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Nurse practitioners in academic nurse managed centres: A new and emergent opportunity for Australian nurses

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Summary  Nursing traditionally has split the career paths of practice, teaching and research. This has limited utility in a healthcare world that is rapidly changing in terms of clinical practice and institutional structures. Academics to be relevant need to remain professionally engaged. Faculty practice is one way for Emergency Department Nurse Practitioner academics to do this. The recent inclusion of Nurse Practitioners as providers in the federally funded Medical Benefits Scheme and the Pharmaceutical Benefits scheme has afforded a context of do ability. The American experience of integrating Nurse Practitioner practice into academia took the form of faculty practice within an Academic Nurse Managed Centre model. The establishment of such a model was innovative, yet the majority of Academic Nurse Managed Centres experienced significant difficulties in management and self sustainability. This paper explores faculty practice in Australia and lessons learned from the international literature to ground the project of Emergency Department Nurse Practitioner faculty practice. © 2010 College of Emergency Nursing Australasia Ltd. Published by Elsevier Ltd. All rights reserved.

Introduction

It is well recognised that factors shaping emergent roles for nurses and nursing include changing population demographics, disease patterns and continued health reform or restructure.1 Reflecting these changes and demands the practice of nursing will continue to evolve and advance. In response, nursing academics must engage with the challenges and opportunities presented by this changing landscape to create new roles and recognise opportunities. Emergency department (ED) nurse academics need to remain immersed in practice to stay contemporary in the rapidly changing health landscape. While scholarship has traditionally been considered as extant within the narrow field of research only, Boyer advocated that the scholarships of teaching and practice be embraced in the same manner

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as the scholarship of research. The challenge for nursing academics is how to develop strategies that integrate these domains of scholarship, at the same time recognising and rewarding each of these different, but evenly weighted domains. As a way forward, this paper considers the viability of integration, and hence true scholarship through ED Nurse Practitioners employed in academe in Australia. This is not the first review of the literature to spark enthusiasm about faculty practice in Australia through developing Academic Health Centres. The novelty is debate in the context of the new enabling federal funding for Nurse Practitioners to seek reimbursement for nursing services through the medical benefits scheme (MBS).

How to manage the varying degrees of investment in the elements of scholarship in line with the ideas written about by Boyer has been problematic in nursing, reflecting historical divisions of labour and conceptual and contextual frameworks that have sustained an artificial division between research, practice and education. In the absence of formal recognition within workload allocation models, nurse academics are often faced with the option of "moonlighting" in the clinical setting to engage in nursing practice. At the other end of the spectrum descriptive accounts identify how faculty practice can be integrated within academic roles through models such as academic nurse managed centres (ANMCs). Such centres provide opportunities for practice, research and education while acknowledging the interrelated nature of knowing, teaching, practice and service.

Although the benefits of faculty practice are widely espoused, Australian universities have been slow to establish practice environments and opportunities for nurse academics. It has been said that "faculty practice has all but disappeared" from Australian higher education, with academic nursing practice minimal and often problematic. However with any challenge, new opportunities and innovative solutions to the challenge arise. The lack of access to the MBS and pharmaceutical benefits scheme (PBS) has traditionally proven the barrier to Australian Nurse Practitioners practicing out-of-side of the government health care system. The recent passing of the Health Legislation (Midwives and Nurse Practitioners) Bill in Australia in November 2009 affords Australian Nurse Practitioners access to the MBS and PBS, with it, the independence to pursue more innovative and entrepreneurial avenues of nursing practice.

It is on the background of these changes that we look to the international literature to find opportunities for integrating the expanding capacity of Nurse Practitioner practice into Australian universities. Conceptually we draw together the concept of ANMCs and the possibilities for Nurse Practitioner faculty and discuss how to utilize the current funding environment to allow the emergence of planned faculty practice.

**Academic nurse managed centres and faculty practice**

ANMCs are defined as health centres owned and operated by a university school of nursing with the aim of providing opportunities for faculty practice and research, a training ground for new practice and educational models, and student clinical placement. These centres are predominantly described in the American context, staffed by faculty employed Nurse Practitioners with nursing services financially reimbursed. Accountability and responsibility for client care remains with the Nurse Practitioner. By bringing nursing practice onto the university campus, ANMCs provide opportunities for teaching that reduces the perceived theory practice dichotomy. Particularly as students observe those teaching demonstrate the expertise of nursing and the possibilities of extended nursing practice. In the context of the ED Nurse Practitioner practice is often channelled through primary care clinics.

There is limited literature on the research output of faculty practicing within an ANMC, however one descriptive survey study of 29 faculty members, 13 practicing in an ANMC and 16 non-practicing found that practicing faculty members were more likely to be involved in scholarly research. In terms of scholarship, currency of academics and integration is axiomatic, but the body of the literature is limited by the descriptive and opinion based nature of the publications. Reporting on faculty practice to the Australian and New Zealand Council of Deans of Nursing and Midwifery, Holmes identified through a survey of Australian academics conveniently sampled through personal correspondence and telephone interviews, that nursing faculty engage in clinical practice in an ad hoc manner in order to maintain their currency and/or professional registration. An earlier survey by Worrall-Carter and Snell of 20 Australian academic’s experience of research and writing for publication also highlighted that nurse academics found it difficult to integrate research into academic teaching. Similarly in the UK, Williamson reviewed 13 studies related to faculty practice and identified that in the context of engaging practice, faculty often experienced, role conflict, stress and burnout.

In Australia in the late 1980s there were a number of unpublished feasibility studies by Australian Schools of Nursing into nurse led Primary Health Care Centres. The proposed centres did not eventuate, mainly out of concerns over reimbursement for services and financial viability. A recent search of all Australian university websites identified four university based health care centres in existence in Australia. These are not nurse managed, and tend to facilitate the learning of other healthcare disciplines. One centre currently offers the services of a Nurse Practitioner in wound care who is not as yet integrated into an academic faculty position.

There is a plethora of discussion within both nursing academic and economic nursing literature about the important elements necessary to successfully establish and sustain an ANMC. While many of the American ANMCs serve patients who have no healthcare coverage and limited ability to provide financial reimbursement for nursing services, the Australian health care landscape, where 99% of Australia’s 21 million people are covered under the MBS provides a very different context. It is anticipated that Australian ANMCs will not be plagued by
the issues of financial viability that saw a percentage of American ANMCs close their doors. However, to realise this possibility and move forward as nurses in a scholarly manner it is fruitful to explore lessons learned from academic practice described in the literature. Whilst the opportunity is new in Australia, a careful synthesis of lessons reported in contemporary nursing and healthcare literature, although largely descriptive in nature, enables building on many years experience. If anything can be learned from the American experience of developing and sustaining ANMCs, it is that a centre’s chance of survival increases if careful thought is given initially to all aspects of its development.

Establishing an academic nurse managed clinic

Operating a successful ANMC demands skills not only in nursing, but also in principles of organisational theory, financial management and budgeting, program planning and evaluation, and personnel management. One of the first priorities in establishing an ANMC is determining the mission. The importance of establishing a mission consistent with that of the parent university and the school was born out in a review of 10 years of data from four ANMCs which confirmed the value of the ANMC to the university reflects the closeness of this fit. In determining the mission, consensus must be reached on whether the purpose of the centre is community service, or whether it is primarily a vehicle for faculty practice, clinical placement and research. A community service priority requires primary engagement with the local community, while a mission focused more on teaching and research will reflect the priorities and areas of faculty practice and research.

Once the mission is defined, strategic and business plans that detail long and short-term goals, priorities, the outcomes to be accomplished, and the range of service and service providers are required. Accessing payment through MBS for Nurse Practitioners requires careful business planning and consideration of nursing practice as a business commodity. Nurses often have a significant sense of social justice and charging for nursing services they have traditionally offered at no cost at the point of delivery may create dilemmas and lead to a reluctance to charge the market price for services.

Accordingly consensus on fee structure needs to occur early in the planning of the centre and be aligned with the overall mission. If a Nurse Practitioner is conducting private practice within the confines of the ANMC, then fee for service over and above MBS is a matter for the individual practitioner’s consideration. On the other hand, if the university ‘releases’ a Nurse Practitioner from academic responsibilities in order to practice in the ANMC for a day, this may raise questions of how much does the Nurse Practitioner owe the university in wages, infrastructure and other associated costs. The cost to a university for releasing an individual Nurse Practitioner will vary depending on the level of academic seniority of the Nurse Practitioner academic and this may need to be factored into the fee for service set for clients.

Three possible workload models emerge for consideration. Nurse Practitioners can be employed on a full time basis within the university faculty, with release from academic responsibilities to practice in the clinic. Alternatively Nurse Practitioners may be employed by the university on a part-time basis and work as private practitioners in the clinic. A Masters prepared Nurse Practitioner employed in full-time clinical practice within the health care system may not be equally financially rewarded upon entering academic life, therefore consideration may be given to a third workload model. This model employs the Nurse Practitioner in academia on a full-time basis and allows for a portion of the financial reimbursement for services generated at the Nurse Practitioner’s clinic to be paid to the Nurse Practitioner.

When determining the model of care it must be taken into account that Nurse Practitioner faculty are also engaged in teaching and research. To ensure sustainability and prevent fragmentation of service a suitable model of care such as one based on a consultancy delivering episodic care, rather than case management needs to be considered. Under this type of model the Nurse Practitioner would refer clients back to the primary health care provider for ongoing case management. The need to consider this type of approach can be born out in Nurse Practitioner faculty surveys by Pohl et al. (n = 452, 50% response rate) and Jones and Norton (n = 128, 50% response rate) that demonstrated Nurse Practitioner faculty typically practiced in the ANMC up to 16 hours per week.

Formulating the workload model is vital and influences issues such as financial reimbursement for services and who is responsible for the provision of professional indemnity insurance of the Nurse Practitioners practicing in the clinic. As it is a requirement of Nurse Practitioner practice in Australia that they carry professional indemnity insurance this issue also poses the question of whether Australian university insurance policies extend to cover Nurse Practitioners engaging in actual clinical practice. When faculty practice is incorporated into integrated models of scholarship, and all financial income for the service provided goes to the university, then it would seem feasible that professional indemnity is covered by the university. However, the Nurse Practitioner is employed on a part-time basis by the faculty and conducts a private practice within the ANMC with all income contributing to the Nurse Practitioner’s income, then Nurse Practitioners will require professional indemnity coverage through a private insurer. How the reimbursement for nursing services will be processed is another issue that will need to be addressed. King found that most academic business offices did not have the adequate infrastructure to accommodate or account for reimbursable services generated by the centre. Reporting findings from a national survey of the coding and billing practices of 33 American ANMCs and an earlier retrospective study of a year’s worth of financial data from 6 ANMCs it was reported that Nurse Practitioners were not vigilant in their recording of the appropriate codes, and often under claimed costs in order to avoid patients having out of pocket expenses. While the coding and billing systems for financial reimbursement of nursing services in America may not be entirely the same as those proposed for Australian Nurse Practitioners using the MBS, it might be anticipated that...
Australian Nurse Practitioners will require education and support around billing practices. Meticulous coding and billing practices are required not only for financial reasons but also the collection of service and demographic data that can be fed into service evaluation as well as informing external competitive grants and increasing the visibility of the centre at the health policy level. Upon reviewing the historical literature on American ANMCs, it is apparent that while individual centres gathered and published details on client demographics, services provided and patient satisfaction, there was until recently a significant gap in the literature describing patient health outcomes. This observation is not to dispute the fact that significant patient health outcomes were achieved, merely that the recording and publishing of such data was not present in the literature and therefore the contribution of ANMCs and the achievements of the Nurse Practitioners who worked in them remained invisible. It would be beneficial to Australian faculties to be mindful of this observation and determine to set and record healthcare outcome measures early in the establishment of an ANMC.

ANMCs provide a service not only to clients, but also to students on clinical placement and faculty maintaining currency of practice. In developing the minimum data set consideration should be given to collecting patient demographics, medical diagnoses, nursing diagnoses, services offered, nursing interventions, nursing outcomes, and student and faculty data. Quality indicators such as patient satisfaction, student evaluation, and practitioner satisfaction will also prove valuable sources of information in shaping and growing the ANMC. Collection of such data not only contributes to building the evidence behind evidence-based practice, it ensures healthcare data is used to increase visibility through publication and provides support for further applications for funding at the state and federal level. Further, strategically, recruiting ED Nurse Practitioners and other Nurse Practitioners with specialties in line with the National Healthcare Strategy priorities will enable health outcome measures to be reported that directly address national benchmarks.

Conclusion

In outlining the possibilities for innovation and integrated scholarship created by Nurse Practitioners employed in academe and practicing in ANMCs we have shown the concept has strong merit in the current Australian healthcare landscape. For nursing, this opportunity presents a perfect fit for the integration of education, research and practice. The American experience of development of ANMCs provides strong lessons for Australian universities. The challenge of integrating a viable health business and practice within academe requires careful consideration of the mission, requisite business systems, and strategic development of a program of research and academic practice. The ANMC may well provide a workable model in which ED Nurse Practitioners can engage in faculty practice.

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References


