

Postgraduate NP and/or PA Training Programs Community of Practice (CoP)

Session Six: Tuesday March 10th, 2025

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- Please change your participant name to your full name and organization
 - Example: Meaghan Angers, CHCI

1
After launching the Zoom meeting, click on the "Participants" icon at the bottom of the window.

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In the "Participants" list on the right side of the Zoom window, hover over your name and click on the "Rename" button.

3
Type in the display name you'd like to appear in the meeting and click on "OK".

Session 6 Agenda

- 1:00-1:10pm Welcome
- 1:10-2:25pm Showcase Presentations
- 2:25-2:30pm Questions, Wrap-Up, and Evaluation

Community of Practice (CoP) Faculty

Margaret Flinter, APRN, PhD, FAAN

- Co-PI, NTTAP
- CHCI's Senior Vice President/Clinical Director
- Founder of America's first nurse practitioner residency program

Kerry Bamrick, MBA

- Executive Director, Consortium for Advanced Practice Providers
- Community of Practice Faculty and Mentor

Charise Corsino, MA

- Program Director, CHCI Postgraduate NP Residency Program
- Community of Practice Faculty and Mentor

Amanda Schiessl, MPP

- Chief of Staff, MWHS
- Co-PI & Project Director, NTTAP

Meaghan Angers

- Senior Program Manager, NTTAP

Bianca Flowers

- Program Manager, NTTAP

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DO IT FOR.**



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MOSES/WEITZMAN Health System

Always groundbreaking. Always grounded.

Community Health Center, Inc.

A leading Federally Qualified Health Center based in Connecticut.

CeCN

A national eConsult platform improving patient access to specialty care.

The Consortium for Advanced Practice Providers

A membership, education, advocacy, and accreditation organization for APP postgraduate training.

National Institute for Medical Assistant Advancement

An accredited educational institution that trains medical assistants for a career in team-based care environments.

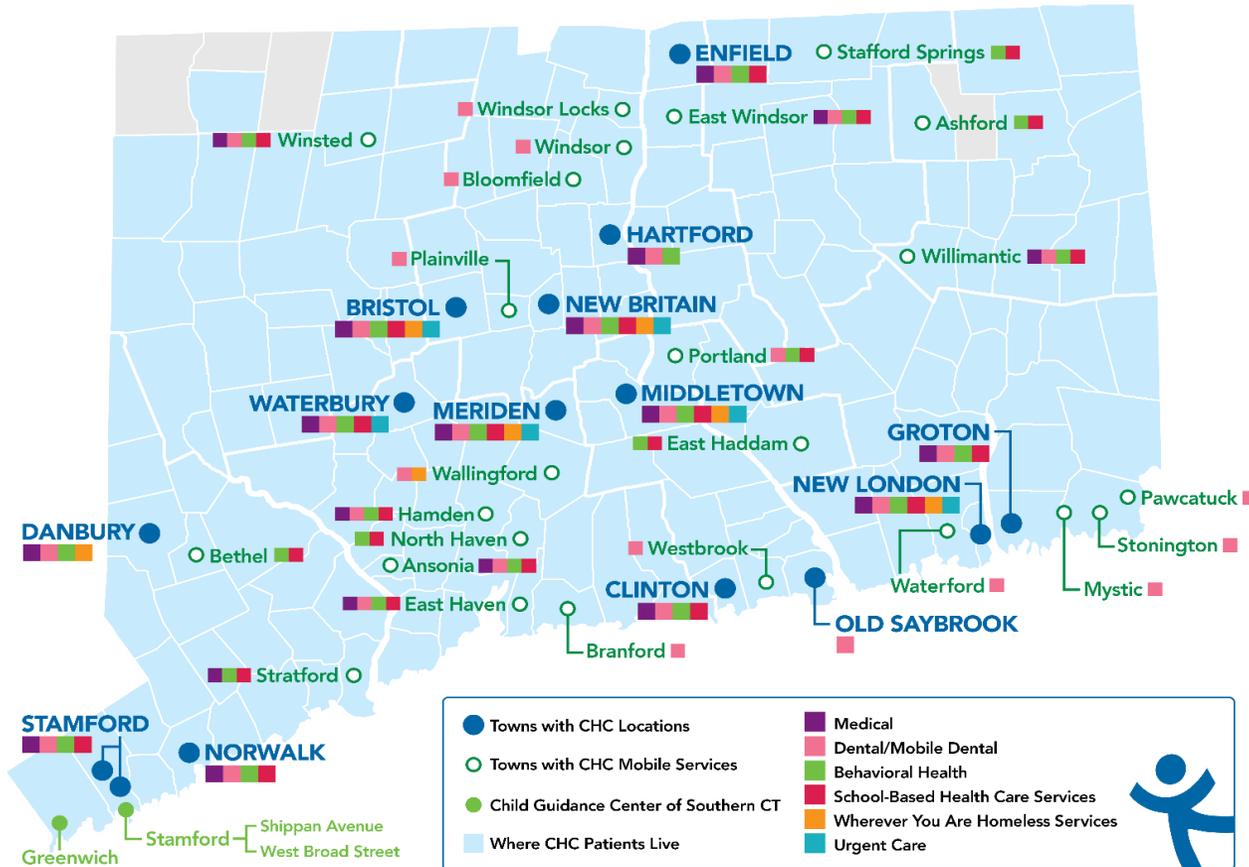
The Weitzman Institute

A center for innovative research, education, and policy.

Center for Key Populations

A health program with international reach, focused on the most vulnerable among us.

Locations & Service Sites



Overview

- Founded: May 1, 1972
- Staff: 1,400
- Active Patients: 150,000
- Patients CY: 107,225
- SBHCs across CT: 152

Year	2022	2023	2024
Patients Seen	102,275	104,917	107,225

CHCI NP Residency Program Today

Family NP Residency



Alicia Thompson, FNP

Kelsi King, FNP

Brenna Keogh, FNP

Shenell Johnson, FNP

Pediatric NP Residency

inspiring primary care innovation



Becky Jenschke, PNP

Seren Carpenter, PNP



Kelly Ho, AGNP

Karen Li, FNP



Becca Collings, FNP

Psychiatric MH NP Residency



Steve Li, PMHNP

Gabriela Disla Suarez, PMHNP

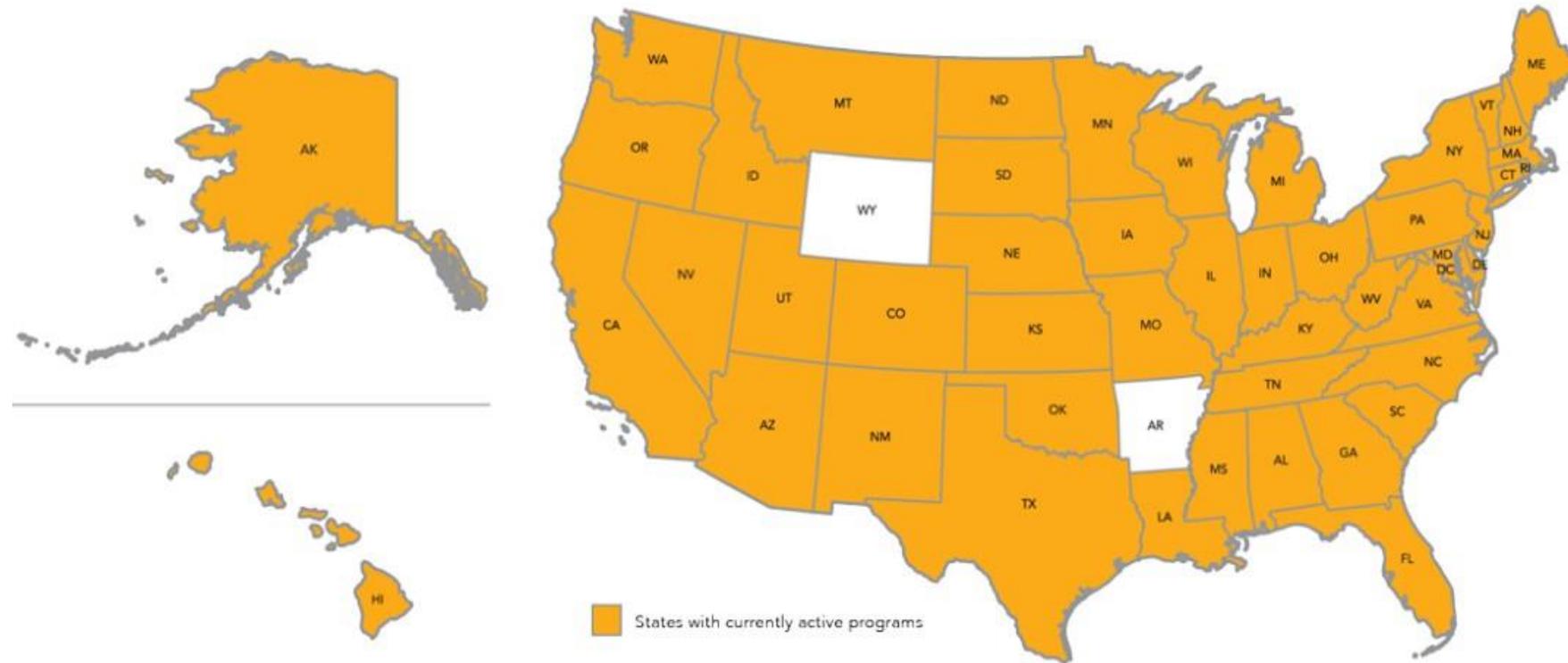
Country's first program (est. 2007)
Operating for 19 years
Graduated 178 alumni

Recipient of three competitive HRSA grants for
Advanced Nursing Education

NP Residency Tracks:

- Family NPs (est. 2007)
- Psych MH NPs (est. 2015)
- Pediatric NPs (est. 2019)
- Adult-Gero NPs (est. 2019) - *discontinued*
- Post-residency Fellowship (est. 2017)

APP Postgraduate Training Programs Nationally



- 565 APP Postgraduate Training Programs
- 259 Primary Care APP Postgraduate Training Programs
- 120 APP Postgraduate Training Programs in FQHCs
- 108 Health Centers participated in HRSA's National Training and Technical Assistance Program (NTTAP)



National Training and Technical Assistance Partners (NTTAP) Clinical Workforce Development

Provides **free** training and technical assistance to federally funded health centers and look-alikes across the nation through webinars, activity sessions, communities of practice, trainings, publications, and more!

To learn more, please visit <https://www.weitzmaninstitute.org/nca>.

CoP Structure

- Six 90-minute learning sessions
- Bi-weekly 60-minute calls between mentors and health center team leader(s)
- Internal team workgroup meetings
- Access resources via the [Weitzman Education Platform](#)
- Use [Google Drive](#) to share your work

Learning Session Dates	
Learning Session 1	Tuesday October 14 th
Learning Session 2	Tuesday November 4 th
Learning Session 3	Tuesday December 9 th
Learning Session 4	Tuesday January 13 th
Learning Session 5	Tuesday February 10 th
Learning Session 6	Tuesday March 10 th

2025-2026 Cohort

Aviva Health DBA Umpqua Community Health Center	Roseburg, Oregon
Brockton Neighborhood Health Center, Inc.	Brockton, Massachusetts
Community Health Center of Cape Cod	Mashpee, Massachusetts
Community Health Centers of Lane County	Eugene, Oregon
DotHouse Health Center	Dorchester, Massachusetts
HealthFirst Family Care Center	Fall River, Massachusetts
Mattapan Community Health Center	Boston, Massachusetts
Morris Heights Health Center	Bronx, New York
Mosaic Community Health	Prineville, Oregon
Neighborcare Health	Seattle, Washington
One Health	Hardin, Montana
River Valley Family Health Centers DBA Olathe Community Clinic, Inc.	Olathe, Colorado
Solano County Family Health Services	Fairfield, California
University of California, Irvine	San Juan Capistrano, California
Upham's Corner Health Center	Dorchester, Massachusetts

Let's Review:

Session 1 October 14 th , 2025	Session 2 November 4 th , 2025	Session 3 December 9 th , 2025	Session 4 January 13 th , 2026	Session 5 February 10 th , 2026	Session 6 March 10 th , 2026
<ul style="list-style-type: none"> • Team Introductions • Program Drivers • Program Mission and Vision Statement • Resource Assessment • Support from Leadership and Board of Directors • Communication Within Your Organization • Overview of Program Structure 	<ul style="list-style-type: none"> • Overview of Program Structure • Key Program Staff • Finances, Sustainability, and Return on Investment • Program Policies and Procedures • Using a Progress Checklist 	<ul style="list-style-type: none"> • Value of Academic Clinical Partnerships • Marketing and Recruitment • Reviewing Candidate Applications • Interviewing and Selecting Candidates 	<ul style="list-style-type: none"> • Preceptors, Mentors, and Faculty: Roles and Responsibilities • Preceptor Panel • Contracts and Agreements • Curriculum Development Overview 	<ul style="list-style-type: none"> • Evaluation of the Training Program & Learner • Orientation • Graduation • Introduction to Accreditation by the Consortium for Advanced Practice Providers 	<ul style="list-style-type: none"> • Showcase



Showcase Presentations!



Showcase Objectives

- Tell the story of your health center's work during this community of practice (CoP)
- Generate reflections among you and the other team members about your involvement in this CoP
- Share your work in future meetings with health center staff, leadership, and stakeholders (e.g. health center board of directors, community partners, funders)

Showcase Order

- 1:10–1:17pm Brockton Neighborhood Health Center, Inc.
- 1:17–1:24pm Community Health Center of Cape Cod
- 1:24–1:31pm DotHouse Health Center
- 1:31–1:38pm HealthFirst Family Care Center
- 1:38–1:45pm Mattapan Community Health Center
- 1:45–1:52pm Mosaic Community Health
- 1:52–1:59pm NeighborCare Health
- 1:59–2:06pm One Health
- 2:06–2:13pm Palms Medical Group
- 2:13–2:20pm Uphams Community Care
- 2:20–2:27pm University of California, Irvine



Brockton
Neighborhood
Health Center

BNHC NP RESIDENCY PROGRAM



Team

Dr. Joe Panerio-Langer, Deputy Chief Executive Officer

Kandyce Casey, DNP, FNP-C, CEN, NP Residency Director

Jen Brown, Administrative Assistant



About BNHC

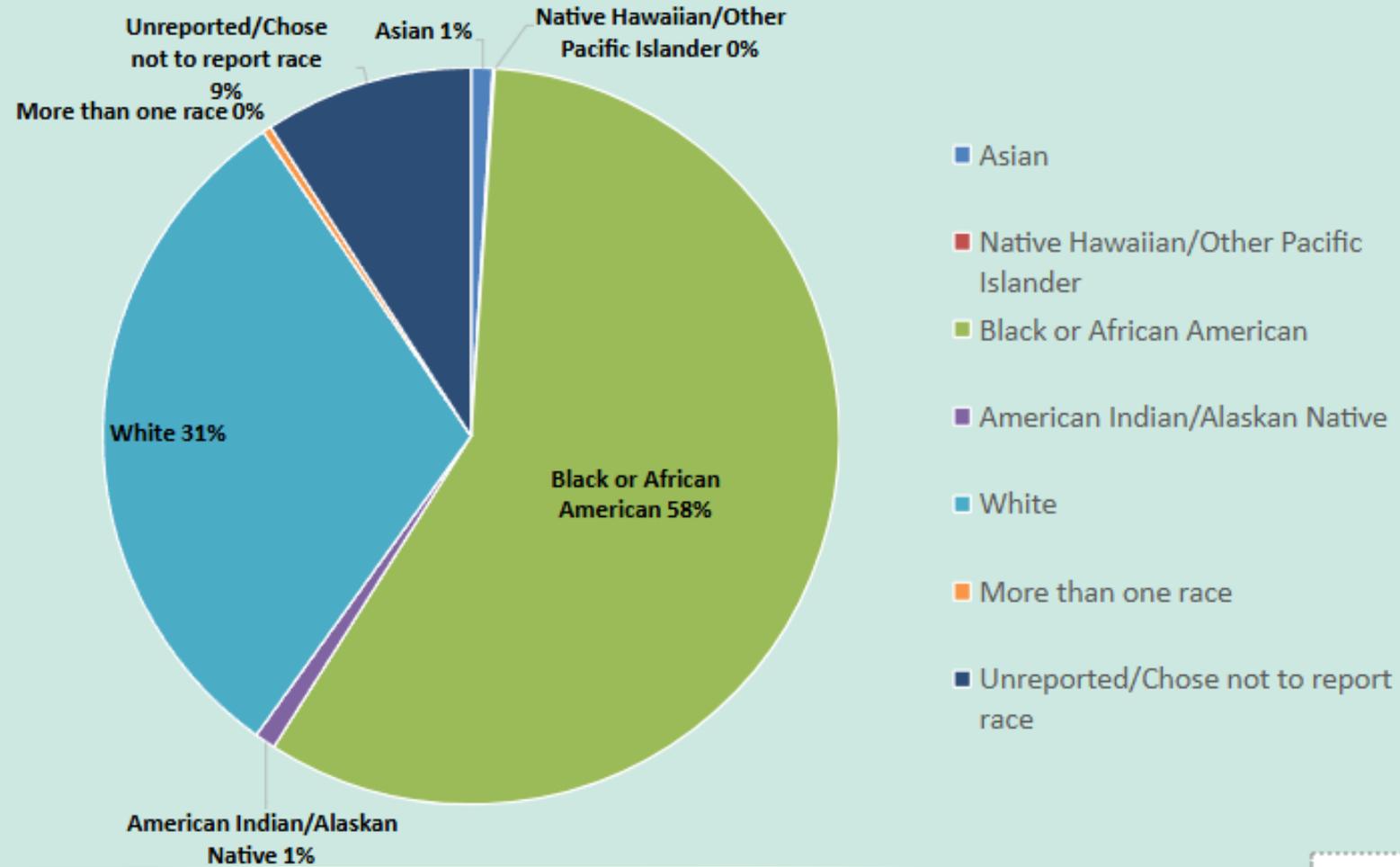
Brockton Neighborhood Health Center (BNHC) has served the Brockton and surrounding areas for 30 years. BNHC is a multicultural organization that collaborates with community agencies and residents to provide high quality comprehensive health care that is responsive to community health needs and is linguistically, culturally, and financially accessible. BNHC is committed to health promotion and disease prevention.

BNHC serves roughly around 39,000 patients a year.



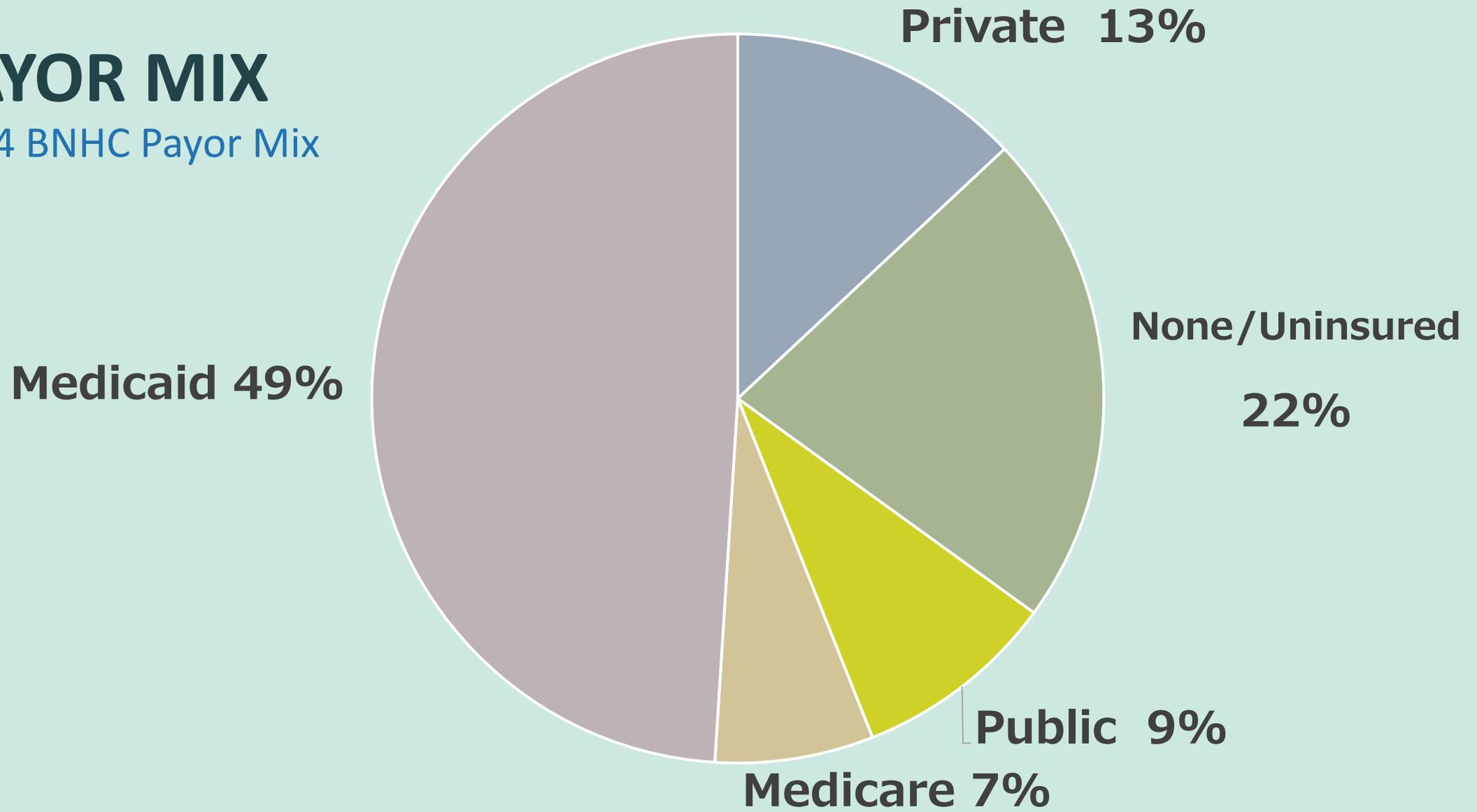
PATIENT DEMOGRAPHICS

Race and Ethnicity of BNHC Patients 2024



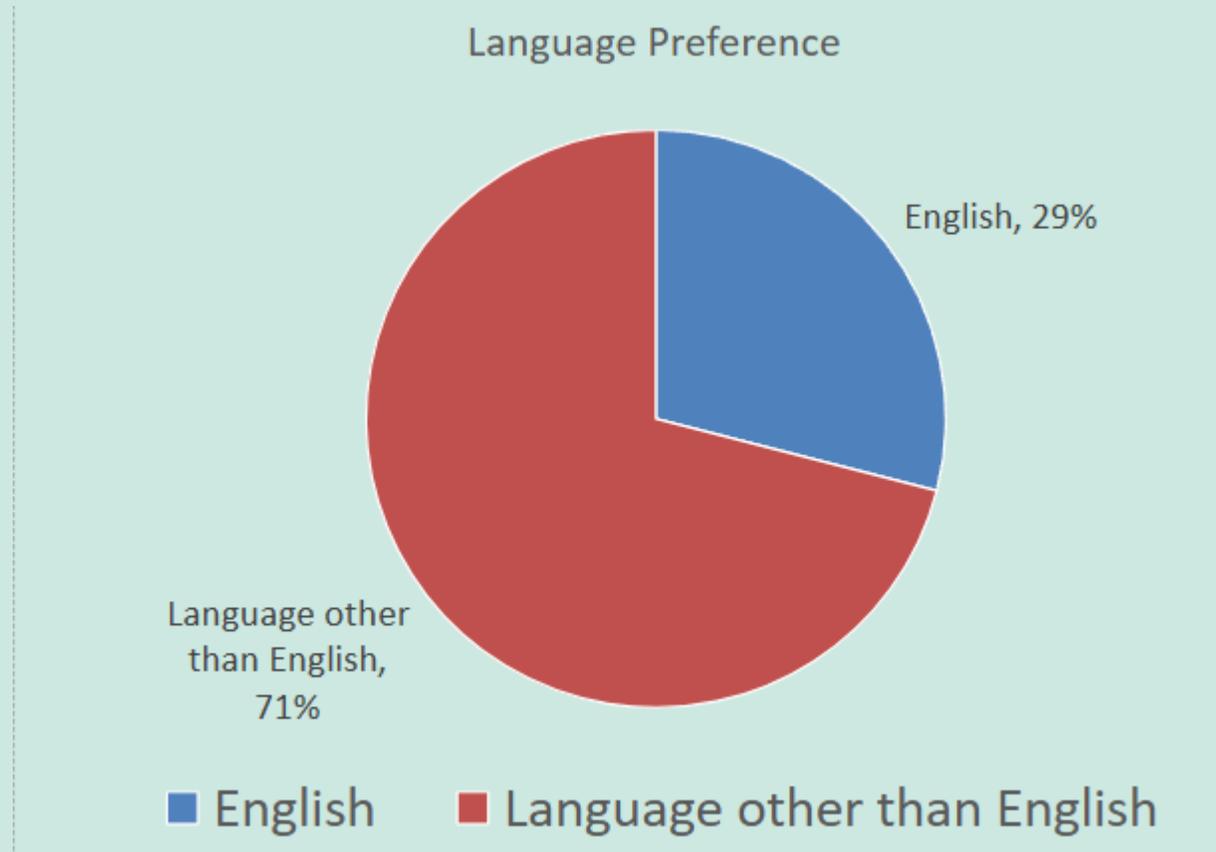
PAYOR MIX

2024 BNHC Payor Mix



PATIENT DEMOGRAPHICS

Language Preferences of BNHC Patients 2024



Language	Count of MRN
English	11122
Portuguese	8151
Haitian Creole	7250
Cape Verdean Creole	7188
Spanish	4406
Arabic	53
French	33
Hindi	25
Urdu	24
Gujarati	23

Departments

- **Adult Medicine**
- **Infectious Disease – HIV services**
- **Endocrinology**
- **Neurology & Neuropsychiatry**
- **Behavioral Health - Adult and Pediatric**
- **Dental**
- **Eye Services**
- **Nutrition**
- **OB-GYN**
- **Pediatrics**
- **School-Based Health**
- **Substance Use Services – Mobile Unit, Shelter**



Program mission, vision, and drivers

Mission and Vision

BNHC's NP residency program is committed to improving patient outcomes in a medically underserved area by enhancing clinical competency and training for new graduate NPs through a multidisciplinary team approach. BNHC strives to create an environment and culture of resiliency and wellness in new graduate NPs to reduce provider burnout and increase the PCP workforce. Graduates of this program will exemplify patient-directed, evidence-based care and facilitate NP retention through a self-sustaining model.

Program Drivers

- Evidence-based didactic and clinical training
- Create an environment and culture of resiliency and wellness
- Retain fellows throughout residency program
- Improve patient outcomes

About Program

- Grant funded program recognizing need for NPs ability to close gap in PCP shortage in the complexity of primary care and exceptional care NPs can provide
- 2 years: 12-month full time program followed by an additional 12 months of service
- Salaried and full benefits
- Opportunity for permanent hire as a staff NP after completion
- Opportunity for loan forgiveness

Specialty Rotations

Examples:

- OB/GYN
 - Eye Services
 - Infectious Disease
 - Endocrinology
 - STI Clinic
 - Homeless Care
 - Substance Use Disorder
- One rotation per month (1 day per week for 4 weeks)



- Didactics three times a month on Wednesdays
- Held by experts in respective fields

Month	Session 1	Session 2	Session 3
1	Role Transition, Imposter Syndrome, Interprofessional Collaboration	Obtaining a Focused History, Exam, and Assessment	Epic Tips & Tricks
2	Billing Basics	Epic Risk Coding	ER vs Outpatient Management
3	Ortho Exam	Lab Interpretation & Diagnostic Ordering	Obesity Management
4	HTN Management	Chest Pain, EKG Interpretation	Heart Failure

Sample Didactic Schedule

Year 2

- Full patient panel
- Ongoing mentorship access
- Monthly case review
- Leadership development
- Continued professional development
- Performance review & growth



Goals of the program

- Ability to manage a full patient panel
- Make evidence-based clinical decisions
- Practice efficient documentation
- Handle complex chronic disease confidently
- Know when to escalate care
- Avoid early-career burnout



Logistics

- Start date: Tentatively September 2026
- Application will open Monday, March 2, 2026. Interviews held in multiple rounds in April 2026.
- Must graduate from FNP or AGNP program by May 2026 including all clinical hours.
- Applicants must be a citizen of the US or a foreign national with a visa permitting permanent residency in the US, or a non-citizen national. Individuals on temporary or student visas are not eligible.
- Accepted residents are required to be completely credentialed and privileged prior to starting clinical sessions. Applicants must agree to all grant requirements, such as the collection of demographic information.

In progress and on the do list

In progress:

1. We continue to advertise the program
 - LinkedIn, Facebook, Instagram
 - Hosted a virtual info session

To do list:

1. Interviews
2. Selecting candidates

THANK YOU

CHC of Cape Cod



Health Center Description

CHC Mission, Vision & Values

Mission

To improve the health of our community through the provision of equitable, patient-directed, high quality, compassionate health care to all, regardless of ability to pay.

Values

- Accessibility
- Quality
- Teamwork, Integrity, Respect
- Consumer Voice
- Integration of Programs and Services
- Transparency
- Innovation
- Sustainability
- Our Staff

CHC of Cape Cod



Mission Statement

The Family Nurse Practitioner (FNP) 24-month Residency Program at the Community Health Center of Cape Cod (CHC) is committed to being a model of excellence in educational development, clinical competencies, and mentorship, while retaining highly-skilled confident and compassionate providers who are equipped to meet the community needs.

Program Purpose

CHC FNP Residents will work at CHC's main location in Mashpee and rotate to other CHC satellite locations to support ongoing training and provide increased access to primary care teams. FNP residents will receive didactic lectures and experiences incorporated into clinical practice and receive support and guidance from a preceptor(s) to prepare them to deliver autonomous and high-quality care for individuals with complex clinical needs across all life cycles. FNP residents will also advance their clinical skills, confidence, productivity and job satisfaction, as well as contribute to the health center's mission and goals for workforce retention and well-being. Participation in the Residency Program includes a full-time paid position with a comprehensive benefit package.

Program Drivers

Through a combination of longitudinal continuity practice, specialty rotations, professional development, and quality improvement initiatives, CHC endeavors to develop advanced practice clinicians who are leaders in community health and advocates for improved outcomes across Cape Cod and beyond.

Goals for Residents

- Train for **Patient Care** in a complex FQHC setting to achieve best health outcomes
- Achieve **Knowledge for Practice**, regarding clinical judgement, patient care, and professional development
- Elevate competence and confidence of residents through **Practice-Based Learning** and Improvement
- Demonstrate effective **Interpersonal and Communication Skills** for patient safety and overall health outcomes
- Model a **Systems-Based Practice** to enhance patient care and outcomes
- Support **Interdisciplinary Collaboration** to improve patient outcomes, resources, and positive work environment
- Cultivate **Personal and Professional Development** through internal and external supportive opportunities to bolster learning

Program Goals

- Strengthen **workforce capacity** retention at CHC by preparing NP's to deliver full-spectrum primary care within CHC's communities
- Advance CHC's **core values** into the residency program curriculum
- Ensure organizational **compliance** by maintaining CMS, Medicaid, HRSA, and FQHC documentation and billing standards
- Address community needs to improve health outcomes, create access to services, and enhance patient engagement

Core Program Elements

- This is a paid 24-month residency
- The FNP residency curriculum follows a progressive structure that builds on fundamental primary care knowledge towards more complex and specialized topics. The design is competency-informed and mirrors clinical challenges likely to be encountered in practice.
- Clinical rotations are supplemented with didactic sessions and clinical learning experiences
- Assigned clinical rotations in primary care, behavior/mental health, walk-in, pediatrics, gynecology, and SUD. Residents are assigned a mentor to act as a resource and provide support as they transition to autonomous nurse practitioners
- Applicants should have a desire to work in primary care, mental health, FQHCs or other community health areas within underserved communities
- Upon successful completion of the residency, a certificate of completion is awarded

CHC of Cape Cod



Innovation(s)

- Collaborated with Maven Project to help create the didactic structure for the NP Residents
- Collaborated with external pediatric and gynecology providers to ensure NP Residents have the ability to learn from advanced rotations
- Created a NP Residency Team that has thoughtfully planned and provided substantial input in the creation of this program

'Aha' Moment(s)

- When creating a didactic curriculum program, it was helpful to hear that while our health center can plan various sessions in advance, the initial resident competency assessment can change the course depending on current abilities
- Understanding the background and timeframe of accreditation was very helpful to learn through the cohort sessions. Knowing that our NP Residency Program did not need to be accredited prior to kicking off allowed us to take a deep breath of relief

Recommendation(s)

- We would recommend doing research on the various accrediting organizations and choose one that best aligns with your mission and values. From there, use their accrediting principles as a guiding outline to create the outline of your NP Residency Program. Following a blueprint tool will not only allow your organization to have a roadmap but also ensure that details are not forgotten.

CHC of Cape Cod



Voice of the Team

“CHC of Cape Cod is a pillar of need within the Upper Cape. We care about the whole health and well-being of our patients and overall community. In order to maintain the required levels of service, we are all excited to not only provide educational opportunities to newly graduated NPs, but to also enhance CHC’s overall workforce. We see this as a win for all, and I am very excited to begin this program!”

-Kristy Brown, DO, NP Residency & Clinical Program Director

Voice of Leadership

“I am thrilled to begin one of the Cape’s only FNP residency programs within CHC to create a supportive and educational environment that provides practical experience for future clinicians of Cape Cod,” Community Health Center Chief Executive Officer Karen Gardner stated. “Our goal is to continually look for ways to improve our own organization’s retention and stability with the overall goal of serving our community. This program serves as a vehicle for growth in various ways, and we are thrilled to see it in action.”

-Karen Gardner, Chief Executive Officer

CHC of Cape Cod



Measures/Impact

- The success of CHC's Residency Program will be evaluated based on three main components, including:
 - 1) the Resident's Self-Assessment. This will be accomplished upon program acceptance (pre-Residency) and at least 6-month intervals. The self assessment will include both quantitative and qualitative information, including productivity, confidence, satisfaction and success in meeting CHC quality and patient satisfaction goals
 - 2) The number of Residents applying to the Program each year, as well as the number of Residents that choose to leave the Program prior to completion
 - 3) the number of residents remaining with the health center post-graduation for at least 2-3 years. Information gleaned from the above will be continuously reviewed and updated to inform areas for Program Improvement. Improvements initiated will be evaluated for success and sustainability

Key Partners

Internal:

- CHC NP Residency Team:
 - Mashpee Medical Director
 - CEO
 - CTO
 - CHRO
 - Chief of Staff

External:

- Contracted Providers
- Contracted Didactic Workshops/Courses
- Patients

CHC of Cape Cod



Other

- CHC launched its NP Residency Program in February via press release and reaching out to local New England Schools to alert them that we are open for application submittal. Our website is also launched and can be found at: chcofcapecod.org/fnpresidency
- Email is available at CHCNPResidency@chcofcapecod.org

NOW ACCEPTING APPLICATIONS
Submission Timeline: February - March 2026
Graduate Nurse Practitioner Residency Program
The Family Nurse Practitioner Residency Program is a full-time, 24-month post graduate residency program designed to ensure residents are fully prepared for primary care in a community health environment. This program supports the needs of residents who are committed to developing their careers as primary care providers through advanced training and on the job experience.
[Learn More Here](#)
Questions?
CHCNPResidency@chcofcapecod.org

Residency Program Highlights
• Paid 24-month residency, beginning September 2026
• Clinical rotations with didactic sessions and clinical learning experiences
• Clinical rotations in primary care: adult medicine, behavior/mental health, walk-in, pediatrics, gynecology, and recovery services
• Residents are assigned a mentor to act as a resource and provide support
• Resident are afforded all benefits of CHC employees
• CHC is committed to the well-being of its residents and provides access to wellness
• Housing available upon request at certain CHC locations
Submission Timeline: February - March 2026
[Learn More Here](#)
Questions?
CHCNPResidency@chcofcapecod.org

Visuals

Graduate Nurse Practitioner Residency Program (HMH GNPRP)
About CHC
The mission of Community Health Center of Cape Cod (CHC) is to improve the health of our community through the provision of patient-centered, high-quality, compassionate health care to all, regardless of the ability to pay. Our vision is to promote lifelong wellness, by providing access through compassionate and preventative health care as our top priorities.
CHC is the largest primary care provider in our region and is a health care home for over 25,000 patients. In addition to primary care, CHC offers dental care, behavioral health, gynecology, walk-in care, optometry, recovery services, nutrition, care management and a wide range of additional support services. CHC's main location is in Mashpee, MA, and has satellite locations in Falmouth, Bourne, Sandwich and Centerville.
CHC's Notable Distinctions Include:
• 2025+ Best of Cape Cod & the Islands
• Patient Experience 2020 Gold
• 2025+ Best Places to Work
• 2025+ Choice of Health
• National Association of Community Health Centers
CHC's Family Nurse Practitioner Residency Program:
The Family Nurse Practitioner (FNP) Residency Program is a full-time, 24-month post-graduate residency program designed to ensure residents are fully prepared for primary care in a community health environment. This program supports the needs of residents who are committed to developing their careers as primary care providers through advanced training and on-the-job experience.
CHC FNP Residents will work at CHC's main location in Mashpee and rotate to other CHC satellite locations to support ongoing training and provide increased access to primary care teams. FNP residents will receive didactic lectures and experiences incorporated into clinical practice, and receive support and guidance from a preceptor(s) to prepare them to deliver autonomous and high-quality care for individuals with complex clinical needs across all life cycles. FNP residents will also advance their clinical skills, confidence, productivity and job satisfaction, as well as contribute to the health center's mission and goals for workforce retention and well-being. Participation in the Residency Program includes a full-time paid position with a comprehensive benefit package.

Applicant Qualifications
• US Citizen or foreign national with a visa permitting permanent residency in US or a non-citizen national
• Graduate of Commission on Collegiate Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN) accredited nurse practitioner programs
• Recent (within 24 months) NP graduate
• Agree to full time position for at least 2 years post residency completion
• Hold a Nurse Practitioner license in Massachusetts and national board certification through ANCC or ACNP with a specialty in Adult/Geriatric, Family or Psychiatric-mental health with a focus on primary care

Application Requirements
• Curriculum Vitae and official graduate school transcripts
• Personal statement that provides insight into personal qualifications, interests and motivation for this residency program
• Copy of professional diploma (BSN,MSN)
• Evidence of Board Certification (or date scheduled)
• NPI number
• Two letters of recommendation (see full application)
• Three references (may be inclusive of above and see full application)
• Federal DEA, MCSR, and MA license, if available at time of application

Benefits
• Full-time position
• Paid time off (4 weeks per year); holidays per CHC policy
• Participation in 403B retirement plan and other voluntary health and benefit programs
• CME as defined in curriculum
• Access to CHC documentation tools (i.e. Nabla) and other programs

Application Timeline
• Accepting applications through March 31, 2026
• Residency start date September 2026

Submit Applications Online
Website: chcofcapecod.org/fnresidency
• The deadline for submitting your completed application (i.e. contains all required recommendations, personal statement, application, copies of licenses/certifications) is March 31
• Applications must be received by this date for consideration and review by the selection committee
• Interviews will begin in April 2026

Questions/More Information
CHCNPResidency@chcofcapecod.org

Program Structure
• This is a paid 24-month residency
• Clinical rotations are supplemented with didactic sessions and clinical learning experiences
• Assigned clinical rotations in primary care, behavior/mental health, walk-in, pediatrics, gynecology and SUD. Residents are assigned a mentor to act as a resource and provide support as they transition to autonomous nurse practitioners
• Applicants should have a desire to work in primary care, mental health, FOHCs or other community health areas within underserved communities
• Upon successful completion of the residency, a certificate of completion is awarded

Mission Statement
The Family Nurse Practitioner (FNP) 24-month Residency Program at Community Health Center of Cape Cod is committed to being a model of excellence in recruiting, developing, and retaining highly skilled, confident and compassionate providers who are equipped to meet the community needs.



DotHouse Health (DHH) is a federally qualified health center in the Fields Corner neighborhood in Boston that has been providing health care and social services for over 50 years.

Our mission is to serve as an essential community resource, providing affordable, accessible, and high-quality health care while fostering the overall well-being, health, and quality of life for our community.

Services provided on site include comprehensive primary care and chronic disease management for all ages, women's health, walk-in care, dental, eye, nutrition, behavioral health, and substance use care.

Mission Statement

The mission of the DHH's Residency Program is to bridge the transition to independent practice by equipping new nurse practitioners with the clinical excellence and leadership skills necessary to practice in federally qualified health centers. Through structured mentorship, interdisciplinary learning, and engagement with our community, our program aims to foster clinical independence and a lifelong commitment to improving health outcomes.

Program Drivers

Completing our Residency Program will equip residents with the following skills:

- Deliver high-quality care to complex patients in a health center setting
- Demonstrate clinical leadership in a multidisciplinary care team
- Understand the effect of health-related needs on patients and communities
- Integrate sensitivity into clinical practice
- Lead quality improvement & community health initiatives

Core Program Elements

DHH's Residency Program is a full-time 24-month, salaried position that facilitates transition to independent practice. The Program consists of the following:

- Precepted clinical sessions in Primary Care, Urgent Care, and RN triage
- Mentored clinical sessions
- Sessions in specialty rotation
- Session of clinical didactics
- Session dedicated to a QI project

Innovations

- Development of a team dedicated to the development of a sustainable NP Residency Program
- Collaboration with like programs within Boston to share lessons learned and develop synergistic programming
- Integration of RN triage and task ownership into our curriculum to facilitate transition to independent practice

'Aha' Moments

- Collaborating with fellow developed or developing like residency programs will allow for formation of a collective cohort of trainees. We hope this will help foster camaraderie and lead to shared lessons learned among NP residents across community health centers in Boston

Recommendations

- Ensure strong support from health center leadership and buy-in from participating clinicians
- Leverage lessons learned from established residency programs serving similar patient populations and like clinical practice settings
- Consider creation of a common application shared among health centers in shared catchment area

Voice of the Team

“I’m excited to help new NPs develop confidence in providing primary care and to grow our NP workforce in CHCs.”

Amy Baron, NP, Program Lead

Voice of Leadership

“I appreciate the team-based energy of building an NP residency, and how willing existing programs have been to share their best practices. Because of this ‘lift all boats’ mentality, I feel more confident in our ability to create a CHC home for our incoming NP residents.”

Rohini Rau-Murphy, MD, Medical Director

Measures/ Impact

DHH serves over 24,000 patients, diverse in their language, country of origin, and financial need. In the last 2 years alone, our unique patient volume has grown by 10%. With many of our providers involved in teaching, QI, and leadership initiatives, DHH is well-positioned to provide an ideal environment for NP trainees to get become independent practitioners of preventive healthcare and chronic disease management across the lifespan

Key Partners

Internal:

- DHH Leadership Team
- Medical provider Team

External:

- University teaching hospital
- Local FNP programs
- Sister Community Health Centers within the Greater Boston area



387 Quarry St. Suite 100, Fall River, MA 02723

www.HealthFirstFr.org

Phone: (508) 679-8111

The background features abstract teal and light blue geometric shapes, including triangles and overlapping polygons, primarily on the left and right sides of the slide. The central area is white.

FNP Residency Program Showcase

HealthFirst Family Care Center, Inc.

HealthFirst Family Care Center, Inc. is a Federally Qualified Health Center located in Fall River, Massachusetts. For over 50 years, HealthFirst has provided comprehensive, high-quality, and responsive care to residents of the Greater Fall River area. Our services include adult and pediatric primary care, behavioral health, oral health, care management, and limited specialty services such as gynecology, addiction medicine, and HIV/hepatitis C care. We also operate school-based health services and offer integrated nutrition and dental outreach programs.

Our team of 175 professionals serves a population of 14,000 patients annually.

Team Members:

Dr. Uma Jaladi, MD, Chief Medical Officer

Dr. Kathryn Collins, DNP

Dr. Daniel Simoneau, DNP

Katie Tavares, FNP

De-Anne Machado M.Ed. Training Specialist



Mission Statement



The mission of our FNP Residency Program is to equip and support the next generation of family nurse practitioners to deliver exceptional, patient-directed care to the medically complex populations we serve.

Vision Statement



With a deep commitment to improving health outcomes, our vision is to enhance clinical quality and improve patient outcomes by strengthening the diagnostic reasoning, patient management, and procedural proficiency of Family Nurse Practitioner residents, while cultivating a skilled healthcare workforce.

Program Drivers

- Prepare residents to deliver patient-directed care to underserved populations
- Strengthen recruitment, retention, and long-term commitment of FNPs in community health
- Build advanced clinical competence and confidence to bridge gap between academic preparation and real-world clinic practice

Core Program Elements

HealthFirst's FNP program will be a full-time, 24-month salaried residency program that will assist new FNPs in their academic training to support their clinical practice through:

- structured clinical onboarding
- preceptorship and mentorship
- didactic and skills development
- providing opportunities for specialty rotations (Women's Health, Behavioral Health, OAR program, school-based nursing care, HIV and Hep-C management)

Innovations

- Gradual increase in resident panel size
- Protected time with preceptor to ensure FNP resident has access to guidance
- Thorough onboarding period prior to residents seeing patients (workflow operations, Epic EMR and documentation, billing and coding, etc)

Recommendations

- Partner with other CHCs or organizations to share the development of didactics
- Schedule regular meetings with team members to clearly outline roles/responsibilities

Voice of the Team

“Our team is excited to lead the development of the HealthFirst FNP Residency Program with purpose and clarity. This initiative reflects our commitment to strengthen the transition from academic preparation to real-world clinical practice, particularly in Fall River, MA. With more than one in five residents living below the poverty line, high regional rates of chronic disease, ongoing behavioral health and limited primary care access, our community requires a sustainable workforce solution. Through structured mentorship we aim to strength provider confidence, improve patient outcomes, and ensure sustainable primary care delivery in our community.”

Katie Tavares, FNP

NP Residency Program Director

Voice of Leadership

“HealthFirst is excited to move forward with the Family Nurse Practitioner residency program. By training and mentoring FNPs in our community, we can recruit and retain talent, shorten onboarding, and expand access for patients facing long waits for primary care. Most importantly, it will develop confident, mission-driven clinicians who improve continuity and outcomes for Fall River.”

Lisa Jones, MD, CEO

Measures/Impact

Access to primary care in the Fall River, Massachusetts community has become increasingly limited. As a result, we have recognized provider burnout and higher turnover rate due to the volume and complexity of patients.

Results of the 2022 Community Health Needs Assessment

	Fall River 2022 (age adjusted)	Fall River 2022 (crude prevalence)	MA 2022	U.S. 2022
Asthma	13.5%	No Data	11.6%	9.9%
Cancer (All cancers)	473 per 100,000	No Data	449.4 per 100,000	442.3 per 100,000
Heart Disease	No Data	8.6%	<u>6.6%</u>	6.8%
Diabetes	14.4%		11.94	
High Blood Pressure	No Data	33.5%*	29%*	32.7%*
Obesity	36%	No Data	28.2%	33.3%

The CHNA identifies key health-related needs and emerging needs, and it directly informs HealthFirst's strategic planning, service delivery, and program development—including the FNP Residency Program.

Key Partners

Internal:

- Leadership Team
- Medical provider team
- Medical Director

External:

- Local FNP programs
- Community specialists
- Our patients



Mattapan Community Health Center

Mattapan Community Health Center (MCHC) is a federally qualified health center committed to delivering high-quality, comprehensive primary care to an underserved community. MCHC serves patients across the lifespan through integrated medical, behavioral health, and supportive services, with a strong focus on improving health outcomes, access, and workforce sustainability.

NP Anchor Program Snapshot

Mission

Our mission is to recruit, train, and support new NPs, particularly those from backgrounds representative of the patients we serve at MCHC, in delivering high-quality, comprehensive primary care to underserved communities. By extending learning beyond the classroom into supported, real-world clinical experiences, the program will equip novice providers with the skills, confidence, and commitment needed to serve complex populations and build lasting careers in community health.

Vision

Our vision is to create a sustainable post-graduate training pathway that helps new nurse practitioners build confidence and clinical competence in outpatient primary care. Through structured precepting, gradual panel development, and exposure to diverse clinical experiences, the program prepares NPs to thrive in community-based settings, reduce burnout, and provide high-quality care to complex patient populations.



Program Drivers & Core Program Elements

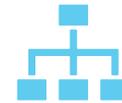
Recognition that newly graduated NPs benefit from structured transition-to-practice training

Commitment to patient safety in a high-complexity, underserved outpatient setting

Desire to reduce early-career burnout and improve provider retention



Two-year, full-time, salaried post-graduate NP residency



Structured, competency-based progression toward independent practice



Early emphasis on outpatient workflow, triage, and care coordination



Gradual increase in supervised NP clinical responsibility



Longitudinal mentorship with dedicated preceptor and NP Director oversight



Focus on patient safety, clinical judgment, and efficiency in primary care

In the Process...

Innovations

- ❖ *Development of a phased clinical model that prioritizes foundational outpatient skills before full panel ownership*
- ❖ *Use of graduated supervision to balance autonomy with patient safety*
- ❖ *Increase collaboration with other health center in Greater Boston to provide access to specialty in the community setting*

'Aha' Moments

- ❖ *Progressive responsibility protects patients, residents, and preceptors*
- ❖ *Retention and job satisfaction are strongly influenced by the quality of early post-graduate training*
- ❖ *Buy-in from Leadership requires proof that program will promote increase in patient access, provider productivity, and is fiscally sustainable*

Recommendations

- ❖ *Design residency programs that explicitly bridge the gap between graduation and independent practice*
- ❖ *Ensure that there is protected time for PDSA cycle*
- ❖ *Allow flexibility in progression based on competency rather than program time frame alone*



Thoughts on the Program....

“This is like an incentive to work at this health center.”
Staff nurses at our health center

“The program will help fill the learning gaps in programs since COVID. This will help decrease the pressure on a new grad, which will build their confidences in their independent practice.”
Sophonia Lucien, NP

“Investing in a post-graduate NP residency program strengthens our workforce, improves patient care, and supports long-term sustainability. This program reflects our commitment to developing skilled primary care providers for our community.”
Chandler Christophe, MD

“This makes me feel better, getting advice/direction from a new grad provider.”
Eileen Rosado RN,MSN

Measures/Impact

- ▶ Baseline assessment to identify variability in NPs readiness for independent outpatient practice.
- ▶ Clear milestones established for progression toward independent practice.
- ▶ Program development advanced through partnering with other Community Center

Key Partners

Internal:

- ▶ Clinic Leadership
- ▶ Medical Directors
- ▶ Program Directors
- ▶ Preceptors
- ▶ Nursing Staff

External:

- ▶ Establishing partnership with other Community Health Centers

Progress and Plans

Completed:

- *Job Description for NP Director and NP Anchor*
- *Leadership Presentation*
- *Identify leadership for the program*
- *Rough Draft of Curriculum and Didactics*

ROUGH DRAFT OF TIMELINE OF THE PROGRAM

2 year or less to complete the program - 2 Anchors per cohort

**progression in the program depends on the mentor's feedback and Anchors ability to advance

▪ 0-3 months (under nursing leadership)

- Employed and onboarded as a RN. Oriented in key roles such as vaccines, triaging and medication management
- Credentialing process starts at time of hire.

▪ 3-6 months (under nursing leadership)

- Nurse will independently work in triage – in person and telemedicine majority of shifts
- Start to shadow visit with other providers in the medical department
- 2 session per week max 4 patients correlating session with Preceptor sessions

▪ 6-9 months (transitions under NP Director leadership)

- 50% nursing role continues
- 50% 4 session per week with max 6 patients per session
- Shadow and participate in specialties visit in house or at other CHC affiliates (once established)

▪ 9-12 months

- 25% nursing role mostly in triage, concluding visits if able to do so.
- 75% 6 sessions per week maximum patient allowed
- Shadow and participate in specialties visit in house or at other CHC affiliates (once established)

▪ 12-18 months

- No longer in the nursing role
- Assist with onboarding next cohort in the anchor program
- 90% 7 sessions per week with maximum patient
- Session no longer need to be correlated with Preceptor, but Preceptor is available for consult related to visit
- Can continue shadowing other specialties if available

▪ 18-24 months

- 100% 8 sessions per week max number of patients

2nd yr Anchors meet with NP Director weekly for mentorship and case review

During the 18-24 months further conversation can occur with organization and Anchors if a permanent position as a FNP is available and a good fit for both.

First year NP Director is meeting with Anchors 2 times weekly for chart and case review outside of supervised patient care sessions

APP New Graduate Onboarding Redesign



Showcase for NTTAP Postgraduate NP/PA Training Programs Community of Practice



Why Mosaic?



- Health Center opened in 2002
- 16 clinics throughout Central Oregon
- Team-based care
- Mission-driven
- Over 80% of patients are low-income
- Internal growth opportunities
- Work-life balance

Our Approach to Care



- Education
- Prevention
- Physiologically-informed Quality Care
- Based on clinical needs, not production
- Integrated Care

Team Based Care



Patient Demographics

AGE RANGE

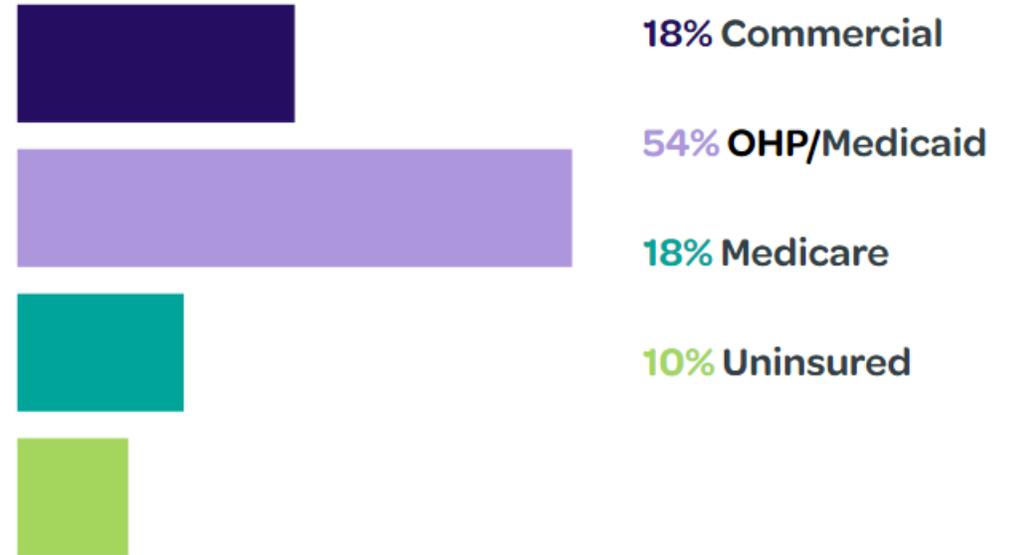


6,076
Children (0-17)

20,181
Adults (18-64)

4,303
Seniors (65+)

INSURANCE



348,548 Care Steps

(Direct interactions)



Medical

287,005



Behavioral Health

37,403



Dental

16,314



Pharmacy

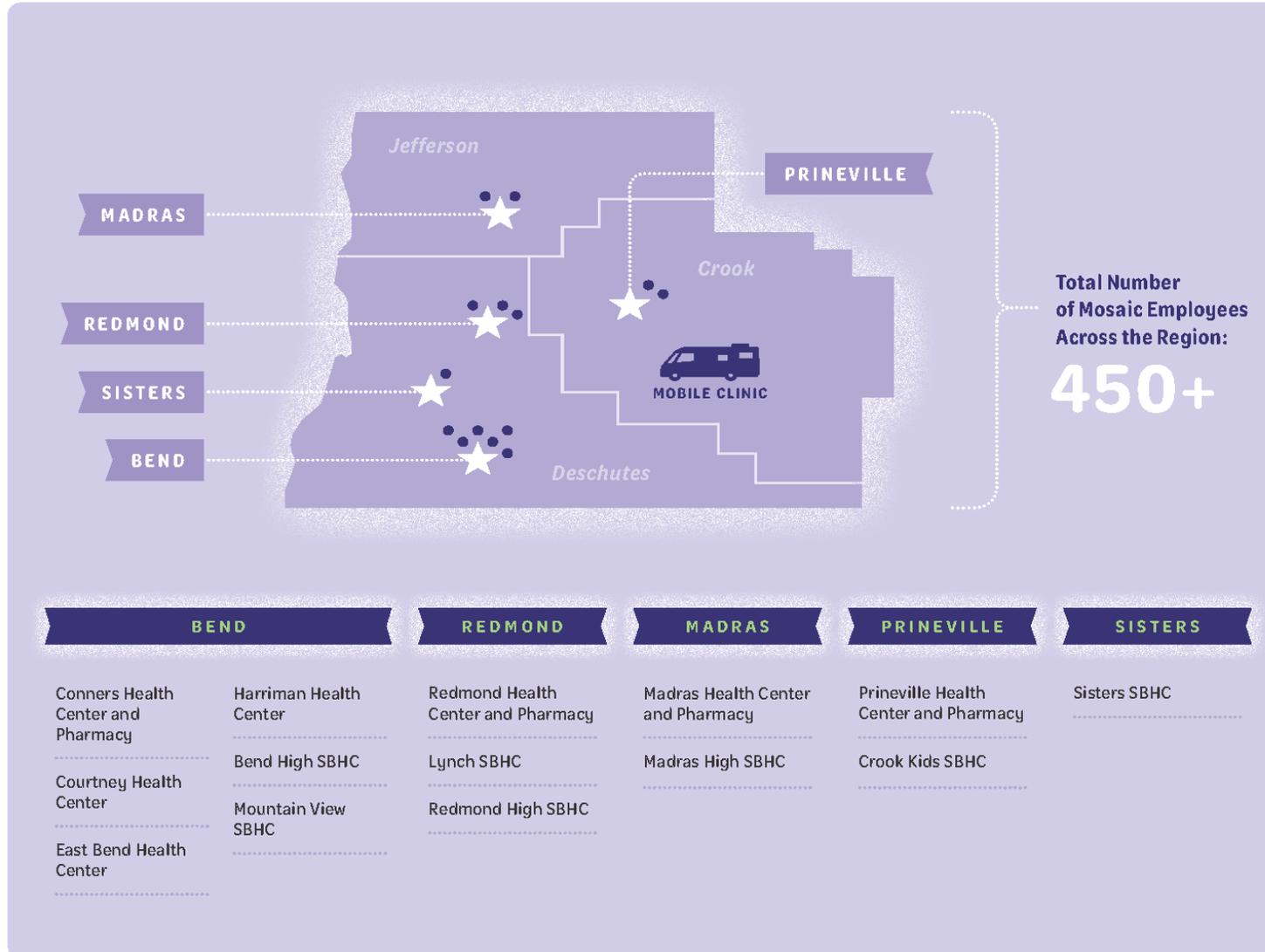
4,197



Nutrition

3,629

Locations Across Central Oregon

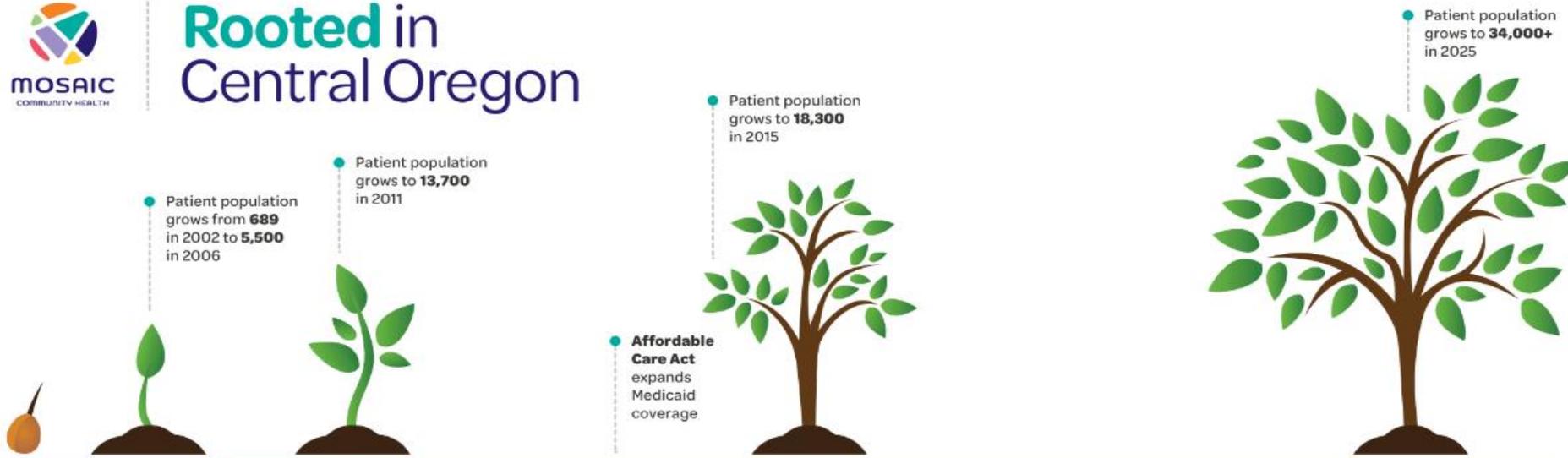


All Staff Gathering





Rooted in Central Oregon



A Vision for a Healthier Community		A Tri-County Presence		Partnership Drives Innovation and Growth										
2002	2005-06	2007-08	2011	2012	2013	2014	2015	2017	2018	2020	2021	2022	2023	2024-25
Mosaic opens first site in Prineville under the name Ochoco Community Clinic	Community Clinic of Bend opens Name changes to Ochoco Health Systems Madras Clinic opens	Prineville Clinic relocates in partnership with Crook County Health Dept. Clinics in Crook, Deschutes and Jefferson counties unite under the name Mosaic Medical	Crook Kids Clinic (SBHC) opens in Prineville Harriman Health Care opens in partnership with Deschutes County Health Services	Mobile Clinic launches Lynch SBHC opens in Redmond	Redmond Clinic opens Complex Care Center (Bridges Health & Internal Medicine) opens in Bend	Ariels Community Clinic opens in partnership with Housing Works Ensworth SBHC opens in Bend	Bend High SBHC opens Bend Clinic relocates to new facility	Madras High SBHC opens Redmond High SBHC opens Redmond Clinic relocates in partnership with Housing Works, new facility includes Mosaic's first full dental suite	Courtney Clinic opens in partnership with Deschutes County Health Services Construction on full dental suite begins at East Bend Clinic	First Mosaic retail pharmacy opens in Prineville Clinic Virtual visits and drive-up care implemented to serve patients during COVID-19 pandemic	Conners Health Center opens on Bend's east-side in partnership with Housing Works, includes retail pharmacy	Madras Health Center opens in partnership with Jefferson County Public Health, includes full dental suite and retail pharmacy Mosaic launches brand refresh and celebrates 20th anniversary	Kingwood Health Center opens in partnership with Deschutes County Health Services in Redmond Sisters SBHC opens Mountain View SBHC opens in Bend	Conners Campus Expansion Project begins – completion projected 2027 Retail Pharmacy opens at Redmond Health Center Street Medicine Program launches

School-Based Health Center (SBHC) partnerships include Mosaic, county health departments and school districts.

Quality Care For All / Atención de Calidad para Todos

Mosaic covers Crook, Deschutes and Jefferson counties



Services expand to include Behavioral Health, Nutrition, Pharmacy, Dental and Substance Use Disorder Treatment Services

Mosaic has a diverse and dedicated staff of 450+

Mosaic Community Health

Mission Statement

- Our mission is to develop, support, and retain new graduate APP. Retention is important for the organization to help provide trusted quality care, with compassion and support for all.

Vision Statement

- Ensure a pipeline of well-trained APP to support a healthy and thriving community for everyone.

Program Drivers

- Retain new graduate APP
- Build Confidence
- Clinical Excellence
- Create a supportive entry to practice environment

Core Pilot Elements

- Developed a 52-week pilot program using components of APP residency model for 3 new graduate APPs
 - 2 clinics participated
 - 4-5 dedicated PCP preceptors assisted (some of which had been in residency programs themselves)
 - Dedicated precepted and mentored sessions
 - Didactic (ThriveAP)

Mosaic Community Health

Innovation(s)

- Operations appreciated having a split clinic day (precepted/mentor time)
- Flexibility with staffing: use seasoned per diem provider to support new grad APP and to alleviate impacts on patient access.
- Incorporating didactic content into new graduate onboarding

'Aha' Moment(s)

- New APPs will still have a challenging few weeks when they transition to full panels
- Dedicated meetings prior to starting the program for preceptors
- Pairing with experienced MA
- Alternative ways to schedule preceptors

Recommendation(s)

- Have dedicated time for team members to work on residency development
- Scheduled meetings for updates and deliverables
- Sim lab and/or case presentations to help with learning soft skills
- Skills or procedure labs/sessions to ensure new grad APP get critical mass of experience in new skills
- Need to rotate to other clinics/specialty clinics

Mosaic Community Health

Voice of the Team

- *More front-loaded Epic time to assist with patient facing ramp up (April Pham, Clinic Manager)*
- *More dedicated preceptor time so preceptors can be more intentional with teaching and mentoring. (Leif Petterson, FNP)*

Voice of Leadership

- *Creating a supportive culture of learning has positive impacts on both the new graduate APP and the entire team . . . Including building trust and a culture of safety. (Bernadette Thomas, APRN, DNP, Chief Health Officer)*

Mosaic Community Health

Measures/Impact

- *Negative impact on access during this pilot*
- *Pilot was unbudgeted*
- *Positive feedback and impact for provider-preceptors . . . appreciation for dedicated time vs. elbow grabs*

Key Partners

- *Stakeholders related to the goals of this project:*
 - *CHO - Bernadette Thomas*
 - *“Acting” Program manager – April Pham*
 - *External:*
 - *Thrive AP – didactic platform for APPs*

Mosaic Community Health

Patients Feel the Impact of Provider Turnover

- *APPs were introduced to our Patient Advocacy Group who were very impressed with the plan for onboarding.*
- *PAC members expressed appreciation for the slowing onboarding process, stating they felt it would help with retention.*

Operational Leaders Collaborated and Lead the Redesign

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LATE SHIFT/THIRD SHIFT					EARLY SHIFT		
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LUNCH	LUNCH	LUNCH	LUNCH	11:00	LUNCH	LUNCH	
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IPV	IPV	IPV	IPV	1:00	IPV	IPV	
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MEET W/ CMD	IPV	IPV	IPV	3:00	IPV	IPV	
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ADMIN	ADMIN	ADMIN	ADMIN	4:30	ADMIN	ADMIN	
END	END	END	END	5:00	END	END	



MOSAIC
COMMUNITY HEALTH

Questions?

— 
Email: hello@mosaicmedical.org

NEIGHBORCARE HEALTH



- Medical (Family Medicine, Midwifery), Dental, Behavioral Health, School-based, Homeless & Housing
- ~600 employees

Team Members

- Kim Herner, MD, Chief Health Officer
- Kalyca Seabrook, DNP, FNP/Site Medical Director

NEIGHBORCARE HEALTH

Mission Statement

Our mission is to provide an in-depth, supportive primary care transition to practice program that prepares new Advanced Practice Providers (APPs) to provide evidence-based, quality care to a patient population with complex medical and socio-economic needs in the community health care setting while furthering the mission and vision of Neighborcare Health.

Vision Statement

Our vision is to prepare APPs to provide evidence-based health promotion, prevention and management of complex conditions for underserved populations while cultivating healthy work-life balance and long-term retention in community health.

Program Drivers

- *Attract new nurse practitioners (NPs) and physician assistants (PAs) to primary care in underserved communities*
- *Improve access to quality health care in a community health center*
- *Support new Advanced Practice Providers (APPs) as they transition to clinical practice*
- *Long-term retention of APPs*

Core Program Elements

- *Precepted/Mentored Clinic (60%)*
- *Specialty Rotations (30%)*
- *Didactic (10%)*

NEIGHBORCARE HEALTH

Innovation(s)

- *Mentor program piloted in 2023 (1 mentor and 1 mentee at 1 clinic) that has grown to 2 mentors serving new graduate APPs across multiple clinics*
- *0.1 FTE dedicated to explore the feasibility of an APP residency at NCH*

'Aha' Moment(s)

- *Opportunities for partnership with local university Sim Lab*
- *Opportunity to build in-house specialty clinics/rotations based on internal expertise*

Recommendation(s)

- *Develop a committee from various stakeholders from the start (i.e. finance, operations, etc)*
- *Reach out to other APP Residency Programs*
- *Get involved with the NTTAP early!*

NEIGHBORCARE HEALTH

Voice of the Team

I am excited about the possibility of a residency program at Neighborcare! NTTAP has helped us organize the foundation and how to approach our board for approval to start a program. I believe it will respond to the needs of both the organization, new graduate APPs, and established providers

Kalyca Seabrook, DNP, Site Medical Director/Family Nurse Practitioner

Voice of Leadership

I have seen a need to better support new graduate APPs as they join Neighborcare Health as well as improve APP retention. Developing a more structured and systems approach to this support with the APP Residency model fits the bill. I appreciate the guidance and expertise of NTTAP in our journey.

Kim Herner, MD, Chief Health Officer

NEIGHBORCARE HEALTH

Measures/Impact

Organizational Readiness For Implementing Change (ORIC)

Total Average Mean Score
4.33

Readiness to Train Assessment Tool (RTAT)

Readiness Score	Readiness Level
3.20	Approaching Readiness

Key Partners

Internal:

- *Senior Leadership Team (CEO, CHO, CFO, COO, CHR)*
- *Directors (DCOs, DMS, Director of PCC), Clinic Leads (SMDs, PSOMs, MSOMs, CAs)*
- *Dental and Pediatric Residency Programs*
- *SEIU Union*
- *Clinic Staff (Providers, MAs, RNs)*
- *Patient advisory group (planned)*

External:

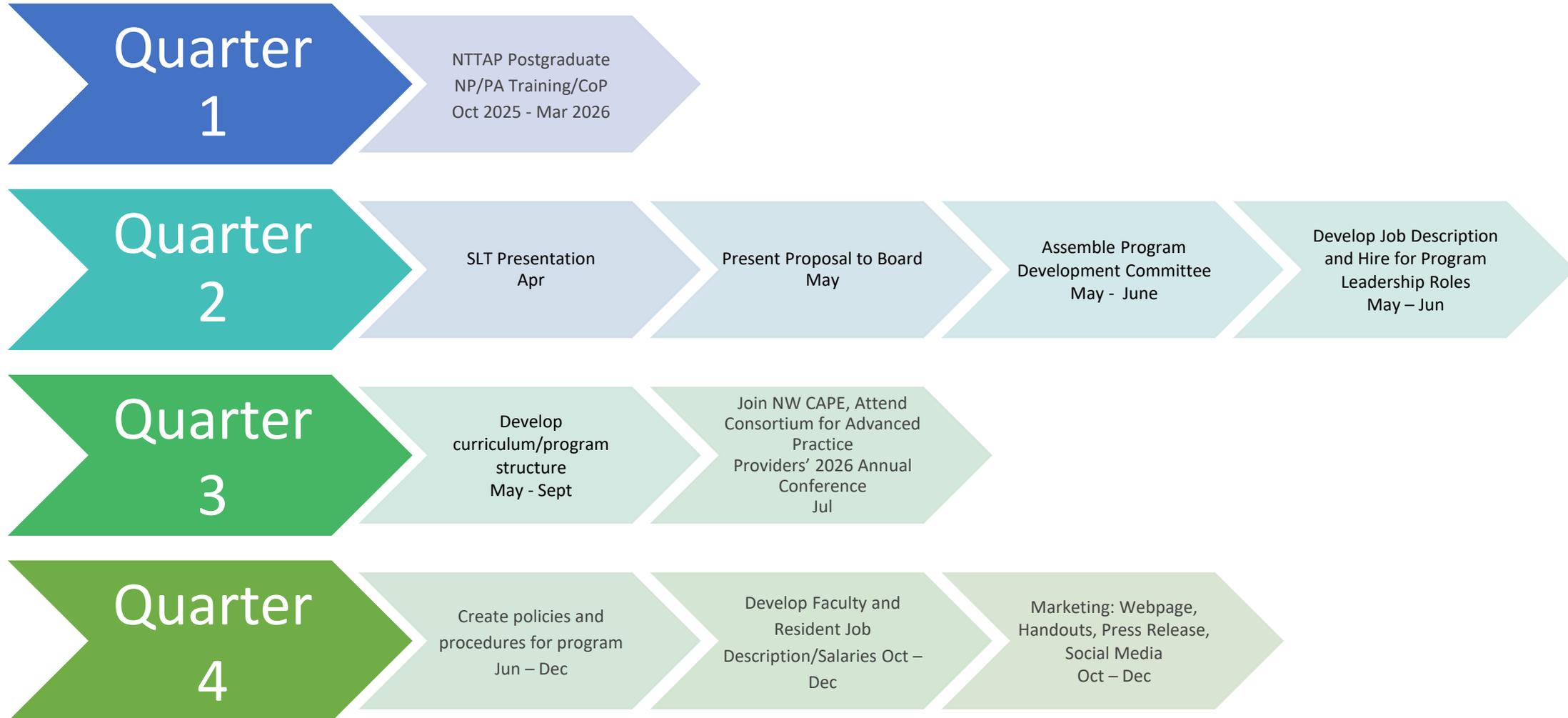
- *University of Washington School of Nursing Sim Lab*
- *Northwest Consortium of Advanced Practice & Education*
- *Specialty Clinics*

NEIGHBORCARE HEALTH



Program Development Timeline

2026

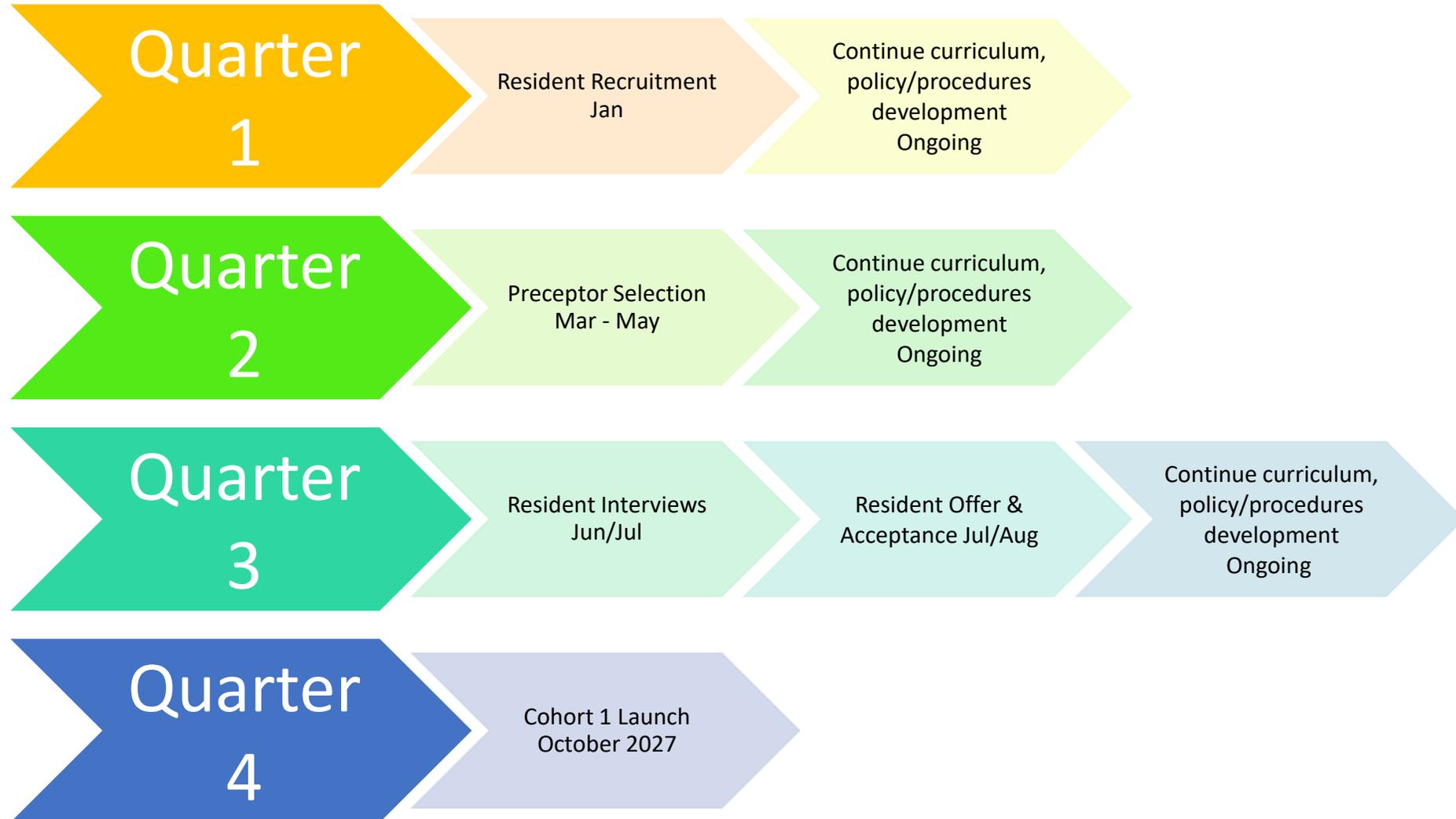


NEIGHBORCARE HEALTH



Program Development Timeline

2027



NEIGHBORCARE HEALTH



Thank you!

One Health



- At its heart, One Health is more than a healthcare organization. We are neighbors and partners, committed to advancing health, hope, and opportunity in the rural and frontier communities we call home. We are honored to serve – and to be shaped by – the communities that inspire and sustain our work every day
- One Health operates numerous sites across central and eastern Montana and northern Wyoming, offering integrated medical, dental, behavioral health, substance use treatment, and pharmacy services. Our model of **Whole Community Care** recognizes that healing must occur not only within individuals, but also within the broader communities they call home. Guided by local boards of directors, we ensure that each site remains deeply responsive to the unique strengths and needs of the people it serves.



Mission:

Educate and prepare APPs of diverse backgrounds to confidently provide compassionate, evidence-based, integrated care to rural and underserved populations of Montana, Wyoming, and beyond.

Vision:

Establish a premier APP residency that equips providers with the skills, experience, and confidence to thrive in frontier and rural primary care. Through comprehensive training and mentorship, we aim to cultivate highly competent, engaged APPs who deliver exceptional, patient-directed care. By preparing APPs for the complexities of rural medicine, we seek to improve the health and well-being of rural communities we serve and strengthen the sustainability of the healthcare workforce.

Program Drivers

Strengthen Onboarding and Support

Smooth transition to practice

Quality/Systems Improvement

Education and quality project for system improvement

Mentorship and Peer Support

Supportive Learning Environment

Professional Development and Role Clarity

Assist in transition to practice, gaining professional skills, and understanding support options in patient care.

Scalability

Develop structure for future APP residency accreditation

Structured Education

Key content over one year, rolling admission



Program Components and Resources

12 month, full-time experience focused on newly hired APPs including NPs and PAs

Continuity Clinic

Residents grow their clinical skills by building their own patient panel with available support from a dedicated preceptor and MAVEN consultation.

Didactic and Online Learning Modules

Core content through MAVEN, self-paced on-demand learning and live sessions

Preceptor and Mentorship Program

Dedicated mentors and clinical preceptors from MAVEN and One Health.

Partner Clinic

Residents will see patients together with their preceptor, allowing for clinical skill development, exposure to diverse conditions, and experience with different practice styles.

Procedure Skills Lab

Residents will meet 1 to 2 times per year for focused hands-on training

Evaluation and Feedback

Structured assessments to guide APP progress, QI, and informed program improvement

One Health



Innovations

- 12-month rolling enrollment for first year of employment offered to new-hires
- In-house "specialty" rotations
- Using live and recorded on-line didactics to maximize remote learning

"Aha" Moments

- MAVEN Partnership – this has been a huge asset for mentorship and didactics
- Making this process an expected part of the first year for all new-hire APPs

Recommendations

- Ensure enough dedicated staff time
- Program must include dedicated program manager & director time
- Vital to ensure cross-organizational buy-in
- Think outside the box
- Use your resources creatively

One Health



Voice of the Team

“The APP Transition to Practice Program is an exciting opportunity to support and creates a strong foundation for new APPs in rural healthcare. I’m passionate about offering structure, guidance, and collaboration with our preceptors to help shape the future of healthcare.”

Stephanie Christman, NP, Medical Director
and Lead Preceptor

Voice of Leadership

“We have really benefitted from the TA support to help develop and implement our APP Transition to Practice Program. This program is addressing our critical need for improved support of new APP's in our rural and frontier practice locations and will undoubtedly lead to increased retention, improved patient outcomes, and increased efficiency across all of our clinic locations.”

Lander Cooney, Executive Vice President

Demonstrating Need for the Program

Surveys of 12 providers onboarded in the last 3 years showed:

- A majority of providers felt that One Health was unprepared to support new providers
- A majority of providers felt as though One Health onboarding was either somewhat effective or not-effective in preparing them for rural primary care

Key Partners

Internal:

- Executive leadership
- Medical directors, HR and clinic managers
- Preceptors

External:

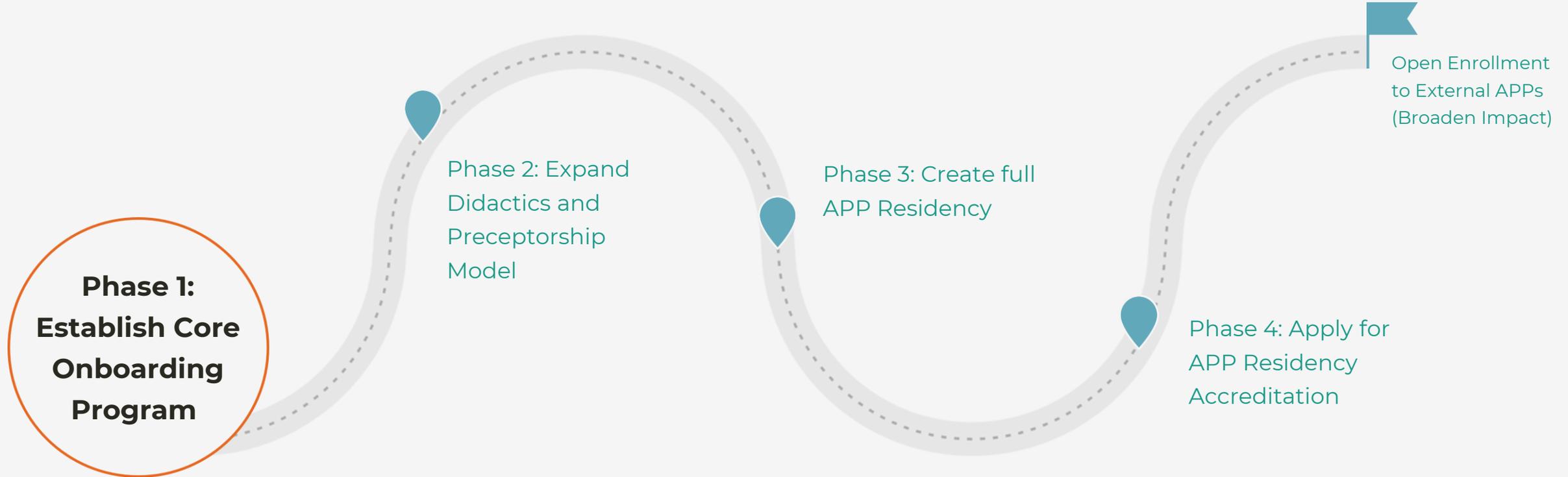
- Montana Primary Care Association
- Maven
- Our community and patients

Organizational Costs

- Retention rate for newly hired APPs over the last 5 years is less than 50%
- Experienced providers consistently identify lack of dedicated time to train new-hires as a factor contributing to burnout
- In Rural clinics, APPs are consistently expected to carry the same complex patient load as residency trained board-certified physicians with 5-7 years more training
- Financial cost of losing a provider: \$165,000 to \$435,000
- Other Costs:
 - Loss of moral
 - Increased burnout in remaining staff
 - Patient attrition
 - Loss of community trust
 - Increased potential for patient harm due to transitions of care

Potential Future Scalability (Toward Residency)

This model aims to ensure that One Health can implement a sustainable, high-quality onboarding process. Aligns current resources while setting stage for future growth into accredited residency program



Palms Medical Group



Health Center Description

- *Our mission is to enhance the health and well-being of our communities.*
- *We serve 7 counties with over 73,000 patients in North Florida*

Palms Medical Group



Mission Statement

- To prepare new providers with the confidence and competence to deliver quality, patient-directed care in community health centers

Vision Statement

- A resilient, values-driven workforce expanding access, improving outcomes, and sustaining quality care.

Program Drivers

- Attract and retain exceptional clinical talent.
- Cultivate a culture of safe, high-quality care that consistently enhances patient outcomes.
- Use a standardized, comprehensive training plan to advance clinical competency and performance.

Core Program Elements

- Full integration with the organization
- Residency is 12 months of full-time employment with 80% clinical based training experience and 20% education.
- Clinical based training experiences will consist of precepted continuity clinics, mentored clinics, and specialty rotations.
- Specialty rotations: Pediatric, chiropractic, women's health, behavioral health, and dental care.
- Education will consist of didactic education, quality improvement training, and project echo training as available.
- Residency is followed by 12 months of independent practice with an available mentor.

Palms Medical Group



Innovation(s)

- *Recognizing the need for additional postgraduate training beyond our current provider training plan*
- *Developed a matrix to identify preceptors and mentors*
- *Identification of the team to carry out the program*

'Aha' Moment(s)

- *Fully realizing the value that a successful residency program could bring to our organization.*

Recommendation(s)

- *Dedicate focused time to program development—probably more than you think you need.*

Voice of the Team/Leadership

- *Before joining this program, I had been struggling to think of new ways to improve clinical care/quality and lessen risk. It felt like a revolving door of providers at times which undermined the improvement efforts. At the same time, I understand how hard it can be to practice in primary care/in an health center. This program has given us what feels like a viable solution to this problem.*
- *Crystal Cullen, Chief Clinical Compliance Officer, FNP*

Palms Medical Group



Measures/Impact

- *Plan to track and compare*
 - *CQM data from providers that complete residency (historically low for first year providers)*
 - *Provider retention data*
 - *Peer review scores*
 - *Patient complaints*
 - *Referral volume*

Key Partners

- *Stakeholders related to the goals of this project:*
 - *Internal: Leadership team, Performance Improvement Team, Quality and Risk department, Education and Human Resources*
 - *External: Local FNP programs, contracted specialty partners, patients*

Uphams Community Care



Health Center Description

- The mission of the Upham's Corner Health Committee, Inc. is to provide high quality, low cost, community-based health and social services to the residents of North Dorchester and adjacent neighborhoods.
- Health center that provides family medicine, internal medicine, pediatrics, behavioral health, women's health, nutrition, vision care, dental care, Women, Infants and Children (WIC), Program of All-Inclusive Care for the Elderly (PACE), and home health services



Uphams Community Care

Mission Statement

- *UCC's Postgraduate Nurse Practitioner Residency Program aims to inspire and train a new generation of Nurse Practitioners to achieve strong clinical competence in primary care. Graduates will thrive as effective and confident clinicians and leaders in the community health setting, thereby expanding access, improving delivery, and elevating the quality of care for all.*

Program Drivers

This program is driven by a desire to increase the confidence of Nurse Practitioners in providing primary care in the community. We aim to increase the availability of high-quality care to better resource our Dorchester community.

Core Program Elements

- *Uphams Community Care's NP Residency Program is a full time, 24-month salaried program that provides a structured and effective learning environment for newly licensed NPs to hone their clinical skills in the primary care setting. This program utilizes the following elements to build competence and confidence in primary care:*
 - *Weekly didactic sessions*
 - *Weekly precepted clinic sessions*
 - *Weekly mentored clinic sessions*
 - *Monthly specialty rotations*

Uphams Community Care



Upham's Community Care
Serving the community since 1971

Innovations

- *Received grant funding for residency training implementation*
- *Expanded provider training for skills building in healthcare teaching*
- *Developed a leadership team for the creation and recruitment of a high quality residency training program*

'Aha' Moments

- *Partnering with universities for recruitment and training support*
- *Collaborating with other sites in residency implementation for support and knowledge sharing*

Recommendations for Other Residencies

- *Find support and funding from leadership prior to implementation!*
- *Partner with universities for recruitment*
- *Create a sustainable team and establish regular meetings*

Uphams Community Care



Voice of the Team

- *“Pioneering a robust training program for new graduate nurse practitioners is both humbling and exciting. I am thrilled to be awarded this opportunity. My goal for this program is to provide new clinicians with the tools and the confidence for a successful and rewarding primary care practice.”*

- Abigail Rezendes, FNP
FNP Residency Director

Voice of Leadership

“The heart of Family Medicine is caring for communities and recognizing how deeply connected we all are—something that feels especially important to hold onto in recent years. It's in this spirit that we are excited to support our Dorchester community with this new program. We're committed supporting early-career FNPs with strong clinical mentorship, team-based training, and a deep understanding of community-based care. We know this will not only strengthen care for our patients, but also support our mission-driven colleagues as they embark on a fulfilling career caring for the community.”

Dr. Marissa Hamrick, Medical Director

Uphams Community Care



Driver for Program Development

Despite the collegial atmosphere at UCC between new providers and senior clinicians, we continue to struggle with new NPs feeling like they have a strong foundation. As a result, we have had a high level of APP turnover over the past five years. We are developing this program to allow new NPs a supported transition to practice as they adjust their role from care team member to care team provider.

Key Program Partners

- Internal:
 - UCC's Medical Leadership Team: CMO, Medical Director, NP Residency Director, Nursing Leadership
 - UCC's Clinical Team
 - UCC's Executive Team
- External:
 - Local Universities
 - UCC's Patients
 - UCC's Board of Directors

UPHAMS COMMUNITY CARE



JOIN OUR TEAM!

**FAMILY NURSE
PRACTITIONER
RESIDENCY TRAINING
PROGRAM**

UPHAMS COMMUNITY CARE, DORCHESTER, MA

- Recruitment efforts with local universities – see our program flyer!
- Visit our website: [FNP Residency Program - Uphams' Corner Health Center](#)

PROGRAM OVERVIEW

- Salaried training program for licensed Family Nurse Practitioners beginning their first year of clinical practice
- Two year supported transitional program beginning October 2016
- Program features didactic lectures, direct clinical supervision and precepting with real time feedback, specialty rotations, and mentorship

**READY TO LEARN
MORE?**

email us at
NPResidency@uphams.org



University of California, Irvine



- **Grant Award & Program Launch**
 - The Sue & Bill Gross School of Nursing at the University of California, Irvine received a \$5 million grant from CalOptima Health
 - Funds support NURSE-OC, part of CalOptima's \$50 million Provider Workforce Development Initiative
- **Purpose of NURSE-OC**
 - Address critical healthcare workforce shortages in Orange County
 - Strengthen the regional pipeline of advanced practice providers
 - Improve access to primary care and behavioral health services
- **Residency Model**
 - Funds 6 nurse practitioner residencies
 - 4 Family Nurse Practitioners (1 per year)
 - 2 Psychiatric-Mental Health Nurse Practitioners (1 per year starting 2026)
- **Community Commitment**
 - NURSE-OC alumni commit to serving in CalOptima-affiliated provider organizations
 - Expands care access for underserved communities
- **Impact**
 - Strengthens the local healthcare workforce
 - Improves health outcomes
 - Aligns UCI Nursing's academic excellence with regional healthcare needs



University of California, Irvine

Mission Statement

Our mission is to cultivate the clinical skills, professional confidence, career satisfaction, and long-term retention of novice nurse practitioners through a comprehensive and rigorous postgraduate training program.

Vision Statement

Our vision is to prepare novice NPs to become leaders in the management of complex disease processes, health promotion, disease prevention, and care for underserved populations. These practitioners will contribute to a diverse, collaborative, and interdisciplinary workforce committed to improving patient outcomes and advancing innovative models of care delivery.

University of California, Irvine



Program Drivers

- Expand the availability of primary care providers in underserved communities to enhance access to comprehensive care and community-based resources.
- Offer newly graduated nurse practitioners (NPs) the opportunity to gain experience managing complex medical conditions within a safety-net healthcare setting.
- Facilitate a structured and supportive transition from academic training to clinical practice.
- Encourage and attract emerging NPs to pursue long-term careers in complex community health settings.
- Foster the development of clinical competence, professional confidence, and subject-matter expertise among novice NPs.
- Provide experiential learning opportunities across multiple domains of primary care, emphasizing the role of health-related needs.
- Mentor new NPs to become proficient in health promotion and disease prevention strategies.
- Prepare NPs to engage confidently in interdisciplinary, team-based models of care.
- Enhance the efficiency, clinical productivity, and decision-making abilities of novice NPs while supporting their progression toward expertise.
- Support NPs in navigating healthcare systems and resources to ensure their long-term success in primary care practice.

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Monday	Tuesday	Wednesday	Thursday	Friday
Specialty Rotation (20%)	Precepted continuity clinic (20%)	Precepted continuity clinic (20%)	Education (20%): 1 Spanish Immersion 2 Hrs QI 1 Hrs Project Echo 4 Hrs Didactic	Mentored Clinic and Admin Time (20%)

Core Program Elements

- 24-month program structure
 - 12-month intensive residency
 - 12-month service commitment in Orange County
- Provides immersive, hands-on clinical training in partnership with community health centers
- Emphasizes:
 - Integrated, team-based care models
 - Management of complex and high-risk patient populations
 - Practice across underserved healthcare settings
- Designed to prepare confident, practice-ready FNP's committed to serving the Orange County community



University of California, Irvine

Innovations

- **Embedded Quality Improvement (QI) Training Framework**
 - Integration of a structured QI curriculum in which residents lead data-driven improvement projects aligned with organizational priorities (e.g., chronic disease metrics, preventive care benchmarks, behavioral health integration). Residents receive formal training in PDSA cycles, community health analytics, and value-based care performance measures.
- **Dedicated Teaching & Preceptor Development Model**
 - Implementation of a formal preceptor development program that provides faculty training in adult learning theory, competency-based evaluation, feedback delivery, and clinical teaching best practices. Protected teaching time and standardized assessment tools ensure educational excellence.
- **Data-Driven Community Health & Outcomes Infrastructure**
 - Expansion of EHR-based dashboards and performance tracking systems to support panel management, risk stratification, and longitudinal patient outcome monitoring—creating a real-time learning environment for residents.
- **Interprofessional Education & Team-Based Care Training**
 - Structured collaboration with behavioral health, pharmacy, and care coordination teams to model integrated, team-based practice while reinforcing teaching and mentorship across disciplines.



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'Aha' Moment

- **No one starts residency fully “ready.”**
 - Growth happens through structured mentorship, progressive autonomy, and real-world clinical experience.
- **We build as we go.**
 - Successful residency programs evolve in real time—continuous assessment, feedback, and refinement are part of the design.
- **A strong team makes the difference.**
 - Interprofessional collaboration, engaged preceptors, and administrative support are foundational to resident success.
- **Flexibility is essential.**
 - Adaptability in curriculum, scheduling, and clinical exposure ensures the program meets both learner and community needs.



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Recommendations

- **Invest early in teaching infrastructure.**
 - Develop a structured curriculum, formal preceptor training, protected teaching time, and competency-based evaluation processes before onboarding residents.
- **Embed Quality Improvement (QI) into the program design.**
 - Align resident projects with organizational priorities and provide formal training in data analysis, community health management, and performance metrics to create measurable impact.
- **Build a strong, interdisciplinary foundation.**
 - Engage leadership, clinical teams, and operations early. Clear communication, shared expectations, and team buy-in are critical to sustainability.
- **Design for flexibility and continuous refinement.**
 - Expect iteration. Regular feedback loops, program evaluation, and willingness to adapt will strengthen the residency over time.

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Voice of the Team

- We prioritize partnering with people, not just organizations.
- Shared values, trust, and authentic relationships are foundational to successful collaboration.
- Personality, communication style, and cultural alignment matter as much as infrastructure.
- Strong partnerships are built on mutual respect, transparency, and a shared commitment to learner and community success.

- Community Partner

Voice of Leadership

- It is truly remarkable to see what has been created from a piece of paper and an idea. What began as a vision for postgraduate NP training is evolving into a transformative workforce pipeline for our organization. This program is strengthening our clinical capacity, enhancing our culture of teaching and quality improvement, and positioning our health center as a leader in developing the next generation of providers committed to serving our community.

- UCI Leadership

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Measures/Impact

- Data Collection in Process

Key Partners

- UCI School of Nursing
- Camino Health Center
- OCHA
- UCI Health
- Orange County Community Partners

University of California, Irvine



- Engaging with peers reinforced that no residency starts perfectly prepared; iterative learning and flexibility are essential.
- Collaboration highlighted that personality and team dynamics matter as much as infrastructure in successful program implementation.
- Shared experiences emphasized the value of embedding quality improvement (QI) training and structured teaching into the program from the outset.
- Strong preceptor development is foundational for resident success and sustainability.
- Interprofessional engagement and mentorship enhance both clinical and educational outcomes.
- Developed a formal residency curriculum including clinical rotations, QI projects, and mentorship structure.
- Designed data tracking and evaluation frameworks to measure resident progress and program impact.
- Strengthened partnerships with community health centers, ensuring graduates contribute directly to local workforce needs.

Questions?

Wrap-Up

Next Steps

Due Tuesday March 31st:

- Submit all completed/drafted work to the [Google Drive](#)
- Complete the Post-CoP Surveys:
 - Each team member, please complete the Post-CoP Evaluation Survey:
https://Qualtrics.ca1.qualtrics.com/jfe/form/SV_3Uk3oirk4UAYgES
 - As a team, review and complete Readiness to Train Assessment Tool (RTAT):
https://Qualtrics.ca1.qualtrics.com/jfe/form/SV_bCtYYz3TZqGgTNI
 - Ask each team member to complete the Organizational Readiness to Implement Change (ORIC):
https://Qualtrics.ca1.qualtrics.com/jfe/form/SV_6u5bK0ZxN34DTKu

Reminders

- **Final Team Leader Check-In Call:** Wednesday March 17th at 1:00pm Eastern / 10:00am Pacific
- **6-month Check-in Call:** Tuesday September 8th at 1:00pm Eastern / 10:00am Pacific
- Please reach out to schedule 1-on-1 calls as needed about your program implementation.

Weitzman Education Platform

Weitzman Education Platform – this will serve as the platform to receive CE credits for each learning session and access recordings/slide decks/resources:

- Register for the course here: <https://education.weitzmaninstitute.org/content/nttap-postgraduate-nurse-practitioner-np-andor-physician-associate-pa-training-programs-5>
 - Access Code: PGR2025
- If you do not have an account, follow these instructions:
<https://education.weitzmaninstitute.org/user/register>
 - Choose a username, password (save it somewhere safe so you can continue to use it!), and fill out some basic user information.
 - Click Create New Account.
 - If you encounter any technical difficulties, please reach out to myself or [submit a ticket](#).

Explore more resources!

National Learning Library: Resources for Clinical Workforce Development

National Learning Library



CHC has curated a series of resources, including webinars to support your health center through education, assistance and training.

[Learn More](#)

<https://www.weitzmaninstitute.org/ncaresources>



The National Training and Technical Assistance Cooperative Agreements (NCAs) provide free training and technical assistance that is data driven, cutting edge and focused on quality and operational improvement to support health centers and look-alikes. Community Health Center, Inc. (CHC, Inc.) and its Weitzman Institute specialize in providing education and training to interested health centers in Transforming Teams and Training the Next Generation through:

National Webinars on advancing team based care, implementing post-graduate residency training programs, and health professions student training in FQHCs.

Invited participation in Learning Collaboratives to advance team based care or implement a post-graduate residency training program at your health center.

Please keep watching this space for information on future sessions. To request technical assistance from our NCA, please email NCA@chc1.com for more information.

Health Center Resource Clearinghouse



<https://www.healthcenterinfo.org/>

- ◆ Mark your calendars and “Save the Date”!
- ◆ Dates: July 12 – 14, 2026
- ◆ Location: Grand Hyatt Denver, CO
 - Pre-Conference Workshop Offerings on 07/12
 - APP Leadership Workshop
 - Administration and Operations Workshop
 - 2 Day General Conference on 07/13 – 07/14



SAVE THE DATE!
Monday–Tuesday, July 13–14, 2026
Pre-Conference Workshops on Sunday, July 12th



The **Consortium for Advanced Practice Providers** 2026 Annual Conference

Make plans to join us in-person for our Ninth Annual Conference on **July 13 and 14, 2026** at the **Grand Hyatt in Denver, Colorado.**

Watch for details coming soon!

Consortium for Advanced Practice Providers
635 Main Street, Middletown, Connecticut 06457

www.APPpostgradtraining.com
info@APPpostgradtraining.com | twitter.com/APPpostgrad

Link to a conference highlights video: <https://vimeo.com/1002782981/a40432e368?share=copy>

Contact Us!

Amanda Schiessl

Program Director/Co-PI

Amanda@mwhs1.com

Meaghan Angers

Senior Program Manager

angersm@mwhs1.com

Bianca Flowers

Program Manager

flowerb@mwhs1.com

REMINDER: Complete evaluation in the poll!

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