Mason and Partners (MAP) Academic Nurse-Managed Network Clinic

Mission: To improve the health status of underserved, uninsured vulnerable populations and to engage nursing, psychology, social work and other health and human service students in direct provision of healthcare services through interprofessional service learning.

Vision: The Mason and Partners (MAP) Clinics are a network of nurse managed health clinics (NMHC) affiliated with George Mason University College of Health and Human Services (CHHS) and managed by nursing faculty in collaboration with other CHHS faculty. The clinics follow a *Bridge Care* model which provides access to healthcare services for patients that lack health insurance. Through community partnerships the clinics focus on health education and preventative care to reduce risk and high-risk behaviors related to ongoing illnesses and chronic disease.

Background

In fall 2013, Mason nursing faculty met within representatives from Prince William and Fairfax Counties to discuss the healthcare needs in their communities. Pockets of areas in both counties have significantly poorer health in comparison to the overall health statistics of the surrounding regions where they are located. These pockets primarily comprise populations of low-income immigrants, racial and ethnic minorities, and families who have not yet integrated well into the existing healthcare system. The respective health studies and population assessments for each county demonstrate that access to healthcare is the most pressing concern.

Through an academic-community partnership with Fairfax County, Prince William County, the local school systems, community centers, the local health department in Prince William County, and the medical reserve corps in these two counties, Mason has successfully launched three academic nurse managed health clinics in the past two years. The purpose of these Mason and Partners (MAP) Interprofessional Clinics is to provide a network of weekly healthcare clinics managed by nursing faculty with collaborative care provided by Mason advanced practice nursing students and students from various health-related disciplines in partnership with grassroots community social service agencies. The clinics provide healthcare to low-income, immigrant, and vulnerable populations using an integrated interprofessional treatment team approach. The MAP Clinics have two main goals: (1) to provide interprofessional practice sites in community-based settings to serve as graduate student clinical/field experiences; and (2) to

increase access to free/low-cost primary healthcare, including health promotion and disease prevention with an emphasis on education to improve healthcare measures to the most vulnerable patients in our communities. The three clinic sites are located in Fairfax County (two clinics) and Manassas Park City in Prince William County (one clinic).

These clinics are open three days a week for approximately six hours each day. The clinics are staffed with three to five Mason nurse practitioner (NP) faculty members serving as providers and educators, two undergraduate nursing faculty members, a Mason faculty pharmacist, and one nurse educator faculty member. On each clinic day, there are eight to 12 graduate NP and educator students, four to six Doctor of Nursing Practice students, and up to 12 undergraduate students. The clinics see approximately 25 to 30 patients a day.

Strategic Direction

The MAP Clinics are not a permanent medical home and do not duplicate existing district or county resources. The MAP Clinics provide a full range of health services, including acute primary care, integrated behavioral health services, health promotion, and disease prevention to low-income, uninsured clients. The clinics reduce health disparities by providing accessible, high-quality, comprehensive medical and behavioral healthcare to populations who have significant challenges accessing care. They serve as crucial primary care access points in areas where primary care providers are in short supply.

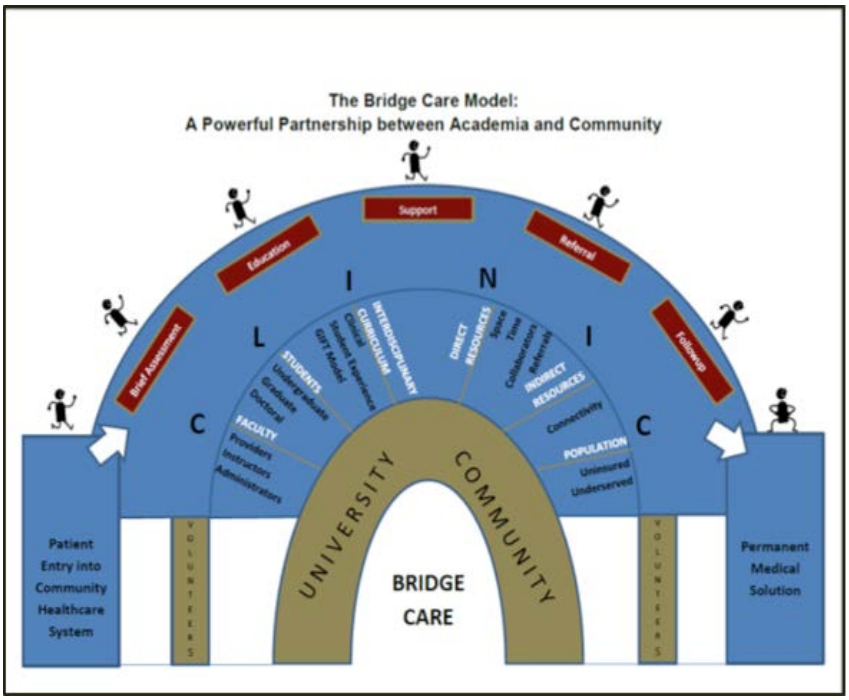
The MAP Clinics address the known gap in care from the initial acute point of entry into the safety-net system until patients can be bridged into a chronic care model of health management. Exposing our future workforce to this responsible model of care will enable competent care to our communities.

We have been strategic in our partnerships. We believe that connecting the players in healthcare and being innovative and forward thinking in the training of our future workforce provides tremendous benefit for the patients we serve, the communities they live in, and ultimately the Commonwealth of Virginia as a whole.

Bridge Care - Bridge Care is a new and innovative approach to improve access to healthcare for low-income, underserved, and uninsured patients. Bridge Care is short-term, high quality, low cost care that addresses urgent healthcare needs of the uninsured population during the transition time between initial point of entry into the health system until the patient is placed into an already existing community health system, existing medical home, or while awaiting healthcare insurance eligibility. Even with the Affordable Care Act (ACA) and Medicaid expansion, there continues to be a gap in healthcare for the low-income uninsured. This gap in care is well documented and often leads to inappropriate use of much costlier health services, including hospital emergency departments. Bridging this gap in health services also provides unique opportunities for interprofessional health and human services education. Focusing on health

education and preventative care practices during this interval period can reduce risk and high-risk behaviors related to ongoing illnesses and chronic disease and help build healthy lifestyle practices.

The Bridge Care model is primarily supported by academic and community resources and reinforced with volunteers. All resources converge at the community clinic, which serves as the point of care for individuals as well as a navigation and resource center. Individuals are led through the following series of steps at the clinic: integrated care assessment, education on healthcare conditions, identification of supportive resources, decision-supported referrals, and closed-loop follow-up with primary care providers until a permanent medical solution is achieved.



Mental Health: There is substantial evidence that links poverty with medical morbidity and mortality, which disproportionately affects individuals with mental disorders. Approximately 35,000 to 40,000 residents of Fairfax and Prince William Counties earn substantially below the Federal Poverty Level (FPL) and lack healthcare insurance (Fairfax County, 2008a). Among the individuals who receive services for mental health issues, two-thirds have income levels below $10,000. While individuals with mental illnesses in these counties have a higher prevalence of metabolic syndrome, liver diseases, hypertension and dental disorders, they are also the least likely to utilize preventative medicine and effective self-care practices. The MAP Clinics are fully committed to integrated care, utilizing an interprofessional model of group care in a nurse-managed environment.