

# What is faculty practice?

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**Faculty practice(s) associated with schools of nursing can be defined and structured in many different ways. The purpose of this article is to define faculty practice, discuss the goals of faculty practice, and outline**

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**different models of implementation. Case examples from the University of California San Francisco, School of Nursing will illustrate different models of faculty practice. Through an understanding of faculty practice and various structural models, it is anticipated that nursing faculty and clinical partners will have familiar terminology and a common framework from which to evaluate strengths and limitations of different faculty practice arrangements.**

Faculty practice(s) associated with schools of nursing can be defined and structured in many different ways. The purpose of this article is to define faculty practice, discuss the goals of faculty practice, and outline different models of implementation. Case examples from the University of California San Francisco (UCSF), School of Nursing will illustrate different models of faculty practice. Through an understanding of faculty practice and various structural models, it is anticipated that nursing faculty and clinical partners will have familiar terminology and a common framework from which to evaluate strengths and limitations of different faculty practice arrangements.

## WHAT IS FACULTY PRACTICE?

Faculty practice is a formal arrangement between a school of nursing /academic health center and a clinical facility/enterprise/entity that simultaneously meets the service needs of clients, while meeting the teaching, practice, service, and research needs of faculty and students. Population targets can be individuals, families, or communities. In some cases, the practice may focus on a specific age group or other sub-population, such as immigrant workers or individuals with mental illnesses. Most faculty practices share the following elements:

- There is a formal contractual arrangement, with a defined focus and clear boundaries,
- Patient care is the central focus of the teaching/practice/service/research activities,

- Clinical scholarship is a key outcome,
- Clinician, educator, researcher, consultant, and/or administrator roles are visible in the settings, and
- Faculty practice sites provide additional resources, in addition to funding already allocated for teaching.<sup>1,2,3,4,5</sup>

A broad and inclusive faculty practice definition from the National Organization of Nurse Practitioner Faculties is commonly accepted by advanced practice nursing educators to guide faculty practice development:

“Faculty practice includes all aspects of the delivery of health care through the roles of clinician, educator, researcher, consultant, and administrator. Faculty practice activities within this framework encompass direct nursing services to individuals and groups, as well as technical assistance and consultation to individuals, families, groups, and communities. In addition to the provision of service, the practice provides opportunities for promotion, tenure, merit, and revenue generation. A distinguishing characteristic of faculty practice within the School of Nursing is the belief that teaching, research, practice, and service must be closely integrated to achieve excellence. Faculty practice provides the vehicle through which faculty implement these missions. There is an assumption that student practica and residencies as well as research opportunities for faculty and students are an established component of faculty practice.”<sup>6</sup>

It is important to emphasize that faculty practice provides faculty the opportunity to maintain and enhance direct and/or indirect care skills, which may significantly augment their mentoring skills for nursing students.

## MODELS OF FACULTY PRACTICE<sup>7\*</sup>

In recent years, faculty practice, particularly for advanced practice nursing, has grown as a mechanism for nursing schools to creatively achieve their mission and vision, and link more directly to vulnerable communities. However, not all nursing faculty practices have the same organizational structure. A variety of faculty practice models have evolved in response to the varying needs of nursing schools and communities in the areas of teaching, research, practice, and service. The advantages and disadvantages of some of the most common models of faculty practice are outlined below.

### *Entrepreneurial or Linkage Model<sup>8,9</sup>*

The nursing school establishes a contractual arrangement with an organization whereby the school agrees to

\*Adapted from Harder and Company Community Research and Saxe J. Department of Community Health System’s faculty practice strategic plan and evaluation: Final report. Appendix 1, Organizational Assessment.

provide services to the agency for a fee. Because the clinicians/administrators/researchers remain University employees, the University pays their salaries. The University employee generally receives no direct reimbursement from the agency. There are numerous benefits to the academic institution under this model. This model may help the school of nursing meet several goals such as improving patient care, promoting faculty’s clinical expertise and contribution to community service, maintaining a curriculum that reflects the current clinical environment, and creating opportunities for collaborative quality improvement initiatives and clinical research. These goals can be accomplished without incurring the fiscal liabilities of a university-owned enterprise.<sup>9</sup> The community agencies and their clients also benefit. They receive expert clinical services augmented by students, an opportunity to contribute to the training of future nurse clinicians, access to evidence-based practice and innovations in technology, and opportunities for research that could potentially benefit the agency and/or clients.<sup>9</sup>

This fee-for-service model does limit University financial liability because it does not necessarily rely on the collection of fees from an uninsured or underinsured patient population. Rather, financial integrity relies upon the capacity of the agency and/or the University to secure grants for core operational support and/or fundraising to support the faculty practice. If the funds raised are insufficient to offset the cost of the faculty practice, the school or department has the option to discontinue the faculty practice at the end of the contract period. A major disadvantage of this model is that the school/department may have limited opportunity to participate in agency decision-making, and, thus, may not have the ability to influence strategic development of the practice’s philosophy, scope and mission.

### *Integration or Nursing Center Model<sup>2,8</sup>*

The nursing school or department operates its own clinic or practice. This model allows the school or department the greatest degree of control over the operation and direction of the practice in addition to the benefits noted under the Entrepreneurial or Linkage Model.<sup>2,9</sup> Despite the potential for revenue generation, the biggest disadvantage of this model is the threat of financial losses.<sup>9</sup>

A 1993 study showed that only 4 academic nursing centers (8% of those surveyed) were revenue-generating.<sup>10</sup> The most notable reason for this disappointing figure was due to the reliance on patient fees as a main source of revenue, which was often insufficient to sustain the faculty practice. Many nursing center patients were uninsured or under-insured with a limited ability to pay for care.

**Table 1.** National Nursing Summit: Nurse-managed health centers summary of work group reports (Michigan Academic Consortium, funded by The Kellogg Foundation, December 2002)

1. Nurse-managed health center (NMHC) operations and management—priority challenges:
  - The lack of sustainability
  - The lack of standardized information
2. Reimbursement and payer relations—priority challenges:
  - Maintain financial sustainability through reimbursement, grants and contracts
  - Operate according to sound business practices
3. University and faculty acceptance and support of academic nurse-managed centers—priority challenges:
  - Gain administrative acceptance of faculty practice and NMHCs as a critical component in schools of nursing and their universities
  - Set and manage realistic revenue expectations by the NMHCs' academic institutions
4. Community and clinical partners and patient relations—priority challenges:
  - NMHCs developing community partnerships
  - Positioning NMHCs as a viable primary care provider option for all patients.
5. Policy, politics, marketing, and regulation (local, state and national)—priority challenges:
  - Address the current payer policies (federal, state, and commercial) that limit reimbursement for nurse-managed health center services
  - Address the variation in licensing, scope of practice, and professional certification among the 50 states.

*Unification Model*<sup>2,8,11</sup>

The clinical agency and the academic entity share a central administrative backbone, and faculty members hold appointments as both clinicians/administrators/researchers and educators. Benefits to the academic institution include maintaining faculty members' professional skills and preserving the institution's credibility by having faculty in service roles.<sup>11</sup> Benefits to the clinical site include improved patient care and education, staff development, improved clinic management, and application of academic knowledge to improve services in addition to the other benefits noted under the Entrepreneurial or Linkage Model.<sup>11</sup> Competing demands between service, teaching and/or research can be a challenge because the primary customer in the clinical setting (the client) is different from the primary customer in the academic institution (the student).

*Collaboration or Joint Appointment Model*<sup>2,8,9,12,13</sup>

Faculty members hold an academic appointment at the University as well as a clinical appointment at a collaborating agency, and they divide their time between the 2 institutions. The University and the agency share the cost of the faculty member's time. Advantages to the service agency include cost savings, educational opportunities for staff, new perspectives on clinic administration and management, and application of research to improve practice along with the other benefits noted under the Entrepreneurial or Linkage Model.<sup>12</sup> Although this arrangement places less of a burden on individual faculty members and the academic institution for supporting faculty salaries, faculty members contribute less time to teaching and other academic responsibilities than they would under the other models. Other challenges in this model include time management and role strain, as faculty members must juggle multiple role expectations from both the academic and service institution.<sup>12,13</sup>

*Private Practice Model*<sup>2,8</sup>

Individual faculty members develop their own practice arrangements and receive direct reimbursement from an agency. In contrast to "moonlighting" outside of designated work responsibilities, this practice model is part of the faculty member's role in the academic institution. This model has the potential to address all of the benefits related to nursing student education, client care, clinical research, and practice innovations as noted in the Entrepreneurial or Linkage Model. However, since this model is often dependent on profit-sharing and productivity expectations, the ability to meet teaching, practice, service and research role expectations is often challenging.

**UCSF, SCHOOL OF NURSING'S MODEL OF FACULTY PRACTICE**

To illustrate these models in greater detail, a description of selected UCSF School of Nursing faculty practice sites via model type is provided in this section. Since the University currently does not have any practices based on the unification model, this prototype is not presented in the following discussion.

As a prologue to these faculty practice descriptions, it is important to note that the UCSF School of Nursing faculty members are dedicated to providing high quality, cost-effective health care services to medically under-served populations within the San Francisco Bay Area, and guide their practices via position statements and principles such as those noted in the *Report of the National Nursing Summit: Addressing Nurse-Managed Health Centers* (See Table 1).<sup>14</sup> Additionally, faculty members recognize that adequately addressing the needs of vulnerable populations along with the needs of students and faculty requires collaborative efforts across

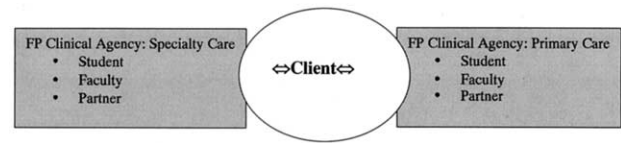
faculty practice sites. Thus, many of the UCSF, School of Nursing, faculty practice initiatives strive for a model of health care that facilitates seamless care for clients at and across the affiliated agencies (partners) (Figure 1). Efforts are being made to address quality improvement and research initiatives, and enhance communication within and between faculty practice sites via the development of shared information management systems.

Viable faculty practice sites can be established in a variety of settings, including community-based outpatient clinics, churches/storefronts, acute care hospitals, skilled nursing facilities, home health agencies, workplaces, and tele-healthcare companies, amongst others. Roles include being direct care providers, administrators, consultants and/or researchers. The practice sites illustrated hereafter are community-based settings with a goal towards addressing the advantages and disadvantages of the various faculty practice models.

### *Entrepreneurial or Linkage Model*

Three of the UCSF, Department of Community Health Systems' Faculty Practices (Glide Health Services, Progress Foundation and the UCSF Community Occupational Health Project) use the Entrepreneurial/Linkage Model as their framework, which works well for the Department and its agency partners. This model allows substantial flexibility for the partner to develop a service that meets both Department and agency needs at affordable costs. The Department does not assume the cost of operating its own clinic, so the potential for financial liability is less than with other models. This model has allowed the Department to maintain a presence in the community and has provided a vehicle for the Department to fulfill its mission in the areas of teaching, research, practice, and service. Finally, but not the least important, under this model individual faculty members have been able to pursue and actualize their own personal and professional visions in a non-academic setting. This model, however, is not without its challenges. Since this approach is based on fee-for-service principles, the partnering clinical agency and school of nursing need to develop explicit language regarding professional services to be provided in the clinical setting, and teaching and research activities that will occur. Additionally, a clear description of fundraising activities and of participation in management decisions is vital. The faculty members involved in these practices have learned through numerous negotiations the value of a well-defined contractual agreement or memorandum of understanding.

***Glide Health Services*** Glide Health Services was founded as the Glide Health Clinic in 1997 and has been a collaboration among 4 partners: Glide United Memorial Methodist Church (Glide), the UCSF School of Nursing, Department of Community Health Systems; Catholic Healthcare West—West Bay's Saint Francis Memorial Hospital; and medical consultation and ad-



**Figure 1.** Building Community Partnerships: An Integrated, Client-centered Faculty Practice (FP) Model.

ministrative support from a volunteer physician. Since Glide is a well-known faith-based organization that houses multiple social services for the poor and disenfranchised in the Tenderloin District of San Francisco, the development of a health care service was considered an important adjunct to its programs. Glide has provided the space, and administrative and ancillary health care staff for the Glide Health Services. The practice arrangement includes UCSF clinical leadership and nurse practitioner staffing by Department nurse practitioner faculty. The Glide Health Services' Clinical Managing Director is a UCSF faculty member who reports to both Glide and UCSF leadership. Glide and UCSF provide funding for this position based on how much this individual's efforts are dedicated to practice, clinic management, and teaching. Funding for this arrangement is negotiated annually. Nurse Practitioners practicing in the Glide Health Services are UCSF faculty members. Glide reimburses the Department for faculty time at a per diem hourly rate. This practice arrangement has provided a dedicated clinical site for training UCSF pre-licensure and graduate nursing students, for conducting faculty-based nursing research, and for facilitating multiple inter-agency projects for graduate students interested in addressing public health issues. Over 70 nursing students have completed clinical experiences at the Glide Health Services. Catholic Healthcare West-West Bay provided start-up funding and offers a sustained commitment to providing diagnostic services and pharmaceutical medications and supplies. The physician provides medical consultation and administrative support for the Glide Health Services, establishing the clinic initially as a satellite clinic of his private practice. An Oversight Board comprised of the partners was developed. Through collaborating efforts, a Memorandum of Understanding was drafted. This legal document defined the terms of affiliation and governance of the Glide Health Services. The original document, with some modifications, was in effect for 5 years and is currently under review. In 2002, Glide Health Services moved from a satellite model to an independent state licensed practice.

The practice has grown from a single 4-hour/week predominantly urgent-care clinic session to a 24 hour/week (6 clinic sessions) primary care service model. Services now include nurse-managed primary care and urgent care. Chronic disease management has been enhanced through participation in the California Health

Disparities Diabetes Collaborative. The Health Disparities Diabetes Collaborative provides an inter-disciplinary framework for the provision of evidence-based diabetes care within a quality improvement model, and monitors patient outcomes through a national registry. Mental health services are provided at every clinic session and consist of individual, couples, and group therapy conducted by a licensed clinical social worker; and the initiation and management of psychoactive medications by nurse practitioners or psychiatrists. Most of these clinicians have UCSF faculty appointments. Complementary healing services are integrated within the clinic sessions and provide a wide array of modalities including acupuncture, chiropractic care, massage therapy, therapeutic touch (including Reiki), and visualization. Additionally, Glide Health Services plays a key role in HIV/AIDS testing, counseling, and primary prevention. In 2003, Glide Health Services was selected as one of 3 sites in the State of California to pilot HIV rapid testing technology and develop counseling protocols for the provision of test results.

**Progress Residential Facilities** Progress Foundation is a community-based non-profit organization funded through local government contracts that provides alternative community treatment options to seriously mentally disabled people in the San Francisco (SF) Bay Area and in neighboring Napa County. For the past 30 years, Progress Foundation has been a pioneer in developing alternatives to institutional care for public mental health systems, providing a variety of residential treatment and supported housing programs. There are 4 acute residential programs with a typical length of stay of 2-3 weeks, and 3 transitional programs (1 home with a typical length of stay of 3 months, and 2 homes with 12 month programs, 1 of which is a women and children's program). The transitional program for elders also has a longstanding day-treatment program for prior residents. Clients are referred to the acute residential treatment programs from the SF City and County Psychiatric Emergency Room, from inpatient hospital psychiatric units or directly from the community through the mobile crisis unit. All services in the agency are built upon a social rehabilitation model, emphasizing self-sufficiency and personal responsibility in the treatment plan.

Due to the increasing medical complexity of clients, nursing services were added to the treatment model at Progress Foundation in 1994, initially as a private consultant agreement with individual faculty providing primary care services at 1 treatment program. By 1998, the faculty practice was formally established with a Memorandum of Understanding between Progress Foundation and the UCSF School of Nursing, Department of Community Health Systems. Currently there are 8 nursing faculty members who provide services at all 9 of the Progress Foundation residential programs

with an estimated monthly visit volume of 250 patient visits. The faculty practice is co-directed by a clinical professor and a research professor in the Department. The practice group also includes a physician consultant hired by the group and a community pharmacist who volunteers his expertise. Nursing services include health assessment, urgent care and chronic disease management as well as staff education and consultation to promote health in aggregate living. Health promotion and psycho-education are critical components of the nursing practice, given that so many of these clients receive sporadic and incomplete health-promotion care in traditional medical settings. Student-directed health promotion group activities include discussions related to sleep hygiene, smoking cessation, nutrition, substance abuse relapse prevention, child rearing issues, and psychiatric symptom management. Financial liability for nursing services is minimal since patients are not directly billed for services. Progress Foundation considers nursing an integral part of its treatment programs. An on-call triage nursing program was developed several years ago to provide support to the Progress staff in the hospital referral system and to assist with determining medical stability of clients referred to Progress Foundation programs.

This faculty practice has expanded over the years to include the integration of teaching, research, and practice activities. The faculty practice sites provide dedicated clinical training for graduate students in the advanced practice psychiatric nursing programs, both adult nurse practitioner and clinical nurse specialist tracts, where students are able to practice alongside faculty mentors and learn blended psychiatric primary care competencies for practice. These integrated psychiatric primary care training sites have provided the foundation for 2 federally funded training grants from 1997-2003. Research activities in the faculty practice include ongoing clinical practice data collection; a small pilot study on service utilization; and in 2001, a National Institute of Nursing Research funded "Clinical Trial of Wellness Training for the Mentally Ill." The faculty practice has received several honors including a 2003 award from the American Psychiatric Nurse Association for "Best Practices in the Treatment of Patients with Schizophrenia." The Program Director received the "Health Care Hero Award" from the UCSF medical student group in 2002. A forthcoming Substance Abuse and Mental Health Service Administration national "Toolkit" on residential programs, which was developed by the executive director of Progress Foundation, recommends nurse practitioner services as a critical component of such programs.

**UCSF Community Occupational Health Project** The UCSF Community Occupational Health Project (COHP) began with the Asian Immigrant Women Workers Clinic in 2000, and included a twice-monthly specialty clinic, focused on work-related injury and

illness prevention and treatment for monolingual Cantonese speaking garment workers in the Oakland, California community. This Clinic then expanded in 2002 to a weekly clinic in a more ethnically diverse neighborhood, targeting other low wage workers, including monolingual Spanish day laborers, janitors, hotel housekeepers, and Vietnamese nail salon workers.

The California Wellness Foundation funds COHP, with partnership arrangements between the UCSF School of Nursing Occupational and Environmental Health Nursing Program in cooperation with the UCSF Division of Occupational and Environmental Medicine; and a legal advocacy group, a union, and 2 women's advocacy community groups. Services provided at the COHP clinic include evaluation, treatment and management of work-related disorders, with case-management and referral for primary care. Education to prevent work-related injury and illness is a key COHP component, with emphasis on health and safety rights, health maintenance, and injury prevention.

The COHP clinic is a clinical site for training of graduate nursing students in the occupational health/adult nurse practitioner program, the occupational health clinical nurse specialist program, and the occupational medicine residency program. Industrial hygiene graduate students from the University of California Berkeley, School of Public Health participate in worksite evaluation health and safety projects. Outcomes of care are the major research foci, linking research and clinical findings to policy implications regarding access to care and occupational health and safety prevention needs of this vulnerable population.

All Occupational Health Nurse Practitioner students complete a 20-hour clinical rotation (4 hours/week for 5 weeks) at COHP, with one of these sessions dedicated to educational outreach. Each year, 2-3 Occupational Health nursing students complete a 60-hour rotation in program planning at COHP with a specific target group (eg, janitors). Unique aspects of COHP include providing students a community free clinic rotation with a worker and union focus. Students gain clinical exposure with a mostly immigrant, undocumented population, with translators available in all aspects of care. The students learn first hand about high hazard work, and about the barriers workers face in seeking health care (eg, lack of health care insurance, temporary or contingency work, and/or fear of reprisal when they exercise their health and safety rights). Students, in partnership with faculty and community agencies, help to build community capacity in occupational health and safety to promote safe work for all.

### *Integration or Nursing Center Model*

**Valencia Health Services** Acquired in 1993, Valencia Health Services (VHS) is a community-based, state-licensed primary care clinic serving a medically under-served community in the San Francisco Mission

District. It is administered and managed by the UCSF School of Nursing, Department of Family Health Care Nursing. General oversight and direct responsibility for the practice lies with the Department of Family Health Care Nursing, and long-range planning is the responsibility of a governing board, whose members include the Dean and Associate Dean for Administration of the School of Nursing.

Clinical care is provided by pediatric nurse practitioner (PNP) and family nurse practitioner (FNP) faculty members (as part of their faculty responsibilities) from the Department of Family Health Care Nursing, a staff nurse practitioner, a staff pediatrician, and a nurse practitioner employed by San Francisco State University (SFSU), School of Nursing. SFSU works in partnership with UCSF to provide clinical case management services as well as direct patient care.

The partnership with SFSU has included bringing mental health services from Child and Adolescent Psychiatry at San Francisco General Hospital to VHS for 4-12 hours per week to improve patient access to these services. Nursing students affiliated with VHS work at local Head Start sites under the supervision and direction of their SFSU nurse practitioner faculty preceptor. Faculty members from UCSF work closely with the Adolescent Health Working Group, a community initiative to improve care for adolescents, to create resources for providers, improve clinical sites, and educate providers about adolescent health care.

On-site services include primary care for children and adolescents, family planning services for clients eligible through Family Planning Access Care and Treatment, social work referrals, clinical case management, and mental health assessment and referral. Services are provided Monday-Friday at the clinic and 24 hour on-call advice is provided by the nurse practitioners and a rotating pediatric physician group, one of whose members is the staff physician at VHS. Patients needing hospitalization are admitted to one of the local community hospitals, depending upon their insurance, with the majority being admitted to the hospital located across the street from VHS. Inpatient care is managed by the part-time staff physician in conjunction with hospitalists.

Staff members include a practice manager, a clinical director (also a provider), a billing agent, a receptionist, 2 medical assistants, a part-time social worker, an administrative assistant, and a programmer analyst. All billing is done on-site. The Department of Family Health Care Nursing provides financial oversight.

Major accomplishments have been the development and implementation of clinical case management; coordination and improvement of asthma care; collaboration with a community initiative on obesity directed towards adolescents; and ongoing work on *Healthy People 2010* data collection, evaluation and targeted best practice guidelines.

The primary challenges facing VHS are interdependent. The first involves the balancing of the competing threefold mission of education of health professionals, provision of health care, and the conduct of research. While ideally these goals support one another, in day-to-day practice they are often at odds. The second, and more pressing, is the challenge of financial sustainability. Financial viability will depend upon business planning and outreach that supports anticipated changes in payer mix.

#### *Collaboration or Joint Appointment Model*

***Marin County Health and Human Services Specialty Clinic*** The County of Marin Department of Health and Human Services HIV/AIDS Program, established in 1990, provides comprehensive HIV/AIDS services to county residents with or at risk of HIV/AIDS. As part of this program, the Marin Specialty Clinic (MSC) provides community-based health care to county residents infected with HIV. Services provided at the MSC include: Evaluation and clinical management of HIV/AIDS, access to National Institutes of Health and industry-sponsored clinical trials, case management, benefits counseling, AIDS drug assistance, in-home support services, and mental health services. In 1998, the mission of the County HIV/AIDS Program was expanded to include hepatitis C (HCV) screening, testing and medical treatment. This new program was integrated into the HIV/AIDS program to provide consolidated services for HIV/AIDS and HCV. As a public health program, the MSC has multiple linkages with substance use treatment programs, mental health services, women's health, sexually transmitted infections services and the HIV/AIDS prevention, testing and outreach programs.

Through an annually negotiated contractual agreement with the Marin County HIV/AIDS Program, the UCSF School of Nursing, Department of Community Health Systems has had a nursing faculty practice located at the MSC since 1998. The MSC-UCSF faculty practice has several advantages for both the University and the County of Marin. This faculty practice provides a dedicated clinical site for training of graduate nursing students, faculty research, research opportunities for doctoral students, and a model of care for patients with HIV/AIDS and chronic HCV. This type of faculty practice takes advantage of an existing infrastructure, in this case the MSC, which provides for the administration and operation of the clinical services removing the burden of administrating a faculty practice and reducing the financial risks associated with running a clinical program. The faculty is thus free to focus on service, teaching and research. There are additional financial advantages for the sponsoring agencies as well as for the faculty member. As a full-time clinical faculty in the Department, the faculty member remains an employee of UCSF and maintains employee benefits and retirement with the University. The

County of Marin pays the University a negotiated portion of the faculty's salary on a quarterly basis. The County gains the expertise of a seasoned NP and saves the cost of providing benefits for an employee.

The contractual arrangement between the sponsoring agencies is flexible and the contract is renewed on an annual basis, further reducing financial risk. The sustainability of this type of faculty practice depends on the funding sources of both the sponsoring agencies and is vulnerable to cuts in services when state and/or federal budgets are restricted. Therefore, it is critical that the NP faculty member maintains and facilitates communication between the Medical Director of the MSC, the Department Chair and the NP Program Director to meet the expectations for both the University and the County of Marin.

The NP faculty reports to the Medical Director of the Clinic and works independently managing her own caseload of patients using Standardized Procedures developed by the Department's Faculty Practice Committee. As a University employee, the NP faculty receives malpractice insurance from the University.

A multidisciplinary team of medical, nursing, mental health, and social service providers staff the MSC. This multidisciplinary team approach offers a rich training resource for students in primary care and HIV/AIDS care. To date, the MSC faculty practice has provided the Department with an opportunity to conduct 2 pilot studies of funded research proposals, the development and initiation of a model of integrated services for HIV/AIDS and HCV care, 80 hours of primary care clinical placements/academic year, and 40 hours of specialty clinical placements/academic year for 2-3 graduate nursing students annually.

#### *Private Practice Model*

***UCSF, Ambulatory Care Clinic, Chest Faculty Practice*** An individual nurse practitioner (NP) faculty member initiated this faculty practice arrangement in July 1988 as a pulmonary clinical nurse specialist, and added role preparation as an adult nurse practitioner in 1993. The faculty member negotiated a contractual arrangement with the UCSF Department of Medicine, Pulmonary Division, in which she holds an academic appointment. The faculty shares revenues with the other faculty clinicians at the end of each fiscal year. The formula is as follows: Total annual billings for the practice, minus the overhead that is charged to the practice, yields a Chest faculty net share. The NP faculty receives the ratio of the NP faculty annual billings to the total billings multiplied by the Chest faculty net share.

The Chest Faculty Practice is staffed by 6 faculty (5 physicians and 1 NP) plus pulmonary fellows, medical residents, and nurse practitioner students. Each faculty member has 1 or 2 half-day clinics per week. Providers from both the community and UCSF Ambulatory Care

Services make up the referral base for the Clinic. The “community” is local, regional, and statewide. Patients may also self-refer. The Chest Faculty Practice NP provides direct patient care in the form of complete pulmonary assessment, diagnosis, and treatment, including self-management education. Additionally, the NP provides ongoing care to patients with chronic pulmonary conditions, including asthma, chronic obstructive pulmonary disease, bronchiectasis, chronic allergies, and other chronic respiratory conditions.

The NP’s faculty practice is a unique blend of specialty pulmonary care integrated with primary care. The NP faculty member has built strong alliances among primary care providers and the different schools on campus where none existed before. With the agreement of the Clinic physician director, the nursing faculty has instituted a more collaborative relationship between this specialty practice and the general medicine practice.

The NP’s faculty practice includes supervising students, residents and fellows from medicine, nursing, and pharmacy. Furthermore, the NP faculty member has strongly influenced pulmonary health care by her ongoing research studies, which include collaboration with the Department of Medicine.

Major challenges associated with this type of practice include the annual renegotiation of the reimbursement formula, the inability of the NP faculty to directly capture billing in her own name, and the difficulty of the institution in understanding the difference between a NP faculty practice and a NP hired as an employee paid by the Medical Center. Fluctuations in the net share of the Chest Practice income, due to problems with collections and decreasing support from the medical center, make the income for the NP faculty unpredictable from year to year. Collections from patient billing go through multiple levels of the medical center, the Department of Medicine, and the Division of Pulmonary Medicine before being transferred to the NP faculty resulting in long delays in reimbursement.

## CONCLUSION

Nursing faculty practice is an exciting and vibrant area that responds to the goals of service, practice, teaching and research. There is an abundance of literature related to the concept of nursing faculty practice, which has contributed to well-accepted position statements on the definition of faculty practices and the diverse models for faculty practice arrangements. Given this common understanding, nursing faculty are better equipped to articulate their practice arrangements to health care colleagues, administrators, and clients. Furthermore, nursing faculty are well-positioned to develop practice arrangements that address specific clinical, educational, research, and business needs and issues. Some challenges include providing primary care to under-served, culturally diverse populations; establishing a variety of

clinical experiences for graduate nursing students from different nursing specialties; implementing clinically relevant research projects that are valued by both the community-based partners and the academic institution; and the actualization of fiscally solvent business arrangements with clinical agencies that service medically indigent populations. Successfully addressing these concerns will help to nurture the growth and development of these clinical enterprises, cultivate nursing care models that enhance the care of clients and the education of nursing students, and measure clinical outcomes of nursing care.

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