WNCCCHS Patient Population Served in 2015

14,740 patients

- 95% At or Below 200% of the Federal Poverty Level
- 42% Racial/Ethnic Minority
- 50% Uninsured

Medical Conditions Served in 2015

- Hypertension 36%
- Diabetes 16%
- Asthma 8%
- Prenatal 3%
- HIV 6%
- Other 3%
What is a Residency Program?

Well, that depends on who you ask, but Wikipedia defines “Residency” as “a stage of graduate medical training”. A resident or house officer is a physician (one who holds the degree of M.D., D.O.) who practices medicine usually in a hospital or clinic under the direct or indirect supervision of an attending physician. Typical MD or DO programs include a residency program as part of the education and training, meaning that you need to complete a residency program to be able to practice medicine.

Make Sense? Ok, so MDs and DOs are considered “primary care providers”. Primary Care Providers or PCPs provide the day-to-day healthcare given by a health care provider. Typically this provider acts as the first contact and principal point of continuing care for patients within a healthcare system, and coordinates other specialist care that the patient may need.

Additionally, primary care providers also include nurse practitioners and physician assistants.

If Nurse Practitioners and Physician Assistants are considered Primary Care Providers, do they have residency programs?

Well, sort of. That is, more and more they do. In 2010, Community Health Centers Inc., in Connecticut, a federally qualified community health center, began the nation’s very first residency program for nurse practitioners. Residency programs are not a part of the formal education of NPs or PAs. Currently, it is not a requirement that a graduate of a NP or PA program complete a residency to be able to provide primary care services... as a PCP.
So why have Residency Programs for safety net medicine, if they are not a requirement?

1. Better prepared clinicians for safety net settings

Safety net medicine is different from other primary care settings because many patients are uninsured, and enter health care with more advanced chronic conditions and with more of those conditions (co-morbidities) than the average person. Most patients at a community health center are living at or below 200% of the federal poverty level... that means they make about $24,000 per year individually – hardly enough to pay rent, bills, food and utility costs AND costly medical insurance or high out of pocket medical costs without insurance. Patients in safety net settings often have other hurdles, like working multiple jobs to make ends meet, or linguistic barriers, stigma, discrimination, limited access to educational opportunities, trouble accessing transportation, childcare, etc. PCPs must consider a patient’s socio-economic health alongside their medical problems. Does the patient have enough money to purchase their medications that are prescribed? Can the patient secure transportation/day care if they need it to come for an appointment? Those are common scenarios faced by PCPs in safety net clinics across the country.

Most graduates of “Advanced Practice Clinician” residency programs feel they are better prepared to practice as a primary care provider – especially if they want to become a PCP in a safety net setting, such as a community health center, rural health clinic, or other setting where there is a disproportionate percent of underserved individuals who lack resources that many people take for granted.

Most patients at a community health center are living at or below 200% of the federal poverty level...
AAMC Research Confirms Looming Physician Shortage

Tuesday, September 27, 2016 | by Sarah Mann

The United States will face a shortage of between 61,700 and 94,700 physicians by 2025, with particularly large shortfalls in certain surgical specialties, according to a new study commissioned by the AAMC (Association of American Medical Colleges) and released in April.

“This continues to be a well-researched and statistically sound projection of a physician shortage over the next 10 years,” said Janis M. Orlowski, MD, AAMC chief health care officer. “It’s important to look at this over 10 years because it takes us about that long to train a physician depending on the specialty. Our workforce plans need to start now.”

The report, conducted by the Life Science division of the global information company IHS Inc., is an update to a 2015 analysis and reflects feedback from the health care research community, as well as the most recent workforce data.

Projected physician shortages have increased slightly for all specialties. For primary care, there will be a shortage of between 14,900 and 35,600 physicians by 2025.

The updated projections from the AAMC research study also finds that the numbers of new primary care physicians and other medical specialists are not keeping pace with the health care demands of a growing and aging population.

“These updated projections confirm that the physician shortage is real, it’s significant, and the nation must begin to train more doctors now if patients are going to be able to receive the care they need when they need it in the near future,” said AAMC President and CEO Darrell G. Kirch, MD.

In addition to projected shortages of psychiatrists and primary care physicians, shortages of general and vascular surgeons will also be a serious problem, particularly for older patients who require two to three times the amount of specialty care to treat chronic conditions and age-related illnesses.

As the U.S. population ages, so too does the physician workforce, with one-third of physicians now over the age of 55, noted Kirch. “More physicians retiring over the next decade also will create challenges for patients who need access to health care,” said Kirch.

For the first time, the 2016 report includes a special analysis of the needs of underserved populations. These data show that if underserved patients had barriers to utilization removed, the United States would need up to 96,000 doctors today to meet patient needs.
“When you consider all the people who do not utilize health care—despite their need—because of financial, cultural, social, or geographic barriers, the physician shortage is actually much bigger. We are very concerned about equity in patient utilization of care and how we can address it going forward,” Kirch said.

Read more at https://news.aamc.org/medical-education/article/aamc-research-physician-shortage

Read more about the report findings: https://www.aamc.org/newsroom/newsreleases/458074/2016_workforce_projections_04052016.html


Help alleviate burnout among physicians

Burnout Increasing Among U.S. Doctors

December 8, 2015 | by Lena H. Sun| Washington Post

Burnout among U.S. doctors is getting worse, according to a study that shows physicians are worse off today than just three years earlier.

Mayo Clinic researchers, working with the American Medical Association, compared data from 2014 to measures they collected in 2011 and found higher measures on the classic signs of professional burnout. More than half of physicians felt emotionally exhausted and ineffective. More than half also said that work was less meaningful.

Read more about the Mayo Clinic study here: http://dx.doi.org/10.1016/j.mayocp.2015.08.023
If there is a growing shortage of primary care providers, like family medicine physicians, why not better prepare nurse practitioners and physician assistants to fill that void?

WNCCHS, our CEO and Board of Directors decided it was time to help address this issue in western North Carolina by creating the Advanced Practice Safety Net Residency Program.

To create a program, we first needed a model. Luckily, we found one!

Community Health Centers, Inc., Middletown, Connecticut

In early 2014 several WNCCHS team members traveled to Middletown, Connecticut to spend a few days with the people at Community Health Centers, Inc., to learn about their nurse practitioner residency program - the first of its kind in the nation at a federally-qualified community health center. The gracious and helpful team members at Community Health Centers, Inc. shared seven years’ worth of learning and insights with us over a few days. We took all this valuable knowledge and applied it to create the Advanced Practice Safety Net Residency Program at WNCCHS in Asheville, North Carolina.
In 2014, WNCCHS launched APSNR - a 12-month immersion in safety net medicine for nurse practitioners & physician assistants who have a strong desire to become a primary care provider in a safety net setting.

APNSR is a “transition to practice” program that provides training in HIV medicine and transgender health services... not to mention all the chronic diseases managed in a primary care setting – hypertension, diabetes, asthma, depression and more. The twist is that in a safety net setting, many patients may not have insurance or access to “specialty care”, pharmaceuticals, mental health services, dental, etc. So, part of the training for PCPs in the APSNR program is to treat patients as comprehensively, and as “wholly” as possible.

We learned a lot the first year.
2014-2015 Inaugural Class

Two nurse practitioners and one physician assistant were part of our inaugural class started in September 2014. We purposefully try and recruit from local/regional schools so that graduates will have a higher likelihood of practicing in our geographic area - preferably in North Carolina and preferably in a safety net clinic, such as a community health center. And what a difference a year makes! Congratulations to our inaugural class of APC Safety Net Residency graduates. Each will be pursuing a career in safety net medicine as better-prepared PCPs.

From September 2014 through August 2015 our three residents provided 4,053 appointments at our health center. That means more patients had access to primary care than before the residency program, AND the residents were learning hands on how to be a better PCP.

Pictured L-R, Sara Mertz, A/GNP, Program Director; Jennifer Abbott, MD, Residency Preceptor; Megan Honor Caine, FNP; Kelly Pearson, FNP; Christi Blake, PA. Not pictured is Mary Scott Hayes, MD, Residency Preceptor.
How is the residency program at WNCCHS sustainable?

1. **It’s part of our annual budget**: We began this program with the idea of sustainability. It’s hard to build a residency program without committed long term funding. The Board of Directors decided that the program was important enough to include in the annual operating budget of our organization. Sustainable funding allowed the Residency Director and other staff to think and plan ahead.

   In essence, we “hired” 3 more primary care providers who began seeing patients after a slow, purposeful transition, enabling them to benefit from a small patient panel at first, and also have structured didactics and dedicated preceptors to mentor them. Because some patients have Medicare, Medicaid, or other private insurances, the income generated from those clinical encounters helped keep the residency program financially stable.

2. **We hire our graduates (when we can)**. To date, we have hired four of our graduates, saving all the costs associated with training new hires. They already know the “system” at WNCCHS and can hit the floor running their first day of work, plus they have built up a patient panel and established a rapport with staff and patients.

3. **Allowing seasoned medical staff to act as Preceptors helps address provider burnout!** When experienced PCPs are allowed to act as a preceptor to a resident, it gives them an opportunity to work with newly graduated PCPs who are enthusiastic and eager to be taught “the ropes”. This helps instill the natural inclination many PCPs have to teach and share knowledge, especially among future PCPs who will join them in practicing in a safety net setting.

   ....also the National Health Service Corps can help newly hired graduates of our residency program with loan repayment, making a safety net setting such as a community health center a very “sustainable” choice for students with lots of college debt.
Christi Blake, PA – 2015 APSNR graduate and Physician Assistant in the VA systems

“I think having a blended PA/NP residency was very beneficial as we each had different skills/strengths that we were able to teach and share with each other. For example, I thought the NPs I worked with were stronger at pharmacology, nutrition, wound care, some aspects of women’s health, etc., and I was able to learn a lot from them related to those areas. I thought I was stronger in procedures, labs, and differential diagnoses and would like to think they also learned something from me.

I appreciated the holistic approach from the residency program and have incorporated that into my practice. The model team approach at WNCCHS was very beneficial for me as a resident. We developed our skills in a collaborative and integrated model. This is an advantage of a blended residency program!

WNCCHS was a wonderful place to learn and grow as a new provider. The FQHC model fosters working as a multidisciplinary team and with WNCCHS’ holistic approach; the team medical decision-making was very beneficial to me. Also providing services to a very complex patient population with great demographic diversity (and diversity among co-workers!) with a variety of medical conditions, exposure to a variety of in-office procedures, and the development of professional boundary setting with patients helped enrich an already very strong learning opportunity during the Residency.

My time at WNCCHS has really influenced how I currently practice at the VA and volunteering at the local free clinic (which reminds me of WNCCHS - diverse medical conditions, 30 countries represented, underserved, collaborative multidisciplinary team, etc.). Many days I miss working at WNCCHS and my lifetime of experiences with my patients.”

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— Christi Blake, PA
VA systems
Learn more about APSNR in this video.  
https://www.youtube.com/watch?v=XKrOUWaL8cA

For more information on the Advanced Practice Safety Net Residency Program at WNCCHS, please visit www.safetynetresidency.org.  
For more information on WNCCHS please visit www.wncchs.org.  
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