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How to Start a Nurse Practitioner Faculty Managed Clinic: Missing Components?

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California State University, Northern Consortium Doctor of Nursing Practice

ABSTRACT

HOW TO START A NURSE PRACTITIONER FACULTY MANAGED CLINIC: MISSING COMPONENTS?

A serious need exists for improved access to primary care for vulnerable populations. Nurse Practitioner Faculty Managed Clinics (NPFMC) can help to alleviate this problem. The purpose of this qualitative, descriptive study was to identify and examine the beginning components necessary for implementing this inter-professional collaboration. A comprehensive literature review identified the absence of these components, which were then revealed through the interviews with founders of NPFMCs. Prior to the interviews two manuals were reviewed about the process of starting a free clinic. Questions were explored relating to the participants' experiences in starting a NPFMC. Review of the manuals was found to be lacking in the beginning process of founding a NPFMC. Through transcription of the interviews recurrent patterns emerged forming themes. The interviews revealed unexpected and important missing components in the formation of an inter-professional collaboration in the form of a NPFMC. These components included vision which provided guidance and foresight, and tenacity which is the motivator for implementing the clinic. These non-tangible components bridge the gap to the concrete steps.

How to Start a Nurse Practitioner Faculty Managed Clinic: Missing Components?

by

Johnna Edmunds

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TABLE OF CONTENTS

LIST OF TABLES

Page vi

LIST OF FIGURES

Chapter 1: Introduction

There is a serious need for primary care for vulnerable populations (Robert Wood Johnson Foundation, 2011). This need can be met by an increase in the number of nurse practitioner faculty managed clinics. According to the American College of Physicians (2009) there is a severe shortage of primary care physicians, which is resulting in a health care crisis impacting not only vulnerable populations, but the health of communities and the public at large (Zerehin, 2009). Primary health care is critical because it is the most common initial point of contact for undiagnosed and chronic health problems (Roussos & Fawcett, 2000; Freundlich et al., 2013).

The goal of this project was to form a blueprint to guide and support the increase in nurse practitioner faculty managed clinics (NPFMC) from inception. In addition to providing improved health care access, this initiative directly supports the Institute of Medicine's strong recommendation for inter-professional education and collaborative practice (Bridges, Davidson, Odegard, Maki, & Tomkowiak, 2011). The formation of a collaborative relationship between those in university education (nurse practitioner faculty / nurse practitioner students) and the community in which the nurse practitioner faculty managed clinic resides clearly demonstrates a mutually beneficial partnering of town and gown (Perez & Cuellar, 2009).

Nurse practitioner students, who will be future health care providers, often lack exposure, understanding, and sensitivity to vulnerable populations. Hence, an additional purpose of the nurse practitioner faculty managed clinic is to expose students to these populations. The goal is that these nurse practitioner students will continue to work or volunteer in underserved areas with vulnerable populations after graduation. These nurse

practitioner graduates will then be another source of health care providers for the 31 million uninsured patients in the United States (Darnell, 2010; Smith et al., 2014).

This project was accomplished with a comprehensive review of the literature and strengthened by conducting interviews with founding members of nurse practitioner faculty managed clinics. These interviews revealed unexpected and important components which will be discussed in chapters four and five.

Significance

Among citizens of the United States, opinions differ significantly regarding whether health care should be a right for all or an earned privilege for those who can afford it. Though the nation remains divided around this issue, within recent years, many of those who formerly did without or received hard-to-find, less-than-optimal fragmented care now have improved access through the Affordable Care Act (ACA) (Medicaid.gov., 2010). The ACA mandated an expansion of healthcare insurance to include those of lesser means, with more consumer choices for affordable healthcare coverage (Shane & Ayyagari, 2014).

Those on the frontlines in healthcare have first-hand knowledge of the human suffering and loss of productivity attendant with the old system, as well as improvement in healthcare access since implementation of the ACA. However, even with implementation of the Affordable Care Act, and the increased numbers of people with health insurance, significant numbers remain uninsured and under-insured. (Centers for Disease Control & Prevention, 2014; Schoen, Hayes, Collins, Lippa, & Radley, 2014).

Another serious problem is the impacted state of health care clinics (Turton-Hansen, 2012). Often even those with health insurance may have difficulty securing an appointment

or finding a consistent provider, agency, or clinic with whom they can develop a trusting, informed therapeutic relationship. These problems feed the rhetoric of those opposed to the Affordable Care Act and threaten the imperfect but significant gains experienced by the previously uninsured. Therefore, it is crucial that the fledgling system continue to address problems and improve. Research suggests that one entity in particular, the nurse practitioner faculty managed clinic can provide some relief to those experiencing no access (uninsured or underinsured) or congested access to health care (Chin, Lam, & Lo, 2011; Newhouse, 2011).

Collaborative relationships between faculty nurse practitioner managed clinics and communities are in unparalleled and unique positions to contribute to the changing health care landscape in positive ways. The dramatic shortage of primary care physicians places nurse practitioners in a position poised to help fill the primary care need, including that of vulnerable populations. Research has shown that students in the nurse practitioner faculty managed clinic programs continue to work after graduation with vulnerable populations in federally identified areas which have an inadequate number of health care providers (Valentine, 2015). These identified areas are defined by the United States Federal Health Bureau as shortage areas (Berman et al, 2014).

Background

The first collaborative effort was in the form of a student managed health care clinic at the University of North Carolina in 1968. This collaborative clinic for vulnerable populations illustrated the success of these efforts with tens of thousands of patients seen at the clinic in the forty years between its opening and 2008 (University of North Carolina School of Medicine, 2008). This collaborative effort was formed by a group of medical students who wanted to

understand and be part of improving the health of their community. Their motto was patient advocacy. Though not specifically managed by nurse practitioners, there was involvement by the schools of Medicine, Nursing, Pharmacy, Public Health, and Social Work; a true inter-professional collaboration.

The University of California, Davis (UCD) followed this model when their first student-managed clinic was opened in 1972, and participation became a required part of the curriculum. UCD at present has seven student-run clinics and five partner clinics in the surrounding communities (Dagang, 2016). The University of California, San Diego (UCSD), is another model with a long history and multiple student run clinics.

For clarity as there may be some confusion about the terms: Student-run; student-managed; nurse-managed or run, all of these phrases or terms denote the same type of clinic for vulnerable and underserved populations as a collaborative effort, and in this study refer to nurse practitioner faculty managed clinics as a service learning educational model. This collaboration exists between the university, as represented by the nurse practitioner faculty and students, and the community as represented by the stakeholders which includes the patients.

Though more than 70-percent of the 250-plus university collaborative clinics in the United States are managed and staffed by physicians and medical students, nurse practitioner managed clinics are increasing. One of the main advantages that medical schools have is the financial support of a large institution often accompanied by a hospital or medical facility. The University of California, Davis; University of California, San Diego; and the University of California, San Francisco (Beck, 2005; Dagang, 2016) are three strong examples of collaboration managed by physicians and or medical students.

Theoretical Framework

The theoretical framework guiding the underpinnings of this project rests upon the foundation of change theory and Senge's Learning Organization (Garcia, 2010; Senge, 2006; Senge, et al., 1999). This framework included the collaborative members who participated, and through their continual learning and sharing, worked toward common goals creating a vision for the present and for the future. Also, change theory is a method for planning, participation, and evaluation, which includes a visual depiction of progress. Because the theory of change includes participation and ongoing evaluation, these components can exchange places in the schema and planning happens throughout the process. It is evident from this description and discussion that the change framework is free-flowing and that the change results from the input and the interpretation of that input.

Both theory and framework are flexible and adapt to the particular situation. Below, is a Venn diagram which represents the input in the center, and shows how the overlaps result in the changes or outcomes. The diagram identifies general areas that each component represents in the appendices and demonstrates what can occur when specific variables and outcomes are reproduced from a review of the literature and the interviews with founders of nurse practitioner faculty managed clinics. The goals of these clinics are increased access to health care for vulnerable populations, increased individual and community health, student exposure to vulnerable persons with an increase in cultural humility, and to encourage a sense of social justice for the student by modeling behavior of the nurse practitioner faculty. The collaboration creates a culture of learning and supports the learning organization (Mason, n.d). The methodology, theory, and framework are discussed in more depth in chapter three.

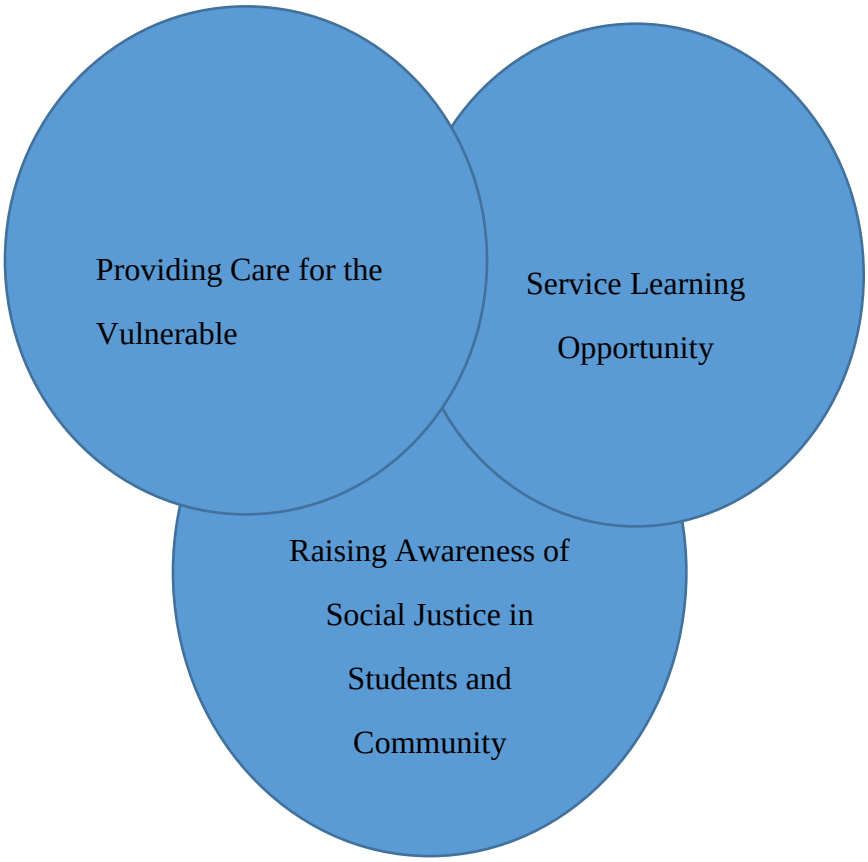


Figure 1. VENN diagram depicting the major areas of a collaborative relationship in the form of a nurse practitioner faculty managed clinic.

Summary

The purpose behind this study was to review data from university-community partnerships that have evolved as nurse practitioner faculty managed and staffed, free clinics for the vulnerable. This purpose was accomplished through a comprehensive literature review and interviews with three founders of nurse practitioner faculty managed clinics. The study was focused on assessing the beginning components, tangible and non-tangible, of nurse practitioner faculty managed clinics. This is significant because these findings will inform and assist in the development of new systems to address and lessen the impact of the lack of health care on

uninsured and underinsured persons (United States Department of Health and Human Services, n.d.).

In chapter two, the comprehensive review of the literature related to this topic will go into more depth with terms and phrases helpful to gain a better understanding of nurse practitioner faculty managed clinics and their integrated components.

Chapter 2: Literature Review

The purpose of this project was to create a blueprint for future implementation of nurse practitioner faculty managed health clinics. The following evidence-based practice literature was reviewed regarding the establishment of these nurse practitioner faculty managed clinics (NPFMC). An appraisal of the relevant research addressing collaborative relationships between universities and communities led to the creation of a blueprint of steps to follow when considering initiating a NPFMC. Initially investigated were the areas of collaborative relationships and nurse practitioner faculty managed clinics, followed by a review of literature regarding lack of healthcare and its implications. The summary at the end of this chapter offers the linkage of the two components of this doctoral project.

The review of the literature was broken down into recurring topics in order to increase the understanding of the progression of collaborative relationships in nurse practitioner faculty managed clinics. Over 900 articles and research studies were compiled and reviewed in the literature search to address the questions of beginning steps in the implementation of a NPFMC and in the value of these clinics. Searches were conducted using the following databases: CINAHL; GOOGLE SCHOLAR; EMBASE; EBSCO; SCOPUS; OVID; CONCHRANE; PUBMED/MEDLINE with key words and phrases such as:

- Nurse practitioner faculty managed clinic
- Student-run clinic
- Collaborative partnerships in health care
- Vulnerable/underserved persons
- Affordable Care Act
- Social determinants of health

From these searches data was extracted and compared with the purpose of identifying the current state of knowledge about nurse practitioner faculty managed clinics. A summary was compiled of what is known about these collaborative relationships and what beginning steps or components were absent or not addressed.

The following is an overview of the pertinent themes found through the literature review:

Among citizens of the United States, opinions differ significantly regarding whether health care should be a right for all or an earned privilege for those who can afford it. Though the nation remains divided around this issue, within recent years, many of those who formerly either did without or received hard to find, less than optimal fragmented care now have improved access through the Affordable Care Act (ACA) (Medicaid.gov, 2010). The Affordable Care Act mandated an expansion of healthcare insurance to include those of lesser means, with more consumer choices for affordable health care coverage (Shane & Ayyagari, 2014).

Those on the frontlines in health care have first-hand knowledge of the human suffering and loss of productivity attendant with the old system, as well as improvement in healthcare access since implementation of the Affordable Care Act in the United States. However, even with the implementation of government-supported health care and the increased number of people with health insurance, a significant number remain uninsured and underinsured. (Centers for Disease Control & Prevention, 2014; Schoen et al, 2014).

Another problem is the impacted state of health care clinics (Turton-Hansen, 2012). Often even those with health insurance may have difficulty securing an appointment or

finding a consistent provider/agency with whom they can develop a trusting, informed therapeutic relationship. These problems feed the rhetoric of those opposed to the Affordable Care Act and threaten the imperfect, but significant, gains experienced by the previously uninsured. Therefore, it is crucial that this fledgling health care system continue to address problems and improve. Research suggests that one entity in particular, the nurse practitioner faculty managed clinic (NPFMC), can provide some relief to those experiencing no access (uninsured or underinsured) or congested access to health care (Chin, Lam, & Lo, 2011; Newhouse, 2011).

An appraisal of relevant research addressing collaborative relationships between universities and communities was done through this literature review; also information was gathered from the literature to validate the value of the nurse practitioner faculty managed clinic and its feasibility, while at the same time examining the foundational steps or components of implementing this type of clinic. The information gained from this review of literature will be used in the future to formulate a blueprint to guide and support the establishment of additional collaborative clinics. These clinics will be initiated by nurse practitioner faculty; from the beginning idea to the fully functioning actualization. Additionally, evaluation of the literature was reviewed to assess the role of the nurse practitioner faculty managed clinic in providing improved health care access while directly supporting the Institute of Medicine's strong recommendation for inter-professional education and collaborative practice (Bridges, et al., 2011). Support for the contributions to vulnerable populations, health care, and students became apparent through the review as an outcome of these collaborations (Bridges, et al, 2011; Chin, Lam, & Lo, 2011; Darnell, 2010; Gaylord & Oppizzi, 2015).

Nurse Practitioner Faculty Managed Clinics

University-community collaborative relationships in the form of nurse practitioner faculty managed clinics are helping to bridge the gap in health care for vulnerable populations (Stuhlmiller & Tolchard, 2015). The clinics may also encourage graduates to continue working and volunteering with vulnerable populations, instilling in students an increased sense of social justice. There are few research studies that have nurse practitioner managed clinics in collaboration with universities as the focus. The majority of the studies were done with student-run free clinics and the students were most often medical students (Smith, et al, 2014). Throughout the literature there were many anecdotal writings about these relationships between universities and communities they serve.

Absent from the review of the literature on the subject of nurse practitioner faculty managed clinics was a discussion about the beginning process and necessary components for implementing such an inter-professional collaboration. Although there are two manuals about starting a free clinic, these guides are missing the beginning steps or components (Beck, 2005; Fabian & Dator, 2013) of a free clinic or an inter-professional collaboration. A map and discussion outlining the initial components or beginning steps that need to be accomplished prior to moving forward with fundraising, gathering volunteers, and opening the doors of the physical clinic to patients, were absent from the manuals. Justification for nurse practitioner faculty managed clinics NPFMC is seen in the demand for free and low-cost health care which exceeds clinic capacity (Schwartz, 2011). Overall, the 1007 free clinics in the United States serve about 1.8 million patients annually, mostly uninsured (Darnell, 2010). These present descriptions and findings suggest that free clinics are a much more important component of the ambulatory care safety net than previously recognized.

Collaborative relationships. Collaborate, in the strictest sense of the word, indicates working together for a common cause. For this study collaborative relationships will refer to the Institute of Medicine's recommended inter-professional relationships in the form of a nurse practitioner faculty managed clinic (Bridges et al, 2011). The collaboration or mutual goal will be between the community and the university. The university will be represented by nurse practitioner faculty and nurse practitioner students, as well as students from other fields and departments (Chin, Lam, & Lo, 2011). The community is represented by the patients, donors, supporters of the clinic, and volunteers, such as the board members of the clinic (Rebholz et al, 2013).

Components of a nurse practitioner faculty managed clinic. The quantitative survey in Free Clinics in The United States: A Nationwide Survey by Darnell (2010) was used as a vehicle for obtaining data from all of the known free clinics in the United States. This is one of the first times that free clinic has been defined so succinctly, there are clear and realistic boundaries provided in this author's definition. In the future, this description will help to sort out valuable information from clinics that meet these criteria. A free clinic is designed as a safety net for vulnerable and disenfranchised populations, and is usually managed by volunteers such as physicians, nurse practitioners, physician assistants, nurses, medical assistants, social workers, and others who have an interest in being involved (Berman et al, 2014; Meah, Smith, & Thomas, 2009). The free health care clinics may have a range and a variety of services to offer to patients, that care is usually focused vulnerable populations, on low-income and uninsured persons at low or no cost to the individual.

Outcomes. Outcomes are patient-centered with the goal of attending to acute and chronic problems, while supporting not just physical wellness, but also emotional, psychosocial,

and socioeconomic wellness (Andera & Baker, 2015). The target of this health care is improved patient, family, and community outcomes. This in turn decreases hospitalizations and emergency department visits, as well as resulting in decreased cost to the health care system. One of the main outcomes is partnering with the patient in their care. This partnership allows the patient to feel heard, enabling them to participate in the discussion of feasibility, what is and is not possible for his or her circumstances. An example of failure to include the patient in their health care decision making would be the insulin-dependent diabetic person who is living in his or her car without refrigeration for the injectable insulin that they need to sustain life.

Other outcomes involve the participant students. Black, Palombaro, and Dole (2013) in their qualitative investigation into student-led pro-bono health care clinics identified elements that described the participant-students' experiences: Leadership, competency, commitment, and social justice, with pride as the overarching and pervasive theme. Generalizability was questionable as the findings were specific to this group, and there were few other studies to compare and contrast with it. Though these findings have the potential to inform and direct other programs moving in the direction of starting a student-run free clinic or a nurse practitioner faculty managed clinic, these findings are just one piece of the puzzle (Sandelowski, 2010).

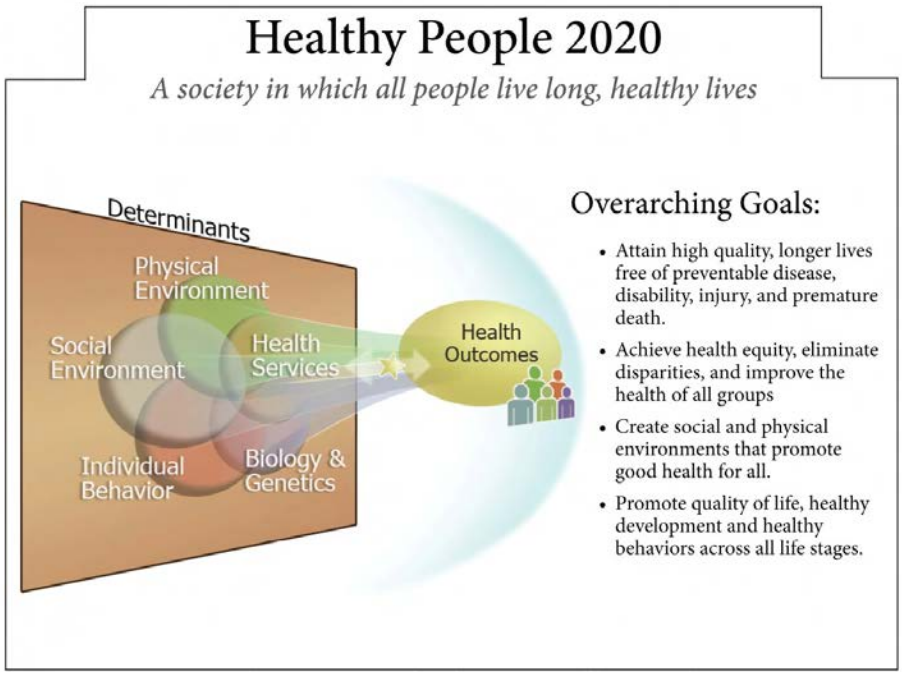
Barriers. Challenges which could become barriers to a viable and comprehensive nurse practitioner faculty managed clinic were: a lack of or limited funding, supplies, and number of volunteers to staff and manage the clinic. A lack of knowledge of the clinic process was also cited as a barrier inhibiting a successful clinic; a successful clinic contributes to improved health and wellbeing of the community (Mallow, Theeks, Barnes, Whetsel, & Mallow, 2014). Included in holding back the progress of the clinic was an insufficient number of volunteers attending to related administrative necessities such as grant writing and public relations. For example, these

clinics need volunteers willing to speak to the community, and organizations such as the Rotary Club, spiritual or religious groups, etcetera.

Supports. The first and foremost support is a strong core of knowledgeable and committed volunteers. Other important aspects are community support, and in the case of a faculty managed clinic, the support of the university, administration, faculty, and students. Further, success relies on the generosity of the community, foundations, businesses, and individuals. Monies are needed in addition to donations of goods, supplies, and equipment to support the origination and ongoing viability of the nurse practitioner faculty managed clinic.

Social Determinants of Health

Social determinants of health (SDH) refer to any factor which affects the health of the individual, family, or country. These are the conditions, whether internal or external, into which the individual was born, lives, grows, and ages and may include gender, age, socio-economic status, and/or educational status (World Health Organization, n.d; Centers for Disease Control and Prevention, 2014; United States Department of Health and Human Services, 2010) The interrelationships of these factors were noted, not a correlation, but rather an association. The Robert Wood Johnson Foundation in Health Care's Blind Side (2011) outlines unmet social needs that have an even greater impact on health; this includes nutrition, housing, and transportation. Below is a graphic model of the goals of Healthy People 2020, whose framework is built on the 2010 version and expanded to incorporate the 2020 goals.



United States Department of Health and Human Services. www.healthypeople.gov (public domain)

What do health determinants have to do with nurse practitioner managed clinics? Faculty nurse practitioner managed clinics lead to positive health outcomes, such as working to prevent disease that can be eliminated, controlled, or decreased by diet and lifestyle, and also by decreasing or eliminating health disparities (Henry J. Kaiser Foundation, 2013; Presidents Commission on Bioethics, n.d.). These goals can be achieved by making health care more accessible, in particular to vulnerable populations, and by making wellness a mutual goal with the patient, family, and community (Schwartz, 2011; Liberati, et al., 2009).

Vulnerable Populations/Underserved

These two terms are often used interchangeably though being underserved can actually be the factor that leads to vulnerability. A vulnerable state is a circumstance that puts someone at risk for attack or harm. The precipitating factors for this state can be economic, ethnic, gender, age, abuse, neglect, lack of health care, and being disadvantaged in some way. These are just

some of the factors which may be involved in setting the stage for vulnerability (World Health Organization, n.d.).

Lack of Health Care and Implications

Though Andera and Baker (2016) identified the lack of health insurance as the major reason for poor access to health care, a lack of insurance coverage is just one of the reasons access can be so difficult or even absent. Now with the Affordable Care Act, 32 million persons who previously were not able to access health insurance are insured (Henry J. Kaiser Foundation, 2015). Yet the wait time to be seen for a new patient is approximately six to eight weeks, or worse yet, they are told that "we are not accepting new patients" or "we only see patients in a certain geographic area." A geographic area is usually defined as the town or city where the clinic is located (Brandenburg, Gabow, Steele, Toussanint, & Tyson, 2015). Access to health care is dependent on a sufficient number of health care providers to provide care; hence, one of the major factors in increasing access to health care (HC) is to expand the provider pool of health care professionals who provide primary care for patients. The inability to access health care, regardless of insurance status, results in an increase in emergency department visits, increased hospitalizations, and declining health or exacerbation of chronic health conditions, such as cardiovascular disease, diabetes, and hypertension (DeVoe et al., 2007).

Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA) or Affordable Care Act (ACA), also known as ObamaCare, was initially enacted in 2010. The goal was to make health insurance available to everyone in America, especially to the 42 million uninsured, and also to curb the growth in health care spending (United States Assistant Secretary of Public Affairs, 2014). The rationale was that keeping people well would lead to a decrease in cost and a

decrease in hospitalizations. Through the Affordable Care Act, it became easier for the vulnerable and uninsured to acquire health insurance with the goal of improving health and decreasing chronic disease. Although the Affordable Care Act has reduced the uninsured by 16 million, there are still 32 million uninsured (Henry J. Kaiser Foundation, 2015) and frequently people with health insurance are still unable to be seen due to the lack of clinics and a lack of health care providers.

Social Justice

A strong value system embodies social justice, which is defined, in the case of health care, as the right to equal quality and accessibility of care regardless of inability to pay, ethnicity, socio-economic or educational status (Beck, 2005), with values that apply to individuals as well as communities. These values include encouragement and support which are often referred to as social literacy of the provider; however, the care is still about 'self', the provider and the patient being able to learn and perform in a certain manner. Encouragement and support connote social humility, which originates from and leads to compassion and humility; social workers describe this as being other-oriented (Hohman, 2013).

Summary

The purpose of this project was to inform persons interested in starting a nurse practitioner faculty managed clinic of the early or beginning steps. This purpose also has the outcome of encouraging and supporting the founding of nurse practitioner faculty managed clinics in order to provide care to vulnerable persons, and to form inter-professional collaborations.

Through this literature review it became apparent little research has been done on the subject of nurse practitioner faculty managed clinics. However the studies reviewed supplied

new and valuable information, stimulated more questions, and reframed previous questions. Most studies were limited to a specific geographical area and lacked the ability to be generalized; however, two of the studies incorporated the entire United States (Darnell, 2010; Simpson & Long, 2007). Though free clinics were concerned that the Affordable Care Act (ACA) would lead to their closure, it was found instead that the patient load and need has increased, with long waiting periods for patients to be seen. Due to the increased ability of marginalized and disenfranchised persons to obtain health insurance, the free clinics are even more impacted as a result of poor or limited access to care than prior to the implementation of the Affordable Care Act (Lydersen, 2014).

There is a gap in the literature about the process early on in considering and implementing a nurse practitioner faculty managed clinic. The absence of this information and direction could defer or deter the implementation of the collaborative endeavor of a nurse practitioner faculty managed clinic. The more in-depth details of the methods and methodology used in this project are outlined and discussed in Chapter Three, and the findings and outcomes are reviewed and discussed in Chapter Four.

Chapter 3: Methodology

The purpose of this project was to examine the beginning stages or components necessary to establish a nurse practitioner faculty managed clinic. The literature review revealed what is currently known about nurse practitioner faculty managed clinics and also what components are missing, starting with an appraisal of the two manuals developed by a free clinic association and a student-run free clinic. The identification of these initial components necessary to the starting of a nurse practitioner faculty managed clinic will help develop a blueprint or map for persons interested in pursuing the development of an inter-professional collaboration in the form of a clinic.

A comprehensive review of the literature was performed by identifying the basic needs, feasibility, and logistics involved in starting a NPFMC, with the goal of providing an evidence-based series of steps for establishing this type of university and community partnership. Globally, these steps will involve linking a nurse practitioner graduate program within a local university with healthcare consumers and leaders in the community to form a collaborative effort through which a nurse practitioner faculty managed clinic could be established. This blueprint or map is meant to serve as a concrete “how-to” from the beginning steps of educational programs which educate health care providers, to their endeavor to form a collaborative relationship between the university and the community. This is particularly true where there is a great need, as in underserved populations and areas. Further, it is anticipated that the findings presented in this study will serve as a catalyst for those who have not yet considered developing this kind of partnership, particularly in communities with a great need for improved access to healthcare.

After completion of the literature review it became apparent what components or steps were missing from the initial stages of formulating a nurse practitioner faculty managed clinic.

This chapter will include the research design methods with a brief discussion of recruitment, participants, instruments, and data collection and analysis.

Project Design

This project utilized a descriptive qualitative design. For clarity of project design it will be separated into two components: comprehensive review and interviews.

1. A comprehensive review of the literature was done with the focus on forming a university/community health care collaborative. Search terms and themes included:
    - Free clinic
    - Underserved
    - Vulnerable
    - Health care
    - Affordable Care Act
    - Collaborative partnerships in health care and in schools of nursing
    - Access to health care
    - Primary care
    - Student-run free clinic
    - Transdisciplinary health education
    - Inter-professional collaboration in health care and education
    - At-risk populations
    - How to start a free clinic
    - Uninsured population
    - Community-based health care

- Partnering with community
- Partnering with patients
- Primary care providers
- Social determinants of health
- Learning organization
- Qualitative research
- NVivo

The literature's date ranges were not limited, as there were seminal research and articles which could not be omitted due to the information they provided. An example of this is the research in 2005 by Ellen Beck at the University of California San Diego. Her "Community Based Participatory Research" implemented the findings of her research, and she published the results as one of the first student-run free clinics to form a partnership with a university in California. However, the majority of the literature compiled is from 2010 to 2015. Several hundred pieces of literature relating to student-run free clinics was reviewed until saturation. Outcomes from this literature focused on meeting the needs of the underserved, lack of access to health care, at risk populations, poor health outcomes, and integrated models of education collaboration with health care (Sandelowski, 2010; Sheu, O'Brien, O'Sullivan, Kwong, & Lai, 2013).

2. The interviews and analysis enhanced the outcomes and findings of this literature review with elaboration and additions from three expert participants who were instrumental in developing a nurse practitioner faculty managed clinic using a qualitative descriptive design, with a summary of the

phenomenon through the identification of recurrent patterns (Thorne, Kirkham, & Magee-O'Flynn, 2004).

Participants

The population for the interviews of this qualitative descriptive study consisted of founders of nurse practitioner faculty managed clinics. A purposeful sample of three founders was chosen from the California Free Clinic's membership list. A timeline was established and adhered to and the interviews were accomplished by January 20, 2016:

1. Potential participants were identified through the Western Regional Free Clinic Association.
2. A formal electronic letter of interest and introduction (Appendix A) was sent initially to the potential participants. If there was no response via email as instructed, a follow-up email was sent after a one week wait time. This interviewer's contact information was included with a letter of introduction; and all three participants made personal contact and responded in the affirmative, agreeing to be interviewed and agreeing to the terms set forth. Participants were not reimbursed for their participation. However they were offered a copy of the results at the end of the study.

Recruitment

The participants were purposefully chosen in order to identify experts who are familiar with the nurse practitioner faculty managed clinic. The goal was to recruit N=3 participants who had a key role in the founding of a nurse practitioner faculty managed clinic. The inclusion criteria consisted of the original founders or heavily invested persons in the formulation of a nurse practitioner faculty managed clinic, from the initial idea to inception of the actual clinic.

These participants also needed to be English–speaking, residing within Northern California, and willing to share their experiences.

Potential participant names were obtained from the Western Regional Free Clinic Association's list of free clinics and narrowed to nurse practitioner faculty managed clinics in California. This interviewer is a member of the association, hence had easy access to the list of clinics and members as it is circulated to association members yearly.

Setting

The venues where the interviews took place were mutually agreed upon by the interviewees and the interviewer. These sites were determined to maximize the comfort and convenience of the participant, as well as securing a location minimizing extraneous interruptions. After receiving the consents to be interviewed and arranging the dates and settings of the meetings, three interviews structured by six open-ended questions were conducted and recorded by this interviewer. Two of the participants chose to be interviewed at their home and the third participant in her office at the university where she is employed. Each interview consisted of two hours in duration, as it was noted that the interviewees' interest or attention seemed to wane after two hours. The participants were encouraged to answer each of the questions until they had nothing left to say. Prior to beginning the interviews the participants reread the information about this study, and it was reinforced that they could stop at any time, decline to answer, or withdraw. The participants were encouraged to ask any questions if they needed further information or clarification during the interview. The interview timeframe was directed by the participant's convenience, but with an end date of mid-March 2016. If necessary, due to physical limitations and/or endurance of the participant might have required that another session be arranged. Each participant, however, was offered an equivalent amount of time for

the interview. The participants were afforded quiet and uninterrupted time since the questions indicated some deep thought and introspection.

Instruments

The data collection tools for the interview portion of this study included a demographic survey in order to ascertain the appropriateness of the participant for this project and a semi-structured set of interview questions. The demographic survey (Appendix B) was electronically sent to the participants along with a description of the study and an explanation that a response in the positive was consent to interview and also to record. All interviews consisted of the same six open-ended questions (listed below) to create consistency and a common platform from which themes could be generated from the participants' responses and used to add dimension and augment interpretation of the systematic review outcomes. The questions were developed to illicit information and used to provide an interpretive descriptive framework (Thorne, 2008) for the interview responses. This interpretive descriptive approach is used specifically to link qualitative outcomes to practice. The questions are as follows:

1. Please tell me about your decision to start a nurse practitioner faculty managed clinic; how did the idea come about?
2. Please tell me about the process involved in moving from the idea "dream" to the opening of the clinic and the steps in-between.
3. In your experience, please talk about what were the most important steps that you took to make the dream a reality; how did you come to the reality that you wanted to be involved in a nurse practitioner faulty managed clinic?
4. Please tell me about any obstacles you encountered and how you overcame them.

5. What advice would you give to someone interested in starting a nurse practitioner faculty managed clinic?
6. Is there anything else that you would like to say or talk about in relation to the clinic?

Data Collection and Analysis

For the interviews of this qualitative study, a recording device was used to capture the full breadth of responses and allow thoughtful analysis in this phase. Thus recurring words and phrases with specific meaning were then input into the statistical program NVivo for analysis as discussed above. The goal was to conceptualize free-floating data into "coherent relational patterns" (Thorne et al, 2004, p. 14). The recordings of these interviews and responses to the open-ended questions were transcribed by the interviewer and patterns were generally identified. This information was input into the qualitative data analysis program NVivo and categorized according to the six questions asked, as well as the other areas that became apparent. These categories were then assigned pods and nodes within NVivo, which resulted in the revelation of patterns.

Benefits

The implications of this study included an examination of what practical beginning stages must be foundational to the origination of a nurse practitioner faculty managed clinic in order to be successful and viable. Also, it became apparent there was a fostering of another level of education by the inception of a NPFMC in the form of a service–learning opportunity for students. The opportunity was provided by the nurse practitioner faculty managed clinic to address the Institute of Medicine's strong recommendation for increased inter-professional collaborative education. Additionally, the collaboration helps to fill a need in primary care.

Publishing the findings of this basic study in the Journal for the Poor and Underserved may encourage other university-community collaborative unions.

The benefits of this project will largely be to those considering the concept of a nurse practitioner faculty managed clinic, to community, students, and patients as the recipients of future NPFMCs benefits.

Risks

Potential risks for this study were minimal. However, there may have been psychological discomfort for the participants from recounting the initial idea of founding a nurse practitioner faculty managed clinic and the process. The psychological discomfort was minimized by the researcher's active and passive listening skills, as well as a shared sense of empathy when appropriate. Also discomforts were minimized by allowing the participant to tell his or her story while defining the timeframe, but without pressure. It was reinforced to the participants that they could refuse to answer or withdraw at any time if they were uncomfortable or did not want to proceed.

The literature review did not directly involve subjects; therefore, there was no risk to this part of the study. The data collection was completed with no identifying information and is reported in an aggregate format.

Confidentiality

The risk of loss of confidentiality was minimized by limiting the collection to exclude personal or identifying information in the analysis and the following write-up. Future articles will be written and submitted by this interviewer, assuring that anonymity is maintained for the participants throughout. In order to accomplish this, pseudonyms were assigned to each interviewee. This pseudonym was then attached to the recordings and transcriptions to protect

the personal identity of study participants. Further, any information that specifically identifies a clinic, university, or location was not included in the analysis and outcome reports. In this way all identifying information presented as anonymous. The recordings and written and electronic records were kept in a locked file drawer in this investigator's locked office at Sonoma State University in Rohnert Park, California. All electronic records related to this study were stored on an external hard drive and locked in the same file drawer. After completion of the study, final Doctor of Nursing Practice student defense, and the publishing of an article on these findings, the records collected from the three participants will continue to be in a locked file drawer for three years before destruction. These records will be maintained for that length of time in the event there is a challenge to interpretation or for use in secondary studies.

Summary

The purpose of this study was to gather information in order to form a blueprint for nurse practitioners, faculty, and universities interested in forming a collaborative partnership as a nurse practitioner faculty managed clinic. This qualitative design project consisted of a comprehensive literature review and interviews of three founders of nurse practitioner faculty managed clinics. Design, methodology, instruments, data collection, and analysis were outlined in this chapter. Chapter Four will include the results of these interviews.

Chapter 4: Results

The purpose of this project was to initially review literature concerning university-community partnerships in the form of NPFMC. The goal was to identify what is known about the beginning steps or basic components for these clinics. Following the review of the literature, interviews were performed with three founders of NPFMC. The need to elicit further information and expand on the process of establishing NPFMCs was accomplished via both investigational processes. The ultimate goal was identification of the early basic components of nurse practitioner faculty managed clinics and formation of a blueprint that would guide further formation of clinics. This chapter will report on the findings of this project and Chapter Five will discuss those findings including the benefits and the limitations of this study.

Literature

Seven themes were identified through the review of the literature. The literature was separated according to the stated focus identified by the researchers of the original studies. This writer then proceeded to compile the studies according to themes and then separated the studies chronologically according to the relationship to this project. The themes are reported in this chapter with the most pertinent ones to the focus of this study listed first. The recurrent themes for both the literature review and the interviews were grouped in order to make clearer the connections among the recurrent themes. After the interviews the threads were further combined into an even smaller group of representative themes. The identified themes are as follows:

- Nurse practitioner faculty managed clinics
- Collaborative partnerships in health care
- Students and student-run clinics
- Vulnerable/underserved persons

- Affordable Care Act
- Social determinants of health (integrate into the ACA)
- Starting a free clinic

Nurse practitioner faculty managed clinics

There were few pieces of literature discussing NPFMC's. Most of the literature addressed student-run clinics and medical student staffed clinics. Also there existed no guide to the very beginning steps of establishing a NPFMC. The earliest steps focused on in the literature were the processes to identify a core group of interested students, identify a faculty advisor/champion, and to find a community partner. These are all important steps, but there was no mention of the steps that preceded these.

Student-run clinics

The studies reporting findings and discussing student-run clinics were abundant, and elaborated on the effects of working/volunteering on students, communities, vulnerable populations, volunteerism, and states of health or improved health outcomes.

Collaborative partnerships

The theme in the literature of collaborative partnerships in health care addressed inter-professional relationships. The Institute of Medicine issued a strong recommendation supporting these relationships. This area was scant in literature and studies.

Vulnerable/underserved persons

This topic was prolific in the amount of literature and studies available. The discussion ranged from basic definitions to the collaborative relationships of free clinics, student-run clinics, and nurse practitioner faculty managed clinics.

Affordable Care Act

The literature about the Affordable Care Act discussed the relationship to vulnerable/underserved persons, as well as its role in free clinics. The literature reviewed on the Affordable Care Act is fairly recent, as it has only been in effect since 2010, and thus is in the process of ongoing evaluation, changes, and updates.

Social determinants of health

The theme of social determinants of health in the literature intersected with the definition of vulnerable/underserved persons. The literature in this area was again abundant with definitions, problems, solutions, and goals.

Starting a free clinic

Review of present literature was in relation to the initiation of free clinics, and specifically to the manuals developed to assist in the formation of free clinics. There were two manuals found in the literature. Absent from these free clinic directions were the very beginning, practical steps in starting a free clinic, and in particular a nurse practitioner faculty managed clinic.

Fifty research articles were selected as representative of the seven themes identified. The threads were further condensed into six themes by combining the Affordable Care Act and the Social Determinants of Health with the Vulnerable Persons and Health Care Shortage themes. Below is a table showing the number of pieces of literature discussing these themes and findings. The theme of “vision/tenacity” was elicited through the interviews and then the literature was reviewed again for studies addressing or incorporating this specific thread.

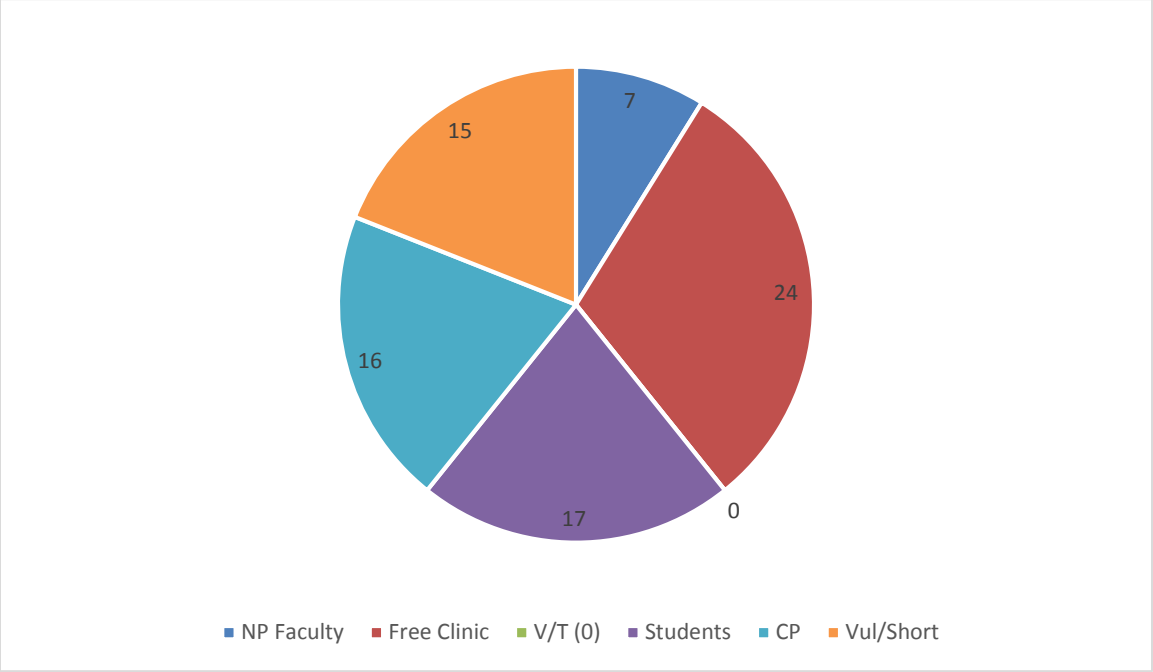
Table 1

Literature Identifying and Discussing the Themes for this Project

Themes from the Literature	**Number of studies reviewed**
Nurse Practitioner Faculty	7
Collaborative Partnerships	16
Students	17
Vulnerable/Shortage	15
Free Clinics	24
Vision/Tenacity (as gleaned from the interviews)	0

Table 2

Pie Chart Depicting Frequency of Themes in Literature Reviewed



Key

NP Faculty=Nurse Practitioner faculty (dark blue)

Free Clinic (burgundy)

V/T=Vision/Tenacity (green)

Students (purple)

CP=Collaborative Partnerships (light blue)

Vul/Short=Vulnerable/Shortage (orange)

Interviews

The interview questions with the three founders of NPFMC were organized in chronological order to identify the very beginning steps - the components that are necessary to achieve the endeavor of founding a nurse practitioner faculty managed clinic. The three non-structured interviews with founders of Nurse Practitioner Faculty Managed Clinics were comprised of six open-ended questions. The responses from each question will be addressed individually and then

at the end will be addressed as an amalgam. Reading over the questions and responses and visualizing the facial expressions and unspoken communication of the three interviewees, a focus group may have given additional insights and richness to the question responses and stories.

Question One:

Please tell me about your decision to start a nurse practitioner faculty managed clinic; how did the idea come about?

Responses: All three interviewees seemed to relish being able to recount their stories of the beginning and prior to the beginning of starting the NPFMC. One participant related that her "adventure" with the NPFMC was serendipitous. She did not seek it out and was not even in the medical profession. However, her experience volunteering at a free clinic was because she was "looking for something to do" and it redirected her path. Her life was changed by her participation working with vulnerable populations and the underserved. "I had no idea such need existed."

Question Two:

Please tell me about the process involved in moving from the idea "dream" to the opening of the clinic and the steps in-between.

Responses: "Where do you want me to begin?!" This participant's voice went up an octave and she began speaking rapidly. The interviewer asked if she was okay and needed a break; however, the interviewee responded that she was excited and was tripping over her own words. "I can't speak fast enough to tell you all that I want to talk about, my mind is working faster than my tongue." All three interviewees spoke of vision and surrounding one's self with others with a like vision as being vital, or else the group would be at odds.

Those involved in the NPFMC all need to work together as a cooperative organization from the very beginning (Garcia, 2010).

Question Three:

In your experience, please talk about what were the most important steps that you took to make the dream a reality; how did you come to the reality that you wanted to be involved in a nurse practitioner faulty managed clinic?

Responses: (This question overlaps somewhat with number one, where the response was serendipity.) "Well, I had to have tenacity and boundless energy in order to accomplish even the minutest detail." "I did a lot of research about free clinics, and went to meetings of the Free Clinic Association." It was unanimous among the participants that they realized the development of a Nurse Practitioner Faculty Managed Clinic from the very beginning could not be accomplished alone; help was needed from like-minded persons. This was again a recurring theme of cooperation.

Question Four:

Please tell me about any obstacles you encountered and how you overcame them.

Responses: "Naysayers were my nemesis and challenged me to stay on my path and reach for my dream." "I overcame this by talking with my colleagues and visiting other free clinics for support, encouragement, and practical input." This interviewee also indicated that her support system was also able to point out when she was "off track".

Question Five:

What advice would you give to someone interested in starting a nurse practitioner faculty managed clinic?

Responses: "Be sure that this is truly what you want to do and why you want to do it." All

three participants found mentors who were invaluable in the process and “in helping me keep my sanity; she listened when the situation was almost unbearable”.

Question Six:

Is there anything else that you would like to say or talk about in relation to the clinic?

Responses: This question drew silence from all of the participants. This interviewer did not respond and did not try to fill the void but rather waited until each interviewee in their own time and interview, felt the desire to add input. It was universally expressed how valuable the Nurse Practitioner Faculty Managed Clinic is and rationale’ which mimics that of the literature was shared, such as increased access to care for the vulnerable, improved health, and multiple benefits for students, as well as community involvement. One respondent expressed that the NPFMC was like community-based participatory research, which is research that is actualized/implemented involving the participants in the process. The NPFMC involves faculty, university, students, and community.

The focus of the semi-structured interview questions was to elicit the participants’ stories in order to identify the very first components or steps necessary to starting a nurse practitioner faculty managed clinic. The recordings of the three interviews were transcribed word-for-word by this interviewer. The results were distilled to identify recurrent words, patterns, and themes.

Themes Recurrent in Interviews

Below are the recurrent themes extracted from the recorded interviews with the three nurse practitioner faculty who had been the originators and the moving forces behind the implementation and collaboration of a nurse practitioner faculty-managed clinic. Demographics were not reported per the request of two of the participants who desired complete anonymity.

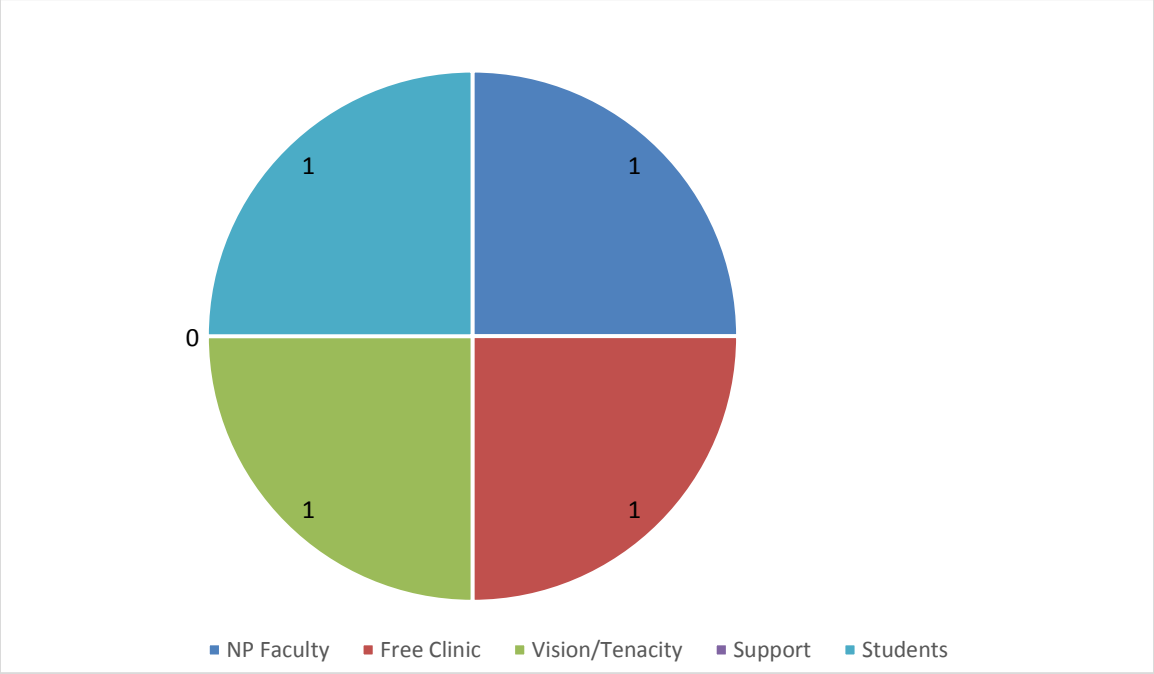
No identifying information or demographics were considered or reported in these project findings.

The themes are based on the participants' personal experiences and extracted from the recordings of the semi-structured interviews. They were identified through the use of NVivo for groupings and threads, and input into the theoretical framework in relation to the participant or participants who shared those thoughts. The threads were grouped into five recurrent patterns and representative of the very beginning steps in developing a nurse practitioner faculty managed clinic. The five themes or common threads are listed below. Note that the additional theme of non-tangible components was not identified in the literature review, but was repeatedly spoken of at length by the three participants.

1. Nurse practitioner faculty/nurse practitioner faculty managed clinics
2. Free clinics
3. Vulnerable/shortage
4. Students
5. Non-tangible components of vision and tenacity

Table 3

Pie Chart Depicting Frequency of Themes in Interviews



The pie chart in Table 3 is equally representative of the key elements: NP faculty, free clinics, vision and tenacity, and students. "Support" as represented by purple/lavender is present but so miniscule that it is not visible. This is most likely due to the grouping of themes into similar or related elements. Support was usually combined by the interviewees with the element "vision," such as support by persons with similar or same vision.

Notable quotes extracted from the interviews

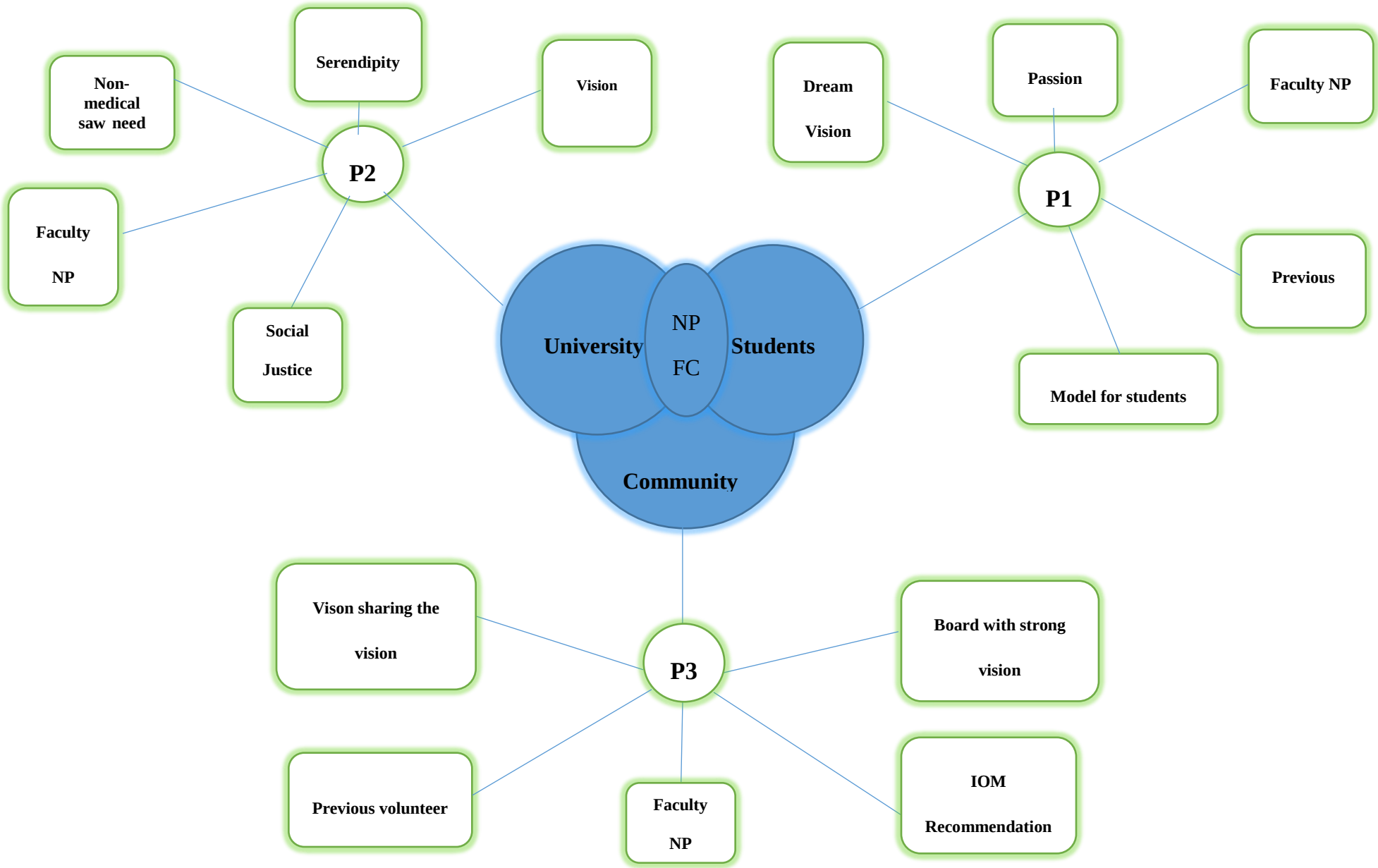
"I base my founding philosophy of the clinic on providing a hand-up not a handout." "The beginning process starts with stepping stones." This participant became tearful as she recollected the feelings and ideas from fifteen years ago. "It changed my life and my direction."

The next page is a pictorial version of the conceptual framework for this study with input selected from recurrent results. The Learning Organizational framework (Senge, et al., 1999; Mason, n.d.) was adapted in order to display and represent the three participants' responses to the

interview questions. These steps led to the common goal of an inter-professional collaboration in the form of a nurse practitioner faculty managed clinic. The following is a key to the components of the Learning Organizational framework on the next page:

- Small orange ovals P1, P2, P3=Participant 1, 2, 3.
- Rectangular boxes=common themes gathered from the interviews with the participants.
- Venn diagram=collaboration of university (nurse practitioner faculty), students, and community resulting in the center blue oval which is representative of working together to form and manage the nurse practitioner faculty managed clinic.

CONCEPTUAL FRAMEWORK



Summary

Chapter four outlined the findings of this study including the literature review themes and patterns from the semi-structured interviews. The purpose of this study was to identify the beginning steps in the founding of a nurse practitioner faculty managed clinic. The results of the interviews as supported by the literature review will meld in the next chapter, Chapter Five Discussion.

Chapter 5: Discussion and Conclusions

Through the process of exploration and examination, identification was made of the beginning steps necessary in the founding of nurse practitioner faculty managed clinics (NPFMC). These steps are important to the first stages in the implementation of collaborative partnerships between community and university in the form of a NPFMC. This project's purpose was to distill the very early steps or foundational components upon which the clinic is based in order to establish a blueprint for development of future Nurse Practitioner Faculty Managed Clinics.

The justification for the comprehensive literature review and interviews was to initiate a search for the beginning steps necessary in the initial phase of developing a NFPMC. The question explored was: What are the first components necessary to the establishment of this type of collaborative relationship? The review of the literature showed collaborative partnerships in the form of NPFMC lead to multipurpose goals. These goals benefit community, vulnerable persons, students, and universities.

The literature review resulted in the distillation of five major themes as listed below:

- Nurse Practitioner Faculty Managed Clinics
- Collaborative partnerships
- Students
- Vulnerable/Underserved persons; Social Determinants of Health.
- Clinics (student run clinics, free clinics, starting a free clinic)

The literature supported the content of the interviews except in one major area. That area was the concept of non-tangible components; specifically the non-tangibles vision and tenacity,

which are necessary to the inception of a NPFMC. Both of these are necessary to move the idea of the clinic forward and bring it to fruition.

The results were similar among the three interviews with minor differences. This similarity and repetition of the beginning implementation of a NPFMC enhanced the identification and validation of those steps necessary to achieve the implementation of the collaborative partnership, thus forming a blueprint for the future.

This idea was reinforced by one of the interviewees in the following quote: "The beginning process starts with stepping stones." This participant became tearful as she recollected the feelings and ideas from fifteen years ago, "It changed my life and my direction."

Discussion

Both the literature review and the interviews focused on the need for increased access to health care for vulnerable populations and the role that free clinics play in that access. For the purpose of this project the NPFMC helps to relieve that need with increasingly positive health outcomes. Also supported is the concept of the NPFMC educating students, modeling good practice, and exposing the students to an environment of social justice.

Table 4

Recurrent themes integrated from the literature and the interviews

Six Themes Combined were Identified from the Literature and the Interviews

Themes	**Literature**	**Interviews**
Nurse Practitioner Faculty Managed Clinics	7	3
Collaborative Partnerships	16	3
Students and Student-Run Clinics	17	3
Vulnerable/Shortage/AHCA/Social Determinants of Health	15	3
Free Clinics	24	3
Non-Tangible Components of Vision and Tenacity	0	3

Missing from the literature, as noted in the table above, was a discussion of the beginning steps of starting a nurse practitioner faculty managed clinic. Also absent from the literature was a discussion of the initial steps of the inception of any free clinic.

The interview outcomes suggest the answer to the question, what is it that is necessary to start a NPFMC? The missing components identified unanimously from the interviews and missing from the literature were non-tangibles. These first steps in developing a NPFMC are vitally important as a guide to reproducing the beginning of a NPFMC. Vision, one of the identified necessary components, acts as a signpost for direction on how to achieve the ultimate goal of a collaborative partnership. Tenacity, another of the identified non-tangible components, represents the staying power needed to achieve that vision.

Also by the identification of these vital and necessary non-tangible components, support is uncovered for the beginning blueprint leading to the success of future nurse practitioner faculty managed clinics.

Implications for Nursing and Education

The findings of this project may have an impact on the successes of future nurse practitioner faculty managed clinics. The blueprint for the initial steps in the development of the clinic will provide guidance in the early development process.

NPFMC's provide a venue for students, registered nurses, and advanced practice nurses to care for vulnerable persons. This model allows for mentoring and exposure for the students to elements of social justice in the form of the provision of health care within their communities. Also, elements of leadership and proactivity are products of responsibility and decision-making in the clinic.

The NPFMC is a collaborative relationship with the university involving not only students but also the community. The Institute of Medicine strongly recommends these partnerships for students' education and to involve universities in inter-professional relationships; making all involved responsible for providing quality health care and working together as a team for the good of many as well as the greater good. The above statement is expressed by an interviewee in the following quote: "I based my founding philosophy of the clinic on providing a hand-up not a handout."

This collaboration will also help to fill an ever-increasing need in primary care. Additionally, by publishing the findings of this study/project in the Journal for the Poor and Underserved, encouragement and guidance will be available for other university-community collaborative unions with these same goals and outcomes.

Significance

The underlying rationale for this project leading to the identification of the beginning steps necessary to the origin of a Nurse Practitioner Faculty Managed Clinic, is poor access to health care for the vulnerable. Undiagnosed and untreated chronic disease accounts for 70% of deaths in the United States. This situation leads to even poorer health, increased health care cost, decreased productivity, and decreased quality of life. As a result families suffer, the community is burdened, and hospitals and Emergency Departments are full (Andera & Baker, 2016; Beck, 2005; Henry J. Kaiser Foundation, 2013). This project's findings of the non-tangible pieces provide an early blueprint for the development of collaborative partnerships in the form of NPFMC. By providing the blueprint for starting NPFMC there will be an increase in their number, which will improve access to health care for the vulnerable, help to address chronic disease, and improve the health of families and communities. In addition, the NPFMC provides a hands-on education and a real experience for students through the collaborative partnership.

Limitations

This was a small study of three participants; therefore, it was limited and may not be representative of a larger population, nor are the findings generalizable for the same reason. Also the literature review was limited in that it was not analyzed and synthesized. The findings might appeal to a larger audience if this project had included a mix-methods study with a quantitative component, meta-analysis, and meta-synthesis.

Search terminology and other criteria may also have influenced the literature reviewed. Relevant studies may have been unintentionally omitted due to these unintentional restrictions or limitations.

This interviewer was concerned about biases on her part as she had participated in the past in the founding of a nurse practitioner/student-managed clinic for vulnerable populations. This was minimized by minimal interaction with the interviewees in order to remain as objective as possible. Another consideration would have been to do the interviews first before the literature review, which would have allowed closer scrutiny of the literature for the non-tangible components related to the beginning steps of starting a nurse practitioner faculty managed clinic, such as passion, tenacity and vision.

In retrospect, reading over the questions and responses and visualizing the facial expressions and unspoken communication of the three interviewees, a focus group may have given additional insights and richness to the question responses and stories.

Future Research

Future research would include a larger study with focus groups for the founders of nurse practitioner faculty managed clinics and could include NPFMCs across the United States rather than limiting the study or research to a single state or area. In addition, a Community-Based Participatory Research study would allow the implementation of a NPFMC as the premise for the research; involving university, students, and community.

Summary

Insights into this early process were gleaned by this interviewer from the three founding members in their recounting of their early journeys in the process of visualizing a nurse practitioner faculty managed clinic.

The importance and significance of the findings of this project are just the beginning stage. By introducing the non-tangible aspects vital to starting a NPFMC, it is intended that future clinics will be able to construct a clear pathway in the beginning which will lead to

successes. Further significance is in the long-term outcomes for universities, students, faculty, community, and vulnerable populations.

Most likely a foundational study of an extended length of time will need to be done to validate the ongoing viability of student-run free clinics and nurse practitioner faculty managed clinics. The implementation and sustainability of this type of clinic takes true long-term commitment, with a vision to the future.

To quote George Lucas (Brainyquotes.com, n.d.), “You simply have to put one foot in front of the other and keep going. Put blinders on and plow ahead.” This quote sums up what the interviewees left me with, that is, after the vision and passion, tenacity is “one foot in front of the other” and allowing nothing to deter you from your goal while keeping in mind the potential outcomes.

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APPENDICES

APPENDIX A: LETTER OF INTRODUCTION

Letter of Introduction and Consent

Hello, my name is Johnna Edmunds I am a family nurse practitioner and a Doctor of Nursing Practice student at Fresno State University. I would like to invite you to participate in this study.

If you consent to participate you will be asked questions that will identify what the basic needs are prior to starting a family nurse practitioner faculty managed clinic (NPFMC). You have been identified through the Western Regional Free Clinic Association as a founder and expert of just such a clinic with affiliation to a university nurse practitioner program.

It is intended that the findings from this study will form a step by step process for future studies and the implementation of faculty nurse practitioner managed clinics in the form of university-community collaborative relationships. Your participation you will be instrumental in identifying key components which will encourage collaborative relationships in the form of Nurse Practitioner Faculty Managed Clinics. These clinics will be utilized by nurse practitioner students, nursing students, and students from other university departments to provide a venue to experience and participate in care of vulnerable populations and to promote a sense of social justice for both students and patients.

Your involvement will take place at a location of your choosing and you will be asked five open-ended questions and your responses will be recorded. By return of this letter you are giving implied consent to be interviewed and recorded. Please click on the link which will be sent to you upon return of this letter. Any information obtained in connection with this study will remain confidential. And all recordings and written material will be destroyed at the end of the study.

If you have questions please contact me. Thank you for your consideration and I look forward to hearing your valuable stories.

Johnna Edmunds

707-477-0540

edmunds@sonoma.edu

APPENDIX B: DEMOGRAPHICS

Demographic Survey

Demographic survey

1. **Where do you reside?**

   Sonoma County

   San Francisco

   Marin County

   Napa County

   Lake County

   Solano County

   Other (please specify) _____

2. **Which category below includes your age?**

   21-29

   30-39

   40-49

   50-59

   60 -70

   71 or older

3. **Which gender do you identify with?**

   Female

   Male

   Other

4. **What is the highest level of education you have completed or the highest degree you have received?**

Some college but no degree

Associate degree

Bachelor degree

Graduate degree

Other (please specify) _____

5. **What ethnicity or race do you identify with?**

American Indian or Alaskan Native

Asian

Black or African-American

Caucasian

Latino or Mexican

Native Hawaiian or other Pacific Islander

From multiple races

Some other ethnicity or race (please specify) _____

6. **Where was or is your clinic located?**

Rural

Urban

Suburban

Inner city

Other (please specify) _____

7. **If given the choice would you choose to start a nurse practitioner faculty managed clinic again?**

Yes

No

Unsure

APPENDIX C: INTERVIEW QUESTIONS

The questions are as follows organized in chronological order or from the very beginning steps/components of starting a clinic, what is necessary to achieve this endeavor, the founding of a nurse practitioner faculty managed clinic.

Question One:

Please tell me about your decision to start a nurse practitioner faculty managed clinic, how did the idea come about?

Question Two:

Please tell me about the process involved in moving from the idea “dream” to the opening of the clinic and the steps in-between.

Question Three:

In your experience please talk about what were the most important steps that you took to make the dream a reality, how did you come to the reality that you wanted to be involved in a nurse practitioner faulty managed clinic?

Question Four:

Please tell me about any obstacles you encountered and how you overcame them?

Question Five:

What advice would you give to someone interested in starting a nurse practitioner faculty managed clinic?

Question Six:

Is there anything else that you would like to say or talk about in relation to the clinic?

APPENDIX D: CONCEPTUAL FRAMEWORK

CONCEPTUAL FRAMEWORK