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 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, who are famously persecuted yet brutalized Baha’is 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’is, particularly the 3 jailed in Mashad presently facing the death penalty.

Religious persecution demands a tireless counter response; it demands a vigilance. If 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. Accordingly, Iran must release the fifteen Baha’is 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 engage in a discussion about 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 nursing 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 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 the state of Colorado, we have established primary care practitioners who have traditionally been the core of these nursing centers. We have consistently demonstrated their commitment to underserved areas.

Another prime example of services provided by nurse practitioners is the Utah Wenden Over Clinic. This clinic, in existence since 1994, provides interdisciplinary primary health services to the 10,000 patients 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 extend care to underserved patients. This model of care practice is well accepted by the larger health care community and is recognized by the American Medical Association, the American College of Physicians, and other professional associations as effective and efficient.

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 0.2 percent of their primary care clients reported hospitalization for heart attacks, fewer than 0.1 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 services to underserved 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 Medicare reimbursement for 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, people living in rural 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 Services (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, I have listened to the testimonies of the three Service Chief Nurses each year, during the Defense Medical Program, and 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 military 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 as the top graduate program 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 Title XIX of 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 consideration of the economic incentive 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.

In closing, I would like 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 very best options for quality health care available.

Mr. President, I thank you for the opportunity to address my colleagues on this most important topic. I ask that an article on this subject be printed in the Record.

The article follows:

[From the U.S. News & World Report, july 27, 1998]

FOR NURSES, A BARRIER BROKEN ÐIT'S A TEST FOR DOCTORS

About 250 New Yorkers have signed up with nurse practitioners (or NPs) in recent months, eight times the number from last year. In addition, a 1993 analysis of studies comparing care offered by physicians with that provided by NPs found that nurses spent about 25 minutes with a patient; doctors spent only two. In general, in their rates of prescribing drugs, but the nurses provided more patient education and stressed exercise more often than the doctors did.

While the debate may seem to pit nurses against doctors, the more important question posed by CAPNA may be between two types of physician, primary-care providers and specialists. Critics of the CAPNA model fear that NPs, because they have less training in clinical procedures such as surgery, may lack the skills to perform them. Many specialists respond that the age of managed care, and overreliance by nurses is far less of a danger than underreliance by doctors, as the interest of patients and, as Eric Rose, the chief of surgery at Columbia-Presbyterian Medical Center, puts it, "the care of their patients."

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CAPNA's acceptance by insurers as a legitimate primary-care alternative to a practice run by physicians is clearly a break-through for nurses, who were long defined as hospitalers who work entirely by doctors, who are torn between the interests of patients and, as Eric Rose, the chief of surgery at Columbia-Presbyterian Medical Center, puts it, "the care of their patients."

The groundwork was laid in 1993, when Columbia-Presbyterian's Mundinger won permission to open a nurse run clinic in two poor, upper Manhattan neighborhoods. The opportunity, Mundinger says, "I asked in return for something that earlier proposals of health care reform lacked: hospital admitting privileges—the ability to get patients into Columbia-Presbyterian and supervise their care. Two new primary-care practices were created, ones with doctors and nurse practitioners working as equals, the other run entirely by NPs.

Mundinger's next brainstorm was to see if the concept would work in a affluent neighborhood. This time, in a move with wide-spread implications for health care, she went after managed-care plans for the right of reimbursement.

Equal treatment. For the HMOs—under constant pressure from employers to cut costs—a nurse-run practice had obvious appeal if it meant lower payments for the same services. But Mundinger rejected support for a condition imposed by an HMO. A nurse practice, insisting that would open the HMOS to the charge of chiseling and cast her practice as a cheap substitute for real medicine. After months of discussions, Oxford Health Plans agreed to go along. Seven more health plans followed suit, all giving the nurses the same fees and service rates as doctors. Mundinger's admirers say she has not only created a significant new model of health care access.
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care but, in doing so, has called the medical profession’s bluff. Say Uwe Reinhardt, a health economist who teaches at Princeton University, “Doctors always say the are rug- ged and free enterprise and be, and now at the first sight of a nurse they run to the government and say, ‘Please use your coercive powers to protect us’!

Even some supporters, however, fear that Mundinger’s model, for all its noble objectives, will appeal to the basest motives of insur- ers and employers, leaving patients, in the end, with less-trained people who are in just as much of a hurry. There is some reason for doubting this: A study in the April 1997 Nurse Practitioner, for example, found NPs more consistent than gynecologists in adhering to medical standards in evaluating cer- vical dysplasia, a precursor to cervical can-

mation and became dual-qualified in the

Sivyer of the Redford Township Police

STRATEGIC COMMAND (STRATCOM). Originally picked as a tech- nical staff officer, he soon became the legislative liaison for STRATCOM. In this capacity, Col-

Colonel Kirsch was assigned to Strate-

Under Secretary of Defense for Acquisi-

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an aircraft commander in the B-52H. Initially he was designated as a flight commander shortly thereafter. He em-

ployed his computer 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 Strate-

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 reside in Springfield, VA with their children Alicia and Benjamin.

Mr. President, our nation, the Depart-

ment of Defense and on Capitol Hill. I wish Lieutenant Colonel Spanky Kirsch the very best in all his future endeavors.

D.A.R.E. MICHIGAN OFFICER OF

THE YEAR 1998

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 commu-

THE COUNTRY OF GEORGIA

Mr. BROWNBACK. Mr. President, I would like to say a few words about Georgia and the recent events which have taken place in this impressive country. Several days ago, Georgia re-

affirmed its commitment to full participatory democracy when the Minister of State requested the resignation of all cabinet ministers, and then resigned himself. His resignation was accepted, and President Eduard Shevardnadze has vowed to reconsti-
tute a new government by the middle of August. This transition, so reminiscent of the ebb and flow of govern-

ments in great parliamentary democ-

racies, has been accomplished without violence or bloodshed, without chaos or confusion, and with the support of the Georgian people. Truly Georgia is an inspiration to peoples everywhere who long for democracy and who struggle against the freedom-stifling legacy of the communist experiment.

Georgia is impressive in other ways as well. Its economy continues to grow in a positive direction, unlike the economies of some of its neighbors; Georgia is not perfect, and it is not pristine. But it is progressive. With a growth rate of nearly 8 percent in 1997 and projected growth of 11-13 percent in 1998, Georgia is on track to a signifi-

This turn-around and the prosperity that will inevitably flow from it, still involve many hurdles. Georgians have bravely faced these challenges, and they face more still. Probably none is so painful as the ongoing conflict in Abkhazia, Georgia’s most northwestern province bordering Russia. This brutal