program. Below is a list of some of the key people, roles, and departments that you will want to engage early in your planning. We discussed these organizational resources briefly in [Chapter 3](#), and review them again here to emphasize that they are essential to your program's success.

Leadership



Your leadership team as a whole is the first group from which to enlist support for starting a new APP postgraduate training program. Given the necessary financial investment in the program and its integration into the clinical setting, your administrative and clinical leadership should fully understand the commitment that a program entails, as well as recognize the value of the program both for your organization and for primary care. Leadership support is critical to your program's success; without it, you cannot move forward.

Human Resources (HR)



Your HR department will play a key role in many parts of the program given the status of the postgraduate trainees as employees. Your HR team will not only act as a resource when it comes to recruitment and interviewing, but they will play a significant role in developing employment agreements or contracts, supporting onboarding and orientation activities, as well as managing employee relations and management issues during the course of the program year. It is important to connect with your HR team early so that you can work to decide on the core activities that will overlap with HR responsibilities and also discuss where modifications may need to be made due to the unique nature of the program.

Credentialing is also a critical role in an organization and may be located within your HR Department or within your clinical leadership structure. As this is the first position for most of your APP postgraduate trainees as a licensed independent provider, they will need your guidance on the critical importance of timely response to requests for information and documents from the credentialing department. Similarly, the credentialing staff need your support in understanding how vital it is that the APP postgraduate trainees are fully licensed and boarded qualify for enrollment in insurance plans, including Medicare, Medicaid, and private insurances, just as any other provider does. Your revenue projections will only be achieved if your postgraduate trainees can bill successfully from day one.

Communications and Marketing



Your Communications, Marketing and/or Public Relations department(s) will be helpful in creating the marketing collateral for your APP postgraduate training program. Marketing collateral may include: press releases, advertisements, informational fact sheets, more detailed booklets, website design, social media content, assistance

with any live/recorded webinars, and more. Once you've decided to launch your APP postgraduate training program you will want to engage your communications team right away to begin creating materials and promoting your program.

Information Technology (IT)



The IT team will need to support the APP postgraduate training program as it does all other employees of the organization. Work with this department early in the process of starting a program so that they understand your needs from a program perspective. Postgraduate trainees should have access to the same technology as other members of the medical staff, including access to physical resources such as laptops or tablets, access to data systems and the electronic health record (EHR), and any resources, such as online access to clinical education and decision supports that are available to your clinical staff. As "new to practice" providers, they will need additional in depth training on optimum and efficient use of the EHR, which may be handled by the clinical leadership team of the organization.

Finance



As we discussed in [Chapter 6](#), the financial implications of your program should be clearly understood across the organization. Your Finance department will play a key role in setting up the fiscal oversight for the program, by determining how cost and revenue for the program is captured, developing budgets, and also supporting return on investment analyses. If billing and revenue cycle activities are housed within Finance, this department will be very important to the training of the postgraduate trainees in the correct use of coding, including training them to the importance of documentation necessary to support billing. Timely credentialing and enrollment in public and private health insurance is critical. In addition, the Finance team likely supports the payroll and benefits functions of the program, if it already does for the entire organization.

Operations



Every organization structures their operations team somewhat differently. It may include a Chief Operating Officer (COO), a layer of operations managers, and the staff assigned to frontline operational support. It is essential that this team understands not just the purpose and goals of the APP postgraduate training program as a whole, but more specifically the operational plan that will ensure that

the postgraduate trainees are on track to see the right number, type, and variety of patients, at the right time and volume, with the appropriate rooms and support staff. It is no small task! The site-based operations staff, including those who register new patients, will need training on how to communicate effectively to patients that the APP postgraduate trainee is a board-certified Advanced Practice Registered Nurse (APRN) or physician associate/assistant (PA) who is also completing a postgraduate training program at your organization. This staff will also help to ensure the appropriate ramp-up in volume of patients as the postgraduate trainee gains in experience and mastery. The support, enthusiasm, and technical competence of the operations team, especially at the assigned clinical sites, is a vital element of a successful postgraduate trainee experience.

Clinical Leadership



While there is variation across organizations and practices, most organizations that host an APP postgraduate training program will have a Chief Medical Officer (CMO) or Chief Clinical Officer (CCO) that holds overall responsibility for the medical staff, as well as the quality and safety of the services provided. If your organization is providing an APP postgraduate Psychiatric/Mental Health Nurse Practitioner (PMHNP) program, there may also be Chief Behavioral Health or Psychiatry Officer. These key leadership positions are vital to the success of the APP postgraduate training program. In CHCI's experience nationally with other Health Centers (HCs) and their clinical leadership, we have been deeply impressed by and appreciative of the enormous support that these individuals and indeed the whole medical/behavioral health clinical leadership structure provide to the APPs during this critical and challenging first year of practice and as postgraduate trainees.

Clinical Support Staff



Finally, other clinical team members, including medical assistants, nurses, care coordinators, and others will need to understand their unique role in supporting the experience of the postgraduate trainees. Your postgraduate trainees will be members of the care team, and should experience the same level of collaboration and cooperation as other providers in your organization. In parallel, as these postgraduate trainees are most likely new to this level of function within a team-based "pod," encouraging your clinical support staff to educate your postgraduate trainees on workflows, knowledge of local resources, and understanding when and how to appropriately delegate will simultaneously empower your support staff and provide increased confidence in the management of a complex patient panel.

Operations: Policies and Procedures

Operational policies and procedures are the foundation for a robust APP postgraduate training program. The program should demonstrate that its operation is in alignment with and appropriately uses the established policies and procedures of the organization.



Well-defined policies and procedures reflect the missions and goals of both the APP postgraduate training program and organization. Although we have reviewed policies and procedures in other sections, it is important to address policies that apply specifically to the APP postgraduate training program. As full-time employees, the postgraduate trainees are expected to adhere to the same organizational policies and procedures as other employees. These policies and procedures should be covered during new hire orientation, and be available to all employees in a central information repository, such as an organizational intranet page.

Postgraduate trainee records and documentation should be maintained by the same department in the same way and manner in which they are kept for all employees. All policies and procedures regarding confidentiality and release of records apply equally to the APP postgraduate trainees. At CHCI, HR is engaged to support the program in identifying and applying any CHCI policies and procedures that are directly related to the Nurse Practitioner (NP) Residents' employment, including health screenings, licensing and credentialing, grievances, performance issues, and more. While the majority of policies and procedures that your organization has already established will apply to the postgraduate trainees, it may be necessary to modify existing policies or procedures to fit the unique nature of the postgraduate trainees' employment.

In addition to organizational policies and procedures, the APP postgraduate training program should develop additional policies that meet specific programmatic and operational needs. For example, as discussed in [Chapter 4](#), CHCI's "Stepwise Increase of Advanced Practice Registered Nurse (APRN) Resident Clinical Scheduling Policy" outlines the procedure for clinical scheduling "ramp-up" and also meets the training need of progressively increasing responsibility and independence in patient assessment, diagnosis, treatment and management, as well as in mastering the principles of team-based care, interprofessional practice, and use of sophisticated electronic data and technology. We recommend that you consider some of the following policies as you develop your program.

- **Stepwise Increase of APRN Resident Clinical Scheduling:** The purpose of this policy is to clearly lay out the structure and procedures for increasing the postgraduate trainees' clinical schedules that are progressive over the course of the program. An additional description and template of this policy is in [Chapter 4](#).
- **APP Postgraduate Training Program Precepting Policy:** The precepting policy provides clear guidelines and structure for all preceptors in their roles and responsibilities, including details on guidelines based on stages of postgraduate training development.
- **Formal Postgraduate Training Program Agreement and/or Contract:** We recognize that not all programs will choose to have a formal contract with their postgraduate trainees, but you should provide the terms and conditions of employment, including traditional items such as salary, benefits, access to Continuing Medical Education (CME) opportunities, and personal time off. We have seen some organizations in which the postgraduate trainees were treated as at-will employees, with a confirming hire letter, but an APP Postgraduate Trainees' Handbook was created to detail all aspects of the responsibilities and privileges.
- **APP Postgraduate Training Program Application Process:** It is important to create a procedure for the application process to ensure transparency, consistency and fairness. The application procedure should include: date of opening of applications, application deadline, qualifications, application and required documentation, compensation and benefits, interview dates, offer date and program start date, CME opportunities, and personal time off.

Operations: Marketing and Recruitment



Marketing and recruitment are essential activities as you plan for attracting your incoming class of postgraduate trainees. Ideally, the recruitment planning process begins at least nine months before the start of the program and should include a communications and marketing plan, as well as who will participate in candidate review and selection. Additionally, you need to determine the qualifications you are looking for in your candidates and include those qualifications in the application, marketing materials, and on your program website. Each individual program and organization will develop their approach. CHCI's approach to recruitment has evolved and changed over the years and we will offer some suggestions based on our experience.

Candidate Qualifications

At CHCI, we recruit specifically for new NPs who have completed their graduate degree, either the Doctor of Nursing Practice (DNP) or the Master of Science in Nursing (MSN), within 18 months of the planned start of the program year. This is consistent with our organizational focus on training the next generation, but is by no means a universal rule for all to follow. Other organizations are open to a wide variety of candidates in terms of length of time since graduation and in practice. We strongly encourage all recent NP and PA graduates to take the national certification examinations as early as possible in order to be fully eligible for credentialing, privileging, and appointment to your medical and/or behavioral health staff, as well as eligible for enrollment in all applicable public and private insurance plans, by the start of the program year. Below are important qualifications to be aware of:

- NPs must be licensed in the state as an APRN and hold national board certification as a nurse practitioner in an appropriate population focus or specialty, or as a Certified Nurse-Midwife (CNM) certified by the American Midwifery Certification Board (AMCB).
- PAs must be licensed in the state and hold current certification from the National Commission on Certification of Physician Assistants (NCCPA).
- NPs/CNMs and PAs must hold current board certification and be licensed—or license-eligible as an APRN or PA—by a date determined by the Program, in accordance with the planned program curriculum.

Organizations may determine if other criteria such as fluency in another language or commitment to remain in the organization post residency for a period of time will be required.

Marketing and Recruitment: Local vs. National

An on-going postgraduate training program is always recruiting, from the initial cohort going forward. We encourage you to develop a recruiting plan and determine if you will recruit nationally or within-state, which universities and programs you will target for direct outreach, and what your strategy will be. At CHCI, marketing and recruitment for the Postgraduate NP Residency Training Program is conducted nationally. We have created a presence on the internet with our Postgraduate NP Residency website (www.npresidency.com) and on social media outlets. We also

reach out to key universities, such as schools of nursing in our state, region, and across the country, providing information and recruitment materials, and on occasion provide online presentations to students or visit the schools in person. Additionally, since the rapid growth of postgraduate training programs over the past decade, we have seen regional cooperation between and among APP postgraduate training programs. A good example of this is a collaborative effort in the Pacific Northwest among programs between Northern California, Oregon, and Washington State, as well as Hawaii, titled the Northwest Consortium for Advanced Practice and Education (NW CAPE) where programs have aligned recruitment timelines and share information amongst one another.

To ensure that you attract the right candidates for your organization, you need to first develop a recruitment strategy that answers the questions: **Who are you seeking to recruit? Does it matter to your organization if applicants are from your local geographic area and universities or are you interested in casting a broader net to include applicants from across the country?** Design your marketing and media approach accordingly. Identify current NP and PA graduate students doing clinical rotations at your organization who might be interested in applying and make sure they are aware of the opportunity. Work collaboratively with other health center sponsoring programs to refer candidates that may not be appropriate for your organization to another organization.

Where will you advertise and recruit? You will once again be guided by your focus on local, regional, or national recruitment. We suggest working with your internal communications team to understand the best place to market your training program. This may include national publications, social media, promotion with your academic partners, and state and national NP and PA conferences. You can also conduct high touch personal outreach to students and academic institutions in your area, such as open house informational events. For instance, CHCI provides presentations to graduate nursing programs in Connecticut to engage graduating students. Another great resource is to utilize your postgraduate trainee alumni to serve as advocates of the training program and outreach to their graduate programs.

When will you recruit? Develop a recruitment timeline that allows candidates to consider the opportunity, assemble their materials, and complete the application process on time. Most training programs begin the recruitment process six to nine months before the start of the program to allow for sufficient time to interview and secure candidates.

Marketing and Recruitment at Miami Beach Community Health Center (Miami Beach, Florida)

Each spring, Miami Beach Community Health Center (MBCHC) begins its annual recruitment preparations for the APP Postgraduate Residency Program. This early planning phase includes

redesigning the recruitment flyer, updating website materials, and coordinating timelines. It is a collaborative effort involving the Program Director, Human Resources team, the Chief Operating Office (COO), IT specialists, and the VP of Quality Management and Clinical Analytics—each contributing to clarity, accuracy, and alignment with organizational goals.

Throughout the year, the Program Director hosts live informational sessions for soon-to-graduate Family Nurse Practitioner (FNP) students at NOVA South Eastern University, MBCHC's academic partner. These sessions offer an inside look at the residency structure, expecta-

tions, and support systems. The students are also given an opportunity to speak to a current resident during the Q and A session.

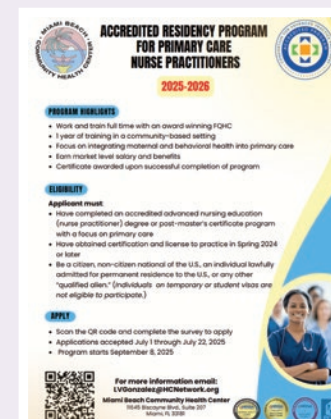
Once finalized, the updated recruitment flyer—with program highlights and application deadlines—is shared widely across social media platforms, including LinkedIn, and posted on the residency website accompanied by an "Application Cycle Open" banner to ensure strong visibility.

As part of the structured recruitment process, all interested applicants complete a prescreening form to verify eligibility and alignment with program criteria. Candidates who meet the requirements are advanced to the Human Resources department, which coordinates and schedules interviews.

Panel interviews are conducted each summer with participation from clinical leadership, preceptors, and program faculty. This ensures a comprehensive, mission-aligned selection process. Final offers are extended in time for the cohort to begin the residency each September, completing a recruitment cycle designed to identify, prepare, and welcome high-potential new graduate NPs into community-focused practice.

—Nadejda Dobrydnik, DNP, APRN, FNP-BC, Family Nurse Practitioner,
Director of MBCHC APP Postgraduate Residency Program; Marie Nguyen, APRN;
Miami Beach Community Health Center (Miami, Florida)

Website to learn more: <https://mymbchc.org/residency-program/>



Communications and Marketing Plan

Once you have answered the questions above, you can begin to develop your communications and marketing plan. Leverage your organization’s resources if you have a marketing or communications department; if you do not, you may need to develop your own materials. We suggest that you pursue the following:

1. Create an APP postgraduate training program website or webpage within your organizational website. This should be in place before you launch your advertising and recruitment cycle. The website/webpage should include at a minimum background on the history and mission of the program, appropriate detail about the structure and content of the program, and key contact(s) for learning more about the program, as well as detailed information with specific deadlines about the application process. This is a process of engagement. We encourage you to use this website to share photos, personal stories, and testimonials from past participants in the program, as well as background information on program leadership and faculty. Potential postgraduate trainees want to know who the people are that will be leading them—postgraduate trainees take into account not just the **what** but also the **who** of the program.
2. Develop key marketing materials, including:
 - a. A press release announcing the launch of your APP postgraduate training program at the organization.
 - b. A single page handout, summarizing key information and frequently asked questions (FAQs), which can be distributed in electronic or hard copy.
 - c. A short presentation, either live, by video, or both, on your APP postgraduate training program that can be shared with visitors, potential candidates, stakeholders, and other interested parties.
3. Identify the most appropriate media outlets through which to spread the press release. For example, local media news outlets may be interested in doing a story about your program. National organizations and schools for NPs and PAs often have news columns and job postings on their websites.

The time you invest in planning your recruitment and marketing campaign is an excellent investment in building a strong program. As part of our HRSA-funded NTTAP on Clinical Workforce Development, we developed a communications and marketing plan grid to help various programs within our organization to track their marketing and communications deliverables (See **Table 7.1**).

Communication and Marketing Plan				
Activity	Person Responsible	Departments	Message(s) or Purpose	Media & Methods
Press release				
Webpage				
Develop postgraduate residency informational sheet/FAQ sheet				
Create postgraduate residency presentation for recruitment				
Determine market for recruitment (local vs. national)				
Develop advertisement (print and digital versions)				
Determine advertisement placement (print and electronic)				
Contact schools of Nursing MSN and DNP Programs (NP Residency) and schools of Psychology (post doc residency program) to inform graduating students of postgraduate opportunities				

Table 7.1: Excerpt of a Communication and Marketing Plan

Operations: Application Process

In this section we will discuss the application process, which includes reviewing, interviewing, ranking, and selecting candidates; making offers; contracts; and the onboarding process. This should be a transparent process for the candidates. Using the recruitment timeline we discussed earlier, you should begin marketing your program at least nine months before the start of the APP postgraduate training program. There is no specific way to recruit candidates. In the following section, we will outline some best practices and models to consider.

The Application

Your HR department has standards for the application process, so it is important that your efforts align. Be clear about the qualifications you are looking for in candidates. Post the qualifications, instructions about the application process, and the application itself on your program's website/webpage.



Consider including essay questions and/or a personal statement. While your requirements for admission are likely to be quite straightforward, the narrative essay questions offer an opportunity to learn about the applicant's interests, life experiences, motivation in pursuing APP postgraduate training, career aspirations, and interests and commitment to practicing as a primary care provider in a health center setting. We have provided sample essay questions for a family NP residency training program below:

1. *What personal, professional, educational, and clinical experiences have led you to choose nursing as a profession and the role of a family NP as a specialty practice?*
2. *Please describe your desire to train in a community health center setting, as well as your long-term commitment to practicing as a primary care provider.*
3. *What are your goals for a Postgraduate NP Residency Training Program, including your aspirations for your short- and long-term career development?*

If possible, structure your process so that the application can be completed electronically and post it on your website/webpage. It is important to define your application window, and identify the staff person responsible for receiving, recording, and reviewing the applications as they are submitted for completeness based on an application requirements checklist. Finally, be prepared to answer lots of questions, especially as the deadline approaches!

PLEASE NOTE: Applicants may not yet qualify for licensure and national certification at the time of submission of the initial application. In order to have both in place—and be ready for credentialing by the sponsoring organization prior to or at the start of the program—applicants must understand the process and timeline in their state for licensure to practice (and to prescribe, where applicable), as well as the requirements for national certification.

National certification must be obtained through an appropriate certifying body, such as the **American Academy of Nurse Practitioners Certification Board (AANPCB)** for Nurse Practitioners, the **American Nurses Credentialing Center (ANCC)** for Nurse Practitioners, the **American Midwifery Certification Board (AMCB)** for Certified Nurse-Midwives, or the **National Commission on Certification of Physician Assistants (NCCPA)** for Physician Assistants.

Selection Committee

If you have a selection committee, they will be responsible for reviewing and ultimately selecting the candidates to invite for interviews. The selection committee may include a variety of roles within the organization including, but not limited to clinical and operational leadership, potential preceptors, and HR personnel familiar with the organization's application process.

Interview Process

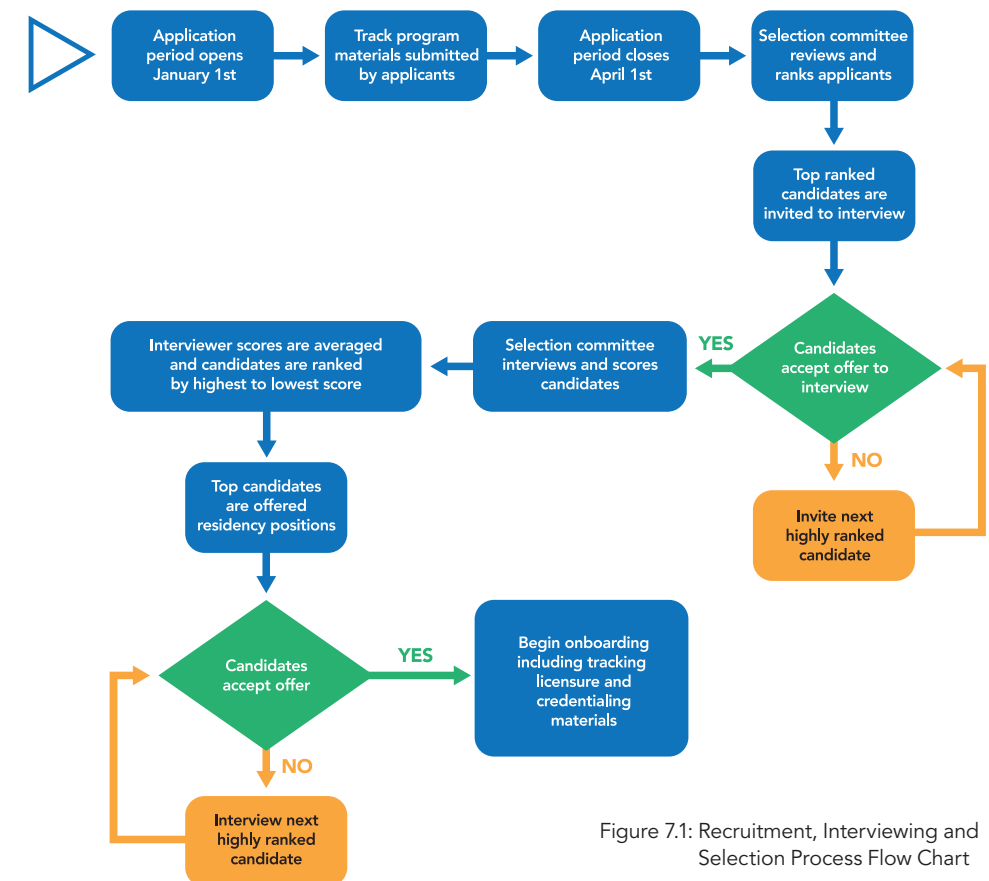


Figure 7.1: Recruitment, Interviewing and Selection Process Flow Chart

At CHCI, the selection committee reviews all applications and ranks them based on your key criteria. Criteria may include: quality of training and education, clinical competency and experience, interest in the populations served by your organization, and successful completion (may be pending) of all requirements for your program. Members of the selection committee score each candidate (1–5) for each category for a maximum total of 25. Please see **Table 7.2** for a sample Application Review Ranking Sheet that can be used by a selection committee.

Application Review Ranking Sheet				
First Name	Last Name	School (Graduate)	CORE CRITERIA 3: International and Volunteer Experience	CORE CRITERIA 4: Letters of Recommendation
CORE CRITERIA 5: Personal Statement Essays		ADDITIONAL CRITERIA 1: Language Skills +2 Spanish (fluent/intermediate) +1 Spanish (beginner) or other language	Language	TOTAL

Table 7.2: Sample—Application Review Ranking Sheet

Based on the ranking/scoring process you are using, you will then identify candidates to invite for interviews. You should decide how many candidates you wish to interview for your available positions and place others on a secondary list if the initial candidates decline to interview. You may also decide to notify those applicants ranking at the bottom of the ranking list that they will not be offered interviews.

Determine if you will require in-person interviews or accept virtual interviews, and if you will schedule all of the interviews in a dedicated block of time. We recognize the time and expense involved for candidates (and for the interview team), but have consistently found this to be the most effective strategy.

This process takes dedicated and intensive support from an assigned staff person, so choose that person carefully. They will provide intensive support to all members of the interview and selection team, prepare full background material sets, support the flow during interview days, and technically support the scoring and selection process. In a well-established program, this will likely fall under the responsibility of someone like the Program Coordinator, but in a start-up program, you may need to ask for help from the HR Department.

Ranking the Candidates

Each interview team will be assigned a set of questions. Each team will use the same questions for every candidate they interview. The behavioral-based questions may focus on the following competencies:

- Teamwork and Collaboration
- Caring and Compassion
- Communication
- Judgment and Problem Solving
- Leadership

The selection committee uses a scoring grid to score the applications and candidate interviews. The grid addresses quality of education, clinical experience, linguistic skills, commitment to underserved placement, and intangibles (See **Table 7.3**). Candidate feedback forms and ranking sheets are provided to the interviewers. Following the interviews, the selection committee will give the candidate feedback forms and scores to the Program Coordinator, who compiles this information for the Selection Committee’s final decision. See **Table 7.3** for a sample Selection Committee Scoring Grid.

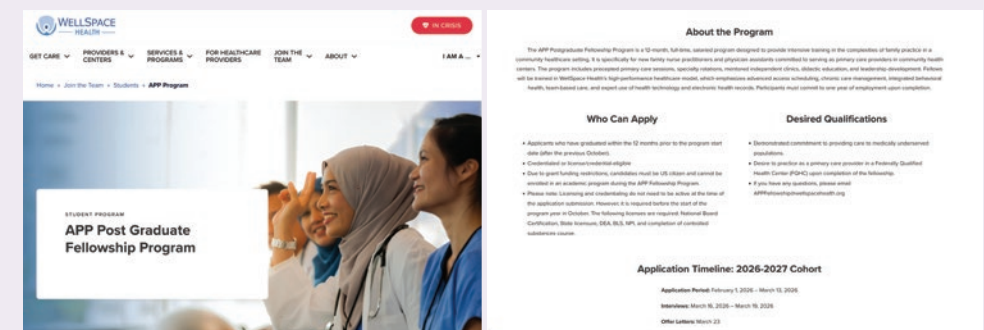
Nurse Practitioner Training Program Selection Committee Interviewing Review Ranking Sheet						
First Name	Last Name	Quality of training and education	Clinical competency and experience	Dedication and commitment to underserved placement	Intangible: Life experience, essay, references	TOTAL
						0
					Scoring 1 to 5 Max Total 25	0
						0
						0

Table 7.3: Sample—Selection Committee Scoring Grid



Program staff from the El Rio Health Advanced Practice Registered Nurse (APRN) Residency Program engage in recruitment for the upcoming cohort in Tucson, Arizona.

Recruitment at WellSpace Health (Sacramento, California)



Rolling Admissions Process

At CHCI, we have moved to a rolling admissions process. Innovative recruitment practices increasingly emphasize rolling admissions, a model that allows applications to be reviewed and candidates interviewed on a continuous basis rather than waiting for a fixed deadline. This approach creates a more dynamic and responsive process, ensuring that strong applicants are not delayed by rigid timelines and that your program can secure top talent as soon as they are identified. Rolling admissions also helps reduce bottlenecks in scheduling, creates more flexibility for candidates who may be navigating relocation or personal transitions, and demonstrates your program's commitment to accessibility and responsiveness. By evaluating candidates as they apply, your organization can foster a more personalized and efficient recruitment experience while maintaining a competitive edge in attracting diverse, highly qualified applicants. This practice also allows your program to continue your recruitment until you find the candidates that are the right fit for your program and organization without the pressure of a rigid timeline. To complement rolling admissions, a tiered interview structure strengthens the vetting process by engaging key stakeholders at each stage. Candidates first complete an initial phone screen with the Program Director who has an intimate knowledge of the program needs and structure. This is also an opportunity to discuss the program and answer any initial questions. The phone screen is followed by a clinical interview to assess practice readiness, which includes the Clinical Program Director and Chief Medical Officer. A final interview is conducted with senior leadership for alignment on organizational values and long-term fit. Each stage acts as a gate, requiring candidates to demonstrate core competencies before advancing, which builds in thoughtful checkpoints for both quality assurance and stakeholder input. Together, rolling admissions and a tiered interview model create a recruitment process that is both timely and rigorous, balancing efficiency with thorough evaluation.

At WellSpace Health, we aim to attract recent graduates who are ready to launch their careers as family nurse practitioners (FNPs) or physician assistants (PAs). We especially look for candidates who are passionate about primary care in community health centers. We highlight our comprehensive 12-month, full-time, salaried fellowship with robust mentorship and training: precepted primary-care clinicals, specialty rotations (women's health, pediatrics, behavioral health, infectious disease/HIV care and more), Primary Care Provider (PCP) mentored clinicals, didactic education via the UC Davis Betty Irene School of Nursing, and ongoing leadership and quality improvement training.

We appeal to candidates who have recently graduated and share our commitment to serving medically underserved communities. The fellowship offers a clear path from structured training to employment, with a required one-year service commitment after the fellowship concludes.

To recruit effectively, we communicate both the professional development opportunities and the mission-driven impact. Fellows become part of a care model rooted in community health and high-quality comprehensive services, aligning with WellSpace's stated mission of "achieving regional health through high quality comprehensive care."

We also emphasize the benefits of working with WellSpace as employees by offering competitive salary, full benefits, paid time off, license reimbursement, all which make our fellowship attractive as a sustainable, early-career launching pad.

—**Darcy A. Wikoff**, DNP, FNP-C, Associate Medical Director,
Primary Care & Clinical Education, Clinical Director, APP Postgraduate Fellowship;
Marcellus Brookshaw, M.Ed., Health Professions Manager;
WellSpace Health (Sacramento, California)

Website to learn more:

<https://www.wellspacehealth.org/join-the-team/students/app-program/>

Offers, Contracts and Agreements

Determine your organization’s process for following up with candidates after the interview. Once the Selection Committee puts together a list of candidates to whom offers will be made, the designated staff person will contact the applicants personally and extend the offer. If an applicant declines, you will proceed down the final ranking list and extend the offer to the next candidate in line.

Following verbal acceptance of the offer, we encourage you to follow up immediately with the formal contract or written offer of employment. Establish a deadline for the return of the signed letter of employment of contract. With that document in hand, the onboarding process begins.

Onboarding

Onboarding has two major components. First, it is imperative that you begin the credentialing process immediately. Together, the APP postgraduate training program staff, HR department, and any specific credentialing department staff will guide the incoming postgraduate trainees through the credentialing process, tracking their status to be sure each postgraduate trainee is fully licensed in your state and credentialed/privileged by your organization by the start of the program year.

Second, the postgraduate trainees should be brought on board within your organization as an employee. Leverage your HR department to execute the organization’s process for onboarding all new staff, including background checks, infection control documents, and required trainings that all new employees should complete.

Operations: Orientation

We encourage you to consider two orientations, one to the organization and one to the APP postgraduate training program specifically. If your organization hosts multiple residencies and fellowship programs with the same start date, you may be able to combine many aspects of the program orientation for a true inter-professional orientation experience. Your organization will already have a solid orientation schedule for all employees, and the postgraduate trainees should fully participate in that, either immediately before or after the APP postgraduate training program orientation.

divorce leads, care is a right, not a privilege since 1972 Community Health Center, Inc. Nurse Practitioner Residency Training Program 2025–2026 Orientation Schedule Community Health Center of Middletown, Community Room, 19 Grand St., Middletown, CT 06457		
TIME	TOPIC	PRESENTER
Day 1: Tuesday, September 9th		
8:30–9:30 AM	CHCI Welcome and Introductions	Mark Masselli, President and CEO Margaret Flinter, APRN, PhD, c-FNP, FAAN, FAANP; Senior VP/Clinical Director
9:30–10:30 AM	History of the Health Center Movement	Margaret Flinter, APRN, PhD, c-FNP, FAAN, FAANP; Senior VP/Clinical Director
10:30–11:15 AM	Population Health and Quality Metrics	Tierney Giannotti, MPA; Director Population Health
11:15 AM–12:00 PM	Peer Meet and Greet	
12:00–1:00 PM	Lunch	
1:00–2:00 PM	Model of Care New NP Provider	Mary Blankson, DNP, APRN, FNP; Chief Nursing Officer
2:00–4:00 PM	History and Interviewing (FNP/PNP)	Garrett Matlick, MSN, MPH, FNP, PMHNP; Clinical Program Director Nicole Seagriff, DNP, APRN, FNP; Regional Vice President
2:00–4:00 PM	History and Interviewing (PMHNP)	Sarah Freiberg, MSN, APRN, PMHNP; Clinical Program Director
4:00–4:15 PM	Break	
4:15–5:15 PM	Trauma Informed Care	Garrett Matlick, MSN, MPH, FNP, PMHNP; Clinical Program Director Sarah Freiberg, MSN, APRN, PMHNP; Clinical Program Director
Day 2: Wednesday, September 10th		
8:30–10:30 AM	Chronic Pain (FNP/PMHNP)	Dan Wilensky, MD; Chief of Preceptors
8:30–10:30 AM	Vaccine Hesitancy (PNP)	Megan Ratchford, MD; Preceptor/Didactic Faculty
10:30–10:45 AM	Break	
10:45 AM–12:45 PM	Center for Key Populations Primer	Jeannie McIntosh, MSN, APRN, FNP, AAHIVS; CKP Provider/Preceptor Mikveh Warshaw, MSN, APRN, PMHNP; Preceptor
12:45–1:45 PM	Lunch	
1:45–3:15 PM	Building Resiliency in Your Practice	Laina Cross, MSN, APRN, FNP; Preceptor/Clinical Education Faculty Lindsay Marmaras, MSN, APRN, FNP; Preceptor/Clinical Education Faculty
3:15–3:30 PM	Break	
3:30–5:00 PM	Residency Alumni Panel	NP Residency Team
Day 3: Thursday, September 11th		
8:30–10:30 AM	Health Equity Primer	Tichianaa Armah, MD; Chief Psychiatry Officer
10:30–11:00 AM	Break and Connect	
11:00 AM–12:00 PM	Obesity and Weight Bias	Garrett Matlick, MSN, MPH, FNP, PMHNP; Clinical Program Director Sarah Freiberg, MSN, APRN, PMHNP; Clinical Program Director
12:00–1:00 PM	Lunch	
1:00–3:00 PM	Lab Values (FNP)	Mary Blankson, DNP, APRN, FNP; Chief Nursing Officer
1:00–3:00 PM	Child and Adolescent Introduction to Psychopharm (PMHNP/PNP)	Anastasia Okoniewski, DNP, APRN, PMHNP; Preceptor Sarah Hunt, MSN, APRN, PMHNP; Preceptor
3:00–3:15 PM	Break	
3:15–4:30 PM	Program Engagement Expectations	NP Residency Team

Figure 7.2: Sample CHCI NP Residency Orientation Schedule

In the CHCI’s Postgraduate NP Residency Training Program, there is an intensive, month-long orientation for all of our NP Residents. Following a review of the history and current status of the APP postgraduate training movement, the orientation includes a series of clinical didactic training activities that prepare the residents to

comfortably begin seeing patients. These include critical policies and procedures related to patient care and the patient population. As months may have elapsed between their last clinical rotations as a student and the start of orientation, we have found that “refresher” didactics in areas such as interpreting electrocardiograms (EKGs), managing chronic pain, interpreting lab values, and high volume procedures is greatly appreciated. Please see [Box 4.5](#) for didactic education session examples. We also add a procedures seminar that lasts a full day focused on suturing and punch/shave biopsies, joint injections, etc., as some postgraduate trainees had not received that experience in their academic programs and others, as above, may have received it but much time has passed. Similarly, a training takes place for Nexplanon certification as well as training for the insertion and removal of IUDs, though both of these take place on a separate day given the additional time needed.

As part of orientation, we encourage programs to create an opportunity for the postgraduate trainees to spend time with key staff members at their assigned clinical sites to provide further connection and understanding of the model of care within the organization, and the contributions of each staff person as a member of the team, both clinical and operations.



As part of their orientation, Community Health Center, Inc. Nurse Practitioner Residents participate in a “Community Immersion Excursion,” including visits to local leaders and institutions.

Community Immersion Excursion

From the outset, structure opportunities for your postgraduate trainees to appreciate that the context of their practice extends beyond the walls of the organization. They need to understand how their practice fits into the larger fabric of the community in which they work, allowing the postgraduate trainees to better understand the context in which the patients and their families live, work, play, and pray.

Community Excursions at Samuel U. Rodgers Health Center (Kansas City, Missouri)



Nurse Practitioner Residents from Samuel U. Rodgers Health Center in Kansas City, Missouri take part in a cultural lunch and learn designed to spark meaningful conversations about their community.

In the Samuel Rodgers Nurse Practitioner Residency Program, one of our unique highlights is community excursions where residents step outside the exam room to explore the communities they serve. These excursions help residents gain perspective that can’t be taught from a textbook and give them experiences that bridge clinical knowledge with real-world understanding about what influences our patient’s lives outside of the clinic. Through cultural lunch and learns, our in-house interpreters take residents to local restaurants serving their native cuisines, while sharing stories of cultural traditions and meaning behind the meals. These shared experiences spark conversations about how culture, diet, and access to resources influence health choices and outcomes.

Residents also participate in a windshield tour of the neighborhoods surrounding our clinic, identifying resources such as grocery stores, playgrounds, and transportation routes—or noting their absence. This hands-on experience deepens resident empathy and highlights the social determinants that shape our patient’s lives.

Additionally, our residents have the opportunity to rotate with our community partners who serve the unhoused, giving firsthand insight into the barriers faced by some of our most vulnerable populations. These experiences cultivate compassion and help form culturally responsive clinicians who see their patients not only as individuals with symptoms, but as people shaped by community, circumstance, and resilience. We find that through these excursions, our residents feel deeply committed and embedded in the community, making them more invested in the care they give and the patients they serve.

—Ginger Vaughn-Pullin, DNP, NE, FNP-BC, Director of Quality,
Director of Clinical Programs, Samuel U. Rodgers Health Center (Kansas City, Missouri)

The “Community Immersion Excursion” is an exercise to promote understanding of the community, and a popular component of the orientation to CHCI’s Postgraduate NP Residency Training Program. In our “Community Immersion Excursion,” we prepare NP Residents for the experience with a deep dive into the Uniform Data System (UDS) data (<https://data.hrsa.gov/topics/healthcenters/uds/overview>) available publicly as a strategy to identify population characteristics in the zip code where their assigned site is located.

We recommend and find it valuable to set up meetings with community leaders and key stakeholders such as the Mayor, School Superintendent, Health Department, local hospital, YMCA, food pantries, shelters, and other community organizations. A key goal here is for the postgraduate trainees to gain an appreciation of the community strengths, challenges, and resources, but also to begin to view themselves as essential community leaders in their developing role as trusted primary care providers (PCPs) in the community.

This exercise is completed with a walking tour during which the postgraduate trainees locate and document, through photographs the local police station, fire station, public library, courthouse, grocery stores, places of worship, pharmacies, and public transportation, this creates a meaningful and memorable orientation to the community.

Administration: APP Postgraduate Training Program Staff

There are several key staff roles that are necessary to operate a high-quality APP postgraduate training program. In this section, we will discuss those roles and their responsibilities based on our experience in developing the model over many years. You will find that your staffing needs will also change as you develop your program over time. Based on the postgraduate training program and/or health center size, one individual may carry multiple roles.

Key Program Staff

Plan to have an NP or PA in a leadership role, either as Program Director or, if the Program Director is not an NP or PA, as a senior clinical position overseeing the program. The overall responsibility for the APP postgraduate training program’s curriculum design, implementation, and evaluation rests with this individual.

This individual is likely to represent your program externally in national forums, as well as internally to the leadership team. They play a prominent role in considering funding opportunities, developing a research agenda if desired, and strategic planning for future growth and expansion.



APP Postgraduate Training Program Director. This position is directly responsible for the operation and oversight of the program. The Program Director leads the postgraduate trainees in their role as PCPs in community health. Based on the size of your program, and the amount of time the Program Director can devote to it, you may need a program manager or program coordinator (or both) as well. The smooth and effective coordination of the logistics of a very complex program, from monitoring schedules and assignments to tracking evaluation data and arranging for didactics, grows more challenging with size and multiple sites. Program staff also serve as a key “touchpoint” for each resident and plays a vital role in quickly identifying and addressing needs and issues that arise. If your program has multiple tracks, you will likely need to target a clinical leader for each one.



APP Postgraduate Training Program Manager/Coordinator. This position is largely responsible for the day-to-day operations. At a foundational level, the Program Coordinator ensures that every postgraduate trainee’s individual schedule, and the entire cohort’s collective schedule, is prepared in advance and disseminated to everyone involved. The Program Coordinator maintains regular contact with all preceptors, office managers, and external/internal specialists to ensure everyone is well prepared for all clinical rotations. The Program Coordinator also personally supervises the didactic sessions to assure that residents are fully present and engaged, and ensure that the evaluation of the objectives for each didactic session is completed. The Program Coordinator is also responsible for the program’s evaluation plan including creating, assigning, and collecting program evaluations.



Chief of Preceptors/Clinical Advisor to the APP Postgraduate Training Program. In 2012, with the program having grown to include 12 NP Residents, five to six different sites, and three specialty areas, CHCI created an additional role for a Chief of Preceptors for the program. This role is limited in hours, but high in its impact. It is open to physicians, NPs, or PAs, with a goal of having a very seasoned clinical expert with a commitment to the postgraduate trainees, serve as an expert resource to all of the preceptors, and as a source of continuity and connection to the progress of each of the postgraduate trainees, regardless of their host site. Unique to the role, which represents approximately 0.2 FTE of a full-time clinician’s role or one day per week, we assigned this individual to precept one day per week at each site hosting

postgraduate trainees in order to personally assess the progress over time of each individual resident. Recognizing that expert precepting, along with immersion in a high-performance model of care, is central to its residency program, and that CHCI's Postgraduate NP Residency Training Program spans multiple sites and numerous preceptors, CHCI established the position of Chief of Preceptors. This role was created to monitor the progress of all NP Residents and to provide guidance and support to preceptors across the organization.

Operations: Graduation

Don't forget to celebrate! Anticipate the end of the APP postgraduate training program year and celebrate the postgraduate trainees' achievements. Whether simple or elaborate, it is important to recognize the APP postgraduate trainees, all of the individuals who made their journey possible, and family/friends if you can. You will choose your own format, but in our experience, the more personal the event and recognition, the more meaningful it is to all. CHCI's Postgraduate NP Residency Training Program graduation includes an opportunity for each NP Resident to speak about their experience, while surrounded by a team of preceptors and support staff from their assigned site. The presentation of a formal certificate of completion concludes the graduation.

Conclusion

A great deal of information was covered in this chapter. To summarize, the operational activities necessary to run the APP postgraduate training program will span across several departments within your organization and are essential to your program's success. Every program should have appropriate program leadership and key staff roles to operate, manage, and support the APP postgraduate training program.

Graduation celebrations! Below, top row, left to right: DePaul Community Health Center, 2025; Community Health Center, Inc. (CHCI), 2023. Middle row: CHCI, 2025. Bottom row, left to right: Shasta Community Health Center, 2021; Eire Family Health Center, 2022.



Shasta Community Health Center offers an in-depth primary care training program that prepares new Nurse Practitioner and Physician Associate/Assistant graduates to safely practice in community health settings.



CHAPTER 8

Evaluation: Real Impact Verified

Evaluation was a guiding force in the original design and subsequent revisions of Community Health Center, Inc.'s (CHCI) Postgraduate Nurse Practitioner (NP) Residency Program. We believed our model for postgraduate NP training would be effective, but we needed to develop the evidence to determine if this was indeed the case, and to identify the relative strengths and weaknesses of the model. During the initial application process, we stressed to the applicants that as the initial cohort of residents, they would be “co-creators” of the Postgraduate NP Residency Training Program, and deeply engaged in the evaluation. They did not disappoint us! We are forever grateful to them and all who followed.

As an innovation without precedent, we were challenged to consider the meaning, reliability, and purpose of each element of the evaluation plan for the Postgraduate NP Residency Training Program. We drew upon our own internal deep experience within the organization, looked at what colleagues in other disciplines were doing with regards to evaluation of postgraduate training of healthcare professionals, and modified our plan as we moved along. Since the Postgraduate NP Residency Training Program is an intensive clinical training program, we knew that setting quantitative goals and evaluating our progress towards meeting them in terms of the type and volume of procedures that residents performed, patients they saw, and diagnoses they encountered would be a meaningful part of the evaluation. We also realized that it was equally important to assess the qualitative aspects of mastery of the primary care provider (PCP) role and later the Psychiatric/Mental Health Nurse Practitioner (PMHNP) role, such as interprofessional teamwork and communication skills.

We realized that each of the key individual elements of the curriculum, that is, precepted clinics, mentored clinics, didactic education sessions, specialty rotations, and procedures training, would require specific learning objectives and assessment of the degree to which they were met by the residents. We also felt it would be critical to include a qualitative feedback component to measure ongoing, real-time, direct, and straightforward feedback from the postgraduate trainees going through the program, and chose reflective journaling to accomplish this. We were not disappointed in the sincerity, honesty, and richness of the information received from the first journal through today, nearly two decades later. Finally, since a key goal for CHCI is to prepare postgraduate trainees for careers as full scope PCPs and

PMHNPs in the safety net setting of community health centers, it was critical to us that we track the outcomes of alumni. This is challenging and grows more challenging with the accumulation of years since completing the program! This includes collecting measures such as retention in primary care, type of practice setting that they chose to work in, such as a Health Center (HC) or a private practice, as well as teaching, leadership, and scholarly activities. We encourage all programs to design a strategy for ongoing collection of alumni data right from the start.

With the advent of formal accreditation for Advanced Practice Providers (APP) postgraduate training programs, new programs have the advantage of adapting to the standards for evaluation from the accreditation requirements. We can say with authority that every bit of planning invested in the initial design of the evaluation, along with a commitment to ongoing improvement, is an investment with tremendous return.

In this chapter, we will start with some fundamental background on evaluation. We will then address four areas of program evaluation relevant to APP postgraduate training programs, using examples from CHCI's Postgraduate NP Residency Training Program: (1) assessment and evaluation of the postgraduate trainees' performance in meeting curricular learning objectives and learner outcomes; (2) assessment and evaluation of clinical faculty, including preceptors, mentors, specialty rotation faculty and those providing didactic content; (3) the organization's capacity and effectiveness in the delivery of the training program and meeting stated program mission, goals and objectives; and (4) evidence of ongoing self-assessment of the program by its staff, postgraduate trainees, and by the organization. We will also discuss the types of data you will want to collect. We will end the chapter with guidance about how to design your own evaluation plan.

About Program Evaluation

Program evaluation is the formal systematic and meaningful process of gathering information to make a judgment about a program's merit, worth, or significance (National Council on Measurement in Education, 2013). As an iterative process that collects and analyzes data and other information about a program over time, program evaluation is planned in advance of launching an educational or training program, and developed along with the program. It cannot be an afterthought. Most importantly, effective program evaluation provides a mechanism for accountability, ensuring that the program meets the standards of quality to which it subscribes, such as standards for program accreditation. The Centers for Disease Control and

Prevention (CDC, n.d.) provides the following questions to answer regarding program evaluation:

- **Program implementation:** Are program activities being completed as planned?
- **Effectiveness:** Is the program achieving what was intended?
- **Attribution:** Did the outcomes achieved happen because of the program?
- **Contribution:** Are factors that could contribute to outcomes identified?
- **Efficiency:** Is the program operating using the appropriate resources?

In other words, program evaluation asks about the effectiveness of an educational or training program in meeting objective professional standards. You will use these guidelines to gather and analyze the evidence you need to judge your program's performance. Is the program achieving the desired goals and objectives? Where is the program working? Where does it need to be changed? Where are the opportunities for innovation or dissemination of best practices, lessons learned or new information?

Why Evaluation is Important



Program evaluation is important for two major reasons: program improvement and stakeholder engagement. First, the primary goal of program evaluation is to make judgments about a program, to improve its effectiveness, and/or to inform programming decisions (Patton, 1987). It also allows the program leadership to clarify program plans by reviewing, revising, and better aligning program objectives and learning objectives so they are more achievable and measurable, thereby increasing the effectiveness of the program. Through the evaluation process, leaders gain insight about best practices, innovation, and opportunities for dissemination of lessons learned. By documenting the impact of the program, there is clarification about how the program contributes to the organization's overall mission and its role in contributing to organizational growth. Program evaluation helps a program to move forward.

Second, program evaluation engages stakeholders. The process of program evaluation requires that the stakeholders who participate systematically reflect on the program's effectiveness, a process that can be a catalyst for self-directed change. And so, one of the benefits of program evaluation is that stakeholder participation in the evaluation process can be empowering, increasing their commitment to the program and their ownership of it, while also reinforcing the program's mission for the host organization and community. Thus, program evaluation provides information

that increases not only your program's productivity and effectiveness, but also its value (My Environmental Education Evaluation Resource Assistant [MEERA], n.d.).

Characteristics of an Effective Evaluation Plan

In general, there are three characteristics of a good evaluation plan. First, it has to be inclusive, involving all of the program participants and stakeholders including postgraduate trainees, preceptors, staff, patients, the host organization/employer, as well as community members. This ensures that multiple perspectives are heard. Second, it has to be honest. Every program has strengths and weaknesses. Program evaluation lets you build on the former, and identify and correct the latter. CHCI's Postgraduate NP Residency Training Program has worked hard for nearly two decades to address its weaknesses, given that it was an innovative approach to postgraduate training without standards against which to measure our effectiveness. Third, good evaluation is replicable and feasible with methods as rigorous as circumstances allow. Multiple evaluators should come up with comparable results.

To be effective, useful and meaningful, program evaluation should be aligned with your program's mission, goals, objectives, curriculum, and resources. Your evaluation plan needs to be developed while you are developing your APP postgraduate training program to provide context and detail to the evaluation findings, as well as invaluable conclusions that can guide future programmatic changes and allocation of resources.

An evaluation plan prompts you to be clear about what you intend to achieve so that you can measure whether or not you have achieved it. For example, if your program's mission is to "contribute to the healthcare workforce in the region," your evaluation plan will need to be clear about what you mean by "contribute" and "region." Is "region" a 50-mile radius of the program? Does "contribute" mean practicing as an NP or physician associate/assistant (PA)? If both are the case, you would track your program graduates to determine the number of individuals who join a practice within a 50-mile radius of the program.

How Data Contributes to Program Evaluation

This last example, being clear about what you mean by "region" and "contribute to the healthcare workforce," brings us to the role of data in program evaluation. Program evaluation relies on measurement and there are a few truisms to consider here. First, not everything that is important is readily measurable, and not everything that is measurable is important (Cameron, 1963). So you need to measure what matters

and what is measurable. Second, if you can't define it, you can't measure it. An example is the need for clarity about how you will define "region." Third, "garbage in-garbage out" is a favorite saying of people who work with data. That is, if you aren't clear upfront what data you want to collect and why, the data that you collect will fill spreadsheets, but not provide you with meaningful results or actionable information. Good data are a prerequisite for good analysis, and good data drive change.

So what is "good" data? As you know, data can be quantitative, such as surveys and assessment tools, and qualitative, such as interviews and self-reflective journals. For program evaluation, you will use both types of data, and you will measure processes as well as outcomes. But first and foremost, program evaluation data should be credible, observable, and measurable. That means data must be reliable and valid. Reliability refers to consistency when different raters make the same decisions about whomever or whatever is being rated. Validity means data are meaningful, that reasonable and/or knowledgeable people agree that the thing being measured is relevant to the evaluation.

As your APP postgraduate training program matures and spreads, it is critical to develop tools that measure competence (validity) and performance in a particular clinical scenario (reliability). Evaluation plans that provide reliable and valid measurement are a vital source of useful information for program planning. The United States (U.S.) Department of Veterans Affairs (VA) has developed one such tool, and we anticipate further development. **Figure 8.1** below provides a visual graphic of validity and reliability.

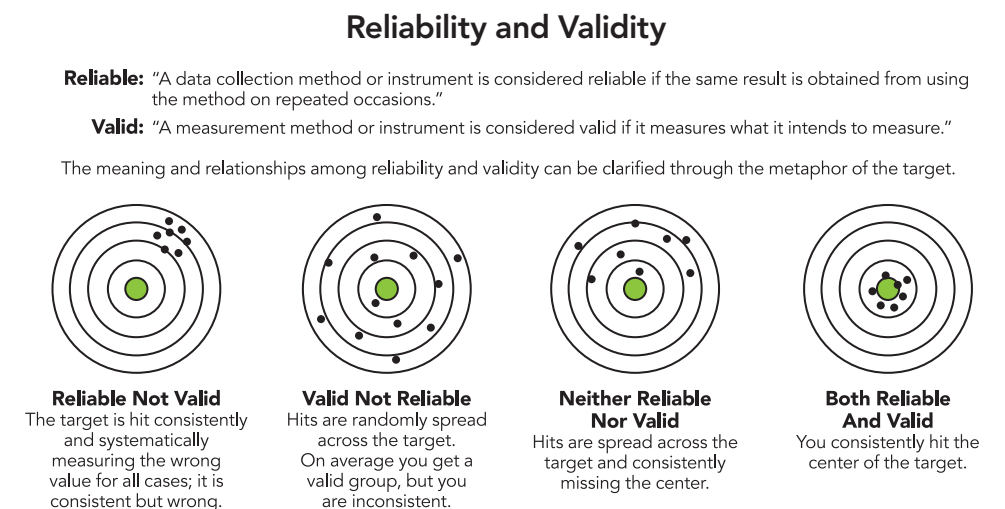


Figure 8.1: Graphic of Validity and Reliability
Adapted from Trochim 2001.

Assessment and Evaluation of Postgraduate Trainee's Performance: Linking Curriculum and Program Evaluation

The core driver in implementing an APP postgraduate training program is supporting the training of new APPs to increase their competence, confidence, and mastery in all domains required to be a full-scope provider in your practice setting. Therefore, one of the most fundamental aspects of your evaluation plan for an APP postgraduate training program is the methods and tools for evaluating the postgraduate trainee's clinical and professional performance in providing patient care. A robust evaluation plan includes mechanisms for continuous monitoring (formative), as well as a method for comprehensively assessing (summative) the performance and development of each postgraduate trainee during the program year. Also, measuring the postgraduate trainee's performance reflects the integrity and quality of your program's curriculum, including clinical and didactic learning experiences, and the competencies, learning objectives, and learner outcomes that articulate expected results.

In order to evaluate your postgraduate trainees, you should have a foundation by which to measure their performance. The Consortium for Advanced Practice Providers (CAPP) provides comprehensive curriculum and evaluation standards for the APP postgraduate training program that provide direction on program curriculum and structure. These Standards are the foundation for CHCI's Postgraduate NP Residency Training Program and for the evaluation of the resident's performance. For example, the CAPP accreditation standards require:

"...that programs assess the performance and development of each postgraduate trainee through periodic and objective assessment focused on the ten competency domains listed in Standard 2." (CAPP, 2025, p. 14).

In this section, we will describe some of the core evaluation components for postgraduate trainee's performance. We will also discuss how postgraduate trainee performance and program evaluation are anchored in the curriculum standards, a schedule for assessing resident performance, different measures of performance, and how to respond when a resident's performance is not up to standards. [Figure 8.2](#) is designed to help you to appreciate the importance of alignment in your postgraduate training program as a whole, from mission through learner outcomes, and from learner outcomes back to mission through the process of program evaluation.

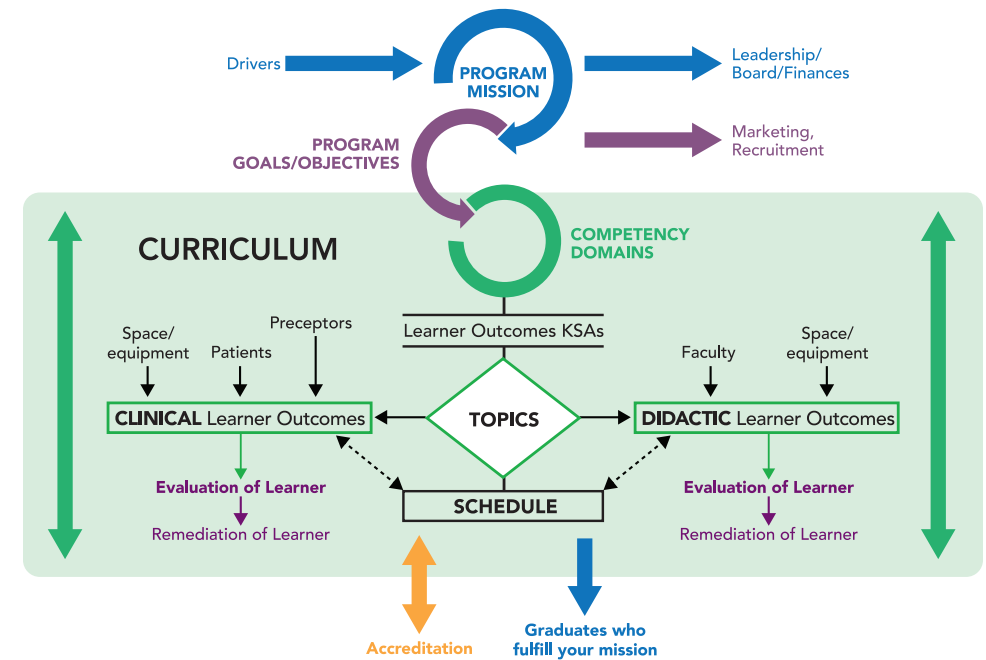


Figure 8.2: Components of the NP Residency Curriculum

Resident Performance and Program Evaluation are Anchored in the Curriculum Standards

The CAPP (2025) Standards require that the APP postgraduate training program curriculum must include the following core elements:

1. Clinically based practice and patient care experience (e.g. precepted clinics, mentored clinics, specialty clinical rotations)
2. Regularly scheduled didactic sessions;
3. System-based learning and quality improvement
4. Population-based health focus
5. Technology
6. Respect for Patient Values, Preferences, and Needs
7. Leadership and professional development
8. Health-Related Needs
9. Certificate of Completion

The written evaluation plan must identify where in the curriculum these activities occur, their learning objectives and how you measure them for each resident, and then summarize the results in the aggregate as part of your program evaluation. One way to do this is to crosswalk the curriculum requirements with an evaluation plan. When you crosswalk the curriculum and evaluation, every element of your training program (curriculum) should be paired with a measure of performance. When the curriculum and evaluation programs are integrated completely, you can draw conclusions about your program’s success in meeting its objectives, identify areas that will benefit from further attention, celebrate success, and disseminate best practices.

Crosswalking curriculum and evaluation. A classic method for pairing curriculum and evaluation is to “crosswalk” the curriculum and evaluation. Just like a crosswalk links one side of a street to another, the crosswalk between curriculum and evaluation links the two together. The curriculum is the starting point, the foundation. Every objective in the curriculum is linked to one or more measures in the evaluation plan. The outcome of the program evaluation provides documentation regarding the accomplishment of the objectives. **Table 8.1** below provides an abbreviated example of aligning a curricular requirement with objectives and evaluation measures. Recall that one of the competencies in CHCI’s Postgraduate NP Residency Training Program is **Patient Care**, and the learning objective is: **Provide patient-focused care that is compassionate, valued, appropriate and effective for the treatment of both common and uncommon health conditions and the promotion of health.**

Curriculum Requirement	Example	Competency Objectives/ Learner Objectives	Evaluation Measures
Clinical-based practice and patient care experience that are sufficient in depth, breadth, variety, and volume of diagnoses and patient demographics to prepare the postgraduate trainee for clinical practice in the specialty of the program	Precepted clinic (40% of resident time) at home-based practice site	Provides patient care that is compassionate, etc.... • Counsels and educates patients and their families • Develops and carries out patient management plans	• Postgraduate trainee competency self-assessment • Preceptor assessment of the postgraduate trainee performance • Postgraduate trainee evaluation of preceptor • Portfolio of numbers of patients seen, diagnoses, demographics, procedures

Table 8.1: Example of Crosswalk of Curriculum and Evaluation

This type of exercise is best done as you develop the curriculum. You could do this for each curricular requirement in order to assure yourself that your program addresses the standards. Most likely, a pattern will emerge. For example, every clinical experience will use the same type of evaluation measures noted in the crosswalk; the details will vary based on the clinical experience, such as a specialty rotation.

Assessment of the Postgraduate Trainee Performance is Objective and Systematic

The CAPP (2025) Standards require that an APP a postgraduate training program “use an objective, systematic and cumulative evaluation and assessment process [of the postgraduate trainee] that is designed based on the Program’s core elements, competencies, and curriculum components” (CAPP, 2025, p.14). We should note that this expectation is consistent with other professional training programs, such as the Accreditation Council for Graduate Medical Education (ACGME) and the American Psychological Association (APA).

An objective assessment process uses tools that align with clear expectations for performance as indicated by learning objectives and learner outcomes. For example, if learner outcome is to perform a specific number of selected procedures, a straightforward measurement would be a systematic way of logging procedures by each postgraduate trainee of the number and name of the procedures completed that are logged and reviewed on a regular basis. If an outcome is that the postgraduate trainee “counsels and educates patients and their families,” the preceptor would have to witness this, with a mutual understanding between preceptors and residents of what this means.

An assessment process is systematic and ultimately cumulative when it is embedded within the training program at specific intervals. This allows careful monitoring of the postgraduate trainee’s progress with sufficient time for remediation as necessary. We will discuss remediation later in this chapter. [Table 8.2](#) is an example of how CHCI schedules assessment of resident performance over the course of the 12-month program.

Evaluation Element	Frequency	Reviewed By
Competency Self-Assessment	1, 6, 12 months	Leadership Team
Preceptor Evaluations	90 days, 6, 12 months	Preceptors face-to-face with residents
Specialty Rotation Evaluations	Monthly	Program Staff
Didactic Education	Weekly	Program Staff
Procedures	Monthly	Program Staff
Mid-year Mentoring Session	Month 6	Leadership Team
Reflective Journals	Weekly	Program Staff
Overall Program Evaluation	6, 12 months	Program Staff

Table 8.2: Schedule for CHCI Systematic Assessment and Evaluation of Resident Performance

Measuring the Postgraduate Trainee's Performance

To assess and evaluate a postgraduate trainee's performance, you need to identify the criteria that you will use, ensure they are reflected in measurement tools, and use an evidence-based measurement scale for quantitative tools. If you have developed your training curriculum and evaluation plan at the same time, much of this work can be accomplished simultaneously.

Tools for measuring resident performance. [Table 8.3](#) gives you a sense of the types of tools used by CHCI to measure their NP resident's performance and when they are used. These tools include:

- Evaluation of the resident's competence by the preceptor in the precepted continuity clinic at the NP Resident's home clinical practice site;
- Evaluation of the NP Resident's competence by the preceptor or mentor in specialty rotations;
- The resident's self-evaluation of competence;
- Weekly reflective journals;
- Mid-year feedback session;
- Monthly tally of procedures performed;
- Presentation of quality improvement project;
- Presentation of case study at Project ECHO® (optional);
- Portfolio (See [Box 8.1](#) for a description on postgraduate trainees' portfolios).

Box 8.1: APP Postgraduate Trainees' Portfolios

At the end of the program, APP postgraduate trainees are provided a portfolio that includes documentation of clinical activity (e.g. procedures performed, types and numbers of patients seen), self-assessment, special projects, chart audits, quality improvement project, any presentations they have given, and all of the evaluation data collected during the postgraduate training year. By offering a comprehensive portfolio, the program gives postgraduate trainees full access to the evaluation metrics collected throughout their training. This transparency highlights their clinical and professional growth and the competencies they've developed. Postgraduate trainees can use the portfolio to clearly articulate and demonstrate their experience, particularly when pursuing any future employment after the program. If you are pursuing accreditation from CAPP, the accreditation standards outline that postgraduate trainees must assemble a portfolio as part of **Standard 3: Evaluation** (CAPP, 2025).

Criteria for measuring resident performance. The criteria for measuring a postgraduate trainee's performance are the learner outcomes that flow from the learning objectives in the competencies. Not every competency in the curriculum is measurable in every learning experience. For example, clinical competencies related to direct patient care are not relevant to the Quality Improvement Seminar. Some competencies may be combined. However, all of the eight competencies in the CAPP Program Accreditation Standards (2025) can be measured in the clinical setting.



WellSpace Health in Sacramento, California celebrates the graduation of the inaugural cohort of its Advanced Practice Provider (APP) Postgraduate Fellowship Program.

CHCI's Postgraduate NP Residency Training Program uses a NP Residency Competency Assessment Tool as its principal tool for evaluation of NP Residents by preceptors. The tool includes questions organized under the eight competency domains, as well as sub-competency areas to evaluate residents, that are found in the CAPP Standards (2025). It also includes elements from the validated assessment tool developed by Rugen and colleagues (Rugen, Speroff, Zapatka, & Brienza, 2016). This is still an evolving field, and we anticipate that more tools will be developed and validated.

The tool is used by the preceptor to evaluate the resident and by the resident for self-assessment in the precepted continuity clinic. Elements of this tool are used to develop other evaluations for specialty rotations. Evaluations completed by preceptors are key in understanding the competency of the residents, as well as areas of strength and deficiency. The self-assessment by the residents provides insight into their own assessment of growth and development in these core domains as well as identifying areas where they would like further experience or supervision. The self-assessment also provides a mechanism to learn about how the program is working and how it supports the trainees' honing of professional knowledge, skills and attitudes.

In [Chapter 5](#), we provided a sample Assessment Tool for Resident Performance. The tool uses a rating scale of novice to expert model published by Dreyfus (2004) and includes room for open-ended written comments. Remember that while the competencies remain the same, the details as they apply to the learner outcomes in different specialty rotations will necessarily change to reflect the patient population.

Postgraduate trainees engage in structured self-assessment throughout the program to track their growth and identify areas for continued development. They complete formal competency self-assessments at baseline, mid-year, and end-of-year using the same evaluation tool preceptors use to evaluate their progress. This allows for meaningful comparison between self-perception and external evaluation. Beyond these checkpoints, residents evaluate each specialty rotation by reflecting on the knowledge and skills gained in relation to the rotation's learning objectives. They also assess their own learning through didactic evaluations that capture newly acquired knowledge and emerging skill sets. Finally, weekly reflective journaling provides an ongoing space for residents to interpret their clinical experiences, recognize progress, and surface challenges that may need support. Together, these self-assessment practices are essential because they build insight, accountability, and the reflective capacity required for independent, high-quality clinical practice.

Former Resident's Perspective: Benefits of Postgraduate NP Residency Training

What are the benefits of doing a residency program when you are a newly graduated, fully licensed provider already? As an individual who completed a nurse practitioner residency program, I am confident in telling you, there are innumerable benefits. A residency program offers an in-depth training experience, which is both hands-on and didactic, integrating quality care across a variety of conditions. While most schools do a good job of training the provider to be a good test taker, they often fall short of actual hands-on experience for day-to-day health issues.

The benefit of spending a month dedicated to a singular health area, such as women's health, dermatology, and orthopedics, gives a provider the opportunity to fully immerse themselves in actual patient care, with specialists in those fields. This added experience allows a new provider a safe place to make decisions alongside the respective specialist.

This kind of training and feedback is invaluable to the growth and maturing of new providers and is not something that can be accomplished during the academic learning or clinical portions of advanced practitioner school. Great value is achieved through transforming the mindset of a newly graduated provider from that of student to practitioner.

—Lewis Head, APRN, Family Nurse Practitioner, CHCI (Middletown, Connecticut)

Measurement Methods and Scales

Note in the tool above that there are multiple methods for gathering evidence to assess resident performance: observed, demonstrated, chart audit, verbalized, and tested. We have also noted that the scale of measurement in [Figure 8.3](#) (adapted from Dreyfus 2004) is Novice to Expert. In CHCI's Postgraduate NP Residency Training Program, the residents, preceptors, and other faculty receive instruction on how to use this scale. With this said, we have found that the headings of "Novice" and "Expert" have led to hesitation of preceptors to rate trainees on the extremes of the scale—this is something that has been identified by other professional organizations as well, including the Accreditation Council for Graduate Medical Education (ACGME) which has led to alternate scales within the ACGME Milestones 2.0 (2025). As such, we have modified our scales to note the content of what describes "novice" and "expert," but have not included that formal heading. A postgraduate trainee is not yet going to be an expert in most clinical areas. However, there should be an

aspirational goal to move toward the top scoring of the evaluation tool that is utilized by your program.



Figure 8.3: Adapted from Dreyfus's Five Stage Model of Adult Skill Acquisition (2004)

Additionally, we should note that there is no consensus on measuring the performance of NPs and PAs enrolled in postgraduate training programs (Sciacca & Reville, 2016). Rugen and her colleagues (Rugen et al., 2016) developed a performance assessment tool for NP Residents working in a VA Postgraduate NP Residency. The tool draws from multiple sources, including the American Association of Colleges of Nursing, the National Organization of Nurse Practitioner Faculty, Accreditation Council of Graduate Medical Education, the top diagnoses among VA patients, among others. Instead of using Dreyfus's criteria, they developed a different 5-point rating scale because they felt it was unlikely that postgraduate trainees would achieve the level of "Expert" over the course of 12 months. Their rating scale is in **Table 8.3**; the assessment tool includes open-ended questions and room for comments as well and has been tested for validity and reliability.

Rating	Criteria
0	Not observed or not performed
1	Observes task only
2	Needs direct supervision
3	Needs supervision periodically
4	Able to perform without supervision
5	Able to supervise others—aspirational

Table 8.3: Rating Scale, Rugen et al. (2016)

Another rating scale that is used for assessing performance of resident physicians in training was developed by Miller (1990). He proposed a prism of clinical competence that integrates a hierarchy of mastery with Knowledge, Skills, and Attitudes (KSAs). Miller's prism is applicable to NP postgraduate training as a template for thinking about how to document the KSAs relevant to the professional development of trainees/residents, which is an indication of the effectiveness of their program. Effective evaluation should capture the trainees' increased proficiencies as they move across the learning curve from 'knows' to 'does'. Miller's model is in **Figure 8.4** below.

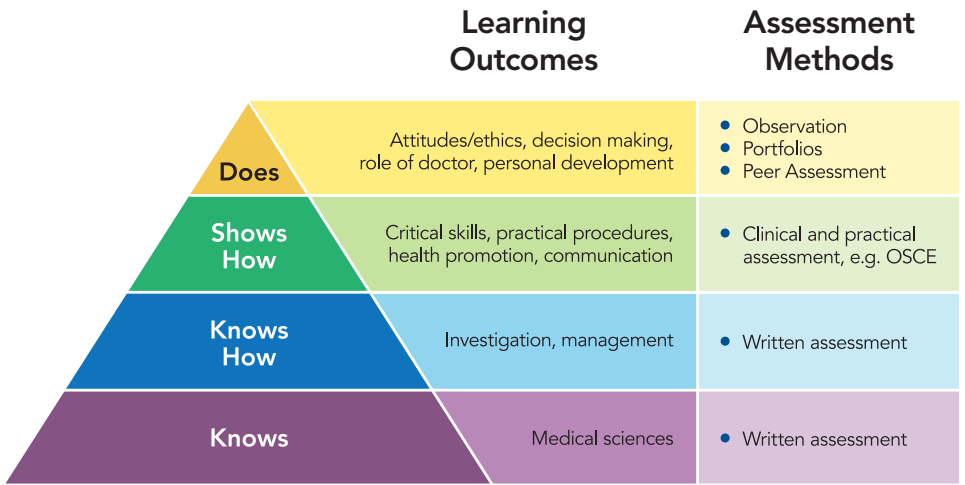


Figure 8.4: Miller's Prism of Clinical Competence

As postgraduate trainees progress through the program, one would expect that their performance in each category would improve. Concurrently, the APP postgraduate training program should be offering experiences that promote the trainees' professional growth. There should be an increase in the postgraduate trainees' knowledge base, their ability to perform isolated clinical skills, and their ability to integrate knowledge and skills into seamless and professional delivery of care.

As you are designing your evaluation program, think about your program objectives, learning objectives and related KSAs, as well as your postgraduate trainees' progression in proficiency from day one through completion. The program objectives and learning objectives will provide direction on what content should be evaluated. The assessment methods listed above provide suggestions on the way to document the postgraduate trainees' levels of proficiency for each content area.

Postgraduate Trainees' Reflective Journals: Cross Assessment of Residents and the Program

One unique evaluation that bridges the assessment of the postgraduate trainee and the APP postgraduate training program is weekly reflective journals. This is a qualitative approach to evaluation used by CHCI's Postgraduate NP Residency Training Program and others. Qualitative data is usually used to gain an understanding of reasons, opinions, and motivations. Qualitative methods use unstructured or semi-structured techniques such as interviews, journals, or focus groups (Wyse, 2011). Unlike quantitative data, which focuses on numbers, qualitative data is non-numeric and describes attributes or properties, such as themes and reflections that reveal meaning and context.

In CHCI's Postgraduate NP Residency Training Program, NP Residents complete a weekly reflective journal. These journals are read by the Program Director and designated program leaders who provide comments, feedback, encouragement, and/or follow-up as needed. This process allows the NP Resident to reflect upon complex clinical cases and their own clinical, personal, and professional growth, while also giving program staff a real-time insight into the challenges residents are facing, which allows for timely support and intervention. Ultimately, this leads to increased program satisfaction for the residents as there is a consistent feedback loop and a perception of individualized attention.

Weekly reflective journals also offer a space for the postgraduate trainee to document the highs and lows of their experience. These journals provide a structured opportunity for self-reflection on their transition into the role of primary care provider. Descriptions of patient encounters and interactions with an interdisciplinary team allow residents, through their own words, to demonstrate competency in core domains. A formal qualitative analysis of more than 1,200 journal entries was discussed at length in [Chapter 1](#) (Flinter & Hart, 2016). The analysis provided significant information on the developmental nature of the transition from newly graduated entry level NP to confident primary care provider.

Remediation of Postgraduate Trainee Performance

One of the advantages of having expert preceptors and mentors is the opportunity to provide feedback in real time to postgraduate trainees regarding their clinical care of patients. But sometimes postgraduate trainees may not always perform as expected despite this ongoing guidance. The frequency of assessment outlined in

[Table 8.2](#) provides several opportunities to identify and address areas of concern. As part of your program's evaluation, you will be expected to provide evidence of written policies and procedures for remediation of postgraduate trainee performance, as well as to inform trainees at orientation the expected process should remediation occur so that they are aware from the beginning of your program.

In CHCI's Postgraduate NP Residency Training Program, preceptors have the opportunity to identify areas of growth for the NP Residents, but also the chance to express any major deficiencies or performance concerns. They can bring major concerns regarding a resident's clinical, administrative, or professional performance directly to the attention of the program staff, who will then assess next steps. When a concern is raised to the program staff, the team will solicit additional feedback directly from the team of preceptors in order to gather as much information as possible and narrow down the major areas of concern. In recent years, CHCI's program established a "Point Preceptor" program, which identified site champions who were not just expert clinicians but also excellent communicators and particularly invested in the residents' success. Once identified, these individuals meet with the Clinical Program Director once monthly to discuss ongoing progress (challenges and successes both clinically and professionally) allowing the program leadership to have a better finger on the pulse of the residents' progress. This format may be especially desirable to programs considering placing postgraduate trainees at multiple sites.

Major clinical performance concerns are dealt with by clinical leadership at the organization, including the Clinical Director of the APP Postgraduate Training Program and the Chief Medical Officer (CMO) through the use of a written performance improvement plan (PIP). The plan clearly outlines performance concerns utilizing the competency assessment tool that trainee performance is measured on, as well as an action plan for improvements on each item addressed and a timeline for expected improvement. Lastly, the program will outline additional areas of training that may be provided to the postgraduate trainee based on the specific area of concern. As postgraduate trainees are employees, any Human Resources (HR) policies that apply to concerns about professional performance and conduct, and grievance procedures are relevant as well.

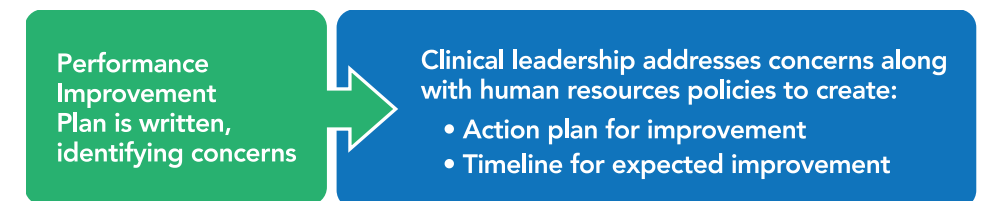


Figure 8.5: Written Performance Improvement Plan

Assessment of Clinical Faculty

The second component of program evaluation that we mentioned at the beginning of this chapter is assessment and evaluation of clinical faculty, including preceptors, mentors, and those providing educational content, by the postgraduate trainees. In CHCI's Postgraduate NP Residency Training Program, the Chief of Preceptors (discussed in [Chapter 7](#)) is also involved in working with and assessing the clinical program faculty preceptors in a more informal way. In addition, the on-site medical leadership at practice sites, and the CMO, can also provide feedback as part of the evaluation process.

Postgraduate Trainees as Members of the Program Evaluation Team

When postgraduate trainees evaluate clinical faculty, they become essential members of the program evaluation team. By having postgraduate trainees provide feedback, this will help identify the aspects of the program that support their training, as well as any areas of the program that would benefit from improvement. It is important that all core components of the program you deliver have the opportunity to be evaluated by the postgraduate trainee. Specialty rotations and didactics can be evaluated based on the postgraduate trainees' experience and the relevance of the component in meeting your APP postgraduate training program's learning objectives. Preceptors and postgraduate trainees should be assessed on a similar timeline to create a bi-directional feedback loop.

Assessment Tools

The assessment tools used by CHCI's NP Residents to assess clinical faculty cover aspects of competency specifically related to the learning objectives of the specific clinical rotation, as well as questions related to the quality of teaching and learning experiences provided by the preceptor or faculty. Other aspects of the rotation, such as the facilities, support services, and overall satisfaction with the rotation, are also included. In addition to room for comments, the tools also utilize a Likert-like scale of 1–5, from strongly disagree to strongly agree, in response to statements, such as the following: "My preceptor gave me an appropriate amount of supervision."; "My preceptor taught me elements of the physical exam and procedures."; "I would recommend my preceptor to other residents."; and "Support services were available from other healthcare workers." As we have noted before, the basic format of the questions will be the same for all of the assessment tools in clinical settings; the details will vary by the type of rotation and patient population.

One of the lessons learned from the evaluation of clinical faculty is that the teaching style of a preceptor and the learning style of the postgraduate trainee may not be complementary. Because of the ongoing communication between program staff, preceptors, and postgraduate trainees, these issues can be addressed in a timely manner, often through informal discussion. However, evaluations provide the opportunity for postgraduate trainees to express areas of concern or challenges they may face that may require further resolution. Postgraduate trainees are made aware that for more sensitive or challenging feedback about faculty they are working with can be brought directly to the program staff in a more anonymous format. Together with the postgraduate trainee, the team will figure out how best to address these concerns in a sensitive way. While the goal is to have formal feedback loops to collect this information, it is also to create a positive training environment between faculty and postgraduate trainee, so support may be needed in navigating tricky interpersonal situations. However, these also provide for excellent learning experiences in addressing professional relationships and dynamics as well as professional self-advocacy. These types of circumstances should be laid out during your orientation so that trainees are aware of the workflow process.

Didactic education sessions are rated by postgraduate trainees using the same Likert scale of 1–5 from strongly disagree to strongly agree in response to statements about the relevance and quality of the content and the presenting speakers. At the end of the year long program, postgraduate trainees also provide feedback on the most helpful and least helpful didactic sessions so that changes can be made. For example, postgraduate trainees have asked that content on women's health and the specialty rotation in women's health, be scheduled earlier in the program. **Figure 8.6** provides a schedule for evaluation of clinical faculty and didactic sessions in CHCI's Postgraduate NP Residency Training Program.

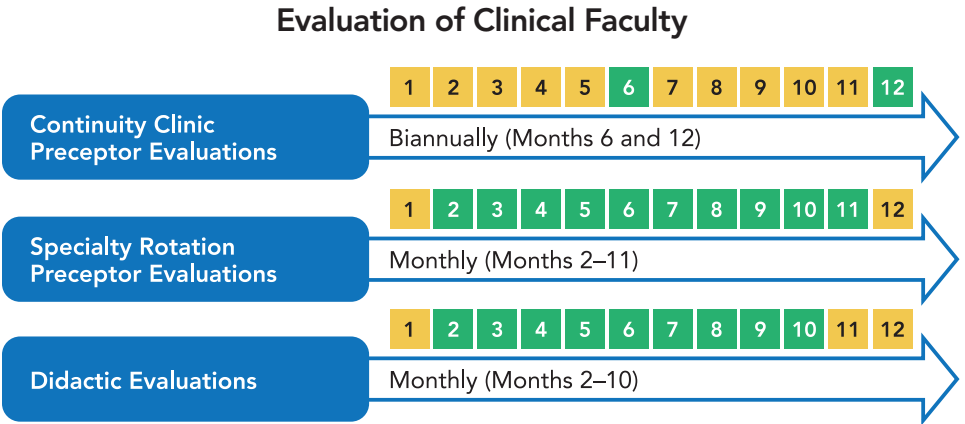


Figure 8.6: Schedule for Evaluation of Clinical Faculty by Residents in CHCI NP Residency Program

Assessment of Organizational Capacity

The third component of program evaluation is the organization's capacity and effectiveness in the delivery of the APP postgraduate training program and meeting stated program mission, goals, and objectives. Organizational capacity refers to the infrastructure that supports program viability, that is, clinical and financial resources ([Chapter 6](#)), and operations and administration resources ([Chapter 7](#)). If a postgraduate trainee is not progressing as expected, or your program is not meeting its program goals and objectives, there is always the possibility that your capacity to provide a high-quality postgraduate training for the NP and/or PA is inadequate. Assessment of organizational capacity includes multiple sources of information from multiple stakeholders. This is another reason to involve stakeholders and to use accreditation guidelines, such as those from CAPP (2025), that set standards for expectations of organizational capacity when you develop your program from the outset, as you will be accountable for meeting those guidelines as part of your program's evaluation plan.

Review of Clinical Sites

It is important to ensure that the clinical sites, both within and outside of your organization, are providing the high quality learning experience needed for the postgraduate trainees' professional development. This can be done through site visits and review of available patient demand. In CHCI's Postgraduate NP Residency Training Program, program staff stays in close communication with stakeholders and NP Residents at all clinical placement sites regarding any operational challenges. NP Residents' journals and evaluations of clinical faculty also provide valuable information.

Operations, Administration and Finance

The operational, administrative, and financial aspects of your APP postgraduate training program, as well as policies and procedures relevant to the program, should be reviewed and revised both on an ongoing basis and as needed for more targeted and comprehensive reviews. At CHCI, the Program Director of the Postgraduate NP Residency Training Program meets with the Chief Financial Officer (CFO) as part of the annual strategic planning and budget development for the organization to review the fiscal and operational impact of the program on the organization, as well as changes in its need for program, resources, or staff in the coming year. This is also an opportunity for the program to establish goals for the coming year.

In terms of targeted and comprehensive reviews, the financial impact of CHCI's Postgraduate NP Residency Training Program is reviewed and assessed by the program staff and finance team no less than annually. During the review, they assess the financial impact of the program as it relates to the program's direct and indirect costs, as well as any revenue generated by its residents.

Designing Evaluation Tools at Lamprey Health Care, Inc. (Newmarket, New Hampshire)

Lamprey Health Care, Inc., a federally qualified health center located in NH, began its NP Fellowship after reflecting that there was more we could and should do to help new NPs transition to practice. The high acuity of patients, the intense pace of practice, combined with some pending retirements motivated us to participate with CHCI's learning collaborative back in 2016. We launched the Fellowship in 2017.

As we developed the Fellowship, we worked with our academic partner, University of NH to design evaluation tools to help us capture the experiences of Fellows, Preceptors, and Mentors, evolving our tools over time to meet accreditation guidelines.

**Accreditation is important as it highlights the quality of the program,
and our commitment to helping build
the confidence and competence of our new NPs.**

One Fellow shared a reflection:

"In the last month or two I have noticed that I am feeling more comfortable with several aspects of this job. Managing hypertension and cholesterol has become easier. I am feeling much more confident in my decision to initiate or change medications. This used to be very hard for me...."

This is exactly the kind of thinking we want our new NPs to have as they progress through the program.

—**Paula Smith**, MBA, EdD, Administrative Director, Lamprey Healthcare NP Fellowship;
Karen Prazar, MSN, FNP-C, APRN, Clinical Director, NP Fellowship Program;
Lamprey Health Care, Inc. (Newmarket, New Hampshire)

Ongoing Program Evaluation

The final component of a program evaluation plan is evidence of ongoing self-assessment of the program by its staff, postgraduate trainees, and by the organization. It is also important that this ongoing process yields actionable information to improve the program. [Figure 8.7](#) illustrates the evaluation activities that occur throughout the Postgraduate NP Residency Training Program year at CHCI. The data from evaluations of resident performance by the preceptors, of preceptor effectiveness by the residents, of the clinical site reviews and didactic sessions can be aggregated over time to present a fuller picture of program performance.

The CHCI Postgraduate NP Residency Training Program staff, including the administrative Program Director, Clinical Program Director, Program Manager, and Program Specialist/Coordinator have multiple weekly meetings to discuss the program’s operations and administration so that challenges can be reviewed and addressed immediately. Issues that may arise include policies that need to be reviewed and revised, changes in resident or preceptor schedules, and allocation of resources. This formative evaluation process concludes with a cumulative, summative evaluation when, at the end of each year, the program staff completes a survey and final debrief meeting with all residents, and then meet to discuss what was learned and what can or needs to be changed.

Final Steps

The final steps in an evaluation plan are to analyze the data and other findings from the evaluation process in the context of the program and its host organization, and to draw conclusions (or judgments). Context is essential in determining conclusions; the same data can lead to different conclusions for different programs based on size, history, and environmental factors. Once you have analyzed the findings and put them into context, the final step is sharing the conclusions with all the stakeholders, both within and outside of your organization. Their feedback evolves into an ongoing process of monitoring and evaluating the program.

As outlined in accreditation standards, the program is expected to have an APP Postgraduate Training Program Advisory Council that is made up of key program and organizational stakeholders, as well as program alumni representatives. It should also, as part of accreditation standards, comprise of stakeholders external to the organization to provide objective input; this can be an academic partner,

a Program Director from a nearby regional postgraduate training program, etc. This advisory council is set to meet bi-annually and is used as a forum to discuss the program successes and challenges as well as the review of the overall program curriculum and potential program improvements. The evaluation data collected through the above mentioned means are critical points of information that the advisory council will use and review to make meaningful recommendations and provide a format for ongoing program evaluation and improvements.



Figure 8.7: Evaluation Activities throughout the NP Residency Program year at CHCI

How to Design and Execute Program Evaluation

As we have noted, we strongly recommend that you develop your APP Postgraduate training program evaluation plan as you design your program. Here again, accreditation standards, such as from the Consortium for Advanced Practice Providers (2025) provide a road map for accountability. The program's components, including curriculum, clinical faculty, and organizational capacity (e.g. resources and the operational, administrative and financial infrastructure), should align with the evaluation plan. Furthermore, the evaluation plan should help to confirm—or not—that you are meeting your program's mission and goals. Evaluation is a continuous loop of investigation, revision, and improvement that is formal, systematic, deliberate, and scheduled at routine intervals.

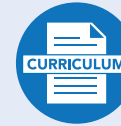


Community Health Center, Inc. Nurse Practitioner Residents, 2019–2020 cohort, engaging in an orientation week skills review workshop.

Here are some basic steps to designing your program evaluation plan:



1. **Engage stakeholders** within and outside of your organization. What would they like to know about how the program is performing?



2. **Develop a written plan linked to the curriculum**, that is, evaluation of postgraduate trainees, preceptors, didactic sessions, and reflective journals provide information about the curriculum's effectiveness in preparing new NPs and/or PAs to become PCPs in your organization. Use both quantitative and qualitative evaluation methods as appropriate.



3. **Use tools to assess postgraduate trainee and preceptor performance that are valid and reliable.**



4. **Develop a written plan that assesses your organizational capacity to offer a program.** Use both quantitative and qualitative evaluation methods as appropriate.



5. **Develop a schedule for collecting data for the evaluation plan.**



6. **Gather the data.**



7. **Analyze the data, interpret the findings, justify your conclusions.**



8. **Share findings and lessons learned** with stakeholders, disseminate findings. This includes sharing the feedback with the postgraduate trainees.

Conclusion

In conclusion, evaluation is a critical component for developing and operating a high-quality APP postgraduate training program. APP postgraduate training programs need an intensive, ongoing, and cumulative evaluation of the postgraduate trainees' performance, the curriculum and clinical faculty, resources, and the operational, administrative, and financial infrastructure that make the program possible. The evaluation process ensures that the program maintains and provides evidence for quality and effectiveness through continuous improvement of programmatic structure, practices, and content.

We would like to conclude this chapter with a quote from *Research to Results Brief*, an online journal for program evaluation focused on children's programming that is an apt summary of evaluation:

"While conducting an evaluation may seem complicated, expensive, or even overwhelming, it is important to remember that program evaluations serve as tools to improve programs. Simply put, program evaluations are conducted to make programs better. Evaluations benefit programs at every stage of implementation. For start-up programs, evaluations can provide process data on the successes and challenges of early implementation; and, for more mature programs, evaluations can provide outcome data on program participants. While evaluation is not without challenges, the information obtained from a program evaluation can help to streamline and target program resources in the most cost-efficient way by focusing time and money on delivering services that benefit program participants and providing staff with the training they need to deliver these services effectively. Data on program outcomes can also help secure future funding."

—Metz, 2007

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Accreditation: Anchoring Credibility and Trust

NOTE: *The Consortium for Advanced Practice Providers (CAPP) serves as expert faculty for Community Health Center, Inc. (CHCI)'s Health Resources and Services Administration (HRSA)-funded National Training and Technical Assistance Partners (NTTAP). This chapter will primarily focus on the accreditation process for CAPP. However, it will also provide initial guidance and information on pursuing accreditation for your advanced practice provider (APP) postgraduate training program with several other currently active accrediting organizations for postgraduate APP training.*

The history of postgraduate training for nurse practitioners (NPs) and physician associates/assistants (PAs) has been driven from within these disciplines with an emphasis on rigor and effectiveness. This applies to programs in all settings, from Health Centers (HCs), to United States (U.S.) Department of Veteran Affairs (VA), from academic medical centers to acute care, specialty settings, and more. Accreditation is an important mechanism to assure the public, trainees, and potential employers of advanced practice providers (APPs) that postgraduate training programs achieve and maintain the quality and rigor consistent with national standards. Accreditation should be based on a coherent set of standards that focus on competency and mastery of advanced practice knowledge, skills, and attitudes. Accreditation promotes the recognition and support of clinical excellence, innovation, dissemination of knowledge, and advancement of practice. When the postgraduate NP residency and fellowship training movement was launched in 2007, there were, of course, no existing accreditation standards for NP postgraduate training. PA postgraduate training programs had developed an accreditation program through Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). Today, as a result of the growth of interest in postgraduate training, there are several choices for accreditation of APP postgraduate programs. These include: The Consortium for Advanced Practice Providers (CAPP), the American Nurses Credentialing Center (ANCC), Commission on Collegiate Nursing Education (CCNE), and ARC-PA. The selection of accrediting organization is specific to each program based on their needs and requirements.

In this chapter, we will describe the evolution of the standards for accreditation developed by CAPP with a particular focus on HC-based APP postgraduate

training programs and the benefits of accreditation for your program and organization. This chapter will focus primarily on CAPP (originally known as the National Nurse Practitioner Residency and Fellowship Training Consortium), as it was developed by the Community Health Center, Inc. (CHCI) and is an affiliate of the Moses/Weitzman Health System (MWHS, <https://mwhs1.com/>). However, other pathways to pursue accreditation will also be provided later in the chapter. Finally, this chapter will provide guidance on how a program can prepare to seek accreditation.

Development of Standards for Accreditation

As discussed in [Chapter 1](#), CHCI convened an informal group of Postgraduate NP Program Directors in 2010 who were early innovators and developers of postgraduate NP residency training programs. The founders called the group the National Nurse Practitioner Residency Training Consortium (NNPRTC), and reached out and welcomed any interested stakeholders to join. The group's initial purpose was to educate stakeholders about postgraduate NP training programs, and advocate for support and investment in such programs. The group later added "fellowship" to the name, becoming the National Nurse Practitioner Residency and Fellowship Training Consortium (NNPRFTC), known simply as the Consortium.

From the outset, the national leaders who developed the accreditation standards for postgraduate NP residency and fellowship training set a goal of federal recognition of the Consortium as an accrediting organization. At the time, there simply were no existing accreditation programs that were interested in developing an accreditation program specific to postgraduate NP residency and fellowship programs. Over a period of several years, the organization then known as "the Consortium", and now known as CAPP developed the standards, processes, infrastructure, and resources to meet the requirements of federal recognition of the United States Department of Education (ED) as a recognized accreditor. This was a priority for the team leading this effort, as federal funding for health professions training programs typically requires that programs be accredited, or eligible for accreditation, by a federally recognized accrediting agency.

"Under the Higher Education Act (HEA), the Department [ED] 'recognizes' (approves) accrediting agencies that the Secretary of Education determines to be reliable authorities as to the quality of education or training provided by institutions of higher education..." (ED, 2025b). The ED recognizes the Council of Higher Education (CHEA) (<http://www.chea.org>), which offers accreditation for degree-granting

academic institutions, that is, colleges and universities. The ED also recognizes organizations that accredit non-degree granting educational and training programs, such as postgraduate NP training. Federal recognition affirms that an accrediting agency meets certain criteria and can operate as a "reliable authority" regarding quality (ED, 2025b).

The ED review process consists of an internal (self-study report) and external evaluation (by ED accreditation analysts) to determine that the applicant accrediting body meets the ED requirements for institutional quality and integrity. When educational and training programs receive accreditation from an ED-recognized accrediting agency, those programs may also become eligible for federal government funds that require accreditation by a federally recognized accrediting organization. The specific ED approach to how accrediting bodies shall accredit individual programs will be described in more detail later in the chapter.

Early on, the Consortium articulated the need for rigorous NP postgraduate training programs to promote quality and foster innovation. The Consortium was unique in its focus on offering postgraduate training program accreditation that was intentionally designed by experts in postgraduate NP training representing not just health centers, but academic institutions, the U.S. Department of VA, and health systems. Ten members of the Consortium representing these varied partners surveyed the literature and state of the science of accreditation in other health professions postgraduate training programs, as well as existing accreditation standards for academic nursing programs, and then worked collaboratively to author the initial Consortium Accreditation Standards. In addition to the Standards, the processes, infrastructure, and governance for accreditation of APP postgraduate training programs were developed with a traditional design of an initial accreditation, followed by triennial reaccreditation and periodic program updates.

In 2015, the Consortium was formally incorporated as a 501 c(3) non-profit. The Board of Directors was drawn from around the country, who represented a broad range of backgrounds and expertise. The first Executive Director was hired in 2015, the Standards for accreditation of postgraduate NP training programs were adopted, and the infrastructure to accommodate a national accreditation effort was begun. The Consortium's website was launched and applications for accreditation were solicited. In 2014, the American Nurses Credentialing Center (ANCC) launched the Practice Transition Accreditation Program (PTAP)TM, which includes standards to accredit APRN fellowship programs as well as RN residency and RN fellowship programs (ANCC, n.d.a.).

In 2022, the Consortium was granted federal recognition by the ED as an accrediting agency for a full 5-year initial period. The Consortium has traveled a long path since the first postgraduate NP training programs were established. Attaining recognition by the ED is a testament to the relentless pursuit of excellence of the leaders of the postgraduate training movement. As noted earlier, the Consortium submitted an expansion of scope petition to the U.S. Department of Education in 2022 to gain federal recognition for accrediting joint NP and PA postgraduate training programs. This recognition was granted in 2024. To date, the Consortium is the only federally recognized accrediting agency to accredit joint NP/PA Postgraduate Training Programs. In 2026, CAPP submitted its petition to the ED for renewal of federal recognition and is currently awaiting a decision.

In early 2023, as joint NP/PA postgraduate programs developed, the NNPRFTC changed its name again to the “Consortium for Advanced Practice Providers,” or CAPP. CAPP’s purpose to serve as a membership, education, advocacy, and accreditation organization for postgraduate residency and fellowship training has remained the same. In 2024, CAPP became an affiliate of MWHS.

Accreditation: What It Is and Why It Is Important



As stated by ED, “The goal of accreditation is to ensure that institutions of higher education meet acceptable levels of quality. Accreditation in the U.S. involves non-governmental entities (accrediting organizations) as well as federal and state government agencies (these three entities are formally known as the Triad). Accreditation’s quality assurance function is one of the three main elements of oversight governing the Higher Education Act’s (HEA’s) federal student aid programs. In order for students to receive federal student aid from the U.S. Department of Education (Department) for postsecondary study, the institution must be accredited by a “nationally recognized” accrediting agency.” (ED, 2025b).

The standards set by an accrediting body represent a consensus among peers in a specific discipline about what constitutes program quality. Thus, accreditation is a systematic process of review against established and relevant standards in that discipline. That review is both internal and external. The internal review is called a self-study, described later in this chapter as a process by which the organization that hosts a program assesses its own performance against the standards. The external review is done by the accrediting body.

Program accreditation evaluates a program’s performance against national standards set by an accrediting body of peers and is a voluntary activity; however, accreditation may be required of the program by its sponsoring institution or by funding entities. External reviewers are professional peers chosen and trained by the accrediting agency. Accreditation should not be confused with institutional or programmatic approval by a state or federal authority, which is often mandated by law for the purposes of licensure, payment, or certification to specific standards. Formal education programs leading to a degree and ultimately individual professional licensure in a practice discipline such as nursing and medicine usually have both state approval and peer accreditation.

Purpose of Accreditation

The primary purpose of accreditation for APP postgraduate training is quality assurance. As we have noted, accreditation standards provide consistency and rigor across programs of the same type, allowing the public to have confidence that a program’s graduates have met requirements set by their discipline and are able to perform safely and effectively as expected. Standards for accreditation cover a wide variety of topics. These include the relevant content of the core training program, expected competencies, types of learning experiences and outcomes; and the programmatic policies, procedures, practices, resources and key structural elements that must be in place for the trainees to succeed. Thus, standards protect trainees and the public by assuring the trainees that they will receive the education and training they need to perform as expected, as well as assuring the public that they can do so.

The goal of accreditation is to ensure that the experience provided by the APP postgraduate training programs meets acceptable levels of quality, rigor and national standards. Accreditation strengthens program operations, reputation, and outcomes.

Benefits of Accreditation

The benefits of accreditation are described below. Accreditation provides the public with a recognizable seal of approval that is an indication of quality and integrity. Potential trainees, potential employers, and others use programmatic accreditation as a mechanism to identify training programs that meet national standards of educational quality and graduate individuals who have been well prepared in discipline-specific knowledge, skills, and attitudes.

Accreditation



The Association for Specialized and Professional Accreditation defines accreditation as “a mark of distinction for academic programs and institutions, signaling high quality and a commitment to excellence... Programmatic (specialized and professional) accreditation conducts an in-depth assessment of specialized or professional programs at a college, university or independent institutions.”

(Accessed <http://www.aspa-usa.org/about-accreditation/> on 12/16/25)

Accreditation also means that an institution that is hosting an APP postgraduate training program can assure applicants who are applying to the program, as well as patients receiving care from the APP postgraduate trainee, that the program sufficiently meets peer-reviewed quality standards. Through accreditation and reaccreditation, organizations can further develop their programs by systematic self-evaluation against the standards. This lets a program readily identify strengths and weaknesses, refine the curriculum, and otherwise enhance the program to reflect the realities of challenging and changing practice environments.

This last point is critical to understanding the benefits of accreditation. Change in healthcare and the health professions is a constant. When APP postgraduate training programs are accredited, they join a group of APP postgraduate training programs that emphasizes collegial and collaborative inter-professional practice, and networking.

This results in a multi-faceted diverse learning community of trainees/residents/fellows, faculty, staff, patients and the public that can share best practices and new evidence, encourage rigorous testing of innovations and be proactive in moving the field forward while being anchored in stable accreditation standards. With the evolution of best practices, new and revised standards emerge. Accreditation is a forward-focused mechanism for formalizing, evaluating, and applying those standards in a programmatic setting. APP postgraduate Program Directors are working together to create a system of quality assurance that is recognized and valued, and that the public can trust as an indicator of excellence.

Pursuing Accreditation at Open Door Community Health Centers (Arcata, California)



Open Door Community Health Centers in Arcata, California supports new Nurse Practitioners and Physician Associates/ Assistants in underserved communities by building clinical skills, confidence, productivity, and job satisfaction, while enhancing workforce retention and employer satisfaction.

Open Door Community Health Centers takes pride in its accredited Nurse Practitioner and Physician Assistant Residency Program, which reflects our ongoing commitment to providing exceptional care to the communities we serve. As a Health Center, we recognize that newly graduated NPs and PAs often face the challenge of transitioning from academic training to the realities of primary care in underserved settings. Our residency program bridges that gap, cultivating confidence, competence, and compassion through structured mentorship, intensive clinical experience, and a culture of continuous learning. The program also brings renewed joy in practice to our seasoned providers, who find deep satisfaction in precepting and mentoring the next generation of clinicians.

Pursuing accreditation was a natural extension of our dedication to quality. Accreditation validates that our program meets rigorous national standards, ensuring that residents receive the highest level of professional preparation while reinforcing Open Door's reputation as a leader in community-based healthcare education. The result is a sustainable model that not only strengthens our workforce but also enhances the health and well-being of our patients.

***By investing in our residents, we invest in the future of primary care
and in building a stronger, more resilient healthcare system for all.***

—Patricia Carter, PA-C, Open Door APC Residency Program Director,
Open Door Community Health Centers (Arcata, California)

The Structure and Process of Accreditation

The ED has six operational requirements of accrediting bodies that are the foundation of the review process they must follow to accredit applicant educational and training programs (ED, 2025a). CAPP has adopted these ED requirements, summarized in [Figure 9.1](#), and which are as follows:



1. Standards: The accrediting agency, in collaboration with educational institutions, establishes standards.



2. Self-study: The institution or program seeking accreditation prepares an in-depth self-evaluation study that measures its performance against the standards established by the accrediting agency.



3. On-site Evaluation: A team selected by the accrediting agency visits the institution or program to determine first-hand if the applicant meets the established standards.



4. Publication: Upon being satisfied that the applicant meets its standards, the accrediting agency grants accreditation or preaccreditation status and lists the institution or program in an official publication with other similarly accredited or preaccredited institutions or programs.



5. Monitoring: The accrediting agency monitors each accredited institution or program throughout the period of accreditation granted to verify that it continues to meet the agency's standards.



6. Reevaluation: The accrediting agency periodically reevaluates each institution or program that it lists to ascertain whether continuation of its accredited or preaccredited status is warranted.

ED Accreditation Process—6 Major Steps

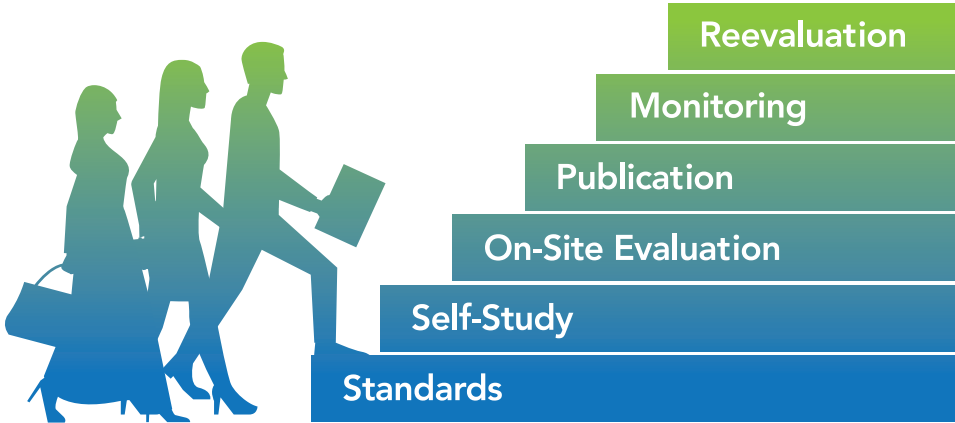


Figure 9.1: Summary of ED Operational Requirements for Accrediting Bodies

Standards for APP Postgraduate Training Program Accreditation



CAPP's approach to implementing these six steps began with the development of its eight Accreditation Standards, designed by a group of national leaders in postgraduate NP training that included NP postgraduate program directors, academicians, researchers, and clinicians. These Standards are outlined on the next page in [Figure 9.2](#): 1. Mission, Goals and Objectives; 2. Curriculum; 3. Evaluation; 4. Program Eligibility; 5. Administration; 6. Operations; 7. Staff; and 8. Postgraduate Trainee Services.

1. Mission, Goals and Objectives. The mission states the core purpose of the program, the goals are what you expect to achieve, and the objectives are measurable evidence that you have succeeded.

2. Curriculum. The curriculum defines the APP postgraduate training program as it is delivered to and experienced by trainees. It is a formal, written framework that specifies the competencies trainees are required to achieve. The curriculum delineates required clinical and didactic learning experiences and clearly articulates learning objectives and measurable trainee outcomes.

3. Evaluation. Evaluation has two levels. The first refers to how postgraduate trainees are in fact demonstrating the expected competencies, that is, assessment of postgraduate trainee performance. The second refers to how your program as a whole is meeting its stated objectives, and includes an evaluation of the organization and the faculty that support the APP postgraduate training program.

4. Program Eligibility. This section of the accreditation standards sets out the eligibility criteria for programs seeking accreditation. For example, the postgraduate training program must be a minimum of 12 months; the sponsoring organization must hold and maintain a current accreditation and/or certification by an entity that recognizes quality and safety of care or provide evidence that the organization demonstrates quality and safety of care; and that the trainees of the program must have a Master of Science in Nursing or Doctor of Nursing Practice, or be a graduate of an accredited PA program who has earned a masters with a concentration in PA Studies. The APP postgraduate trainees must hold board certification and be licensed or license eligible as an advanced practice registered nurse or PA in the state in which the program is located by a date determined by the Program in accordance with the planned program curriculum.

5. Administration. This refers to the administrative support and resources that a sponsoring organization must have in order to offer an APP postgraduate training program, including the clinical and financial resources, assigned clinical sites and patient population, electronic resources, and working environment required to meet the needs of the program.

6. Operations. This includes operational policies and procedures that a program must follow to assure quality, such as preceptor requirements, liability issues, dismissal, and grievance.

7. Staff. The staff that both direct and support the APP postgraduate training program are a critical component to the effective program operations. The sponsoring organization must provide program leadership, faculty, and staff in identified roles that facilitate the operation, management, and overall program support to meet CAPP's standards.

8. Postgraduate Trainee Services. As the APP Postgraduate trainees are employees of the sponsoring organization, the organization must provide the same services as other employees.

As a federally recognized accreditor by the ED, CAPP is required to periodically conduct a comprehensive and systematic review of the accreditation standards to assure the standards are adequate, relevant and meaningful indicators of quality for APP postgraduate training programs and their trainees. In 2023, CAPP conducted a complete review and revision of the accreditation standards. A summary of those changes include: the addition of utilizing new technology, and promoting

wellness within the APP Postgraduate training program. A significant addition was the inclusion of PA and joint NP-PA programs in addition to NP-only programs.

Accreditation standards can serve as templates to guide emerging programs' development and delivery and as a peer-reviewed yardstick to measure the quality of existing programs. The Standards serve as a blueprint for excellence and quality assurance as well as inspiration for innovation.



CAPP's Standards Driving Excellence in Program Design

- Standard 1: Mission, Goals and Objectives
- Standard 2: Curriculum
- Standard 3: Evaluation
- Standard 4: Program Eligibility
- Standard 5: Administration
- Standard 6: Operations
- Standard 7: Staff
- Standard 8: Postgraduate Trainee Services

Figure 9.2: CAPP Accreditation Standards

Accreditation Process

The Standards provide the basis for the internal (self-study) and external (site visit) evaluations. The evaluations focus on the training environment, trainee achievement and trainee success. The Standards also serve as a mechanism that promotes consistency in decision-making—every program is measured against the same set of criteria. The programs conduct their internal evaluation (self-study) to determine the program's level of adherence to the Standards. The findings of the self-study are written up and submitted to CAPP.

The next step is the in-person site visit by at least two professional peers (site visitors). CAPP site visitors are trained to a model of external evaluation that promotes consistency through a deep understanding of the Accreditation Standards, simulations of site visit meetings, in-person evaluation observations and understanding how to validate the findings of the program's self-study, and exploring techniques for conducting an objective, yet collegial, review.

Next, CAPP’s Accreditation Commission, a separate and independent decision-making entity, considers the program’s application materials including the self-study; the site visitor report; the applicant program’s comments responding to the site visitor findings; public commentary and other relevant materials. The Commission makes a motion and votes on the accreditation action. The outcome of the accreditation review, the accreditation decision, is then published on CAPP’s website so the public is informed. Additionally, CAPP is required to notify the ED appropriate State or authoring agencies and appropriate accrediting agencies within 30 days of the accreditation action. The program and accreditation action are then published in the National Database of Accredited Postsecondary Institutions and Programs (DAPIP). Annually, accredited programs submit a report containing demographic information and any updates on programmatic changes that impact the structure or function of the program to CAPP. Re-evaluation occurs at three years following the initial accreditation and then every subsequent five-year period should a program’s initial re-accreditation effort be successful.

When a program is accredited, it is a public recognition that trainees are offered experiential learning in an environment that adheres to accepted indicators of quality. CAPP’s accreditation process is outlined in the Accreditation Process Map below in **Figure 9.3**.

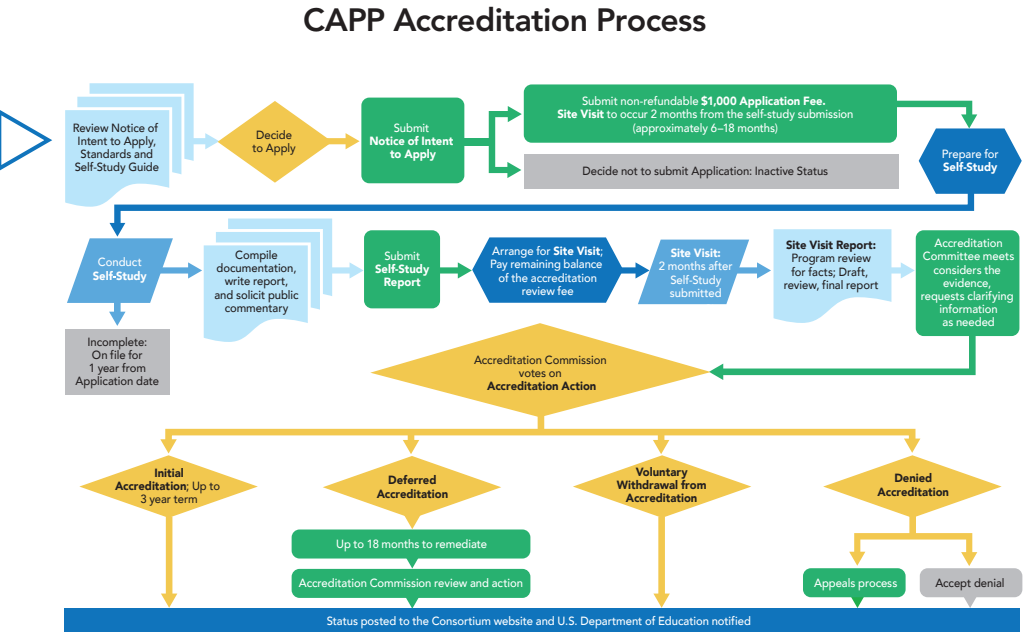


Figure 9.3: CAPP Accreditation Process Map

Accreditation of an APP postgraduate program by CAPP is awarded for up to three years after the initial accreditation period. Subsequent accreditation efforts after this period are awarded at five-year intervals. Details about how to apply can be found on CAPP’s website at: www.APPpostgradtraining.com. Additional resources such as an FAQ, the Accreditation Fact Sheet, the Accreditation Standards, Self-Study Guide, and a gap-analysis tool to facilitate accreditation readiness review are also available on the website. Technical assistance is available throughout the entire process. Final accreditation decisions and a portal for public commentary are available on CAPP’s website.

**Pursuing Accreditation
at Oak Street Health (Chicago, Illinois)**

Accreditation has been foundational to the success of Oak Street Health’s national New Graduate Nurse Practitioner (NP) Fellowship in Adult Primary Care. From the outset, the accreditation standards provided a roadmap for designing a high-quality, mission-driven program that equips new graduate NPs to care for older adults in a value-based primary care setting.

After we launched and began to expand across multiple states, the Consortium for Advanced Practice Providers (CAPP) conferences, workshops, and broader community sparked continuous innovation and improvement. Learning from peers and engaging with CAPP’s thought leaders pushed us to refine our approach and evolve with the needs of our learners.

The accreditation process itself strengthened our processes and validated the work of our faculty and preceptors, ensuring we deliver the level of quality our NP fellows deserve.

And now, in an increasingly competitive postgraduate training landscape, the accreditation seal serves as a powerful signal to applicants that our fellowship meets the highest national standards and is deeply committed to developing exceptional providers.”

—Jean Reidy, DNP, MPH, APRN, ANP-C, NEA-BC, FAANP,
National Medical Director of Provider Education at Oak Street Health (Chicago, Illinois)

Additional Accrediting Programs for Postgraduate Training to Pursue Accreditation

In addition to CAPP, organizations can also pursue accreditation through the American Nurses Credentialing Center (ANCC), the Commission on Collegiate Nursing Education (CCNE) and Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) partnering with the Accreditation Commission for Education in Nursing (ACEN).

American Nurses Credentialing Center (ANCC)



The ANCC offers accreditation through its Practice Transition Accreditation Program (PTAP)[™], which accredits fellowship programs that transition advanced practice registered nurses (APRNs) into new practice settings (ANCC, n.d.a.). ANCC's Advanced Practice Provider Fellowship Accreditation program[™] (APPFA), recognizes transition-to-practice programs for physician assistants (PA) and APRNs. (ANCC, n.d.b.). The Phases of the APPFA Evaluation Process include:

- **PHASE 1: Application and Self-study**
- **PHASE 2: Self-Study Submission**
- **PHASE 3: Appraisal Review**
- **PHASE 4: Learner Survey**
- **PHASE 5: COA-PTP Decision**

AAPPFA conducts four application cycles per year. Application acceptance dates are for each document submission cycle are posted online at: <https://www.nursingworld.org/organizational-programs/accreditation/appfa>

For the most up-to-date information and to learn more about AAPPFA accredited programs, please visit: <https://www.nursingworld.org/organizational-programs/accreditation/appfa/appfa-programs/>

Commission on Collegiate Nursing Education (CCNE)



The Commission on Collegiate Nursing Education (CCNE) offers accreditation for Nurse Practitioner Fellowship/Residency Programs (CCNE, n.d.). The CCNE accreditation process consists of the following steps:

1. The program conducts a self-study process (self-assessment).
2. An evaluation team of peers is appointed by the Commission to visit the program to validate the information in the self-study document and to determine whether the program meets the accreditation standards.
3. The program is provided with an opportunity to respond in writing to the team report.
4. The self-study document, the team report, the program's response, and any other information designated by CCNE are reviewed by the NPFRAC, which makes a confidential recommendation regarding accreditation to the Board.
5. The CCNE Board, taking into consideration the NPFRAC recommendation, decides whether to grant, deny, or withdraw accreditation of the program.
6. The Commission periodically reviews accredited programs between on-site evaluations in order to monitor continued compliance with CCNE standards as well as progress in improving the quality of the fellowship/residency program

For the most up-to-date information and to learn more about CCNE's accreditation process, please visit: <https://www.aacnnursing.org/ccne-accreditation/what-we-do/np-fellowship-residency-application-process>

Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) and Accreditation Commission for Education in Nursing (ACEN)

Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) partners with Accreditation Commission for Education in Nursing (ACEN) to accredit joint Nurse Practitioner (NP) and Physician Assistant (PA) postgraduate training programs (American Association of Colleges of Nursing, n.d.)



The ARC-PA and ACEN accreditation process focuses on self-evaluation and peer-review to support programs in their efforts to enhance and maintain quality and rigor in their residency program. The NP & PA Residency Program Accreditation Process (National Pediatric Nurse Practitioner Association, 2024) includes the following steps:

1. Eligibility/Candidacy Form. Informs ACEN/ARC-PA of Institutions intent to apply for accreditation.
2. Placement on NP & PA Subcommittee agenda. Application sent to program.
3. Program submits Initial NP & PA Accreditation Application. Includes information related to how program will be compliant with standards, curricular design and plan for self-assessment.
4. Virtual Site Visit (1.5 days). Virtual review of facilities, documents, interviews with key individuals associated with the program. The program is provided the opportunity to respond to observations made by the site visit team in writing
5. Program reviewed by NP & PA Subcommittee. If accepted, the program is awarded initial accreditation. If not accepted, program must repeat process.

For the most up-to-date information and to learn more about ARC-PA and ACEN's joint accreditation process, please visit: <https://nppa-accredit.org/>



Members of Shasta Community Health Center's NP/PA Postgraduate Primary Care Fellowship Program, accredited by the Consortium for Advanced Practice Providers.

Conclusion: Accreditation Anchors Excellence in Program Development

Accreditation fosters a community of like-minded professionals and interested parties who are dedicated to excellence in APP practice and training. Community creates a forum for sharing best practices, for working together to identify and address challenges. Life-long learning and professional growth become implicit and explicit. In a supportive peer environment, innovation and creativity flourish.

Accreditation is a promise. It is a tangible promise of quality and meaningful content. For the evolving movement of APP postgraduate training, accreditation offers an opportunity to create and join a community of like-minded leaders in shaping the future of the next generation of socially responsible healthcare providers. Promises speak to the future.

They organize expectations. They encourage actions.

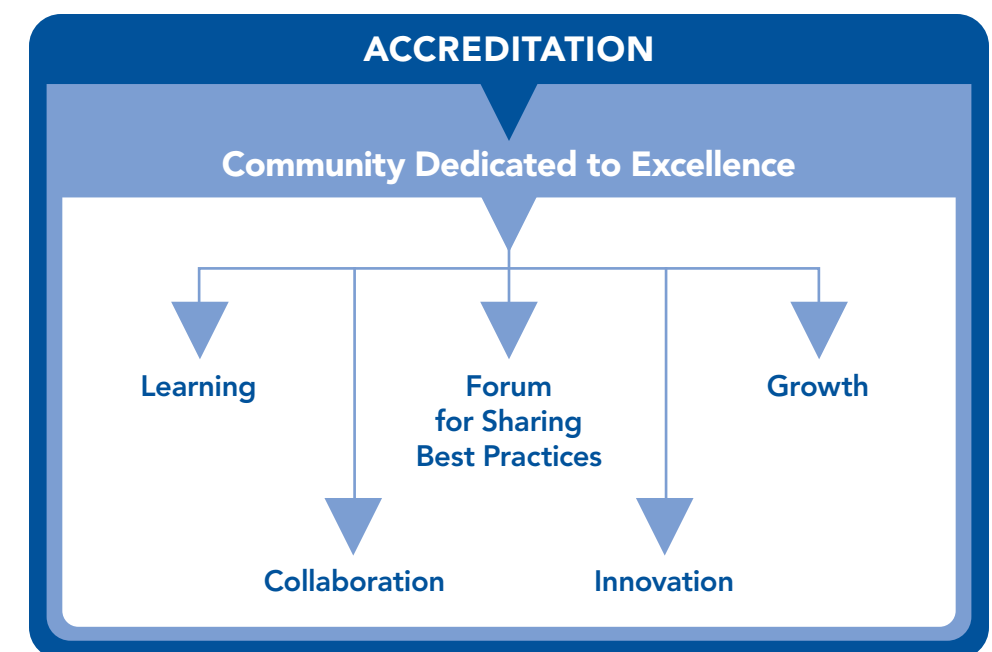


Figure 9.4 Accreditation Anchors Excellence in Program Development

Conclusion: Accreditation Anchors Excellence in Program Development

(Continued)

To summarize the value of accreditation, it provides: systematic, programmatic quality assurance (QA) through:

1. **Formative and summative program evaluation** that is validated by external peer review.
2. **National recognition of quality.**
3. **Fostering innovation, dissemination of best practices and new knowledge.**
4. **Applying policies and procedures that are consistent** with the best practice standards that underline the ED requirements for federal recognition.

In conclusion, accreditation provides public recognition of excellence and national acknowledgement of quality. Accreditation means that an institution that hosts an APP postgraduate training program can assure applicants who are applying to the program, as well as patients receiving care from the APP postgraduate trainee, that the program sufficiently meets peer-reviewed quality standards.

Through accreditation and reaccreditation, organizations can further develop their programs by systematic self-evaluation against the standards. This lets a program readily identify strengths and weaknesses, refine the curriculum, and otherwise enhance the program to reflect the realities of challenging and changing practice environments. This last point is critical to understanding the benefits of accreditation.

Change in healthcare and the health professions is a constant. When APP postgraduate training programs are accredited, they join a group of APP postgraduate training programs that emphasizes collegial and collaborative inter-professional practice, and networking. Accredited programs stand out for their commitment to quality and excellence, while empowering APPs to thrive in advanced practice roles.

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At the 2024 Consortium for Advanced Practice Providers (CAPP) Annual Conference in San Diego, California, attendees gathered around the themes of collaboration, support, and community.

AFTERWORD

As we finalize this second edition of *Training the Next Generation: Advanced Practice Provider (APP) Postgraduate Training Programs in Community Health Centers*, we find ourselves reflecting on how profoundly the field of advanced practice provider (APP) postgraduate training has evolved since the launch of the nation's first formal nurse practitioner (NP) residency program at Community Health Center, Inc. (CHCI) in 2007 and the publication of the first edition of this book in 2017. What began as a bold effort to better prepare newly graduated NPs for practice in community health centers has grown into a national movement dedicated to strengthening the healthcare workforce and improving access to care to high-quality primary care and primary care providers.

From the beginning, our vision was not only to create a single successful program, but to develop a model that could grow and be sustained across the country. Over the years, that vision has expanded significantly. This second edition reflects the remarkable evolution of the field and the maturation of APP postgraduate training through the development of accreditation standards, evaluation frameworks, and national collaboration. In September 2017, there were 48 primary care postgraduate NP residency and fellowship training programs and today there are 276 primary care postgraduate APP training programs.

We remain deeply grateful to the many colleagues, educators, clinical leaders, postgraduate trainees, alumni, and partner organizations across the country who have contributed to this movement over the past two decades. Their innovation, persistence, and commitment to excellence have continually challenged us to refine and strengthen these programs to meet the changing needs of patients and communities. We especially acknowledge the graduates of these programs, now practicing as clinicians, educators, researchers, administrators, and both clinical and executive leaders, who represent the very "next generation" envisioned in these pages. We also want to acknowledge our federal partners and legislators who have championed and supported investment in this model.

The work is far from complete. Healthcare systems continue to face significant workforce shortages, growing behavioral health needs, provider burnout, and persistent issues in access to care. Yet, we remain optimistic. We have seen firsthand the impact that well-designed postgraduate training programs can have, not only

on APP confidence and mastery of practice, but also on workforce retention, quality of care, leadership development, and the long-term strength of safety-net health-care systems.

Although much has changed since the first edition of this book, our core commitment remains steadfast: to provide new NPs and physician associates/assistants (PAs) with the opportunity for postgraduate residency and fellowship training. In this way, we will help ensure a future where outstanding health care truly is a right, not a privilege. We hope this second edition continues to serve as both a practical guide and a source of inspiration for organizations committed to training the next generation of healthcare professionals.

—**Kerry Bamrick**, MBA, Executive Director,
Consortium for Advanced Practice Providers



Nurse Practitioner (NP) Residents, faculty, and leadership gather on the first day of orientation for 2024-2025 cohort of Community Health Center, Inc.'s Postgraduate NP Residency Program.

Training the Next Generation

Advanced Practice Provider (APP) Postgraduate Training Programs in Community Health Centers

2ND EDITION



"With nearly two decades of history, programs in 48 states (as of this edition), and several generations of NP and PA alumni dispersed across the country, the impact of those who have benefited from postgraduate training in a community health center is being felt both in their delivery of health care as expert primary care and psychiatric/mental health providers, but also by their engagement in research, education, policy, and leadership."

—Margaret Flinter, APRN, PhD, c-FNP, FAAN, FAANP;
Co-Principal Investigator, NTTAP on Clinical Workforce Development;
Senior Vice President and Clinical Director,
Community Health Center, Inc. and Moses/Weitzman Health System

Learn more about Community Health Center, Inc.'s
Nurse Practitioners Postgraduate Training Program at www.chc1.com

The **Weitzman Institute** is the national research, education, and policy arm of the



MOSES/WEITZMAN
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For more information on Community Health Center, Inc. and its Weitzman Institute's
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