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DNP Project: Development of a Nurse-Led Pop-Up Clinic Model in San Diego

Jennifer King
jkking4@dons.usfca.edu

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Jennifer King MSN RN CNS PHN

University of San Francisco

Jo Loomis DNP RN FNP-C CHSE NCMP CNL
Chair
Juli Maxworthy DNP MSN/MBA RN CNL CPHQ CPPS CHSE FSSH
Committee Member

Section I: Acknowledgement & Abstract

Acknowledgements

I am grateful for the opportunity of furthering my nursing education at the University of San Francisco. The faculty have served as incredible mentors who have inspired me to stretch my heart and mind beyond expectations. I want to express my deepest appreciation for Dr. Jo Loomis and Dr. Juli Maxworthy for their commitment to see my project through. The patience and grace they extended me during my own health challenges is what carried me to completion. For the past two years, I have lived one course at a time—supported by an incredible tribe of family, mamma friends, and my husband. I have taken many long walks listening to lectures, zooming with my peers and faculty to engage in this gift of education. This project has been a work of passion and perseverance. I began with grand visions of what I would do to change the world but was quickly humbled by the scale of this project. I was gently and wisely reminded that I am not supposed to change the world in one single project. My vision will become an evolving work that will likely shape the next half of my career. I never imagined I would join the ranks of being a DNP, but I always knew I would leave a legacy by honoring my chosen vocation of nursing. I love being a nurse and no matter what letters come after my name, I will care for every patient, student and human being I meet as a child of God. I ask for grace and prayer from all as I quest for greater knowledge, and the wisdom to help shape a healthcare system that meets the needs of every individual in this country. James 1:2♥

Abstract

Baccalaureate nursing programs across California (CA) are required by the state board of nursing to provide theory of public health and applied clinical learning to meet the requirements of the state's public health nurse (PHN) certification. Students in Bachelor of Science in Nursing (BSN) programs are expected to enter the workforce prepared to address population health needs that synthesize community-based assessment and understand epidemiologic approaches to strategize interventions in diverse populations at the local, state and national levels. To adequately prepare nurses for true population health practice, clinical experiences need to be in appropriate settings where they can apply theory to practice and experience interacting with vulnerable patient populations. Opportunities for interprofessional collaboration and multi-sector system partnerships are essential to preparing BSN graduates for the workforce. Give the growing trends in nursing education to meet the Institute of Medicine recommendations to prepare thirty percent more nursing graduates with BSN as the point of entry to practice by 2020, the competition for clinical placements has accelerated. Parallel to this problem is a growing homeless population across CA. The county of San Diego has become the fourth-largest homeless population in the United States (U.S.), growing at a nearly 10% increase annually. This is a local crisis requiring cooperation at all levels of public and private sectors to unite and develop innovative solutions to address the humanitarian needs of those affected. Preparing nurses who understand the historical, ethical and unique healthcare needs of this population is imperative to solving this urgent situation. An innovative approach to meeting the needs of BSN students and individuals experiencing homelessness with unmet healthcare needs is to provide nurse-led pop-up clinics within the homeless community of San Diego. This upstream approach brings students to the patients where they are. Students gain intimate experiences with diverse

patients in community-based settings working alongside community partners to develop public health skills. This authentic immersive experience not only meets the competency requirements for the CA PHN certification but serves to support the multi-disciplinary actions needed to address the homeless crisis in San Diego. This paper outlines the development and implementation of a pop-up clinic model led by Point Loma Nazarene University School of Nursing beginning in 2019.

Keywords: nurse-led clinic, homeless, clinical hours.

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Section II: Introduction

Background Knowledge

Nursing is deeply rooted in service to the poor, underserved, broken and most vulnerable members of our society. From Florence Nightingale's diligent work developing hygiene practices and a nursing school to train graduates of the importance of *"ordinary work"* while caring for ill patients in their homes, to the foundational organizing of Lillian Wald and Mary Brewster in the late 1800's crowded ghettos of New York City, these nurses recognized the linkage between nursing care, social justice and public health (Keeling, 2006). The early role of nursing in the community was focused on primary and secondary prevention interventions. Though Nightingale, Brewster and Wald often provided tertiary care with treatments using medicines, salves and other tinctures of the period, they rarely called attention to these activities in their work. They highlighted the importance of sanitation, nutrition, shelter, social support, education and spirituality. They also recognized that disease is not the only element that causes suffering. This visionary approach led to Wald and Brewster's creation of the Visiting Nurses Association in 1893. This was the beginning of nurse-led, community-based interventions. They were responding to their own collection of epidemiological data to address the health inequities they observed between the rich and poor and the need for care to be accessible to all (Keeling, 2006).

This early understanding of how social determinants influence health has guided nursing professional practice into the modern era. The Nurse Practitioner (NP) role established in the 1960s was in response to the need for increased primary care access for more vulnerable populations including children. Education for NP practice includes understanding social issues and how diversity influences health behaviors (Van Zandt, Sloand, & Wilkins, 2008; Waite,

Nardi, & Killian, 2013). This humanistic approach to care is why nursing has continued to play a vital role in extending care to uninsured and underinsured populations in modern healthcare delivery systems. Academic nurse-managed health centers are a shining example of how high-quality, efficient care can be delivered to diverse populations. These community-based settings provide a teaching-learning environment to hone critical clinical skills for nursing students while engaging patients holistically to address social and wellness needs. Collaboration with academic nursing and allied health programs provides a rich environment for student engagement outside of the mainstream healthcare system. The focus on health promotion and understanding of social determinants of health is what makes these practice settings ideal for addressing the unique health needs of vulnerable populations. The United States alone has more than 250 nurse-managed health centers, and literature supporting the use of academic-based, nurse-managed health centers is growing (Van Zandt, Sloand, & Wilkins, 2008; Waite, Nardi, & Killian, 2013).

The National Academies of Medicine's publication *For the Public's Health* in 2012 called for public health reform that includes greater collaboration among community-based providers and more development of effective population-based interventions that address complex care needs (The National Academies of Science, Engineering, Medicine, 2012). Innovative approaches to address the challenge of integrating social, socioeconomic, science and medicine are needed to transform our current healthcare system. Development of more nurse-led centers provide opportunities for schools of nursing to support this endeavor and grow socially conscious clinicians prepared for population-focused care (Pilon, et al. 20215; Van Zandt, et al. 2013).

The Regional Nursing Problem

There is a steadily increasing demand for pre-licensure Registered Nurse (RN) clinical placements in California that is exceeding current acute care capacity for pre-licensure Associate Degree Nursing (ADN), Baccalaureate Science Nursing (BSN) and Entry Level Masters (ELM) nursing programs and students (Health Impact, 2019). Over the past decade, enrollment in RN-BSN programs has increased ten percent (BRN, 2017). Partnerships between ADN programs and BSN education has added 3,000 more graduates annually since 2007 (BRN, 2017).

The California BRN requirement to satisfy the Public Health Nursing (PHN) certification specifies that 90 clinical hours are earned in a public health setting. According to the California business and professions code 1491, article 2818, public health nursing requires training in areas that prepare the nurse to care for communicable diseases, family health, prevention of abuse and neglect, and care coordination for families and communities (CA-Legislature, 1992). Clinical settings that provide these training opportunities are limited and remain in high demand for schools to meet CA BRN certification requirements.

This increase in graduates of BSN programs coupled with tightening of clinical site availability by healthcare organizations already overwhelmed by placement needs has resulted in tension among schools in some regions of California (Health Impact, 2019). Operationally, healthcare systems and academia must work more closely together to meet the dynamic preparation needs of patients in both acute and community-based settings to achieve quality delivery of care from new graduate nurses (Health Impact, 2019).

There is regional competition furthering this problem in San Diego. There are five schools of nursing and allied health graduating nearly 1,000 RNs annually. San Diego’s regional presence as a national border county of 3.3 million residents makes it the second-most populous

county and the second-largest public health agency in the state. According to the 2017 Health Impact data, graduation rates have provided a well-balanced labor market with RNs seeking local employment (Health Impact, 2018). However, in a 2018 report by the California auditor's office, the county health agency has consistently operated above benchmarks for their PHN to patient ratios. San Diego is budgeted for 192 PHN positions in 2018, but have only 163 filled (CA State Auditor, 2018). They have reportedly struggled to hire enough appropriately trained PHNs to fill vacant positions. Training demands of the public health sector have increased to meet the complexity of health issues faced by at-risk populations. Without enough existing PHNs to train new graduates in preceptorships, the pipeline of adequately trained nurses has slowed (Health Impact, 2019).

The San Diego Nursing and Allied Health Service and Education Consortium (SDNSEC) places pre and post-licensure students from schools across the county into 148 approved clinical sites (SDNSEC, 2018). Of the over 7,000 placements they complete, there are only two public health agencies for placement to meet the needs of the five BSN Programs. RN-BSN programs are also required to satisfy the California Board of Registered Nursing PHN guidelines. This body of students are licensed RNs who are typically new graduates working full time in a new position while attending night classes to fulfill their BSN degree. Approximately 700 BSN students in San Diego County seek clinical placements each year at only two approved sites (M. Reece, personal communication, May 2, 2018). Each PHN consortium site accepts a limited number of students per semester, leaving a gap of nearly 400 students without a designated PHN clinical site annually (SDNSEC, 2018). With so many traditional undergraduate BSN students left to be placed, the consortium continually votes against inclusion of RN-BSN programs.

At Point Loma Nazarene University (PLNU) in San Diego this author serves as course coordinator for public health programs in the School of Nursing. In response to the Institute of Medicine's 2010 Report on the Future of Nursing goal of advancing the number of BSN prepared nurses from 50% to 80% by 2020, PLNU started an RN-BSN program in the Fall of 2015 (IOM, 2011). This program has grown from 52 graduates per year to 257 BSN graduates in 2018. As of January 2019 there are 125 students enrolled who will graduate by May 2020. This program is in addition to the university's well-established traditional BSN program which produces an average of 90 graduates annually (M. Riingen, personal communication, September 1, 2018).

Without the support of the SDNSEC, the RN-BSN program must actively seek out community partners who serve in a public health capacity and are willing to take on student preceptees. This has become a growing challenge as other RN-BSN distance learning programs compete with the local brick and mortar nursing institutions in the region. Community agencies are already stretched to serve their population needs with limited resources. Though many programs working to meet the health needs of vulnerable San Diegans like the idea of collaborating with a school of nursing, they may not be able to see how the nursing role fits within their organizational model.

Current practice for providing clinical hours to RN-BSN students at PLNU is inconsistent. Depending on the size of the cohort(s), students will attend tours of public health facilities, attend community health fairs, volunteer as medical support for local sporting events, provide immunizations at sponsored flu clinics, serve meals at soup kitchens or serve alongside non-clinical staff at a facility for developmentally delayed adults. Many activities are seasonal with limited capacity for volunteers.

Each semester clinical experience varies within cohorts. Students have seven weeks to complete their clinical hours during the public health theory course. In the existing model, students often struggle to meet the required hours utilizing the various clinical opportunities. PLNU has attempted to mitigate this problem by allowing students to complete PHN service hours throughout the program. This poses a curricular challenge for students who have not yet taken the public health didactic course, as they are not able to tie the clinical learning outcomes to their experience.

Commission on Collegiate Nursing Education (CCNE), the accrediting body for schools of nursing, requires clinical experiences to be tied to course learning outcomes that are standardized and aligned with American Association of Colleges (AACN) of Nursing BSN essentials for all graduates of a BSN program (CCNE, 2019). Leadership within the PLNU School of Nursing (SON) have spotlighted discrepancies within the PLNU SON programs for PHN clinicals following the SON accreditation visit in Spring 2018 (M. Riingen, personal communication, September 1, 2018). This has further prompted the SON to improve the method for clinical placements and ensure consistency of clinical experiences for all graduates.

Traditional undergraduate BSN students at PLNU participate in the local nursing consortium and are placed at SD County Public Health clinics with a PHN or at a San Diego Unified School District site with a school nurse. Those students are guaranteed placement hours to meet the CA PHN certification requirements. This provides consistent clinical outcomes and linkage to course learning outcomes of the theory course.

The university also operates an academic nurse-managed health center in an urban, low income region of San Diego. The PLNU “Health Promotion Center” (HPC) is a CA designated “Free and Charitable” primary care clinic run by SON NP faculty and undergraduate nursing

students serving uninsured and underinsured individuals. The clinic is embedded in a multi-cultural church that also serves as a Food Bank of San Diego distribution site. Primary care, mental health care, and complex care in collaboration with community partners and dental services are offered. Students have been volunteering here as part of their community clinical rotations since 2000. Due to the limited schedule of the clinic hours, other levels of students within the school of nursing have been excluded from participating. The clinic relies on limited general university funds and a mix of grant funding, which has limited expansion of their services to include more hours of care (M. Rowe, personal communication, February 11, 2019).

Specific Aims

To meet both the needs of students seeking their PHN certificate as well as the regional demand for RNs prepared to care for at-risk populations in San Diego, this proposal aims to demonstrate the value in developing nurse-led clinics for PLNU. The free clinic model supervised by clinical faculty, led by graduate nursing students and staffed by RN-BSN students would expand the provision of care for vulnerable populations and meet clinical preparation needs of BSN students receiving PHN certification. This model can be developed and implemented within one year to meet impending placement needs. This intermittent clinic location would further expand clinical site placements, while providing authentic teaching-learning opportunities for students seeking PHN employment in San Diego.

The aim of this project was to develop a nurse-led clinic model to be implemented by summer of 2019, and to evaluate the utility of this model in fulfilling clinical placements for RN-BSN students to meet CA BRN PHN certification requirements. The proposed evidence-based quality improvement project was formally submitted to the author's chair per the University of San Francisco's Doctor of Nursing Practice guidelines in Appendix A.

Available Knowledge

Utilizing the Melnyk's evidence-based practice framework, a PICOT question was formulated (Melynk & Fineout-Overholt, 2015). *For BSN Nursing students in San Diego, do weekly nurse-led free community clinics provide appropriate clinical experiences to meet PHN competency compared to students' independent volunteer experiences?* (See Appendix B)

A review of the evidence was conducted searching PubMed, CINAHL, and Cochrane databases. National websites explored included the National Healthcare for the Homeless Council (HCH), Institute of Medicine (IOM) and Healthy People.gov. The initial search used keywords: *free clinics; nurse led; homeless; indigent; community clinics; community nursing; mobile clinics.* The initial search yielded 1,208 articles. A brief review of articles revealed the need to narrow the search terms to encompass more community-based clinics. Subject headings were then utilized to further drill down the results. The subject headings *nurse managed centers; homeless persons; community health; indigent healthcare* resulted in more relevant evidence.

An imposed limitation on publications between 2008-2018 generated 133 articles. Articles from non-western countries were excluded to maintain appropriate cultural representation of studies. Further limitations to include only peer reviewed journals was imposed. The final search yielded 22 articles. Selections for this paper were chosen based on a careful review of the outcomes and relevance to nurse-managed community clinics. Upon initial review of the evidence, the author noted relevant citations available to provide historical context dating back to the 1980s. A movement between the late 1980s and early 2000s provided valuable source material to understand the value of nurse-managed clinics. These were included to complete the body of evidence. Quality of evidence was then reviewed and appraised using the John Hopkins Evidence-Based Practice Tool Appendix C (Dearholt & Dang, 2017). From the

initial review of 133 articles, the author appraised 14 articles that were relevant to the PICOT (See Appendix C).

Evidence to Support Project

Nurse-led free community clinics offer a valuable resource for expanding access to low-income underserved populations (Sutter-Barrett, Sutter-Dalrymple, & Dickman, 2015).The National Advisory Council on Nurse Education and Practice (NACNEP) issued a 2015 statement to the U.S. Department of Health and Human Services that recommended providing more opportunities to educate, train and augment professional development to advance the field of public health nursing. They further recommend academic and community partnerships to create meaningful opportunities for inter-professional collaboration (NACNEP,2015).

The United States has had nurse-led community clinics in place dating back to the 19th century, founded by public health nurse icons like Lillian Wald. Presently, there are approximately 250 independent nurse-managed centers in the United States. Literature supports growth of these centers to serve as a platform for interprofessional collaboration where community stakeholders, organizations providing upstream resources, and nurses from entry-level to advanced practice can collaborate to achieve better health outcomes for our most vulnerable patient populations (Holt, Zabler, & Baisch, 2014).

UCSD Study

A 2014 cohort study conducted by the University of California San Diego (UCSD) evaluated the attitudes of medical students towards caring for the underserved using a pre-posttest design. The study collected data from January 2001 through December 2010. A survey tool was developed by faculty and tested for validity and reliability over a three-year period prior to use in this study.

A total of 934 medical students were surveyed prior to serving in the UCSD student-run free clinic as an elective course over the nine-year period. The anonymous survey included unique participant identifiers that allowed for pairing of pre and post data in the evaluation phase. Students were surveyed at the end of a 10-week course. Significance was noted in both matched and unmatched pairs using multiple descriptive statistics, demonstrating improved knowledge, attitudes and skills towards working with the underserved populations.

Though this study lacked a true control group, it was noted to highlight the significant change in attitudes of medical students desire to work with vulnerable populations after immersion experiences with faculty who mentor and model the importance of this work. The study demonstrated the role of student-run free clinics as a mechanism to shift attitudes of new graduates who seek opportunities to work in underserved communities upon graduation (Smith, Yoon, Johnson, Natarajan & Beck, 2014).

Homeless Services Study

A pilot study led by a school of nursing and a homeless services agency evaluated health outcomes of homeless patients who participated in a nurse-managed clinic. Student nurses and volunteers from an urban hospital provided a nurse-led free clinic held twice a week over 18 months at a local church site during meal distribution service. Between September 2003 and April 2005, over 400 patients were seen and 136 participated in the study. The aim of the study was to evaluate the participants' health outcomes and improvement in quality of life, as well as if these clinics reduced emergency room visits. The pre-posttest quasi-experimental design utilized a 95-item survey questionnaire that had been modified from a reliable and valid tool by Ware et al. in 1996. Only 43 participants remained for the post-test interview, while the others were lost to follow up. This study did demonstrate improved health outcomes and improved perceptions of

access to care. Substance abuse was evaluated as a health outcome. Emergency department visits were not improved, but referrals to primary care and other resources showed significance after intervention. Limitations included the subjective nature of the interview style which relied on the self-reporting of improved health and lifestyle. This study was also limited to homeless adults and did not include families or children (Savage, Lindsell, Gillespie, Lee, & Corbin, 2008).

Systematic Review of Community-based Nurse Clinics

A systematic review examining the impact of community-based nurse-led clinics on the measures of patient satisfaction, health outcomes, access and cost effectiveness was appraised. This article published in May 2017 was the most comprehensive and relevant review found. The authors reviewed fifteen studies that included the care of nearly 4000 homeless individuals. The majority of studies evaluated patient satisfaction, with only two studies examining cost effectiveness and six studies measuring outcomes, while ten also included access as an outcome. The limitations of this review included the self-reporting measures and methods of the studies, and the small number of studies that were available for review. Patient satisfaction and patient access were significantly improved. Qualitative themes of patient and provider satisfaction supported the role of these clinics. Cost effectiveness and health outcomes were too varied to demonstrate generalizable data (Randall, Crawford, Currie, River, & Betihavas, 2017).

Systematic Review of Nurse-led Primary Care

Another systematic review by Desborough, Forrest, and Parker (2012) examined fifteen studies of nurse-led primary care walk-in clinics. This was an international review to compare both quantitative and qualitative methods across the United Kingdom (UK). The review concluded that there is more research needed using higher quality methods, and larger sample sizes to demonstrate improvement in equity, access and quality of care generated by nurse-led

clinics. The studies demonstrated patient satisfaction and higher primary care utilization. Though there was duplicity in the sites studied among the articles, it did not provide the breadth of sample necessary to recommend this method of practice to meet improved health outcomes and be cost effective (Desborough, Forrest & Parker, 2012).

Charity Care Impact on ED

The final article chosen for inclusion by Wang et al. (2015) evaluated the efficacy of charity care and primary care interventions on emergency department (ED) use among patients experiencing homelessness. This was a retrospective study that utilized reviews of medical records of homeless Texans who received emergency care between July 2013 and June 2014. The New York University ED Algorithm (NYUA) was utilized to identify appropriate vs. inappropriate use ED care. Despite high levels of charity care utilization and/or primary care access in this population, the use of the ED for both appropriate (crisis care) and inappropriate (non-crisis care) accounted for nearly 50% of all visits. This single study concluded that preventive access interventions in the homeless did not help to reduce ED visits. Limitations included the evaluation of data in only one hospital center and the potential bias associated with record review. The hospital ED was also known for its inpatient psychiatric center referrals and may have influenced the sample and ED usage percentages (Wang et al. 2015).

Evidence Synthesis

The body of evidence reveals consistency in improved patient and provider satisfaction in a variety of settings of nurse-led community-based clinics. Trust and quality of relationships between patient and provider are positive outcomes with this intervention. Utilization of primary care services is improved in the homeless population by offering these community clinics,

though ED recidivism does not seem to be reduced. Further studies evaluating health outcomes need to be conducted and reviewed to demonstrate effectiveness of this practice model.

The literature also points to many benefits of positioning nurses on the frontline of care for the homeless community. There is an opportunity to make an impact by addressing more upstream issues that affect health in this population, while supporting Healthy People 2020 goals of increasing access to care in this vulnerable group (Desborough et al., 2012; HHS, 2014; Randall et al. 2017; Savage, et al. 2008; Smith et al. 2014; Wang, et al. 2015).

Nurse-led free community clinics offer a valuable resource for expanding access to low-income underserved populations. These clinics can also serve as a platform for interprofessional collaboration where community stakeholders, organizations providing upstream resources, and nurses from entry level to advanced practice can collaborate to achieve better health outcomes for our most vulnerable patient populations (AACN, 2013; Sutter-Barrett, Sutter-Dalrymple & Dickman, 2015). Nurse-led practice settings align with IOM's mission for nursing to lead the way in providing more critical touch points and continue to reduce gaps in care. These settings also positively influence provider attitudes towards vulnerable populations and help to develop culturally competent nurses who can begin to see the meaning of population health in all areas of nursing (Smith et al., 2014).

Bringing nursing students together from all levels in a community-based setting can also provide a rich clinical experience that helps to influence future generations to consider health policy which supports a more equitable healthcare delivery system for all (AACN, 2013; APHN, 2016; Hassmiller,2014; Randolph et al., 2016;Sutter-Barrett, Sutter-Dalrymple & Dickman, 2015).

Rationale

The conceptual framework used to guide this project will include Dorothea Orem's Self-Care Deficit Nursing Theory (SCDNT) and the Mobilizing for Action through Planning and Partnerships (MAPP) model. The MAPP frames the process and will inform the direction of measurable outcomes and sustainability of the project (Community Toolbox, 2018).

Orem's theory was chosen based on her description of the dynamic relationship between nursing and those who need nursing support. She portrays the necessity of quality nurse-patient relationships to develop patients who seek self-care and create agency for themselves in the healthcare system. Patients served in community based free clinics often neglect their own health and need advocacy in healthcare to help them see their own value and ability to have health (Green,2013).

This concept of how nursing and patients can intersect in a community setting is the essence of her vision, and will support the development of pop-up clinics to serve those who will benefit from interactive, positive nursing relationships to support self-care (Fawcett, 2003; Green, 2013; Petiprin, 2016).

The MAPP model was jointly developed by the Centers for Disease Control (CDC) and the National Association of County and City Health Officials (NACCHO) to address health as a community issue. There are seven underlying principles and six phases to provide structure and guide the process using MAPP. The principles include systems thinking, dialogue, shared vision, data, partnership, strategic thinking and celebration of success. The phases begin with organization/partnership development, visioning, assessment of community and resources, identification of strategic issues, goals and strategies, and concludes with the action cycle (see Appendix D) (Community Toolbox, 2018). This model was chosen as most appropriate for

developing this project in partnership with the university's existing clinic and creating a strategic vision for extending the reach of the clinic in tandem with the growing student body from undergraduate through Doctor of Nursing Practice students. Using these guiding principles to address community health needs from a systems perspective was essential to the success of this DNP student-led project.

Section III: Methods

Context

Nursing faculty are challenged to place students in clinical settings that satisfy the California Board of Registered Nursing outcomes for the PHN certificate. Nursing faculty are also seeking opportunities to remain clinically relevant by practicing alongside their students as clinical mentors (Sutter-Barrett, Sutter-Dalrymple, & Dickman, 2015). BSN students across San Diego are in competition for volunteer service-learning opportunities to gain immersive experiences and apply public health nursing theory to practice. BSN graduates are expected to be prepared to promote and protect the health of communities and populations (Hassmiller, 2014). Community and public health agencies continue to experience greater numbers of clients with chronic mental and physical health needs. The nurse ratios for community and public health nursing are often one nurse per 1,000 patients (D. Foster, personal communication, August 25, 2018). Public health funding has been cut since the rollout of the Affordable Care Act (ACA) and primary care practice settings more impacted than ever (Randall, Crawford, Currie, River, & Betihavas, 2017).

San Diego ranks fourth in the United States for homelessness (Regional Task Force on Homelessness, 2018). The lived experience of homelessness often makes engagement in regular healthcare challenging. Complicated by poor social determinants of health and limited access to preventative care services, these community clients need more service providers to bridge the gaps in their care (National Healthcare for the homeless Council, 2018; Regional Task Force on Homelessness, 2018; Randall, Crawford, Currie, River, & Betihavas, 2017). Nurse-managed centers that are regionally positioned where patients experiencing homelessness can access compassionate and holistic care will be instrumental to facilitate relationships between

disenfranchised individuals and the healthcare system at large (Wilde, Albanese, Rennells & Bullock, 2004).

Work Breakdown Structure

The Work Breakdown Structure (WBS) served as an outline of essential tasks necessary to carry out the project from conception to dissemination. Initial objectives included introduction of the project to PLNU School of Nursing's dean to discuss the impetus for the project and feasibility of incorporation of the model as a clinical site for the RN-BSN program. Complete list of tasks from inception to evaluation can be found in Appendix E.

SWOT Analysis

A SWOT analysis was performed to help mitigate any strengths, weaknesses, opportunities and threats that may influence the intended goal of this project. This is graphically summarized in Appendix F.

Strengths are identified as aspects of the project that improve the potential success and sustainability of the project. These include the author's role as course coordinator for the RN-BSN program clinical placements. The need for placements that meet the BRN guidelines for direct patient care hours to PHN certification is clearly demonstrated. Projected growth of the nursing program and extension of needs for graduate student placements was considered a strength of developing a pop-up clinic model that can be transferable and reproducible at multiple locations to meet this demand. The existing HPC clinic is also noted as an advantage and will serve as the base clinic from which this new expanded care clinic will derive. This will benefit the ease of model development and legal issues typically associated with creating a clinic. The existing policy and procedures, CA Public Health and safety code status, and liability insurance is transferrable to the new model as an intermittent clinic as outlined in Appendix T.

The cost savings of creating independent clinical placements outside of SDNSEC should be realized in the first year.

Weaknesses are identified as factors that might challenge the creation and sustainability of the project. These include the potential increased faculty workload to implement the model and the necessity of faculty oversight for student-led clinics. The accelerated schedule of the RN-BSN program and variance in student nursing experience are considerations that may negatively impact services offered by the clinic. Scope of practice liability for RN students in the absence of an advanced practice provider or physician may present challenges to MOUs in some settings. Though the clinical hours are required to meet program outcomes, student engagement is inconsistent across cohorts and at the individual level. As a new model for the school of nursing, unforeseen circumstances, changes in leadership, program requirements and other variables may not support smooth integration of the pop-up clinic sites.

Opportunities are considered to be benefits of the project that may generate other potential positive gains for students, the university and the community. The new relationships and community partnerships achieved through this project development may open collaborations for more resources to benefit students and patients. The university may also find inter-professional collaborative opportunities through the new clinics. Students' ability to expand knowledge of public health nursing through practice while impacting patient populations may support more empathic graduates who understand population health models. Creating a model that can be replicated to multiple sites and grow with the school of nursing improves sustainability of the project. It may also prepare the university for expanded graduate advanced practice education in the saturated nursing school market of San Diego. Furthermore, positioning the School of Nursing for funding through the San Diego and Imperial County hospital

association foundation and improving grant eligibility will support greater outreach into the community.

Threats to the project are thought to be variables the author had less control over which may negatively influence the development, interrupt the implementation, and change potential outcomes. Funding for a start-up clinic model by the university may not be released in time for rollout. The university politics may not support need for additional MOU's at community sites. Lack of student volunteers outside of traditional semester schedule limits the operational ability of the clinic to be sustained. Ability to get physician and NP providers to volunteer and assume responsibility for RN-BSN students at clinic sites cannot be guaranteed for any or all of clinic locations.

Gap Analysis

A gap analysis was done to identify the actual and potential gaps in clinical placements for RN-BSN students at PLNU. The current plan for traditional undergraduate BSN students at PLNU supports 100% of placements for students completing the 90 clinical hour requirement during their public health clinical rotation. These students have precepted clinical experiences in the County of San Diego and at public schools throughout the San Diego Unified School District. RN-BSN students who are held to the same CA BRN PHN certification standards do not have precepted clinical placements. Each semester, students are placed by the author at any available event or opportunity that is appropriate for the number of students in the cohort. Most often, a group of up to 8 students is accepted to volunteer at The Arc of San Diego day program for developmentally delayed adults. A typical semester has 24 students divided into two cohorts over a seven-week quad course. This leaves a gap of approximately 16 students per quad without a guaranteed clinical placement.

Using the 2019 RN-BSN enrollment of 125 students over three semesters, 48 students could be placed at two different Arc of San Diego locations, leaving 77 students without a site. Based upon similar models, the development of a single student-led clinic location operated three days per week could accommodate 15 students per semester. This would reduce the gap to 33 students annually. This project sought to create a model that is transferable to multiple locations and eventually eliminates this gap in placements for the growing needs of the PLNU RN-BSN program. A graphical representation can be seen in Appendix G.

Planning for this project through all phases required support from the PLNU SON faculty, community partners required to establish the first clinic location and ongoing advisor support by the author's DNP advisor. Multiple methods of frequent communication through all phases of the project are summarized in Appendix H.

Preparing the Clinic

A scouting mission was done to identify potential clinic locations and community partner organizations. Buy-in with stakeholders was established through team development, meetings and site visits. A letter of intent and Memorandum of Understanding (MOU) with PLNU was established between partner locations and organizations as appropriate (See Appendix I). Potential clinic set-up and mock clinics were completed as part of the planning process. Other student-run free clinic sites in San Diego were visited. The author volunteered and observed at several clinics to observe different clinic models in action.

Clinic Model Plan

The development of this pop-up clinic model included the legal documents necessary to identify this clinic as an expansion of the SON's HPC clinic. Approval by the dean and clinic director with appropriate MOU's were secured. This was designed as a unique, nurse-managed

student-run free healthcare facility. The clinic was overseen by clinical faculty, managed by a graduate student and staffed by RN-BSN student volunteers. An administrative hierarchy can be found in Appendix J.

The clinic operates based on the schedule of the initial pilot location at the Wesley United Methodist Church. Students were scheduled prior to the semester in clinical groups to maintain continuity of care at the site over the course of the semester. The goal was for the graduate student to maintain a leadership role for two semesters in fulfillment of their own advance practice requirement. Free medical care was provided on a first come, first serve basis. Screening of vital signs, blood glucose, minor acute injury assessment, wound care, health promotion activities, health education, harm reduction strategies and addressing social service needs will be included elements of care provided. Students have the ability to refer patients to higher levels of care as needed through partnerships with other community agencies. The students also have the ability to consult or refer back to our own HPC for full primary care services. Students have access to electronic referral platforms to improve interoperability of patient data between the pop-up and full-service clinics in the region through the "Community Information Exchange" (CIE) platform. By remaining connected to community partners, the clinic also provides an opportunity for students to serve alongside other disciplines. These volunteers may include medical providers, social workers, health coaches, community health workers and public health promotion specialists to gain experience and develop critical understanding of how the social determinants of health play in health outcomes.

The author's role in founding a street health 501c3 organization *San Diego Street Medicine Alliance* has grown partnership opportunities for students to engage and interact with vulnerable and underserved populations in San Diego. This stream of alliance partners will

further the scope of needed services to clients at the clinic site and broaden students' cultural competence in caring for these populations. A full summary of newly established PLNU community partners is outlined in Appendix K.

A pamphlet was created to market the pilot clinic with a summary of services rendered, clinical partners and hours of operation. This can be seen in Appendix L.

Intervention

A nurse-led pop-up clinic was established at the community partner location Wesley Co-Op in the First United Methodist Church of San Diego. The center offers two hot meals daily, shower facilities and a weekly food distribution on a first come, first serve basis. The facility was opened in 2016 to meet the needs of the surrounding low-income neighborhood of City Heights in central San Diego.

Recognizing the growing need for student clinical placements, PLNU approached the Wesley Co-Op in the fall of 2018 to offer free medical care to the attendants of the food distribution. An agreement was reached in January of 2019 to begin providing nursing care by licensed students in the RN-BSN program. An initial pilot of four nurses and a faculty member established the site in early spring of 2019. The tasks of organizing the clinic supplies and establishing an operations manual was completed. The director of the PLNU Health Promotion Center was integral in providing the necessary legal documentation and paperwork to begin an offsite nurse-led clinic.

The first student cohorts for the implementation phase began in May of 2019. Students in the RN-BSN program matriculating into their third semester were required to have an active RN license to participate in the clinical course. There were 62 students divided among five cohorts. Students were assigned their clinical rotations using Google Docs in advance of the course. The

first group of 33 students were assigned to the pop-up clinic three days per week. The remaining 29 students were assigned to a previously established clinical site at a day care center for developmentally delayed adults. A graduate student in the MSN CNS program for family health led the first groups through the rotation at the clinic. The clinic was held Monday, Wednesday and Friday from 08:30-12:00. These hours were requested by the clinical site, and followed the serving of breakfast, lunch and free showering times at the church. This period also included the initial data capture of number of students participating. The tasks and timeline of this project are summarized in the GANTT chart in Appendix M.

Cost Benefit

The RN-BSN students are required to complete 90 hours of clinical in a public health setting providing patient care to qualify for PHN certification in CA. RN-BSN programs are excluded from participation in the San Diego Nursing Consortium, and therefore are not assigned a clinical site. The clinic will provide 7,920 hours of clinical placement based on 15 students per week serving 44 weeks of the year and aligned with the graduate School of Nursing calendar.

Initial funding sources have been received from the SON general fund and revenue generated by PLNU SON jacket sales. Based on review of other similar clinics and utilization by our own HPC, the university has provided $6000 per year of SON budget funds to cover clinic expenses. Profits from School of Nursing jacket sales were secured for initial seed money. Jacket sales began in anticipation of this project in fall 2018. The sale of each jacket to RN-BSN students generated $5.00 of profit. Jacket sales have continued to raise money and have reached a fund of $725.00 to date in fall 2019. Sales are projected to remain consistent each year as a sustainable income source as new students matriculate through the SON. Existing agreements with the County

of San Diego will provide necessary vaccines, electronic medical records, and medical provider services as needed to support clinical operations at no cost to patients or PLNU.

The clinic would be supervised by clinical faculty who are paid by their unit load, which exists as part of the budget for this course regardless of clinical placement. The clinic will be organized by the faculty lead for public health programs as part of her doctoral project at no expense to PLNU. The clinic staffing and weekly organization will be maintained by graduate students as part of their required clinical hours. The cost of care by RN-BSN and graduate students are considered "in-kind" and do not impact the operational budget. Students in the RN-BSN program will be able to meet their clinical requirements in a service-learning environment embedded in an at-risk neighborhood of San Diego.

Collecting data on the type and number of patients served at the clinic will increase opportunities for funding by community foundations and local healthcare systems. The "in-kind" expenses of licensed clinical staff accounts for $372,000 annually will also be highlighted when future funding opportunities are presented. The cost avoidance of emergency department visits serves as a valuable number when demonstrating the cost effectiveness of this model. A single pop-up clinic has the ability to serve a broad base of patients who need clinical and case-management care. A single location could potentially see 1,320 patients in one year. Benchmarking data from similar endeavors demonstrates approximately 50% reduction of those patients who would have otherwise use the emergency room. The other 50% of those patients may have been seen as a one-time visit in a urgent care or uninsured primary care visit (Williams, 2019). This realization of savings to local healthcare services in Year One will be considered when planning for clinic expansion. Analysis of cost considerations is summarized in Appendix N, followed by a three-year pro forma in Appendix O.

Financial Impact of Clinical Placements

A compelling benefit of this model is the cost savings extended to the healthcare system. The average cost of a clinic visit for an uninsured individual in 2018 is estimated at $479.00 (National Healthcare for the Homeless Council, 2018). A visit to the emergency department in CA in 2018 was listed at $2,000.00 (Williams, 2019). By providing an additional point of contact to link services, referrals and screening, the outcomes should demonstrate a reduction in emergency department visits, thus saving the healthcare system money. Data to support this will be collected in the second phase of the clinic development and is expected to mirror other similar outcomes of successfully reducing healthcare cost (Sutter-Barrett, Sutter-Dalrymple & Dickman, 2015). This will also provide needed care to the uninsured and underinsured without costing the individual out-of-pocket expense (National Healthcare for the Homeless Council, 2018). The net benefit to the healthcare system is estimated to be an annual cost avoidance of $1,636,140 by implementing this single location pop-up.

The financials of this proposal clearly demonstrate the value in establishing nurse-led clinics as an extension of the PLNU HPC. The clinic was prepared by the DNP candidate at no charge to PLNU and was operational within one year. The cost of clinical faculty remains the same regardless of clinical placement option and will be paid at a rate of $150 per student for the one-unit clinical course. By providing secure placement for students, faculty can spend time mentoring and facilitating application of PHN theory rather than scrambling to find appropriate clinical hours each semester.

The first-year cost of clinic operations was $24,900. This is assumed to increase at a typical rate of 10% to account for rise in student enrollment and clinic expenses. By the second and third year, the cost of operating the clinic is only $26,833 and $29,005 respectively. Serving

the same number of students, a cost of $66,000 is avoided in the first year by not participating in SDNSEC. This cost savings increases to $72,000 by Year Three of clinic operations. This represents a return on investment based on mitigation of costs greater than 200% beginning in Year One. A complete breakdown highlighting the year to year cost differences demonstrated by this independent model vs. the SDNSEC option and the projected savings to the San Diego healthcare systems is illustrated in Appendix P.

This type of service learning reflects the mission of the university to prepare holistically minded providers who understand how social determinants of health impact communities (PLNU, 2019). This clinic model was designed to be operational with limited resources and maintain sustainability through university support. Growth and expansion of this model to additional sites will provide a long-term solution for all levels of programs to provide clinical opportunities that align with the university's mission of serving faithfully, while still meeting the BRN clinical requirements. Consideration of all "in kind" expenses, revolving and one-time costs are summarized in Appendix N.

Funding

The PLNU Health Promotion Center Free Clinic and University council were made aware of resource needs. The established university clinic has historically applied for Kaiser Community Foundation grants each year. They have received $25,000 in grant funds each year through 2018. This year the pop-up clinic extension of the university clinic was mentioned in the Summer 2019 grant application. The Wesley Co-Op applied independently to the Kaiser grant as well, with the intent of funding more clinic hours in partnership with PLNU. The grants are awaiting approval as of fall 2019. Partnerships have been established with the County of San Diego that have supported provision of additional clinic supplies, case management services and

administrative support without a fee. This clinic was designed to be operational with limited resources and maintain sustainability through university support. Growth and expansion of the model to additional sites would require further budgeting and alternative funding sources.

Outcome Measures

A pilot initiated in May of 2019 was phase one implementation. This included participation of three cohorts and one dedicated graduate student. The data collection consisted of demographic data on both students serving at the clinics and number of patients being served. One semester of RN-BSN students utilizing the pop-up model evaluated the model over a seven-week semester period at a single location. An instrument to evaluate the model was prepared by the author (See Appendix Q). The clinical evaluation tool has been utilized by PLNU School of Nursing since 2012. It was modified in the fall of 2018 and approved by the curriculum evaluation committee in the spring of 2019 to be implemented in the summer semester of 2019. This instrument is used to assess student learning with course learning outcomes aligned with CA BRN PHN curricular standards. The clinical sites had previously not been consistently assessed. By adding the clinical site evaluation to the tool, the various clinical sites attended by students can be evaluated to ensure they meet the clinical learning needs of the program.

Analysis

All student data was collected through the Live Text software program and prepared by the assessment team at PLNU. PLNU student assessment analyst Stephanie Lehman provided the data through a Google Drive document for review. Total number of student clinical hours created by the clinic were also computed. Patient data was collected at the pop-up clinic by the graduate MSN students and verified by the Wesley Co-Op director, Terry Scott. Number of patients seen

during clinic hours were collected on paper and provided to the author. The model was measured for effectiveness to meet PHN outcomes, number of students utilized, student clinical hours created by the clinic, number of collaborations or community partners engaged, and number of patients served. A summary table of outcomes can be viewed in Appendix R.

Ethical Considerations

This project was designed to align with the PLNU SON mission, vision and values as a Christian university. The five "Faithfully's" that guide the student learning outcomes for the SON are *inquiring, caring, communicating, following* and *leading* (Point Loma Nazarene School of Nursing, 2019). These exemplify the call of nursing as a vocation and highlight the goal to develop compassionate and holistically minded graduates from our programs. The experiences gained by serving at the pop-up clinics not only supports the CA BRN requirements in our course learning outcomes for competency but commits to our focus on servant leadership in our students (See Appendix S).

As a DNP student at University of San Francisco, the author also represents the values inherent in the mission, vision and values of this university's Jesuit tradition. The commitment to education that is rooted in faith and a culture of service to all people is extremely important. Advocacy for dignity of every patient is central to the practice of nursing and is echoed in the Jesuit spirit of illuminating the souls of the underserved. These humanistic ideals that see the union of hearts and minds will also be woven into all phases of this project.

This DNP project was designed as a quality improvement project utilizing the best available evidence to produce an innovative solution to meet the growing needs of the PLNU School of Nursing RN-BSN program. This project also hopes to support population health initiatives for the local homeless crisis in San Diego to expand preventative care services and

access to medical care. The author completed the National Institute for Health (NIH) course in *'Protecting Human Persons Research'*. Based upon NIH criteria, this project did not require approval of Internal Revenue Board (IRB). The project was submitted to the University of San Francisco DNP department with approval in the spring of 2019.

The project is guided by the American Nurses Association (ANA) code of ethics provision one: highlighting the foundation of nursing practice as rooted in compassion, respect for the uniqueness of individuals and belief in the value of every human being (ANA, 2015). The pop-up clinic model serving the homeless creates an immersive experience for nursing students to develop understanding and appreciation for the many barriers to care experienced in this population. The model further supports ANA code of ethics provisions three and eight, wherein the nurse exemplifies the role of patient advocate through active community partnerships and engagement to promote equity and reduce health disparities (ANA, 2015).

Many ethical principles are addressed within this project. Beneficence is the fundamental principle that guides this project. It is designed to cultivate BSN graduates who desire to understand how social determinants of health impact outcomes and want to be compassionate providers. It is also designed to increase the access to care and reach out into the most vulnerable communities within San Diego. Autonomy is represented by the students' experiences serving a diverse community at the clinic and respecting individual choice in care engagement. Fidelity is also considered as we maintain a presence for the patients being served at the clinic to increase trust with the healthcare providers. Justice is represented by the mission to serve as a free clinic in partnership with other free and charitable clinic providers to extend care to this vulnerable population.

Section IV: Results

Results

The results provide compelling evidence to support development of this project. As seen in Appendix R, of the 62 students in need of clinical placement for summer 2019, a maximum of 30 students could be placed at the only existing clinical site for the RN-BSN program, leaving 32 students without clinical placement. 29 RN-BSN students were placed at this location. The other 33 students were placed at the new Wesley Co-Op nurse-led clinic. This accounted for 54% of students being placed at this new alternative location. Among those who attended, 25 of the students found this clinical site to meet their course learning outcomes aligned with the CA PHN BRN requirements. In the Arc of San Diego group, only 12 students felt the site met their needs, while 10 stated it did not support the course learning outcomes. Within both groups, a total of 14 students did not evaluate the site. Faculty were also asked to evaluate the learning outcomes using the same tool. All clinical faculty agreed the nurse-led clinic met the expectations for expected outcomes.

Narrative comments by students on their clinical evaluation revealed engagement of the patients while applying public health nursing theory to practice. Students noted how they came to understand how social determinants of health played a role in care and appreciated the freedom to collaborate alongside other health professionals in the clinic setting. Students also commented on how the benefits of autonomy at this site allowed them to explore more of their nursing knowledge.

A total of 1,320 clinical hours were generated at the new site, compared to 1,160 at the existing site. The pop-up clinic site also served 222 patients during the seven-week clinical

rotation as compared to zero patients previously served at this location. There are no clinic services offered at the Arc of San Diego.

Section V: Discussion

Limitations

The limitations for this project include the author's experience in developing a clinic model and reliance on another SON faculty who has previously accomplished this. Using community benchmarks for how to develop a nurse-led clinic has been helpful, but each school, location and scope of practice model are unique. Determining the right approach, services rendered and partnerships created will be an evolving process. The author's dual role as a DNP student and faculty member at the project implementation site has been a challenge to develop and implement in real time while completing other required coursework. The scope of the project had to be amended to fit the timeline of the RN-BSN students schedule and the author's DNP project.

The body of literature to support the model for nurse-led clinics for both their efficiency in providing quality care and improving access is clear, but not many nursing schools have published successes in independent clinic development. More programs need to contribute and support each other in generating more current data that reflect the changing tides in scope of practice for advance practice nursing providers who are capable of meeting population health needs (Ferrari & Rideout 2005; King, 2008).

Faculty release time for clinicians to engage in teaching-learning models at university-based clinics is a universal problem in academia (Hansen-Turton & Miller, 2006). The author serves as the only full-time faculty providing care in the community while teaching students. The obligation to maintain a full-time didactic course unit load without release in a clinical setting is

not sustainable and will need to be considered if more clinic sites are to be developed. The clinic director of the HPC does not provide any didactic instruction and has administrative support through the university. Demonstrating success of this model after evaluation will be necessary to gain more university support. The consideration of future data collection may include type of patient encounters, number of referrals generated and involvement of local healthcare systems to provide care. Generating more data to support this population health intervention is needed to further grow the evidence validating the significance and impact of nurse-led clinic models.

Funding by the university and support for grant applications will also be needed to maintain growth of clinical sites. The first clinical partner at Wesley Co-Op has expressed concerns about maintaining care during academic breaks. This concern has been raised by other clinical settings and will also need to be considered in the future. Patient trust and relationships are key to success in engaging patients in their community. Creating a model that is patient-centered while meeting student learning needs is a challenge that will hopefully be met by this DNP project.

Conclusions

Given the limited period of evaluation during this DNP project, the instrument utilized to measure the outcome was not validated. Though the clinical evaluation document had been utilized for many years, the clinical site evaluation piece had only been approved by the curriculum committee during the same semester it was rolled out. The traditional undergraduate students who are members of the San Diego Nursing Consortium are provided documents to evaluate each given clinical site in a paper format and have not had their evaluation tied to course learning outcomes. This new format revealed much more narrative commentary from students to help faculty understand how learning was achieved to meet clinical outcomes at the

site. Sharing this tool with the traditional undergraduate students and across other clinical experiences will increase the reliability of using this tool for future studies.

The sample size of 62 students was the largest number of students matriculating through the PHN course in the history of the RN-BSN program. There are typically only two cohorts at any given time in the course requiring clinical placements. This group of five student cohorts needing PHN clinical hours was appropriately timed to launch the intervention of the pop-up clinic. The challenge of placing these students among five faculty in a new clinical site impacted the time students had to orient to the site, and was overwhelming for the site itself. Having five separate groups of students to manage the three day per week clinical schedule was confusing for the site director and graduate student at times. However, students reported positive experiences in their site evaluations and students at the alternative clinical site asked to complete hours at the clinic because of their peers' high reviews of the experience. Due to the need for independent evaluation of the clinical site for the purposes of this project, students were not allowed to switch sites at any time during the semester.

This project did not seek IRB for the initial rollout. The next iteration of this project would need to include IRB approval to further evaluate the patient population being served. Generating more data on what type of preventative care can be offered by nursing and how many patients can avoid ED visits will improve the university's ability to obtain funding to grow this nurse-led clinic movement. More detail generated on patients will also assist in gaining access to interprofessional partners who may be seeking to meet the needs of a similar patient population. Growing collaborative community relationships by demonstrating unmet needs at this clinic could benefit the patient and student populations. Studies of similar immersive student

experiences reveal understanding of how health equity can only be achieved through experience (Cheshire, Montgomery, & Johnson, 2017).

Training future nurse leaders who learn to manage and operate independent nurse-led clinics within their scope of practice provide invaluable opportunities to align theory to practice (Randolph, Evans & Bacon, 2016; Smith et al., 2014). Working with vulnerable communities to serve real population health needs prepares nurses to think beyond the bedside (Van Zandt, Sloand & Wilkins, 2008). The demonstration of deferred patient care collectively reducing 660 unnecessary emergency department visits and another 660 uninsured clinic visits per year would make a significant impact on local healthcare systems.

The journey to meet the growing needs of RN-BSN students while maintaining an evidenced-based approach to population health issues in San Diego will continue long after the completion of this project. The author recognizes and accepts the challenges of placing students outside of the San Diego Nursing Consortium. Creating meaningful and immersive experiences for students is both a personal and professional long-term goal of this project. The author understands the demand for population-health focused nurses who serve as informed, flexible, holistic providers and who can remain compassionate providers in a rapidly changing healthcare environment. Further growth of this model will include extending hours of the Health Promotion Center operated by PLNU and extending the reach of more street-based health clinics throughout the county of San Diego. Development of partnerships and collaborations with other schools of nursing and health agencies are also included in this vision.

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Section VII: Appendices

Appendix A

DNP Statement of Non-Research Determination Form

Student Name: Jennifer King

Title of Project:

Development of a Nurse-Led Pop-Up Clinic Model to create clinical sites for Public Health Nursing students in a BSN program.

Brief Description of Project:

The development of a pop-up clinic is designed to meet the clinical needs of RN-BSN students at Point Loma Nazarene University, as well as the healthcare needs of the patients who frequent food distribution centers and churches in the local area. This project will develop an evidence-based model based on similar nurse-led pop-up clinics. The model will be implemented and evaluated by the DNP student who is the course faculty to ensure it meets the needs of the students to fulfill CA BRN PHN requirements.

Aim Statement:

The aim of this project is to develop a nurse-led clinic model to be implemented by summer of 2019 and evaluate the utility of the model for PHN BSN students.

A) Description of Intervention:

A pop-up clinic model to be led by RN-BSN students and their faculty in San Diego from Point Loma Nazarene University.

This evidenced based model will include:

- Site Description & demographic information of population being served
- Student Expectations at site
- Clinical guidelines for BP screening/wound care/mental health screening/referral

to clinic v. ED

- Resource guide of local clinic providers that are community partners to refer patients to from the pop-up.

- Participation in San Diego Street Medicine Alliance

B) How will this intervention change practice?

RN-BSN students at Point Loma Nazarene University must fulfill 90 clinical hours in a public health setting to meet the BRN guidelines for PHN certification in CA. There are currently no clinical sites provided through the San Diego nursing consortium. Students and faculty must seek volunteer service opportunities independently that satisfy PHN criteria to complete clinical hours. Many food distribution sites and churches in San Diego desire nursing presence to help meet the needs of medically underserved populations who attend their events. We are partnering with these sites to both meet the needs of our students and the clients at these sites. This will fulfill our BRN requirement and also support the mission of our university to produce graduates that have had meaningful experiences working with vulnerable populations. Evidence supports nurse-led clinics to develop more culturally competent nurses, while applying public health theory to practice.

C) Outcome measurements:

Outcome measurements will include:

- <u>Evaluation of the model:</u>

- Did it meet the needs of student's application of theory to practice per BSN essential standards for PHN practice?

- Does is satisfy the clinical requirements for PHN practice CA BRN?

- How many student hours were provided by the model?

- How many patients did it serve?

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used:
(http://answers.hhs.gov/ohrp/categories/1569)

☐ This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

☐ This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

Instructions: Answer YES or NO to each of the following statements:

Project Title: Development of a Nurse-Led Pop-Up Clinic Model to Serve the Homeless in San Diego	**YES**	**NO**
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	**Yes**	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. ALL participants will receive standard of care.	**Yes**	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that overrides clinical decision-making.	**Yes**	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.	**Yes**	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	**Yes**	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	**Yes**	

The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	**Yes**	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	**Yes**	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	**Yes**	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

STUDENT NAME (Please print):
_____Jennifer King _____
Signature of Student: Jennifer King_____DATE____10/11/18_____

SUPERVISING FACULTY MEMBER (CHAIR) NAME (Please print): _____Jo Loomis_____
Signature of Supervising Faculty Member (Chair): _____DATE_____

Appendix B

AIM Statement: The aim of this project is to develop a nurse-led clinic model to be implemented by summer of 2019 and evaluate the utility of this model in fulfilling clinical placements for RN-BSN students to meet CA BRN PHN certification requirements.

Picot Question: *For RN-BSN Nursing students in San Diego, do weekly nurse-led free community clinics provide appropriate clinical experiences to meet PHN competency compared to student's independent volunteer experiences?*

Outcomes:

Appendix C

Evidence Table

Citation	**Study Design** **Sample Setting**	**Statistical Tools**	**Results**	**Highlights** **Strengths** **Limitations**	**Level of Evidence using JH Appraisal Tool C**
Desborough, J., Forrest, L., & Parker, R. (2012). Nurse-led primary healthcare walk-in centres: An integrative literature review. *Journal of Advanced Nursing, 68*(2), 248-263.	• Systematic Review • International • 15 studies examined nurse-led primary care	Included quantitative and qualitative studies Search limited 1990-2010	5 Themes were Identified: 1. Use of centers 2. Quality of care provided	✓ Provided clear evidence for the importance of walk in centers in meeting healthcare demands	Level III-A

	walk-in clinics	Sources: Medlin; Cinahl, Ebsco Only Peer Reviewed journals	3. Satisfaction of center 4. Impact on other providers 5. Perceptions of walk-in centers	✓ Need for nursing workforce to be prepared to care in these settings ✓ Limitations: UK/Australia studies ✓ Lack of large-scale studies with homogenous variables/results	
Randall, S., Crawford, T., Currie, J., River, J., & Betihavas, V. (2017). Impact of community-	• Systematic Review • 15 studies covering	Sources: Medline, Cinahl, Embase	Themes identified: 1. Positive patient satisfaction	✓ International study included USA in about half of studies	Level III-A

based nurse-led clinics on patient outcomes, patient satisfaction, patient access and cost effectiveness: A systematic review. *International Journal of Nursing Studies, 73*, 24-33.	3965 participants • Limited to 2006-2016 • Reviewed nurse-led primary care and ambulatory clinics • Mixed methods studies/qualitative and quantitative	MeSH terms included: Nurse-managed Centers; Practice: Patterns; Nurse, ambulatory care Keywords: nurse-led clinic and community	with nurse-led clinics 2. Self-reported patient outcomes were improved 3. Access was increased by nurse-led clinics 4. Cost-effectiveness was not well reported and	✓ Looked at many clinics serving the homeless and indigent ✓ Many subjective and self-report measures were found in the results of majority of studies ✓ More objective measures are necessary for building evidence ✓ Sample of review was small but	

		Appraised using Joanna Briggs criteria	had mixed results	very relevant to project plan	
Savage, C. L., Lindsell, C. J., Gillespie, G. L., Lee, R. J., & Corbin, A. (2008). Improving health status of homeless patients at a nurse-managed clinic in the Midwest USA. *Health and Social Care in the*	• Mixed-methods Design • Pre-post survey using a 95-item survey tool by Ware et al. 1996. • Intervention was nurse managed homeless	Qualitative interviews using the validated tool and participants were compensated with a restaurant gift card. SPSS was used to	✓ 112 participants met inclusion criteria ✓ Demographics were reported	Highlights included the evaluation of substance abuse as a health outcome. Improved perception of availability and quality of care provided was Sig. Demographics of population served and use of RN & APN is very relatable to this project Limitations included the self-reported measures	Level II-B

Community, 16(5):469-475	clinic in a church meal distribution setting • 412 attended the clinic; 136 participated in the survey • Pilot went for 18 months from 9/2003-4/2005	evaluate Means and SD t-test; Mann Whitney U test; chi-square	✓ Almost 2/3 (62.8%) had used the ED more than 2 times per month for care ✓ Sig. P-value for: improv	rather than objective health outcome data. Inclusion and exclusion criteria were subjective and duplication of study would be challenged by this.	

			ed physical, mental, vitality, and social functioning. ✓ Sig. positive impact on feeling of quality		

			of care and increased availability of care.		
Smith, S.D., Yoon, R., Johnson, M.L., Natarajan, L., Beck, E. (2014). The Effect of Involvement in a Student-run Free Clinic Project on Attitudes toward the Underserved and	• Survey of medical students from 2001-2010 in their 1st and 2nd year working in a student run	Wilcoxon's rank test was performed on all matched pairs and intent-to-treat analysis included	✓ 934 students enrolled in the SRFCP cohorts were	This study highlights the work of SRFCP and the benefits for shifting culture to more empathy and greater attention to the needs of vulnerable populations The intervention group had many opportunities	Level II-B

Interest in Primary Care. *Journal of Health Care for the Poor and Underserved, 25(2):877-889.*	free clinic program (SRFCP) • 15 item-survey (internally developed by UCSD and tested over 3-year period) using a Likert type scale pre/post	unmatched pairs Cronbach's alpha for internal consistency Shapiro-Wilk test for normal distribution SPSS was utilized to examine Likert scale scores	surveyed ✓ 97/9% response rate ✓ Matched pairs were available for 47.4% of respondents ✓ 32.7% unmatc	to collaborate and reflect on their work which may not be realistic in all free clinic settings The high percentage of positive responses after this experience provides great evidence to support this type of program for allied health campuses Limitations include a true control group Change in attitudes and beliefs were not measured beyond the 10-week course.	

	survey design • Participants rated satisfaction of working with homeless/indigent populations and likelihood of engaging in community-based		hed pairs were evaluated ✓ Improvement on hands on skills with this population were	Longitudinal changes and adherence to positive attitudes need to be studied further.	

	clinics as a provider		highly rated ✓ Attitudes were improved greatly after participating in the SRFCP		
Wang, H., Nejtek, V.A., Zieger, D., Robinson, R.D., Schrader, C.D.,	• Retrospective chart review from 2013-2014	• Categorical data was	54% of all patients HER reviews were seen as	Retrospective study could not account for all variables and had	Level V-B

Phariss, C., Ku, J. & Zenarosa, N. (2015). The Role of Charity Care and Primary Care Physician Assignment on ED Use in Homeless Patients. *American Journal of Emergency Medicine, 33 (2015) 1006-1011.*	using EHR of homeless patients seen in the ED in a level-1 trauma center in Texas • Examined the appropriateness of ED using based on the	compared using Pearson x2 test • Continuous data analyzed using t-test • Correlation coeffic	applicable to the NYUA algorithm Non-charity care charts were excluded 2396 ED visits of 867 homeless patients were part of the final analysis Use of the ED for appropriate crisis care and inappropriate	subjective criteria to meet NYUA algorithm This single study was done in a facility that offers in patient psych access which may influence the visit volume and use of ED by homeless Factors regarding the PCP relationship to the patients reviewed in this study are unknown Study makes the case for need of education about ED use in the homeless	

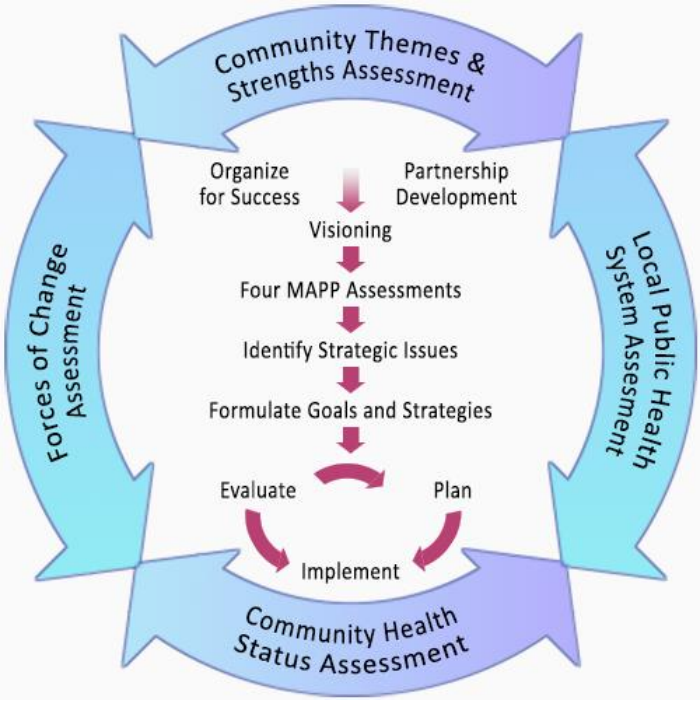
	NYUA scale: 1. Emergent 2. Primary care non-emergent 3. Emergency care need but preventable/avoidable consider	ients were reported to show relationship • All analysis was performed using STATA 12.0 and	non-crisis care accounted for nearly 50% of all visits Concluded that primary care access did not reduce ED visits in the homeless Use of ED was not dependent of PCP status	population and what is true "crisis" and what is considered "non-crisis"	

	ation would have prevented necessity of ED 4. Non-emergent but did not fit into other categories	p<.05 was considered sig.			

Appendix D

Framework

MAPP: Mobilizing Through Action Planning and Partnerships



Integration Using MAPP Model:

1) Community Themes and Strengths:
   a. Assessment of Homeless population in SD
   b. Identification of PLNU SON resources
2) Organize & Partnership Development:
   a. Investigate potential partner locations for clinics
   b. Partner with other Pop-Up Clinics
   c. Partner with SD County PH
   d. Establish MOU's with partners
   e.
3) Visioning:
   a. Create Street Medicine Alliance to integrate community partners
   b. Examine Informatics options to integrate care delivery and improve resource allocation for patients/providers
   c.
4) Identify Strategic Issues:
   a. Meet with community and public agencies providing care to similar populations
5) Formulate Goals and Strategies:
   a. Develop care delivery goals
   b. Develop model with partners using community benchmarks
6) Implement model with partners in place
7) Evaluate model
8) Share and disseminate outcomes & lessons learned

Appendix E
Work Breakdown Structure

1.0 Introduction to the project and implementation plan

- 1.1 Meet with Dean of PLNU SON to discuss plan
- 1.2 Identify gap
- 1.3 Identify stakeholders
- 1.4 Complete SWOT analysis
- 1.5 Develop GANTT timeline
- 1.6 Identify potential organizations and locations to partner with

2.0 Buy-In from PLNU and Community partner locations

- 2.1 Create team and identify roles and responsibilities
- 2.2 MOU for pop-up clinic sites
- 2.3 Site visits and set-up planning
- 2.4 Meet with other student run free clinic directors
- 2.5 Meet with SD county PHN

3.0 Pop-Up clinic model development

- 3.1 Community Needs assessment to identify scope of service/student needs
- 3.2 Establish practice guidelines
- 3.3 Create paperwork for intake/screening
- 3.4 Create Education files for patient handouts
- 3.5 Make a list of supplies needed

4.0 Establish Funding sources

- 4.1 PLNU jacket sales
- 4.2 Identify grant resources

4.3 Present financial needs to University council

5.0 Pop-up clinic Model Implementation

5.1 Establish clinic schedule

5.2 Set up supplies

5.3 Print paperwork

5.4 Rollout first RN-BSN cohort team

5.5 Host Flu Clinic kickoff day

5.6 Begin seeing patients

5.7 Initiate data capture/pre-survey of students

6.0 Project Evaluation

6.1 Have debriefing with first cohort weekly over 8 weeks

6.2 Compile patient data

6.3 Survey student experience

6.4 Survey patient experience

6.5 Analyze results

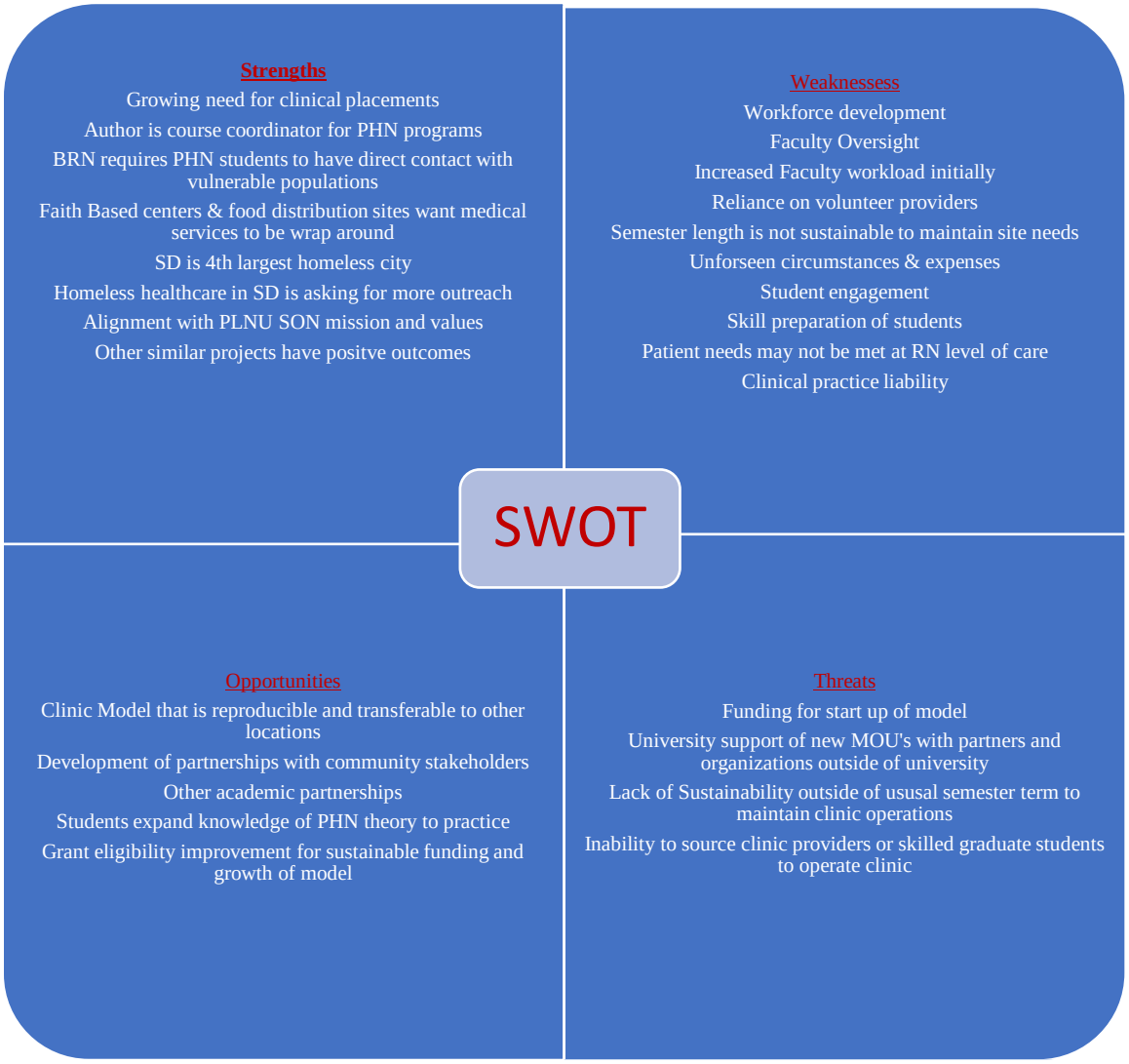
7.0 Dissemination

7.1 Present findings and lessons learned to PLNU

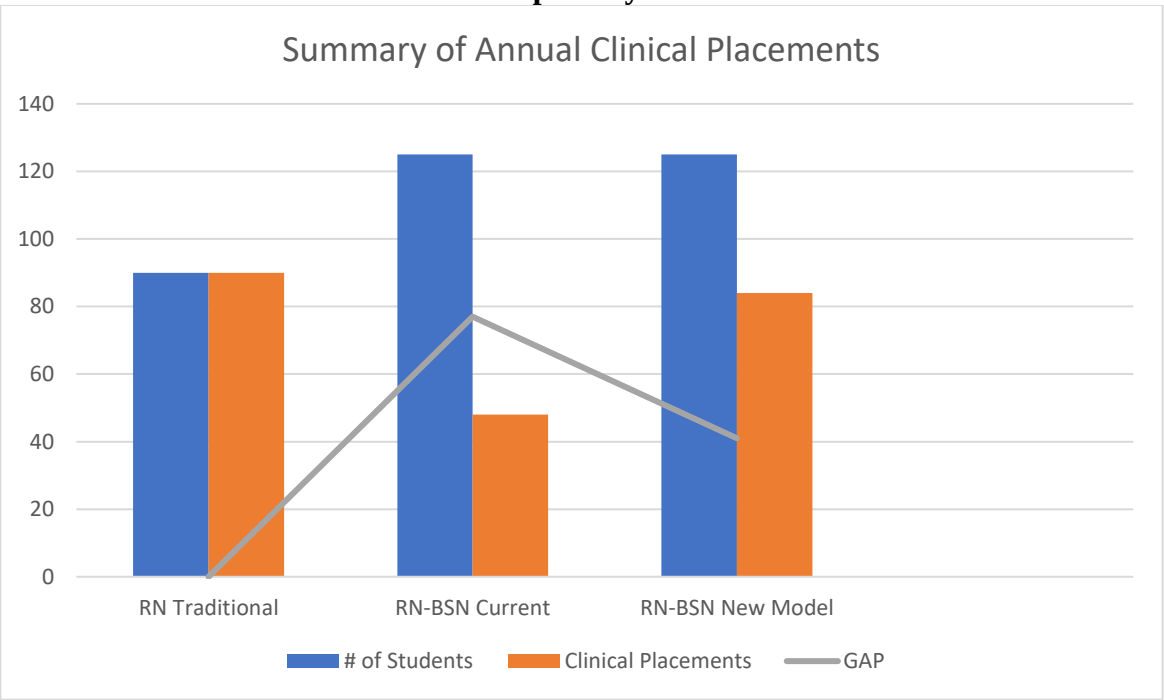
7.2 Complete DNP paper of project

7.3 Present DNP project

Appendix F
SWOT Analysis



Appendix G
Gap Analysis



Appendix H
Communication Matrix

Contact	Category	Topic	Method	Frequency
Dr. Jo Loomis	Project Advisor	Project development/progress/completion	Zoom/email	monthly
Dr. Michelle Riignen	Associate Dean PLNU	Project development/RN-BSN program dean/ strategic planning and implementation approval	Email/in person/con-call/text	Weekly and as needed
Marsha Reece	PLNU SON program coordinator	MOU documents/consortium approvals and SON budget distribution	Email/in person/con-call	Development and as needed
Stacey Wilson	PLNU SON RN-BSN program coordinator	Cohort planning/Regional college collaborations/student contact information/ RN-BSN budget and marketing distribution	Email/in person/con-call/text	Weekly and as needed
Mary Margaret Rowe	NP Director PLNU SON Free clinic	Project development advising through all phases	Email/in person/con-call	Weekly and as needed
Reverend Terry Scott	Director of patient advocacy Wesley C0-op	Project development through all phases as partner and clinic site location	Email/in person/con-call/text	Weekly and as needed
Mauricio Orantes	Patient Engagement Specialist Family Health Centers	Partner development through all phases to provide patient referrals and medical providers/resource support	Email/in person/con-call/text	Weekly and as needed
Lyssa Melanakos	Director of patient advocacy ladle fellowship street corner care	Partner development/ street medicine national benchmark planning through all phases	Email/in person/con-call/text	Weekly and as needed

Appendix I
Letter of Intent: Wesley Community Services Center
MOU and Clinical Site Agreement

March 15, 2019

This letter serves as an agreement for services between the Wesley Community Services Center and Point Loma Nazarene University (PLNU) School of Nursing in accordance with our Memorandum of Understanding as executed in September of 2018. Nursing clinic services will be provided by PLNU within the academic calendar during your scheduled hours of operation. Community partners including Family Health Centers, County of San Diego Health and Human Services Agency and Champions for Health will participate in providing clinical health promotion resources to clients of the Wesley Co-Op.

Thank you for your partnership and providing a location for us to extend the reach of nursing care to this wonderful population.

Jennifer King MSN RN CSN PHN
Nursing Faculty Professor PLNU

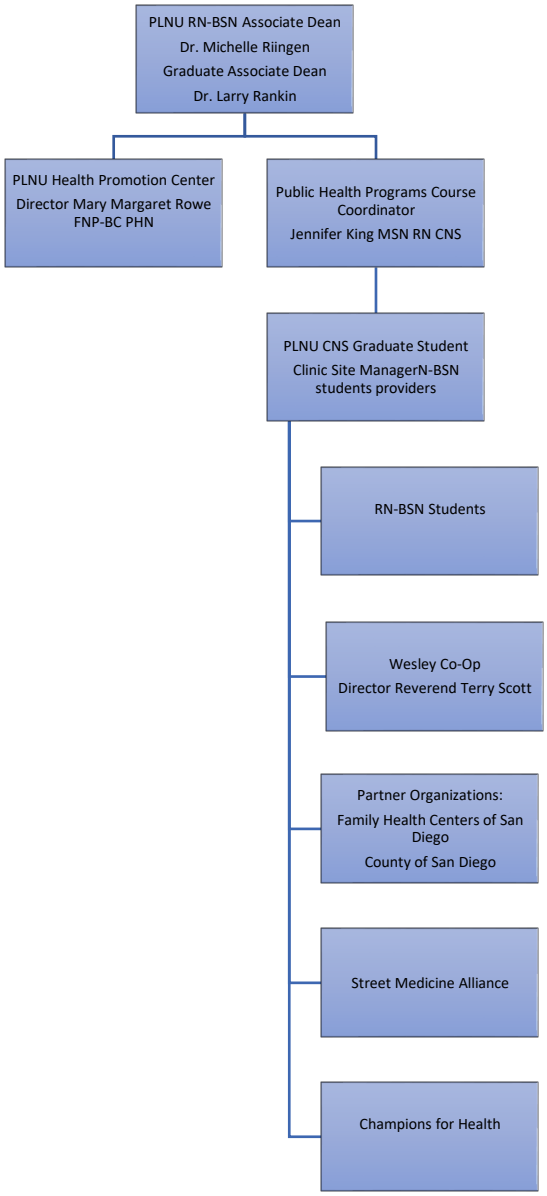
Jennifer King
_____

Reverend Terry Scott
Patient Advocacy Director Wesley Community Services Center

Rev. Terry Scott MA

Appendix J

PLNU Pop-Up Model Clinic Administrative Structure



Appendix K

PLNU Community Partners

Organization	Services Provided	MOU Affiliation Agreement:
County of San Diego Health and Human Services Agency	✓ Immunizations ✓ San Diego Immunization Registry (SDIR) ✓ Regional Medical Clinics ✓ County Mental Health ✓ Eligibility for SDHHSA programs	**Yes**
Champions For Health	✓ Volunteer MD's/PA's/Np's ✓ Immunizations ✓ Free prescription drug coupons ✓ Health Education	**Yes**
211 San Diego	✓ Community Information Exchange (CIE) system (medical referral and Free EHR tool) ✓ 24-hour call center and online services addressing SDOH ✓ Medical & other CA benefits enrollment	**Yes**
Family Health Centers of San Diego	✓ Patient Engagement Specialists	**Yes**

	✓ Referrals for same day and scheduled appointments ✓ Whole Person Wellness Initiative eligibility and enrollment ✓ Volunteer Medical Providers & specialist care	
San Diego Street Medicine Alliance	✓ Partnership with multiple homeless service organizations in SD ✓ Interprofessional organization ✓ Affiliated with 3 schools of Nursing in SD: Azusa Pacific University; Cal State San Marcos University; San Diego State University	**Yes**

Appendix L
Clinic Model & Documents

The process to establish a nurse led clinic through an academic setting requires many steps. An overview of the necessary components is outlined in this document.

---

1. Assessment of need for clinical placements
2. Identification of scope of practice for students that will be participating
3. Approval by School of Nursing
4. Procure legal documents for clinic operations
5. Create community partners MOU
6. Establish clinic sites with MOU
7. Procure funding
8. Create outline of appropriate clinical activities to be carried out at site
9. Create supply list including educational materials
10. Develop paperwork
11. Collaborate with local partners to add multi-disciplinary providers
12. Engage students to support model development
13. Outline clinic structure including faculty oversight

Clinic Site:

- Shelter
- Church
- Food Distribution Location

Clinic Structure:

Lead: Public Health Clinical Course Faculty

Site Supervision: MSN or DNP student

Nurse Providers: RN-BSN students (# 4 per site for clinical groups)

Clinical Activities:

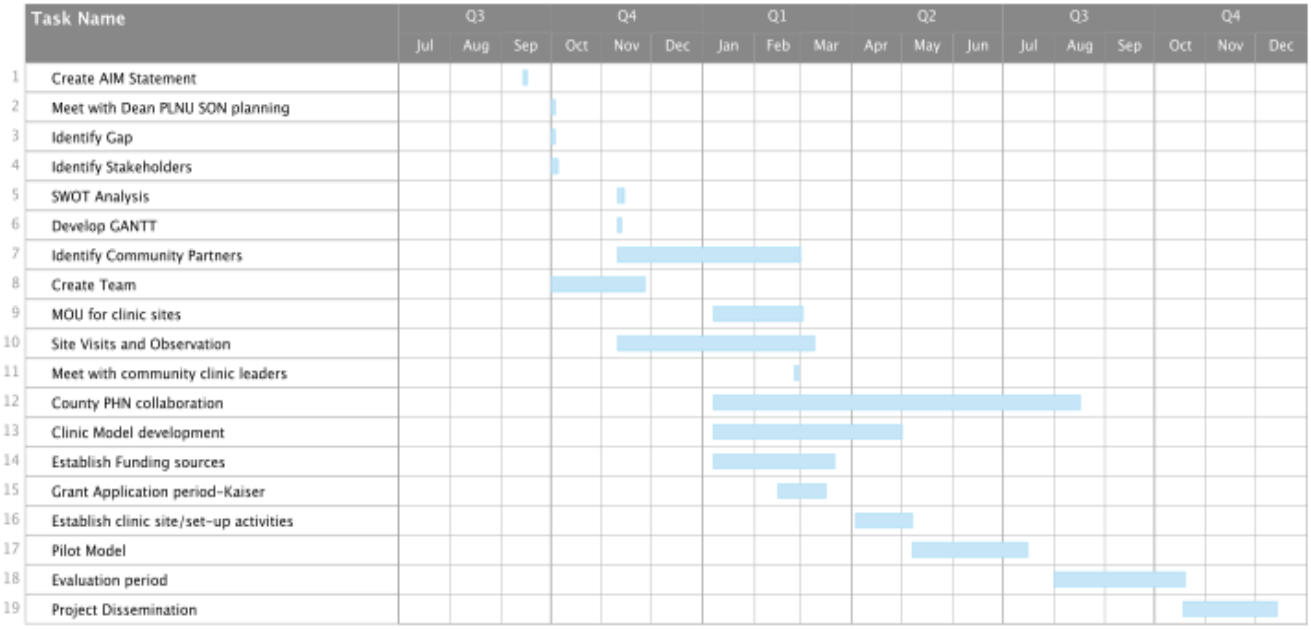
- BP Screening
- Blood Glucose Screening
- Health Education
- Health Assessments
- Immunization surveillance and provision in partnership with local agencies
- Depression Screening
- Case Management
- Referrals to Partner clinics
- Health Promotion Activities
- PLNU Health Promotion Center & Pop-Up Clinic Documents

PLNU Health Promotion Center Brochure	**https://drive.google.com/file/d/0B853vibqnkIUd2FybWFacC1RbTFxMS0tOVFoS1hNbXBucTdN/view?usp=sharing https://drive.google.com/drive/u/0/my-drive**
PLNU Pop-Up Clinic Brochure	**https://drive.google.com/open?id=1z2JnEiPGrJPuoZAXHFr2DkEwt0g_wYkc**
Pop-Up Clinic Intake form	**https://docs.google.com/document/d/1IBA9usdCMREm99oOi5lsXGnAgEr-Le35BcQUgqpV7CI/edit**
PLNU BP Referral Form	**https://drive.google.com/drive/u/1/folders/0ADuCY3P5uK3SUk9PVA**
Community Clinic Resources Drive Collection	**https://drive.google.com/drive/u/1/folders/0ADuCY3P5uK3SUk9PVA**
Community Clinic Policy & Procedure Manual	https://drive.google.com/open?id=1FTnjNC2gSFY3i7s52XUepSz_9B7YoOt5

Interprofessional Community Resource Volunteer Contact List	**https://docs.google.com/spreadsheets/d/1nA3ei_fBo3zbmv2GcwNIHM-uFCCwhVAYni4epmwwHGA/edit#gid=1153289665**

▪

Appendix M
GANTT Chart
Fall 2018-Fall 2019



Appendix N
Total Cost Consideration

SUPPLIES/SERVICES	COST	QUANTITY	TOTAL
RN-BSN Faculty course coordination	$150/student	125	$18,750
Model development by DNP student	$70/hr.	500 hrs.	($35,000)* *based on 500 hours of DNP student at average faculty salary rate of $70/hour
Printing of Materials	$0.15/page	1000	$150
Clinic Supplies per semester	$2000	3	$6000* *semester budget provided by PLNU SON based on RN-BSN trimester
RN student services (12 students per week)	"in kind"	6,336 hours* *based on clinic 12 hours per week over 44weeks per year	($285,120)* *Based on average new grad RN rate of $45/hour
Graduate student services (3 students per week)	"in kind"	1,584 hours* *based on clinic 12hours per week over 44weeks per year	($87,120)* *Based on average case manager clinic salary of $55/hour
BSN Student Consortium SDNSEC	$350.00 Per student consortium membership fee	125 *based on 2019 enrollment	($43,750) Annual cost avoidance to SON for not utilizing consortium
Patients served	$2,000 *average ED visit 2017 Source: (Williams, 2019)	660* *average of 30 encounters/week over 44 weeks assuming 50% would otherwise attend ED	($1,320,000)* Annual cost avoidance to hospital healthcare system
Patients Served	$479.00* Average cost of PCP visits for uninsured	660* *average of 30 encounters/week over 44 weeks assuming 50%	($316,140)* Annual cost avoidance to outpatient healthcare system

	Source: (National Healthcare for the Homeless council, 2018)	would otherwise attend PCP clinic	
		Total Cost: **Total In-Kind patient services by PLNU:** **Total Y1 Savings to SD Healthcare systems:**	**Y1 startup cost to PLNU:$59,900** **$372,240** **$1,636,140**

Legend

One-time cost	On-going costs	Clinical service by students/volunteers	Patient/Student cost avoidance

[*These are actual costs following first year implementation of this project. All numbers are considered actual and projected budgets have been realized by this author.]

Appendix O
3-Year Proforma Budget
Nurse-Led Clinic

	2018-2019	2019-2020	2020-2021
SON Income *Annual budget allowance	$6000	$6000	$6000
Nursing Jacket Sales	$725	$725	$725
Year Total Income:	**$6,725**	**$6,725**	**$6,725**
Faculty Clinical Coordination *Rate is contract per unit load $150/student assuming 125 enrolled.	$18,750*	$20,625	$22,687.50
Clinic Supplies (*10% rise assumed annually)	$6000	$6060	$6120
Printing of Educational Materials (Based on initial printing adjusted for increased patient volume)	$150	$198	$198
DNP Faculty Project Coordinator *Replaced by Graduate Rate Student coordinator in Y2 &Y3 All rates are in-kind	($35,000)	*($22,500)	*($22,500)
Year Total Expenses:	**$24,900**	**$26,833**	**$29,005.50**

Annual Cost to operate clinic:	**Y1=$18,175.00**	**Y2=$20,108.00**	**Y3=$22,280.50**

Appendix P
Cost Difference/ROI

	2018-2019	2019-2020	2020-2021
Free-Clinic: Annual Cost to operate clinic:	**Y1=$18,175.00**	**Y2=$20,108.00**	**Y3=$22,280.50**
Consortium: Annual cost to participate in SDNSEC:	**Y1=$66,875.00**	**Y2=$69,625.00**	**Y3=$72,610.65**
Net Savings to PLNU choosing Free-Clinic:	**Y1=$48,700.00 ROI:$48,700/$18175=2.68x100=268% to PLNU**	**Y2=$49,517.00**	**Y3=$50,330.15 ROI: $50,330.15/$22,280.50=2.48x100 =248% to PLNU**
ROI Clinic: *Cost of in-kind clinic leadership labor costs included **Health care system savings by PLNU serving the community with a free clinic	**$1,636,140**/$59,900*=27.31 x100=%2,731 to SD Healthcare system for future funding purposes.**	**$1,636,140**/$49,333*=33.2 x100=%3,320**	**$1,636,140**/$51,505.20*=31.8 x100=%3,180**

Appendix Q
Clinical Evaluation Tool

NRS 421 Clinical Evaluation – PART 1: STUDENT COMPLETED FORM

Completing Clinical Evaluation: Instructions

Instructions to Complete Form:

Student Self-Assessment: In the columns below, rate yourself in each category by placing your initials in the box where you feel that you are performing. If you rate yourself "Needs Improvement," include narrative in the "Areas for Growth" comment column. Please rate the site of your clinical placement and answer "YES" if meets program learning outcomes or "NO" if it did not. Please write comments on areas for improvement at clinical site.

Faculty Evaluation: Instructor may elect to document in narrative fashion in accompanying assessment rubric.

How to complete and submit form:

1. Click the **EDIT** button to the right of heading for the Student Self-Assessment section below
2. Type your responses in the space provided within Student Self-Assessment
3. When finished typing, click the green **Save And Finish** button
4. Click the red **Attach to Assignment** button at top of this assignment page

Student Self-Assessment

PART 1: ADHERES TO ANA STANDARDS OF PRACTICE

CRITICAL BEHAVIORS WHICH IMMEDIATELY RESULT IN PROBATION OR POSSIBLE FAILURE OF COURSE:

- Falsifying a client record.
- Blatant disregard of client confidentiality.
- Denying responsibility for one's own deviation from standard practice.
- Actions which place the client in jeopardy.
- Actions which place student or colleague in jeopardy.
- Abusive behavior toward clients.
- Ignoring the need for essential information before intervening.
- Not maintaining the standards of professional practice (for example: uniform, conduct, communication)

Student MUST meet outcomes at a minimum of 75%

Please complete table by marking "X" in appropriate column, and proving total clinical hours:

OUTCOME:	**YES**	**NO**
Completed 100% of clinical time		
If not, make-up time completed / arranged		
TOTAL number of clinical hours completed this semester:		

PART 2: NRS 421: Practicum - Caring Faithfully in the Community

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Please complete table by responding in the appropriate column:

OUTCOME:	**MEETS EXPECTATIONS**	**AREAS FOR GROWTH (COMMENT)**	**CLINICAL SITE PROVIDED OPPORTUNITY TO MEET LEARNING NEEDS: *YES OR NO* (COMMENT)**
INQUIRING FAITHFULLY: I.6. Integrate global, national and local concepts of the public health model and theories of nursing to clinical practice. PLOs I.B, II.B, III.A, IV.A, V.B, V.C PHCCR 1491-6: A-C			
I.7. Utilize knowledge from previous nursing courses and public health science in providing care for community clients. PLOs I.D, II.B, III.C, V.C PHCCR 1491-6: A-C			
I. 8. Engage with diverse, cultural, ethnic and social backgrounds and link resources to meet patient,			

family and community needs. PLOs I.A, I.D, II.C, III.D, V.B, V.C PHCCR 1491-6: A-C			
CARING FAITHFULLY: II.4. Model consistent self-care practices for healthy living, including support of self, peers and community clients PLOs I.D, II.A, III.A, IV.B, V.B PHCCR 1491-6: A-C			
II.5. Incorporate those nursing practices that demonstrate respect for ethnic identity, sociocultural practices of clients in the community. PLOs I.C, I.D, II.B, III.A, III.D, IV.B, V.C PHCCR 1491-6: A-C			
II.6. Assess ethical/legal standards of nursing practice that impact the community settings PLOs I.D, II.C, III.C, V.C PHCCR 1491-6: A-C			
COMMUNICATING FAITHFULLY: III.6. Assist clients to exercise their rights to select, participate and evaluate health care PLOs I.B, I.C, II.B, III.B, IV.C, V.C PHCCR 1491-6: A-C			
III.7. Investigate cultural influences to communication patterns in families and communities.			

PLOs I.D, II.A, III.A, IV.B, V.B PHCCR 1491-6: A-C			
III.8. Provide clinical skills relevant to the public health nursing practice including: screening, immunizations, home assessments, individual and family health assessments, chronic disease self-management, and care coordination. PLOs I.A, I.D, II.B, III.A, IV.B, V.A PHCCR 1491-6: A-C			
FOLLOWING FAITHFULLY: IV.5. Promote public health through partnership with clients and agencies as a model of respect for the needs of others PLOs I.D, I.E, II.A, III.D, V.A PHCCR 1491-6: A-C			
IV.6. Assume responsibility and accountability for provision of quality care with indirect supervision in public health settings with individuals, families, and community PLOs I.B, I.D, II.B, III.E, IV.B, V.C PHCCR 1491-6: A-C			
IV.7. Demonstrates presentation of targeted health information to multiple audiences at a local level, including to community groups and agency peers. PLOs I.B, I.C, III.D, IV.A			

PHCCR 1491-6: A-C			
LEADING FAITHFULLY: V.5. Model consistent self-care practices for healthy living, including support of self, peers and community clients. PLOs I.C, II.B, III.E, IV.B, V.C PHCCR 1491-6: A-C			
V.6. Strategize with colleagues and clients the best practices in dissemination of community resources for clients. PLOs I.D, I.E, II.B, III.C, V.A PHCCR 1491-6: A-C			
V.7. Affirms clients informed values and choices when different from the student's own. PLOs I.C, I.D, II.C, II.D, III.C, IV.B, V.C PHCCR 1491-6: A-C			

NRS 421 Clinical Evaluation – PART 2: FACULTY RUBRIC

NRS421 Clinical Evaluation Rubric

	Meets Expected Standards (1.000 pt)	**Needs Improvement to Meet Expectations** (0.000 pt)
INQUIRING: I.6 Integrate global, national and local concepts of the public health model and theories of nursing to clinical practice (1.000, 6%)		
INQUIRING: I.7. Utilize knowledge from previous nursing courses and public health science in providing care for community clients. (1.000, 6%)		
INQUIRING: I. 8. Engage with diverse, cultural, ethnic and social backgrounds and link resources to meet patient, family and community needs. (1.000, 6%)		
CARING: II.4. Model consistent self-care practices for healthy living, including support of self, peers and community clients (1.000, 6%)		
CARING: II.5. Incorporate those nursing practices that demonstrate respect for ethnic identity, sociocultural practices of clients in the community. (1.000, 6%)		
CARING: II.6. Assess ethical/legal standards of nursing practice that impact the community settings (1.000, 6%)		
COMMUNICATING: III.6. Assist clients to exercise their rights to select, participate and evaluate health care (1.000, 6%)		
COMMUNICATING: III.7. Investigate cultural influences to communication patterns in families and communities.(1.000, 6%)		
COMMUNICATING: III.8. Provide clinical skills relevant to the public health nursing practice including: screening, immunizations, home assessments, individual and family health		

assessments, chronic disease self-management, and care coordination.(1.000, 6%)		
FOLLOWING: IV.5. Promote public health through partnership with clients and agencies as a model of respect for the needs of others (1.000, 6%)		
FOLLOWING: IV.6. Assume responsibility and accountability for provision of quality care with indirect supervision in public health settings with individuals, families, and community (1.000, 6%)		
FOLLOWING: IV.7. Demonstrates presentation of targeted health information to multiple audiences at a local level, including to community groups and agency peers (1.000, 6%)		
LEADING: V.5. Model consistent self-care practices for healthy living, including support of self, peers and community clients. (1.000, 6%)		
LEADING: V.6. Strategize with colleagues and clients the best practices in dissemination of community resources for clients. (1.000, 6%)		
LEADING: V.7. Affirms clients informed values and choices when different from the student's own. (1.000, 6%)		

Link to Tool:
https://docs.google.com/document/d/1QBtfuKo1tqs8E_udqQj9HYy_iyToFBEyR_kaMf3o5Xk/edit#

Appendix R

Outcome Table

Clinical Placement	Wesley co-op Nurse Led Clinic	The Arc Adult Day Center
# of Students Summer 2019	33=54% of students	29=46% of students
Met Clinical Outcomes (YES or NO) *self-reported on evaluation	YES: 25=40% NO:1=<1% N/A:7	YES: 12=19% NO:10=<3% N/A:7
# Of Clinical Hours completed	1,320	1,160
# Of Patients Served	222	0

Link to Google Drive Data: https://drive.google.com/open?id=1-pxGrAa6_-apLII6PNFYvM6uHae4YX4M

Appendix S
PLNU SON Mission CLO's & CA BRN PHN Requirements

Inquiring Faithfully: Applied holistic nursing skills to practice	**8. Engage with diverse, cultural, ethnic and social backgrounds and link resources to meet patient, family and community needs.** **PLOs I.A, I.D, II.C, III.D, V.B, V.C** **PHCCR 1491-6: A-C**
Caring Faithfully: Aim to foster optimal health and offering grace	**5. Incorporate those nursing practices that demonstrate respect for ethnic identity, sociocultural practices of clients in the community.** **PLOs I.C, I.D, II.B, III.A, III.D, IV.B, V.C** **PHCCR 1491-6: A-C**
Communicating Faithfully: Advocacy with cultural competence and respect for autonomy	**8. Provide clinical skills relevant to the public health nursing practice including: screening, immunizations, home assessments, individual and family health assessments, chronic disease self-management, and care coordination.** **PLOs I.A, I.D, II.B, III.A, IV.B, V.A** **PHCCR 1491-6: A-C**
Following Faithfully: "Divine Imposed Duty of Ordinary Work"	**5. Promote public health through partnership with clients and agencies as a model of res the needs of others** **PLOs I.D, I.E, II.A, III.D, V.A** **PHCCR 1491-6: A-C** **6. Assume responsibility and accountability for provision of quality care with indirect sup in public health settings with individuals, families, and community** **PLOs I.B, I.D, II.B, III.E, IV.B, V.C** **PHCCR 1491-6: A-C**
Leading Faithfully: role-model the need for	**6. Strategize with colleagues and clients the best practices in dissemination of community resources for clients.** **PLOs I.D, I.E, II.B, III.C, V.A** **PHCCR 1491-6: A-C**

“Sabbath Rest” as a means of personal renewal, and true care of the self, so that service to others is optimally achieved.	

***(Adapted from PLNU RN-BSN syllabus 2018 King)**

Appendix T

CA Laws for Clinic Designation Per HHSA CA DPH

State of California—Health and Human Services Agency

California Department of Public Health

PRIMARY CARE CLINIC

DEFINITIONS

Free clinic	is "a clinic operated by a tax-exempt nonprofit corporation that is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services. In a free clinic there shall be no charges directly to the patient for services rendered or for drugs, medicines, appliances, or apparatuses furnished." [HSC section 1204(a)(1)(B)]
Intermittent clinic	is "a clinic that is operated by a primary care community or free clinic and that is operated on separate premises from the licensed clinic and is only open for limited services of no more than 30 hours a week. An intermittent clinic as described in this subdivision shall, however, meet all other requirements of law, including administrative regulations and requirements, pertaining to fire and life safety." [HSC section 1206(h)]

HEALTH AND SAFETY CODE - HSC
DIVISION 2. LICENSING PROVISIONS [1200 - 1797.8]
(Division 2 enacted by Stats. 1939, Ch. 60.)

CHAPTER 1. CLINICS [1200 - 1245]
(Chapter 1 repealed and added by Stats. 1978, Ch. 1147.)

ARTICLE 1. DEFINITIONS AND GENERAL PROVISIONS [1200 - 1211]
(Article 1 added by Stats. 1978, Ch. 1147.)

(a) Except with respect to the option provided with regard to surgical clinics in paragraph (1) of subdivision (b) of Section 1204 and, further, with respect to specialty clinics specified in paragraph (2) of subdivision (b) of Section 1204, any place or establishment owned or leased and operated as a clinic or office by one or more licensed health care practitioners and used as an

office for the practice of their profession, within the scope of their license, regardless of the name used publicly to identify the place or establishment.
(b) Any clinic directly conducted, maintained, or operated by the United States or by any of its departments, officers, or agencies, and any primary care clinic specified in subdivision (a) of Section 1204 that is directly conducted, maintained, or operated by this state or by any of its political subdivisions or districts, or by any city. Nothing in this subdivision precludes the state department from adopting regulations that utilize clinic licensing standards as eligibility criteria for participation in programs funded wholly or partially under Title XVIII or XIX of the federal Social Security Act.

(c) (1) Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization, as defined in Section 450 or 1603 of Title 25 of the United States Code, that is located on land recognized as tribal land by the federal government.

(2) Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization, as defined in Section 450 or 1603 of Title 25 of the United States Code, under a contract with the United States pursuant to the Indian Self-Determination and Education Assistance Act (Public Law 93-638), regardless of the location of the clinic, except that if the clinic chooses to apply to the State Department of Public Health for a state facility license, then the State Department of Public Health will retain authority to regulate that clinic as a primary care clinic as defined by subdivision (a) of Section 1204.

(d) Clinics conducted, operated, or maintained as outpatient departments of hospitals.

(e) Any facility licensed as a health facility under Chapter 2 (commencing with Section 1250).

(f) Any freestanding clinical or pathological laboratory licensed under Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code.

(g) A clinic operated by, or affiliated with, any institution of learning that teaches a recognized healing art and is approved by the state board or commission vested with responsibility for regulation of the practice of that healing art.

(h) A clinic that is operated by a primary care community or free clinic and that is operated on separate premises from the licensed clinic and is only open for limited services of no more than 40 hours a week. An intermittent clinic as described in this subdivision shall, however, meet all other requirements of law, including administrative regulations and requirements, pertaining to fire and life safety.

***PLNU Health Promotion Center CA Free & Charitable Clinic**

***PLNU Pop-Up Clinic as an Intermittent Clinic Designation**

Source: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/PCC-Licensing-Certification.aspx#De