JULY 30, 1998

CONGRESSIONAL RECORD — SENATE
S9485

because they dared to quietly celebrate their faith. I speak as much for them today as I do in protest to the brutal killing of their fellow-believer.

This hour, I call on the Government of Iran to ensure the safety of these individuals, and call for the release of these individuals whose only crime was the sincere expression of their faith, which happens to be a minority religion. Most importantly, I call upon the government of Iran to provide freedom of religion to its people, and more famously to the peaceful yet brutalized Baha'i community.

I want to take this opportunity to commend the international community for its swift response to Mr. Rowhani's execution and urge other governments and organizations to vigilantly monitor the fate of the 15 jailed Baha'i, particularly the 3 jailed in Mashad presently facing the death penalty.

Religious persecution demands a tireless counter response; it demands a vigilance such as the one we held the principle of religious freedom to be a precious and fundamental right, something worth protecting, then we must always defend those who are wrongfully and brutally crushed for their faith by hostile national governments.

We cannot bring Mr. Rowhani back or right the wrong that was done to him and his family, but we can advocate against this happening again. Iran must abide by global human rights principles. Accordinly, Iran must release the fifteen Bahai who have been incarcerated for their faith. Iran must preserve the lives of those facing execution for their faith. Iran must honor its commitment to the religious freedom principles of the Universal Declaration of Human Rights and set these prisoners free.

NURSING SCHOOL ADMINISTERED PRIMARY CARE CLINICS

- Mr. INOUYE. Mr. President, I rise today to speak on an health issue of great importance now and in future years. As our population continues to increase, our elderly live longer, and healthcare technology advances, the need for access to care will undoubtedly also increase.

Because of these monumental increases in the need for healthcare access for many Americans, I wish to take this opportunity to discuss the need for support of nursing school administered primary care centers.

Nursing centers are university or nonprofit entity primary care centers developed (primarily) in collaboration with community based schools of nursing and the communities they serve. These centers are staffed by faculty and staff who are public health nurses and nurse practitioners. Students supplement patient care while receiving preceptorships provided by colleges of nursing faculty members, and are often associated with academic institutions, who serve as collaborators with nurse practitioners.

Nurse practitioners, and public health nurses, in particular, are educated through programs which offer advanced academic and clinical experiences, with a strong emphasis on primary and preventive health care. In fact, schools of nursing that have established these primary health care centers blend service and education goals, resulting in considerable benefit to the community at large.

Nursing centers are rooted in healthcare models established in the early part of the 20th century. Lillian Wald in the Henry Street Settlement and Margaret Sanger, who opened the first birth control clinic, provided the earliest models of care. Since the late 1970's, in conjunction with the development of educational programs for nurse practitioners, college of nursing faculties have established nursing centers. There are currently 250 centers nationwide, affiliated with universities and colleges of nursing in Arizona, Utah, Pennsylvania, South Carolina, Tennessee, Texas, Hawaii, Virginia, and New York. The Research Consortium, an association of eighteen nursing centers in New Jersey, Pennsylvania and Delaware, was established in 1996 to foster greater recognition of, and support for, nursing centers in their pursuit of providing quality care to underserved populations.

Nursing centers tend to be located in or near areas with a shortage of health professionals or areas that are medically underserved. The beneficiaries of the centers and their families have traditionally been the underserved and those least likely to engage in ongoing health care services for themselves or their family members. In the 1970's, I sponsored legislation that would give nurses the right to reimbursement for independent nursing services, under various federal healthcare programs. At the same time, one of the first academic nursing centers was delivering primary care services in the inner city.

As the Vice Chairman of the Committee on Indian Affairs, I am pleased to note that the University of South Carolina College of Nursing has established a Primary Care Tribal Practice Clinic, under contract with the Catawba Indian nation, which provides primary and preventive services to those populations. The University also has a Women's Health Clinic and Student Health Clinic, which are both managed by nurse practitioners.

Another prime example of services provided by nurse practitioners is the Utah Wendover Clinic. This clinic, in existence since 1994, provides interdisciplinary rural health services to the 30,000 residents annually. The clinic now has telehealth capabilities that provide interactive links from the clinic to the university hospital, 120 miles away. This technology allows practitioners to direct access to primary care, pediatrics, mental health, potential abuse, and emergency trauma treatment.

To date, nursing centers have demonstrated quality outcomes which, when compared to conventional primary health care, indicate that their comprehensive models of care have resulted in significantly fewer emergency room visits; fewer hospital inpatient days, and less use of specialists. The Lasalle Neighborhood Nursing Center, for example, reported for 1997 that fewer than 0.02 percent of their primary care clients reported hospitalization for asthma, fewer than one percent of expectant mothers who enrolled delivered low birth rate infants; 90 percent of infants and young children were immunized on time; 50 percent fewer emergency room visits; and the clinic achieved a 97 percent patient satisfaction rate.

What makes the concept of nurse managed practices exciting and promising for the 21st century is their ability to provide care in a "spirit of serving" to underserved people in desperate need of health care services. Interestingly, nurse practitioners have consistently provided Medicaid sponsored primary care in urban communities for a number of years, and have consistently demonstrated their commitment to these underserved areas.

The 1997 Balanced Budget Act (P.L. 105-33) included a provision that for the first time ever allowed for direct Medicare reimbursement of all nurse practitioners and clinical nurse specialists, regardless of the setting in which services were performed. This provision built upon previous legislation that allowed direct reimbursement to individual nurse practitioners for services provided in rural health clinics throughout America. The law effectively paved the way for an array of clinical practice arrangements for these providers; however, I note that nurse run centers, as opposed to individual practitioners, was not formally included in the law.

Federal law now also mandates independent reimbursement for nurse practitioners under the Civilian Health and Medical Programs of Uniformed Servicemen (CHAMPUS), the Federal Employee Health Benefits Plan (FEHBP) and in Department of Defense Medical Treatment Facilities.

As the Ranking Member of the Defense Appropriations Subcommittee, my distinguished colleagues and I have listened to the testimonies of the three Service Chief Nurses each year, during the Defense Medical hearings. I am proud to report that the military services have taken the lead in ensuring the advancement of the profession of nursing. Military advanced practice nurses provide care to service members and their families in the Department of Defense Medical Treatment Facilities. The Graduate School of Nursing at the Uniformed University of the Health Sciences (USUHS), which has a very successful nurse practitioner program, was recently recognized by the Army Surgeon General as the best in the United States. The Commanding General at Tripler Army Medical Center, a two star position, is a nurse. This
is a first ever accomplishment for nurses in the military. I hope to see more nurse officers in these leadership roles, even at the three star level.

At the beginning of this session of Congress, I proposed legislation to amend the Social Security Act to expressly provide for coverage of services by nursing school administered centers under state Medicaid programs, similar to payments provided to rural health clinics. Today, as we debate a number of health care issues, I urge the consideration of legislative avenues for expanding health care access for all Americans, particularly the poor and underserved. Nursing centers, as new models of health care providers, offer quality services for lower payments.

Faced with the challenge to reiterate that nurse practitioners provide cost-effective, preventive care in underserved areas across America. Their educational programs emphasize the provision of care to patients with limited financial and otherwise. A recent article in U.S. News and World Report showcased the successful Columbia Advanced Practice Nurse Associates (CAPNA), a nurse run primary care clinic in New York City. Dr. Mary Mundinger, the Dean of the Columbia School of Nursing and a Robert Wood Johnson Health Policy Fellow in 1984, was the catalyst for the center, which she envisions as a "prototype of a new branch of primary care."

"Nurse practitioners have proven themselves to be well trained providers of high quality, cost effective care.

Nursing school administered centers offer viable alternatives to health care access for the poor and underserved, and allow Americans more choices in their selection of cost-effective, quality care services. The issues surrounding quality, access and the provision of patient care services are, Mr. President, at the crux of our current debates over health care reform. We owe it to each and every American to provide the health care reform. We owe it to each and every American to provide the health care reform. We owe it to each and every American to provide the health care reform. We owe it to each and every American to provide the health care reform. We owe it to each and every American to provide the health care reform. We owe it to each and every American to provide the health care reform. We owe it to each and every American to provide the health care reform. We owe it to each and every American to provide the health care reform.

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Tribute to Lieutenant Colonel Kevin "Spanky" Kirsch, USAF

Mr. WARNER. Mr. President, I rise today to pay tribute to Lieutenant Colonel Kevin "Spanky" Kirsch, United States Air Force, on the occasion of his retirement after over twenty years of exemplary service to our nation. Colonel Kirsch's commitment to excellence will leave a lasting impact on the vitality of our nation's military procurement and information technology capabilities. His expertise in these areas will be sorely missed. My colleagues and I here in the Pentagon and on Capitol Hill.

Before embarking on his Air Force career, Colonel Kirsch worked as an estimator/engineer for Penfield Electric Co. in upstate New York, where he designed and built electrical and mechanical systems for commercial construction. In 1978, Colonel Kirsch received his commission through the Officer Training School at Lackland AFB in San Antonio, TX. Eagerly traveling to Williams AFB in Arizona for flight training, Colonel Kirsch earned his pilot wings after successful training in the T-37 and T-38 aircraft.

In 1980, Colonel Kirsch was assigned to Carswell AFB, in Fort Worth, TX, as a co-pilot in the B-52D aircraft. While serving in this capacity on nuclear alert for the next five years, he earned his Masters degree, completed Squadron Officer School and Marine Corps Command and Staff School by correspondence, and earned an engineering specialty in computer science with the Civil Engineer Squadron.

An experienced bomber pilot serving with the 7th Bomb Wing, Colonel Kirsch, then a First Lieutenant, served as the Staff Resource Manager for the Director of Operations—a position normally filled by an officer much more senior in rank. He was selected to the Standardization Evaluation (Stan-Eval) Division and became dual-qualified in the B-52H. Subsequently, he was selected ahead of his peers to be an aircraft commander in the B-52H.

Colonel Kirsch was selected in 1985 as one of the top 1% of the Air Force's captains to participate in the Air Staff Training (ASTRA) program at the Pentagon. His experience during that tour, working in Air Force contracting and legislative affairs, would serve him well in later assignments.

In 1986, Colonel Kirsch returned to flying in the FB-111 aircraft at Plattsburgh AFB, NY. He joined the 529th Bomb Squadron as an aircraft commander and was designated a flight commander shortly thereafter. He employed his skills to help automate the scheduling functions at the 380th Bomb Wing and was soon designated chief of bomber scheduling.

Following his tour with the 529th, Colonel Kirsch was assigned to Strategic Air Command (SAC) Headquarters at Offutt AFB, NE. As Chief of the Advanced Weapons Concepts Branch, he served as a liaison with the Department of Energy on nuclear weapons programs and worked on development of nuclear strategic systems, including the B-2 bomber. Colonel Kirsch was one of four officers chosen to be part of the commander-in-chief's (CINC's) staff group to facilitate the transition of SAC to Strategic Command (STRATCOM). Originally picked as a technical expert, he soon became the legislative liaison for STRATCOM. In this capacity, Colonel Kirsch organized congressional delegations to visit STRATCOM, and managed CINC STRATCOM's interaction with Congress.

In 1994, Colonel Kirsch traveled here to Washington, to begin his final assignment on active duty. Initially serving as a military assistant to the Assistant Secretary of Defense for Legislative Affairs, Colonel Kirsch once again quickly distinguished himself and was designated the special assistant for acquisition and C3 policy. Representing the Secretary of Defense, the Under Secretary of Defense for Acquisition and Technology, and the Assistant Secretary of Defense for C3, Colonel Kirsch managed a myriad of critical initiatives including acquisition reform and information assurance. He also served as the principal architect for the organization's web page, computer network, and many of the custom applications used to automate the office's administrative functions.

Colonel Kirsch's numerous military awards include the Defense Superior Service Medal, the Defense Meritorious Service Medal with Oak Leaf Cluster, the Air Force Meritorious Service Medal, the Air Force Commendation Medal with Oak Leaf Cluster, and the Air Force Achievement Award.

Following his retirement, Colonel Kirsch and his wife Carol will continue to enjoy their time in Michigan.

Mr. ABRAHAM. Mr. President, I rise today to recognize Officer Kimberly Sivyer of the Redford Township Police Department. He has been named the D.A.R.E. Officer of the Year for 1998 in the state of Michigan.

Officer Sivyer started with the Redford Police Department in 1981. He has dedicated his time and service to D.A.R.E. since 1990. Over the course of these eight years he has touched many students' lives educating them about the dangers of drugs and violence. He has and continues to be an excellent role model for the youth of his community. His colleagues at the Redford Township Police Department and the members of his community recognize this and it is for these reasons that he is very deserving of this award.

I want to once again express my sincerest appreciation and congratulations to Officer Sivyer for being named D.A.R.E. Officer of the Year 1998. He should be very proud of this achievement.