Increasing Access to Primary Care Using NP’s: The Framework for an Academic Based Nurse-managed Center in California

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Sandhu, Prabjot (Jodie), "Increasing Access to Primary Care Using NP’s: The Framework for an Academic Based Nurse-managed Center in California" (2016). Doctor of Nursing Practice (DNP) Projects. 89.
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INCREASING ACCESS TO PRIMARY CARE USING NP’S: THE FRAMEWORK FOR AN ACADEMIC BASED NURSE-MANAGED CENTER IN CALIFORNIA

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Acknowledgements

The DNP (Doctoral of Nursing Practice) journey for myself is one that has proved a valuable experience of engagement with professionals, peers, mentors, students, and organizations within the health care field. I do not stand alone at the end of this journey as there are many lessons, spoken words of advice, moments of great thought, and ideas portrayed by all those who surrounded me, and without that energy, I could not have fostered this vision.

I most sincerely give gratitude to my DNP chair, Dr. Jo Loomis, who is an inspiration for compassion in healthcare and innovative ideas involving NP’s, and whose mentorship and support have braced my accomplishments. My committee Dr. Wanda Borges and Dr. Brian Budds hold incredible warmth in my heart for their motivation and enlightenment. I thank the Dean, Dr. Judy Karshmer for her support of life-long learning and contribution to the vision of future NP practice and my project. There are many more to be thanked through the long and hard days of this journey; fellow students for support, faculty colleagues for encouragement, all of you hardworking NPs, and the many millions that support the NP profession.

I cannot close without acknowledging the value of my family, who have sacrificed and supported my dream and endeavor; my amazing husband, who is my pillar of strength and positive motivation, who makes me believe that I can do anything I desire, he is the absolute image of unconditional love; my three wonderful children, who are my impetus to work hard and reach for the stars, so as to continue to inspire them to be all that they can be; my parents for raising me to believe that “I can” and I should; and my siblings for all their help. I love you all so much!
Abstract

The dynamics of health care delivery and the role of health care providers is a changing canvas in the United States. The implementation of the Affordable Care Act (ACA), sets a goal to increase access to health care. The systems that support the ACA are constantly under scrutiny as failing to provide key answers to provider shortage and health care access issues. Nurse Practitioners (NPs) who are recognized by the ACA as a comprehensive part of this revolution are in a unique place to find opportunities to promote increased access to health and primary care services. While NPs in California are not recognized as independent providers and must work in collaboration with physicians, the opportunity still exists to expand access. Academic institutions generally utilize licensed and credentialed NP faculty to provide clinical education to NP students and have an unrivalled opportunity to provide community healthcare through education. To maintain licensure/certification, NPs must continue to provide evidence of clinical practice hours alongside teaching. While this dilemma is probably not unique to NP schools and perhaps adds to the shortage of fully practicing clinical professionals; the focus of this DNP project is to introduce an academic based, nurse managed model of care delivery which will display an integration of these three components: increasing access to care by using academic institutions, the dual role of the academic NP, and the opportunity for increased collaboration between physicians and NPs in California.

Keywords: primary care shortage, nurse practitioners, academic based health centers, affordable care act, NP/MD collaboration
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Section II: Introduction

Background Knowledge

Significant reporting of physician shortage in the United States has been documented over the last decade. The American Association of Medical Colleges (AAMC) describes a shortage of about 46,000-90,000 physicians nationally by 2025 (The American, 2015). While the shortage of physicians will contribute to the decreased availability of primary care providers, specialty areas will also be affected. AAMC (2015) relates the shortage to a number of factors including “thousands of baby boomers”, “aging physicians”, and the “current length of residency and training” programs. Furthermore, the clout of millions of patients that have recently entered the healthcare system with the implementation of the Affordable Care Act (ACA) in 2010, challenge our healthcare delivery system capabilities (Brimmer, 2015).

While the ACA aims for expanded healthcare coverage including free preventative health screenings through enrollment, it currently cannot ensure that those services will be met, given the lack of available access to care. Huang (2013) studied the primary care workforce shortage and future needs. Huang (2013) estimates that with the established status of the physician shortage and influx of new patients, physicians will need to add 25.7 million additional visits to their workload. He advocates through research that “to increase the overall supply of primary care providers, promoting and refining policies related to the distribution of primary care providers and community health centers is important” (p. 619, para 2).

The fact that there is a shortage has been disclosed, yet there is much controversy on how to best intervene. Freeman (2014) suggests that greater attention be paid on how to getting more out of the workforce, such as redesigning workflow “co-locating” physicians, giving ancillary
staff some of the physicians’ responsibilities, improving physicians’ time through improved Electronic Medical Records (EMRs), requiring fewer signatures, and reexamining policies such as using non clinicians for “routine protocol driven care”. Nusbaum (2009) insinuates options such as bridgework for physicians after retirement in healthcare shortage areas, moving specialty physicians into primary care allowing for shorter training times, recruiting physicians from abroad, in addition to retaining older physicians for longer. It is clear that the problem is multifactorial and therefore will require a few different approaches.

It is not merely the shortage of providers that is the principal obstacle. To improve the current structure of healthcare delivery, access to care must also be considered. Primacy Care Shortage Area (PCSA) is a term given by the Department of Health and Human Services (HHS), to highlight locations of provider care shortage across the nation. These areas are geographically burdened with an unstable number of physicians to patients. Incentives are offered to physicians to practice in these areas. The Robert Graham Center reports that while the number of physicians practicing in PCSAs has decreased from 2008-2013, by 2.4%, the number of areas that gained classification as PCSAs from 2008-2013 increased by 8.6% (Buerhaus, P., DesRoches, C., Dittus, R., & Donelan, K. 2014). With ACA goals to provide healthcare coverage to every American, it is important for states to examine how this is possible if there are not enough practicing physician providers. The potential value to the healthcare system by allowing thousands of already trained primary care health providers, nurse practitioners (NPs) to provide care, cannot be overlooked and or underestimated.

NPs are registered nurses with many years of clinical experience, who move to further their education, by obtaining a master’s or doctoral degree and extending their practice ability to manage patients in various settings, then better known as Advanced Practice Registered Nurses
Currently, there are an estimated 205,000 practicing NPs in the United States, with 86.5% located in primary care settings (“NP Fact Sheet”, 2016). NPs are unique in their training as the educational focus underscores treating the whole person and integrating care across disciplines. NPs are well known for educating their patients and contributing to improved health outcomes. NPs are professionally involved on many levels; educators, mentors, researchers, clinicians, and administrators. NPs offer high quality healthcare, are rated favorably for the care they give, and can be a cost effective and efficient way to decrease the gaps in healthcare delivery (“What’s an NP?” 2016).

The physician shortage, lack of access, and increasing need for primary care providers, confronts the needs to investigate opportunities for enhanced models of healthcare delivery. Much talk has been directed towards team based medical care, patient centered medical homes, and enhanced electronic communications (Green, 2012), which are all aimed at easing the current situation; but education and awareness about the model of Nurse Managed Health Centers (NMHCs) is lacking.

The NMHC is a health center operated and managed by advanced practice registered nurses (APRNs) including NPs or nurse midwives, alone or in collaboration with physicians, and staffed with public health nurses, certified nurse specialists and other members of the interdisciplinary team. While the concept of NMHCs may date back as far as the 1800’s, when nurse Lillian Wald founded the Henry Street Settlement Center, it continued as a process when Margaret Sanger started the first birth control clinic in 1916, which led to the development of Planned Parenthood clinics. NMHCs stem from the need for public health in communities and can provide a full range of primary care services. In the 1990’s significant interest in NMHCs was developed by the Independence Foundation (IF) out of Philadelphia, whose key interest had
been to promote funding for nursing programs to address the nursing shortage. An abundant amount of funding was given to academic based as well as other nonprofit and nonacademic NHMCs, in a quest to produce data and assess feasibility of this model. This data led to evidence of reimbursement issues and challenges in the infrastructure. In response, the Regional Nursing Centers Consortium (RNCC) was created to help address these issues. For the coming years into the mid 2000’s, continued financial crises were seen, and many NMHCs conjoined with existing community centers that are federally funded (FQHC’s). Research of this period led to significant findings that were acknowledged by Dr. Eunice King, who was the initiative officer from IH. Lessons learned regarding health policy, staff retention, community partnerships, business expertise and guidance, and the difficulties associated with ABNCs, helped strengthen the work of NHMCs (Hansen-Turton, Sherman, & King, 2015). NMHCs have evolved to showcase the nursing professional practice model (Appendix A) which centralizes the patient, the family, and the community, to provide a relationship of respect, care, and integrity, using collaboration and professional practice to guide the quality of care ("About Nurse Managed," 2016). Ironically, the vision for transforming health care today, to be more cost effective, holistic, and patient centered seems to be positioned around the same elements that have long existed in nursing.

The RNCC which later became the National Nursing Centers Consortium (NMCC) which currently stands as a network of over 200 NMHCs. While it is reported that many of these centers are associated with Schools of Nursing today, NMHCs can also stand alone as federally qualified health centers and community clinics. Together these centers are providing care to about 2.5 million patients ("Raise the Voice," 2014). NMHCs which are associated with academic institutions are sometimes also referred to as Academic Based Nursing Centers (ABNCs). The philosophy and mission of an ABNC is deeply grounded within the nursing
model of care. ABNCs are typically established to serve the community and fill a gap. The model of the ABNC has evolved over time allowing ABNCs to provide care to the underserved populations, allow for clinical experiences for nursing students, and practice opportunities for faculty practitioners (Esperat et. Al, 2004). The mission and vision for ABNCs are fostered by the parent university and have long been recognized as vital functioning components in public health (Esperat et al., 2011). NMHCs have been recognized as a vital component to healthcare delivery and a model for decreasing the access barriers.

Local Problem

In California 47.1% of the population lives in a Primary Care Shortage Area (PCSA) (“Primary Care,” 2010) (Appendix B). The designation used to classify a PCSA is as follows: a) a population area where there is 1 physician to anywhere between 3000-3500 people and where the population might also have an unusually higher need, and b) a dominant lack of access due to either distance, overutilization, or access issues (“Primary Medical HPSA,” n.d.). These areas of provider shortage are not the typical areas within reach of most hospitals, community centers, or clinics, which is why the term “access” to care is a more important and relevant topic of this project.

The population of San Francisco is about 852,000 people. About 13.3% of this population lives in poverty and 12% under the age of 65, do not have health insurance (“Quick Facts, n.d.). In San Francisco, there are three designated PCSAs, the census tracts known as Bayview/Candlestick/Hunters Point/Portola/Visitacion Valley; Excelsior/Glen Park/Ingleside/Lake Merced/Merced Heights/Ocean Beach South/Park Merced/Saint Francis Wood/Westwood Park; and Golden Gate Park/Parkside/West Portal/Sunset. These areas account
for about 280,526 people, which is 25% of San Francisco’s total population (“Primary Care,” 2010).

Primary care shortage areas are a matter of concern, because these areas often end up supporting health through the “safety net”, which are the public and private hospital systems. In 2014, it was estimated that 3/10 Californians are considered part of the safety net population. Safety net patients usually do not have a good source of primary care and third party payer spending for this populations accounts for 1/3 of the total spending (Connolly & Newman, 2016).

**Purpose of Change**

Established in 1855, the University of San Francisco (USF), currently stands as an internationally recognized Jesuit Catholic academic institution. The core philosophy of “*cura personalis*” – care of the whole person - lies behind the strong educational values of the university. USF commits to educating individuals with “a common good”, building students that are “socially responsible”, and morally shaping individuals “to take seriously how we choose to be in the world” (“About USF,” n.d.).

In the fall of 2015, the university gained access to the use of a fully functioning mobile health van. The goal of the university was to incorporate the mobile health unit in an innovative way, using nurse managed health services to provide care to the community, educate its’ students, and deepen clinical experiences for its’ NP faculty. The university has no prior experience as an ABNC. Furthermore, tools for implementing ABNCs in the state of California were discovered as limited given the restrictions to the scope of practice of APRNs.

Given the resources of a mobile health unit, the aim of this author’s DNP project was to develop a framework for a collaborative NP/MD model for the outreach of NP services in
primary care shortage areas using an ABNC. The model would aim to renovate the traditional school centered ABNC while cultivating the use of mobile NP managed health services, and continue to foster clinical sites for faculty as well as promote development of advanced integrated learning experiences for nursing students. The framework will outline features of function, regulation, legal protection, and healthcare service as pertaining to the use operation of an ABNC in California.

**Aim Statement**

In light of restrictive NP practice in the state of California, innovative models for allowing NP providers to practice, are vital to meeting the current demands in healthcare. The model of care under which ABNCs function, varies from state to state. The aim of this DNP project was to develop a framework for a collaborative community healthcare model in the academic setting, that encourages NPs and physician’s in California to work together to increase access to primary care. The framework aims to promote community practice partnerships, provide accessible care, and educate tomorrow’s healthcare leaders in a more socially responsible manner.

**Review of Evidence**

A comprehensive literature search was performed in several foci to validate the need of this project and gather tools for the development of the model. Literature was reviewed in the following areas: NP practice authority, physician shortage, access barriers, current models of academic health centers, nurse practitioner quality and safety data, and mobile health clinics. Several databases including CINAHL, PubMed, Ovid, Fusion, and Scopus were used. Keywords used for inquiry were: “np practice”, “np safety”, “np quality”, “physician shortage”, “academic based health centers”, “nurse managed clinics”, “mobile health clinics”, and
“primary care shortage”. The searches were enhanced by using article with similar topics and related research. Secondary sources were also reviewed (Appendix C).

**NP Practice Authority in California**

The American Association of Nurse Practitioners (AANP), state practice environment information (2015) reveals that in 22 states (40% of the nation), NPs are recognized and performing as primary care providers with full authority to their scope of practice and preparation. These states allow nurse practitioners to practice as they are trained; to provide evaluation, diagnosis, to order and interpret lab tests, initiate and manage treatments, and to prescribe medications all without an additional supervising license of a physician (“State Practice,” 2015). However in California, the circumstances are much different. NPs practicing in California are regulated by the Board of Registered Nursing (BRN). The NP scope of practice (SOP) is defined by the California BRN as:

A registered nurse who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, who has been prepared in a program that conforms to the educational standards as specified in California Code of Regulations (CCR), 1484. (“General Information,” n.d., para 1, pg. 1)

Additionally, the California BRN denotes that the “NP does not have an additional scope of practice beyond the usual RN scope and must rely on standardized procedures” (“General Information,” n.d., para. 4 pg. 1).

The NP in California maintains practice through authorized standardized procedures. The standardized procedures (SP) are “policies and protocols formulated by organized health care systems for the performance of standardized procedure functions”. (“Standardized,” n.d., para. 3,
While it would be difficult to explain the entire set of functions named in the Business and Professions Code 2725(c), these are the functional capabilities of the NP, as regulated by the BRN and defined by the advanced education. The SP includes information on the type of patients treated, the supervising agency or physician, and when “direct or indirect supervision” of the physician is required. The SP functions as a high level legal document for NP scope of practice in California and is sometimes interchanged with the term “collaborating agreement” as it discusses the terms for collaboration and supervision between NP and physician.

NPs in California are authorized to “furnish” or order medication, but only in strict accordance with the SP. The SP should document the types of drugs, and under what circumstances the NP can furnish the medication. In California, NPs may furnish drugs within the Controlled Substances categories II-V, with patient specific protocols in place as documented in the SP (Phillips, 2016).

Because NPs are not considered independent providers in California, and are not able to practice without a SP agreement, the NP may only work under the given conditions by the healthcare organization or employer. Other practice considerations include, the inability for NPs to bill for and receive compensation for most services on his/her own name at the same rate as physicians, with the exception of Medi-Cal. California NPs are not authorized to sign death certificates, but can sign the Physician Orders for Life Sustaining Treatment (POLST) (Phillips, 2016). Practice regulations for NPs vary from state to state and pose a strong question to the validity of education and training of NPs, which clearly prepares and recognizes them as primary care healthcare providers.
Physician Shortage

Over the last 10 years, there has been growing concerns regarding physician shortage in the United States. In March of 2015, AAMC released a report addressing the projected physician shortage from 2013-2025. Key findings from this report are: 1) The demand for physicians continues to grow faster than the supply, 2) By the year 2025, there will be a shortage of about 46,000-90,000 physicians, 3) About 30,000 physicians will be needed in primary care alone, 4) The physician shortage is estimated to persevere with many different scenarios, including the use of APRNs (Advanced Practice Registered Nurses), delayed physician retirement, the formation of accountable care organizations (ACO’s), and despite the greater use of alternate settings like retail clinics, 5) Addressing the shortage will require a multi-faceted approach, use of all health professionals, innovation related to care, and enhanced technology (Association of, 2015).

The “multi-faceted” approach has not yet been defined and while many researchers and agencies are hoping to identify this, the RAND Corporation declares that “new models of care” can be expected to eliminate a significant amount of the physician shortage (Chen, 2013). These new models of care include the expansion of patient-centered medical homes as well as nurse-managed health centers. These models may prove effective because of their use of various types of health care providers, including advanced practice nurses, physician assistants, pharmacists, nutritionists and others. Under the ACA, millions of dollars have been provided to pursue these services (Chen, 2013).

Access Barriers

A number of barriers to accessing primary care have been recognized over the years. The Kaiser Family Foundation (KFF), describes the lack of healthcare coverage, increased access to “safety nets” and lack of access to primary care, soaring medical costs even with insurance, and
gaps in coverage, as among some of the notable factors (“The Uninsured,” 2013). Bodenheimer & Hoangmai (2010) describe the primary care shortage landscape as one in which 65 million Americans are residing in. The density of patients to providers, disproportionally high; these are the areas that are also termed PCSAs. They describe the majority of primary care providers working in smaller practices located in more of the urban areas and many physicians also choosing to work only part time. They note that while 56% of visits to the physician practice are for primary care, there are only 37% physicians practicing primary medicine. They report access issues as ones that include being able to contact the physician, be seen after hours, or get a timely visit. They also emphasize the importance of insurance acceptance, with Medicaid patients having a far more difficult time getting access. Boccuti, Fields, Casillas, and Hamel (2015) also suggest that Medicare patients have access issues due to about 20% physicians not taking new patients (Appendix D).

Prior to the implementation of the ACA, the uninsured population contributed to a large market of people that were not getting access to needed healthcare. However, since the implementation of the ACA, research is revealing additional information. When reasons were studied for the use of the Emergency Department (ED) for care, Janke et al. (2014) report, 27.7% of users were ones that had no usual source of care. Other reasons included proximity, doctor’s office not open, and no other place to go (Appendix E). Rocovich and Patel (2012) also confirm the use of EDs as a convenience method more often than an urgency/emergency. Acuity while being a primary reason to seek ED care, contributed to only 67% of the visits (Janke et al., 2014).

PCSAs are defined by an imbalanced distribution of providers to patients. While most fall in rural areas, urban pockets are also affected. In the rural counties of the United States, approximately 65% of the population lacks an adequate number of healthcare professionals
(Macdowell, Glasser, Fitts, Nielsen, & Hunsaker, 2010). Of the common specialties reported to be most scarce; family medicine, psychiatry, and general internal medicine were top of the list (Macdowell et al., 2010). Research shows that various factors including financial, professional, and cultural influence the lack of supply in rural areas (Ewing & Hinkley, 2013). Rural areas are less attractive to newer physician graduates because of pay, distance, and the resources available in urban areas. The Agency for Healthcare Research and Quality (AHRQ) (2012) however, reports that NPs who are primary care trained are much more likely to work in rural areas than their physician counterparts (28% to 22%, respectively).

**Academic Health Centers**

There are two types of academia based health centers; those with a medical model which are affiliated with a teaching institution and hospital (AHC), and those that are adopted by schools of nursing as community partnerships and managed by APRNs (ABNC). The AHC model has long provided medicine with hi-tech interventions, “breakthrough” research, and pioneered new diagnostic techniques, all while serving to create the most brilliant physicians and subspecialists (Fuch’s, 2013). There are many challenges that face this model, describes Fuch’s (2013) as US health care is being transformed into value-based care. The organization, pricing, and delivery of care in the AHC model has consequences as patient population becomes more elderly, chronic, and vary in their risk profiles. AHC models may entertain a higher salary, but at the cost of often a life, work balance.

The ABNC model, which follows the trail of nurse managed health center’s (NMCHs) from the 1850’s, which were initially developed in response to the lack of access to health care for the poor, function in the academic setting with a different emphasis. The two primary efforts are to provide treatment to underserved populations and to serve as clinical sites for students and
faculty (Ely, 2015). In a systematic review of 9 published works regarding NMHCs, Ely (2015) finds some common themes. The first being the commonality of integrated care, NMHCs offered primary care as well as mental health services. Another repeating theme was the mission and vision, demonstrating the need to serve marginalized populations, regardless of the ability to pay. Furthermore, Ely reveals important information on financial sustainability, including factors such as lack of government funding, lack of reimbursement for services and procedures, as posing the highest threat for these clinics.

Financial stability is the key factor in the sustainability of an ABNC, as the model for startup has traditionally been derived from federally funded grants and university contributions. King (2008) points this out as well as some other challenges that have faced ABNC’s in the past. A host of issues from another study (King, 2008) on four ABNCs was conformed. King (2008) describes community factors such as: trust, marketing, building a client base; parent organization issues such as: internal politics, limitations on fund raising, competition with other entities; and nursing center issues such as: staff retention, the generation of revenue and funding, lack of business expertise, and compromised productivity. This evidence provides fundamental information that can be applied to future models for ABNCs.

Auerbach et al. (2013) calculate that NMHCs, if they became more prevalent, would reduce the need of many more additional primary care physicians by the year 2025. This was done by forecasting the supply and demand of physicians and NPs for 2025, using growth calculations (Appendix F), and then applying it to various medical models that are supported by NPs such as the patient centered medical home and NMHCs (Appendix G). They were able to demonstrate that even without the growth of new physicians, the expected growth of NPs
delivering care through these various models, would provide health access to a larger number of patients decreasing the gap.

**Nurse Practitioner Quality and Safety**

While many studies have methodologically evaluated the care given by NPs as compared to physicians and demonstrated equal outcomes, the nature of the evidence has frequently been scrutinized. A recent meta-analysis by Stanik-Hutt et al. (2013), compares data from 37 published works, showing evidence for high quality care, safety, and effectiveness for 11 outcome measurements comparing NPs to physicians. The evidence using patient surveys to document satisfaction was affirmative for quality of care. Measures to evaluate the hospital course and Length of Stay (LOS) showed equal efficacy in both provider groups. Patient results for the management of blood glucose and blood pressure were reported to be of equal outcomes. In this large meta-analysis, there was also support that in managing lipid disorders, NPs outperformed physicians.

An interesting study in Thailand, which underwent significant health care reform in 2010, examined primary health outcomes using three models of care. The purpose was to study outcomes using NP-MD (full time collaboration), vs NP-MD (part time collaboration), vs NP independent care settings in patients with diabetes. In the NP-MD full time collaboration model, MDs were responsible for screening, diagnosing, and treating, with the NP was mainly responsible for education and self-care, and assisting the MD when needed. The part time NP-MD model, was a provisional care model, using both MD’s and NPs part-time (three and two days respectively). In the NP model, NPs provided care on in all 5 aspects, including screening, diagnosing, treating, education and lifestyle, and referred patients when blood sugar could not be controlled according to the National Health Security Office (NHSO) guidelines.
Mekwiwatanawong, Hanucharurnkul, Piaseu, & Nityasuddhi (2013), used six different clinical settings, 300 patients affected with diabetes, and measured outcomes of fasting capillary blood glucose (FCBG), patient satisfaction, and the Diabetes Quality of Life Questionnaire (DQOLQ). Results proved remarkable. The model of care using just NPs proved the lowest mean FCBG, the highest mean scores on the Diabetes self-care ability, and highest mean scores on patient satisfaction surveys compared to the other models.

A recent randomized control trial (RCT) by Oliver, Pennington, Revelle & Rantz (2014) examining NPs with full practice authority versus restricted practice, examined the results of patient care outcomes with Medicare and Medicaid patients in states with unrestricted practice, and demonstrated a significant impact from NP care and evidence of improved outcomes. Oliver et al. (2014) confirm that states allowing NPs to practice to their full extent of their education, establish a decreased rate of hospital readmission within 30 days, an increased rate of avoided hospitalization, and an improved rate of overall health outcomes. The benefits of allowing NPs to coordinate care for their Medicare and Medicaid patients are clearly evident.

Improving health outcomes is an important measurement in today’s delivery of healthcare. Swan, Ferguson, Chang, Larson, & Smaldone (2015) provide a meta-analysis of the evidence regarding the safety and effectiveness of primary care provided by advanced practice nurses (APNs). Ten articles with over 10,000 patients were reviewed. APN’s generally demonstrated equal or improved outcomes when comparing physicians and NPs amongst physiologic measures of care, satisfaction, and cost. Using the Medical Outcomes Shortform 36 (SF-36), symptom resolution showed no difference in the two groups. While most physiologic measure outcomes, such as glucose outcomes, change in body mass index (BMI), and peak expiratory flow, reported equal outcomes, APNs had significant favor in results when comparing
diastolic blood pressure at six months and cholesterol levels. Three studies demonstrated higher patient satisfaction with APNs. Three studies investigated cost of care, and of these studies two demonstrated that APNs care was less expensive than physician care. Other significant findings include, increased return rate on APN scheduled visits and APN consultations which were typically longer than physicians, leading to less frequent visits over the course of two years.

Mobile Health Centers

A mobile health center (MHC) is a medical unit on wheels capable of providing various types of care through outreach into communities. There are an estimated 2000 mobile clinics nationwide supporting about 5-6 million patient visits annually (US Department of, 2013). MHC’s have been recognized as an important piece of healthcare reform because they overcome access barriers, offer care at decreased costs, and improve the health of diverse populations (US Department of, 2013). MHCs have the ability to access the poorest areas as well as urban communities. They can reach patients of all ages. They can provide a range of services including, primary care, dental health, routine screenings, and mental health. The US Department of Health and Human Services (DHHS) (2013), reports that MHCs save money via many aspects, including: decreasing emergency department visits, delivering preventative services and also generally gain a higher rate of return on investment, $20 for every dollar invested.

Harvard Medical School and the Mobile Health Clinic Association come together to support one of the largest initiatives in the nation for mobile health, the Mobile Health Map. Harvard Medical School recently published clinical data on its mobile health program, The Family Van. Using evidence from over 5900 patients, with more than 10,000 visits over 2 years of service, Song, Hill, Bennet, Vavasis, & Oriol (2013) concluded that average reductions in
systolic and diastolic blood pressure (BP) were reduced by 31%. The overall relative risk reduction for stroke and myocardial infarction was 44.6% and 32.2% respectively. Estimated dollar savings based on a calculations of avoidable emergency visits valued at $474 in Massachusetts, was about $1.4 million.

While the US Department of HHS (2013), declares that the mobile clinic sector is an “underutilized resource” for achieving the goals of the Triple Aim (improving care, improving health outcomes, and cost savings), and while mobility is a major asset, critics worry about the cost and financial sustainability of these models. DHHS is a core funding resource for a number of these clinics, but not all. Aung et al. (2015) disclose that organizations piloting mobile health clinics may not have the operational and logistical tools. Information technology and connectivity in rural areas may pose yet other challenges for optimal care. Support from public and private payers, systematic deployment of the vehicles, and patient satisfaction, are all areas that require further investigation.

**Theoretical Framework**

The theoretical framework for this project is shaped by a community nursing and population focused model, known as Block and Josten’s Ethical Theory of Population Based Nursing. The theory embodies three essential elements of providing patient care. The first element is the obligation to the population. The second element is the primacy of prevention. The third element is centrality of relationship-based care. Together these elements form the basis of providing healthcare to underserved populations. The theory implies that nursing and public health are intersecting. Ethically, it is the responsibility of healthcare providers to render access to care. Beyond this however, prevention strategies including education, screenings, and
the furnishing of primary care, all be it a public health problem, pose incredible risks to the population as a whole. The nurse-patient relationship has been valued for the holistic vision, therapeutic touch, and compassionate focus. The essential principles of nursing protect the client dignity and autonomy and focus on trust and respect. This relationship provides the core component to a community based healthcare model (“Nursing Theories,” 2012).
SECTION III: Methods

Ethical Issues

Social justice should not only encompass fair distribution of resources and equal access, but also require equal respect, and the preservation of human dignity (Gostin, 2010). Academic health centers in their various forms are generally initiated to obtain a number of goals as previously defined in this paper. Of the goals to teach students, allow faculty practice, engage in research, as well as provide medical care, there is a significant requirement to focus on the principles guiding this care. In order to remain ethically just, the mission and vision of the supporting academic health center must maintain patient care as its’ first priority. There is a public duty of health professionals to be accountable for the care they give. While faculty are placed in vulnerable situations in academic health centers, by being obliged to the patient and the student and the responsibility of nurturing both, many ethical boundaries will come into question. Prior to establishing a health care site, a code of ethics provided by the academic institution establishing guidelines by which patient care, and student learning is delivered under all recognizable circumstances, should be developed.

Additional matters of ethical concern include the responsibility of caring for diverse, underserved, and fragmented communities. As healthcare providers, cultural competence, a liberal approach to sensitive populations, and appropriate assessment skills of communities at risk are topics of deliberation prior to the implementation of the academic health center. The academic institution must have in place standards of care for these populations and provide appropriate training to the faculty and students. All other principles of providing ethical medical care, including obtaining institutional review board (IRB) consent for authorizing any potential research, as a protection right of all participants, maintaining privacy and confidentiality of
INCREASING ACCESS TO PRIMARY CARE

patients by adhering to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Setting**

Academia has been a resource for healthcare for about 50 years. NMHCs trace back to the 19th century with the establishment of the Henry Street Settlement. The first academic based nursing center came to life in the 1980’s (King, 2008). The Open Data page of California Department of Public Health (CDPH) (2016), houses information on the number of currently licensed mobile units. The total number of mobile health units in California is 295. Of those units, most are licensed to general hospitals, and only five are identifiable by their name as academically hosted units. Of those five it is unclear whether they are functioning in local or rural communities, offering primary or screening services, or even active.

At the University of San Francisco, the prospect of initializing a mobile health unit, was an enticing opportunity to establish a model for a nurse based academic health unit. In this era of health reform in which a strong need for distinctive models of care are evident, USF, whose mission is a socially just environment, equality, and movement towards innovation and global change stands in the right position. The USF School of Nursing and Health Professions (SONHP) is host to many degree programs and an interdisciplinary approach to community outreach, including nursing, psychological health, behavioral health, public health, and health informatics was all a part of the vision. A project proposal requirement was initiated by the SONHP, for interested faculty to bid for time in the mobile health unit. A clear explanation of how it is going to be used, funded, and support the goals of the University were requested (See Appendix H).
The stakeholders in the proposal of an ABNC mobile unit were the University, and then more specifically the SONHP, all SONHP faculty and students, the community partners with whom mobile health practices would be initiated, the city in which the mobile health unit would launch, the consumer (patient), any support staff, supply vendors, potential in-kind donors, and a collaborating physician.

Planning the Intervention

The initiation of an ABNC is a practice that is different from state to state, as a result of varying scope of practice laws for NPs, imprecise explanations of advanced practice nursing legal implications, and state restrictive regulations (“State Practice,” 2015). It is important to remember that the process of operating an ABNC is not well defined in California, there are no clear guiding organizations, and definitely no operational manual for this. During the initial planning phase, it was quickly realized that the first steps to designing a model for implementation was to thoroughly research California state practice regulations, mobile health practice guidelines, and organizational requirements for an academic center without the experience in the delivery of healthcare. At this time the project was split into two phases: 1) Research for the tools required to initiate an ABNC in California, 2) Development of the Framework for the ABNC.

The team responsible for developing the framework for the ABNC which would be used for the mobile health model, was the author as DNP candidate, her Chair, Dr. Jo Loomis, and her Committee member/Community Outreach Partner, Associate Dean Wanda Borges. The author is an actively practicing FNP, with over 13 years of experience in various settings, and a student with a progressive vision for NP practice. Dr. Jo Loomis, is an Assistant Professor in the FNP program at USF. She is distinguished as clinical faculty with experience in various mobile health
projects. Her involvement in both urban and rural mobile health ventures as a joint effort between USF SONHP and diverse communities in California held significant value to the team. Associate Dean Wanda Borges, who is also an ANP (Adult Nurse Practitioner), sustains a role of active engagement in community partnerships with USF SONHP and proves an asset in mobilizing the framework into action.

**Communication Matrix**

Communication methods included in person meetings, phone calls, email exchanges, and virtual conferencing via Zoom. Communications were more frequent with key team players where updates and issues were addressed regularly. Project tempo varied during the initial phases of research as well as near completion to a more independent phase of culmination for the author (Appendix I).

**Project Implementation**

**Phase I: Research of Tools and Requirements**

Given the lack of existing published resources for guidance on this model, or the development of an ABNC in California, a significant amount of research was required prior to the development. A gap analysis of the existing state of practice and the need for pursuing additional health delivery models was completed. The gap analysis demonstrates the lack of access issues for California, physician shortage, NP practice barriers, and USF’s lack of participation as a health center (See Appendix J).

**Key Areas of Research**

**NP Managed Clinic Models in California:** Because California is considered a restrictive practice state, models for independent NP practice do not exist. The function of the NP relies
strictly on the process of adapted Standardized Procedures (SP) (see template in Appendix K). The SPs require the approval of a supervising physician (MD). A supervising physician’s role can only extend to four NPs who prescribe drugs. While a physician does not have to be physically present, allowing for an NP to practice in a “given setting” alone, the SP serves as the written protocol and regulation for this authority ("Standardized Procedure," n.d.). Of note, while all language on the California BRN website refers to the physician working with a NP as a “supervising” physician, conflicting language transpires through literature, numerous websites and documents, referring to the supervising physician as “collaborating”. Communications were also made with Melanie Balestra, NP, Esq., a nurse practitioner/lawyer who practices law on behalf of physicians, physician assistants, nurses, nurse practitioners and other health care providers. Clarifications regarding NP practice in California were that while some NPs pursue “owning” a health practice, they are not independent providers in California and must still practice with the same regulations and a set of SP (M. Balestra, personal communication, March 18, 2016).

**The Academic Health Center Model for Schools of Nursing:** During the research phase, the author was able to find an excellent resource called, “*Nurse-led Health Clinics, Operations, Policy, and Opportunities*” (2015), by Tine Hansen-Turton, Susan Sherman, & Eunice King, that would provide a foundation for the framework related to implementation in California. Turton et al., (2015) beautifully encapsulate the history, work, and importance of the NMHC as well as current issues, trends, and needs for academic centers. The work of Wink (2000) was also of great value as it offered understanding and guidance to the implementation of an ABNC in an in-depth manner and will be outlined here.

1. Considerations prior to implementing an academic based nurse–managed center
a. What is the scope of service for the ABNC?

b. How are the obligations of faculty going to be met when serving multiple systems?

c. Is continuity of care going to be maintained?

d. What is the financing method?

e. Will data be collected, stored, and evaluated?

f. What are the legal and regulatory requirements?

2. Types of ABNC

   a. The Community Model

      i. The setting is the community center, or neighborhood, storefront, public building, in which nurses can be participating in activities including assessment, education, case management, referrals, and screenings. This model may be staffed by faculty and nursing students. This model can also be used by other health disciplines. Further, these centers might only be utilized when school is in session and often are designed to meet specific objectives of courses. Typically, this type of service does not get reimbursed.

   b. The Primary Care Model

      i. This model focuses on a particular portion of the population (i.e. underserved, homeless, rural, college students, school based, etc.). In this model, screening and interventional therapies are rendered. Focused care can also be delivered. These centers are usually staffed by physicians, NPs, nurses, physical therapists, social workers, medical technicians, and
c. A “Center without Walls”

i. While this model is the most flexible for location and types of services (offering care at the site, i.e. employee health, Head start, senior center) and can be cost efficient, it may be limiting to the delivery of care. Lack of privacy and space, and tools available may pose constraints on the practice. The scope of services can vary from essential nursing to advanced practice but may have restrictions. Contracts with the organizations are often necessary.

3. Important Considerations

a. Interactions with the Community

i. The ABNC must set goals that reflect the vision of the community in which it chooses to work. A willing partnership and identification of the sources of funding are crucial for success. Sensitive (underserved) communities can easily lose trust in academic based centers because they may leave, once the school’s goals are accomplished. Up front acknowledgement of expectations, types, and duration of services will be helpful.

b. Interactions with existing health systems

i. While reaching out as an ABNC it will be important to identify the health needs of the community. Duplication of services that are already offered,
will be of little importance. The ABNC’s efforts need to be coupled with resources in the area and provide links so as not to fail as a free-standing system. Primary care centers (PCC) need to be fully integrated into the existing health system as they may need formal and informal contacts to initiate referrals.

c. Care Continuity

i. This is an important aspect for ABNC’s to consider. Communities that host ABNC’s may favor the service over others and seek longer partnerships and presence. Schools that do not plan for a sustainability model, may be threatened. Furthermore, to provide the continuity of care, schools must be well informed about the culture of that community and care they need to provide.

d. The Financials

i. ABNC’s are not an option for schools that do not have adequate financial resources. For the most optimum performance the ABNC should be profitable.

   1. Key Elements

      a. Charge fees? Use Donations? Use School funds?


      c. Use grants and community funding?

      d. What is the ongoing source of funding?

      e. If there is income, how will it be dispersed?
Other considerations regarding data collection, including keeping formal client records, quality improvement methods, and risk-management services are essential. All ABNC’s must follow state based laws and regulations (Wink, 2000).

Mobile Health Unit Requirements for California: According to the California Primary Care Association, a mobile unit can be approved using two methods: 1) as part of a service to an already operating licensed clinic, 2) as a separate entity licensed as a PCC (California Primary Care Association, n.d.). Steps for operation include:

1. Registration of the vehicle
2. Licensing of the unit, by California Public Health Department (CDPH) as a PCC or an affiliate of an already functioning PCC.
3. An inspection of the unit by the CDPH Housing and Community Development department.
4. Documentation from the Office of Statewide Planning and Development (OSHPD) approving the vehicle as self-contained or as facility approved hook up.
5. Approval from the local planning or zoning authorities to park and operate the vehicle in the desired area.

All licensing packets for California PCC and simultaneous health program applications can be found at the CDPH website, licensing page (http://www.cdph.ca.gov/pubsforms/forms/Pages/HealthFacility-PCC.aspx).
Phase II: Development of the Framework for the ABNC

After gathering respective data and information regarding various models, implementation requirements, and the potential design of ABNC’s in California, the author began work on development of the framework. Given the landscape of NP practice in California, considerations for a community based model ABNC was developed first (Appendix L). Specific to California, rules and regulations for practice as a primary care clinic for the nonprofit organization were researched. The author presented the framework as an operational guide in print for the University of San Francisco, Dean and Associate Dean of the School of Nursing and Health Professions (Appendix M).

Methods of Evaluation

Evaluation of this framework as an applicable model to USF’s current setting and structure was contained within a few key elements. The SWOT (Strengths, Weaknesses, Opportunities, and Threats) Analysis held the first position to explore reasons for continuation or to recognize significant threat factors. The strengths associated with an academic based mobile clinic for USF are many. Having a mobile unit at hand, idealizes the goal of moving to areas that lack access to healthcare, and extending the use of NPs as envisioned. Long term benefits of increased primary care services include: reduction in mortality, reduction in healthcare spending on preventable chronic disease, and increased community health and education (National Conference, 2013). The ability for USF to establish a community partnership mobile health site can lead to the growth of USF and the community clinic model, enhancing its development as a health profession school, providing heightened learning environments for its students. By placing NPs in the clinics, USF would be addressing the national problem of a primary care physician shortage. The benefits of local access to healthcare providers in this community, can extend in
the forms of outreach, referrals, care coordination, and educational opportunities; all of which have the potential to lead to improved outcomes and decreased ED visits. The Dean’s vision and support of the model to promote collaboration between NPs and physicians as a way to extend care was also pronounced.

Not to overlook the potential weaknesses, it is realistic to say that a community clinic model endures challenging issues such as staffing, financial support, limited resources for care delivery, and space limitations to address only small quantities of populations at a time. While the opportunity is there to create the academic based mobile clinic model, cultural and psychological barriers may pose issues to receptiveness of care. Another weakness, being a new project for USF, the lack of knowledge associated with starting a mobile clinic, will lead to a learning project rather than an experienced venture.

Once beyond the learning curve however, there are many opportunities for USF. In addition to local communities, there are many other communities within the Bay Area region that suffer from similar disparities in health care. The possibility for expansion and growth is exponential. The mobile clinic would have the capability to reach populations for education, wellness, and preventative services without added cost. For future, USF may choose to expand the ABNC mobile clinic model and incur revenue, by accumulating a percentage of insured patients. By providing an ABNC that serves as a learning environment for students, USF SONHP can also diversify its curriculum, reputation, and marketability. There are numerous grants available for the use of increasing primary care to areas of need and with the use of such grants the services provided by USF can really make a difference in healthcare.

Along with the many visible opportunities, several threats were also perceivable. Threats to this project include lack of evidence for sustainability. Without appropriate funding in place
there is a risk that the project may not be able to continue. While the mobile van that has been 
donated to USF has some working permits for providing health in the city of San Francisco, it is 
not yet clear as to what additional permits and licenses will be required based on the scope of 
services. Pending the approval of such entities can make this project circumstantial. Safety 
concerns while in communities that lack access to care because of location being poverty 
stricken isolated areas, and locations within San Francisco with high rates of crime including 
gang violence, are potential hazards to a clinic that is primarily female staffed. Legal counseling 
and a thorough evaluation will provide more information on additional threats (Appendix N).

The most important method of evaluation for implementation of an ABNC is to utilize an 
individualized cost/benefit analysis. While most ABNC’s strive for a similar mission, they do not 
have equal resources. The ABNC model is a philanthropic model where the core benefit lies in 
outcomes that are not specifically measured in pecuniary terms. The opportunity to increase 
access to care, provide clinical sites for faculty, and educational sites for students; the 
development of community based-academic partnerships; and furthermore the possibility of 
improving other health outcomes such as decreased emergency room visits, increased screening 
protocols and access to health education, and reducing gaps in healthcare, are fundamental to 
consider as benefits. An exemplar cost benefit analysis template (CBA) was shaped for USF 
(Appendix O). Because the proposed model of a MHC aims to serve a population that is not 
mainstream and envisions a purpose that cannot be measured exclusively on fiscal terms, Oriol et 
al (2009) tested an algorithm to calculate Return on Investment (ROI) for mobile health units and 
suggest that the relative value of a MHC should equal the annual projected costs avoided by the 
emergency department and the value of life years saved by offering the mobile service. Hence,
the ROI ratio would equal, the relative value, divided by the annual cost to operate the mobile health center.

While quantifying benefits and ROI sounds complicated at the moment, because it is, given the lack of tools to properly assess this, a starting point for institutions who are wishing to embark on an ABNC journey, is to evaluate operating expenses and the funding source for sustainability of those expenses for at least 2 years. The operating budget can be calculated using the cost portion of the CBA template, a preliminary budget was created for USF (Appendix P). Recognition of the fact that nonprofit organizations achieve to leave the mark of human impact rather than support the financial byproduct, is an important part of the equation (Heaton, 2016), but should not be the only one if we want to consider growing the ABNC model.

**Analysis**

This DNP project’s aim was to research and design a framework for the implementation of an ABNC specific to California, which it was able to do. The framework was also able to develop a pre-implementation assessment tool for ABNC’s, supported by current literature, which stresses the importance of recognizing and assessing the goal of sustainability. The core elements of success for this framework in California are both long term sustainability and the collaborative model, but also the opportunities for funding.

**Section IV: Results**

**Evaluation**

The framework set forth by this author, highlights methods, format, and ideology that is useful to implementing an ABNC in California. The framework for the ABNC in California strives to initiate conversation towards a model of healthcare that has the potential and power to improve delivery of care. Important aspects to consider are sustainability models, funding for
such programs, and potential barriers such as scope of practice laws that limit nursing schools to advance without physician approvals and oversight. The framework is an evidence based resource that can help foster the growth of NP managed health centers for academic institutions that are in a position to take action. During the course of this project, there was no direct evaluation of the framework, but without any other like resources available for nursing schools in California, it sets the stage as a paradigm, that can further be enhanced.

Section V: Discussion

Summary

With over 250 nurse managed health centers (NMHCs) around the United States, one of the biggest impediments of substantial growth of this model is the void of information regarding management, frameworks, and outcomes data. The NNCC is found to be the only guiding agency and reporting organization for NMHC’s. There is some important work and research being done, but in truth policies and funding issues exist. In 2010, the ACA first identified the NMHC as a health care model that aims to improve accessibility to lower income and minority populations (Holt, Zabler & Baisch, 2014). With the fundamental issue being sustainability, there are several strategies being pushed and considered. Key policies around scope of practice for NPs, have reformed regulation in many states over the last 5-7 years, supporting the notion for continued growth of nurse managed care centers. The ACA allocates specific funding for models of care that help support the safety net organizations, which includes NMHCs (Holt et al., 2014). The Health Resources and Services Administration (HRSA) which previously offered funding for NMHC’s currently does have any active programs ("Nurse-Managed Health," n.d.).

The Advanced Nursing Practice field is one that is growing progressively and has demonstrated safe and effective care. There are currently more than three million members of the
nursing profession and they carry the largest portion of providers in the United States health workforce. The Institute of Medicine (IOM), now known as The National Academies of Science, Engineering, Medicine (NAM), reports that nurses are underrepresented as leaders, have the ability to transform care by meeting the increased demands of caring for patients that are newly insured or from underinsured populations, and when they work in collaboration with other leaders, have the ability to improve outcomes and reduce costs (The National Academies of Science, 2010).

Specific to California, a quintessential hurdle for the ABNC is the scope of practice regulations for NPs and political issues regarding supervision and collaboration, directing the best model to be more of a community partnership based. The community based model relies on a partnership organization, perhaps with an already functioning organization structure. The model would allow for NP’s to deliver care with supervision by practicing physicians in the community partnership, instead of seeking new relationships as an academic organization. Within the community model, it would be important to investigate whether true nurse managed care could be delivered.

**Relation to other Evidence**

Plentiful peer reviewed evidence regarding the functionality of ABNC’s in California is lacking. A model for the ABNC in California, which has also been recognized as a national model by the James Irvine Foundation ("Glide Health," 2012), known as the Glide Health Services (GHS) clinic, was one of the clinics that received $1.5 million in funding from HRSA in 2010. The clinic established in 1997, has seen its fraction of hurdles and closed several times, but today has procured status as a federally qualified health center. GHS is associated with the University of California (UC) system in San Francisco and operates a two level ABNC that leads
in delivering high quality, low cost care to the homeless, mentally ill, and low income populations of San Francisco ("Special Initiatives," 2012).

The University of California Los Angeles (UCLA) Health Center at the Union Rescue Mission (HCURM) is another example of a vivid ABNC that functions in a community partnership model with the Community Clinic Association of Los Angeles County (CCALC). The clinic, established in 1983, based out of a homeless shelter, is an ABNC and serves homeless families with children in the Skid Row community. Covering about 9,500 visits annually in 2013, the HCURM admits to its own challenges of limited resources and access to community referrals ("Rn-Led, Shelter," 2014).

UC Irvine (UCI) California, School of Nursing in collaboration with El Sol Wellness Center is another prime sample of a California based ABNC. The UCI School of Nursing which began in 2007, associates with the vision of “compassionate, community-based health care” ("Mission and Vision," 2016). The joint partnership which is funded by the HRSA 5 year $1.5 million federal grant, offers free care to a predominately Hispanic population that is poverty stricken ("Uci News," 2011).

Of the standing NMHCs, very few have gained status as a FQHC. About 112 NMHCs are known to be independent nonprofit or hospital clinics, while a little over half are associated with university’s (ABNCs). NMHCs sustained the most growth during the time of funding from HRSA in 2010. This funding model resulted in variable success as some centers were able to maintain themselves beyond the initial funding and others have departed. It is clear that while the mission of a NMHC is driven by community services, obtaining financial means is momentous task and indicator of success (Esperat et al., 2011).
**Barrier to Implementation/Limitations**

The most significant limitations posed to the NMHC and ABNC models of patient care delivery are funding and sustainability. The ABNC faces challenges without initial funding, when caring for populations that are underserved or underinsured. The community service model tendered by the ABNC relies on community funding, Medicaid reimbursement, and donations. Other significant barriers include scope of practice laws, affecting the ability of NPs to practice independently, relying on physician partnerships to be able to thrive (Hansen-Turton, Ritter, Rothman, & Valdez, 2006). More factors including lack of hospital privileges and prescription restrictions as part of the limitation to the scope also affect the patient care spectrum. Policies affecting NP credentialing for managed care health plans, prohibiting NPs to be recognized as primary care providers (PCP), position them negatively in the managed care market, where reimbursement fuels growth.

**Discussion**

**The Quality and Efficacy of NMHCs**

There has been no question through research that while the challenges that face NMHC’s are many, and even with sustainability as an issue, the quality of care and effectiveness of the NMHC model is paramount. The NMHC Report (2011) summarizes that millions of patients are served annually by NMHCs, expanding access to care and increasing health prevention. Ninety five percent of NMHCs are in low income areas and serving 64% of minority and ethnic populations. A clinic run by a nurse practitioner, results in a medical cost savings of $2.18 million in direct costs over a two year period. NMHCs have a higher rate of generic prescriptions filled and lower hospitalization rates than other similar providers (National Nursing, 2011).
Coddington, Sands, Edwards, Kirkpatrick & Chen (2011), used data from 500 NMHC serving uninsured and Medicaid patients and compared it to the national benchmark Healthcare and Data Information Set (HEDIS). The measures included complete immunizations, proper treatment goals of viral respiratory infections, continuity of care, and well child visits. The results demonstrated that the quality of care delivered by Pediatric NPs met or exceeded the national benchmark.

**Sustainability**

It is not untrue that the health of an individual depends on their access to care and using ABNC’s to extend access is a viable option. Sutter-Barrett, Sutter-Dalrymple, & Dickman (2015), launched three NMHC’s under the Bridge Care Model – an ABNC in Virginia. The clinics offer care to the low income or uninsured, and even with the implementation of ACA, they note, gaps in healthcare are apparent due to access issues. The clinics serve the community, but importantly are illustrious to also serve as clinical sites for student NPs, emphasizing the need for a well-educated and prepared workforce. One of the major factors distinguished by Sutter-Barret et al. (2015) in preparation of future NPs is the lack of clinical sites. With this in mind, they also clarify that their model of success has not been to rely on financial support from private grants, charities, or other government agencies, rather, to develop a model of sustainability that includes: a) a secure relationship with a community partner for access to clinic space and resources, b) a plan which subsidizes faculty workload for clinical time, and c) activities to help raise as well as other efforts to get funding. Sutter-Barret et al. (2015) demonstrate that some of the costs of operations can also be absorbed through student tuition.

All of these are important considerations to an ABNC, because much about the design and organization can predict the sustainability. The funding required for an ABNC can be
dissented into three areas: a) legal/licensing b) staff, and c) day to day practice needs. The business and legal operations of the clinic are first and foremost in expenditure. Discovering the resource for the initial funds to overlook legal and licensing has in itself many opportunities. Schools of Nursing may allocate development funds for this annually as part of its strategic plan for growth; academic/community fundraising abilities should be examined; and engagement in grant writing and or federal programs which offer funding for community education, prevention, and health promotion projects are also an option. The Centers for Disease Control (CDC), Agency for Healthcare Research and Quality (AHRQ), and National Institutes of Health (NIH) are among these organizations which can serve as vehicles to deliver care and achieve sound outcomes through collaborative initiatives ("Search Grants," 2016). As Sutter-Barret et al. concur, that the faculty practice and service model is probably the most idea method to contain the cost of staff, and fulfill mutual goals. Many models of faculty practice exist, and the National Organization of Nurse Practitioner Faculty (NONPF) supports that academic centers offer faculty the opportunity to engage in clinical practice using innovative methods, as a scholarly mission, and maintain a salaried workload (Nurse Practitioner Faculty, 2015). This method incorporates current faculty and integrates classroom and clinical experiences. Finally, the development of a plan where the day to day practice needs, such as supplies and running costs of the academic health practice, can be absorbed by the fees of students that are participating in these clinical settings, is a matter of consideration. Furthermore, NPs can and should seek Medicaid and Medicare reimbursement for clinic practice.

Conclusion

In an environment of evolving health policies, an emphasis on increasing the availability of healthcare professionals, and a need to not only offer basic healthcare and services to all
Americans, but to ensure that care is “accessible”, ABNCs have the opportunity to frame a model of care delivery that is distinctive, fundamental, and that which embodies the holistic realm of nursing practice. NMHCs do not rely on physician presence, serve as educational sites, and enhance the care given in communities. Efforts by Schools of Nursing to evaluate the framework for ABNC implementation, assess their current structure and capacity, and organize to move towards community health partnership models to promote a progressive model of NP care are entreated.

SECTION VI: OTHER INFORMATION

Funding

The author did not have affiliations with any agency to fulfill this project. This author did not receive any funding for the development of the ABNC framework for California project. The author endured mild expenses related to printing the resource guide, occasional travel, time and attendance at meetings.
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*Health Affairs*, 29(5), 799-805.


Appendix A: Nursing Professional Practice Model
Appendix B: California Primary Care Shortage Area (PCS A) Map

The California Primary Care Shortage Areas correspond to the 2010 U.S. Census and use two criteria: percent of population below 100% federal poverty level and primary care physicians to population ratio. Data used include U.S. Census, American Community Survey 5 yr population and poverty estimates and InfotracUSA 2013 Physicians for each Medical Service Study Area.

January 2015
### Appendix C: Evidence Table for Nurse Practitioner Impact of Care

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Design</th>
<th>Sample/Setting</th>
<th>Topic Studied</th>
<th>Key Findings</th>
<th>Strength of Evidence (Johns Hopkin’s Appraisal Tool)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stanik-Hutt et al (2013)</td>
<td>Systematic Review</td>
<td>n=37 published articles, selected from 27,993 total studies during 1990-2009 United States</td>
<td>The impact of Nurse Practitioner’s vs physician on health care quality</td>
<td>Eleven patient outcomes for measures of quality and effectiveness of care were identified: patient satisfaction with provider, patient self-assessment of perceived health status, functional status, number of unexpected ED visits, hospitalization, duration of ventilation, and hospital level of service, blood pressure, blood glucose, serum lipids and mortality. Among these outcomes it was determined care delivered by NPs was no different than the care delivered by physicians in regards to patient satisfaction, functional status, number of ED visits, hospitalization rates, and self-report of perceived health status. The outcomes for mortality were equal among both providers, and outcomes for blood glucose and blood pressure were also similar. NPs had slightly improved outcomes on serum lipid measures.</td>
<td>Level I Quality A</td>
</tr>
<tr>
<td>Jennings, N. et al. (2015)</td>
<td>Systematic Review</td>
<td>n=14 research articles selected from 1013 studies between 2006-2013 United States</td>
<td>The impact of NP services on quality of care, cost, satisfaction, and waiting times in the emergency department.</td>
<td>The evidence demonstrated that quality of care, patient satisfaction and wait times were impacted positively by NP care, however little evidence pointed to any cost benefit that might lead to any reform of emergency room services.</td>
<td>Level I Quality B</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Study Type</td>
<td>Participants</td>
<td>Study Details</td>
<td>Findings</td>
<td>Quality Level</td>
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<tr>
<td>-----------</td>
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<tr>
<td>Mekwiwatanon, C. et al. (2013)</td>
<td>Descriptive Comparative Study</td>
<td>n=315 provider participants, n=300 patient participants, Thailand</td>
<td>Three primary care models: a) NP-MD with fulltime supervision, b) NP-MD with part-time supervision, and c) NP without supervision, attending to patients with Diabetes</td>
<td>Using standardized guidelines for care of the diabetic patient, 3 clinic models were studied for outcome comparison. The NP role in Thailand remains in much question and conversion as here in the United States and data for better understanding of NP care delivery and safety of outcomes was examined. The interventions examined were: screening and diagnosis of diabetes, treatment for glycemic control, follow-up and evaluation of treatment, complications and diabetes education for self-care and lifestyle adjustment. The results demonstrated the lowest mean for fasting blood glucose in the NP without supervision model as well as the highest score for self-care, lifestyle adjustment, and patient satisfaction.</td>
<td>Level II Quality A</td>
</tr>
<tr>
<td>Buerhaus, P. et al. (2015)</td>
<td>Qualitative Analysis</td>
<td>n=972 clinicians NPs and physicians from 2011-2012</td>
<td>The identification of practice characteristics of NP’s vs physicians in the United States</td>
<td>A 61.2% response rate was achieved using a mail survey to study practice demographics, compensation, billing practices, NP privileges, and types of clinical activities performed. The data demonstrated that NP’s were more likely to practice in rural areas, delivered a smaller range of services, found that regulations were impeding their capacity to perform, and did not have salary adjustments for quality or performance. Both sets of providers supported collaboration and team practice and felt that NP’s could offer some relief in expanding primary care access.</td>
<td>Level III Quality B</td>
</tr>
</tbody>
</table>
Appendix D: Physicians Accepting Medicare

More than 9 in 10 primary care physicians accept Medicare—similar to private insurance—but acceptance of new Medicare patients is comparably lower

Percent of non-pediatric primary care physicians accepting new/current patients, by insurance type, 2015

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>Accepts new patients with given insurance type</th>
<th>Accepts given insurance type, but not currently taking new patients with that insurance type</th>
<th>Does not accept patients with given insurance type</th>
<th>Not applicable, No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>72%</td>
<td>21%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Private Insurance</td>
<td>80%*</td>
<td>14%*</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>45%*</td>
<td>22%</td>
<td>32%*</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Analysis excludes pediatricians. (†) The overall percent of primary care physicians accepting Medicaid increases to 71% when pediatricians are included in analysis. (*) indicates statistically significant difference at the 95% confidence level from Medicare. Percentages may not sum to 100 due to rounding.

SOURCE: The Kaiser Family Foundation/ Commonwealth Fund 2015 National Survey of Primary Care Providers

Figure 1: More than 9 in 10 primary care physicians accept Medicare—similar to private insurance—but acceptance of new Medicare patients is comparably lower
Appendix E: Access Issues for ED visits

<table>
<thead>
<tr>
<th>Access Issue</th>
<th>ED</th>
<th>None</th>
<th>Error</th>
<th>Error</th>
<th>ED</th>
<th>Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Least One of the Above Access Issues</td>
<td>63.8%</td>
<td>1.8%</td>
<td>76.4%</td>
<td>4.2%</td>
<td>93.7%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Didn’t Have Another Place To Go</td>
<td>97.9%</td>
<td>1.7%</td>
<td>56.3%</td>
<td>4.9%</td>
<td>64.3%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Closest Provider</td>
<td>33.7%</td>
<td>1.8%</td>
<td>47.0%</td>
<td>4.7%</td>
<td>67.9%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Usual Place To Get Care</td>
<td>7.7%</td>
<td>0.9%</td>
<td>37.9%</td>
<td>4.8%</td>
<td>79.3%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Doctor’s Office Or Clinic Was Not Open</td>
<td>45.3%</td>
<td>1.7%</td>
<td>27.4%</td>
<td>4.5%</td>
<td>23.5%</td>
<td>5.4%</td>
</tr>
</tbody>
</table>

Fig. 1.
Access issues for last ED visit by usual source of care group. The figure depicts self-reported access-based reasons (not mutually exclusive) for last ED visit among American adult ED users. Percentages are adjusted using weights based on the 2010 Census to be nationally representative of the American adult civilian population in 2013. Error bars depict 95% CIs.
Appendix F: Supply of Physicians and NPs in 2010 and 2025

<table>
<thead>
<tr>
<th>Provider type</th>
<th>2010</th>
<th>Percent of total</th>
<th>2025</th>
<th>Percent of total</th>
<th>Percent change, 2010–25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>210,000</td>
<td>71</td>
<td>216,000</td>
<td>60</td>
<td>3</td>
</tr>
<tr>
<td>Nurse practitioners</td>
<td>56,000</td>
<td>19</td>
<td>103,000</td>
<td>29</td>
<td>85</td>
</tr>
<tr>
<td>Physician assistants</td>
<td>30,000</td>
<td>10</td>
<td>42,000</td>
<td>12</td>
<td>37</td>
</tr>
<tr>
<td>Total</td>
<td>296,000</td>
<td>100</td>
<td>361,000</td>
<td>100</td>
<td>23</td>
</tr>
</tbody>
</table>
Appendix G: Demands for Full Time Providers per 10,000 population in Three Models of Care Delivery

<table>
<thead>
<tr>
<th>Model</th>
<th>Number of providers per 10,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse-managed health center</td>
<td>0.8 10.4 0.0</td>
</tr>
<tr>
<td>Patient-centered medical home</td>
<td>6.1 2.2 1.5</td>
</tr>
<tr>
<td>Status quo</td>
<td>6.9 1.7 0.9</td>
</tr>
</tbody>
</table>
Appendix H: Mobile Health Unit Proposal Submission

SONHP Integrated Health Clinic

Mobile Van Initiative

Project Proposal

Criteria:
1. Priority will be given to projects that are inter-professional and/or span SONHP departments and programs
2. Projects MUST include student learning experiences
3. Projects must advance the USF and SONHP vision, mission, and values
4. The financial implications of the project must be considered

Project Name: “Expanding primary care/preventative health to HPSA’s (Health Provider shortage Areas) and high risk communities, through mobile clinic outreach using FNP’s” Date: 9/29/2015

Faculty Champions:
Prabjot (Jodie) Sandhu & Dr. Jo Loomis

Project Goals:
This project aims to identify/screen communities in need of health interventions such as education, referrals, physical exams, immunizations, screenings and other primary care interventions. This is a population health project. By using the mobile van and a collaborative agreement between Dr. Svenson & FNP’s there will be a standardized protocol set up to evaluate certain communities and pilot health based interventions- 1 day a week. The FNP’s will be able to maintain autonomous practice to their full extent with this collaborative agreement and develop a holistic philosophy of care to be delivered through USF that is aligned with the mission and values of the Jesuit community.
The project will provide students at USF with the opportunities of service, community outreach and interaction and a holistic perspective to providing health needs.

Students (FNP, Behavior Health, PSY D, and even CNLS’s) can be involved in these outreach projects as clinical preceptorships or with outcome intervention change projects.

Target Population: Local and rural communities, HPSA’s (Health Provider shortage areas)

Will probably begin with Ella Hutch as an established partnership community that has health based needs.

Location: All/Any to be determined by setting up a community assessment tool that can be used broadly, along with web based research through communities

Student Population (number of students; type of students; nature of commitment; expected time and duration of commitment, etc.)

1-2 FNP faculty per shift- with one to two FNP, or other SONHP students as appropriate for intervention

Student Outcomes:
1. FNP students can obtain clinical hours, develop clinical skills, do community practice, develop and lead DNP projects for USF via community outreach.
2. CNL students can apply educational projects.
3. Behavior health students can assist in health administration tasks and complete their internship/project hours.
4. PSY D students can also obtain hours by attending to psych/mental health community needs.

Faculty Commitment (planning v. implementation; weekly commitment; projected impact on load, etc.)

Jodie is leading the DNP project and will pilot one day a week and further strategize continued efforts and regularity with faculty load.

Currently all FNP are assigned faculty load for precepting students and can have the flexibility to use those hours on this project in rotation.

Financial Considerations:

The staff/students to pilot this project is already in place.

The collaborative agreement can be set up without financial implications.
Risk management at USF will be able to provide a double check on all legal aspects.

Need for specific state licenses and waivers will be researched and costs provided if applicable.

Supplies and equipment that is currently available through LRC and FNP programs will be used.

Additional equipment list can be made after designation of project based on first pilot and actual need > not to exceed $1500.

Grant from the Jesuit fund will be attempted.

Future funding efforts will be made through HPSA- if we can pilot the method and gain access to health service shortage areas on a regular basis.

Project Timeline:

November through February – Pilot project

Evaluation Metrics/Timeframe:

1. Establish a community with a health need in which we can provide a regular service using the Mobile Health Van, using the project timeline.
2. Provide the designated service with satisfactory scores from the community (scoring and quality metrics to be determined)
3. Assess the benefits of the service to the community by direct measurement of given intervention, ie screening leading to proper follow up, education leading to increased knowledge, immunizations leading to higher vaccination rates, health exams leading to proper referrals and gaining access to care.
4. Successful integration of various SONHP departments in providing care to the community through USF mobile health.

Requested Van Access (days, frequency, and hours)

Mondays and or Wednesdays 4-8 hours weekly, possible Saturday
Appendix I: Communication Matrix

**Communication Matrix**

<table>
<thead>
<tr>
<th>Category</th>
<th>Information</th>
<th>Method</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile Health</td>
<td>Project Supervision/Execution</td>
<td>Email/In Person</td>
<td>Semi-Weekly/Weekly</td>
</tr>
<tr>
<td>Dr. Jo Loomis</td>
<td>Project progress, issues, status</td>
<td>Email/Phone/In Person</td>
<td>Semi-Weekly/Monthly</td>
</tr>
<tr>
<td>Dean Wanda Borgess</td>
<td>NP Practice at USF Community Partners</td>
<td>Email/In person/Zoom</td>
<td>Semi-Weekly/Monthly</td>
</tr>
<tr>
<td>Dr. Brian Budds</td>
<td>Project Planning/Implementation/Evaluation</td>
<td>Email/In person</td>
<td>Monthly/As Needed</td>
</tr>
<tr>
<td>Entire DNP Team</td>
<td>Project updates, Progress, Status/Issues/Updates</td>
<td>Email/In person/Zoom</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Legal Risk Management</td>
<td>Legal Questions and Issues</td>
<td>Faculty Practice Guidelines for USF</td>
<td>Through Dean Borgess</td>
</tr>
<tr>
<td>Dean Judy Karshmer</td>
<td>Project Initiation/Development Approval</td>
<td>In person</td>
<td>As needed</td>
</tr>
<tr>
<td></td>
<td>Process Goals Approvals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix J: Gap Analysis

![Gap Analysis Chart]
Appendix K: Sample Standardized Protocol Template

SCOPE OF PRACTICE AND STANDARDIZED PROCEDURES
FOR NURSE PRACTITIONERS

1. PURPOSE: To outline a policy and procedure for requesting approval of Scope of Practice and Standardized Procedures for nurse Practitioners (NPs), as well as define the scope of practice and standardized procedures of the NP's within the [Name of facility].

2. POLICY:

A. This policy gives authorization to NPs and defines the general conditions for implementation of the "Standardized Procedures.""

B. By utilizing their assessment and health care management skills in accordance with the Standardized Procedures, NPs can diagnose, treat, and manage all patient situations to meet the health care needs of the patient.

C. All Standardized Procedures are to be approved by the NP, collaborating physician, Director of the Service Line, Nurse Executive, and the Chief of Staff.

D. The NP and collaborating physician will review the scope of practice and standardized procedures for that NP annually and when modification is deemed necessary. This review will utilize data obtained from the ongoing medical record peer review process. The review will be documented at the time of the annual recertification of proficiency and competency. The Peer review process will be utilized for resolution of disagreements between the Nurse Practitioner and physician.

E. The NP scope of practice and standardized procedures will be renewed every two (2) years.

3. DEFINITIONS: None Necessary.

4. RESPONSIBILITIES:

A. The NP will manage primary, complex, and urgent/emergent medical problems within the primary, secondary, and tertiary care setting, as outlined in this document.

B. The NP is authorized to implement the Standardized Procedures in this document (Attachment A).

C. Physician consultation will be available at all times on site or by telephone.

D. Consultation with a physician will be required:

(1) Whenever situations arise that go beyond the competence, scope of practice, experience of the NP, or the intent of the standardized procedures.

(2) Whenever a patient's condition fails to respond to the management plan in an appropriate time or manner.

(3) For any patient conditions that are uncommon or unstable.

(4) For any patient conditions that do not fit the commonly accepted diagnostic patterns for a disease or disorder.

(4) For any patient conditions that do not fit the commonly accepted diagnostic patterns for a disease or disorder.
(5) For all emergency situations after initial stabilizing care has been started.

(6) For significant unexplained physical, historical, or laboratory findings.

(7) At the request of the patient, nurse practitioner, or physician.

F. Whenever physician consultation is obtained, a notation to that effect, including the physician's name, will be made by the NP in the patient's medical record.

F. NPs will perform these standardized procedures at the \[Enter name of facility\].

G. The NP will be held responsible for the preparation of a complete medical record entry for each patient contact per existing policies.

H. The NP will provide for patient coverage in the case of absence, as needed.

5. PROCEDURES:

A. In addition to basic RN qualifications, each nurse practitioner performing these functions must have the following:

   (1) Advanced education in a university-affiliated NP program or in an accredited university-based master's prepared NP program.

   (2) Current state certification/licensure as an NP.

   (4) Current American Nurses Association or other nationally recognized certification as an NP.

   (5) A furnishing license as an NP in the State of California or a corresponding prescriptive authorization from the state of origin.

   (a) In the State of California, to be eligible for a furnishing license the NP must have completed a BRN-approved pharmacology course and have six (6) months of physician-supervised experience in furnishing drugs and devices.

B. The Credentialing and Privileging Office is responsible for:

   (1) Verification of NP and collaborating physician credentials.

   (2) Verification of competency documentation appropriate to Scope of Practice and Standardized Procedures.

   (3) Processing, tracking, and maintaining Scope- of-Practice files on all NPs.

B. The NP's Scope of Practice and Standardized Procedures will be reviewed and approved by the NP, collaborating physician, Director of the Service Line, Nurse Executive, and Chief of Staff.

6. REFERENCES:

7. REVIEW DATE:

A. \[Enter Date\]
FOR NURSE PRACTITIONERS

Attachment A

This Scope of Practice and Standardized Procedures are for:

_________________________________________ Nurse Practitioner

_________________________________________ (Check applicable items)

1. Definition: Standardized procedures address delivery of care for primary, complex and urgent/emergent medical problems, prescribing practices, and ordering/interpreting laboratory and diagnostic studies.

   A. Primary care is the provision of integrated, accessible health care services by clinicians that are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The nurse practitioner is authorized to diagnose and treat primary care problems as follows:

      (1) A treatment plan is developed, documented and based upon clinical guidelines/pathways and standards of practice.
      (2) All other applicable procedures in this document are followed during patient care management.
      (3) The policies regarding approval, setting, education, evaluation, patient records, supervision and consultation for the Nurse Practitioner are in force.

   B. Complex medical problems are those that fall beyond the scope of management of primary care but do not present as urgent/emergent medical conditions. The nurse practitioner is authorized to diagnose and treat complex medical problems and may practice as follows:

      (1) A treatment plan is developed, documented and based upon clinical guidelines/pathways and standards of practice.
      (2) Management of the patient may be in conjunction with a physician.
      (3) The consultation or referral is documented in the patient’s medical record.
      (4) All other applicable procedures in this document are followed during patient care management.
      (5) The policies regarding approval, setting, education, evaluation, patient records, supervision and consultation for the Nurse Practitioner are in force.

   C. The nurse practitioner is authorized to diagnose and treat urgent / emergent conditions as follows:

      Initial evaluation and stabilization of the patient may be performed with concomitant notification of and/or immediate management by a physician.

      (1) The consultation or referral is documented in the patient’s medical record.
      (2) All other applicable procedures in this document are followed during patient care management.
      (3) The policies regarding, setting, education, evaluation, patient records, supervision and consultation for the Nurse Practitioner are in force.
D. The nurse practitioner is authorized to order, collect and interpret laboratory and diagnostic studies as follows:

1. Laboratory and diagnostic studies may be ordered as appropriate in accordance to clinical guidelines/pathways and standards of practice.
2. Complex and/or invasive studies are ordered/obtained, utilizing physician consultation as appropriate.
3. All other applicable procedures in this document are followed during patient care management.
4. The policies regarding approval, setting, education, evaluation, patient records, supervision and consultation for the Nurse Practitioner are in force.

E. The nurse practitioner may prescribe drugs or devices pursuant to [Enter name of facility], “General Guidelines for Establishing Medication Prescribing Authority”. The nurse practitioner is authorized to prescribe medications or devices as follows:

1. A treatment plan is developed, documented and based upon clinical guidelines/pathways and standards of practice.
2. All other applicable procedures in this document are followed during patient care management.
3. The policies regarding approval, setting, education, evaluation, patient records, supervision and consultation for the Nurse Practitioner are in force.

4. Non-restricted legend and non-legend drugs and pharmaceutical devices, including schedule III through schedule V controlled substances, may be RENEWED within the [Enter name of facility] Formulary. A Drug Enforcement Agency number (DEA#) is required in order for the APN to prescribe controlled substances. In addition, prescribing of controlled substances schedule III will be in accordance with patient specific protocols in agreement with the collaborating physician (attachment C).

5. Non-restricted legend and non-legend drugs and pharmaceutical devices, including schedule III through schedule V controlled substances, may be INITIATED and/or MODIFIED within the [Enter name of facility] Formulary. A Drug Enforcement Agency number (DEA#) is required in order for the APN to prescribe controlled substances. In addition, prescribing of controlled substances schedule III will be in accordance with patient specific protocols in agreement with the collaborating physician (attachment C).

6. Nurse Practitioners assigned to sub-specialty areas are approved to RENEW drugs restricted to the specialty area, in accordance with clinical guidelines/pathways (see attached list).

7. Nurse Practitioners assigned to sub-specialty areas are approved to INITIATE and/or MODIFY drugs restricted to the specialty area, in accordance with clinical guidelines/pathways (see attached list).

F. Specialized Standardized Procedures (attached if applicable).

Recommended Approval:

Nurse Practitioner: ___________________________ Date: ____________

As collaborating physician for the above named Nurse Practitioner, I agree to supervise and regularly evaluate the performance of the Nurse Practitioner.

Collaborating Physician(s): ___________________________ Date: ____________
Appendix L: Outline for Designing Framework

ABNC Community Clinic Model

I. Setup Considerations
   A. Operate as a 501(c)(3).
      a. Organize as a 501(c)(3) OR
      b. Affilite with an existing nonprofit- 501(c)(3)
   B. Services Offered
      a. Primary: non-life threatening, minor injuries and illnesses, provide pharmacy services and referral program
      b. Mental and Behavioral health: screening, diagnosis, treatment, case management and health counseling
   C. Staff and personnel
      a. Volunteer, Licensed, Non-licensed
   D. Funding and Support
      a. Sponsorship- affiliated with other organizations and community foundations
      b. Fundraising- Charitable donations, organized under IRC Section 170 (a)
      c. Grants- major source of funding
      d. Unrelated Business Income- can be taxed, but permissible
      e. Donated Supplies- Written acknowledgement for any donation over $75, Donor must get receipt if claiming anything over $250
      f. Exchange of services- clinic provides service to another organization in exchange for something
   E. Articles and Bylaws
      a. Organizing Document- Registered location, service, description of operation, board of directors, personal liability, duration of existence and how to distribute assets upon dissolution
      b. Bylaws- formal rules under which an organization operates- day to day operational procedures
         i. General Information- Type of entity, place of business and 501c3
         ii. Members- other than the board of directors, list members, duties and rights
         iii. Board of Directors- makeup, powers, titles and duties, process of election etc.
         iv. Meetings- describe board meetings
         v. Committees-
vi. Amendments to Bylaws procedure

F. Medical Director
   a. A person who provides clinic oversight

G. Applying for tax Exempt Status
   a. Form 1023
   b. Schedule A

II. Clinical Operations

A. Licensing a free/community clinic in CA

Primary Care Clinic - Community or Free Clinic (Including Mobile Clinic) CDPH WEBSITE

Required Forms to be licensed:

- Licensure & Certification Application: HS 200
- Title 24 Building Requirements: In lieu of a letter from a licensed architect, the licensed architect may use the attached form, “Certification Form For Clinics and Freestanding Outpatient Clinic Services of A Hospital”. (PDF)
- Applicant Individual Information: HS 215A (PDF)
- Administrative Organization: HS 309 (PDF)
- Transfer Agreement Between: HS 602 (PDF)
- Fire Safety Inspection Request: STD 850 (PDF)
- Civil Rights Compliance Review (Title VI, Section 504, ADA): DHCS 1051 (PDF)

Required Forms to be certified with Medicaid/Medi-Cal:

- Application for Medi-Cal Certification as a Primary Care Clinic Provider: HS 269 (PDF)
- Notice - Effective Date of Provider Agreement: HS 328 (PDF)
- Medi-Cal Provider Agreement: DHCS 9098 (PDF)

B. Operations
   a. NP managed clinic requirement
      i. Collaborating Physician
      ii. Standard Operating Procedures
      iii. Malpractice Documents and Coverage
      iv. Clinic Protocols and Procedures
b. Space Considerations
   i. Lease
   ii. Rent
   iii. Share community site
   iv. Follow ADA laws

c. Employees
   i. Training Program
   ii. Volunteer Clearance, Program
   iii. Background checks
   iv. Employee Handbooks
   v. Job Descriptions

d. Running the clinic
   i. Good Samaritan Statute
   ii. Property and Casualty Insurance
   iii. “Slip and Fall” insurance
   iv. Worker’s Comp Coverage
   v. OSHA
   vi. Equipment Insurance
   vii. Crime insurance
   viii. Hours of Operation
   ix. Interpreters
   x. Patient records (EMR)
   xi. Terminating the patient relationship laws
   xii. Drug Management (Donation vs Prescription & Distribution, Security)- Contact with commercial pharmacies for drug programs
   xiii. Patient privacy (HIPAA)
   xiv. Mandatory Reporting Guidelines
   xv. Exchange of records policies
   xvi. CLIA lab setup and policies

e. Quality Care and Safety
   i. Supervisory structure
   ii. Staff Meeting and continued training
   iii. Coordination of care
   iv. State Peer review laws for medical records
   v. Medical record safety

f. Education and Marketing
   i. Identify marketing needs and strategies
THE ACADEMIC BASED NURSING CENTER IN CALIFORNIA

Operational Framework
Resources for Framework

The efforts behind the operational framework outlined in this toolkit are a compilation of information from two credible resources for health centers. One guidebook helps navigate information regarding the free and community clinic model in California and is published in part by the American Medical Association Foundation (AMA) and American Health Lawyers Association (AHLA). The second is a published book, “Nurse led health clinics, Operations, Policies, and Opportunities”, by Hansen-Turton, Sherman, & King, leaders in the Nurse Managed Health Center movement.

These resources can be found at:

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Business Checklist ..............................................................................................8
Legal Checklist ..................................................................................................9
Organization Checklist .......................................................................................10
In an effort to increase access to care in underdeveloped areas, the first nurse managed health centers, can be dated back to the 1850’s.

The Academic Based Nursing Center (ABNC) is a model of healthcare delivery designed to promote increased access to care, fulfill the community service mission of the academic institution, engage advanced nursing faculty in clinical roles, and serve as an educational model for nursing students.

The ABNC can face many challenges in light of restrictive Advanced Practice Nursing (APN) regulations, identifying sustainable partnerships, and procuring operational funding.

This operational guide offers an overview of the business and legal directives, to consider when implementing the ABNC.
The Academic Based Nursing Health Center Model

Academic Based Nursing Health Centers, also known as ABNC’s, or Nurse Managed Health Centers (NMHC’s) are a longstanding part of our healthcare system. Traditionally built and designed to increase access to care, address public health shortage issues, and integrate the experienced nurse to meet healthcare demands, these centers have continued to grow and expand over the last 80 years.

The Nurse Practitioner (NP) is a vital component and heart of the ABNC. State to state regulation variances for this profession, have either allowed tremendous growth in nurse managed care, or hindered access to care within this model. In California, NP’s are not recognized as primary care providers and do not have legal protection to independently operate a NMHC. While there is an increasing opportunity for the NP profession to help advance primary care, increase access in areas of shortage, and delivery competent care to the underserved, there are many legal and regulation barriers.

One of the models of care delivery that has potential benefits to healthcare and education is the academic based nursing health center model. While NP’s are clinical professionals, they are also needed in academia as faculty and educators in Schools of Nursing across the nation. Their dual role as clinicians and educators offers the opportunity to establish faculty based clinical practice and use the practice to educate students. A viable model for ABNC’s in California, is a physician and NP collaborative care model. Because NPs require oversight by the physician to deliver care in California, it is imperative to help support and strengthen this model using appropriate regulatory guidance and structure.
Establishing the Academic Based Nurse Health Center

The process of establishing an ABNC requires many steps. An overview of the necessary components is outlined in this algorithm.
Initiating an ABNC requires studying the landscape in which the Academic center and community partner is going to function. The first step in preparing for this journey is to complete a thorough needs assessment of the community. Determining what services and in what area they are required is essential in forming a lasting community partnership. Both organizations have a vision and mission and identifying each’s values and expectations is a critical process for sustainability. Here are some questions to consider in early conversations of the ABNC model.

**ABNC Startup Checklist**

1. Identify the objective of initiating the ABNC.
   a. Who is being served?
   b. What is the mission?

2. Identify the goals that will meet this objective as an academic and community partnership.
   a. What are the needs of the academic institution?
   b. What are the needs of the community?
   c. Do they align?

3. Who is involved?
   a. Identify all stakeholders and secure support

4. Procure funding
   a. What funds are available?
   b. Will you need to secure additional resources?
   c. Are these funds sustainable?

Needs Assessment Tools:

1. [http://strengtheningnonprofits.org/resources/guidebooks/Community_Assessment.pdf](http://strengtheningnonprofits.org/resources/guidebooks/Community_Assessment.pdf)
2. [https://coast.noaa.gov/needsassessment/#/](https://coast.noaa.gov/needsassessment/#/)
Identify Funding

The Academic Based Health Model can be supported in many different ways. The success of the ABNC lies in the structure of organization. The ABNC’s are generally operated under the nonprofit model as community centers, free clinics, or by becoming licensed as federally qualified health centers (FHQC’s). Funding and support for the ABNC is the key factor in sustainability given the dual role of education and community partnered health centers.

Some options for funding include:

1. Sponsorship or Community Partnership Model
   a. The joint and collaborative partner model of an academic institution and a community based organization is the most effective model for serving underserved populations. Developing a relationship with a faith-based group, hospital organization, and community partner may offer financial, space, and access benefits.

2. Fundraising
   a. The support of a clinic or health center as a community based need usually lacks government support. While there are possibilities for grants and funding in some areas, the work behind this can be deterrent. The academic center however may engage the community through annual fundraisers and donations from community based businesses, foundations, and other agencies.

3. Grants
   a. Grants from various federal and business agencies can aide in the funding that will establish the ABNC. A typical grant process will require preparation of a proposal of the service and a budget. A great site for federal grants, is Grants.gov

4. Donations
   a. Accepting donations for supplies and products is a great way to gather start up material. The academic center may choose to reach out to local hospitals, equipment and supply companies, and offices to find goods and sometimes even donated services such as marketing, radiology, pharmaceutical supplies, and brochures.
Procure Support

Support for an ABNC must come not only from within the organization but also the community in which it wishes to be involved in. While the academic institution must have internal conversations to procure support for this project, including involving various departments from the Schools of Nursing and other Health disciplines, Education, Social Justice, Technology, and Business departments with whom is chooses to collaborate and of course the member that will be immediately involved in clinical and educational duties.

Considerations:
1. Speak with the Nursing Department and gather support for the health center. Be clear about outcomes, goals, resources, advantages and disadvantages.
2. Speak with other health disciplines within the school to integrate care.
3. Approach various schools within the academic center to find resources for incorporating other students in the model of education and healthcare.
Business Checklist

Considerations for the initiation of an Academic Based Nursing Center include identifying the key business regulations. Most academic institutions in California are either nonprofit, private, or state funded programs. The most common method of starting an Academic Based Nursing Center is to organize as a free or community clinic, or affiliate with a nonprofit organization, under a tax title for nonprofits, named 501(c) (3).

The business entity must also pursue:

1. Recognition of a Vision or Mission
   a. Create a Vision and Mission statement to reflect the goals of the academic institution and community health needs.

2. Determine the services to be offered
   a. Determine what type of health services will be offered: primary, screening, education, referral, intervention, urgent, etc.

3. Develop Articles and Bylaws
   a. Establish a Board of Directors – this is the governing body which will make decisions for the organization. A well rounded body would include, a Chair, a Vice Chair, a secretary, and a treasurer. Job descriptions for board members and duties within state regulatory rules are essential. Tools for enacting Boards and governance in California can be found on the Department of Human and Health Services Office of the Inspector General website.
   b. Create Organizing Documents- describes the registered location, services offered, description of operations, list of board of directors, distribution of assets
   c. Institute Bylaws which are formal rules guiding the day to day principles of the organization

4. Establish a Medical Director or Chief Medical Officer
   a. The ABNC in California, must identify a medical director, who may also be the physician providing oversight to the clinic.

5. Other Business Requirements
   a. Obtain a EIN number
   b. Apply for Tax Exemption
   c. Obtain licensing as a community or free clinic from the California Department of Public Health (CDPH)
   d. Complete application as a Medi-Cal/Medicaid provider if serving this population from CDPH
Legal Checklist

In the state of California, NPs function under the supervision and collaboration model. The standardized procedure (SP) is a legal document which outlines the care a NP can provide in collaboration with a physician. While the supervision does not have to be physical and onsite, the SP serves as the legal agreement under which manner the supervision, delivery of care, and collaboration is achieved.

The Board of Nursing (BRN) in California clearly lays out the requirements for this legal document with 11 mandatory objectives and they can be found at:


For a nominal fee, NPs can find adaptable protocols for the use in a SP agreements in a workbook style online, by Rebecca Zettler, located at: http://processprotocols.com/about/

To function as a NP in California these are the basic requirements:
1. Meet all educational requirements in California and be licensed by the Board of Registered Nursing
2. To furnish drugs in California, the NP must possess a furnishing license under the BRN
3. Function in accordance with SP guidelines
To ensure that the NP practicing in California is adhering to state regulations it is important to stay up to date with the BRN practice requirements. These can be found at

http://www.rn.ca.gov/regulations/np.shtml

Organizational Checklist

The operation of a health center is a large scale task. Here you will find and outline for all the important matters:

1. Clinic Initiation
   a. Clinic Tools
      i. Clinic Policies and Protocols
      ii. Mandatory Reporting guidelines
      iii. Patient privacy law policies
      iv. Policies regarding terminating patient relationships
      v. Exchange of records policies
      vi. Drug Management if prescribing or dispensing samples
   b. Space Considerations
      i. Rental Agreements
      ii. Lease Agreements
      iii. Community Site Agreement
      iv. Nurse without Walls (Freestanding model)
   c. Employees
      i. Faculty
      ii. Staff
      iii. Volunteer or Paid
      iv. Job Descriptions
      v. Employee Manuals
   d. Day to Day operations
      i. Good Samaritan Statue Protection
      ii. Property and Casualty Insurance
      iii. “Slip and Fall” Insurance
      iv. Workers Comp requirements
      v. Occupational Safety and Health Administration (OSHA) requirements
         https://www.osha.gov/
      vi. Equipment Insurance
vii. Crime Insurance  
viii. Hours of Operation  
 ix. Interpreters  
x. Electronic Health Records  
 xi. Lab supplies and setup, including Clinical Laboratory Improvement Amendments (CLIA) waivers and licensing http://wwwn.cdc.gov/clia/  

e. Quality Care and Safety  
   i. Coordination of Care protocols  
   ii. Medical Record Safety  
   iii. Benchmarking protocols  
   iv. Staff meetings and continued training programs  
   v. Peer review laws for medical records  
   vi. Quality program review  

f. Marketing  
   i. Establish tools for marketing of the clinic
## Appendix N: SWOT Analysis Academic Based Mobile Health for USF

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ability to increase access in settings of shortage due to mobility of practice</td>
<td>1. Lack of sustainability models</td>
</tr>
<tr>
<td>2. Expand NP ability to practice in collaborative vs restrictive setting</td>
<td>2. Innovation rather than proven concept for USF</td>
</tr>
<tr>
<td>3. Dean support</td>
<td>3. Lack of knowledge/experience in management of Clinic Operations</td>
</tr>
<tr>
<td>4. Huge population in SF to reach</td>
<td>4. Connectivity to internet in remote areas</td>
</tr>
<tr>
<td>5. Have access to a mobile health unit</td>
<td>5. Access to space in various communities for a mobile health van</td>
</tr>
<tr>
<td>6. Low overhead with mobile unit related to lack of brick and mortar costs</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Provide care through an academic based NP managed healthcare practice</td>
<td>1. Funding</td>
</tr>
<tr>
<td>2. Expand as mobile practices to other areas</td>
<td>2. Time constraints to get approvals for licensing and permits to operate</td>
</tr>
<tr>
<td>3. Health Promotion, Education, expand model to other schools of health within USF</td>
<td>3. Lack of buy in from all shareholders</td>
</tr>
<tr>
<td>4. Expand services to insured patients in the area and collect revenue.</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix O: Cost Benefit Analysis Template

### Cost Benefit Analysis Template for ABNC Model

<table>
<thead>
<tr>
<th>Costs</th>
<th>Category</th>
<th>Item</th>
<th>Quantity</th>
<th>Price</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site</td>
<td>Mobile Health Unit</td>
<td>1</td>
<td>75,000-150,000¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Site</td>
<td>1</td>
<td>Rent/Lease/Buy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse without Walls</td>
<td>1</td>
<td>Tent setup</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>Examination Kits²</td>
<td>1</td>
<td>Depends of level of service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CLIA Testing Supplies³</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>First Aid Kit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Supplies⁴ (Office, Utility)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital Equipment</td>
<td>Customization of Van if Mobile Unit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Exam tables, Workstations)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Exam Table for other Sites</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tent/Room Dividers/Privacy Curtain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Laptops</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Software (EMR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Practice Fusion or Kareo (free)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Forms and Documents/Brochures/Printing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location Based Expenses</td>
<td>Licensing Fees (Van)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>State Public Department License</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hazardous Waste Disposal</td>
<td>Liability Coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vehicle/Building Maintenance</td>
<td>Marketing Costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative Costs</td>
<td>Physician</td>
<td>1</td>
<td>Volunteer</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NP/Faculty</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Project Manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Driver (Mobile Unit)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Risk Management Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Malpractice, Liability, Workman’s comp)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Costs**

**Benefits**

1. Reduce ER visits
2. Increase faculty practice site
3. Student clinical sites
4. Health promotion and education in the community
5. Cost of care reduction
6. Value of increasing access to care

**Total Benefits**

1- Quotes for pricing based on research of used and new mobile health units ([http://www.mobilehealthcareauthority.com/vehicles/185.html](http://www.mobilehealthcareauthority.com/vehicles/185.html))
2- Exam kits includes, stethoscopes, otoscopes, reflex hammer, penlight, tuning fork
3- CLIA testing kits may include urine dipsticks, pregnancy test, and rapid strep
4- Other includes office supplies such as paper, pens, staples, paperclips etc., and utility supplies such as hand towels, sanitizer, cotton balls, Band-Aids, tongue blades, all as appropriate to scope of service.
### USF MOBILE CLINIC OPERATIONAL BUDGET

#### STARTUP EXPENSES

<table>
<thead>
<tr>
<th>Mobile Health Unit</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchase price</td>
<td>75,000-150,000</td>
</tr>
<tr>
<td>Customization of new unit</td>
<td>10,000-30,000</td>
</tr>
<tr>
<td><strong>Total Liability</strong></td>
<td><strong>$180,000</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Available Mobile Health Unit</th>
<th>Total Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>($180,000)</td>
</tr>
</tbody>
</table>

| **Total**                    | **$0.00**     |

#### Medical Equipment

<table>
<thead>
<tr>
<th>Item</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Examination Kits (Vital Signs equipment, Penlights, Reflex Hammers, Otoscopes, Ophthalmoscope, Pulse oximeters)</td>
<td>$500.00</td>
</tr>
<tr>
<td>Disposable Supplies (tongue blades, cotton balls, swabs, Band-Aids)</td>
<td>$100.00</td>
</tr>
<tr>
<td>CLIA Waived Testing supplies Urine Dipsticks/HCG Dipsticks/Rapid Strep/Urine cups</td>
<td>$100.00</td>
</tr>
<tr>
<td>First Aid Kits (2)</td>
<td>$50.00</td>
</tr>
<tr>
<td>Other Supplies (lightbulbs, paper towels, office supplies (pens, paper, staples, clipboard, paperclips, etc.), toilet paper, Lysol wipes, batteries)</td>
<td>$100.00</td>
</tr>
</tbody>
</table>

**Total Medical Equipment Liabilities**: $850.00

**Shared usage on medical equipment with USF FNP lab**: ($600.00)

**Total**: $250.00

#### CAPITAL EQUIPMENT LIST

<table>
<thead>
<tr>
<th>Item</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam table (2) Included in van</td>
<td>$0.00</td>
</tr>
<tr>
<td>Refrigerator (included in van)</td>
<td>$0.00</td>
</tr>
<tr>
<td>Kareo Software EMR (FREE web based)</td>
<td>$0.00</td>
</tr>
<tr>
<td>Item</td>
<td>Amount</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Laptops (2)</td>
<td>$750.00</td>
</tr>
<tr>
<td>Chairs and workstations (built into mobile van)</td>
<td>$0.00</td>
</tr>
<tr>
<td>Other Forms/Documents/Printing Fees</td>
<td>$250.00</td>
</tr>
<tr>
<td><strong>Total Capital Liabilities</strong></td>
<td><strong>$1,050.00</strong></td>
</tr>
<tr>
<td><strong>Shared usage with USF Faculty Lines</strong></td>
<td><strong>($850.00)</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$0.00</strong></td>
</tr>
<tr>
<td><strong>LOCATION EXPENSES</strong></td>
<td></td>
</tr>
<tr>
<td>Vehicle registration</td>
<td>$0.00</td>
</tr>
<tr>
<td>Hazardous waste disposal (through current contract at USF lab- not to be billed separate)</td>
<td>$0.00</td>
</tr>
<tr>
<td>Permits and other fees (based on location and to be determined)</td>
<td>$0.00</td>
</tr>
<tr>
<td>Workman comp insurance (through USF faculty/student contract)</td>
<td>$0.00</td>
</tr>
<tr>
<td>Mobile Van Use (Current Driver Salary) $50/hr x 6 hours (once weekly)</td>
<td>$15,600</td>
</tr>
<tr>
<td>Community site Access Fee (Parking)</td>
<td>$0.00</td>
</tr>
<tr>
<td><strong>Total Location Liability</strong></td>
<td><strong>$15,600 + unknown fees and permits based on location</strong></td>
</tr>
<tr>
<td><strong>Administrative Cost</strong></td>
<td></td>
</tr>
<tr>
<td>Faculty Salaries (NP, Physician Oversight)</td>
<td>Volunteer MD/Faculty NP</td>
</tr>
<tr>
<td>Billing Services not needed at this time</td>
<td>$0.00</td>
</tr>
<tr>
<td>Maintenance (Cleaning, Stocking) –Done by Faculty and students</td>
<td>Volunteer staff</td>
</tr>
<tr>
<td>Project Management (DNP Student)</td>
<td>Volunteer Admin and Student</td>
</tr>
<tr>
<td>Risk Management (USF Risk Management Department)</td>
<td>$0.00</td>
</tr>
<tr>
<td>Legal Fees (Drafting additional documents and overview) $250.00/hr x 8 hours</td>
<td>$2,000.00</td>
</tr>
<tr>
<td><strong>Total Admin Liability</strong></td>
<td><strong>$2,000.00</strong></td>
</tr>
<tr>
<td>DNP Student Work (Project Manager/Maintenance/ Faculty position) MD supervision is volunteer</td>
<td>Total Admin Assets</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADVERTISING AND PROMOTIONAL EXPENSES</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>USF to seek community partnership model</td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>Total $0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER EXPENSES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reserve for Contingencies/Risk</td>
<td>$5,000.00</td>
</tr>
<tr>
<td></td>
<td>Total $2000.00</td>
</tr>
<tr>
<td>Total Operational Budget for Year 1</td>
<td>$22,850</td>
</tr>
</tbody>
</table>