Public health nursing—with its focus on compassionate, holistic care and services to the poor, the aged, those suffering from social injustice, and those without adequate health facilities—had its origins over a century ago with the founding of the Henry Street Settlement in New York City. Embracing the same foundational principles, Nurse-Led Health Clinics is the first book to describe innovative, nurse-managed solutions for improving health care today. It addresses the key business, policy, medical, financial, and operational considerations necessary for successfully opening and operating nurse-led health facilities. With the mission to dramatically expand access to primary and preventive health care, these clinics provide a full range of services—including primary care, health promotion, disease prevention, and behavioral health care—to residents of underserved communities throughout the United States.

The book delivers a wealth of comprehensive information for nurses who are considering opening their own clinics. Reinforced with best-practice models and case studies, it discusses what it takes to successfully start and run a nurse-managed health center. The book addresses the history and growth of nurse-led clinics and describes the nurse-led paradigm of care. It identifies the different types of nurse-led clinics (primary care, school based, wellness, and more) and the clinical services offered within them. Also discussed are the requirements and mind-set of potential consumers and strategies for sustainability along with the role of the collaborative team. The pros and cons of a variety of business and operations models are examined along with quality metrics and initiatives. The book also covers various state and federal policy challenges and opportunities and explores the future of nurse-led care in view of ongoing health care reform. Helpful appendices include a start-up checklist, sample bylaws, and a managed-care contracting toolkit.

Key Features:

- Describes key business, policy, medical, financial, and operational considerations for running a nurse-managed health center
- Addresses the pros and cons of a variety of business models for nurse-led care
- Identifies the most common clinical services offered
- Presents quality metrics, best-practice models, and case studies
- Includes state and federal policy and regulatory challenges and opportunities
Nurse-Led Health Clinics
Tine Hansen-Turton, MGA, JD, FCPP, FAAN, is a social entrepreneur who has started several national and global social and public innovations in the health and human services sector. For the past two decades she has been instrumental in leading a movement of nurse-led primary health care, positioning advanced practice nurses and nurse practitioners as primary health care providers. She is currently the chief strategy officer of Public Health Management Corporation (PHMC), where she oversees and leads corporate strategy, development, and operations for a public health institute. She serves as CEO of the National Nursing Centers Consortium, a nonprofit organization supporting the growth and development of over 500 nurse-led health centers, serving more than 2.5 million vulnerable people across the country. Additionally, she serves as the founding executive director for the Convenient Care Association, the U.S.-based trade association of the private-sector retail clinic industry. She is co-author of numerous publications including but not limited to Partnerships for Health and Human Service Nonprofits; Social Innovation and Impact in Nonprofit Leadership; Convenient Care Clinics: The Essential Guide for Clinicians, Managers, and Educators; Community and Nurse-Managed Health Centers: Getting Them Started and Keeping Them Going; and Nurse-Managed Wellness Centers: Developing and Maintaining Your Center. In 2009 she cofounded Philadelphia Social Innovations Journal (PSIJ), an online publication that brings a focus to social innovators and their nonprofit organizations, foundations, and social sector businesses. Following the creation of PSIJ, she cofounded the Philadelphia Social Innovations Lab to serve as a hub to test new social models which she now teaches as an adjunct professor at University of Pennsylvania, Fels Institute of Government.

Susan Sherman, MA, RN, has served as president and CEO of the Independence Foundation since 1996. The Independence Foundation, a private philanthropy dedicated to supporting programs in Philadelphia and surrounding Pennsylvania counties that provide services to people who ordinarily do not have access to them, has four specific areas of funding: culture and arts; health and human services; nurse-managed primary health care; and public interest legal aid. Ms. Sherman is a member of the board of directors of the Public Health Management Corporation (PHMC), Project H.O.M.E., and the Academy of Vocal Arts, and was chairperson of the Philadelphia Award Committee. She serves on the advisory committees of the American Academy of Nursing, Philadelphia Social Innovations Journal, the Metropolitan AIDS Neighborhood Nutrition Alliance, Students Run Philly Style, and Meds & Eds Alliance. She also serves on the Eisenhower Fellowships Philadelphia International Leadership Initiative Steering Committee, the Pennsylvania Action Coalition Steering Committee, and the Pennsylvania Bar Association Judicial Evaluation Commission. She is a fellow of the American Academy of Nursing and the College of Physicians of Philadelphia.

Eunice S. King, PhD, RN, is a senior program officer and director of research and evaluation for the Independence Foundation, where she has overseen the foundation’s grant making under the nurse-managed health care initiative. In addition, she is the program evaluation consultant to the National League for Nursing’s Advancing Care Excellence for Seniors (ACES) program, a partnership between the National League for
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Nurse-Led Health Clinics
Operations, Policy, and Opportunities

Tine Hansen-Turton, MGA, JD, FCPP, FAAN
Susan Sherman, MA, RN
Eunice S. King, PhD, RN
Editors
This book is dedicated to Lee Ford, the mother of nurse practitioners; Phyllis Beck, the chair of the Independence Foundation board of directors and longtime champion of nurse-managed health clinics; and Andrea Mengel, for her leadership on the Independence Foundation board of directors and her passion for the health-promoting work conducted by nurse-managed health clinics.

In addition, co-authors Tine Hansen-Turton and Eunice S. King dedicate this book to their co-author, colleague, and mentor, Susan Sherman, the mother of nurse-managed health clinics.
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Foreword

I believe that the entry of nurse practitioners (NPs) first into nurse-managed health clinic settings in the 1990s and then into convenient care (retail) clinic settings in the early 2000s was the most innovative, creative, and courageous effort to address the community health needs of surrounding populations ever undertaken. These NP-led clinics get an “A” on every score: accessibility, accountability (quality), and affordability, with the further benefits of availability, acceptability, and affability. Furthermore, the clinics have data to prove it. Early, sophisticated electronic patient data collection systems afforded a broad base for planning, executing, and evaluating NP practices and patient needs, desires, and demands.

None of this would have been possible without the expert NP leadership exemplified by Sandra Ryan, Donna Torrisi, and others, as well as by trade associations like the National Nursing Centers Consortium and the Convenient Care Association, both of which pushed for positive policy changes in state capitals and in Congress. These nursing leaders and leaders of the focused trade organizations brought professional nursing values; high standards for the practice, recruitment, and guidance of staff; enthusiasm and energy; and the amazing ability to work successfully within the complexities of the corporate world. These nursing leaders and associations bore the brunt of the challenges, mainly from organized medicine, of introducing the community-based, nurse-led, convenient care setting with the skills of participation, negotiation, decision making, and change theory, plus their intelligence, street smarts, staff support, and chutzpah.

The nurse-led clinic innovation and movement also introduced something very important to the current costly sector of sick care: prevention and health promotion. NPs are known for their blended skills of case finding, educating patients in health and illness self-management, and opening the
gates to what could be the future of health care in this nation...moving from a sick care model of primary care to primary health care.

The data on the spread of nurse-led services, the millions of patients served, and the high level of patient acceptance and satisfaction position nurse-led care—whether in community-based nurse-managed health clinics or convenient care clinics—to fit well into the health care reform legislation to improve 21st century health care!

_Fond regards, Lee (the mother of nurse practitioners)_

(Loretta Ford, RN, PNP, EdD, FAAN, FAANP)

Dean and Professor Emerita
University of Rochester School of Nursing
Foreword

We are in an exciting time in the history of health care and nursing. The demand for health care services and the need for innovation and a strong nursing presence to meet patient needs has never been greater.

Nurse practitioners and nurse-led clinics and operations have been breaking new ground and are helping to meet the needs of patients nationally and globally! With over 1,600 nurse practitioner convenient care (retail) clinics, dozens of university nurse practice centers, and hundreds of community-based health care centers nationally, patients are receiving care by nurse practitioners in every community across our country.

It is more important than ever that these models of care delivery continue to succeed and meet the needs of the patients they are there to serve. In order to do that, nursing leaders must keep up with the latest research and be ready and willing to innovate, negotiate, communicate, and change themselves and the system to meet the needs of the patient. The use of technology will continue to advance and change the way we are doing business today. As nursing leaders, we must embrace the use of technology and look for innovative ways to keep the patient at the center of what we do. Patients will soon be receiving real-time information on their biological functioning through the use of sensor technology, and we must be ready to help them decide what they want to do with the information and to continue to be their trusted resources for guidance.

Health care is increasingly becoming driven by the patient, and the patient is becoming an active, informed player in this evolving, ever-changing sport. In the past, the provider–patient relationship was a one-way street: The health care provider made the diagnosis, engaged the patient in the health plan, and sent the patient out to execute the plan. Today, with shifts in the
health care landscape in the way that performance and payment will be measured, and with innovations in technology and information readily available to patients, there has been an increasing demand for this relationship to be more of a two-way communication, with patients who are more educated, empowered, and engaged in their personal health.

As a nursing leader, I say to you: Our time is now! We must be at the table, we must be change agents who are seen as forward-leaning innovators in health care delivery, and we must always remain committed to putting our patients at the center of everything we do. Nursing is an honorable, knowledgeable profession that has contributed immensely to the health care system today. Let us remain strong, focused, and unwavering in our commitment to quality, affordable, convenient health care for all.

_Sandra Festa Ryan, MSN, RN, CPNP, FCPP, FAANP, FAAN_
Robert Wood Johnson Executive Nurse Fellow
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Preface

We are pleased to present you with *Nurse-Led Health Clinics: Operations, Policy, and Opportunities*. In this book, we provide a historical perspective on nurse-managed health centers (NMHCs); include chapters on the practical aspects of starting and operating NMHCs, combined with case studies that illustrate the challenges, lessons learned, and successes of NMHCs; and conclude with an assessment of the current status of NMHCs and a vision for their future. It has been an honor and privilege to be part of such an incredible health care movement during the past 25 years and to help shape it into what it has become today. Nurse-managed health clinics represent a paradigm shift in health care, and we did not want their history to be left untold. The story holds many lessons. Nurse-managed health clinics have not only been a global policy and practice game changer for nursing and the role of nurse practitioners, but have also given birth to many other nurse-led models like retail clinics and school-based health clinics. The influence of NMHCs on the delivery of health care will only continue to evolve in decades to come.

We want to thank the thousands of nurses and non-nurses who have been passionate about this model of care and whose passion and commitment have inspired others. They laid the groundwork for the movement and had the vision for providing nurse-led quality, community-based care that is accessible and affordable to all. In particular, we wish to acknowledge the vital contributions of two organizations: the Independence Foundation and the National Nursing Centers Consortium (NNCC). The strategic work of the members, board, and staff leadership of the NNCC (www.nncc.us), whose mission is to advance nurse-led care globally, has effected changes in many health policies that have strengthened the viability of NMHCs and
other nurse-led models of care. Since 1994, the board of the Independence Foundation has designated nurse-managed health care as one of its funding priorities and has supported NNCC and nurse-managed health clinics in the Philadelphia region for two decades. In 1996, NNCC and the Independence Foundation set out on a mission to put nurse-managed health clinics and nurse-led care on the global map and, as is evidenced by the book, their mission has been a success.

_Tine Hansen-Turton_
_Susan Sherman_
_Eunice S. King_
Introduction

Over a century ago, on the Lower East Side of New York City, a young New York Hospital nursing graduate named Lillian Wald was teaching immigrant women about home care and hygiene when a young child, the daughter of one of Wald’s students, entered the classroom in tears. She told Wald that her mother was sick. Wald followed the child to her apartment, where a woman lay in a filthy, blood-soaked bed. The child’s mother had given birth 2 days earlier and was hemorrhaging. Wald treated the woman, cleaned the room, and comforted the family.

That event compelled her to start the Henry Street Settlement, where she and her nursing colleagues dedicated their lives to caring for some of society’s most vulnerable. They not only treated their community’s health needs but also sought to improve where their neighbors lived, worked, and played. They offered social services and instruction in everything from music to English. In doing so, they became the first public health nurses in the country. They fearlessly focused on the needs of the poor, the aged, those suffering from social injustice, and those living in areas without access to adequate health care facilities.

In the years since Wald founded Henry Street, the nursing profession has continued to offer innovative solutions to meet the needs of patients, families, and communities. The challenges may differ, but the impetus that drove Wald to start Henry Street remains the same: to provide compassionate care to the most vulnerable and to improve health and health care for all. As our country undergoes rapid health care transformation, driven by an aging and sicker population, rapid technological innovation, persistent health care disparities, and skyrocketing costs, nurse leaders are devising solutions every day in communities large and small to improve health and health care for all.
INTRODUCTION

Health care models increasingly rely on nurses to drive success. Nurses serve in clinical leadership and care coordinator roles. Certified nurse midwives offer pre- and postnatal care and assist with labor and delivery with little technological intervention at birthing centers. Advanced practice registered nurses provide a full range of health care services at nurse-managed health clinics, including primary care, health promotion, disease prevention, and behavioral health care to residents of underserved communities. And nurse practitioners at convenient care clinics improve access to care and save costs by enabling people with minor ailments to get treated in their communities rather than in the emergency room.

These innovative, nurse-managed solutions were featured in the Institute of Medicine’s (IOM’s) landmark report The Future of Nursing: Leading Change, Advancing Health, which offers a blueprint for how our country can improve health through nursing. The Robert Wood Johnson Foundation, the nation’s largest philanthropy devoted to improving health and health care, and AARP, the nation’s largest consumer organization, realized the potential of the IOM recommendations for improving our nation’s health. That is why we launched The Future of Nursing: Campaign for Action, a 50-state initiative to advance the IOM recommendations and improve health and health care. The campaign seeks to promote practice and leadership, strengthen nursing education, foster interprofessional collaboration, and improve workforce diversity.

Up to 25 million Americans gained access to health insurance in 2014 under the Affordable Care Act, and our country needs to do everything it can to ensure that practitioners will be available to see these newly insured individuals when they need one. Nurse practitioners and nurse-managed health clinics can, without question, dramatically expand access to primary and preventive health care throughout the United States. Nursing’s time is now.

Nurse-Led Health Clinics: Operations, Policy, and Opportunities is required reading for clinicians, nursing leaders, nurse-managed and convenient care clinic operators, managed care organizations, and physician organizations to fully understand the potential of nurse-managed clinics in the future of health care. It is my hope that many of the readers of this book will be inspired to open their own nurse-managed clinics and play an instrumental role in the future of health care, just as Lillian Wald did over a century ago.

Susan B. Hassmiller, PhD, RN, FAAN
Senior Advisor for Nursing, and Director, Campaign for Action
The Robert Wood Johnson Foundation
Nurse-led models of care are dynamic health care innovations that provide accessible, affordable, high-quality, patient-centered care that integrates the mind and body, aims at high patient satisfaction, and produces outcomes that are as good as and often better than the care provided by MDs in traditional primary care clinical settings. Throughout this book, the terms nurse-led care, nurse-managed health center, nurse-managed health clinic, nurse-led center, and nurse-practice arrangements are used interchangeably. However, all terms should be interpreted as corresponding to the definition provided by the Patient Protection and Affordable Care Act (ACA). According to Section 5208 of the ACA, a nurse-managed health center (NMHC) is defined as “a nurse practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit health or social services agency” (42 U.S.C. § 330A–1) (Patient Protection and Affordable Care Act, 2010).

Section I opens with an introduction to the NMHC concept, including an overview of the history of NMHCs and a thorough discussion of what it will take for those who are interested in pursuing an NMHC to build a successful practice. Subsequently, a number of renowned practitioners and nursing leaders in the field contribute insights on specific aspects of NMHC
care, such as practice sustainability, quality and safety, and behavioral health. Readers will acquire a very thorough grounding in NMHC operations and will find the material in this section to be a valuable guide to establishing a successful nurse-managed clinical practice.

REFERENCE

In the past few decades, an innovative model of primary health care has emerged in the form of nurse-managed health centers (NMHCs). With managed care systems and state-level reforms being introduced to try to control health care costs, the nursing profession has had increasing opportunities to demonstrate the ability to contribute in the areas of health care access, quality, and cost-effectiveness (Lang, 1996). In a landmark randomized control study, Mundinger and colleagues (2000) found that outcome measures such as satisfaction ratings, health service utilization rates, and health status were comparable between advanced practice nurses (APNs), or nurse practitioners (NPs), and physicians. Such studies affirm that NPs can play a vital role in health services in today’s environment.

While NMHCs play a key role in improving the quality of life for many people, they face a number of challenges. Because they are innovative models, they often find obtaining necessary mainstream funding to be problematic. Some centers have had to close due to a lack of funding, even though they have been shown to have a positive impact on the health care delivery system. Other obstacles to sustainability include legal, regulatory, and research issues.
BACKGROUND: ORIGINS OF THE NMHC MODEL OF CARE

While today’s health centers trace their immediate roots to changes in national health care laws that began in the mid-1960s, the nursing model of holistic care that integrates health promotion with primary care and focuses on serving vulnerable populations dates back to the late 19th century. As far back as the 1890s, visionaries such as Lillian Wald and Margaret Sanger founded the Henry Street Settlement to provide health care to the poor in New York City and opened the first birth control clinic, respectively. These were the earliest nursing service models, and both women were pioneers in the public health movement. Almost three decades later, in the 1920s, Mary Breckinridge, a certified nurse–midwife who had graduated from St. Luke’s Hospital School of Nursing in New York, studied public health nursing at Columbia Teacher’s College, and completed her education in Great Britain to become a certified nurse–midwife; she became concerned about the lack of accessible health care for childbearing women and young children, except for an occasional physician and untrained “granny midwives,” in mountainous eastern Kentucky. Seeking to improve the status of maternal–child health in the region, Ms. Breckinridge established the Kentucky Committee for Mothers and Babies, a forerunner of the Frontier Nursing Service (Bartlett, 2008, pp. 39–74). By 1930, the Frontier Nursing Service comprised six very small centers, each managed by an educated nurse or nurse–midwife, and each provided midwifery, sick care, routine immunizations, and checkups for infants and preschoolers within a five-mile radius. Most of the care was delivered in homes by nurses on horseback. The centers were financed in part by a $1 annual prospective payment, in either cash or goods, from every household (Glass, 1989). Challenges faced by those centers were similar to those faced by today’s NMHCs: funding, recognition of nurses’ importance as providers of care to underserved populations, and scope of practice issues.

When the Social Security Act of 1935 was passed and it appropriated money (a) for nurses to work with state and local health departments to establish health organizations to monitor and protect the health of the community and (b) to train public health nurses (PHNs), public health nursing departments or divisions were established within many municipal or county departments of public health. Although the PHNs provided some care to the sick in their homes, their focus was largely on preventive services, such as administering immunizations, performing well-child checkups, conducting screening for communicable diseases, and tracking the contacts of patients with communicable diseases such as tuberculosis or venereal diseases. While PHNs always functioned very autonomously, they worked collaboratively with physicians,
who conducted physical assessments, diagnosed, and prescribed treatments (Health Resources and Services Administration, Bureau of Health Professionals, Division of Nursing, 1997 [see “The Role of the Division of Nursing in the Development of NMHCs”]). It was not until the mid-1960s, when educational programs were developed to prepare nurses for expanded roles and legislation was passed that allowed nonphysicians to provide primary care, that nurses were able to become primary care providers (PCPs) and could thus develop the model of nurse-managed health care as it emerged in the late 1970s and 1980s.

THE ROLE OF THE DIVISION OF NURSING IN THE DEVELOPMENT OF NMHCs

The Division of Nursing (DoN)—an organizational unit within the Bureau of Health Professions, one of the four divisions within the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (DHHS)—has played a very important role in the emergence of the NMHC model of health care delivery. Historically, the DoN has been the federal agency responsible for providing the national perspective on the nursing workforce, nursing practice, and nursing education. Its contributions to the NMHC movement have included (a) support for the creation of the NP role and (b) advocacy for federal funding to support the development of models of health care for the underserved, one of which was the NMHC.

In 1965, the Commonwealth Foundation supported an innovative project designed by Loretta Ford, RN, and Henry Silver, MD, at the University of Colorado to prepare PHNs to provide comprehensive, well-child primary care in ambulatory settings. An evaluation funded by the DoN documented the NPs’ competence and found that 75% of well and ill children in ambulatory settings could be independently managed by pediatric NPs.

In 1968, the DoN, under its project grants, began to fund innovative patient care and educational programs that prepared nurses to practice in expanded roles, such as NPs. In 1971, the report Extending the Scope of Nursing Practice concluded that in order for the nation to provide equal access to health care for all its citizens, the practice of nursing should be expanded to include many responsibilities that were traditionally performed only by physicians. Consequently, the Nurse Training Act of 1971 broadened Title VIII authority and earmarked funds to encourage advanced nursing roles (e.g., NPs, clinical specialists, and nurse-midwives) and to increase resources for underserved areas (HRSA, 1997).

By the late 1970s, with the advent of NP programs, schools of nursing were emphasizing the importance of faculty clinical practice in order
to maintain and demonstrate expert clinical competence. Some schools, such as the University of Massachusetts Lowell, established NP faculty-run clinics that simultaneously provided a site for faculty to practice and a clinical practice site for NP students. Through Section 3 of the Nurse Education Amendments of 1985, which extended Title VII of the Public Health Service Act, the DoN’s Special Projects Program was authorized to fund projects that improved access to nursing services in noninstitutional settings (Clear, Starbecker, & Kelly, 1999). It was under this initiative that funding was available to support NMHCs established by schools or departments of nursing. Support for these centers increased dramatically over the next several years from 2 centers receiving support in 1986 to 9 in 1987, 13 in 1988, 15 in 1990, and 17 in 1992 (Starbecker, 2000). Requirements for receiving funding under this program were the following:

- The academic-based nurse-managed center operated under the administrative aegis of the school of nursing that operated it.
- The center was staffed by faculty and students in the affiliated school of nursing.
- At least 25% of the students enrolled in the school of nursing obtained clinical primary health care experience in the nursing center.
- The center improved access to primary care in a medically underserved area.
- The center offered programs and services to facilitate the achievement of the Healthy People Objectives for the population served (Starbecker, 2000).

Grants made under this program were 5-year awards and were not designed to be renewed. Five years of funding was considered adequate for a center to become established; to apply for other sources of funding, including credentialing by third-party payers; and to build the practice with sufficient numbers of patients to enable it to become self-sustaining. Initially, this seemed theoretically possible. However, a number of changes within the health care reimbursement milieu prevented the attainment of this goal. First, during the mid-1990s, reimbursement for care to clients enrolled in Medicaid programs shifted from cost-based reimbursement to capitation in response to efforts to rein in health care costs, and this shift resulted in a great reduction in service-generated revenue for the centers. This was particularly problematic for the NMHCs because many of them served a high (30%–50% or greater) percentage of uninsured clients and relied on the cost-based reimbursements to enable cost shifting. Second, insurance regulations in many states prevented the Medicaid insurance companies from credentialing NPs,
and even after this changed, many of the centers discovered that the process of applying to become approved Medicaid health maintenance organizations (HMOs) and Medicare providers was very time-consuming, labor-intensive, and fraught with delays of as much as a year. Third, NPs in many states did not have prescriptive privileges, which necessitated greater dependence on collaborating physicians. Finally, there was no reimbursement for health promotion programs, so support for those had to be obtained through grants and contracts with private foundations and public organizations (Hansen-Turton, Ritter, & Valdez, 2009).

WHAT IS AN NMHC?

Following in the footsteps of early nurse-managed centers, the nursing professionals in today’s NMHCs provide health care that is responsive to each community’s unique needs. Since the late 1970s, in conjunction with the development of educational programs for NPs, faculties in schools of nursing have established NMHCs. In addition to providing necessary services to the community, these linkages have provided clinical sites for educating nurses at all levels and settings for faculty practice. Although academic-based nursing centers are a common model, there are also hospital-based and freestanding community-based NMHCs.

NMHCs are managed and staffed by RNs and APNs, NPs who have advanced education and clinical training in a health care specialty. RNs, NPs, and nurse faculty, as well as clinical specialists and PHNs, generally function as the clinical and executive directors of the health centers. These centers are sometimes known as nursing centers, community nursing centers, or nurse-run clinics. They work in partnership with the communities they serve, often at the invitation of the community, and they are embedded in the core of community life (Hansen-Turton & Kinsey, 2001). Staff includes NPs, RNs, PHNs, mental health therapists, health educators, community outreach workers, collaborating physicians, and other health care professionals. Although some NMHCs are located in the suburbs, most serve vulnerable urban or rural populations who would otherwise not have access to health care services.

The National Nursing Centers Consortium (NNCC) adheres to a modified version of the American Nurses Association’s (ANA’s) Nursing Centers Task Force definition of nursing centers:

Organizations that give clients and communities direct access to professional nursing services. Professional nurses in these centers diagnose and treat human responses to actual and potential
health problems, and they promote health and optimal functioning among target populations and communities. The services provided in these centers are holistic, client-centered, and affordable. Overall accountability and responsibility remain with the nurse executive/director. Nurse-managed health centers are not limited to any particular organizational configuration; they can be free-standing businesses or may be affiliated with universities or other service institutions like home health agencies and hospitals. Their primary characteristic is their responsiveness to the health needs of populations. The nurse is responsible for all patient care and operations. (American Nurses Association, 1987)

While NMHCs share the core elements of the ANA definition, they vary in their practice models. Services offered at nursing centers range from wellness and health promotion to traditional primary care. Some are for-profit businesses and others are nonprofit academic centers developed primarily as student clinical laboratories (Lundeen, 1999), which is reflected in the mission of these academic-based centers. Nonprofit centers have a mission based solely on direct service. Centers also vary in reimbursement methods, which may include any or all of the following: fee for service, sliding fees (usually based on federal poverty guidelines), grants, third-party payments, and the cost-based reimbursement available to federally qualified health centers (FQHCs).

Regarding service delivery, there are two types of NMHCs. Nurse-managed primary care health centers provide comprehensive primary care, including integrating health promotion, disease prevention, and disease management. Nurse-managed wellness centers provide health promotion, disease prevention, and disease management services in established wellness centers or through extensive outreach into schools, housing developments, and community-based agencies. Just like the primary care centers, wellness centers have partnerships with local community agencies, local governments, and managed care organizations. Wellness centers provide services to the community that can be grouped into one of four categories: health teaching, guidance, and counseling (e.g., dental care education, safety education, cardiovascular health, and health and life management); surveillance (e.g., height and weight measurement, vision and hearing screening, glucose monitoring, and blood pressure evaluation); providing immunizations; and administering treatments and procedures (e.g., wound care and first aid).

Today, with burgeoning health care costs and a growing number of uninsured Americans, access to high-quality, preventive health care is a
key concern for policy makers: NMHCs provide a positive solution to the problem. Along with a tradition of community leadership, NMHCs provide evidence-based care and health care education. NNCC member centers have demonstrated significant positive health outcomes for patients, including decreased emergency room visits, hospital inpatient stays, and use of specialists, as compared with conventional health care providers. Primary care NMHCs report excellent pregnancy outcomes, with some reporting close to 100% normal birth weight infants.

Starting any health care enterprise takes careful consideration and planning. This is particularly true of NMHCs because they are not in the traditional model. It is suggested that the steps outlined in this guide be taken into consideration by any organization that is planning a new health center. Those already in existence can also benefit from the experience put forward here.

REFERENCES


I. INTRODUCING NURSE-MANAGED MODELS

