

111TH CONGRESS
1ST SESSION

S. 1104

To amend the Public Health Service Act to establish the Nurse-Managed Health Clinic Investment program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 20, 2009

Mr. INOUE (for himself, Mr. ALEXANDER, Mr. AKAKA, and Mr. KAUFMAN) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To amend the Public Health Service Act to establish the Nurse-Managed Health Clinic Investment program, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Nurse-Managed
5 Health Clinic Investment Act of 2009”.

6 **SEC. 2. FINDINGS AND PURPOSE.**

7 (a) FINDINGS.—Congress makes the following find-
8 ings:

(1) Nurse-managed health clinics (referred to in this section as “NMHCs”) offer their patients primary care and wellness services based on the nursing model, which emphasizes the protection, promotion, and optimization of health along with the prevention of illness, and the alleviation of suffering in conjunction with diagnosis and treatment. Nurses are advocates and educators providing care for individuals, families, communities, and populations.

(2) More than 200 NMHCs are currently in operation across the United States. Such clinics record over 2,000,000 client encounters annually.

(3) NMHCs offering primary care services meet the Institute of Medicine’s definition of safety-net provider by providing care regardless of their patients’ ability to pay. A substantial share of the patient mix is made up of uninsured individuals, Medicaid recipients, State Children’s Health Insurance Program recipients, and other vulnerable populations. A recent study funded by the Centers for Medicare & Medicaid Services reported that more than 45 percent of the payor mix for NMHCs is uninsured, and 37 percent are Medicaid recipients.

(4) NMHC patients are very diverse. According to recent data, 46 percent of NMHC patients are

1 Caucasian, 29 percent are African-American, and
2 another 20 percent are Latino.

3 (5) Approximately 133,000,000 people in the
4 United States (45 percent of the population) have at
5 least 1 chronic disease. These diseases account for
6 81 percent of hospital admissions, 91 percent of all
7 prescriptions filled, and 76 percent of all physician
8 visits. About 75 percent of health care spending in
9 the United States is related to chronic care. Chronic
10 disease management programs have the potential to
11 reduce costs and improve outcomes for chronically ill
12 patients. NMHCs providing wellness services
13 strengthen the health care safety-net by expanding
14 access to chronic disease management services for
15 geriatric and medically underserved populations.

16 (6) NMHCs offering primary care provide a
17 medical home for medically underserved individuals,
18 and are viable partners with the Federal Govern-
19 ment to reduce health disparities. They provide a
20 full range of health care services, including primary
21 care, wellness services, and behavioral health care to
22 the residents of rural and urban underserved com-
23 munities. Because NMHCs are often located in pub-
24 lic housing developments, senior living arrange-
25 ments, schools, and community centers, they help re-

1 move barriers preventing access to care and are in-
2 strumental in addressing and eliminating the factors
3 contributing to health disparities.

4 (7) NMHCs offering wellness services reinforce
5 the medical home concept by providing a critical
6 first level of care for populations living in rural
7 areas with limited access to physicians and other
8 primary care providers. NMHC patients partici-
9 pating in wellness services are connected to a med-
10 ical home through established referral networks.

11 (8) As new strategies for increasing health cov-
12 erage are implemented, utilization of nurse-managed
13 health clinics offering both primary care and
14 wellness services will help meet the increased de-
15 mand arising from newly covered individuals while
16 alleviating current primary care physician shortages.

17 (9) In spite of their numerous benefits, NMHCs
18 of all types have limited access to both Federal and
19 State funding. Initially, many NMHCs were estab-
20 lished through grants from the Division of Nursing
21 of the Health Resources and Services Administration
22 (referred to in this paragraph as the “Division of
23 Nursing”). Soon after their inception, NMHC direc-
24 tors recognized their patients had a desperate need
25 for primary care and wellness services, a need that

1 continues. To meet that need, NHMCs across the
2 country have expanded their mission to focus on in-
3 creasing access to primary care and wellness services
4 the medically underserved populations, while still
5 maintaining their role as clinical sites for nursing
6 education. Available sources of Division of Nursing
7 grant funding cannot accommodate the increased
8 cost associated with caring for the uninsured and
9 medically underserved populations that has accom-
10 panied the expanding focus of nurse-managed care.
11 As a result, 50 percent of the NMHCs established
12 between 1993 and 2007 have had to close. Such
13 clinics frequently are the only source of health care
14 for their patients, and such closures have left thou-
15 sands without health care.

16 (10) In recognition of the growing needs of
17 NMHCs, in Senate Report 109–103, Congress called
18 on the Bureau of Primary Health Care (BPHC) to
19 “consider establishing a grant program . . . that
20 would support the establishment or expansion of
21 nurse practice arrangements commonly referred to
22 as nurse-managed health centers . . .”. The goal of
23 this Act is to comply with the language of such Sen-
24 ate Report by establishing a grant program within
25 BPHC that is a better fit for the changing role of

1 NMHCs. The program will give NMHCs access to a
 2 stable source of funding, further enabling them to
 3 expand primary care and wellness services in under-
 4 served communities, while reducing the level of
 5 health disparities that vulnerable populations
 6 throughout the Nation face.

7 (b) PURPOSE.—It is the purpose of this Act to fund
 8 the development and operation of nurse-managed health
 9 clinics to—

10 (1) provide comprehensive and accessible pri-
 11 mary health care and wellness services to vulnerable
 12 populations living in the Nation’s medically under-
 13 served communities; and

14 (2) reduce the level of health disparities experi-
 15 enced by vulnerable populations.

16 **SEC. 3. NURSE-MANAGED HEALTH CLINICS.**

17 Title III of the Public Health Service Act (42 U.S.C.
 18 241 et seq.) is amended by adding at the end the fol-
 19 lowing:

20 **“PART S—NURSE-MANAGED HEALTH CLINIC**
 21 **PROGRAM**

22 **“SEC. 399JJ. GRANTS TO NURSE-MANAGED HEALTH CLIN-**
 23 **ICS.**

24 **“(a) DEFINITION; ESTABLISHMENT OF CRITERIA.—**
 25 **In this section:**

1 “(1) NURSE-MANAGED HEALTH CLINIC OR
 2 ‘NMHC’.—The term ‘nurse-managed health clinic’ or
 3 ‘NMHC’ means a nurse-practice arrangement, man-
 4 aged by advanced practice nurses, that provides pri-
 5 mary care or wellness services to underserved or vul-
 6 nerable populations and is associated with a school,
 7 college, university, or department of nursing, feder-
 8 ally qualified health center, or an independent non-
 9 profit health or social services agency.

10 “(2) MEDICALLY UNDERSERVED POPU-
 11 LATIONS.—The term ‘medically underserved popu-
 12 lation’ has the meaning given such term in section
 13 330(b)(3).

14 “(3) VULNERABLE POPULATION.—The term
 15 ‘vulnerable population’ means a population that
 16 lacks access to adequate primary care or suffers
 17 from increased health disparities due to factors such
 18 as health, age, race, ethnicity, sex, insurance status,
 19 income level, or ability to communicate effectively.

20 “(4) BEHAVIORAL HEALTH CARE SERVICES.—
 21 The term ‘behavioral health care services’ means
 22 health care related to adult, family, and pediatric
 23 emotional health and well-being and consists of iden-
 24 tifying, assessing, and defining mental health prob-
 25 lems and developing a plan of care, which may in-

1 clude psychopharmacological management, education
 2 about specific mental illnesses, or basic counseling
 3 services that are furnished by qualified health care
 4 professionals.

5 “(5) COMPREHENSIVE PRIMARY HEALTH CARE
 6 SERVICES.—The term ‘comprehensive primary
 7 health care services’ means health care related to
 8 adult, family, and pediatric health and consisting of
 9 adult health, pediatrics, obstetrics, or gynecology
 10 services that are furnished by nurse practitioners,
 11 physician assistants, physicians, nurse midwives,
 12 clinical nurse specialists, other advanced practice
 13 nurses, or other qualified health care professionals.
 14 In addition to primary care services, specific services
 15 may include—

16 “(A) preventive health services;

17 “(B) prenatal and perinatal services;

18 “(C) appropriate cancer screening;

19 “(D) well-child services;

20 “(E) immunizations against vaccine-pre-
 21 ventable diseases;

22 “(F) screenings for elevated blood lead lev-
 23 els;

24 “(G) screening for communicable diseases;

25 “(H) cholesterol screenings;

1 “(I) pediatric eye and ear screenings to de-
 2 termine the need for vision and hearing correc-
 3 tion;

4 “(J) emergency medical services;

5 “(K) diagnostic laboratory and radiologic
 6 services;

7 “(L) care navigation services;

8 “(M) pharmaceutical services, as may be
 9 appropriate for each clinic; and

10 “(N) voluntary family planning.

11 “(6) WELLNESS SERVICES.—The term ‘wellness
 12 services’ means any health-related service or inter-
 13 vention, not including primary care, which is de-
 14 signed to reduce identifiable health risks and in-
 15 crease healthy behaviors intended to prevent the
 16 onset of disease or lessen the impact of existing
 17 chronic conditions by teaching more effective man-
 18 agement techniques that focus on individual self-care
 19 and patient-driven decisionmaking. Specific services
 20 may include—

21 “(A) chronic disease self-management
 22 training;

23 “(B) health screenings relating to hyper-
 24 tension, diabetes, cancer, HIV, lead exposure,
 25 and other chronic conditions;

- 1 “(C) health and patient education;
- 2 “(D) immunizations against vaccine-pre-
- 3 ventable diseases;
- 4 “(E) outreach and home visiting services;
- 5 “(F) environmental health risk reduction
- 6 services;
- 7 “(G) case management services;
- 8 “(H) interpretation and translation serv-
- 9 ices;
- 10 “(I) weight control programs;
- 11 “(J) smoking cessation programs;
- 12 “(K) physical activity and fitness programs
- 13 involving geriatric, youth, and other vulnerable
- 14 populations;
- 15 “(L) occupational safety and health; and
- 16 “(M) cognitive behavioral services.

17 “(b) AUTHORITY TO AWARD GRANTS.—The Sec-
 18 retary shall award grants for the cost of the operation of
 19 NMHCs that meet the requirements of this section.

20 “(c) APPLICATIONS.—To be eligible to receive a grant
 21 under this section, an entity shall—

22 “(1) be a NMHC; and

23 “(2) submit to the Secretary an application at
 24 such time, in such manner, and containing—

1 “(A) an assurance that the NMHC pro-
2 vides direct access to client-centered nursing
3 services with access to other health care serv-
4 ices and that nurses are the major service pro-
5 viders at the NMHC;

6 “(B) evidence that an advanced practice
7 nurse (‘APN’) holds an executive management
8 position within the organizational structure of
9 the NMHC and that an APN has direct respon-
10 sibility for overseeing the daily operations of the
11 NMHC;

12 “(C) an assurance that the NMHC will
13 continue to provide comprehensive primary care
14 services or wellness services for the duration of
15 the grant period;

16 “(D) an assurance that the nurse-managed
17 health clinic will establish, not later than 90
18 days after receiving a grant under this section,
19 a community advisory committee composed of
20 individuals, a majority of whom are being
21 served by the clinic, the purpose of which is to
22 provide input into the nurse-managed health
23 clinic decisionmaking process;

24 “(E) an assurance that the NMHC will
25 demonstrate the receipt of non-Federal match-

1 ing funds equaling at least 20 percent of the
2 Federal portion of any grant awarded under
3 this section, and evidence that the necessary
4 matching funds will be acquired not later than
5 180 days after receiving the grant; and

6 “(F) an assurance that the NMHC will
7 provide care regardless of the insurance status
8 or income of a patient.

9 “(d) WAIVER OF REQUIREMENTS.—The Secretary
10 may, upon a showing of good cause, waive any aspect of
11 the matching funds requirement described in subsection
12 (c)(2)(E).

13 “(e) USE OF FUNDS.—

14 “(1) IN GENERAL.—Funds awarded under a
15 grant under this section may be used for the provi-
16 sion of primary care services and wellness services,
17 for the management of NMHC programs, for the
18 payment of salaries for NMHC personnel, and for
19 providing training for the provision of required
20 health services. Funds may also be used for acquir-
21 ing and leasing buildings and equipment (including
22 the cost of amortizing the principle of, and paying
23 interest on, loans for such buildings and equipment).

1 “(2) AMOUNT.—The amount of any grant made
2 in any fiscal year to a NMHC shall be determined
3 by the Secretary, taking into account—

4 “(A) the financial need of the NMHC;

5 “(B) State, local, and other operational
6 funding provided to the NMHC; and

7 “(C) other factors as determined appro-
8 priate by the Secretary.

9 “(f) TECHNICAL ASSISTANCE.—

10 “(1) IN GENERAL.—The Secretary shall estab-
11 lish a program through which the Secretary shall
12 provide (either through the Department of Health
13 and Human Services or by grant or contract) tech-
14 nical and other assistance to NMHCs to assist such
15 clinics in meeting the requirements of this section.
16 In determining appropriate providers to assist in of-
17 fering technical assistance, the Secretary shall con-
18 sider whether the provider has demonstrated the ca-
19 pacity to effectively address the unique needs of
20 NMHCs.

21 “(2) TECHNICAL SERVICES.—Services provided
22 under this section may include necessary technical
23 and nonfinancial assistance, including fiscal and pro-
24 gram management assistance, training in fiscal and
25 program management, operational and administra-

1 tive support, and the provision of information to
2 NMHC regarding the various resources available
3 under this section and how those resources can best
4 be used to meet the health needs of the communities
5 served by NMHCs.

6 “(g) EVALUATION.—The Secretary shall develop and
7 implement a plan for evaluating NMHCs funded under
8 this section. Such evaluations shall monitor and track the
9 performance of the grantee as well as the quality of the
10 services that are provided under the grant.

11 “(h) AUTHORIZATION OF APPROPRIATIONS.—For the
12 purposes of carrying out this section, there are authorized
13 to be appropriated \$50,000,000 for fiscal year 2010, and
14 such sums as may be necessary for each of fiscal years
15 2011 through 2014.”.

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