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Establishing nurse practitioner clinical practicums: Addressing fiscal realities

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ABSTRACT

As demand expands for nurse practitioner clinical practicum sites, the supply of preceptors is decreasing. The traditional model of in-kind clinical training is losing its foothold for a variety of reasons. A looming question is how quickly a "pay to precept" norm will grow and what will be the costs. The pay for precepting movement is discussed including current trends, costs, and emerging compensation models. To adapt to this trend, alternative ways of drawing the precepting value proposition are suggested, particularly decreasing preceptor and site demands while increasing students' readiness to enter clinical practicum and tapping into faculty expertise to add value to the partnership. The authors provide suggestions on building a strategy for rethinking the structure of student precepting arrangements and compensation models.

Keywords: compensation models; education; nurse practitioner; preceptor.

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It is increasingly difficult to arrange nurse practitioner (NP) students' clinical practicums. Difficulties arise from both the demand of student numbers and the diminishing supply of preceptors. The number of licensed NPs in the United States increased by 30% with the majority of growth occurring in the Family Nurse Practitioner group (American Association of Nurse Practitioner, 2018). As demands generated by student numbers grow, the supply side of clinical preceptors seems to be decreasing. A variety of reasons underlie the tightening of preceptor availability, for example, productivity expectations on providers' time, complicated legal contracting, and managerial gatekeepers who control the number of students accepted at a site (Forsberg, Swartwout, Murphy, Danko, & Delaney, 2015; Webb, Lopez, & Guarino, 2015).

Several recent surveys examining precepting barriers and incentives confirm that numerous factors contribute to a clinician's willingness or availability to precept (Davis & Fathman, 2018; Roberts, Wheeler, Tyler, & Padden, 2017; Wiseman, 2013). In one survey, choosing from a list of incentives, preceptors ranked financial compensation as the highest inducement (Roberts et al., 2017). Although compensating preceptors has been the "elephant in the room" for quite some time (Brown, 2016), raising the issues around the traditional model of in-kind clinical training is timely. Program directors report they are feeling the pressure to provide some form of financial compensation to preceptors although at this time few do (4%) (American Association of Colleges of Nursing (AACN), 2016). However, if physician assistant (PA) programs are an indication, then the trend may accelerate. Approximately 21% of PA programs report compensating preceptors (Physician Assistant Education Association, 2015). In light of these rapidly evolving dynamics, a looming question is how quickly a "pay to precept" norm will grow and what will be the costs.

The purpose of this study was to examine the potential difficulties of adapting a model where NP preceptors are financially compensated. The pay for precepting movement is discussed including indicators for how quickly the trend will grow, how much it might cost, and emerging compensation models. Alternatives to a compensation are discussed, particularly an academic partnership model where one component could be the practice partner assisting the school in clinical training and the other in academic institutions establishing mechanisms for shared learning and scholarship that might be of benefit to the practice partner (AACN, 2016). This would broaden the benefits to the practice partner which have traditionally

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fallen along the lines of leadership opportunities or professional development for providers or clinical staff.

We suggest drawing the value proposition along additional dimensions such as students' potential contribution to care and optimum use of faculty expertise to address the practice site's needs. Also considered is how schools/colleges (here to fore the nursing educational institution, be it a school, program or college is referred to as a school of nursing) of nursing might decrease preceptor and site demands while increasing students' readiness to enter clinical practicums. Innovative approaches are considered such as increasing student's foreign language competencies, rethinking how to optimize faculty preceptors at a site, and compensating sites for year-long clinical placements of several students. Finally, we suggest a tiered strategy to working with sites that orders various forms of compensation.

Pay for precepting—early indicators of the trend

Although this study focused on a preceptor compensation model, it is not our intent to discount other forms of preceptor recognition. To be sure, there are several approaches to preceptor incentives such as hours for recertification, library services, continuing education (CE) opportunities, and adjunct faculty status (Webb et al., 2015). Nor should we undervalue a consistently reported motivator for preceptors to give back to the profession (Davis & Fathman, 2018). Still, recent surveys indicate preceptors believe they should be compensated for their time and lost productivity (Germano, Schorn, Phillippi, & Schuiling, 2014; Roberts et al., 2017). There are several indicators that a trend to compensate preceptors may be emerging.

Currently, three companies independent of nursing schools offer preceptor matching services (MedMatch, Clinical Match Me, and PreceptorLink). For a fee, these agencies will find a preceptor for the student. The current rates are from $6 to $15 an hour. Not all of the monies the student pays go to the preceptor because costs include the organization's fee. One agency's representative explained that while the company posts a "usual fee," it is subject to change if the provider has a set fee that he/she requests or if a preceptor asks for a larger compensation than the company's standard compensations. The cost also depends on the preceptor's availability and the time frame to find a match.

Another indicator of the pay for a precepting trend is schools of nursing offering financial compensation for preceptors (https://portal.frontier.edu/web/fnu/preceptor). As the preceptor web site of this institution explains, students are allotted an honorarium ($2,000) that is to be distributed among all preceptors. A central office at the college handles all monies. Of interest, there is an option for the preceptor to donate back the honorarium to a student scholarship fund. Although other schools of nursing post rather large additional NP costs for clinical courses (up to $450.00), it is unclear whether these monies are for preceptor compensation.

Preceptor shortages and compensation are being addressed somewhat differently at the state level. Particularly among states with primary care shortages, novel preceptor compensation arrangements are being trialed. The Georgia Preceptor Tax Incentive Program now supports advanced practice registered nurse (APRN) training. This was a cooperative initiative of medicine, PAs, and APRNs working through their Area Health Education Center (Martin & Mundy, 2018). This state joins Hawaii, Colorado, and Maryland who in the last two years have passed legislation, offering income tax credits to APRN preceptors in select shortage areas. South Dakota now offers financial compensation to APRN preceptors, and a similar system is being considered by North Dakota.

On a national level, the federal government has trialed demonstration projects to address workforce development and building preceptor capacity. The recently completed Graduate Nursing Education (GNE) demonstration was a four-year program to determine whether monies to compensate preceptors would facilitate expansion of the primary care workforce (Center for Medicare and Medicaid Services [CMS], nd). GNE funds were awarded to five medical centers that formed several models for developing preceptor networks (Hull-Grommesh et al., 2018). GNE provides insights into what such compensation might cost and how it could be used to build both urban and rural preceptor networks. The Graduate Medical Education (GME) system provides some $15 billion dollars in support for medical education, largely to resident training (Heisler, Jansen, Mitchell, Panangala, & Talaga, 2016). Only a small percent of GME's expenditure moves through Medicare to support nursing training, and these monies go to the schools of nursing that provide clinical education at the diploma level. Although the GNE findings support the argument for reforming the GME system to include monies for APRN training, changes to the GME system to support APRN education have been proven difficult to engineer (Aiken, Dahlerbruch, Todd, & Bai, 2018).

Pay for precepting: the challenges

Who and how much: a slippery slope

Given all the factors in securing quality preceptors and the emerging preceptor compensation arrangements, it is time to examine the exigencies of a pay for precepting model. Several issues are immediately apparent. The first question centers on the decision of whether to establish a compensation system for all preceptors. A universal compensation system may be premature for a school; perhaps only particular APRN specialties are struggling to secure placements. However, once schools begin to compensate select preceptors, it is likely to become normative for all preceptors. Particular clinical sites and their academic partners may be working well as a mutually beneficial relationship. In these instances, once a compensation norm is in place, the practice partner may begin to entertain the benefits of moving to a payment system. Another concern is that if universal

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compensation becomes the norm: Will a school have a choice? In an area where several NP programs operate, one program adopting a compensation model may create undue competition for preceptors, inadvertently forcing other area programs to move to a pay for precepting model. Additional decisions loom for nursing programs connected to large medical centers: Will they compensate in-house preceptors?

Another question is how a school will determine what to pay. GNE provided monies to preceptors at a rate that was determined, in some instances, by an estimate of lost provider productivity associated with precepting. The formula was loosely based on approximate hours with payment at approximately $25.00 an hour. This may not be a correct way to think about preceptor stipends for it seeds the idea that precepting results in lost productivity, which is not necessarily the case particularly for students in their last practicums. Compensation might be best viewed as an honorarium, a payment for a professional service that can be rendered without charge and for which a price is not customarily set. In this instance, however, the actual amount paid becomes somewhat arbitrary and it may actually seed competition.

Local idiosyncrasies may affect the issue of a universal policy of preceptor compensation. For particular regions of a state or particular NP specialties, it may be that providers are willing to precept students in return for the opportunity to employ graduates. Should these specialties or sites be in a different category? The supply and demand of students and preceptors may vary within a state. In such a situation, a nursing school may determine a market rate for particular regions, perhaps dictated by the local demand for preceptors. All of these issues are in need of data, dialog, and debate so that our profession can reach reasonable decisions around preceptor compensation.

Contracts and payments

Although determining the amount of compensation is a fairly obvious question, other problems with a pay for precepting model are less apparent. For instance, there can be issues with preceptors actually receiving the payment. Some organizations may not allow direct payment to preceptors. During the GNE demonstration, schools had monies to reimburse preceptors and developed models for doing so. At the authors' site Rush College of Nursing (CON), with a few rare exceptions, did not pay preceptors directly but provided funds to clinical sites. It was left up to the organization to decide how to use the monies. One reason for this strategy was to avoid creating a pay for precepting model with its inherent competitive advantage. A second reason for this reimbursement scheme was that the Rush GNE project aimed more at creating partnerships, new models of care, and setting the ground for eventual cost-sharing of preceptors.

This strategy informed us that it is difficult to pay an individual preceptor when the nursing school's legal contract is with the larger organization, as are most contracts. In this instance, offering stipends to preceptors might not be straightforward or even allowed (Hanks & Loudd, 2017). In addition, it is unclear whether the college has a responsibility or any say in who receives the monies and how they are distributed. If direct preceptor compensation is allowed within an organization, it may necessitate an additional contract with individual preceptors. Once that occurs, it is difficult to predict how the organization will respond, given the productivity expectations set for clinical staff.

Amidst all these considerations looms the question of who will pay for these costs. One might assume compensation costs will get shifted to students, but will federal loans absorb the costs? If the school of nursing absorbs the costs, it is not clear how this will factor into their projected budget. Once students are aware of the costs involved, other issues may surface. Students are very busy individuals; many are employed and have families. In a pay for precepting system, students may assume they could stipulate particular preceptors they want to be matched with or be on a schedule that fits with their busy lives. As the nursing profession moves toward a preceptor compensation model, all of these issues must be considered.

Responding to the pay for preceptor trend

Calculating the value proposition

Any response to the pay for precepting question depends on the school location, its size, and the strength of its academic practice partnerships. When considering preceptor compensation, however, we suggest faculty think broadly about student training and the value equation; the demands precepting places on a preceptor against the potential benefits to the site. Several areas should be reframed in discussions of the demands versus benefits of precepting. The first centers on reframing and decreasing the demands students place on the clinical site.

Value proposition: reframing and decreasing the denominator. A norm is growing that training is a drain on preceptors' time and thus costs the system. However, it may be that students actually contribute to the efficiency and financial performance of the system. A partnership might explore the tangible ways students assist with patient care at the clinical site. Students might participate in previsit planning with patients, increasing the efficiency of the provider during the actual visit, increasing engagement, and possibly reducing attrition. Perhaps with a student nearing the end of the program, preceptors find that the student's participation in patient care increases productivity. Capturing data around these practices would add additional elements to the value equation and make the discussion of preceptor time demands tangible.

In addition to reframing the potential strains on the system, schools may adopt additional strategies to decrease demands a student places on the system. Student readiness and motivation to learn is a critical element for

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preceptors (Keough, Arciero, & Connolly, 2015). Thus, a school might implement processes to increase student readiness for practice and to ease off preceptor/site demands. A trial of this strategy is currently in place at the authors' CON. To increase student readiness, the CON implemented a series of clinical simulations both before and during clinical rotations that were designed to facilitate students' transition into clinical practice. A simulation curriculum was developed with faculty, preceptor, and student feedback on skills/competencies needed to improve student readiness. Readiness was also enhanced by providing Spanish lessons to select students, which greatly decreased drain on sites' translator services and facilitated students' engagement with the population.

Another strategy the CON developed, in collaboration with another school of nursing, was a system for year-long training in one large Federally Qualified Health Center (FQHC) system for multiple students. This cohort of students moves through different clinic sites and different preceptors within the FQHC. Having a student stay at one large, multiple-site system reduces demands for student onboarding and orientation. We found that these students become a more valuable addition to the team, and preliminary data indicate students appreciate these longitudinal placements.

The value proposition: reframing and increasing the numerator. The potential benefits to the clinical site should also be considered with a broader lens. The value proposition must go beyond granting preceptors library privileges or adjunct faculty status. The perceived benefits to the system could include potential employment of graduates and the potential of Doctor of Nursing Practice students to assist in a site's quality projects. Another potential incentive for a site could be drawing on nursing faculty expertise and/or a school's resources to address a site's need for training or for team development. Curricular topics such as training in motivational interviewing could easily be transported to the preceptors' sites. In one project, the Rush CON designed site-requested educational modules for staff that also served as shared learning opportunities for students. Other incentives considered in a precepting value proposition might include partnering on grants or developing select staff member's scholarship.

Another area of faculty expertise that could be offered to a clinical site is mentoring in strategies that improve processes of care, for instance, honing care team functioning or work flow. registered nurse (RN) optimization could be of benefit to the site; it has been shown to promote high quality and increase access particularly in communities with scarce resources (Norful, Martsolf, de Jacq, & Poghosyan, 2017; Smolwitz et al., 2015). Faculty might help sites with developing "top of scope" utilization of RNs in care coordination, population health skills, or new models of care such as the RN "Co-Visit" model (Funk & Davis, 2015). This is a rich area for improving team-based care coordination and well suited to academic practice joint initiatives.

A strategy with multiple benefits for both the site and student is to consider how to derive the maximum use of on-site, college-supported faculty preceptors. The CON has placed faculty at sites using various fiscal arrangements. In one case, there was a cost-sharing arrangement with the site. In another, the CON paid for 2 days of faculty time with a site whose mission closely aligned with developing innovative care for the underserved. In each instance, the arrangement allowed the faculty to provide both clinical services and training for students.

An on-site faculty preceptor may allow for a broader preceptor/student ratio of two or even three students at varying levels in their training. In a 2:1 precepting model, NP students nearing graduation support students early in their training. For faculty practice arrangements to work, the institution would need to provide faculty work load credit for their clinical work. Such agreements may impinge on an existing system where faculty are allowed to practice and keep any monies earned. At Rush, it was found that cost-sharing of faculty can work to the advantage of both the site and CON.

Rethinking preceptor compensation: a menu of approaches to the value equation

Another strategy for a school of nursing approaching the issue of preceptor compensation is to build on existing academic practice clinical site partnerships. In this instance, a school should not necessarily take a "one-size-fits-all" approach. When partnering with preceptors and organizations, the value and incentives may be different depending on the organization. For example, partnerships might be categorized by the number of students the site annually accepts, thus resulting in different levels of partnership. Clinical site placement is predicated on retaining high-quality preceptors and investing in administrative infrastructure to develop and maintain strategic clinical relationships. However, within this ideal, a school of nursing might begin to look broadly at their clinical placement sites and their value to the school, both long-held partnerships and more recently arranged placements.

Rush CON has considered this tiered approach to incentives for clinical placements depending on the partner (organization or individual) and the number of students placed annually. A list of incentives is considered with each relationship including traditional offerings (e.g., CE courses, library privileges) and innovative incentives (e.g., mentoring in scholarship or grant applications). The scheme is still in development and includes an honorarium as one option but also broadens the idea of compensation. One challenge encountered is that incentives such as CE courses, mentoring in scholarship, and other innovative rewards require financial investment, administrative oversight, and faculty workload. Thus, financial investment is necessary regardless of the model which includes honorariums paid to a preceptor

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or organization or money invested in administrative and faculty infrastructure.

Recommendations for moving the issue forward

Securing qualified preceptors for NP students is a significant problem for educators. Clearly, discussion and problem-solving needs to continue around the issue of preceptor shortages and compensation. To move this discussion, several recommendations are forwarded:

1. Nursing needs to consider what data would inform the discussion on preceptor compensation, particularly information on if and how nursing schools are compensating preceptors. The Physician Assistant Education Association (2015) gathered such data, and their survey strategy is a good beginning model. These questions on preceptor compensation could be added to the annual ANCC enrollments and graduation or perhaps taken up by the larger professional organizations.
2. With data on trends of preceptor compensation, the professionals can examine whether the issue is best addressed at a national or regional level. Should there be different preceptor compensation strategies for rural versus urban areas? When there is a broader notion of how preceptors are compensated and for what region and what specialties, recommendations can be forwarded for a universal approach versus one where select preceptors are compensated.
3. There is tremendous inequity in GME compensation for medical school education versus APRN training (Aiken et al., 2018). The GME compensation for faculty precepting medical students is extensive (Stephens & Ballentine, 2018), but by the nature of the way GME is organized, the system also delineates the number of residency slots that will be supported at each institution. It is time to introduce equity into the system of federal workforce support, but nursing will need to examine the potential trade-off between federal support for APRN education and current unrestricted enrollment of APRNs.
4. Precepting demands may differ for various levels of NP students, that is, first semester students versus students in their last terms. Very little is actually known about the extent precepting results in time and costs to a system. Research on this issue would inform the argument on preceptor demands and may lead to strategies for how schools of nursing could mitigate specific demands through increasing student readiness.
5. One of the lessons learned from the GNE was the difficulty in directly compensating preceptors. As schools of nursing approach the issue of preceptor compensation, potential solutions to sort out this difficulty should be delineated. One strategy might be to offer compensation as an honorarium, which is an approach used by one nursing program, but the relationship between the clinical site's legal contract with the school and the preceptor compensation agreement will need to be carefully delineated. Through GME, academic institutions offset a portion of faculty salary, and this might also be one strategy.
6. Data on enrollments and regional needs would provide a platform for discussing not just preceptor compensation but other issues that affect precepting demands, such as schools admitting large numbers of students they cannot accommodate with clinical practicums (Staples & Sangster-Gormley, 2018). The issue with preceptor shortages should not be addressed with shifting the responsibility to students to locate clinical placements with no restraints on the number of students a school admits. If the specialty organizes around seeking federal support for preceptors, they will need to consider how- or if- to determine the number of students eligible for support, particularly for programs that admit large numbers of students.
7. One important area of preceptor demands involves the CMS restrictions on NP documentation. Recent changes to CMS documentation rules allow teaching physicians to verify in the medical record any student documentation of the components of E/M services, rather than redocumenting the work (Department of Health and Human Services, 2018). These new rules did not extend to NP and PA students and their preceptors. The Center for Medicare and Medicaid Services has the authority to interpret the word "student" in its regulations and to include NP and PA students. Focused effort should be exerted toward enacting this rule change, which would significantly increase efficiency and reduce preceptor demands.

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