NURSE PRACTITIONER'S ABILITY TO IMPACT CHANGE FOR THE UNINSURED

By

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Nurse Practitioner’s Ability to Impact Change for the Uninsured

Abstract

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In health care treatment disparities persist which represents a major health and social challenge. As our country’s jobless rate soars to record levels, many have experienced the reality of trying to obtain health care and insurance that is too expensive or not available. The reality is people are dying because of lack of health care from preventable causes. Two models of care that currently exist to provide care for the uninsured population will be acknowledged and discussed. Safety net clinics and academic nurse managed centers (ANMCs) represent innovative ways to care for the uninsured which helps to bridge a health care system gap. Greater emphasis will be on the ANMC model, for the continuum of direct care, clinical practice, and research contributes to the development of heightened student awareness of the uninsured needs though socialization, understanding and skill in human diversity and sensitivity.

Nurse Practitioners (NPs) can aim to make a real difference of service by participating and building relationships in their communities which can have an impact and improve the lives of the patients in the short term until the fight for long term systemic health reform is achieved. We are at a crucial juncture in the health policy debate for the best strategies to provide universal coverage.
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According to the United States Census Bureau (USCB), 46.3 million people, or 15.4 percent of the population under the age of 65 did not have health insurance in 2008. This percentage has been rising steadily at a rate of 0.25 percent each year over the previous two decades. The number of people covered by employment-based health insurance decreased by one million from 2007 to 2008 (US Census Bureau [USCB], 2009). At the start of the recession in December 2007 the unemployed rate was 7.7 million persons, which equaled five percent of the population. The last survey in December of 2009 revealed that the number of unemployed increased to 15.3 million with the unemployment rate at ten percent (Bureau of Labor Statistics [BLS], 2009). As our country’s jobless rate escalates to record levels many Americans have experienced insurance rates which are too expensive or unavailable due to the current link between employment and access to an affordable health care system. Strong causation occurs between health insurance coverage and access to health care services. Americans who do not have health care insurance are at risk for poor health as a result of their lack of coverage (Institute of Medicine [IOM], 2002).

**Background of the Problem**

A recent study in accord with earlier research by prior investigators linked as many as 44,789 adult deaths between the ages of 18 to 64 per year in the United States (U.S.) attributed to lack of health insurance (Wilper, Woolander, Lasser, McCormick, & Himmelstein, 2009). The insured have access to health maintenance and preventative services which result in subsequent overall better health and earlier comprehensive intervention when ill (Deck, 2008). Many people walk a fine line between health and illness without the safety of health insurance (Orne Fishman, Manka, & Pagnozzi, 2000). In the U.S. health care model, equal treatment does not exist and
disparities prevail, the reality sometimes being when people need health care the most they have no insurance and hence cannot access the system which might help them.

In humanistic nursing theory, an existential phenomenological approach develops from the idea that both nursing and the nurse’s existence can be understood by uncovering phenomena (Kleiman, 2002). A phenomenological study was developed to illuminate the experiences of the uninsured through personal narratives. Dominant themes of the findings were uncertainty, vulnerability, fear, lack of self-esteem, marginalized existence, disenfranchisement, and apprehension about the future experienced by the study participants. The authors maintained critical social consciousness perspectives to analyze their findings and provided a glimpse of the uninsured ignored by health care providers (HCPs), the public, and policy makers (Orne et al., 2000). The International Center for Health and Society (2003), as cited by Jecker, states that social beings need to feel useful, valued, appreciated, have friends, sociable societies, and a degree of control over meaningful work and “without these we become more prone to depression, drug use, anxiety, hostility and feelings of hopelessness” (Jecker, 2008, p. 7). This essential study not only gleans significant feelings experienced by the uninsured population but it also provides a connection possibly bridging the gap to health reform. “By providing a window into individual life stories, qualitative or humanistic studies can help reframe the issue of health insurance so that instead of appearing through the lens of commerce, it can be seen with the eyes of benevolence” (Burman, Mawhorter, & Heede, 2006, p. 637).

**Purpose**

The American Nurses Association’s (ANA) purpose is to foster high standards within the nursing profession and articulate the social contract in accordance with nursing and society established by a *Code of Ethics*. ANA’s cornerstone policy is through standards of competency
and professional performance. There are currently fifteen standards of practice. Number twelve concerns ethics pertaining to integrating ethical provisions in all areas of practice. ANA developed a moral Code of Ethics, which guides nurses with ethical obligations within a framework for social contract within the society served. Provision eight states, “The nurse has a responsibility to be aware not only of specific health needs of individual patients but also of broader health concerns such as world hunger, environmental pollution, lack of access to health care, violation of human rights, and equitable resources” (American Nurses Association [ANA], 2001: p.23). Applying ethics to health care means putting our social values into practice. Values of compassion, stewardship and justice are paramount for achieving ethical aims of health care with a focus on society (Forsyth et al., 2008). For eight consecutive years the public has repeatedly validated nursing as the most ethical and trusted of all professions (Gallup Poll, 2009). Nurse Practitioners (NPs) are an essential dynamic part of society and a segment of the health care system. Therefore social responsibility needs to be relevant and evolve towards the broader changes in the phenomena of the American healthcare system.

Nurse Practitioners (NP’s) play a role in the health care system by improving the population’s health. NP’s academic curriculum is integrated within a science-driven paradigm through evidence based practice (EBP) and clinical practice guidelines (CPGs). EBP and CPGs provide scientific rigor to ensure quality patient care (Friedman et al., 2009). EBP and CPGs albeit credible and quality practice competency models exist largely and geared for the insured, broadly defined as those persons who have access to health care. This raises a moral and ethical dilemma in providing equal evidence based care by NPs if it is practiced solely within the confines of the insured population. There have not been any set competencies or guidelines in caring for the underserved or non-served. This is paradoxical considering the NP movement
began in 1965 in response to underserved and vulnerable populations (VanZandt, Sloand, & Wilkins, 2008). Out of eleven primary care NPs only one NP had taken an ethical course or even had ethics integrated into their nursing education curriculum (Beidler, 2005). Within core health care a parallel needs to exist between a joint ethical paradigm and a deliberate scientific approach. The Code for Nurses reflects constancy by the identification of virtues and norms and change in relationship to interpretation of those virtues, norms and growth of the profession. “It is comforting to note that moral duties and values of the profession were set in place long before the dizzying and sometimes chaotic forces of contemporary science and technology added to the burdens of clinical decision making” (Fowler, 2008, p. xviii). NP’s may not always identify the Code of Ethics as their guide to practice as cited by Beidler but most will articulate their commitment, caring, and advocacy of their patient. The broader advocacy role of equitable access to health care is also a fundamental part of NP’s social responsibility. Ethical vision and concern are relevant to the potential strategies that NPs might use to make a difference in the lives of the uninsured.

The NP’s commitment to ethical practice is challenged by the traditional health care delivery system not making measurable gains towards meeting the needs of uninsured and vulnerable populations. The longer people live with this disadvantage the more likely they will suffer from a variety of health problems. The ethical values and essence of compassion, stewardship and social justice will provide context and frame the literature review directed at providing care for the uninsured by NPs at present, and moving forward, always cognizant of the accomplishments of the nurse leaders and activists of the past: Lillian Wald, Margaret Sanger and Mary Breckenridge. Understanding the accomplishments set forth by our past leaders is inherent to creating a desired evolved future, from the past is preparation for our future. For these
nurse leaders helped raise awareness of a need for health care reform and championed change that helped improve the well being of society.

Compassion will drive the virtuous ethical models of care based on volunteerism by NPs through safety net clinics. "Caring and compassion begets healing for self and others" (Shiau & Chen, 2008, p. 369). Stewardship will be explored as a utilitarian ethical model directed at the nursing education curriculum serving as a catalyst for prepping NPs to care for diverse, underserved, and vulnerable populations. The lack of recognition of socioeconomic variations in disease etiology and management highlights the limitations of the current education programs that prepare NPs for practice in a diverse environment (VanZandt et al., 2008). Socioeconomic success or failure, resulting in a lack of health insurance, can significantly depend on factors well beyond a person’s control (Banja, 2008). Access to health care is a result of human agency and the policies that governments make and are always subject to change (Jecker, 2008). Health care reform as framed by ethical and moral justice is contributed by our Greek philosophers “that all equals should be treated equal” (Santa Clara University [SCU], n.d.). Equal access to fundamental health care will provide an enhanced environment for distributive justice and, hence, a better quality of life for the society as a whole.

**Review of Literature**

A broad literature search was conducted with the electronic databases CINAHL and PubMed using the key words “uninsured” AND “health care” AND “nurse practitioner” with search criteria after 2004 revealed over 1,500 articles with the majority describing health care reform imperatives. Using key words “uninsured” AND “healthcare” AND “ethics” with search criteria after 2004 to 2009 revealed over 31,000 articles providing a vast array of subjects dealing
with mental illness, illegal immigrants, universal health care, HIV, disparities and more. Thirty four articles were attained using the key words, “uninsured” AND “health care” AND “free health care” AND “safety net clinics.” “Nurse Practitioners” AND “nurse managed health care clinics” AND “uninsured” revealed a scarcity of five articles. The articles that included nurse managed health care centers (NMHCCs) reference citations were used as well as an even broader Google search since there were so few articles written. In keeping within the broader context of compassion, stewardship and social justice the literature review will be directed towards exploring some current models of community care used for the uninsured and the examination of the Institute of Medicine (IOM) meta-analysis on the consequences for adults who lack coverage.

Volunteerism through Safety Nets

A recent study (Geletko, Beitsch, Lundberg, & Brooks, 2009) was completed in an attempt to encourage volunteerism among health care providers (HCPs) at free standing clinics or caring for patients in their private facilities in the state of Florida. The success of the program was related to reports of collaborative relationships in the local communities that evenly distributed the burden of providing charity care. HCPs reported a renewed sense of camaraderie in their profession and a commitment to their community. The number of health care volunteers increased to close to 20,000 and the total number of patient visits was 290,026 from 2006-2007.

Analysis of randomly selected representative sites within the U.S. community health centers or free clinics revealed that numerous community based approaches for providing care for the uninsured are invaluable but only serve a small portion of residents. This is due in large part because there is greater reliance on funding by the private sector. Charity care also referred to as donated care will be challenged with increased financial and time pressures. Donated care has been a prevalent model since the mid to late 1990’s with one of the earliest models being
Project Access which began in 1996 and provides primary and specialty services. In 2006 at least forty U.S. communities adapted that model (Taylor, Cunningham, & McKenzie, 2006). Project Access provides care for the uninsured without undue burden on any one provider group.

Authors of an interim report from the Project Access of Northwest Oregon and Washington (PANOW) (Burke, Hascall, Hehnke, Sleeger, & Owen, 2009), summarized comprehensive qualitative and quantitative data prospectively from the first day of client service, March 2008 until June 30, 2009. The enrolled clients tallied 1,339 who varied demographically by gender, homelessness, race/ethnicity and age. Prior to access to PANOW, 42% had been to the emergency department (ED) six months prior to enrollment. The proportion dropped significantly to 26% after enrollment. Client satisfaction rates, with one being the worst and ten the best, scored an average ranking of nine. There was an improvement in self reported health status. The providers surveyed reported 66% agreed that PANOW added value to the community.

Three outcome variables were analyzed in a retrospective cohort design study (Gill, Fagan, Townsend, & Mainous, 2005) in Delaware: Emergency Department (ED) visits, hospital admissions and satisfaction with health care at a Community Healthcare Access Program (CHAP). ED visits decreased from 10% to 4% after enrollment. The numbers hospitalized before and after did not change, with most hospital visits being unavoidable such as surgery or pregnancy. Satisfaction scores increased from 9% to 46% and the percentage who rated their care as poor to fair decreased from 9.5% to 3.7%. The positive results were most attributed to having a regular source of care with follow up of preventative services with improvements in cholesterol and breast and cervical screening.
Data were collected in an ethnographic study (Duffy, 2006) involving in depth patient and staff interviews in the Midwest over a five month period of time. The purpose of the study was to provide HCPs an understanding of the patient’s views towards the professional relationships and delivery of health care in the free clinic setting. The patients reported that they felt respected and the care was genuine and humanizing. Comments by the staff reported that the free clinic was integral to the community but constrained by limitations of care.

**Academic Nurse Managed Centers**

Few studies exist that describe the community’s response to academic-nurse managed centers (ANMCs). Community focus groups ranging in size from three to nine with 37 participants representing four universities in the Michigan Academic Consortium were evaluated by the Michigan Public Health Institute (MPHI) (Pohl, Barkauskas, Benkert, Breer, & Bostrom, 2007). The demographics included 23 females, 14 males and all over the age of 18. Four main themes were identified: valued patient centered care, quality of care, increased access to care of the safety net and evidence of outreach. Participants commented on the importance of having a particular NP because of familiarity and comfort level they valued coordination of care through case management as a gateway to specialty services. Participants described their care as quality through responsive caring, listening and the time taken.

A task force from the Temple University Department of Nursing organized a feasibility study of a proposed nurse-run, nurse managed health care center in Philadelphia (Rothman, Lourie, Brian, & Foley, 2005). A community assessment was performed by senior nursing students revealing high unemployment rates, low education, and 66% of people living below the poverty level. The multiple health problems included teenage pregnancy, inadequate pre-natal care, premature births, low birth weight babies, high infant mortality, tuberculosis (TB) and
sexually transmitted infections (STIs). The vision of the Temple Health Connection (THC) was to meet the primary care needs of the neighborhood including family planning, disease prevention and health promotion programs. Over nine years of service to the bordering neighborhoods of TMC revealed positive impacts and outcomes. In 2004, there were over 5,263 primary care encounters, 15,385 disease prevention/health promotion encounters which included: prenatal classes, postpartum and elderly home visits, parenting classes, lead poisoning prevention, asthma education, after school camp, teen groups, exercise for cardiovascular health, tobacco education, and health and educational screenings. Evaluation of the program revealed improved self- esteem and an increase in the number of teens seeking family planning services prior to their first sexual encounter. The child immunization rate increased to 91% at two years of age. Inpatient days ranged 5-29% below compared to other primary care practices. Birthing rates to mothers under the age of 18 decreased by 61%. Fewer visits to the ED were reported by parents of asthmatics. With the increase in STI screening at the clinic hypertensive readings were documented at the screening and 53% of the patients returned for blood pressure (BP) readings and subsequent treatment provided. Establishing broader primary care services provides the opportunity to intervene prior to the onset of more debilitating and costly illnesses. The fees to the uninsured were by sliding scale.

The University of Maryland’s School of Nursing (UOMSON) demonstrated that a nurse-managed community based practice model is valuable to the states health care delivery system for the uninsured, underserved populations (Heller & Goldwater, 2004). The UOM developed the Governor’s Wellmobile, which is a full service health clinic van. This concept not only met the primary care needs of the community but provided clinical learning sites for the undergraduate, graduate, doctoral students and faculty. The benefits became evident that three
more vans were obtained from grants to expand care. The Wellmobiles are fully equipped with exam rooms, laboratories and receptions areas. They travel regular established routes and offer curbside care throughout the state. The undergraduate students learn the roles of the NPs through observation and experiential learning in community health nursing with an emphasis on primary culturally competent care, health promotion, and disease prevention. In 2009 the Wellmobile program provided 4,762 primary care visits, and 2,903 clients were tested for high risk behaviors, and 783 of Maryland’s children were assessed through outreach programs and eligible for Maryland Children’s Health Program (MCHIP) applications.

Another innovation within the UOMSON is a nurse managed center named Wellness Centers. The Wellness Center works in collaboration with the UOMSON and the school system. The pediatric nurse practitioners (PNPs) and family nurse practitioners (FNPs) provide on site primary care services in elementary, middle and high schools and address unmet needs of children and adolescents. Advanced Practice and Community Health Nursing students are assigned to these sites for their clinical practicum under faculty supervision providing them with population based clinical experience (University of Maryland School of Nursing [UOMSON], n.d.).

The University of Medicine and Dentistry of New Jersey School of Nursing (UMDNJ-SN) implemented a nurse-faculty managed mobile health care project to improve access to care to underserved regions of the state (McNeal, 2008). The units serve as sites for clinical rotations for graduate and undergraduate nurses. All patients are assessed, diagnosed, treated, scheduled follow up care and referred for specialty care if needed regardless of the ability to pay. Screenings for health education, nutrition, physical exams, hypertension, diabetes, cancer, cholesterol, electrocardiography, lead poisoning, and sexually transmitted infections are
performed. The number of patient encounters range from five to twenty two per day. The project goals consist of identifying minorities at high risk for chronic disease, reduce morbidity of minorities already diagnosed with disease, reduce hospital admission rates, improve resource utilization, improve access to care, and implement patient education strategies.

The Difference Health Care Coverage Could Make to the Uninsured Population

The IOM committee has identified and reported potential impacts of health insurance on those that lack coverage through multi methodological observational studies (IOM, 2002). The appropriate use of health care reduces the burdens of disability and death due to chronic diseases such as cardiovascular, cancer, diabetes, depression, HIV infection, kidney disease and arthritis by screening, early diagnosis, and disease management. Patients with severe mental illness are more likely to die early from physical conditions and only 40-60% receive any outpatient treatments (IOM, 2002).

The lack of health insurance converges with other risk factors such as low socioeconomic level, lower educational attainment, and minority status. Low literacy skills may interfere with the ability to understand instructions, participate in medical decisions and environmental influences are also a determinant of poor health. Additionally HCPs are not always competent in cross cultural communication. Health insurance will not eliminate these disadvantages yet it may improve health related outcomes. Health insurance increases access to a primary HCP and this relationship is hallmark to quality health care. Chronically ill patients who require medications are more likely to follow their treatment if they have insurance coverage for their medications. What was learned from this large body of observational research on the impact of health insurance and providing those lacking insurance coverage included: use of more health care services, appropriate preventive care, and better management of chronic conditions.
Health care coverage is subsequently associated with better physical functioning health status and better quality of life, and better survival overall for patients with the aforementioned chronic diseases. Health insurance coverage needs to be acquired well before development of advance disease for later diagnosis increases mortality in cancer and cardiovascular diseases. The committee concluded that broad health care strategies across the uninsured population would more likely produce benefits of enhanced health than would rescue programs for the seriously ill. The research review did not examine patient satisfaction or quantify the sense of being valued when professional caring attention is provided which are just as real as improvement in survival rates.

Discussion

Health care reform in America is presently in a state of suspended transformation and the forces of change are stalled as the number of uninsured rise and continue to die from lack of care that comes late in the course of illness in the U.S. The big picture is one of national change while the little picture continues to be that people need access to health care. Patients without health insurance commonly rely on some type of “safety net.” Therefore the network of safety nets needs to be explored for the here and now.

The Project Access Model brings together medical resources in a comprehensive program providing free care to the uninsured by volunteer health care professionals. The commitment to accepting five to ten patients gratis in a community of HCPs allows the health care needs of the uninsured to be met without placing any undue burden on any one group or organization. (Uhlig, 2000). These models of care are generally associated with increased preventative care, decreased ED visits, and increased satisfaction. The donated care models are fairly limited by capacity and enrollment and there is difficulty in attracting and retaining HCPs.
and specialists. Charity care as cited by Taylor, Cunningham, and McKenzie (2006) is declining the last decade due to financial and time pressures. Some of the care is constrained by limitations of bare essential laboratory tests, X-rays, and medication choices.

Community health centers are a vital part of the health care safety net, and it is essential to understand their limitations as well as their strengths as alternative strategies are debated to address the needs of the uninsured (Gusmano, Fairbrother, & Park, 2002). Findings support beginning at the local level. The general limitations of safety nets in the community are patchy because of inadequate funding, lack of coordination, and high demand. Many clinics operate on a walk-in basis rather than appointments which can discourage patients from using safety net providers. The care may not be comprehensive as including preventative services but rather a patchwork of acute care and prevention determined by available resources (Nadkarni & Philbrick, 2003). Free clinics are dependent on a small group of local donors and vulnerable to the donor’s financial status. Clinics in poor urban and rural areas are at a fundraising disadvantage. Growth in the number of uninsured is a main threat to the safety nets. Nearly 1,800 free clinics and volunteer referral networks serve only 2.5 million people which is only a fraction of the need (Isaacs & Jellinek, 2007). “Free clinics as gap filling are not the answer for the uninsured. Free clinics are a band-aid on an intolerable system” (Jacobson, Dalton, Berson-Grand, & Weisman, 2005, p. 934).

The Wellmobiles and ANMC initiatives offer vital and innovated quality models of clinical nursing education as a teaching strategy that benefits the university, faculty, and the community that it serves. ANMC’s purpose is to provide educational experiences for students, a practice site for faculty, nursing services for the community, and a research site for nursing (Barger, 2004). Location within the colleges of nursing provides enriched opportunities for
student clinical experiences that provide a deeper appreciation of the difficulties and rewards focusing on the vulnerable communities and providing relevant responsive clinical experiences. Best practice guidelines in working with the uninsured population must be developed then modeled by faculty and students. The best vantage point from which to look at the larger world of health care and to address themes related to health care administration and financing is through primary health care clinics (Mason, 2001). Nurses realize their role in providing culturally competent care and developing a keen understanding of resources necessary to establish care and advocacy suited to the community needs.

The nursing models of care provide a focus on health promotion, disease prevention and case management. Cultural sensitivity gained from working with the uninsured is an important competency for all NPs to possess for this is tantamount to the skill necessary for human diversity and social issues (VanZandt et al., 2008). ANMCs are a pivotal bridge to quality, holistic, and innovative education that encompasses the seven core competencies set forth by the IOM: quality, safety, effectiveness, patient centered, timeliness, efficiency and equity (Barger). These visionary approaches are a clarion call set forth by the IOM for the improvement of quality care through clinical education (McNeal, 2008). However, the ANMCs require multiple funding streams yet currently fewer resources are available.

NP's commitment to ethical practice is challenged by health disparities due to inequities of the health delivery system which can cause moral distress and burnout (Beidler, 2005). The ethics of virtue, with emphasis on moral character, is integral to the practice and socialization of NPs and needs to be incorporated into the educational process (Fowler, 2008). NPs are socialized with the same stereotypes as the general population and they must identity their preconceptions in order to develop compassion and concern about social trends and issues that have implications
for health care (Martino- Maze, 2006). ANA does not support one specific ethical theory but posits that virtue ethics can provide moral character and integrity. Teaching virtues requires a dynamic, sensitive, and nurturing approach. If virtue is knowledge then virtue can be taught and cultivated by role modeling of leaders, critical reflection through exemplars in life experiences, and reading then discussing literature dealing with moral problems (Begley, 2006). “A morally good person with the right configuration of desires and motives is more likely than others to understand what needs to be done, more likely to perform attentively the acts required, and even more likely to form and act on moral ideals” (Beauchamp & Childress, 2009, p. 32-33). Ethical awareness should be as salient as signs and symptoms of disease and calculating drug doses. Ethical issues arise while caring for vulnerable patients and a structure is needed to provide a coping framework to decrease moral distress. An ethical code as a system of principles reflects the responsibilities of the NP profession as guided by the framework of ANA’s Code of Ethics.

The ANA endorses a restructuring of the health care system to include high quality healthcare for all. ANA believes that a single-payer system is the most desirable with an emphasis on the use of advanced practice registered nurses (APRNs) providing community based primary care (Brotherton, 2008). ANA believes that health care is a basic human right as originally articulated by the World Health Organization (WHO). ANA states that the focus on primary care, prevention, and chronic disease can alleviate the more expensive acute care. ANA has recognized that individuals can shape public policy in the best interest of patients.

Conclusions and Implications for Nurse Practitioners

Volunteers benefit from the help that they provide as much as those receiving the services (Post, 2005). In our present day volunteers remain crucial to the health and welfare of many
people. One way to exemplify service leadership is by volunteering at a free local clinic. Participation in the community supports a strong image and provides visibility of tangible nursing excellence and camaraderie. The nurse leader can impact the healthcare delivery system on a large scale by clinical expertise and an understanding of systems (Hill, 2008). Nurses must show that our leadership is in the best interest and society at large.

Health care for the uninsured is not just a national policy but an organizational issue that requires local leadership by NPs. NPs have a commitment and responsibility to society by taking on leadership roles in the community and are in an excellent position to facilitate positive change for unmet community needs. The status quo is dysfunctional and ineffective and negatively impacts every aspect of society. Being medically uninsured can happen to anybody and safety nets are becoming a scarce commodity. “Ignoring a serious illness does not cure it: ignoring the illness of uninsurance is equally ill-advised” (Ahmed, Lemkau, Nealeigh, & Mann, 2001, p. 452).

NPs with strong ethical background have the familiarity of the complexities of the uninsured and can be actively engaged advocates for policy discussions. Participation in health policy increases public support of the profession which will strengthen nursing effectiveness (Drought & Epstein, 2008). NPs must be involved and in tune with the crisis and issues of the uninsured and be active in the grassroots community organizations and raise public awareness to work towards solutions for the public good. NPs can lobby state and federal government to expand health care to the uninsured and balance the budgets in other areas besides healthcare. It is time to bestow that level of trust that society gives nurses to campaign for guaranteed, high quality, affordable health care for all. “I am firmly convinced that nurses are capable of finding
solutions—maybe even cures—if we refuse to allow our imagination and forward movement to be thwarted by precedent....”(Mason, 2001, p. 64).

It is essential to be involved with advance practice nursing (APN) organizations whether that be ANA, American Academy of Nurse Practitioners (AANP) or American College of Nurse Practitioners (ACNP) as well as your state level affiliates, for NPs are collectively a substantial key to healthcare reform. We need more nursing involvement at the tables when health care policy and funding decisions are discussed that affect accessibility, quality, and the cost of health care. Legislators must be supportive of NP’s practice, billing, and revising federal guidelines to expand payments to ANMCs so EBP can be provided on a consistent basis for all. Our lack of universal health care is negatively impacting society and a mandate for change is imperative and urgent.
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