

# ISSUE BRIEF

## The Nursing Center in Concept and Practice: Delivery and Financing Issues in Serving Vulnerable People

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A discussion featuring

**Mathy Mezey, R.N., Ed.D., F.A.A.N.**

*Director*

John A. Hartford Foundation  
Institute for the Advancement of  
Geriatric Nursing Practice  
Division of Nursing  
New York University

**Mary Jo Baisch, R.N., M.S.**

*Director*

Institute for Urban Health Partnerships  
School of Nursing  
University of Wisconsin–Milwaukee

with an urban case study presented by

**Katherine K. Kinsey, R.N., Ph.D.,  
F.A.A.N.**

*Director*

Neighborhood Nursing Center  
LaSalle University School of Nursing

**Donna L. Torrissi, B.S.N., M.S.N.**

*Director*

Abbottsford Community Health Center

and a rural/frontier case study presented by

**Susan E. Huether, R.N., Ph.D.**

*Associate Dean for Clinical Services*  
College of Nursing  
University of Utah

## The Nursing Center in Concept and Practice

As the health care marketplace reconfigures—becoming more capitated, more profit-driven, more integrated, and more ambulatory—concern is growing in some quarters that the safety net for vulnerable people is changing, too. Whether the safety net is stretched too thin, as some say, or has too many holes, as others say, is open to question, but the numbers of publicly insured, working poor, and uninsured needing preventive and primary care services are obviously straining its fabric. So-called “safety-net providers” or “community health service providers” that have endeavored to provide that fabric are changing as well. Federal community health centers (CHCs) and migrant and rural clinics are responding to new incentives, state and local direct-delivery organizations are looking to other public health roles, and private voluntary agencies are defining their place in “a civil society.”

In some communities, nursing centers are joining CHCs and other public as well as private agencies in addressing safety-net needs. The nursing center, which also may be called a “nurse-managed center,” “nurse-run-clinic,” and “community nursing organization,” is one in which “(1) a nurse occupies the chief management position, (2) accountability and responsibility for client care and professional practice remain with nursing staff, and (3) nurses are the primary providers seen by clients visiting the center.”<sup>1</sup> Nursing centers are responding to various factors, such as advanced practice nurses’ drive for an expanded role in health delivery, some managed care plans’ use of advanced practice nurses as primary care providers, and greater discretion under state practice laws for advanced practice nurses to exercise authority. Schools of nursing, based at academic health centers (AHCs), see nursing centers as sites for health promotion, disease prevention, primary care services, and training. Community activists view them as grass-roots community health care models, partnerships that exist at the invitation of the community and have established community boards. Everyday citizens—particularly in inner-city and isolated rural areas—perceive them as essential sources of preventive and primary services.

With the advent of managed care and other health marketplace changes, nursing has put forth its model of providing access to preventive and primary services through nursing centers in schools, community and recreation facilities, public housing projects, homeless

and domestic violence centers, strip malls, and other places in urban and rural/frontier areas where people gather. While physicians are involved—to review records, prescribe drugs, and handle referrals, depending upon state nursing practice laws—the centers are nurse-operated and nurse-managed.

But, just as the old public health nursing model faced funding problems, the nursing center must piece together clinical service, teaching, grant, and other funding in order to establish and maintain itself. While the same is true for other safety-net providers, the nursing center faces some particular difficulties. The relative newness of the reshaped model, the difficulty of moving from subsidized to self-sustaining, and issues surrounding independent practice for nurses are major barriers.

This Forum session will delve into the field of advanced practice nursing to examine the nursing center. Centering on the role that advanced practice nursing plays for vulnerable populations in this country’s evolving health marketplace, the meeting will explore the field’s history, goals, inner-city and rural outreach, services, workforce, payment concerns, and educational functions. This session is based in part on two site visits that NHPF hosted—to Philadelphia and to Utah and the Utah-Nevada border area—to look at essential community health services. Since then, while the Philadelphia nursing centers have held their own and even opened a new facility, the frontier Nevada nursing center has lost its base—despite a thriving

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#### Analyst/Writer

Karen Matherlee

#### National Health Policy Forum

2021 K Street, NW, Suite 800

Washington, DC 20052

202/872-1390

202/862-9837 (fax)

nHPF@gwu.edu (e-mail)

www.nHPF.org (Web site)

**Judith Miller Jones**, Director  
**Karen Matherlee**, Co-Director  
**Michele Black**, Publications Director

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practice—and is in the process of closing. The meeting will look at the conceptual framework of the nursing center and probe the framework in practice, through urban and rural/frontier case studies.

## BACKGROUND

Advanced practice nursing dates to 1965, when Loretta Ford, Ph.D., R.N., and a colleague at the University of Rochester developed a model “focused on the promotion of health in daily living, growth and development for children in families, as well as the prevention of disease and disability.” Although there was resistance to the idea, demands for more primary care practitioners (in part due to a shortage of primary care physicians) provided the opportunity, according to Ford.<sup>2</sup>

While nursing centers—in addition to providing comprehensive primary health care—may focus on health promotion and disease promotion services, on the one hand, and on single-purpose functions (such as women’s health) on the other, most are involved in primary care. In 1994, the Institute of Medicine, National Academy of Sciences, defined primary care as

the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community,<sup>3</sup>

a definition seemingly compatible with nursing centers’ mission. Nursing centers tend to place a great deal of emphasis on integrating preventive and primary health services, according to a holistic health care model. As expressed by Patricia Gerrity, R.N., Ph.D., F.A.A.N., and Katherine K. Kinsey, R.N., Ph.D., F.A.A.N., of Philadelphia:

The integration of health promotion into primary care presents unique challenges to both administrators and clinicians. The traditional emphasis on episodic and illness-oriented care is no longer appropriate in today’s health care environment. . . . The idea that people should obtain routine preventive care is not a commonly accepted practice, particularly by low-income families who live in economically depressed areas, in both rural and urban settings. Therefore, many people will not seek wellness care, and their first contact with a provider is for a sick visit. Thus, the provider must view this point of contact as an opportunity for health promotion as well as illness care.<sup>4</sup>

Approximately 161,711 registered nurses (RNs)—6.3 percent of the 2,558,874 RNs identified by a Department of Health and Human Services (DHHS) national sample survey in March 1996—were recog-

nized as having formal preparation for advanced nursing positions. Of these, 63,191 were nurse practitioners (NPs), 53,799 were clinical nurse specialists, 30,386 were nurse anesthetists, and 6,534 were certified nurse-midwives (CNMs).<sup>5</sup> Of these, NPs and CNMs tend to be most closely associated with the development of nursing centers. Other health professionals—RNs, social workers and community outreach workers, and business and clerical personnel—staff the centers, too.

According to the American Association of Colleges of Nursing (AACN), “an estimated 53,753 RNs were nationally certified as NPs or held state recognition as NPs or advanced practice nurses” in 1996. They either had post-RN master’s degrees or “received training in certificate programs that require up to two years of additional clinical training beyond the master’s degree in nursing.” Most worked “in clinical specialties such as pediatrics, family practice, adult acute care, neonatal care, oncology, obstetrics and gynecology (ob-gyn) [and/or] women’s health, occupational health, school health, and gerontological care.” While many practiced in emergency rooms, critical-care units, and other departments in hospitals, a growing number were in health promotion and primary care.<sup>6</sup> As primary care becomes the center of the continuum of services across the country, the nurse practitioner is becoming central to its practice, for the fully insured as well as for the vulnerable, but particularly for the latter.

Between 1993 and 1995, the American College of Nurse-Midwives surveyed its members about their educational backgrounds and current employment. The college’s 1993 survey went to 3,966 CNMs, 3,452 of whom responded, along with 381 students. The 1994 survey was mailed to 5,060 members; 4,399 (3,830 CNMs and 569 students) returned their completed forms. Two-thirds of the 1993 respondents indicated that they held graduate degrees, most in nursing. Of the 1994 respondents, nearly 69 percent had master’s degrees and almost 4 percent had doctorates. A little more than half worked for hospitals or physicians, while slightly more than 7 percent were in private practice. The overwhelming majority—71 percent—responding to both surveys said that their primary employment involved “clinical nurse-midwifery with births.”<sup>7</sup>

Nursing historians trace the beginning of the nursing center as it is known today to the start of the Rochester program in 1965. The program in part responded to initiatives in the federal Nurse Training Act of 1964, which provided public funds to support training of advanced practice nurses in inpatient settings. (At the time of implementation, the federal Medicare and

federal-state Medicaid programs also came into being.) But historians see nursing centers' roots in the Henry Street Settlement Lillian Wald founded for the sick and the poor in New York City in 1893, for it joined many of the elements—nursing operation, service, and teaching for vulnerable people—found in nursing centers today.<sup>8</sup>

Various individuals and organizations contributed to nursing centers' growth during the 1960s, 1970s, and 1980s. For example, a series of directors of the Bureau of Health Professions' Division of Nursing, DHHS, provided leadership. O. Marie Henry, R.N., Ph.D., for instance, who served in the division for years, heading it from 1989 to 1990, "challenged nurse educators to take control of practice by creating centers for the integration of practice, education, and research where new methods of nursing care and delivery could be developed, tested, and demonstrated." She urged establishment of nursing centers in various settings, such as nursing homes, rehabilitation centers, and community sites.<sup>9</sup>

Nursing schools had started establishing their own practices in the 1970s. "By the early 1980s, 63 schools of nursing were affiliated with or were sponsoring nurse-managed centers, the National League for Nursing (NLN) had established a Council for Nursing Centers, and the first national conference on nursing centers had been held."<sup>10</sup> There were approximately 553 teaching programs in the AACN, 119 of which reported nursing centers in the association's 1998 annual survey, according to Linda Berlin, Ph.D., AACN director of research and data services.<sup>11</sup>

Not only the Division of Nursing and nursing organizations such as the NLN and AACN but also charitable foundations contributed to the growth of nursing centers. For example, the Robert Wood Johnson Foundation, W. K. Kellogg Foundation, John A. Hartford Foundation, and Independence Foundation have provided guidance and support over the years.

## A PROFILE AND EXAMPLES OF NURSING CENTERS

Although nursing centers may be found in middle-class suburbia and yuppie workplaces, they are most apt to be in sites that serve vulnerable people—the working poor, low-income mothers and children, homeless persons, and others with special needs. The 1998 AACN survey (with 119 nursing-school-associated nursing centers reporting) indicated that most of the

centers—63 percent—were in urban areas, with 65 percent in inner-city sites. Only 7 percent were in rural sites. Although about 27 percent were based at the nursing schools themselves, 28 percent were in elementary or secondary schools, 25 percent were at senior or neighborhood centers, 22 percent were in public housing projects, 16 percent were in community centers, 15 percent were in shelters, 15 percent were in student health centers, 9 percent were in churches, 8 percent were in storefronts, 7 percent were in hospitals, 5 percent were in mobile vans, 3 percent were in businesses and other commercial locations, and 24 percent were listed as "other" (some schools had centers at more than one site). Culturally diverse patients made up 54 percent of the centers' caseloads, with persons over age 85 comprising 30 percent; non-English speaking, 25 percent; homeless, 19 percent; victims of abuse, 14 percent; people described as substance abusers, 11 percent; mentally ill, 8 percent; HIV-positive, 2 percent; migrants, 6 percent; developmentally disabled or handicapped, 5 percent; pre-term infants, 3 percent; prisoners, 2 percent; other, 21 percent; and none of the above groups, 19 percent (again, there was overlap among the categories).<sup>12</sup> In an earlier AACN survey of nursing centers, conducted in 1992, "community need was cited by 43 percent of the schools as the most important reason for establishing a nursing center, followed by clinical training for students (40 percent)."<sup>13</sup>

The AACN survey responses correlate fairly closely with information—some of it anecdotal—on nursing centers from DHHS' Division of Nursing and the Regional Nursing Centers Consortium (RNCC), an association of nursing centers in Pennsylvania, New Jersey, and Delaware. For example, the Division of Nursing, which provides grants to nursing centers across the country, has projects in San Francisco; Denver; Newark, Delaware; Coral Gables, Florida; Atlanta; Baltimore; Amherst, Massachusetts; Sault Ste. Marie, Michigan; Columbia, Missouri; Kansas City, Missouri; West Wendover, Nevada; Newark, New Jersey; New York; Akron, Ohio; Philadelphia; Johnson City, Tennessee.; Austin, Texas.; Beaumont, Texas; San Angelo, Texas; Norfolk, Virginia; and Huntington, West Virginia.

RNCC represents 24 nurse-managed health centers in Pennsylvania that provide health care services to 25,000 people and encounter 250,000 people annually, half of whom are children and youth. From one-fifth to more than one-half of an individual center's patients may be uninsured on any given day, according to Tine

Hansen-Turton, M.G.A., RNCC executive director. “The nursing centers see their members an average of 1.8 times more than other providers; their patients are hospitalized 30 percent less often and use the emergency rooms 15 percent less frequently than those of other health care providers.” She also indicates:

Children in our care are immunized on time and receive the proper care needed to help them grow up to be healthy individuals. The nursing centers have aggressive tracking and outreach programs that are especially vital to well childcare. Moreover, following comprehensive prenatal care, several primary care nurse-managed health centers have experienced 100 percent of women giving birth to normal birth-weight infants.<sup>14</sup>

Participants in NHPF’s March 30-31, 1998, Philadelphia site visit, *Providing Community-Based Primary Care: Nursing Centers, CHCs, and Other Initiatives*, saw four of RNCC’s nursing centers. These centers—Abbottsford Community Health Center, Health Annex at Myers Recreation Center, LaSalle Neighborhood Nursing Center, and Temple Health Connection at Norris Homes—provide services to vulnerable populations in poor neighborhoods. In addition to primary health care services, they are involved in tobacco cessation, lead poisoning prevention, health screening, diabetes and asthma education, violence prevention, well childcare, and other health promotion and education activities. At the time of the site visit, Philadelphia had just moved to Medicaid managed care, a capitated system called “HealthChoices.” Of the four health plans that contracted with the commonwealth of Pennsylvania, three recognized certain nursing centers in Philadelphia as primary-care providers.

With service delivery overseen by a nurse who has control over the budget and with services provided by nurses (especially but not exclusively NPs, nurse midwives, and public health nurses), the centers tend to be identified with schools or departments of nursing. For example, LaSalle University’s center—one of two the university operates—combines both service delivery and training, as do those of Temple University and the Health Annex (a part of the University of Pennsylvania). Nurse providers refer to physicians for specialty care; moreover, a physician visits each center periodically to review records.<sup>15</sup>

As another example, participants in NHPF’s October 27-30, 1998, Utah and Utah-Nevada border site visit, *Essential Community Health Services on the Frontier*, visited the University Wendover Clinic, in West Wendover, Nevada, on the Utah-Nevada border. A nurse-

managed clinic—linked to the University of Utah’s College of Nursing—in which five NPs provided health services and had clinical rotations for 40 to 70 nursing students a year, the clinic offered preventive and primary services and also served as an emergency and trauma unit. The only full-time health provider in the isolated area (there was also a prenatal clinic that saw clients a day and a half a week in a trailer), it provided primary care to the regular population and to the hundreds of additional persons—many of them elderly—who crowded West Wendover’s casinos on weekends. It also had arranged 860 ambulance runs and 235 air transport flights the previous year. Through a telehealth program, it had links to specialists, who also were available through referral. Having lost its subsidy from the University of Utah, the clinic is due to close by the time of this session.<sup>16</sup>

## **RECONFIGURATION OF THE HEALTH MARKETPLACE—BARRIER OR OPPORTUNITY?**

As the health marketplace has moved to managed financial arrangements in many parts of the country, mainly for privately insured and Medicaid patients and for a small percentage of Medicare beneficiaries, the impact upon vulnerable persons is still being sorted out. Some—those eligible for Medicaid who have linked with primary care providers, ideally in their communities—may benefit, while others, unable to “work the system” for transportation, language, and other reasons, may not. For those persons left out of the system, the 43 million uninsured in this nation, there may be few alternatives. As hospitals place greater restrictions on or close their emergency rooms, as providers have less ability to cost shift and to apply other subsidies to charity care, and as employers—particularly in service industries—become less apt to offer health coverage, the safety net seems increasingly strained.

Traditional essential community health services providers, such as CHCs, are in some instances frozen out as managed care plans, under capitated state contracts, serve the publicly insured patients who once were the CHCs’ patients. At the same time, cutbacks in income maintenance programs that were once linked to health services and elimination of certain benefits for immigrants are adding to safety-net needs. On the positive side, the Child Health Insurance Program, initiated by all but one state, is serving increased numbers of children, although those states that have chosen to link their programs with Medicaid may

bypass traditional providers. The result, while seemingly more efficient and cost-effective to the states, may mean a greater burden on safety-net providers, without a corresponding increase. Indeed, safety net providers may have a larger caseload but less revenue.

Nursing centers' sources of income tend to be capitated payments, for those recognized by managed care plans as primary care providers; discounted fee-for-service reimbursement in some instances; a small amount of indemnity insurance; a sliding-fee scale for self-pay clients; special grants, such as for lead-poisoning screening or prenatal care; foundation support; and university, government, and other subsidies. By all accounts, financing is the major barrier to nursing centers' growth. Proponents contend that, "despite abundant research demonstrating the quality and efficacy of advanced practice nurses, barriers to payment have impeded utilization of [them] in mainstream health care delivery and stifled development of innovative care models." The result is that "NPs have not been widely included in either private or public payment databases."<sup>17</sup>

The decision by some private health plans, such as Oxford Health Plans in New York and Keystone Mercy, Health Partners, and Health Management Alternatives in Philadelphia, to utilize NPs as primary care providers is altering the picture somewhat. Advanced practice nurses have entered into agreements that range from bearing full risk to taking a fee for a given service. Rules governing practice, of course, remain with the states.

In Texas and Delaware, health maintenance organizations (HMOs) are prohibited from discriminating against advanced practice nurses' services; New York has legislation stating that nurses are qualified as primary care gatekeepers; Arkansas has included advanced practice nurses as "any willing provider" in the 1995 Patient Protection Act.<sup>18</sup>

Federal legislation is also altering the picture. The Balanced Budget Act of 1997 (BBA) "removed several payment barriers for advanced practice nurses." The legislation, effective January 1, 1997, "enabled NPs and clinical nurse specialists to receive direct Medicare reimbursement in all geographic settings."<sup>19</sup> Because NPs have received payments directly from Medicaid since 1989, that opened up public health program funding to the field. (Earlier, Medicare payment had been authorized for CNMs and certified registered nurse anesthetists. Moreover, a community nursing organization [CNO] program was established as a demonstration for providing "community-based services to older adults . . . under a capitated nurse-managed model at a controlled rate with integration of financial

and health delivery structures."<sup>20</sup> The Omnibus Budget Reconciliation Act of 1987 authorized a demonstration program to experiment with capitated nurse-managed, community-based services for Medicare beneficiaries. For instance, Carondelet Health Network in southern Arizona was a site, as were nursing organizations in Illinois, Minnesota, and New York.<sup>21</sup>)

The Civilian Health and Medical Program of the Uniformed Services and Federal Employee Health Benefit Plan also cover NP, clinical nurse specialist, and CNM services.<sup>22</sup> Moreover, nursing centers themselves are seeking federally qualified health center (FQHC) status, in order to receive fee-for-service reimbursement from federal payers, even though the special treatment is being phased out through 2002 under the BBA. For example, Abbottsford Community Health Center in Philadelphia is an FQHC.

Addressing nursing centers' financial survival, Elizabeth J. Holman, M.S., R.N., and Ellamae Branstetter, Ph.D., R.N., offer six strategies for success:

- Paying for services and collecting fees for services.
- Developing a realistic business management plan.
- Aggressively using planned marketing strategies.
- Obtaining profitable contracts and agreements.
- Cooperating with other agencies in addressing specific local health needs.
- Soliciting and obtaining 'provider' status with selected HMOs.<sup>23</sup>

All of these reflect the changing dynamics of the health marketplace. In a January 1998 article in *The Nurse Practitioner*, Carolyn Buppert, C.R.N.P., provides a primer on reimbursement policies for Medicare, Medicaid, indemnity insurance, managed care payments, billing (including coding), direct contracting with businesses and agencies that want health services, and self-pay patients.<sup>24</sup> It underlines what Kinsey, director of the LaSalle Neighborhood Nursing Center, has had engraved on the coffee cups of her nursing students: "I am in the *business* of nursing as well as the art and science."

## RESISTANCE FROM AND COLLABORATION WITH PHYSICIANS

Advanced practice nurses' greater autonomy has not come without resistance. Some physicians as well as consumers have opposed the idea of NPs and other advanced nurses having a greater role in primary care, as well as in other fields, such as ob-gyn and anesthesia. Medical societies in some states, such as New York and California, have worked to assure that advanced practice nurses have formal relationships with physicians; those in

other states have fought efforts to have nurses with advanced training prescribe medications. While state practice laws vary in terms of clinical nurse specialists, nurse midwives, and nurse anesthetists, in 26 states NPs can practice without physician supervision or collaboration. In 16 states, physician supervision or collaboration is required. In six states, physicians, through boards of medicine, have roles limiting what nurses may or may not do. NPs may prescribe medications without physician involvement in 18 states, must have physician involvement in 19 states, and both must have involvement and are precluded from prescribing controlled substances in 13 states. They cannot prescribe at all in Illinois.<sup>25</sup>

On the opposite pole is collaboration. In an article on collaborative practice, Colleen Dwyer, M.S., R.N., N.P., and three co-authors pick up a definition used by the National Joint Practice Commission of 1972: “nurses and physicians collaborating as colleagues to provide patient care.” In describing collaborative models, such as that of the University of Rochester Community Nursing Centers, they contend that collaborative practices “not only reinforce a holistic care model, but also facilitate expanding health care services to those with limited access.”<sup>26</sup> William Kavesh, M.D., who objects to the idea that “NPs can simply do primary care in loose collaborative practice with physicians,” states it this way:

The problem is that primary care—at least in the challenging types of home care, nursing home care, and even office practices that I see as a geriatrician—does not fit . . . [the] description of primary care where the nurse practitioner bears the principal responsibility for the diagnosis and management of uncomplicated illness and uses the primary physician as a consultant. The NPs with whom I work are not seeing uncomplicated illness. They are increasingly seeing people with multisystem disease that are often unstable and don’t fit into neat protocols. Yes, they do bear the day-to-day responsibility for the diagnosis and management of these patients and I usually have no doubts about their skills. But, what we really seem to be engaged in is a series of collaborative partnerships—with each other; with the specialists whom we sometimes need to consult; with a whole array of other professionals, nurses, social workers, and therapists; and with patients and their families or other important people in their lives.<sup>27</sup>

## ROLE OF EDUCATION

Education rivals provision of health services as a nursing center mission. From the beginning, with passage of the Nurse Training Act of 1964, education

of advanced practice nurses has been both a federal and a private-sector goal. In 1986, as a result of the Nurse Education Amendments of 1985, “grant funds were awarded to support two unique nursing practice arrangements” under the act’s Nursing Special Projects authority. One setting was a correctional services center for male and female adolescents. The other setting was a clinic for the homeless. “In both instances, primary health care services, including health promotion and disease prevention programs, were planned and implemented by nurses.”

There were 9 nursing centers in the demonstration program in 1987, 13 in 1988, 15 in 1990, 17 in 1992, and 41 in 1998, as the Nurse Education and Practice Improvement Amendments Act of 1992 and subsequent reauthorizations—the most recent in 1998—provided grant funds. As the program has grown, it has taken on new requirements, so that it presently supports improving access to primary health care for the medically underserved, targeting special populations (for example, persons who are elderly; are substance abusers, homeless, or subject to domestic violence; and/or have HIV-AIDS), developing cultural competence as a nursing skill, enabling nurses to work in managed care and other evolving health systems environments, promoting career mobility in nursing, and offering nursing students opportunities for education in informatics (including distance learning). The program combines service delivery with structured educational opportunities in primary health care. Through the program, a new generation of nursing students is becoming aware of the roles of nursing relative to community-based primary health care services. Because the focus is mainly on medically underserved populations, the goal is for students who have been trained in nursing centers to choose employment in similar settings.<sup>28</sup>

As care continues to move from inpatient to outpatient settings, the demand for appropriately trained practitioners—whether physicians, advanced practice nurses, physician assistants, or allied health professionals—also is on the rise. Graduations of new NPs increased by 15.8 percent in 1998 over 1997, according to an AACN survey. Of nursing students pursuing master’s degrees, 60.8 percent were in nurse practitioner tracks in 1998. That represented a significant increase from 1994, when 40.2 percent were in nurse practitioner programs. Of those in the programs, 52 percent were in family practice, 17.8 percent in adult practice, and 8.9 percent in pediatric practice. The proportions tended to hold for students in post-master’s certificate programs, too. The majority of nurse practitioner students were part-time.<sup>29</sup>

Part of the teaching mission is evaluating outcomes, in terms of clinical practice improvement. Some nursing centers, such as those in the RNCC, are gathering data as they develop the model, in order to create databases on providers, patients, services, students, payments, and other variables.

## KEY QUESTIONS

Following are the major questions the session will address:

- Does the nursing center represent, in part, an evolution of advanced practice nursing?
- How did the emphasis on providing access to primary care influence the development of advanced practice nursing? Of nursing centers?
- To what extent do many nursing centers' academic ties help them in providing health services to vulnerable populations? To what extent do they hinder them?
- To what extent is managed care—publicly and privately financed—a factor in nursing center payment? A factor in the spread of nursing centers? A factor in the opposition of some other providers against them?
- What is the financial base for health services provided by nursing centers (preventive as well as primary services)? For nursing education provided by nursing centers?
- How viable is the nursing center as a rural model of health care delivery for vulnerable populations? As a frontier model? What is the significance of volume of services? Of economy-of-scale in terms both of the range and volume of services?
- How important is telehealth to the operation of a rural or frontier nursing center?
- What competitive and collaborative forces do nursing centers face? Do they compete with other providers, such as CHCs and physicians in private practice? What types of partnerships have they formed?
- What is the role of the community in a given nursing center? In its establishment? In its governance? As a patient base? As a political force?
- Can nursing centers be self-sustaining? What role do federal entitlement and grant funds play?
- What impact have charitable foundations had on the development and growth of nursing centers? What impact has the federal government had?

- What is the status of data collection and monitoring at nursing centers?
- What influence is the nursing center having on advanced nurse training? On recruitment and retention of advanced practice nurses in underserved communities?

## THE FORUM SESSION

**Mathy Mezey, R.N., Ed.D., F.A.A.N.**, will start the session with an overview of advanced practice nursing and its relationship to independent practice and the provision of primary care services to vulnerable populations. She is the director of the John A. Hartford Foundation Institute for the Advancement of Geriatric Nursing Practice and the Independence Foundation professor of nursing education at New York University Division of Nursing. With Diane O. McGivern, R.N., Ph.D., F.A.A.N., she recently edited *Nurses, Nurse Practitioners* and has authored various other publications. Earlier, she directed the geriatric nurse practitioner program and the Robert Wood Johnson Foundation teaching nursing home program at the University of Pennsylvania School of Nursing.

**Mary Jo Baisch, R.N., M.S.**, will address the nursing center concept: its scope, objectives, services, opportunities, and barriers. Director of the Institute for Urban Health Partnerships and a lecturer and clinical assistant professor at the School of Allied Health, School of Nursing, University of Wisconsin-Milwaukee, she is situated at one of the premier nursing schools in terms of nursing center development and practice. Previously, she was a part-time staff nurse at Sinai Samaritan Medical Center, executive director of the Sixteenth Street Community Health Center, and director of the Teen Pregnancy Service of Milwaukee.

**Katherine K. Kinsey, R.N., Ph.D., F.A.A.N.**, and **Donna Torrisi, B.S.N., M.S.N.**, will present a case study of nursing centers in Philadelphia. Related to NHPF's March 1998 site visit, the case study will feature LaSalle University's Neighborhood Nursing Center (one site adjacent to the inner-city LaSalle campus and the other at the Hill Creek housing project) and Resources for Human Development's Abbottsford Community Health Center and Schuykill Falls Community Healthcare Center. Kinsey is the director of the Neighborhood Nursing Center, associate professor, and Independence Foundation chair, all at LaSalle University School of Nursing. Prior to joining LaSalle in 1996, she was assistant professor and director of home



visiting and outreach at the Neighborhood Nursing Center site adjacent to the campus. She also has served as an administrator and assistant professor at Thomas Jefferson University, a public health coordinator, and a hospice-home care public health nurse. Torrisi has directed the Abbottsford and Schuykill centers since 1992. Earlier, she was a nurse practitioner in adult health with Philadelphia Health Associates. She has won numerous awards for primary care and nursing practice leadership.

**Susan E. Huether, R.N., Ph.D.,** will give a case study of the University of Utah's nursing center in West Wendover, Nevada, the frontier clinic that will close in early September. The center was featured in NHPF's October 1998 site visit. In addition to addressing the center's practice and its reception by the community, she will talk about barriers to providing services in rural and frontier areas. Associate dean for clinical affairs at the University of Utah College of Nursing since 1995, she was previously the associate dean for academic affairs, a division director, and a program director at the college.

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## ENDNOTES

1. Carol Ann Lockhart, "Community Nursing Centers: An Analysis of Status and Needs," *Nursing Centers: The Time Is Now* (New York: National League for Nursing, 1995), 3. The league uses the term, "community nursing center."
2. Diane O. McGivern and Mathy D. Mezey, "Advanced Practice Nursing: Preparation and Clinical Practice," *Nurses, Nurse Practitioners: Evolution to Advanced Practice* (New York: Springer Publishing Company, 1999), 4.
3. Ellen D. Baer, "Philosophical and Historical Bases of Advanced Practice Nursing Roles," *Nurses, Nurse Practitioners: Evolution to Advanced Practice* (New York: Springer Publishing Company, 1999), 75.
4. Patricia Gerrity and Katherine K. Kinsey, "An Urban Nurse-Managed Primary Health Care Center: Health Promotion in Action," *Family and Community Health*, 21, no. 4 (January 1999): 36.
5. Division of Nursing, Bureau of Health Professions, DHHS, "Advance Notes II from the National Sample Survey of Registered Nurses, March 1996"; accessed May 14, 1999, at <http://www.hrsa.dhhs.gov/bhpr/dn/advnote2.ht>.
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