2-1996

Symposium on Nursing Centers: Past, Present and Future

Marilyn Frenn
Marquette University College of Nursing, marilyn.frenn@marquette.edu

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Recommended Citation
Frenn, Marilyn, "Symposium on Nursing Centers: Past, Present and Future" (1996). College of Nursing Faculty Research and Publications. 133.
https://epublications.marquette.edu/nursing_fac/133
 Symposium on Nursing Centers: Past, Present and Future

Marilyn Frenn  
Marquette University College of Nursing, and a Postdoctoral Fellow at the University of Michigan School of Nursing

Sally Peck Lundeen  
Associate Professor and Director of the Silver Spring Community Nursing Center, University of Wisconsin-Milwaukee

Karen S Martin  
Health Care Consultant in Omaha, Nebraska

Susan K Reisch  
Professor and Associate Dean, University of Wisconsin-Madison

Sarah A Wilson  
Assistant Professor, Marquette University College of Nursing, Milwaukee, Wisconsin

Abstract  
A call for articles related to nursing centers was generated (Tanner, 1994), based on the fact that many existing nursing centers operate out of schools of nursing. Proceedings of a symposium on nursing centers presented at
the Midwest Nursing Research Society (MNRS) meeting in April 1994 are shared as a way of advancing the development, implementation, and evaluation of nursing centers. The four contributions represent a review of the historical, empirical, and anecdotal literature, key elements in creating and maintaining a research laboratory, data sets useful for practice and research, and policy issues germane to nursing centers, which are a cornerstone of health care reform.

A Review of Historical, Anecdotal and Empirical Reports on Nursing Centers
A nursing center is a place and a concept. A review of the historical, anecdotal, and empirical literature reveals that nursing centers are not a new concept and have served as fertile ground for the definition and advancement of nursing practice. Numerous definitions of nursing centers have been proposed based upon a Delphi survey (Fehring, Riesch, & Schulte, 1987), services delivered (Kos & Rothberg, 1981; Ossler, Goodwin, Mariani, & Gilliss, 1982), or providers of the service (Lang, 1983; Thibodeau & Hawkins, 1987; U.S. Senate, 1983). The common themes identified among all the definitions are that nursing care is directly accessible to the client, family, or community and that the practice is controlled by nurses.

Historical Review and Contemporary Resurgence of Nursing Centers
Glass (1989) linked nursing centers with turn of the century district nursing which ultimately became public health nursing. Citing Sanger, who said nurses should be at the call of the people who need them, and Breckenridge, who developed the first prospective payment system at the Frontier Nursing Service, Glass provided evidence that patient care was the impetus behind nursing centers, not financial gain. This, most likely, remains true today.

A contemporary resurgence of nursing centers occurred. The Loeb Center in New York was referred to by Hall (1963) as "a nursing center, close to public health nursing." The underpinnings of the current era of nursing centers include Milio's (1970) description of a Detroit storefront clinic, Kinlein's (1972) independent nursing practices, and Henry's (1978) demonstration of 24-hour, 7 day per week nursing care units accountable and responsible for patient and community care not under the supervision of other disciplines. In addition to nursing practice, several societal influences contributed to the resurgence of nursing centers. These influences included the need for clinical training in wellness, health promotion, and illness prevention (Riesch, Felder, & Stauder, 1980) as well as opportunities for demonstration centers particularly among underserved or disadvantaged aggregates of the population (Mezey & Chiamulera, 1980).

Conceptual Schemes to Guide Nursing Centers
On the basis of services provided to clients, nursing centers may be conceptualized into three categories: a) community health and institutional outreach models; b) wellness and health promotion models; and c) independent practice or nurse entrepreneur-ship models (Riesch, 1992a).

Community Health and Institutional Outreach models of centers may be free-standing or sponsored by a larger institution such as a hospital, public health agency, medical center, or university. Examples of freestanding clinics include the Erie Family Health Center in Chicago (Lundeen, 1985) and the Minnesota Block Nurse Program (Jamieson & Martinson, 1988). The hallmarks of these clinics are the delivery of primary care services in health professional shortage areas to medically underserved communities using a multidisciplinary staff funded by diverse public and private sources. The nurse is Executive Director and reports to a Board of Directors representative of the community. Institutional outreach clinics also provide primary care services to specific populations based on either a disease model or ambulatory care model (Allison, 1973; Hill, 1986; MacLeod, 1984; Runyon, VanderZwaag, Joyner, & Miller, 1980). The care is managed by a nurse who generally is an employee of the larger institution.
Wellness and Health Promotion models are based on community need and services are developed and targeted to promote health. Often, services are delivered where aggregates gather such as workplace, school, church, or homeless shelter (Fehring & Frenn, 1986; Hawkins, Igou, Johnson, & Utley, 1984; Lenehan, McInnis, O’Jonnell, & Hennessey, 1985). Many of these centers were developed as academic health centers (Barger, 1986) and thus student learning may be an objective of such a center (Culbert-Hinthorn, Fiscella, & Shortridge, 1985, 1986). Data have accumulated on client satisfaction, description of the community using the services, and number and types of visits. Such centers are often viewed as alternative to traditional health care delivery (Barger, 1993).

Faculty Practice, Independent Practice, and Nurse Entrepreneurship models include agencies and services owned and operated by nurses. Such practices vary from a solo practice (Dickerson & Nash, 1985) to collaborative multidisciplinary practices (Aydelotte, Hardy, & Hope, 1988). Examples of the practice include the Yale Nurse Midwives and the Maternity Center (Nichols, 1985; Rooks et al., 1989) and consulting, counseling, and home health services (Herman & Krall, 1984). Methods of payment for services are fees, grant monies, and insurance. Walker (1994) stressed the importance of using a comprehensive business model to develop diverse revenue streams thereby reducing dependence on grant monies.

State of the Art of Nursing Center Knowledge

Research on nursing centers has been limited, but important studies have revealed the location and demographic profiles of nursing centers and have begun to document achievements in: a) student learning (Hauf, 1977); b) changes in client and family knowledge, attitudes, behavior (Duffy & Halloran, 1987; Kos & Rothberg, 1981; Munroe & Natale, 1982; Muhlenkamp, Brown, & Sands, 1985); c) changes in health status (Allison, 1973; Jamieson & Martinson, 1988; Jones, Pagel, & Wittman, 1973; Lewis & Resnick, 1967; Newman, Sloss, & Anderson, 1984; Riesch, 1988); d) client satisfaction (Bagwell, 1987; Gresham-Kenton & Wisby, 1987; Hill, 1986); and e) cost effectiveness and quality of care (Kos & Rothberg, 1981).

Issues for further research include examination of the scientific adequacy of the care delivered, cost of the care, and outcomes of the care that can be compared with local, state, and national data sets. Nursing centers have the potential to deliver nonfragmented, community-based, integrated, cost-effective, safe, and accessible health care. To demonstrate this, future research should be grounded in theory or guided by nursing conceptual frameworks, use multi-site clinical trials, include appropriate sample sizes, use reliable and valid measures, and be disseminated in peer-reviewed, multidisciplinary journals (Riesch, 1992b).

Analyses of the knowledge developed to date reveals that the process of setting up a nursing center is documented. In general, an opportunity knocks or a community need is recognized. A group of advanced practice nurses (faculty or practitioners) develop goals and objectives, acquire funding and space, set up recordkeeping, billing, marketing, quality assurance, and care systems. Data have shown that clients, families, and communities who use a nursing center are satisfied. To continue the momentum, the profession must demonstrate how to maintain nursing centers, measure their significance, and establish them within the mainstream of health care delivery as environments for care delivery, health research, and student socialization. Upon reviewing the literature, Phillips and Steel (1994) referred to ideas similar to these as nursing center survival strategies: and listed them as: a) delivery of high quality nursing services, b) public and community support, c) healthy, collaborative relationships with other health care providers, and d) documentation of patient outcomes through nursing research.
Principles for Creating and Maintaining a Research Laboratory: Funding Community Nursing Centers

Community nursing centers (CNCs) have great potential to serve as laboratories for research in the areas of primary care, organizational development and change, nursing interventions, health professionals education, and health care delivery models. Because of the unique characteristics of many academic CNCs, these organizations can provide opportunities for outcome research studies focused on nursing interventions that are not easily duplicated in other practice settings. A significant challenge that must be met in order to capitalize on these, however, is the need to secure consistent funding to: a) build the CNC as a research laboratory, and b) support research activities over time.

Building the Laboratory

For those interested in studying CNCs, the issues of funding this type of research present some unusual challenges. Due to the innovative nature of community nursing centers, there are still a limited number of fully operational CNCs in the country today. Nurse researchers interested in a program of research focused on the impact of CNCs on the health status of particular aggregates may be required to build the CNC as a laboratory as a part of their program of research.

This concept is not common in nursing circles, particularly in academic settings, where issues of tenure and promotion are sometimes inseparable from issues of generating new knowledge. Nonetheless, if schools of nursing are to maintain a leadership role in the development and testing of innovative nursing models of primary health care delivery, a greater appreciation and understanding of the scholarly nature of the activity required to conceptualize, fund, and implement new service delivery models, such as academic CNCs, must be developed. In fact, documentation of the process of successful CNC development and identification of the factors that contribute to the viability of these new health care delivery structures are critical to the development of a new body of knowledge so pertinent to the health care reform agenda.

Discussion of the multiple factors that contribute to the development of a successful and viable CNC are beyond the scope of this article. However, the principles for funding research activities within a CNC cannot easily be separated from factors that are relevant to the implementation and maintenance of a viable organizational entity. It is not possible to study community nursing centers per se, nor maximize their potential for research with frequently underrepresented populations, if these organizations do not exist. In the current medically oriented health care delivery environment, building CNCs based on nursing models of care requires multiple funding strategies.

Principles for Funding CNCs as Research Laboratories

The following principles have been developed by the author during nearly 20 years of experience in building community nursing center "laboratories" in urban communities. They have been refined over the years (Lundeen, 1989), but have consistently focused on the challenges of integrating a program of research (and education of health professionals) into the CNC practice environment in ways that respect and protect the autonomy of the communities being served. The results in fiscal terms have been substantial ($3,414,329 at one project and over $3,100,000 at a second). The more important outcomes, however, have been the development of community-based practice settings that provide opportunities for nurse researchers, students, other health care professionals, and community leaders to discover the answers to important questions regarding community nursing center models of care.

The five principles identified by this author as key to the successful creation and maintenance of a CNC research laboratory are:
1. Recognize and capitalize on funding trends while maintaining the integrity of the CNC philosophy.

2. Establish strong collaborative partnerships with other community organizations and institutions, while maintaining CNC autonomy.

3. Establish visibility and credibility with key funders and policy makers through extensive participation in community activities.

4. Build the costs of funding research activities into all applications even when the primary focus of the hinder is not research-oriented.

5. Demonstrate both flexibility and persistence when seeking funding sources.

Recognize and Capitalize on Funding Trends

It is inappropriate to simply "chase the money" when building a CNC as a research laboratory. Although it can be tempting to allow the availability of funding (private or public) to determine the focus of the center, simply following funding streams dictated by the whims of others will usually result in an organization that cannot demonstrate a coherent conceptual base. On the other hand, once a firm conceptual model has been articulated, it is frequently necessary to seek various sources of revenue over time in order to develop the full range of services envisioned in the CNC model.

Accurately assessing and responding to current funding trends by developing various CNC programs serially as funds are available is critical to early stages of survival and growth in many CNCs. This "patchwork funding" phenomenon, while facilitating CNC growth, is very labor intensive for administrative staff and must not be undertaken lightly. The key to successful implementation of this principle is the ability of the leadership of the CNC to maintain a clear and present vision which guides decisionmaking about potential funding sources without compromising the long-term philosophy of the CNC model.

Establish Strong Collaborative Partnerships

Collaborations and partnerships with other organizations can strengthen both the delivery model and the funding base of CNCs. In recent years, collaboration has become the "name of the game" for many flinders. Submitting joint applications with other health and human service agencies can greatly enhance the chances for successful funding. Although creating collaborative applications (and subsequently implementing collaborative programs) entails significantly more time and energy than developing programs alone, the dramatic outcomes that can result are well worth the effort.

The challenge for CNCs is to maintain a nursing model of care as an identifiable aspect of programming in the midst of building collaborative interdisciplinary partnerships. When collaborating with either human service agencies or medical institutions, the least understood model of service delivery is likely to be the nursing model. Once again, conceptual clarity and consistency about the CNC model is critical to securing long-term funding without sacrificing the overall CNC goals and objectives.

Establish Visibility and Credibility with Key Funders and Policy Makers

It is not possible to overestimate the importance of active participation in ongoing community planning and coordinating activities to the successful funding of new and continuing CNC related research. Although this requires the allocation of scarce and valued CNC administrative and clinical personnel to community development activities, it may be the single most important investment that the CNC can make in terms of long-term funding success. Several factors can be identified to support this assertion. First, community-wide strategies to address the health needs of particular populations or aggregates are usually developed through planning groups over a period of time. In order for CNCs to be adequately included in any eventual resource
allocation for project support, program evaluation or research activities that frequently emanate from this community-wide participatory process, a consistent place "at the table" is mandatory. Second, often key funders and/or local and state policy-makers are involved in these planning and developmental activities. The opportunity to develop a reputation as a credible health care expert with these key decision-makers through interaction with them in this arena greatly enhances the chances of success when proposals for research funding are submitted to them in related areas.

Build Research Costs Into Applications for CNC Funding
Many private and public funders state quite clearly that they do not support research activities. This does not necessarily mean that they do not support data-based program evaluation efforts. It is often possible to build the costs of program evaluation, data collection (particularly when related to clinical documentation data), computer costs, and analysis of program-related data into contracts and grants that are primarily focused on the provision of direct services. Although it must again be stated that the administrative and fiscal management expertise necessary to fund research activities in this manner is considerable, it can result in significant base funding for longitudinal data collection and analysis at CNC settings.

Flexibility and Persistence Needed When Seeking Funding Sources
Flexibility and persistence should be the motto for all nurses developing a CNC program and research plans. The fact that many services provided by nurses through CNCs, including many of the primary prevention, health promotion and care coordination interventions, are not currently reimbursable through traditional reimbursement or revenue streams indicates that there will be a continued need for great creativity in the funding of both programmatic and research activities in community nursing centers. The most successful CNCs appear to be those who approach this task with innovation and dogged persistence. One final advantage which appears to be applicable is that "those who have get more." The most difficult part of creating a research environment in a CNC is developing a strategy and getting started. Success in this important area for nursing research will require a critical mass of professional nurses who are willing to face the challenge.

Data Sets: Usefulness for Practice and Research
Nursing centers have a tradition of valuing clinical data because of their involvement with research and informatics. Lang’s quote (Clark & Lang, 1992) "If we cannot name it, we cannot control it, finance it, teach it, research it or put it into public policy" underpins the philosophy of nursing centers. Qualitative research methods need to be used in nursing centers to produce sets of meaningful data that can be transformed into information and knowledge. However, data generated with quantitative methods may be even more critical for the centers. Counting data can be added to naming data in Lang’s quote in order to generate the information necessary for the growth and survival of nursing centers. Examples of nursing center data elements that need to be quantified as well as described include clients, nursing diagnoses, interventions, outcome measures, and costs.

Data Issues
Nursing centers offer our profession an ideal setting for the collection, sorting, analysis, use, and dissemination of valuable clinical data. When centers are compared to other nursing practice sites in a local community, the centers are often more recently established. Nursing centers tend to be smaller, more flexible operations in contrast to public health or home care agencies and other community-based organizations. Although diversity exists within nursing centers, the population served and programs offered may be more focused and homogeneous than other practice sites. The type of individual who becomes the director of a nursing center tends to be a leader with vision, motivation, and access to persons and resources that are necessary for developing and maintaining valuable data sets. In addition, many nursing centers have been funded by grants
that require automation. Therefore, some centers are partially automated as they initiate nursing services. This is in sharp contrast to other practice settings, many of which are struggling with the initial steps of a computer-based client record (Dick & Steen, 1991).

The principal data issues for nursing centers can be classified as theoretical, empirical, and practical. The categories were recently described in relation to automated nursing clinical data bases applicable to diverse settings (Hays, Norris, Martin, & Androwich, 1994).

Theoretical Issues
Informatics offers nursing centers remarkable tools for managing data. Automation is more efficient and effective, however, when a framework is used to organize the data elements (Meintz, 1993; National Center for Nursing Research, 1993). The Nursing Minimum Data Set (NMDS) is such a framework (Werley & Lang, 1988). NMDS categories include client demographic, service, and nursing care elements. When nursing centers decide to use the NMDS, they should select nomenclature for the data elements. Currently, all nursing centers are not automated; those that are automated are not all using the NMDS or one consistent standardized nomenclature. Therefore, while comparable data may be available within some nursing centers across time, data cannot be compared across centers.

The American Nurses Association (ANA) established a Data Base Steering Committee to explore nomenclature options in 1991. The ANA Committee decided to: 1) recognize four diverse classification systems that met research and practice-based criteria, 2) publicize the systems in a monograph scheduled for release in 1994, and 3) collaborate with the National Library of Medicine to include the systems in the Metathesaurus which is available internationally (ANA, 1993). The four systems are: North American Nursing Diagnosis Association (NANDA), the Omaha System, the Iowa Nursing Interventions Classification, and the Georgetown Home Health Classification. NANDA consists of nursing diagnoses that have been most frequently used in acute care settings (Carroll-Johnson & Paquette, 1994). The Omaha System is comprised of nursing diagnoses, interventions, and an outcome rating scale; it is used most frequently in community-based settings (Martin & Scheet, 1992). Because the Iowa Nursing Interventions Classification was designed for use with NANDA, it is also used in many acute care settings (McCloskey & Bulechek, 1992). The Georgetown Classification focuses on interventions generated by home health care agencies and includes some of the NANDA nursing diagnoses (Saba, O'Hare, Zuckerman, Boondas, & Oatway, 1991).

Empirical Issues
Clinical data generated by nursing centers can be used by the staff, administrators, faculty, and students to produce valuable information and knowledge. Accurate, timely data can lead to enhanced communication among clinicians, clinicians and administrators, and administrators and third party payers. Data can also facilitate documentation of services, quality improvement activities, and research. Many nursing center leaders recognize the value of aggregate data and use it to obtain community support, funding, and to influence public policy (Lundeen, 1994).

Although there are important benefits of using nursing center data, potential problems must be addressed. These include accuracy, reliability, validity, and aggregation (Hays, Norris, Martin, & Androwich, 1994). Both clinicians and clients influence accuracy and can contribute to omissions and errors in the data set. Reliability and validity issues must be considered in relation to practice and documentation patterns of individual clinicians as well as nursing center policies and procedures. Documentation is rarely a priority for clinicians. It may be negatively influenced by factors such as personal characteristics, time pressure, reimbursement regulations, and the environment (Hays, 1989; Martin & Scheet, 1992; Morrissey-Ross, 1988; Zielstorff, Hudgings, Grobe, &
NCNIP, 1993). Producing and using aggregate data occurs infrequently in service settings. Too often, data are entered into a computer and then buried in data cemeteries.

Practical Issues
For maximum benefits, the content and organization of automated nursing center data sets should be determined by all users before the nursing center becomes operational. Ideally, users will be considered customers according to the philosophy of quality improvement. Users will be asked to consider who, why, when, how, and how much in relation to clinical data and data sets.

The data content and organization needs of user groups differ. Clinicians need a clear history of client-specific data as they provide services to individuals, families, and groups. Group work is an important service of many nursing centers, frequently including nutritional, prenatal, parenting, family planning, disease prevention, and screening services. Regardless of who is the recipient of service, clinicians need data that are comprehensive yet brief, and documentation methods that are user-friendly. Although nursing center administrators may be interested in client-specific data, they are more likely to need group or aggregate data for program planning, staffing, updating volunteers, reporting to established funding sources and accreditors, and obtaining new sources of funding. Both aggregate data and individual case studies can produce powerful information to influence policy formation. Faculty and students are a significant user group because so many nursing centers are joint education-service efforts. Both faculty and students may provide direct service and use clinical data in research.

Control and cost of information are critical issues for nursing centers. Differences of opinion frequently occur among users as documentation and automation decisions are made. Nursing center directors need to give thoughtful consideration to benefits versus costs for both immediate operations and the future. When a nursing center is a part of a larger organization, whether that is a college of nursing or a neighborhood health and social services program, control and cost become entangled in various issues. The nursing center director and staff need a clear vision about data sets initially and then must review that vision periodically.

Potential Benefits
Data sets generated by nursing centers have significance for nursing practice and research. Data can be converted to information and knowledge which describe client care outcomes, acknowledge professional achievement, and quantify practice. Such powerful data will facilitate reimbursement, enable nurses to conduct sound research, and influence public policy.

Nursing Centers: Policy Issues
In order to assure that nurses are allowed to practice to their optimal ability, thereby further expanding patient access to care, and to assure that adequate funding of nursing centers is available, policy issues and implementation strategies need to be shared among nurses and policy-makers. Much can be learned and shared among states within the Midwest because a large number of nursing centers exist within these states and policy development at both state and federal levels could be better informed through such information.

The purpose of this study was to replicate and extend a previous study (Frenn, 1989) to examine the major policy issues affecting nursing centers in the Midwest. The specific research questions were:

1. What major policy issues affect nursing centers in the Midwest?
2. What changes in policies affecting nursing centers are forecast by identified experts in each state?
3. What specific legislative and administrative rules currently govern advanced practice, payment for nursing services, and prescriptive privileges for nursing centers in each state?
4. What barriers exist to prevent further development and maintenance of nursing centers?

Method and Sample
Experts on nursing centers in the Midwestern states were surveyed by telephone. A snowball technique was used such that the experts were asked to respond to the survey and also to suggest other experts who could shed further light on the questions asked. The initial sample of experts was obtained from members of the National League for Nursing Council for Nursing Centers, Midwest Nursing Research Society members, and state nurses associations. Nineteen experts responded to the survey questions, while seven others provided contact persons and analysis regarding reasons for barriers to nursing centers.

Instrument
The Nursing Centers: Policy Issues Survey was used to conduct the survey. This survey is an extension of the instrument used by Frenn (1989) and was reviewed by nurses knowledgeable about nursing center policy issues. The interviews lasted from 15 to 45 minutes. Following proposal review for protection of human subjects, potential respondents were contacted by telephone and the purpose of the study was explained.

Reliability and Validity
The interview proceeded following verbal consent. Responses were recorded on the survey as given. Data shared by respondents were compared and contrasted with information in the literature and with that obtained from other respondents to ensure accuracy. Issues were restated on completion of the response to also ensure accuracy.

Results
A broad definition of nursing centers was used for this study, i.e., that the center provide nursing services and that the chief executive officer was a nurse. Thus defined, nursing centers were located in all states in the Midwest. Had other elements commonly used to define nursing centers been used, all centers included would not have met the criteria. Some centers could not facilitate direct access to all clients, e.g., centers serving faculty and students, that were not funded to enable access to underserved groups and centers that operated on a fee-for-service, for-profit basis. Other centers would not have met the element of nurse-owned, e.g., nurse-operated home care agencies, state-funded school primary care centers operated by nurses.

Answers to research question 1: "What major policy issues affect nursing centers in the Midwest?" were: a) lack of prescriptive authority, b) restrictive Nurse Practice Acts, c) insufficient reimbursement for services, d) competition versus collaboration between nursing and medicine, e) a need for multisectoral policy development, and f) public perceptions that only physicians provide health care. The answer to research question 2: "What changes in policies affecting nursing centers are forecast by identified experts in each state?" given by all respondents was health care reform. Answers to research question 3: "What specific legislative and administrative rules currently govern advanced practice, prescriptive privileges and payment for nursing services for nursing centers in each state?" are shown in Tables 1 and 2.

Title authority for advanced practice was absent only in Ohio. However, legislation is in process to establish such authority and three university-based pilot projects including title authority, prescriptive authority, and reimbursement are in process in Ohio. States were in various stages of adopting full or protocol-based prescriptive privileges as shown in Table 1. States are listed in order of greatest to least prescriptive authority. Reimbursement by third party payers, Medicare and Medicaid, and other sources, such as state or grant funds is shown in Table 2 with the states ordered according to Table 1 for comparison across issues.

TABLE 1 Prescriptive Authority in Midwestern States in Order of Greatest Authority
<table>
<thead>
<tr>
<th>State</th>
<th>Type of Practitioners</th>
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<tr>
<td>IO</td>
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<td>IL</td>
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<td>OH*</td>
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*No Title Recognition for Advanced Practice

S=With MD Supervision; P=Full Pending; NP=Nurse Practitioner; CNS---Clinical Nurse Specialist; CNM=Certified Nurse Midwife; CRNA=Certified Registered Nurse Anesthetist

TABLE 2 Reimbursement for Nursing Services in Midwestern States

<table>
<thead>
<tr>
<th>State</th>
<th>Type of Practitioners</th>
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<td>OH*</td>
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* % OF MD

A=Legislative Requirement; B=Some Voluntary; F=Federal; P=Pending; T=Trial Project in Process

Research question 4 stated: "What barriers exist to prevent further development and maintenance of nursing centers?" Answers to this question included: a) clients who cannot access nursing centers because of restrictive entitlement requirements, b) unsupportive state or local departments of health, c) insufficient numbers of nurse practitioners to staff the centers, d) limits on advanced practice, e) difficulty in "staying afloat" amidst barriers to reimbursement and physicians who do not wish to collaborate, f) clients who did not have transportation to get to the centers (especially in rural areas), g) needs for better information management systems, and h) institutional barriers to further development of the nursing center.
Discussion

What costs are there to society because of these barriers to further development of nursing centers? The major issues described by respondents in this study concerned health care dollars, rural access, culturally appropriate care, and access to health promotion and prevention services. Respondents reported that health care dollars could be saved because nursing center-provided services often cost the consumer less than those provided in traditional health care systems. Rural health care also could be expanded if nursing centers provided chronic illness management and health promotion services, requiring rural clients to travel only for more acute health services. Nursing centers that provided culturally appropriate care, including bilingual services, reduced use of costly care provided in emergency rooms. Nursing centers also increased access to health promotion services, such as school-based clinics, caregiver support groups, and stress management classes.

Why are some states further along in developing a climate conducive to nursing centers? What does this mean for the future of nursing centers?

Some respondents said they were in very conservative states where not only legislators, but legislative assistants, consumers, and regulators also were equally restrictive in their views about nursing. This made progress in advanced practice or prescriptive authority difficult, however, even in the most restrictive of states, a nursing center had continued operating for eight years. As one respondent said, "Even when there were barriers, we found a way around them." Some of the states where elected leadership was conservative also had some of the least restrictive policies governing nursing practice.

Payment for services continued to be a problem across states even though a multitude of approaches were used to maintain centers, such as state funds and foundation grants. Nurses in a few centers found it difficult to get grant monies because of their for-profit status. Medicaid/Medicare reimbursements continued to require lengthy forms and delayed payment to nurses. Federal legislation passed in 1989 still has not been fully implemented in some states to enable nurses to receive Medicaid and Medicare reimbursement.

Health care reform continued to be the most often cited response regarding what policies likely would change. Several respondents expressed concern that health care reform may be problematic for nursing centers in that PPOs often do not accept nurses as autonomous providers and clients of such a medical practice then could not use the nursing center.

A continual theme in responses was that people in states successful in accomplishing an environment conducive to nursing centers had stayed with the struggle, involved students in contacting policy-makers so as to socialize a new group of nurses into the notion that policy is important to nursing practice. As one said, "When students see someone they know giving testimony on TV and writing letters, these activities begin to assume the importance they require for nursing to stop being its own worst enemy and to move forward!"

References


