Disruptive Innovation
The Next Generation of Nurse Managed Centers within Academic Settings
Lessons Learned and a Vision for the Future

Sustaining the Future of Nurse-Managed Health Clinics
National Nursing Centers Consortium
Annual Conference
Philadelphia, PA
November 12, 2015

Nancy M. Valentine, RN, PhD, MPH, FAAN, FNAP
Associate Dean, Practice, Policy, and Partnerships
Professor, Department of Health Systems Science
Institute for Healthcare Innovation (MC 802)
University of Illinois at Chicago
College of Nursing
Discussion leads

Amy Barton, PhD, MSN
Associate Dean for Clinical Affairs
University of Colorado Health Sciences Center
School of Nursing

Kathryn (Kate) Fiandt PHD, APRN-NP, FAANP, FAAN
Professor and Associate Dean for Transformational Practice and Partnerships
University of Nebraska Medical Center
College of Nursing

Bonnie Pilon, PhD, NEA-BC, FAAN
Alexander Heard Distinguished Service Professor
Vanderbilt School of Nursing

Nancy L. Rothman, EdD, RN
Interim Chair
Independence Foundation Professor of Urban Community Nursing
Director of Community-based Practices
Dept. of Nursing, College of Public Health
Temple University

Cynthia Selleck, PhD, RN, FAAN
Associate Dean Clinical & Global Partnerships
The University of Alabama at Birmingham
School of Nursing

Patricia Vanhook, PhD,FNP-BC, FAAN
Associate Dean, Practice & Community Partnerships
East Tennessee State University, College of Nursing
Report of the Roundtable Group

National Academic Health Centers - Nurse Managed Clinics Roundtable

Leading the Way in Developing Nurse Managed Clinics for the Future

Building the capacity in Colleges of Nursing to showcase the call

_Nurses are the Solution_

Inaugural meeting hosted by University of Chicago College of Nursing
Institute for HealthCare Innovation
Chicago, Illinois
July, 2015
Mission of the Roundtable

Explore Unique Challenges of Nurse Led Programs in Academic Settings
Convening of a special interest meeting to address common issues in NMC

Underlying assumptions and questions

- If advanced practice nurses are going to propose solutions to meeting the primary care and psychiatric care needs of communities, how do we position ourselves locally, regionally and nationally now in order to be successful?

- This is a national call to action and we need all thought leaders on board
  - Should academic health centers take the lead?
Roundtable Origins
Motivations for the University of Illinois at Chicago College of Nursing for reaching out to academic colleagues

Can we solve our problems at home and survive on the way to devising a national model?

- The University of Illinois at Chicago’s College of Nursing operates 3 community based clinics referred to as Integrated Health Care.
- These clinics have evolved over the past 2 decades and have had multiple HRSA grants to get established.
- The clinics utilize an integrated model of care—combining primary care and mental health services.
- The clinics are partnered with both a social service organization referred to as Thresholds* and to the University of Illinois Medical Center through the Mile Square Health Center, an FQHC (Federally Qualified Health Center). The MSHC FQHC allows for enhanced billing rate.
- The clinics have been grant supported until 2015 when all grant support ended signaling operating at a significant financial loss.
- Given the current environment of the university and the implementation of PPACA, the clinics are rapidly losing money and will not be sustainable as a free standing operation for the long term.
- Recognition that we cannot do this alone and be successful—that we need partners in building the future became clear early on in 2014.

*Established in 1959, Thresholds provides healthcare, housing, and hope for thousands of persons with mental illnesses in Illinois each year. Through care, employment, advocacy, and housing, Thresholds assists and inspires people with mental illnesses to reclaim their lives.
Nurse led programs have lots of challenges especially in complex university settings

- Academic setting prize grants however HRSA grants do not include a toolkit for transitioning from grants to self-sustaining
- HRSA recognizes this dilemma but this fact has not been adequately addressed
- Developing a business model post grant funding appears to be fraught with many hazards and has led in many instances to program closures or absorption by other entities
- Despite excellent quality outcomes, developing a business model is essential to the stability of a nurse led program—“No Money, No Mission”
- There does not appear to be a “best practices” road map for how to develop, build and sustain these models with or without grants
- With no case mix to offset the very sick, nurse programs have no base for financial sustainability as it is difficult to break even with a panel of very sick people
- The business side of healthcare is not a strong attribute among most clinicians and faculty
- Developing a business model has many challenges that are both internal and external in a changing healthcare world where all “stand alone” practices are at risk
Origins of the Roundtable

Question #2 Who and Where are our partners?

- Internal Issues within the Academic Setting
  - The value proposition of *why nurse led?*
    - Is not easily understood by many within the field and among other colleagues, including faculty of both the CON and COM
  - Lack of general understanding among university clinical leaders of what nurse led programs do and what specifically do they contribute?
  - Lack of a clearly stated value proposition that serves to “tell the story” and communicate overall success as measured by;
    - Financial stability
    - Outstanding clinical outcomes
    - Service to the Community
    - Student mainstreaming through these models as part of the educational process
    - Research on best practices
    - Expansion into new models of care using an interdisciplinary team model for which there is no clear payment mechanism
  - In assessing who we could work with to address many issues-few supporters could be found
Origins of the Roundtable

Question #3 How have external policy issues related to PPACA impacted clinics?
The Illinois Experience

- Medicaid move to managed care companies via privatization of indigent care formerly paid for by Medicaid has not been smooth for either providers or members
- Distribution of newly insured people has been complex and confusing to consumers and had led to many patients now being assigned to other providers
- Nurses are having a difficult time getting on manage care insurance panels
- Continuation of the legislated collaborative agreement with physicians in most states further complicates all aspects of independent practice. Illinois congressional HB 421 made little difference
- Move from episodic care based on number of visits to population health management based on bundled payments is a new model for which few have experience in operating
- If we are having financial survival problems in a FFS world—how will we make it in a bundled payment approach?
Origins of the Roundtable
Question #4 What are our assets?
What do nurses bring to the table?

- Nurses are strong in the following areas:
  - Innovative ideas
  - Willingness to work with very complex, impoverished patients and communities and “give it our all” is impressive
  - Patient-centered approach that emphasizes education and client choice is strong for positioning for population health shift
  - Burning the midnight oil to write and submit proposals and do the leg work to get a program up and running
  - Desire to achieve and be successful
Origins of the Roundtable
Question #5 Challenges faced by nurses
How can we improve our approaches?

- Try to do too much on our own and not skilled at drawing in joint partners-easy to get isolated and “siloed” which leads to discouragement
- Do not seek partners in all aspects of the business of operating clinical programs especially in building a business model
- Going above and beyond generally leads to burnout of clinical staff
- Do we have enough students to justify having the clinics as a student practice center?
- Interpreting nurse led to be nurse managed for all the work is not efficient and we need to become more interdisciplinary, but not simple to draw in others and it is added cost to bring in other players such as social workers
- Having a universal value proposition for why nurses are the solution to many care delivery challenges makes it difficult to sell this idea to non-nurse audiences who hear this as nurses “beating the drum in a self serving manner”
- If we do not move to interdisciplinary care—we will have a difficult time justifying the work
Concluding “Crossroads” questions

We recognize that we need help and how can we best get answers?
Is everyone else having the same set of challenges?

Can we strengthen existing nurse managed programs and develop guidance for “newbies” who want to get into the game?

Is it realistic to think that we can get to a national model?
Choices

- Trial and error learning
- Call a friend...do we know one?
- Attend workshops ~ NNCC and AACN etc.
- Gather together a team of experts
  ...we opted for this choice
- Planning team organized
  - Amy Barton-Colorado
  - Bonnie Pilon-Vanderbilt
  - Nancy Valentine/LaTasha Pryor-UIC/Chicago
Let’s ask the Experts!
Why re-invent the wheel when we can harness all the wheels and build a platform for success...

- Planners set Goals of Meeting~ Broaden experience and Information Sharing
  - Identify Best Practices- What is out there that can be used now?
    - Share Lessons Learned
    - Identify the Unique Challenges of an Academic Health Center
    - Organize this Forum as a Special Interest Group and vet for ongoing dialogue
    - Opportunity to Share Resources

- Is there an appetite for ongoing thought leadership ~ Could this be an ongoing forum?
  - Paper-Proceedings of the roundtable
  - NNCC presentation in Philadelphia-Conference exchange to review proceedings of the roundtable
  - On going thought leadership meetings
    - Shared strategic planning
      - Can we develop a strategic plan on a more national scale?
    - Development of a tool kit
    - Consultation among group members

![Diagram](image-url)
Amy Barton, PhD, MSN
Associate Dean for Clinical Affairs
University of Colorado Health Sciences Center, School of Nursing

Nancy DeLeon Link, MGA
Chief Operating Officer - NNCC
National Nursing Centers Consortium

Patricia Dennehay, DNP, RN, NP-C, FAAN
Consultant
Dennehay and Associates

Diane Ebbert, PhD, APRN, FNP-BC
Clinical Associate Professor
Director, Advanced Practice Programs
University of Kansas, School of Nursing

Christina Esperat, RN, PhD, FAAN
Associate Dean for Clinical Services & Community Engagement
Texas Tech University Health Sciences Center, School of Nursing

Kathryn Fiandt, PhD, APRN-NP, FAANP, FAAN
Associate Dean for Transformational Practice & Partnership
University of Nebraska Medical Center College of Nursing

Tine Hansen-Turton, MGA, JD
Executive Director of NNCC
National Nursing Centers Consortium: Centre Square East

Anita Nivens, PhD, RN, FNP-BC
Professor & Graduate Nursing Coordinator
Armstrong Atlantic University, Department of Nursing

Julie Novak, DNSc, RN, CPNP, FAANP, FAAN
Professor & Vice Dean, Practice & Engagement
University of Texas Health Science Center
San Antonio School of Nursing

Bonnie Pilon, PhD, NEA-BC, FAAN
Alexander Heard Distinguished Service Professor
The Clinic at Mercury Courts
Vanderbilt School of Nursing at Scarritt Place

Joanne Pohl, PhD, ANP-BC, FAAN, FAANP
Professor Emerita
The University of Michigan, School of Nursing

Cynthia Selleck, PhD, RN, FAAN
Associate Dean Clinical & Global Partnerships
University of Alabama at Birmingham, School of Nursing

Denise Schentrup, DNP, ARNP-BC
Associate Dean of Clinical Affairs
University of Florida College of Nursing
Archer Family Health Care

Nancy Valentine, RN, PhD, MPH, FAAN, FNAP
Associate Dean, Practice, Policy & Partnerships
Institute for Healthcare Innovations- College of Nursing
University of Illinois at Chicago

Patti Vanhook, PhD,FNP-BC, FAAN
Associate Dean, Practice & Community Partnerships
East Tennessee State University, College of Nursing
The Gathering
University of Illinois, Chicago
College of Nursing
Institute of Healthcare Innovation Staff

- Monique Allen, Finance Director
- Diane Cesarone, RN, Director of Quality
- Kevin Dorsey, Director of UIC Managed Care
- Brenda Madura, CNM, Director of Nurse Managed Clinics
- Elizabeth Raleigh, Director of Provider Practice
- Marsha Snyder, PhD, PMHCNS-BC, Clinical Staff
- Ruth Woroch, APN Clinical Staff
- Lisa Young, RN, MSN, Data Manager

- Guest:
  - Mary Samania—Michigan State University
Getting Started - Agenda Focus on Lived Experiences

- Introductions
- Sharing of experiences
- Identification of specific challenges
- Sharing of Best Practices
- Discussion of ongoing barriers
- Identification of themes
- Identification of solutions
- Scope of ongoing work
Findings: Shared Commitments to Practice

- Commitment to the community
- Commitment to EBP, scholarship, research
- Commitment to underserved
- Commitment to access
- Commitment to Triple AIM
- Commitment of addressing social determinants
- Safety net provider (underserved vulnerable populations)
- Giving birth to nurse managed care centers model/changed mainstream model
- Patient centered models (not on medical/illness model)
- Provide primary care, wellness center
Findings: Shared commitment to Education

- Students (clinics used as educational site)
- Bringing classroom theory to real world practice
- Opportunity for faculty to remain clinically relevant through faculty practice
Findings: Shared Commitment to LEADERSHIP

- Diverse portfolio
- Perseverance; persistence
- Integration of services (i.e. behavioral health)
- Integration of mission
- Support of leadership from within university/Dean
Findings: Shared Commitment to COMMUNITY PARTNERSHIPS

- Strategic partnerships in the community are important
- Partnering with others/diverse partners is an aim
- Community engagement - community always lead the dance and must be part of the process
- Recognition that we need to find new partners in a changing healthcare environment and we need to determine who these can be?
Findings: Recognition that FINANCE is a key driver and often where programs get stuck

- Income stream for school of nursing if clinics is making money
- Private/public grants/funding is essential and an ongoing challenge
- Student/Employee health can help financially until clinic is self-sustaining if this is possible in a given setting however there may be limitations to add these to the CON portfolio if other departments such as COM already “own” these services
- Do NMC need to be subsidized or do they have the ability to sustain business on their own?
- New lines of business need to be considered to grow
Findings: Recognition that **Results** are key to success

- High quality outcomes are essential to tell the story of nurse managed success
- These need outcomes need to be highlighted and used to leverage our conversation with others
- We need to recognize that in some cases if we are so successful, others may want to claim our success as their own as one CON experienced
Key Themes Related to NMC Practice and to the Leaders who have dedicated their careers to this work~

- We need to honor all the work that has been done to date over several decades throughout the country in launching the NMC’s
- These have been vital services to the poor who have been served in many communities
- These programs have benefited the schools, faculty and students
- The fact that businesses such as Walgreens and CVS have made a business model out of these early efforts and have been able to replicate the model on a national scale is the greatest tribute that could be made to the ground work that has been done in the field overall
Discussion Conclusions

- There are a lot of differences in the payment structure and laws surrounding APN practice and nurse-led clinics.
- Depending on the laws, policies, and university/academic culture in which the nurse-led clinic resides in, each nurse-led clinic will face different challenges.
- However, with national health care reform, changes in payment structure will affect the future of all clinics.
- Health Care Reform is an opportunity but without funding we cannot demonstrate our ability to be impactful.
- We need to broaden the discussion and bring in others to work with us and we need to identify influential players.
- There was shared recognition that we need to join forces to address the many challenges we all face.
Our Quest for Solutions led to agenda outline of inventory of barriers and future state

- Business model(s)
- Elements of institutional support or non-support—tips and what to do if there is no support
  - Role of Dean
  - Role of Faculty
  - Faculty Scholarship
  - University infrastructure of other players
  - Building capacity in each of these areas of support
- Role of Insurers
- Legislation—barriers/facilitation
- Credential and privileging
- APN preparation
- Academic Preparation at the doctoral level
- Role fit
- MD consultation needs
- On-boarding
- Curriculum design
- Research opportunities
Barriers that need to be addressed now

**Mission**

- Nursing has had their roots in serving the underserved. This is difficult to give up in the face of needing to diversify case mix in order to survive financially—how can we progress in getting access and gaining comfort with other groups?
- How do we position for new lines of business in order to expand our reach?
- If our mission is to provide education for students—how can this be a clear expectation in a CON and what will it take to make this the norm for APN education?
- Need a practice paradigm for APN’s that includes exposure to NMC as part of their education
- Undergraduates need exposure to this as well in order to stimulate interest in becoming APN’s
- Given that there are not enough faculty and clinical sites - what innovations can we design for addressing these realities?
- Does curriculum design need to change so we have less of MD’s training the NP’s and set the expectation that at least 50% of clinical need to be with APN mentorship? This would then drive expansion of the clinics.
- Programs for complex case management would be relevant to current care needs of the populations typically served
Barriers that need to be addressed now

- **Practice Models**
  - Nurse managed needs to be re-defined as a leading in an interdisciplinary world
  - Use of evidence based approaches is a strength that needs to be reinforced and expanded as we engage other provider types
  - Is telehealth a possibility?
  - Telephonic care can be difficult due to poor electronic communication between treatment team and hospitals/other clinics
  - Assisted living, retirement communities, independent living, nursing homes—can be difficult to capture as they all have PCP arrangements already established
  - Self care and education is one of our strengths—how can we do this work most effectively?
Barriers that need to be addressed now

- Financial Models
  - Lack of sustainability is a major issue and revenue streams must be identified as grants are not intended for supporting ongoing operations.
  - Clinics operate with little if any reserves and this is unrealistic for survival and growth.
  - CON are educational businesses not health care businesses therefore there is an inherent conflict in goals and how can these be aligned?
  - Financial model of retail clinics involved negotiating for better prices with insurers—NMC’s may want to consider this approach.
  - No one is making money in primary care so we need diversity to survive and what are the best alternatives to augment?
  - Even successful nurse managed clinics are not scalable and therefore no one such as CMS will see this as a solution to the care needs of the country which could leave us out of being a player for new care delivery models.
Barriers that need to be addressed now

- **Infrastructure and Policy**
  - Staffing. Models of using just nurses is weak.
  - Bare bones staff with no business acumen or management oversight is a major challenge.
  - Faculty practice on a part time basis and there is lack of continuity of care due to schedule.
  - Academic constraints on business and degrees of freedom as they relate to the bureaucracy and university politics can make very burdensome.
  - Knowledge on how best to run a clinic and deal with workflows, EMR, and efficiencies is a knowledge base that must be taught and acquired for success.
  - Challenges with reimbursement for APN services—APN’s need to be independent in order to facilitate getting on panels and getting 100% of reimbursement as they are doing 100% of the work.
  - Policy work in gaining independent practice for APN’s is essential to success.
Barriers that need to be addressed now

- Leadership and Influential Partners
  - Lack of support within a CON can be a deal breaker—and can change with changes in dean’s leadership—high level of variability
  - What strategies can be used to get the deans engaged and collectively invested in supporting this work?
  - Does NMC’s need to be “baked into” AACN requirements? How can we position clinics to be mainstream?
  - What would it take to make CON clinical practices the norm, such as they are it the COM?
  - How can we address the power differential with the COM?
Future State Predictions

- Care Models to consider
  - Disease management - chronic care
  - Population health - risk stratification
  - Big data - Where the sources are? How is that data mined? Who has access to it? What information is available? - How can we tie this back in with population health?
  - Education and big health initiatives - sustainable and replicable
  - Personalized health - genetics, nutrition; implications for curriculum in educational setting
  - Telehealth - social media; actual provider visits; consultations
  - Social determinants
  - Medical home model and school health clinics
  - Wellness models- What is meant by “Gaps in care”?
  - Adhering to contemporary language/core competencies - team-based; evidence-based
  - Realizing that success in America is when private sector adopts your idea as stated by Tine, but how can we go around that? Possibly by linking our model to training of clinicians (no one can buy this idea or steal from us because we are degree granting) - i.e. Birth-center models; standardized nursing process for nursing schools
Getting to Future State Predictions

- **Partnership Imperatives**
  - Needs assessment of potential partners (businesses, payers)
  - Partners - Who are the top 10 people/organizations that we need to talk to? (NONPF, AACN, RWJ, AARP, IHI, CMS/HRSA, Gates foundation, Clinton Foundation ANA, Buffett, big business employers, insurers, self-insured employees, pharma, government)
  - Dean support - how can we gain Dean and faculty support if clinics are not financially viable? We need to find new ways to generate money and revenue. We need Deans to support us on a national level for nurse led clinics so changes can be made and standardized across the nation

- **Refine our direction**
  - Value proposition of nurse-led clinics - what exactly are we selling? (Is there only value once physicians owns the product/service?) - How will we define this?
  - Assessment of our environment and community (SWOT). Each clinic will have different experiences, strengths, challenges depending on the environment. There is no one-size-fits-all
Parking Lot Issues

- Research
- Consumer engagement
- Engagement of insurers
- Best Practices-evidence based care
- The “How to’s” of many issues discussed
- Review Dr Pohl’s background information regarding INC Data Warehouse Tool. Institute for Nursing Centers-funded by the WK Kellogg Foundation. 2008
Wrap up: Evaluation and Next Steps

Clear interest in taking these discussions to the next step

- What have we learned? And what do we want to do next?
- Collaborative Opportunities in both Operations and Clinical Aspects as a Result of the Roundtable
- Future Meeting Opportunities as an Special Interest Group
  - Joint Strategic Planning
  - Identification of Best Practices
  - On-going sharing of Lessons Learned
  - Future Directions
Brainstorming Possible Deliverables of an Ongoing Interest Group

Begin with:

- **Strategic Plan** - Mission (purpose) Vision, Values

**Funding**

- Framework for a business, including finance plan
- Internal & External marketing plan
- Plan for creative locations for NMHC’s (work sites, self-insured orgs, assisted living facilities)
- Plans for more sustainable funding

**Practice Tools**

- Decision-making matrix (grid/requirements)
- Tool kit/white paper/road map
- Exemplary models of care - Inter-professional care team
- Community/environmental needs assessment
- Statements on functional responsibilities for inter-professional core team members
- Plan for exposing inter-professional students to the care of highly complex, underinsured patients
- Development of a balanced scorecard (plan for measures and dates elements with data collection plan)
Brainstorming Possible Deliverables of an Ongoing Interest Group

- **Policy Initiative**
  - Consensus statement on model of Nurse Led Care and corresponding National Policy to drive the model
  - Standards and requirements (build partnerships w/NSBN’s and other organizations)
  - Plans for working with key organizations: IHI, RWJ, J&J, IOM Academy Health, United Health Care
  - Partnerships with legislators/policy makers
  - Nurturance of partnerships - NONPF, AACN, AAMP

- **Leadership Initiatives**
  - Exemplary models of inter-professional education
  - Model for gaining support from Executive Decision Makers
  - Planned mentorship for primary care NP’s
  - Immersion Institute for emerging leaders who will carry these programs forward
  - Plan for workforce development to prepare the next generation of care providers
Finding a Home: Launching a Collective Strategic Planning Process
Partner with NNCC and leverage their resources

- Technical Assistance-HRSA grant for technical assistance-models for sustainability
  - EMR implementation
  - Patient Center Medical Home review
- Policy-part of a 60 member nursing community coalition. Gov’t affairs for AACN is the lead.
  - Identify the policies—what are the goals? Strategies?
  - Definition of a NMHC for federal law—give it visibility in the law
  - Interface with HRSA
  - Tool kits
  - Next steps
- Providing guidance and leadership
- Guest on Nov 11th 3 hour Session
  - July meeting members will attend
  - NNCC board members
  - NNCC staff
  - AACN liaison
Come join us and create the future of NMC’s