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## **NNCC Launches Lead Safe D.C.**

This spring, the NNCC opened its first official office in Washington D.C. as the headquarters for the Consortium's Lead Safe D.C. program. The program, which aims to prevent children from becoming lead poisoned, comes at a critical time for the city.

Recent news stories and research have revealed that the water pipes leading to many neighborhoods are contaminating the water with dangerous levels of lead.

Repairing the pipes may take years, but Lead Safe D.C. hopes to help parents reduce their child's contact with lead from all sources immediately. The program, which is funded by a \$100,000 grant from the United States Environmental Protection Agency, calls for home visits to be made by outreach workers. The workers will guide families with a curriculum written by the NNCC that explains lead poisoning and how it can be avoided.

The program also provides for a Lead Safe D.C. interactive website, the formation of a lead safety coalition and 20 educational outreach conferences for the community.

The Washington D.C. office is also funded by NNCC and will serve as a launching point for the consortium's member services initiative and other potential programs. The

*Continued on page 30*



*Don Welsh, Congresswoman Norton, Tine Hansen-Turton, Laura Line*



*Congresswoman Norton speaking at the podium*



*Rich Kamps, Gail Tindal, Tine Hansen-Turton, Harrison Newton, Don Welsh, Dr. Guidotti, Dr. Gitterman, Nonye Harvey, Felicia Eaves, Dr. Cotroneo, Laura Line*

## Greetings from the Board Chair

By Elaine Tagliareni

The growth of the NNCC over the past three years has been wide-ranging and rapid. We have moved from a regional organization to one with over 100 members nationally. Our Executive Director, Tine Hansen-Turton, has done a remarkable job in piloting our young organization through these pivotal times. At the NNCC Board meeting in November 2003, a discussion took place about the need to fully consider the NNCC's future in light of this rapid growth. After further conversation board members decided that a face-to-face business planning retreat was needed so that we could spend time analyzing and planning for the NNCC's organizational well-being, and concentrate on its own ongoing sustenance. The Board met together in February 2004 in Philadelphia and contracted with Fairmount Ventures, Inc., a consulting group that positions non-profit organizations to grapple with key strategic issues through program design and strategic planning, to run the retreat. During the meeting Board members considered a wide variety of issues:

- What is a reasonable revenue portfolio for the NNCC (i.e. the mix of grants, membership dues, earned income etc)?
- What types of programs should the NNCC operate and how can they be financially sustainable?

- What is the optimal staffing and organizational structure?
- What are the ideal composition, roles, and responsibilities of the Board moving forward?
- How can the NNCC assure that it is developing a national movement that will position nursing centers to be an integral part of America's health care system?

Over two days, members of the Board considered these issues, reviewed the current vision and mission of the NNCC, and set in motion a process to develop a business plan that will serve as a "road map" for NNCC's growth and development over the next three years. Our work will continue throughout the summer and fall and the outcome of our deliberations will be presented at the NNCC's 3<sup>rd</sup> Annual conference in Nashville, October 15-17, 2004. It is our hope that by undertaking this review, Board members will provide the leadership that is required to maintain NNCC's sustained growth, while continuing to offer support to NNCC's membership and to the nursing center movement as a whole. I hope to see you in Nashville as we unveil our business plan and celebrate our continued success.

## Message From the Board of Directors

We are very pleased to report that the NNCC has continued to see significant growth in staff and programs that all support the nurse-managed health center movement. This newsletter captures some of these successes. The reason for our success is that at the core of what we all do is the willingness of everyone in the Consortium to share with one another. The majority of our programs have sprung out of best practices from individual health centers that decided to share the programs with the NNCC and make them available to colleagues.

We are very fortunate to have supportive funders. Special thanks to **Senator Arlen Specter** for his support of the NNCC to evaluate the role nurse-managed health centers play as safety-net providers,



Senator Arlen Specter

for NNCC's Data Mart Network and for a Nurse-Managed Health Center Wellness Center Demonstration, to the **Independence Foundation** for its operating and data infrastructure support for the NNCC, to the **U.S. Environmental Protection Agency** for its support of Lead Safe Babies, Asthma Safe Kids and our new Lead Safe DC project, to the City of Philadelphia for its support of Lead

Safe Babies and HomeSafe, to the **Samuel S. Fels Fund** for its support to conduct a cost of care analysis of nurse-managed health centers, to the **Corporation for National Service** for its support of our AmeriCorps VISTA program, to **The Pew Charitable Trusts** for its support of the FQHC capacity building project and the Beck Cognitive training program, to the **Center for Medicare and Medicaid Services** for its support of an evaluation of nurse-managed health centers, to the **Health Resources and Services Administration** for its support of the NNCC Data Mart Network, to the **Centers for Disease Control and Prevention** for its support of the Lead Safe Babies Program, to the **Edna G. Kynett Memorial Foundation** for its support of the Heart and Soul Program, to the **U.S. Department of Housing and Urban Development** for its support of the HomeSafe Program, to **Independence Blue Cross** for its support of the Data Mart Network, and to **The Philadelphia Foundation** for its support of the Students Run Philly Style Program and to NNCC member centers, and private donors. We would like to thank them all for their ongoing support. We are also grateful for our dedicated staff and member center volunteers who continue to work tirelessly and demonstrate their commitment to our vision and mission.

***From The Desk of the Executive Director***

## **Politics, Nursing and Anthills**

By Tine Hansen-Turton

Most of us grow up professionally in our own disciplines and grow accustomed to its unique culture. Rarely do we get the opportunity to become members of a different professional culture and experience what it is all about. I have had both the honor and privilege of becoming part of the culture of nursing and the nurse-managed health center movement. However, my home base continues to be what brought me to nursing in the first place, policy, or in our line of business, what I more appropriately call politics. Recently a colleague of mine made me reflect on my own personal journey leading me to advocate for nurse-managed health centers and what they are all about. Our very successful annual conference in Baltimore this past November made it all so evident to me. The passion, commitment and energy of the more than 200 people, representing 75 nurse-managed health centers serving 27 states, along with government and non-profit professionals, were so illuminating. We are an unstoppable movement that is at the forefront of eliminating health disparities.

My 3-year old son, Nikolaj, loves Disney's Pixar animation movies, and I will admit, so do I. One of his favorite stories is about life on an anthill. The synopsis of the movie is that ants are being enslaved by the big bad grasshoppers, who make the ants collect all their food while the grasshoppers' enjoy a lazy life on the premise that the collection of food means securing the ants' protection against bigger bugs. In one of the scenes, Hopper, the vicious grasshopper leader, makes a strong statement – these ants outnumber us 100 to 1 and when they one day realize this, we'll all be in trouble. So his game is to keep the illusion going that ants need the protection of grasshoppers. However, one little brave visionary ant, Flick, catches on to their scam and takes the grasshoppers on. The rest is history, and in

the end, the ants win and take control of their anthill. So why is this story relevant? In many ways, the anthill is a microcosm of our nurse-managed health center movement. Just like Flick, we are mavericks in the health care system, asking some critical questions. Why do we keep practicing health care in the same way? Is the medical model really working for everyone and for all populations? If we as a society are really serious about eliminating health disparities, we need to critically determine how we practice health care in this country. It is time to allow nurse-managed health centers a seat at the table.

This newsletter, more so than others we have done in the past, focuses on data and policy with the underlying elements of the politics we have to play to position nurse-managed health centers to become a sustainable recognized safety-net model of health care in the U.S. and beyond. Throughout this newsletter, you will see how data through our national member survey and the Health Promotion data collection project illustrate the incredible job nurse-managed health centers are doing with regard to eliminating health disparities for over one million vulnerable people in the U.S. Our colleagues around the country, like the Michigan Consortium and the Mid-west Consortium, are also collecting data. It all leads to the same conclusion: Without nurse-managed health centers in their communities, over one million people and growing would have to resort, again, to the good old emergency room for care. I want to conclude with suggesting you read Pat DeLeon's column. Pat DeLeon, a passionate supporter and friend of nursing who for over two decades along with Senator Inouye have been our stellar supporters, says it as it is:

**THE FUTURE IS NURSING.**

## The Future Is Nursing

By Pat DeLeon, Office of Senator Daniel Inouye

It was a great personal honor to be invited to participate in your second annual conference, Best Practices in Nurse-Managed Health Centers: Eliminating Health Disparities. The 21st Century has arrived and clearly professional nursing is taking advantage of its inherent opportunities. Change requires proactive vision, persistence, and time; especially when we are considering fundamental change in the status quo – which is always unsettling to those directly affected. In the early 1980's, Linda Aiken edited what health policy experts back then must have considered a very futuristic book. Health Resources Administration Director of the Division of Nursing, Jo Eleanor Elliot, noted: "Nursing has begun a reexamination of its role in the health care delivery system. Since the mid-1950s, the Division of Nursing has supported studies of the concept of an expanded role for nurses in hospitals as well as in ambulatory and community settings... In his Health Message of 1971, President Nixon highlighted the significant contribution that specialized nurse practitioners could make in extending health care services, and the Nurse Training Act of that same year provided a broadened special project grant authority for this purpose... Support for nurse practitioner training programs was the federal response to the need for greater access to primary health care.

Later that decade, I had the opportunity to address the American Association of Colleges of Nursing Deans' Summer Seminar in Jackson, Wyoming. "From my vantage point, at this time in our nation's history, our schools of nursing possess the opportunity to truly shape our nation's health delivery system for decades to come. In my judgment, more than any other health care discipline, you and your colleagues really are in a position to determine both what society will be willing to consider acceptable 'quality of care' and what will be deemed reasonable patient expectations for those who ultimately 'pay the bills.' From a public policy frame of reference, it is your faculty and your students who possess the clinical and scientific expertise that our nation requires. But, I suggest that most of you really do not appreciate your collective potential or power, nor am I afraid, your societal responsibilities... Why then, if your practitioners are competent and cost-effective, is the Congress (and society) not giving greater weight to your profession's expertise? Why is it that we are not developing our nation's health care systems around your profession? Why do we continue to stress the status quo and to defer to the medical profession?" This, of course, turned out to be the underlying theme of your Baltimore confer-

ence, attended by over 200 people from 27 states and Canada – more than twice last year.

Over the years we have learned that substantive change, no matter how logical it may seem at a given point in time, requires the contributions and dedication of earlier generations in order to be ultimately adopted. Foundations must be established. Popular myths must be addressed. "Naysayers" must be addressed or ignored. Within the health care arena, we would suggest that the key to success is consistently focusing upon the underlying question "What is best for the patient?" and being willing to personally take a chance (i.e., to take risks). One must truly believe in one's professional expertise and personal values. One can not accept organized medicine's ploy that non-physician providers are "public health hazards" who will affirmatively harm their patients. Accordingly, it was very nice on Sunday evening to witness nursing's long-time visionary Vernice Ferguson receiving her award. Collectively, you are demonstrating that nursing has matured sufficiently to accept its societal responsibilities. And in so doing, that nursing will systematically strive to ensure that all Americans will have access to the highest quality health care which they may require, regardless of their ability to pay, their geographical location, age, sexual orientation, or ethnic background.

The 21st Century will be an era of Educated Consumers utilizing the most up-to-date technology to ensure that they and their loved ones receive the type of health care that is most appropriate for their individualized situation. From a health policy perspective, it was strikingly evident that throughout your conference the evolving themes of the next generation were present and being thoughtfully addressed. Today 70-100 million Americans utilize the Internet to obtain health related information. Yet, at the same time, the health delivery system is, at best, in the "horse and buggy days" of embracing technology, unlike almost every other industry in our nation. The Institute of Medicine (IOM) estimates that: "the lag between the discovery of more efficacious forms of treatment and their incorporation into routine patient care is unnecessarily long, in the range of about 15 to 20 years. Even then, adherence of clinical practice to the evidence is highly uneven." Today, 43.6 million Americans do not have health insurance, with young adults being least likely to have coverage. Their health profiles (and those of their children) are unquestioningly in danger of being compromised. While racial and ethnic minorities represent only one-third

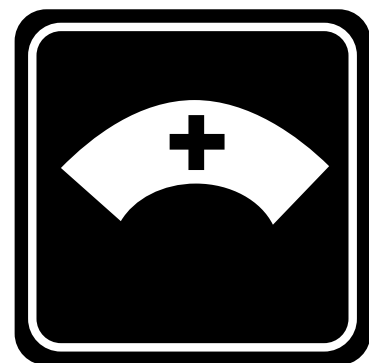
of our non-elderly population, they represent more than half of the uninsured. Employees across the nation have recently “gone out on strike” over the issue of ever-escalating health care costs which are expected to rise 12 percent next year, the fifth year in a row of double-digit increases – a doubling since 1999. And, we absolutely know that the availability of health insurance coverage and the psychosocial-economic-cultural gradient of health care are critical to health outcomes. Today, the United States spends over 50 percent more per person on health care than many other Western nations. Yet, according to the IOM and our own personal observations, it does not appear that these vast expenditures are buying reliable levels of quality or access.

The 21st Century will also be a time when we will see a conscious movement away from traditional silo-oriented (i.e., isolated) health professions training and service delivery models, these being replaced by a concerted emphasis upon interdisciplinary training and service delivery. Data driven, culturally-sensitive care will be demanded by consumers and educated practitioners. By the year 2005, it is projected that the number of non-physician primary care providers will equal that of primary care physicians. Treatment facilities will possess ready access to “real-time” clinical pharmacy consultation services, either through virtual reality arrangements or pharmacy clinical staff. The IOM estimates that approximately 48 percent of the prescription drugs on the market today have become available only since 1990 and medications are the most frequent medical intervention, with an average of 11 prescriptions per person in the nation. Today’s dedicated clinicians must be responsive to an explosion of specialized knowledge demands. When teaching hospitals incorporate clinical pharmacists into their regular patient care rounds, the rate of preventable adverse drug events related to prescribing decreases significantly, in the range of 66-70 percent. Basic “quality care” concerns require pharmacy’s professional involvement and the unprecedented advances occurring within the technology and communications fields will make their services readily available. As raised during your conference deliberations, your clients would also be well served by access to quality specialized behavioral health, wellness care, and dietary services, just to mention a few. No one profession possesses all of the answers or the wisdom required.

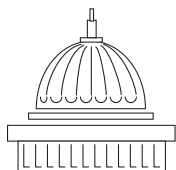
In my judgment, professional nursing has now embarked upon a journey which will serve our nation admirably and ultimately will revolutionize society’s expectations regarding “quality” health care. There is absolutely no doubt in my mind that nursing’s leadership

is highly cost-effective, patient centered, and of the highest possible quality. Clinically you are extraordinarily competent; objective study after study has demonstrated that simple fact. Being “right” however is not sufficient. The next step is to develop the political (i.e., public policy) expertise and the collective will to ensure that your services will become (and remain) available to all citizens who desire them. It is not the prerogative of any other profession to limit your scope of practice. To be ultimately successful in the political process you must possess a clear vision, be committed to the long haul, and I would further suggest, actively involve your next generation of clinicians and researchers, as well as your allies within other professions. When, for example, you are addressing the pressing needs of women who are depressed, have you involved your professional colleagues in psychology or the women’s bar association? Your patients are their clients; their professional concerns are yours. Professional silos can no longer be afforded, especially in an age when it is becoming increasingly possible – due primarily to the impressive advances in the communications field – to fully integrate and respond to an individual’s or family’s concerns.

In the early 1990s, the then-Agency for Health Care Policy and Research issued several reports on depression in primary care. At that time AHRQ (the Agency for Healthcare Research and Quality, as it is now known), noted that: “(u)p to one in eight individuals may require treatment for depression during their lifetimes.... Despite the high prevalence of depressive symptoms and major depressive episodes in patients of all ages, depression is underdiagnosed and undertreated by primary care and other nonpsychiatric providers, who are, paradoxically, the providers most likely to see these patients... Once identified, depression can almost always be treated successfully with medication, psychotherapy, or a combination of both.” The same situation exists today. As you are very aware, many of these individuals will be seen by nursing managed health centers. The underlying policy question for your consideration remains: “Whether you are, in fact, receiving your fair share of federal resources to provide the care required?” The past is prologue for the future. My sincerest congratulations to Elaine Tagliareni, NNCC Chair, for a truly outstanding conference. Aloha.



**POLICY & ADVOCACY NEWS**



***National Nursing Centers Consortium  
Policy Committee***

by Katherine K. Kinsey, Policy Chair

Public policy, legislation and regulations at the national, regional, state and local level influence the practice of nursing and the delivery of high quality health care to the vulnerable and underserved. The National Nursing Centers Consortium 2003- 2004 Policy Committee consists of nursing professionals across the nation committed to improving the health of the public through the nurse managed health center model.

The 2003 Annual Meeting enabled Policy Committee members to dialogue with attendees regarding public policy and legislation that positively and/or adversely influences advanced nursing practice in community settings. The Policy Committee deeply appreciates the NNCC as the vanguard for nursing and the nurse managed health center model. Our Executive Director and superb staff daily advocate for each and every member center and the nursing workforce. Individual and group meetings with elected officials and aides as well as congressional briefing(s) in Washington, DC attest to our advancing recognition as **valued and essential safety net providers**.

On March 25, 2004, The School of Nursing of Texas Tech University Health Science Center with the NNCC hosted a Congressional Briefing in the Rayburn House Office Building, Washington DC. The Policy Committee thanks Alexia Green, PhD, RN, FAAN, Dean and Professor of the School of Nursing for her opening and closing remarks. Also, a special thanks to Representative Randy Neugebauer from Texas for opening the session and welcoming all of us to DC. The briefing engaged the audience in learning about the NMCH model, current opportunities/challenges and concluded with discussion about what congress can do to position the NMCHs as mainstream health care providers. The following points below were emphasized and are the Policy Committee's "mantra" as we continue our work.

Congressional support is needed to sustain nurse-managed health centers in two key areas: 1) To document through data and research what many have observed: that nurse-managed health centers are an effective approach to reducing health disparities; and 2) To facilitate cost-based reimbursement for the primary care and preventive health services nurse-managed centers provide. Five areas of Congressional support were suggested:

**DATA AND RESEARCH**

- Commission the Institute of Medicine to research the effectiveness of nurse-managed health centers as a national model to reduce health disparities.
- Appropriate funding to include nurse-managed health centers and advanced practice nurses in research and demonstration projects conducted by agencies such as the Agency for Healthcare Research and Quality, the National Institutes of Health, the National Institutes for Nursing Research, and the National Institute of Environmental Health.

**SERVICE AND SUSTAINABILITY**

- Direct the Bureau of Primary Health Care to provide reimbursement for services provided by nurse-managed health centers either through Community Health Center status or other forms of cost-based reimbursement.
- Direct the Department of Health and Human Services to provide an alternative means to secure cost-based reimbursement for nurse-managed health centers, by granting university-based centers CHC or cost-based reimbursement.
- Facilitate the expansion of existing seed money for demonstration projects gauging the efficiency of nurse-managed Geriatric Wellness Centers.

**To best represent all nursing centers regarding national policy issues and individual challenges, the NNCC Policy Committee seeks additional representation from members of individual centers.** The NNCC is fortunate to have Brian Valdez as a Special Assistant in Policy. He is a graduate of Temple University School of Law and provides much support to the Policy Committee Chair and its members. And our Committee needs more members so all voices and experiences can be heard and represented at the National Level. If each Center could designate one or more staff interested in local as well as national policy work and advocacy, our Committee would better serve the Consortium at large. Please contact Brian Valdez at [Brianv@phmc.org](mailto:Brianv@phmc.org) if you wish to join the Policy Committee. Your expertise is welcomed.

A principal challenge faced by the Committee (and the Chair) is how to best communicate with members across the nation. Every member center and its staff are very busy. Logistics regarding conference calls versus emails versus in person meetings must be considered. Various methods of communication might be tested to engage and retain committee members.

If you have immediate concerns and/or solutions, please feel free to contact me (Kay Kinsey) at 609-865-6275 (cell). I look forward to hearing from you. I wish and predict all members a year filled with positive policies that advance nursing models in our local communities.



*Rep. Neugebauer & Dean Alexia Green, School of Nursing, Texas Tech University Health Sciences Center*



*from left: Tine Hansen-Turton, Christine Bingman, Laura Line, Margaret Cotroneo, Maureen Leonardo; In the back: Elaine Taglareni and Kay Kinsey*



*from left: Tine Hansen-Turton, Lynn Breer, Joanne Pohl, Laura Line, and Kay Kinsey*

### ***Lieutenant Colonel (P) Ellen E. Forster is New Nurse Detailee***

ITC (P) Forster is serving as the Uniformed Services Nurse Detailee to Senator Daniel K. Inouye during calendar year 2004. Prior to arriving on Capitol Hill, she has served at Fort Belvoir, VA, since August of 2002, where she was assigned as the Assistant Deputy Commander for Nursing. Her first duty assignment in 1982 was as a staff nurse on a surgical unit at Letterman Army Medical Center, Presidio of San Francisco. From there she spent 18 months in Korea as a pediatric staff nurse. Upon her next move to Fort Campbell, KY, she transitioned into the adult Intensive Care Unit, and 18 months later to the Emergency Department. From there, in 1989, she was assigned as nurse manager of the Emergency Department at Walter Reed Army Medical Center for three years. From Washington, D.C., she moved to Fort Lee, VA, where in the span of a four year tour she served as nurse manager of the Intensive Care Unit, and later the Emergency Department. After a deployment to Haiti in 1994, she returned to Fort Lee and was assigned as the Chief of Ambulatory Nursing. Upon moving to San Antonio in 1996, she was assigned as the Nurse Methods Analyst at Brooke Army Medical Center and later as Nursing Supervisor for Specialty Care Clinics. In March of 2000, she was selected to be the senior staff officer in the Office of the Army Nurse Corps at Fort Sam Houston, TX. ITC (P) Forster graduated with her baccalaureate degree in nursing from Viterbo College in La Crosse, WI, and a Master of Arts in Education and Human Resource and Organization Development from the George Washington University. She is a member of the Emergency Nurses Association and is married to Michael Loy.

### ***Removing the Barriers to Nurse-managed Health Center Growth, and Increasing the Access to Care for the Medically Underserved: A Timeline of NNCC Policy and Advocacy Accomplishments from 1999-2003***

The NNCC's *mission* is to strengthen the capacity, growth and development of nurse-managed health centers to provide quality health care services to vulnerable populations and to eliminate health disparities in underserved communities. Soon after its inception, the NNCC realized that the goals included in its mission statement could not be achieved without first eliminating certain regulatory and legislative obstacles which are hindering the growth and development of nurse-managed health centers, as well as preventing underserved communities from accessing care. Below is a year-by-

**POLICY & ADVOCACY NEWS**

year timeline that lays out some of the NNCC's successes in removing these obstacles. The timeline highlights some of the NNCC's major advocacy successes on both the state and federal level, as the NNCC initially began as a regional advocacy group.

- **Fall 1999 - The NMHC is entered into the U.S. Congressional record as a “model of care that works.”**- This is important because it adds legitimacy to the model of care practiced in NNCC nurse-managed health centers. The congressional recognition also set the stage for the federal funding the NNCC would receive in later years.
- **Winter 2001 - NNCC advocacy prompted the U.S. Congress to encourage the inclusion of more NNCC member centers in the Federally Qualified Health Center (FQHC) Program.** Achieving FQHC or look alike status is important for NNCC member centers because it offers them a steady stream of cost based reimbursement for the services they provide to the Medicaid and Medicare population. A 2001 report submitted by both the House and Senate Appropriations Committees encouraged the Bureau of Primary Health Care, which administers the program, to “expedite” the FQHC applications submitted by nurse-managed health centers, and to provide “technical assistance” to nurse-managed health centers in order to ensure that they comply with all the requirements of the FQHC application process.
- **Winter 2002 - The NNCC secured \$100,000 of federal funding for its member centers to conduct a demonstration project for the Centers for Medicare and Medicaid Services (CMS).** This project is designed to evaluate the potential of nurse-managed health centers to serve as an alternative safety net model of community-based primary health care and health promotion.
- **Summer 2002 - The NNCC, the National Association of Community Health Centers (NACHC) and the Bureau of Primary Care conducted the first technical assistance training for the FQHC look-alike program.** This training was a direct result of NNCC advocacy efforts on a federal level. It was designed to provide assistance to nurse-managed health centers attempting to access this source of funding. Similar trainings are being conducted periodically. The NNCC also prepares a quarterly readiness plan for the Bureau of Primary Care, that outlines which nurse-managed health centers are ready to apply for grant funding or look-alike status.
- **Spring 2003 - The NNCC weighed in on a U.S. Supreme Court case regarding MCO provider discrimination.** In *Kentucky Association of Health Plans Inc., ET AL v. Miller*; the Supreme Court ruled that states could enforce Any Willing Provider (AWP) laws. AWP laws, which force MCOs to contract with any provider willing to meet its fee schedule, are important because they offer CRNPs protection from discrimination at the hands of MCOs. The NNCC gave its full support to the ruling and raised awareness of the importance of AWP laws by conducting a legal analysis of the case from an advanced practice nursing perspective. The analysis can be found on the NNCC website.
- **Summer 2003 - The NNCC developed strategies for addressing MCO CRNP reimbursement obstacles on a national level.** NNCC staff conducted research designed to help address the obstacles to MCO reimbursement faced by CRNPs on a national level. A briefing paper with the results of the research can be found on the NNCC website. It important to address these challenges to MCO reimbursement because currently 50% of the care provided at nurse-managed health centers is not reimbursed.
- **Fall 2003 -The NNCC secured \$98,000 of federal funding to support its practice-based research infrastructure network.** This money will be used to purchase computer equipment needed to support the implementation of an electronic medical record and practice management system in six NNCC member centers. This practice-based research network is important because it will provide the NNCC with data that can be used to further policy and advocacy efforts. In addition, the data gained from this network will position the NNCC to successfully compete for national research studies of special populations and health disparities.
- **Winter 2003 - the NNCC joined forces with the Veterans Administration (VA) to conduct an evaluation of VA Nurse-Managed Health Centers.** This evaluation will be similar to the one the NNCC is conducting for CMS. This collaboration with the VA adds legitimacy to nurse-managed health centers on the Congressional level, and provides the NNCC with a potentially powerful ally for policy and advocacy purposes.



Visit the NNCC Website

[www.nncc.us](http://www.nncc.us)



## Collecting Health Promotion/Disease Prevention Data In Nursing Centers: A Report On Development of a Uniform Data Reporting Tool

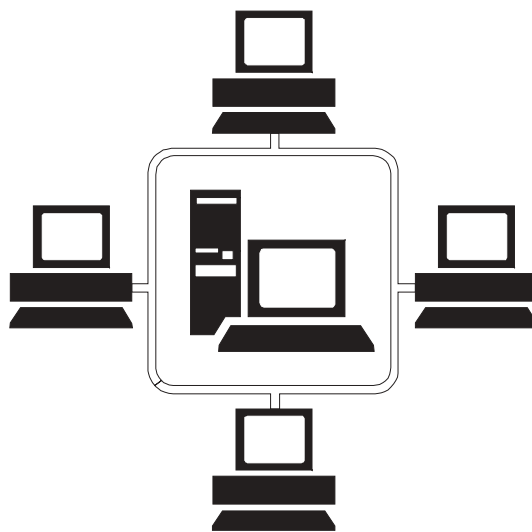
M. Elaine Tagliareni, EdD, RN, Community College of Philadelphia

In 2001, with funding from the Independence Foundation, faculty in the Department of Nursing, Community College of Philadelphia along with collaborators from four NNCC member centers, began work on a web-based tool to collect data on the health promotion/disease prevention services offered in representative nurse managed centers. Participating in the initial phase of the tool development were East Stroudsburg University, Fairfield University, Pennsylvania State University, Temple University, and Community College of Philadelphia. Implementation of the first version of the tool began in September 2002. Following a meeting of the five participating centers in Summer 2003, major revisions were undertaken and in September 2003, two additional centers joined the project: Messiah College and Northern Virginia Community College. In Summer 2004, project staff from all six centers will meet again to discuss findings for the last two reporting periods (August to January and February to July yearly) and to make revisions as indicated. Refinement of the tool will continue through December 2004.

The goals of this project are to describe and document the scope of common health promotion/disease prevention services in a pilot sample of NNCC centers. The data are analyzed for types, themes, and patterns of health promotion/disease prevention services and have been provided to the NNCC to inform it about the scope and recipients of health promotion/disease prevention services provided in seven nursing centers. These data are critical to the NNCC in its efforts to secure funding to support and expand existing health promotion programs. In the future, it is anticipated that additional NNCC member centers will use the tool and that the data collected will lead to the development of health promotion/disease prevention protocols and guidelines. These data will also be used to track selected health outcomes for individuals and communities.

As of August 2003, seven NNCC affiliated nursing centers, which serve divergent populations in rural, urban, and suburban settings, are currently affiliated with the project.

- Community College of Philadelphia, 19130 Zip Code Project, a Wellness Center without walls, provides services to residents of lower north Philadelphia through partnerships with over twenty neighborhood agencies.
- East Stroudsburg University, Wellness Center, is a clinical site for the Department of Nursing that is sponsored by the Monroe County Area Agency on Aging and its Prime Time Health Program. Additional outreach sites exist throughout Monroe County.
- Fairfield University, Health Promotion Center, located in Bridgeport, CT, provides health screening, education and referral services to clients from the local community as well as outreach to schools and community centers by faculty and students.
  - Messiah College, The Wellness Center, provides services to persons living under the auspices of the housing authority, through a partnership between the Department of Nursing and the Housing Authority of the county of Dauphin, PA.
  - Northern Virginia Community College, Nurse Managed Health Care Network, provides primary care, health education and screening services at six locations through partnerships with several community agencies that provide space and referral services.
- Pennsylvania State University, Rural Nursing Center of Pennsylvania State University, provides a full range of health promotion and screening services to clients from rural areas near the University.
- Temple University, Temple Health Connection, is an academic nursing center with both primary care and public health initiatives for individuals and families in north Philadelphia.



***This article will present group and individual data reported by those centers from August 2003 through January 2004 and describe the data collection tool revisions.***

***Data Collection***

Data have been collected and recorded at each site using a web-based tool developed and maintained by Community College of Philadelphia's Information Technology Services. Each week staff at participating nursing centers enter data and generate reports from the data collected by their site. Aggregate reports are provided to the NNCC and to the Independence Foundation at the conclusion of each reporting cycle.

During the early stages in the tool development, the group determined that most health promotion/ disease prevention activities are either directed to groups of two or more persons, such as exercise classes or health education programs, or to individuals, e.g., one to one counseling or brown bag medication reviews. The activities themselves could generally be grouped into one of four categories:

- Health teaching, guidance, and counseling, e.g. dental care education, safety education, cardiovascular health and health and life management;
- Surveillance, e.g. height and weight measurement, vision and hearing screening, glucose monitoring, blood pressure evaluation;
- Immunizations; and
- Administration of treatments and procedures, e.g. wound care, first aid.

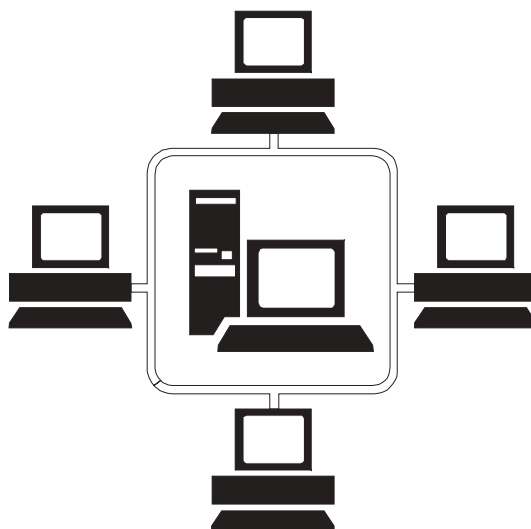
Over the past three years, staff associated with the development of the health promotion/disease prevention tool have developed a list of common activities associated with each category. The list of activities were designed to be discrete, yet representative of all centers' activities. A "data dictionary" giving explicit directions and examples of how activities should be coded was developed and has undergone extensive testing and revision. Group-directed activities fall into one of the first three categories listed, whereas individual-directed activities can encompass any of the categories.

Data collected during group directed activities or encounters are referred to as 'group data' and reflect total attendance at all programs. Each program attendee is referred to as an encounter. Because many individuals attend more than one program, the total number of encounters is a duplicated count, reflecting total attendance at programs, not the total of individual participants. During each group session, the nurse leaders observed and recorded their subjective assessment of the demographic characteristics of the

group participants. For example, the nurse counted the number of participants and categorized them according to racial background and broad age groups, e.g., 20 attendees, all aged 60 or older, 10 African American, 5 white, and 5 Asian.

'Individual data' are those collected during one to one sessions (encounters) between the nurse and the client, either in a nursing center, community agency, or the client's home. As with the 'group data,' the aggregate number of individual encounters can include multiple sessions with the same client and thus do not reflect the number of actual individual clients served. All referrals made following or during group encounters are recorded as 'individual data.' Data collected for individual encounters are self-reported through interviews with clients seen on a 1:1 basis. For children seen in head start programs or in elementary schools, agency records are utilized; if data are not available, nurses record data as unknown. Clients often participate in group activities on a weekly basis and clients seen on a 1:1 basis at selected NNCC Wellness

Centers often visit weekly. No attempt has been made to identify clients; data are collected only as aggregate data. Data reported in this article were collected from September 2003 through January 2004.



***Results***

***Service Locations***

Although the location for the health promotion and disease prevention activities varied, a large number of group activities occurred in schools, ranging from pre-schools and head start programs (13%) to elementary (9%), middle (6%), and high school (3%).

In contrast, only 3% of individual encounters occurred in school settings. Twenty-two percent of groups were conducted in senior centers and an even larger number of individual encounters for health teaching, surveillance, immunizations or treatments occurred in those settings. These data suggest that a major out-reach conducted by nurses in NNCC affiliated wellness centers targets older adults. Over 40% of individual encounters took place in nursing wellness centers. When these data were examined by individual centers, we noted considerable variation that reflected the demographic characteristics of the communities where they were located or whom they served. Ultimately what emerged was an understanding that NNCC wellness centers

**Table 1**  
**Locations here services were provide**

<b>Location</b>	<b>Percent of Group Programs</b>	<b>Percent of Individual Encounters</b>
Preschool/Crisis Center	2.1	0.0
Head Start	11.1	1.5
Elementary School	9.1	0.5
Middle School	5.6	0.6
High School	3.1	0.8
College or University	3.8	15.7
Health Center /Nursing Center	8.8	40.5
Senior Center	22.0	32.8
Community Health Program-Outreach	18.3	7.6
Public Housing	11.7	0.0
<b>Total</b>	<b>100.0</b>	<b>100.0</b>

are not homogeneous; services provided are dictated by the community and populations served.

***Participation in Services***

As expected, group programs accounted for the largest number of encounters, 82% of the total. Four hundred eighty six groups were conducted with a total attendance of 13,536. Subsequent to the group sessions, 904 referrals were made. The number of one-to-one individual encounters totaled 2886. Of those, more than half (52%) were for surveillance, 25% were for health teaching, guidance or counseling, 14% for immunizations, and 19% for treatments.

Considerable variation was found between the racial backgrounds of participants in the group vs. individual-directed programs. Since staff estimates the race for group participants, rather than query them individually, the data provide an approximation of the racial background of participants. Slightly over half of the participants in the group programs were African American (54%), followed by White (28%), Asian (5%), and 13% from other races. Among the individual encounters, slightly more than half (53%) were with white clients, followed by African American (23%), Asian (5%), and other races or combinations (19%). These differences between the distribution of racial backgrounds of group vs. individual encounter participation reflected demographic differences in the populations served by centers that focused primarily on individual- vs. group-directed activities. For example, Temple and Com-

munity College of Philadelphia located in Philadelphia with a majority African American population who are the target of their activities, conducted primarily group-directed programs, whereas, Pennsylvania State University and Messiah College, located in predominately white communities, conducted primarily individual-directed programs.

**Individual Encounter Client Characteristics.** The majority of individual encounters (61%) occurred with older adults, ages 60 through 90+. Because a large number of individual encounters occurred in nursing centers which targeted senior citizens, or in senior centers, older adults comprised over 50% of individual encounters. Approximately 15% of individual encounters were with children in middle school and high school and many of these encounters occurred as a result of referrals made following group teaching and surveillance activities. Although clients in 32% of the encounters reported having Medicare coverage, another 32% were with clients who did not have any insurance coverage. The remainder of the encounters was with individuals reporting having Medicaid or a state subsidized insurance program (11%), commercial insurance (15%), or some unknown or unspecified coverage (10%). Over one-fourth of the encounters were with clients who did not have a regular provider (27%), but over 40% were with those who had a regular physician and another 13% with clients who saw a nurse practitioner. We were unable to ascertain whether the nurse practitioner was employed by a nurse-managed primary care center or a physician practice. In the revised tool, the category of nurse practitioner has been changed to primary care nursing center in an effort to determine if clients seen by nurse practitioners are affiliated with NNCC centers.

**Group Encounter Client Characteristics.** Since these data were obtained from nurses’ observations, broad categories were used to record data about age. Most of the group activities were attended by senior citizens (26%), elementary school children (21%), or preschoolers (17%). Another 11% of the group encounters were with middle/high school age or young to middle age adult clients. In some groups, participants’ ages spanned a wide age range that could not be readily categorized. Again, these data differed across sites according to the centers’ target populations and program topic.

***Services Provided***

***Health teaching, guidance, and counseling***

These services were provided in both group and individual directed sessions. Health teaching, guidance and counseling included giving information, anticipating client problems, encouraging cli-

ent action and responsibility for self-care and coping, and assisting with decision making and problem solving. Table 2 shows that individual encounters focused primarily on nutrition education (39.4%) and wellness education (38.5%). Teaching in these areas is often combined with education directed towards disease management, for example, signs and symptoms management education (25.6%) and management of medication and/or its side effects (12.9%). These two categories combined to account for over 35% of the encounters between nurses and individual clients. This is important because education related to chronic disease management assists clients in maintaining self-care and sustaining independent living status, a major goal in NNCC centers. Group encoun-

ters focused primarily on wellness education (35.7%), nutrition education (25.5%), and signs and symptoms education (23.1%).

**Implications for Tool Refinement.** Analysis of these data revealed that the wellness education category was too broad and non-specific and therefore did not adequately describe the patterns and types of services provided. For the data reporting period from February to July 2004, this category has been refined to include specific topics that will allow us to describe what wellness education encompasses. Also, for individual encounters, project staff determined that the advocacy/counseling role of the nurse who teaches the client about management of chronic illness, including helping the client to secure transportation, call pharmacies and negotiate

reimbursement with insurance carriers, is a significant role and one that is not adequately captured by the tool. For those centers that target wellness services directly to older adults, finding a way to capture the advocacy role was of paramount concern. Therefore, for the current reporting period, the category, Health and Life Management has been added to the tool.

***Surveillance***

Services in this category include detection, measurement, critical analysis, and monitoring to assess client status in relation to a given condition or phenomenon. All abnormal screenings are referred for case management and the individual encounter tool is completed to record the type of referral indicated. Table 3 shows the percent of specific surveillance activities for both group and individual encounters.

Blood pressure screening accounted for the largest number of both group and individual encounters. Hypertension screening and monitoring is a major initiative of all nursing centers due to the large number of older adults. However, screening must be, and in fact was accompanied by activities designed to promote clients' ability to manage their hypertension, such as medication teaching and signs and symptoms education. Additionally, weight measurement for individual encounters (20%) was completed as part of hypertension management, since weight has been used as an indicator of hypertension and cardiovascular risk and as an out-

**Table 2**  
**Aggregate Group and Individual Data:**  
**Health Teaching, Guidance and Counseling**

Type of Education	Percentage of Group Programs Directed Toward Health Teaching Topics *	Percentage of Individual Encounters Directed Toward Health Teaching Topics *
Family Planning Education	2.3	2.8
Growth & Development Education	3.7	4.6
Mental/Emotional Education	7.0	4.1
Dental Care Education	3.3	20.7
Exercises	11.1	24.7
Environmental Education	12.8	5.2
Personal Care	7.8	9.1
Stress Management	4.3	4.8
Substance Use	11.9	5.8
Stimulation/Nurturance	11.3	2.5
Safety	4.5	4.9
Wellness Education (This category includes Immunizations, Prenatal Education, Postpartum Education, HIV/STI Prevention, Prostate Health Education, Breast Health Education and Pap Smear Education)	35.7	38.5
Nutrition Education (Includes Breast Feeding Education)	25.5	39.4
Medication Action/Side Effects Education	6.0	12.9
Signs and Symptoms Physical/Mental (This category includes Diabetic Care Education, Asthma Care Education, Disease Management and Cardiovascular Education)	23.1	25.6

\*Multiple health teaching services are provided during each group and individual encounter; therefore percentages total more than 100%.

come to be evaluated. Although weight measurement also was conducted in school settings, its purpose was to assess developmental status in children.

For each referral following an abnormal screening, data were collected to describe where the referral was made. At present the tool gives the total number of referrals made for group encounters (904) and individual encounters (1291) and describes the type of referral made for each abnormal finding by category of surveillance activity for individual encounters. For example, for blood pressure screenings on the individual tool, 52% of referrals were made to the client's physician, 39% to a CRNP and in 9% of the encounters a referral was determined to be not indicated.

This change was necessitated because project staff voiced a concern that it is not always appropriate to refer all abnormal screenings, especially if the client was regularly followed by nurses at the wellness center. In these cases, the nurse followed the client on a weekly basis but did not record that a referral had been implemented. In the revised tool, project staff will record abnormal readings that are the client's norm as baseline and a referral back to the Wellness Center for follow-up will be recorded. Baseline data do not need to be referred to a primary care provider. Project staff will evaluate this new approach following collection of data during the current reporting period

In two other instances what constituted performing an activity required further definition. For example, depression screening accounted for a relatively small percentage of surveillance activities for individual encounters. It was unclear whether this reflected a problem with reporting or infrequent screening. Staff reported that older adults were frequently asked about mood and interest in activities, the two key questions that alert staff to potential depression, according to the Prime MD Scale. However, unless the center staff conducted a full screening (Prime MD or Geriatric Depression Scale), depression screening was not recorded as having been performed. Since all participating staff agreed that performing a two-question screening represents a valid depression screening, this will be recorded as depression screening in future periods. Similarly, although center staff asked older adults questions about their ability to perform activities of daily living, they often did not record these conversations as a functional assessment. In the future, staff will make an effort to record those conversations as functional assessment surveillance.

*Summary*

Findings of the data collected from the September 2003 through January 2004 have accomplished the following:

- They have described the scope of services provided by seven nursing centers, the extent of participation in those services, and characteristics of the clients who use them.
- They have underscored the variation between nursing centers in the characteristics of the clients they serve and in the services provided.
- They have shown quite clearly that the pattern of services is determined by the target populations served.

**Table 3**  
**Aggregate Group and Individual Data: Surveillance**

Type of Surveillance	Group Data Percentage Participating*	Individual Data Percentage Participating *
Back Screening, Scoliosis	0.0	0.9
Bone Density	2.3	0.2
Blood Pressure	28.6	81.5
Cholesterol	8.8	10.7
Developmental Scale	0.8	0.5
Depression Scale (Prime MD)	0.6	2.3
EKG	0.2	0.0
Functional Assessment	0.4	0.5
Glucose Monitoring	9.3	11.4
Head Lice Screening	0.0	0.9
Hearing Screening	13.6	10.0
Height/ Weight Measurement	26.1	20.2
Hemoglobin/Hematocrit	0.2	0.9
Lead Screening	2.2	0.0
Urine Screening	0.6	0.7
Vision Screening	15.8	11.8
TB Screening	0.6	1.4

\* Multiple services are provided during each encounter, therefore, percentages total more than 100%.

**Implications for Tool Revision.** During the reporting period from February to July 2004, referral data will be collected differently. Data will be collected for each type of surveillance activity, as in the past, but the list of referral sources has been revised to include primary care nursing centers, as well as wellness centers.

*Continued on page 30*

**FACTS ABOUT NURSE MANAGED HEALTH CENTERS**

**Nurse-Managed Health Centers (NMHCs) have a Nation-Wide Presence**

NMHCs are neighborhood based health centers, which are managed by nurses in partnership with the communities they serve. **NMHCs provide a full range of health services to over one million low-income, underinsured and uninsured clients nation-wide.** These services include primary care, health promotion and disease prevention services. The services are provided by nurse practitioners, clinical nurse specialists, registered nurses, health educators, community outreach workers, health care students and collaborating physicians.

**NMHCs Address Present Needs**

Statistics show that there are currently over **44 million Americans without health insurance**, and the number is expected to grow to **55 million by the year 2010.** NMHCs directly address this problem in that **up to 50%** of the clients receiving treatment at NMHCs are uninsured.

**NMHCs Reduce Health Disparities**

By providing accessible, high quality, comprehensive primary care services to populations who have trouble accessing care NMHCs. Serving medically underserved urban and rural areas and located in sites such as public housing developments, schools, churches, community centers, and shelters, NMHCs provide care to low-income, minority, homeless and migrant families, and uninsured populations. **NMHCs are essential safety-net providers**, recognized by the U.S. Department of Health and Human Services through both "Models that Work" and "Community Service" awards. **The future of NMHC's continues to be threatened and the economic crisis of these centers needs to be addressed.**

**Outcomes**

Managed care data and preliminary data collected by the NNCC comparing outcomes from nurse-managed health centers to those of other safety net providers, suggest that:

- Nurse-managed health center clients use the emergency room 15% less than the aggregate of similar family practices;
- Clients use non-maternity hospital days 35-40% less than the aggregate;

- Nurse-managed health center prescription cost is 25% less than the aggregate;
- 85% of the babies born clients of NMHC are of a normal birth weight;
- NMHCs offer effective smoking cessation programs: In 2003, 62% of the clients who participated in the program, attempted to quit stopped smoking, an outcome considerably higher than the national average;
- NMHCs see their members an average of 1.8 times more than other providers; and
- NMHCs have a 95% performance rate for childhood preventive health care.

**NMHCs Cut Health Care Costs**

By treating the uninsured, NMHCs reduce emergency room usage and cut Medicaid costs. In addition:

- The average primary care encounter cost for clients treated by NMHCs participating in the Community Health Center (CHC) program is 10% less than the primary care encounter cost for CHC's managed by physicians and other providers;
- The Average personnel cost for NMHCs participating in the Community Health Center (CHC) program is 11% less than the personnel costs for CHC's managed by physicians and other providers;
- Geriatric health promotion and disease prevention programs run by NMHCs help cut annual health care costs by as much as \$ 37,500,000.



**NNCC 2003 NATIONAL MEMBER SURVEY**

In 2003, NNCC conducted a member survey. The following represents the **60 responses** or approximately 60% of member organizations in **35 states** nationwide.

**Type of NMHCs**

- 16 provide **primary care services only**.
- 5 provide **health promotion or disease prevention services only**.
- 35 provide **both primary care and health promotion**.
- 4 **did not answer**

**NMHC Operating Budget and Funding Sources**

- The average annual operating budget of the survey respondents is **\$1,436,370**.
- The largest operating budget of any respondent was **\$21,000,000**, and the lowest was **\$400**.

The responding centers indicated that their funding sources remain a mix of private and government grants. Along with some insurance reimbursement, and some self pay.

**NMHC Hours of Operation and Schedule**

- **88%** of the Centers are open 12 months a year while **12%** do not operate all year round.
- The Centers average **29.8 operating hours per week**.

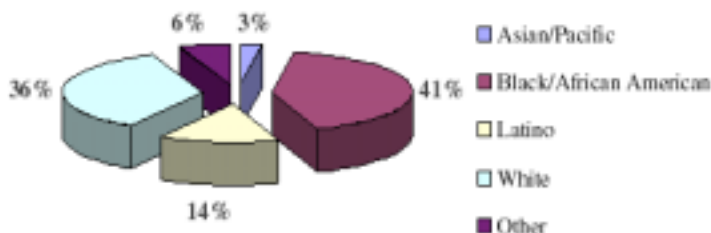
**NMHC Full Time Staff Statistics**

- **Certified Registered Nurse Practitioners - 20%**
- **Advanced Practice Nurses - 23%**
- **RNs - 9%**
- **Therapists and social workers - 6.5%**
- **Community outreach workers - 4%**
- **Collaborating physicians - .5%**
- **Administrative Support Staff - 12% of total**
- **Health educators, students and others - 25%**

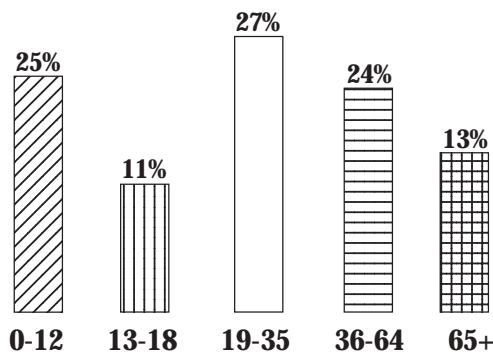
**Number of Clients and Client Encounters**

- NMHCs reported a total of **486,632** client encounters in 2003, involving **396,747** total clients.
- **244,180 (51%)** of these encounters involved the utilization of health promotion and/ or disease prevention programs
- **152,567 (31%)** involved the utilization of primary care services.
- **89,885 (18%)** were clients utilizing both sets of services.
- Respondents averaged a total of **8,852** encounters
- The highest number of encounters for any one respondent was **128,000**, the lowest was **8**.

**NMHC Client Demographics Based on Race**



**Age Demographics**



**NMHC Client Demographics Based on Employment Status**

- Of the clients who received services from NNCC member centers in 2003, **69,468** reported provided data on their age.
- **37,674 (54%)** reported being unemployed.
- **31, 824 (46%)** reported being employed.

**NMHC Client Demographics Based on Highest Education Level Attained**

- **16,777 (31%)** reported having completed some high school.
- **28,873 (54%)** reported having graduated from high school.
- **5,373 (10%)** reported having completed college.
- **2,465 (5%)** reported having graduated college.

## **NNCC's Annual Conference 2003 – A Great Success**

### **Best Practices In Nurse-Managed Health Centers: Eliminating Health Disparities**



**NOVEMBER 9<sup>TH</sup> AND 10<sup>TH</sup>, 2003**  
**MARRIOTT INNER HARBOR, BALTIMORE MARYLAND**

Dear Colleague,

On November 9<sup>th</sup> and 10<sup>th</sup>, 2003, health care professionals from nurse-managed health centers and other community organizations came together in Baltimore, Maryland at the National Nursing Centers Consortium **Best Practices in Nurse-Managed Health Centers Annual Conference 2003**. Over 200 participants participated from 27 states, and Canada, representing over 75 nurse-managed health centers, to share their expertise as well as best practices from nurse-managed health centers in eliminating health disparities, program stability and research and data collection.

A special thanks to our sponsors: the U.S. Department of Health and Human Services (HHS), and especially to Dalton Paxman, Regional Health Administrator of the HHS, and Rhoda Abrams, former Director of the Center for Managed Care (Health Resources and Services Administration), who helped plan the conference along with the NNCC Program Committee. Thank you to all program sponsors: HHS, Independence Foundation, Johnson & Johnson, MISYS, GlaxoSmithKline, Advance for Nurses Magazine, and The University of Maryland.

**This year's conference is in the process of being planned in partnership with the Vanderbilt University, School of Nursing for fall 2004 in Nashville, Tennessee and will again feature dynamic panel and poster presentations that will examine how nurse-managed health centers address and eliminate health disparities.**

We look forward to seeing you in fall of 2004 in Nashville, Tennessee.

**SCENES FROM NOVEMBER 9<sup>TH</sup> AND 10<sup>TH</sup>, 2003  
MARRIOTT INNER HARBOR, BALTIMORE MARYLAND**



**SCENES FROM NOVEMBER 9<sup>TH</sup> AND 10<sup>TH</sup>, 2003  
MARRIOTT INNER HARBOR, BALTIMORE MARYLAND**



## Out of the Briar Patch: Sustaining Nurse-Managed Practice

By Linda Campbell, PhD, RN, Loretto Heights Department of Nursing Regis University, Denver, CO

Community-based nurse-managed practice (CBNMP) offers local populations the opportunity to contract directly with professional nurses for primary health care services. Despite provision of high quality care below the average cost of primary care providers, an estimated 21 percent decline in the number of academic CBNMPs was documented between 1989 and 1998. A multiple case study was conducted to address the overall research question: What factors are believed to facilitate or hinder the innovation development process of CBNMP in prevalent practice contexts? A model synthesizing concepts from the Theory of Diffusion of Innovations and the Theory of Community as Partner was used to organize data collection strategies: background survey, document review, observations, and interviews (N=85).

The study described and compared the evolution of the innovation development process for CBNMPs in three practice settings that differed on environmental context. Commonalities across sites included diminished reliance on grant or federal funding, increased size of practice, increased diversity and acuity among patients, and transformation from local clinic to citywide or regional practice. Five themes were derived from data analysis:

- covenantal care (serving through sacrificial efforts)
- contextual stewardship (managing resources and responsibilities)
- community partnership (identifying and targeting populations' needs)
- chronic invisibility (lacking recognition)
- compelling distinction (delivering holistic primary health care to diverse populations)

The first three themes reflect how CBNMPs have been able to advance their missions, expand their practices, and promote their sustainability. The theme of chronic invisibility, however, is a pervasive problem due not only to legal, reimbursement, and interdisciplinary barriers but also to lack of direct linkages with nursing theory. Making explicit the science behind CBNMP's compelling distinction of care suggests a way to countermand the invisible nature of CBNMP and fulfill its promise as nursing's quintessential contribution to 21<sup>st</sup> Century health care (Barrett, 1993).

In particular, CBNMP must come *out of the briar patch* and loudly proclaim (Peters, 1997) its compelling distinction in primary health care delivery. To make the desired proclamation, seven imperatives are offered. CBNMPs must:

- Articulate a mission in support of exemplary practice, because an organizational vision is more important than a charismatic leader or particular product (Collins & Porras, 1994).
- Identify their practice as *nursing* and operate from nursing theoretical frameworks that both communicate nursing's holistic approach and contribute to nursing science (Barrett, 1993).
- Create a team approach to support exemplary practice through contributions from volunteers, nursing and business students, support staff, advanced practice nurses, administrators, and community champions.
- Balance mission with margin. Although initial grant funding may permit "margin before mission," a CBNMP must plan *from the beginning* to balance its mission with fiscally responsible management.
- Promote a "beautiful systems initiative" (Peters, 1997, p. 497) and "say yes to wow" (p. 309) to develop a steady stream of diverse users of CBNMP.
- Plan not only for growth but also for different types of leadership to accommodate evolving primary health care delivery.
- Apply for local and national awards to increase their visibility and professional and political clout.

Other contributions of the study include description of potential patients, lack of referral sources for CBNMP, impact of word of mouth on diffusion, examples of survivable crises, and role of visionary advocates. In addition, the themes of covenantal care, contextual stewardship, and compelling distinction had not been articulated in the literature. Finally, the study documented patients' trust in advanced practice nurses, thus corroborating the value of respect for all persons that is central to the trust bond between nurses and their service populations (American Nurses Association, 2001; Hansen-Turton & Kinsey, 2001).

Funding for this study was provided by NIH/NINR National Research Services Award (5 F31 NR07573-02), Nursing Economic\$ Foundation, and Sigma Theta Tau International, Alpha Kappa Chapter-at-Large.



Visit the NNCC Website  
[www.nncc.us](http://www.nncc.us)



Prior to becoming Deputy Executive Director at the Consortium in March, Laura Line helped develop grantmaking strategies for addressing problems and issues at the Pew Charitable Trusts. This article describes some of the lessons learned from this work and comes from the Trusts' magazine.

By Laura M. Line

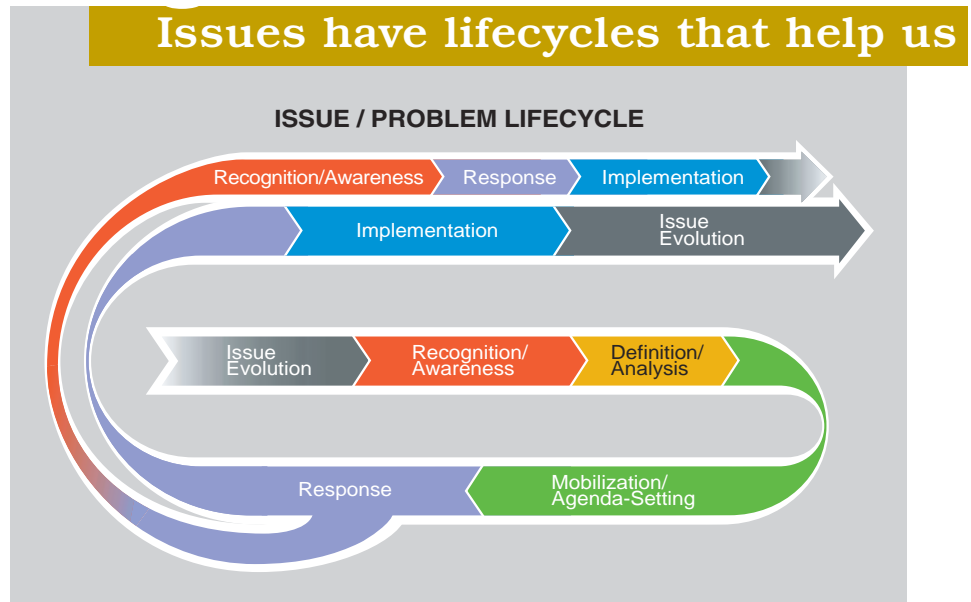
**F**ew people would equate grantmaking with farming, but the comparison may be apt. Farmers adapt their crop decisions to different variables of soil and climate and develop a keen sense for when their crops are ripe and should be harvested. Like a farmer, a grantmaker must consider conditions, timing and ripeness to be effective.

For a grantmaker, timing and ripeness occur not within a crop's growth cycle, but within the lifecycle—or development stages—of a social issue. An issue goes through stages set off by events or societal shifts and is carried forward by how groups in society decide to respond. Because issues evolve in a social context that is constantly changing, a grantmaker can more clearly determine how it might address them if it has a framework to understand the lifecycle.

Drawing from work by the sociologist Herbert Blumer and by the political scientist John W. Kingdon, a committee within the Trusts developed a five-phase lifecycle that ranges from the first notice of a social issue to the eventual course of action:

- Recognition or Awareness
- Definition and Analysis
- Mobilization and Agenda-Setting
- Response
- Implementation

This framework helps the Trusts make decisions about whether and how to invest in a particular issue. It also provides a common point of reference for staff, enabling them to more easily discuss similar grantmaking approaches and transfer lessons across our seven programs so that we may improve our strategies and interven-



The "stages" of an issue may proceed linearly or overlap.

tions. Specifically, the lifecycle can help staff to:

- Diagnose the status of an issue. Is the public aware of the problem? Do objective, nonpartisan data exist to inform decisions?
- Choose an approach appropriate to the issue's stage of development. Do we know enough about this issue to address stakeholder consensus?
- Set realistic goals based on the stage of the issue and how far (i.e., through how many stages) we intend to support advancing the issue. How much progress is reasonable for a foundation to expect on this issue, especially given limited resources?
- Monitor the evolution of the issue to ensure that the approaches being used match its stage. Has the issue progressed to another stage that might call for a new course of action?

Over a sufficiently broad span of time, most social issues move through two or more stages of the lifecycle,

although it is essential to note that these stages are not necessarily chronological and an issue may bypass, repeat or overlap phases. The Trusts may fund work at one stage of an issue or over multiple stages.

### Eyes Opened

The earliest stage in the issue lifecycle, *recognition or awareness*, is marked when a new or neglected problem first begins to receive wide attention. Recognition may be precipitated by many means: for instance, a critical event or crisis (September 11), a demographic shift (marked increase in the Latino population), a political decision (withdrawal from the Kyoto negotiations on global warming) or a medical innovation (the invention of magnetic resonance imaging). Recognition can also result from a campaign by interested parties to raise the public's awareness of an issue or problem (e.g., Mothers Against Drunk Driving).

In the recent Public Health Initiative, the Trusts funded a public education campaign by Health-Track which focused on dispelling the common misperception that the United States

### understand them.

had a chronic-disease tracking network and raising awareness about the importance of such an infrastructure.

#### Probing Deeper

Once attention turns to an issue, people want to address it. At the *definition and analysis* stage, those with a stake in the outcome of an issue strive to understand and subsequently define it, often through public deliberations or discussions within a sector or field. These ongoing conversations give the issue legitimacy, prompting decision-makers to take notice of its significance.

Analyzing the issue typically entails researching the source and dimensions of the problem. Stakeholders may collect data, review existing research, commission new research, consult experts and study existing laws or policies. Defining the issue is an attempt to frame its boundaries, a process that will occur through the lens of the stakeholders' underlying values and beliefs.

An example of the Trusts' work at this stage is the Pew Internet and American Life Project, an effort of the Tides Center, which performs research on the impact of the Internet on American society in order to describe the reach and ramifications of this relatively new means of communication.

#### Taking a Stand

Once stakeholders have clarified their understanding and their own position, they then begin to advocate for their point of view in the larger public arena. This stage is *mobilization and agenda-setting*. Stakeholders often vie among one another to assure that their perspective predominates (on environmental issues, for example, one side may emphasize the benefits of environmental protection while another will focus on the costs).

Public discussion and debate occur around different solutions and/or recommendations as stakeholders compete for the attention of those who can advance their position. To augment their power and authority, stakeholders build alliances with influential individuals or groups. As the mobilization/agenda-setting stage unfolds, certain perspectives gain wider appeal by public debate while others diminish, until the most powerful points of view capture the attention of the relevant decision-makers.

An example of the Trusts' work at this stage is the effort of The Pew Center on Global Climate Change (Center), a project of Strategies for the Global Environment, to organize major U.S. corporations to speak out on the need to address global climate change through reductions in greenhouse gas emissions. The Center now has 38 corporations in its Business Environmental Leadership Council, which is bringing the voice of progressive business to the climate-change debate and working to build support of business and government to reduce those emissions.

#### Deciding on Direction

In the *response* stage, decision-makers, after weighing proposals, adopt a particular approach or formal response to the issue at hand. For initiatives with a policy focus, they might create a favorable environment for legislation, an executive order or adoption of regulations. For non-policy projects, a formal response likely would entail the adoption of a plan of action by leaders in a sector (e.g., broadcast journalism or the local arts community).

One example of the Trusts' grantmaking in playing an important role in promoting an informed response is the McDonnell-Pew Program in

Cognitive Neuroscience (Program). To meet its objective of advancing this emerging field, the Program sought to establish cognitive neuroscience as a recognized discipline. One sign of success was the decision of the National Institutes of Health and the National Science Foundation to fund research in this area.

#### Going for It

After leaders choose a response, they then want to put plans into action. Whether and how well this *implementation* stage proceeds will determine the effectiveness of the response. An example of the Trusts' grantmaking that seeks an impact is the Clear the Air Campaign, a project to reduce harmful emissions from the nation's electric power sector through stronger federal and state air-emissions standards. In this case, part of the funding has gone to citizen groups so that they may provide input on the implementation of environmental regulations.

Of course, implementing programs and policies often raises new problems, setting the issue lifecycle in motion all over again. For example, as a nation we now know that improving or expanding highways can alleviate congestion but increase suburban sprawl. Yet experience has also taught us to anticipate unintended consequences, and so we monitor new policies with the idea of minimizing the unexpected and unwanted turns of events.

As diverse and changeable as the conditions a farmer faces in producing a healthy crop, so too are the surroundings of social issues. The lifecycle framework provides one tool to understand a complex situation, place it in a larger context and, in our case, inform a funding decision. ■

**NEW MEMBER HIGHLIGHTS**

## On The Road With Nurse-Managed Health Centers...

***NNCC Welcomes The Orvis Nursing Clinic In Reno Nevada*** - The concept of the Orvis Nursing Clinic was established in 1999 and was initiated through the support of the University of Nevada, Reno, the College of Human and Community Sciences and the Orvis School of Nursing. After and an intermittent and less than optimal beginning, ONC has now begun a tremendous growth phase. The staff is limited to five employees: a nurse practitioner, a receptionist, two licensed practical nurses (job sharing one FTE), and a director, but our practice base continues to grow daily! The mission of the Orvis Nursing Clinic is twofold. The primary mission is to enhance the health and wellness of families in the community through service, education, and research. Services are provided to disadvantaged and at-risk individuals in the community; predominantly low income, under insured or uninsured working families. Primary and preventive services offered include annual physicals, women's health exams, well-child check-ups, immunizations, as well as management of acute and chronic illnesses. Local physicians provide collaborative services to the nurse practitioners in accordance with Nevada state law. Orvis Nursing Clinic is a provider for state and federal Medicare and Medicaid Programs; and

for those with no health coverage, a sliding fee scale is available based on income, size of family, and ability to pay. The secondary mission of the Orvis Nursing Clinic is to provide an educational practice site for undergraduate and graduate nursing students, and for students in other health related fields. Access to healthcare is the cornerstone of disease prevention. We believe we can make a difference, one life at a time, and we are proud to become a new member of the National Nursing Centers Consortium.



Doreen Begley, RN, MS, Director, ONC  
Margaret Durand, APRN, Family Nurse Practitioner  
Carole Shochat and Susan McFeely, LPN's  
Ginger Washington, Receptionist

## From the Desks of Our VISTA Volunteers

NNCC would like to acknowledge its dedicated VISTA Volunteers,



who spend a year volunteering at the NNCC and member nurse-managed health centers.

Nakia Brunson is our youngest VISTA Volunteer. Over the past year, she has created health education and interactive games for kids and youth to learn and have fun about key health disparities issues, such as asthma, lead poisoning and diabetes.

### ***From the Desk of Nakia Brunson***

I'm Nakia Brunson. I am a VISTA worker for the NNCC. If you would like kids to learn about health issues, one way is to use education games as a learning tool. Games are a great way to educate kids

about the health issues in their lives. I learned in the past that kids react to games better than somebody just talking, because they learn and have fun at the same time with a game. One of the first games I created was "Pin the inhaler on the asthma trigger." That turned out to be a good learning experience because it shows kids what triggers asthma and what's not a trigger. For example, when cockroaches die the fumes from their bodies become an asthma trigger. The game changed kids ideas about asthma. Most kids had thought if you have asthma that you could not play the same as other kids.

I also play this game at health fairs and get a good reaction from kids and adults. They learn that more than just dust is an asthma trigger. Pet dander is also a trigger. The other game that I created was the "Wheel of Asthma" game. Each year we use it for World Asthma Day. The response is good. It helps kids to spell and learn more about asthma and to work as a team.

If you are interested in using these games in your programs, I can be a resource to you. For more information you can contact me at [nakiab@phmc.org](mailto:nakiab@phmc.org).

## Warm Welcome to New Staff

The NNCC is pleased to welcome our new staff members and volunteers, **Laura Line**, who is the new Deputy Executive Director; **Kate Taylor** and **Jacob Burkett**, who are two VISTA Volunteers; **Alex Lehr**, who is the new Program Coordinator and Grant Writer; and **Harrison Newton**, Program Director for Lead Safe D.C.

**Laura Line** recently joined the NNCC as the new Deputy Executive Director where she will take part in the development of new business and funding opportunities, as well as oversee operational aspects of the organization. Prior to joining the Consortium **Laura** worked in the Planning and Evaluation department at a national foundation, The Pew Charitable Trusts, where she engaged program staff in strategic planning and evaluation activities to strengthen the development of grant programs and inform the decision-making of program staff, senior management and the board. With previous experience in the nonprofit sector and a masters degree from the New School University's Milano Graduate School, her background is in nonprofit management, research and policy analysis. She is excited to apply her experience and knowledge to the Consortium's work to support and promote nursing centers.

**Alex Lehr** joined the NNCC in December of 2003. As Program and Development Coordinator his responsibilities include grant writing, grants management, program development and coordination of the *HomeSafe* environmental health hazard education and remediation program. He passionately believes in the importance of cooperative athletics and healthy eating as major facets of youth development and joins the NNCC with the goal of furthering these and related causes. **Alex** graduated from Haverford College in 2000 with a B.A. in Classical and Near Eastern Archaeology. He has been through a variety of sports-related injuries, both while insured and not, and has become sensitized to the severe problems facing the masses of Americans without reliable health care.

**Jacob Burkett** started as a Vista with the National Nursing Centers Consortium in February of 2004. Among his various responsibilities, he is tasked with coordinating the Lead Safe Babies Program in Baltimore as well as the responsibility to edit the Center's web site. **Jacob's** main focus however, is on policy research. The vast majority of his research involves sustainability issues for various programs of the Consortium. **Jacob** graduated from Desales University (formerly Allentown College) in 1998 with a B.A. in Political Science. Thereafter, he spent a year at Widener University School of Law where he was actively engaged in maintaining the Law School's web site. After trans-

ferring to the University of Pittsburgh in 2000 (Juris Doctor, 2003), he continued his work with the interplay between technology and policy by editing *The Jurist*, an online resource for legal students and scholars. In addition to academics, **Jacob's** professional credentials include a wide range of experiences. His work history includes an externship with the American Civil Liberties Union, a year as a Law Clerk within civil litigation, and a position of Evening Supervisor for a University Office.

**Kate Taylor** began her service as an Americorps\*VISTA member at the National Nursing Centers Consortium in the beginning of December. **Kate** is responsible for coordinating and sustaining the Asthma Safe for Kids (ASK) program, which is a program to help eliminate asthma triggers in households throughout Philadelphia, Western Pennsylvania and West Virginia. She is also working on the Tobacco Cessation program, and writing grants for the organization. **Kate** is from Bethlehem, Pa., and moved to the Philadelphia area, at the end of November. She graduated from Indiana University of Pennsylvania (IUP) in December 2001, with a Journalism B.A. and a History minor. **Kate** became interested in the healthcare, non-profit field, while interning at the Leukemia and Lymphoma Society in Whitehall, Pa., during college. Since college she has volunteered at the Society, and worked other various jobs.

**Todd Ziegler** is a new full-time employee at the NNCC. He has recently finished a one-year Americorps VISTA service coordinating the Lead Safe Babies program in Philadelphia. His new position includes Lead Safe Babies outreach and implementing Geographic Information Systems (GIS) mapping at the consortium. He has a B.A. in Geography with a focus in Geographic Analysis from West Chester University of Pennsylvania.

**Harrison Newton** is the new Program Director for Lead Safe D.C., a primary prevention program modeled after the NNCC's Lead Safe Babies initiative. The program is funded by the U.S. Environmental Protection Agency and seeks to help young mothers prevent their children from becoming lead poisoned. **Harrison** came to the NNCC as a VISTA volunteer in 2003, helping to manage an NNCC lead safety program in Baltimore and working with EPA's public outreach office. At EPA, he developed and coordinated a Public Service Announcement campaign aimed at preventing the pollution of drinking water. **Harrison** graduated from Texas Christian University in 1997 with a degree in Journalism and Political Science.

**MEMBER SERVICES**

## Supporting Nurse Managed Health Centers to Attain a Sustainable Operation

By Donna L. Torrissi, MSN, Director, Family Practice & Counseling Network, Philadelphia

**The FQHC (Federally Qualified Health Center) Task Force-** Tine and I have been facilitating monthly conference calls since November 2002. More than twenty-five nurse leaders nationally have

participated in these calls. The purpose of the Task Force and the monthly calls is to provide technical assistance for nurses to assess their readiness to become an FQHC and explore avenues to achieve this status. FQHC status provides many benefits that support the center to sustain itself. Benefits include cost-based reimbursement for medical assistance visits, access to HRSA grants (Health Resources Service Administration), such as dental, oral health and medical capacity expansion, malpractice coverage through the Federal Tort Claim Act and drug purchasing through a discount warehouse. If you would like to receive notification of upcoming conference calls, please email me at [donna@rhd.org](mailto:donna@rhd.org).

### ***How To Start A Nurse-Managed Health Center Guide***

On March 31, excited and exhausted, Donna Torrissi, Ann Dinehart and Tine Hansen-Turton packed up and sent off the manual to Springer Publishing to meet its April 1 deadline. This is very exciting because the NNCC manual will serve as a guide and a resource for people or organizations interested in starting new nurse-managed health centers or in learning more about the operation of such centers. There are step-by-step guidelines to consider in planning a center. Issues of sustainability are addressed as well as questions on accreditation and the necessary components to achieve Federally Qualified Health Center (FQHC) status. Additionally, a tool kit is included that is a compilation of twelve years of documents that we developed for our own operation. Some of the items included in this kit are sample contracts with outside agencies and physician collaborators, job descriptions, business and health plans for federal grants, policies and procedures for health center operations, community health center bylaws, quality improvement plan, strategic plan, and sources of funding. I am currently a Robert Wood Johnson Executive Nurse Fellow. I would like to thank them for providing the funding that supported the creation of this manual and for setting the stage for the establishment of the FQHC Task Force.

### ***NEW PUBLICATIONS***

Springer Publishing Company has announced that ***Academic Nursing Practice: Helping to Shape the Future of Health Care***, edited by Lois K. Evans and Norma M. Lang at the University of Pennsylvania, is now available. With contributions from several NNCC members, this book describes how to develop and implement nurse-managed practices that can serve as living laboratories where the education, clinical care and research missions of schools of nursing can be integrated to advance the discipline while providing essential community health services. The experience of the University of Pennsylvania School of Nursing together with case examples from other programs serve to provide practical strategies for securing university support, obtaining outside funding, and networking and partnering with other schools and communities for success. 296 pp 0-8261-2044-X hard \$49.95 prepub. Order online at [www.springerpub.com](http://www.springerpub.com)



### ***Johnson City Downtown Clinics, Tennessee... On the Go!***

*"The women used to come in when they were already in labor. No prenatal care at all. Now most of them have had good care, and we have a much better understanding of their situations. And we have healthy deliveries of healthy babies!"*

— (Labor Room Nurse)

*"They tell me that I might have had to have my foot amputated. But these nurses kept taking care of me day after day and now you can't tell my foot was infected, can you?"*

— (Homeless man in Johnson City)

*"The nurses at the clinic were the only people in town who would see my little boy. We just moved back here and didn't have any insurance at all. He was so sick, and they took care of him, and me too."*

— (Young mother in Johnson City)

Faculty in the ETSU College of Nursing started the Johnson City Downtown Clinic in 1990 with one small room in the Salvation Army building and later expanded the practice to several rooms in their building. In 1996 they moved to a small medical office site on Fairview Avenue, leased for \$1 a year from the Mountain States Health Alliance, where care is delivered today. In January, 2003, an additional site was opened in the Keystone Community Center to serve the special needs of women and children. In 2003 alone, more than 10,000 caring visits took place in the clinics.

Homeless people were the original population served, but it quickly became clear that many additional community members lacked access to health care for a variety of reasons. Some people don't have health insurance. Some people cannot negotiate a health care system that frequently unnerves even the most astute. Some people have behavioral or other health concerns that have seemingly exhausted other health care providers. Some people have TennCare health coverage not accepted by other practices. Some people speak no English and rejoice to be provided care in Spanish. Some are just relieved to be welcomed inside on a cold, wet day and have a hot cup of coffee and human kindness.

The largest portion of the population served are working poor. Nearly æ of the clients served lack any type of health insurance, some of the estimated 70,000,000 people in the USA without health insurance for all or part of the past year. Contrary to common belief, all children in Tennessee are not covered by health insurance. In 2003, 56% of the 480 children seen at the clinics were without health insurance.

Clinic staff, often in conjunction with volunteer faculty and students from the Colleges of Nursing, Public Health, and Medicine also provide outreach to community members. These outreach activities range from offering tuberculosis screening to persons staying in homeless shelters, offering services to persons living on the streets, providing nutrition education for youngsters in day care settings, or offering uncomplicated clinical care to migrant farmworkers. Nearly 1,500 outreach contacts were made in 2003.

People in need are turned away daily. For over a year, the clinic staff has been completely booked for appointments and walk-ins. Clinical care is managed by nurse practitioners who are hired or volunteer for a total of less than 4 full-time employees. Although the ETSU College of Nursing owns and operates the clinics, along with 8 other nurse-managed centers, no direct clinic funding is provided by ETSU. All personnel and operating expenses come from local, state, and federal grants and donations. Funding, space, health care volunteers, working relationships with medical specialists, and the continued expressions of support and caring from the community are all urgently needed.

### ***The Health Annex Joins Forces with the Family Practice & Counseling Network***

By Megan Kelly, Primary Care Coordinator

The Health Annex, a nurse-managed health center, in South West Philadelphia, gladly joined forces with The Family Practice and Counseling Network in July 2003. We have been granted Federally Qualified Health Center status. Through the federal grant and other funds from the state of Pennsylvania, the Health Annex will be undergoing renovations over the next 6 months. Plans are to expand Primary Care services on the first floor and Behavioral Health services on the second floor. This is an exciting time for the Health Annex, the southwest Philadelphia community and nurse managed health centers.

☆ Visit the NNCC Website: [www.nncc.us](http://www.nncc.us) ☆

**MEMBER NEWS**

***Mount Morris Health Center Receives FQHC Look-Alike Status***

Mona Counts from Mount Morris informed us that the Medicaid-MCO, Three Rivers Health Plan, has finally credentialed her practice as a primary care provider site. She reports that the consistent support of the National Nursing Centers Consortium in the many facets of practice has been the mainstay of the Primary Care Center of Mt. Morris's ability to keep their doors open.

***GlaxoSmithKline Honors Face to Face***

Face to Face, Inc., home to St. Vincent Health Center, was recognized for excellence in community healthcare by GlaxoSmithKline at GSK's Seventh Annual IMPACT Awards on March 10, 2004. Award nominees were assessed for: innovation, creativity and technical excellence; measuring and delivering results; process, product outcomes; adapting to new challenges and opportunities; community, client, customer focus; taking initiative, making extraordinary effort.

Through many years of commitment to its community, Face to Face has created an environment of trust and hospitality, which began in 1985 with St. Vincent Dining Room, a weekend meal program. This trust flows through St. Vincent Health Center, a health promotion nursing center, making it easier for guests to access healthcare. Nurses provide nursing care, foot care, and education about health and the healthcare system. The recent addition of an on-site staff social worker has improved the center's capacity to link clients to needed health and social services. Guests who do not visit the health center benefit from it via a hallway outreach program where blood pressure screening and health education and information are provided by university nursing students and health center staff.

Other services provided by Face to Face include a legal clinic, a neighborhood art program, and two related children's programs. Its summer camp for 75 neighborhood children extends throughout the school year to continue promoting play and friendship while supporting the growth and development that began at camp.

Face to Face and St. Vincent Health Center are deeply grateful for the recognition and award presented by GlaxoSmithKline for their work. The respectful effort and care of many volunteers, staff, students and guests for almost twenty years have made this possible.

***New Mexico Nursing Practice Clinic Raises Awareness During Immunization Awareness Month***

April was proclaimed Childhood Immunization Awareness Month in New Mexico to raise the awareness and the number of children fully immunized in the state. Even though New Mexico has been ranked 43<sup>rd</sup> in the nation for childhood immunizations, one clinic has proven to be effective in keeping their young patients up to date on their vaccinations according to the Department of Health CASA audit. The percentage of one and two year olds who get immunized at the University of New Mexico College of Nursing Practice Clinic at the Los Griegos Community Center is significantly higher than the state average which means they are less vulnerable for diseases like Hepatitis B and Polio.

Reasons for the great success contributed to several factors:

- 1) Located in the neighborhood of patients it serves
- 2) Mothers are followed for their pregnancy at the clinic before the birth of child and continue to bring the child after it is born
- 3) There are multiple services under one roof
- 4) The advance nurse practitioner-run facility has created an environment and a relationship with the patients in which they feel very comfortable; the nurses are able to spend more time talking to the mothers to put emphasis on preventative health care for babies.

The general family practice clinic has been running for 5 years and is open to everyone. According to Jim Stapleton, Family Nurse Practitioner, mothers will bring not only their first child to the clinic, but their second and third child. "This is very important because it helps the provider to be able to treat the whole family," Stapleton said.

Every two years the DOH produces a summary of childhood vaccination rates. The sample taken at the UNM College of Nursing Practice Clinic was over one hundred patient charts. The clinic was just slightly below or above national benchmark levels for all immunization rates. The UNM College of Nursing provides nursing education, research, service and leadership in nursing for the state and nation. With baccalaureate and master's level education and web-based programs in such areas as acute care, midwifery and community health, the college focuses on asking and answering the most difficult questions about nursing care and how nurses can design and manage health care delivery to meets the needs of the state.

***Changes are underway for Hill Creek Nursing Center and Project Salud***

Changes are underway for Hill Creek Nursing Center and Project Salud, two of NNCC's member centers. Operations at Hill Creek have recently turned over to NNCC's parent organization, the Philadelphia Health Management Corporation (PHMC). Without support from PHMC, Hill Creek would have been forced to close.

Formerly operated by La Salle University, the nursing center sits in a diverse area that has twice the rate of foreign-born residents than the city average, with large Cambodian, Vietnamese, and Latino communities.

Hill Creek Health Center fills a great local need for accessible, affordable health care. Twenty percent of the families in the neighborhood live at or below poverty. Health services are a long ride by public transportation. One in three adults in the area suffer from a chronic health condition that requires treatment, and one in six children have asthma.

In 2004, the center will continue to offer primary and preventive care, emergency medical services, and well-child care. It will expand its disease screening, pharmacy assistance and nutrition education programs. New programs will address family planning, prenatal care and midwifery services.

PHMC and La Comunidad Hispana in Kennet Square, Pennsylvania, are planning organizational affiliation scheduled for early summer. Project Salud, the nursing center that is part of La Comunidad Hispana, is a member of NNCC and is a pilot site for the Data Mart project.

Project Salud provides comprehensive, quality services to all patients in both Spanish and English, and without regard to health insurance status. Project Salud served 1,032 patients in 2003. Of these, 99% were uninsured. Project Salud provides culturally and linguistically competent and holistic primary care, including: evaluation and treatment of acute episodic and chronic illnesses; evaluation and treatment of injuries; provision of immunizations, flu vaccines and physical examinations; prenatal care; well baby and well child care; well woman care such as breast and cervical cancer

screenings and treatment; and, physical therapy evaluation and treatment. Project Salud also offers a myriad of preventive health education, outreach and promotion services. In 2003, Project Salud offered more than 100 health promotion events/services, reaching nearly 2,000 individuals.

NNCC has provided critical support to PHMC and these member centers throughout the changeover process. Specifically, NNCC has advocated to executive and legislative branches of government for funding, along with third-party reimbursement from managed care organizations to sustain these health centers. In addition, NNCC has provided technical assistance with regard to applying for federal grants and determining the best way to get federal funding, such as community-health center and federally qualified health center status. PHMC is excited to expand its role in the provision of health services provided by nurse-managed health centers. PHMC and NNCC will work closely to fully integrate these nursing centers into PHMC's network.

***NATIONAL NURSING CENTERS CONSORTIUM'S***

***MISSION:***

*To strengthen the capacity, growth and development of nurse-managed health centers to provide quality health care services to vulnerable populations and to eliminate health disparities in underserved communities.*

***GOALS:***

- Goal # 1:** *To provide national leadership in identifying, tracking and advising healthcare policy development.*
- Goal # 2:** *To position nurse-managed health centers as a recognized mainstream health care model.*
- Goal # 3:** *To foster partnerships with people and groups who share common goals.*

**MEMBER NEWS**

## **Primary Care Center of Mt. Morris, Inc. designated as a Federally Qualified Health Center Look-Alike**

**By Clinical Director Mona M. Counts**

On October 7, 2003, the Primary Care Center of Mt. Morris, Inc. (PCC) received official notification of their designation as a Federally Qualified Health Center Look-Alike (FQHCLA), the culmination of over two and half years of administrative efforts.

There were many times when Counts and company encountered seemingly insurmountable obstacles – applications requiring volumes of substantiating documentation, time constraints that forced them to choose between sleep and paperwork, financial struggles that turned paid staff into volunteers, negative reviews and reapplications.

But they never lost sight of the ultimate goal – to be able to provide affordable, accessible, integrated primary and behavioral health case services to an underserved population. The FQHCLA designation will allow the PCC to survive as an independent, nurse-

managed primary care facility that can serve as a model of rural health care in medically underserved and health professional shortage areas across the county.

Credit needs to be given to the NNCC and the AANP for their continual support and reassurances during the process of achieving the FQHCLA designation. Their simultaneous efforts to change national health policy and promote nurse practitioners as primary care providers guarantee that the PCC would be able to stand front and center in the struggle to gain recognition for the work and abilities of nurse practitioners.

In addition, the collaborative efforts of the (now) PA Coalition of Nurse Practitioners, the NNCC, AANP Legislative group and Morgan Plant has led to some insurance companies recognizing nurse practitioners as primary care providers. This insures sustainability for the PCC by providing multiple revenue streams.

Resources such as those provided by Bill Brehans, CPA of Dixon Hughes PLLC and The Pennsylvania State University, and consultation services through the NNCC by William Tierney, enabled the PCC to understand and complete many of the complicated financial reports required both pre- and post- designation.

The support of local residents and the impact of donations can also not be minimized. It was through a local initiative that the clinic was created and it is through community efforts that the clinic continues to grow to meet identified needs. Nevertheless, the PCC continues to seek donations and grants to support the high percentage of uninsured and underinsured served by the clinic.

Was it worth it? To be able to realize a dream? Absolutely. Yet Counts cautions others who are contemplating establishment of an independent nurse-managed center to look at the process critically. The barriers are real; the complexities daunting. But, she is also encouraging – if it can be accomplished in the nightmare world of health care called the Commonwealth of Pennsylvania, it can be done anywhere.

And, for Counts and the PCC staff, FQHCLA is just the beginning.

### ***NNCC Services and Membership***

NNCC provides a wide array of services and technical assistance to its member health centers, associate and individual members. These services include, but are not limited to, business and strategic development, health center development, program development and support, marketing and public relations, information systems and data sharing, research, public policy, staff and professional development training, conferences, information list-serve, funding support, newsletters and networking. Currently, there are NNCC-member nurse-managed health centers, associate and individual members throughout the U.S. If you would like membership information, please visit our NNCC web site at [WWW.NNCC.US](http://WWW.NNCC.US) or contact us at (215) 731-7140.

## **Vulnerable Populations Served by Community Health Centers & Non-Physician Health Centers**

Presented by Dr. Leiyu Shi, Johns Hopkins University, School of Hygiene and Public Health, Co-Director of the Primary Care Policy Center for the Under-served Populations



*Dr. Leiyu Shi*

Author of three textbooks and nearly 100 journal articles, Dr. Leiyu Shi has received accolades for his research on the association between primary care and health outcomes as well as his work studying the health care provided to vulnerable populations. In "Vulnerable Populations Served by Community Health Centers," Dr. Shi examines the role of Community Health Centers

in providing care to vulnerable populations. In Spring 2004, Dr. Shi presented his findings at an Independence Foundation-NNCC Conversation in Philadelphia. The study sought to define the populations served by the centers, the characteristics of the centers, and

establish significant indicators of the populations served. Among the conclusions, Dr. Shi found that Community Health Centers serve as safety-net providers to an increasing number of Americans and that expansion of these centers could prove effective in serving additional individuals in vulnerable populations. In addition, he found that non-physician run centers, defined as health centers where services are provided by non-physician providers such as Certified Registered Nurse Practitioners, provide comparable health outcomes at a significantly lower cost than physician or physician-team models. As such, the findings indicate that policy makers should include community health centers, particularly non-physician modeled centers and CRNP-run, in addressing the health care needs of vulnerable populations.

For a full copy of Dr. Shi's presentation, please visit the NNCC web-site: [WWW.NNCC.US](http://WWW.NNCC.US).

### ***Quality Assurance and Research Committee***

Nancy Rothman, Chair – [Rothman@temple.edu](mailto:Rothman@temple.edu)

Within an evolving organization, the Quality Assurance and Research Committee of the NNCC continues its attempt to define the committee's charge to: 1) establish a mechanism to identify, in a timely manner, potential researchers from member centers to participate in NNCC responses to requests for proposals, 2) better identify the NNCC as a Practice-based Research Network, and 3) gather potential quality assurance measures applicable across centers. Initially we created a survey to gather the above information from member centers, but with a poor initial response and reviewing the data gathered, it was decided that perhaps the survey was not the way to proceed. At this point, the committee is in a holding pattern awaiting direction from the Governing Board as to what are the priorities and what is our charge. However, we would like to invite others who are interested in quality assurance and research within nursing centers to join the group.

### ***COMMITTEE UPDATES***

#### ***Education and Program Committee***

Chris Esperat, Chair - [christina.esperat@ttuhsc.edu](mailto:christina.esperat@ttuhsc.edu)

**NNCC 2004 ANNUAL CONFERENCE** - The NNCC Annual Best Practice Conference has been scheduled for October 15 - 17, 2004 at the Loews Vanderbilt Hotel in Nashville Tennessee. Registration information is posted on the NNCC web site: [WWW.NNCC.US](http://WWW.NNCC.US). We invite you to join our dynamic committee.



***Lead Safe D.C.***

*Continued from page 1*

office is located at 2100 M Street N.W., Suite 203, Washington D.C. 20052. It is being contracted to NNCC by George Washington University, through a health policy organization called the Mid-Atlantic Center for Children’s Health and the Environment (MACCHE).

MACCHE is partnering with the NNCC to help implement several aspects of Lead Safe D.C.

The Lead Safe D.C. program director is Harrison Newton. Harrison came to NNCC as a VISTA volunteer in 2003 and has represented the NNCC at policy meetings of the nursing community. He also supervised the first phases of the Baltimore Lead Awareness program and worked for the EPA’s outreach and communications office.

He graduated from Texas Christian University with a bachelor’s in journalism. He has worked as a reporter in several states and for

the City of Fort Worth’s program “Our City, Our Children,” which helped businesses create and conduct programs for youth.

On Friday, May 21, 2004 the EPA held a press conference in the Children’s National Medical Center, Washington, D.C. to announce the NNCC Lead Safe DC grant. Don Welsh, the EPA Regional Administrator, and Congresswoman Eleanor Holmes-Norton along with Tine Hansen-Turton presented at the press conference. Nancy Rothman from Temple Health Connection and Margaret Cotroneo from University of Pennsylvania were also in the audience. Congresswoman Norton spoke eloquently about the role nurses play in addressing health disparities. NPR and Associated Press reported on the new NNCC program. A special thanks to Harrison Newton and Laura Line for all their work in pulling this program off.

***A Report On Development***

*Continued from page 13*

- They have led to additional areas of exploration about the centers’ activities.
- They have identified the need for further tool revisions and the importance of monitoring data entry and coding.

In Summer 2004 project staff, including staff from Messiah College and Northern Virginia Community College, will meet again to discuss findings for the last two reporting periods and make revisions as indicated. It is our hope that the tool developed for Fall 2004 will be the final edit before the tool is ready for dissemination to all NNCC sites. Additionally, when the group meets in Summer 2004, a qualitative analysis will be completed to describe factors that have influenced the ability of the group to work cohesively and collaboratively over the past three years. What is most remarkable about the process to date is that project staff, who originally sought to develop a tool that corresponded with needs specific to their

center and to their region, have now found a common ground to develop a tool that yields data that is comprehensive and inclusive of services provided at all centers.

A program describing tool development and an analysis of patterns and themes of health promotion/disease prevention activities in NNCC affiliated centers from February to July 2004 will be presented at the NNCC Annual Conference in Nashville, TN, October 2004. The final outcome of this project will be to use the data to facilitate implementation of best practices for health promotion/disease prevention programs and to develop uniform data reporting of health promotion services in NNCC centers nationally. Project staff are grateful to the Independence Foundation for supporting tool development and for assisting them to efficiently and uniformly describe health promotion/disease prevention services. A major part of the discussion between project staff and the NNCC during year two of the project will focus on how the tool can be utilized by more centers to accomplish this outcome.

Grateful acknowledgment is extended to Dr. Eunice King, Independence Foundation, for her assistance with data analysis and to project staff: Karen Karner and Carol Heinrich, East Stroudsburg University; Lydia Grenier, Fairfield University; Kay Huber, Messiah College; Wanda Dooley, Northern Virginia Community College; Carole Smith and Karen Grant, Pennsylvania State University; Nancy Rothman and Rita Lourie, Temple University; Ivory Coleman, Jean Forsha and Laureen Tavolaro-Ryley, Community College of Philadelphia. Special thanks are extended to Sapna Doshi, Institutional Research, Community College of Philadelphia, for her dedication to the project.

**It’s News To Me**

If you, or someone at your center, is doing something worth telling, let us know. We are looking for opportunities to increase public awareness about nurse-managed health centers. Spread the word, contact any NNCC Staff, and we will take it from there.



**COLLEAGUES IN THE NEWS**

## Honors & Awards

**The National Academies 2004 African American Portrait Collection Honorees** - In February 2003, The National Academies honored Vernice Ferguson in Washington D.C. by unveiling her portrait, which will be part of a collection of portraits recognizing the outstanding achievements of African Americans in science, engineering and medicine.



**American Academy of Nursing Civitas Award** - Susan Sherman, President and CEO of the Independence Foundation, received the American Academy of Nursing's 2003 Civitas Award for her distinguished service to nursing and healthcare and in the shaping of healthcare policy.

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### ***NNCC Services & Membership***

NNCC provides a wide array of services and technical assistance to its member health centers, associate and individual members. These services include, but are not limited to, business and strategic development, health center development, program development and support, marketing and public relations, information systems and data sharing, research, public policy, staff and professional development training, conferences, information list-serve, funding support, newsletters and networking. Currently, there are NNCC-member nurse-managed health centers, associate and individual members throughout the U.S. If you would like membership information, please visit our web site or contact us at (215) 731-7140.

***We encourage you to communicate to us what topics you would like to see included in our future newsletters. If you would like to submit articles for consideration for publication in future issues, please let us know. Should you have any questions, concerns or need additional information about the NNCC, and how to become a member, please feel free to contact us at (215) 731-7140. You can also email your inquiry to [Tine@RNCC.org](mailto:Tine@RNCC.org)***

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***Enjoy your summer and we'll see you in the fall!***