NURSE-MANAGED HEALTH CENTERS: ASSURING QUALITY CARE  
Revised March 2011

“The need for accessible, affordable, quality health care in the United States has never been greater”  

INTRODUCTION
On March 28 and 29, 2008, leaders from the National Nursing Centers Consortium (NNCC), the Institute for Nursing Centers and Nursing Centers-Research Network convened the first meeting of a Quality Task Force with the goal of establishing voluntary quality standards for nurse-managed health clinics. This document is a direct outcome of that meeting. The first section provides a background on nurse-managed health clinics and the second section lists the recommended Quality Standards.

BACKGROUND
Quality Task Force Goal
The three organizations listed above are widely recognized as possessing the history and expertise to most appropriately identify voluntary quality standards for nurse-managed health clinics. They have collaborated in recent years on data collection related to service delivery, research, advocacy and policy. The organizations recognize the changes required in health care delivery to provide access to health care for all, and they understand that establishing uniform Quality Standards will communicate to patients and policymakers the safety and quality of care they should expect from nurse-managed health clinics. This document provides Quality Standards jointly endorsed by the three organizations representing nurse-managed clinics in the US, with the hope that the Quality Standards will serve as the basis for future certification or credentialing of nurse-managed health clinics.

Nurse Managed Health Clinics
Nurse-managed health clinics (NMHCs) are accessible service sites that deliver family and community oriented primary health care. The majority of care is provided by advanced practice nurses in collaboration with other nursing and health care providers, e.g. social workers, physicians, and dentists (Pohl, et al., 2010).

While today’s NMHCs trace their immediate roots to changes in national health care laws that began in the mid-1960s, the nursing model of holistic care dates as far back as the turn of the 20th Century, when Lillian Wald founded the Henry Street Settlement on the Lower East Side of Manhattan in 1893 and Margaret Sanger opened the first birth control clinic in Brooklyn in 1916 (Mason, Leavitt, & Chaffee, 2002). Since 1993, some NMHCs have received start-up funding from the Bureau of Health Professions, Division of Nursing, and the U.S. Department of Health and Human Services under the term “nurse practice arrangements.”

NMHCs may be free-standing businesses or may be affiliated with universities or other service institutions, such as home health agencies or hospitals. The majority (74%) of nurse-managed health clinics are affiliated with university-based schools of nursing. The remaining health clinics (26%) are independent nonprofits or hospital outpatient clinics (Institute for Nursing Centers Survey, 2008). Although NMHCs offer services across a continuum of care, they are generally differentiated as primary care practices or wellness clinics. Of the 250 nurse-managed clinics, approximately 160 identify themselves as “wellness clinics” while more than 90 offer comprehensive primary care services (NNCC Survey, 2008). In all NMHCs, “health problems and potential health problems are not viewed in isolation, but within the context of societal, environmental, and cultural influences that have impacted
the patients’ past and present health and that have the potential to impact future health” (Hansen-Turton & Torrisi, 2005).

**Primary Care NMHCs:** NMHC primary care practices provide comprehensive, coordinated and continuous care for acute and chronic health problems, as well as a wide range of health promotion and disease prevention services appropriate to the gender, age, race and ethnicity of the patients being served. Nurse-managed primary care clinics refer patients to medical specialists for health care beyond their scope of practice as defined by state and federal legislation.

**Wellness Clinics:** NMHC wellness clinics focus on primary prevention (health promotion, disease and injury prevention), secondary prevention (screening and disease and injury management), and tertiary prevention (prevention of complications and maintaining optimal wellness in the presence of chronic health problems) appropriate for the health problems of the populations served, based upon current needs assessments. Some wellness clinics serve specific population sub-groups (such as seniors, for example). Many NMHCs provide both primary care and wellness services.

NMHCs are primarily staffed by advanced practice nurses, such as nurse practitioners, nurse midwives and clinical nurse specialists. Nurse-managed primary care clinics may also be staffed by collaborating physicians, registered and licensed practical nurses, social workers, psychologists, medical assistants, nutritionists and outreach workers. Nurse-managed wellness clinics may include clinical nurse specialists, community/public health nurses, public health educators, registered nurses, social workers, nutritionists and outreach workers.

**CHARACTERISTICS OF NURSING CLINIC PRACTICES**

**Advanced Practice Nurses**
Although most NMHCs have many health professionals on staff, the core services are provided by advanced practice nurses who have advanced education and training that allows them to make independent clinical decisions and provide high-quality comprehensive health care.

**Quality and Safety**
NMHCs, like all health care practices, must create a culture of quality and be committed to monitoring and improving health care quality. To this end, quality improvement processes, outcomes and evidence-based clinical practices are incorporated into all NMHC practices and are used to ensure high-quality patient/consumer driven health care. They have consistently demonstrated excellence in quality health care outcomes (Barkauskas, Pohl, Benkert, & Wells, 2005; Benkert, George, Tanner, Barkauskas, Pohl, & Marszalek, 2007; Pohl, Barkauskas, Benkert, Breer, & Bostrom, 2007; Hansen-Turton, Miller, & Greiner, 2009; Barkauskas, Pohl, Tanner, Onifade, & Pilon, 2010).

**Nursing Model of Care**
Several conceptual models of health care are integral to the nursing center model. All of these models are consistent with the nursing philosophy of care that is patient-centered, holistic and community based.

**Primary Health Care:** NMHCs recognize the importance of primary health care as broadly defined in the Declaration of Alma-Ata by the International Conference on Primary Health Care (1978):
Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health process.

**Primary Care:** NMHCs that provide traditional primary care services use the Institute of Medicine (1996) definition of primary care and are committed to assuring the services are “integrated, accessible health care services (provided) by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” (p. 32) (italics original)

**Patient-centered Care:** Whatever the scope of services provided, all NMHCs share a common philosophy of providing holistic care that allows the patient (defined as individual, family, population group or community) to provide input into decisions regarding their care. As a result, patient-centeredness is a key concept in all NMHCs.

**Community-based Care:** Operating within a nursing model, all NMHCs acknowledge the role of the community in health care and use community input to inform their services and delivery care model. Community-focused interventions including coalition building, advocacy and policy development are essential to improve the health of communities and are common interventions in NMHCs.

**Safety Net Providers**
Most NMHCs are located in medically underserved areas in urban, rural and suburban communities, such as public and Section 8 housing developments, schools, churches, community and recreation clinics, and homeless and domestic violence shelters. These health clinics form a safety net for low income, minority, homeless and migrant families and uninsured population and provide access to care for many people who would otherwise do without. Virtually all studies of the demographics of patients served suggest that NMHCs serve as safety net providers (Fiandt, Neilson, Lanning, & Latzke, In Press; Hansen-Turton (2005b); Pohl, Vonderhein, Barakauskas, & Naglekerk, 2004). The majority of the patients served are poor, uninsured, and/or are people of color. Whether the NMHC serves urban, rural and suburban populations, they are likely to serve patients who otherwise would do without health care and are at risk for health disparities and poor health outcomes. NMHC research and practice leaders have regularly suggested that the model is ideally suited to have a positive impact on patient outcomes, especially for patients who are at risk for health disparities.

**Outcomes**
Because the NMHC model is relatively new and designed to impact patients in more holistic ways than traditional health care, documentation of the outcomes of NMHCs is critical. It is, of course, essential to document that the services reflect standards of care identified in health care. As noted earlier, there is a growing body of evidence supporting the quality of care provided using traditional medical measures. It is, however, equally important, due to the unique nature of the model, that NMHCs document the impact of the model on increasing access and elimination of health disparities. In addition, the
emphasis on wellness, or health promotion and disease prevention, necessitates that documentation not only include process outcomes that assure patients have access to these services, but also clinical and cost outcomes that document the value of these services that are often de-emphasized in traditional health care models.

Conclusions
NMHCs are an innovative model of health care delivery. They are uniquely designed to address two critical needs in our health care system: increasing access to quality care and elimination of health disparities. As these models evolve and seek funding support to demonstrate the impact of NMHCs on patients and communities, it is essential that Quality Standards to address unique aspects of the practice model be established. To that end, the following Quality Standards have been developed. At this point, the Standards are seen as voluntary but should serve as essential guidelines for minimal expectations as practices are developed and evolved.

QUALITY STANDARDS FOR NURSE MANAGED HEALTH CLINICS

Introduction: As a unique practice model, the Quality Task Force believes that nurse-managed health clinics should have specific standards for quality. Some standards are generic to most ambulatory health care practices but many address unique aspects of a nurse-managed health clinic. Unique aspects include the focus on the nursing model, the emphasis on providing care across the continuum of prevention, and the commitment to increase access to care and to eliminate health disparities. These quality standards are based on the assumption that the nursing model of care is particularly well suited to achieve the national health care reform goals; specifically, increasing access and the elimination of health disparities.

Recommendations for Quality Standards: The Quality Task Force believe that all nurse-managed health clinics should meet the following STANDARDS to assure that the NMHC is adhering to the unique practice model and is demonstrating a commitment to increasing access to quality care and elimination of health disparities.

Mission:
• **Standard 1:** The stated mission of the NMHC reflects a commitment to increasing access to quality care
• **Standard 2:** The stated mission of the NMHC reflects a commitment to elimination of health disparities.

Nursing Model: The clinic reflects a nursing model of care.
• **Standard 3:** Care is patient centered, i.e. the needs of the patient are central to all practice decisions, and includes integration of self-management support strategies.
• **Standard 4:** Primary, secondary, and tertiary prevention services are provided by the practice and the practice facilitates access to services not directly provided.
• **Standard 5:** Services provided are community oriented and based on the identified needs of the community.
• **Standard 6:** Partnerships with community agencies are formally established and are sufficient to assist with patient self-management support and meeting patients’ basic human needs (e.g. food, clothing, shelter, and safety).

• **Standard 7:** Patient education and case management services are core services provided by the nursing clinic.

• **Standard 8:** The nursing clinic supports health professional education by encouraging all health profession students to have clinical experiences at the clinic.

**Quality and Safety:** The clinic provides quality health care.

• **Standard 9:** A formal on-going quality improvement program is in place.

• **Standard 10:** Quality outcomes are benchmarked against national standards of care and measured regularly.

• **Standard 11:** The clinic has all appropriate emergency plans in place.

• **Standard 12:** The clinic meets national standards and legal requirements of state and federal regulators.

• **Standard 13:** When evidence exists, practice interventions, including practice management strategies, patient education, and case management services, as well as direct patient care, are evidence-based.

• **Standard 14:** Patient satisfaction is monitored on a regular basis and reflects criteria integral to the mission and vision of the practice.

**Health Services:** Clinics provide health care that reflects the health care home model and provide services that are comprehensive, coordinated, accessible, continuous, patient-centered, and community-based.

• **Standard 15:** Recognizing the complex determinants of health, the nursing clinics provide or facilitate access to health care system services.

• **Standard 16:** Solutions to patient health problems are addressed at multiple levels, i.e. individual, family and community interventions.

• **Standard 17:** The nursing clinic demonstrates the value of inter-professional collaboration to deliver quality care through partnerships with a variety of members of the health care team.

• **Standard 18:** The environment, staff, and services provided are respectful to all patients and are culturally appropriate.
• **Standard 19**: The clinic addresses the needs of the whole patient to include bio-psycho-social-spiritual concerns as the impact on the patient’s health and well-being.

• **Standard 20**: Behavioral and mental health issues are addressed as part of the management of all health problems.

**Access**: The clinic increases access to quality care.

• **Standard 21**: The nursing clinic increases access to quality health care services across the continuum of care, including facilitating access to specialty services.

• **Standard 22**: The clinic increases access to people who are risk for health disparities through assuring that the practice is culturally appropriate and that services are affordable.

• **Standard 23**: Services are available at times and in locations that meet the needs of the patient community being served.

• **Standard 24**: As a part of determination of patient satisfaction, the nursing clinic documents that services provided are acceptable to patients being served.

• **Standard 25**: Services are affordable to patients being served or mechanisms are in place to assist patients with the cost of care.

**Sustainability**: The clinic is fiscally and structurally sustainable.

• **Standard 26**: An annual budget is sufficient to support the activities of the nursing clinic.

• **Standard 27**: The budget reflects and supports the mission and strategic plan of the practice.

• **Standard 28**: The clinic makes an effort to limit its impact on the environment.

**Organizational Leadership**: The clinic is led by a nurse and the leadership/management team supports a nursing perspective.

• **Standard 29**: The parent organization supports the nursing model and provides institutional support for the practice.

• **Standard 30**: The clinic supports all employees, staff and clinicians, to practice at the full scope of their education and competency.

• **Standard 31**: The clinic leadership supports the nursing model.

• **Standard 32**: The clinic has strategic and business plans in place that serve as the basis of major decisions and are updated annually.
• **Standard 33:** Policies and procedures are in place to assure that clinic operations are standardized and that all employees know proper clinic operations.

• **Standard 34:** The clinic has an advisory board that includes consumers/patients and staff as well as practice leadership.

• **Standard 35:** The clinic regularly evaluates the satisfaction of all employees with the work environment.

• **Standard 36:** There is evidence that the work environment is considered by employees to be safe, supportive of their professional development, that their voices are heard and respected as members of the clinic team, that work expectations are clearly described and that they are provided with sufficient resources to do their work.

**Outcomes:** Data are collected that reflect the impact of services on patient clinical outcomes, access to care, elimination of health disparities, and cost effectiveness.

• **Standard 37:** A health record, preferably electronic, is in place to collect data that support a patient registry function as well as a patient health record and practice management functions.

• **Standard 38:** Data are collected that reflect care process, e.g. blood pressure checks or self-management goals.

• **Standard 39:** Data are collected that reflect clinical outcomes, e.g. A1c or patient utilization of health resources.

• **Standard 40:** Data are collected that reflect balancing outcomes, i.e. processes that support the infrastructure, e.g. cost effectiveness or patient satisfaction.

• **Standard 41:** Data are collected that reflect the impact of the nursing clinic on the elimination of health disparities.

• **Standard 42:** Data are collected that reflect the impact of the nursing clinic on the increasing access to health care.

• **Standard 43:** When appropriate, data collection processes are IRB approved.

**Physical Environment:** The physical environment is safe and sufficient to implement the work of the nursing clinic.

• **Standard 44:** The clinic meets ADA standards for accessibility.

• **Standard 45:** The clinic meets OSHA standards for employee and patient safety.

• **Standard 46:** Policies and procedures are in place to handle hazardous waste and to protect hazardous drugs and materials.
REFERENCES


