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Nurse Practitioner Training With the Underserved: Building a Skilled Workforce

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ABSTRACT

The Affordable Care Act has increased access to services, but, for some individuals, insurance coverage, co-pays, or medication costs remain out of reach. For these individuals, free and charitable clinics are a vital resource. These clinics are also ideal for training nurse practitioners (NPs) with complex patients, but clinical placements are difficult because they are largely staffed with professionals who volunteer their time. In this study we report on a college of nursing partnership with free/charitable clinics that established 2 NP clinical training sites. The unique training opportunities for NP students are discussed, including the expanded competencies, barriers, and policy implications.

Keywords: barriers to care, charitable clinics, free clinics, NP practice with vulnerable populations, training opportunities for NPs, underserved areas

INTRODUCTION

Despite great strides accomplished by the Affordable Care Act, 13.1% of all Americans continue to be uninsured. The number of uninsured rises to 24.9% for Americans aged 25-39 years and soars dramatically to 35.7% among Latinos aged 18-64 years.[1] These people remain uninsured largely for financial reasons. This is problematic in a number of ways, but particularly because they tend to be not as healthy as individuals with private insurance and less likely to receive follow-up care, even when living with a chronic condition.[2] Nurse practitioners (NPs) are recognized as a viable solution to primary care shortages, particularly in underserved areas. It is critical that NP primary care programs purposefully and strategically train NP students with the competencies to serve the uninsured as a special population with unique needs. Prepared NPs are poised to develop efficient, patient-centered models of primary care for the uninsured and to evaluate their outcomes.

For the uninsured population, free and charitable clinics are an important link in the provision of health care. The 2 types of clinics are very similar; both are volunteer-based and considered safety-net health care organizations that can provide a range of services at no cost (free clinics) or a nominal fee (charitable clinics) to economically disadvantaged individuals who are predominately uninsured.[3] In the region studied, 32 free and charitable (F/C) clinics operate in the urban and rural areas of the state. In a 2013 survey of clinics, 21 F/C clinics across the region studied served 67,861 unduplicated patients and provided > 83,000 health care visits.[4] As noted in that survey report, the majority of F/C clinics are designed to care for adults who are uninsured and low income and who do not qualify for Medicaid or Medicare.

The clinics become an integral part of the surrounding region. Each clinic's leadership team is in tune with the population needs of the community. According to one clinic director, her relationships and communications with various county boards and community groups facilitates some of the specialized programs and services at the clinic, such as women's health issues, legal assistance, and dental services. The clinics also accommodate the language needs of many

of their clients, > 50% of whom require services in another language. In the region studied, the predominant second language is Spanish.

F/C clinics represent a largely untapped resource for training primary care NP students in the competencies needed to work with uninsured populations. However, their use as training sites is often barred by their structure. They have few full-time employed staff, so staff are stretched too thin to be able to support the precepting of NP students. The F/C clinics rely predominantly on large cadres of volunteers who provide several hours of service a week to the site and may have inconsistent or rotating schedules. Although clinic administrators are adept at organizing volunteers to provide primary care services, these professional arrangements often create a barrier to training, particularly of NPs, which relies on the consistent presence of a preceptor who is employed at the site to provide ongoing experiences over several months. Lately, community sites have found funding support for training resident medical doctors—funding that has recently increased via teaching health centers.[5] However, nursing relies almost solely on preceptors who volunteer their time, which results in few training resources at F/C clinics.

This lack is unfortunate because training in these sites with their special population provides a unique educational experience for the NP student. There is very little written about the work of NPs in these clinics,[6] and even less about NP training. In this study we report on the use of graduate nursing education (GNE) funding to establish 2 NP training sites at F/C clinics: Community Health of Chicago, and Family Health Partnership in Crystal Lake, Illinois. Educational opportunities are discussed, including an iterative identification of the expanded competencies needed to care for patients in these settings. Barriers, facilitators, and policy implications are outlined.

GNE DEMONSTRATION

The GNE is a 4-year demonstration project funded by the Center for Medicare and Medicaid services to 5 sites in the United States. The GNE provides funds to support the clinical training of NPs. At Rush College of Nursing (CON), the authors allocated a fraction of the funds to creating preceptor roles at sites where NP training had not yet been established, such as F/C clinics. As noted, due to the staffing structure of the clinics, but also space considerations, these clinics had traditionally limited opportunities for NP training.

With GNE funding, the authors placed CON faculty members as preceptors at 2 free and charitable clinics for 1 or 2 days per week. Once established, this faculty member began to precept NP students. The 2 clinics serve different populations. One is an inner-city clinic and the other rural; both serve primarily immigrant populations and both draw from wide geographic areas surrounding the clinics. The GNE funding allowed the site and preceptor to establish the NP training model, such as determining the volume of patients the preceptor and student could see in a day and productivity expectations. At sites that rarely bill for services, the authors also hoped to establish mechanisms to cost-share the preceptor's salary after the first trial year.

NP STUDENT TRAINING AT F/C CLINICS

NP training is structured to provide learning experiences such that the student achieves a level of mastery. The competencies are developed by the National Organization of Nurse Practitioner Faculties in collaboration with educators and clinicians.[7] Upon graduation from an accredited NP program, in this instance the CON's family NP specialty, the student sits for national family NP certification and is then licensed by the student's state board of nursing.

The 2 F/C clinics provide students with rare and valuable experiences. Students diagnose and manage patients presenting with an exceptional variety of physical and behavioral conditions. They have the opportunity to examine and manage the care of complex patients while taking time to understand contributing factors that affect their treatment plan. Patients are not scheduled every 10-15 minutes, as in other settings, but in slots of 20-30 minutes to allow time for discussion and guidance. Students begin to appreciate how the lack of access to health care may have contributed to the current severity of illness. They work beside the preceptor to identify how to best use scarce resources. They inquire into circumstances of the client, arriving at a workable plan that fits with the client's life. For instance, in determining the type and dose of insulin for a client with diabetes,