D.C.'s New Pediatric Nurse Practitioners

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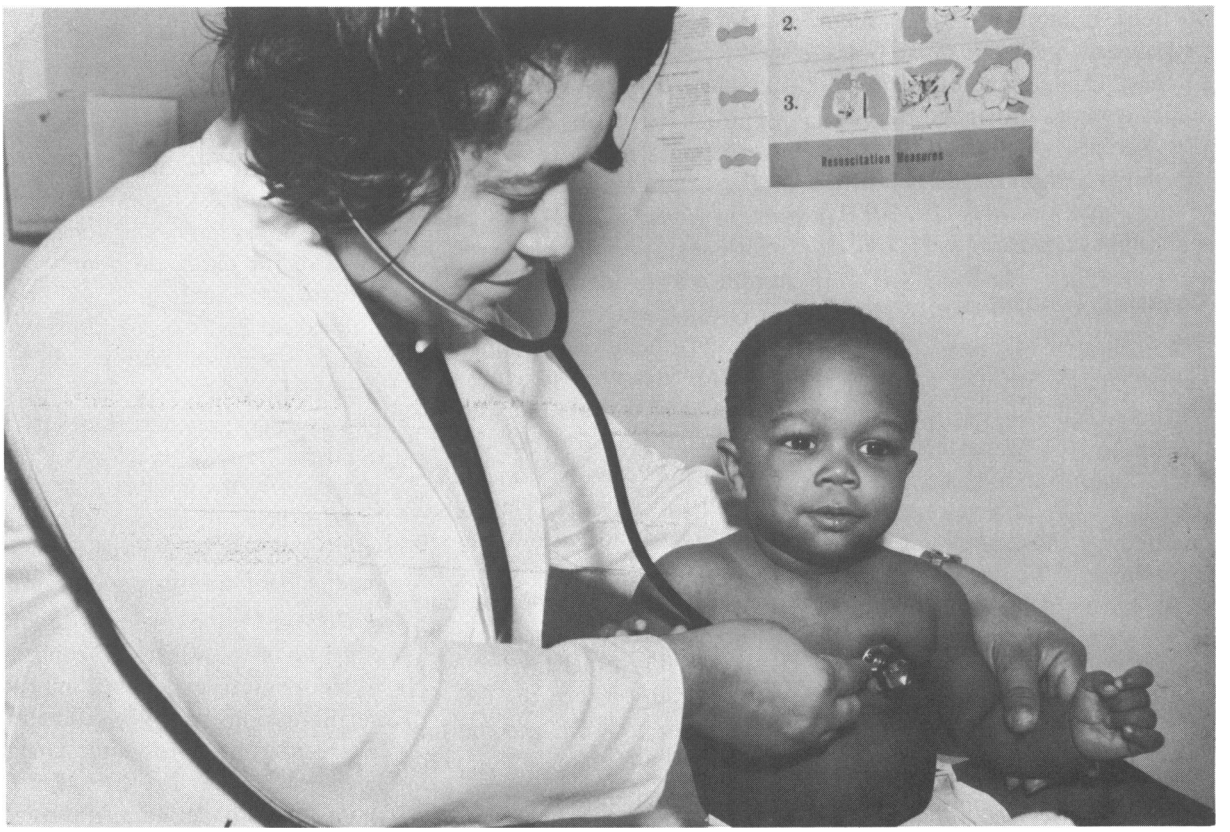

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As the population of the District of Columbia continues to increase in numbers of minority poor, elderly, and the very young, and as the accessibility to health services and health professionals seemingly diminishes, the gap between the District resident's needs and his access to health services widens. Thus, it is becoming increasingly more difficult for the District resident to share readily in the benefits of total health care.

Over the years, the consumers' demand for health services has increased tremendously, while the supply of health professionals and health services has remained relatively unchanged. These increased demands have created an added strain on the city's health care delivery system.

While a number of remedial actions have been taken by both the private and public sectors of the city to help alleviate this problem, the need for more posi-

tive actions remains. One such action, taken by the Department of Human Resources' Community Health Services Administration, is the initiation of a pilot pediatric nurse practitioner program. This action was designed to increase the supply of quality pediatric care in the health delivery system of the District.

The program initiated by the Department is a comprehensive 40-week training program which prepares the pediatric nurse practitioner who completes it to assume a more independent role than her previous one in the care of infants and children. The program began on May 10, 1971, with eight trainees.

Choosing Trainees

Trainees for the program must be highly motivated, licensed registered nurses, currently employed by the Department, and have completed a basic nursing education in an institution accredited by the National League for Nurses. In addition, they must have at least 3 years of nursing experience, one of which must have been in pediatrics or public health nursing.

The first trainees could be characterized as heterogeneous, and therefore they were an interesting group for this pilot project. All eight students were women; their ages ranged from 30 to 42 years with the mean age of 37. Two had received a bachelor of science in nursing degree, one was pursuing a master of science in nursing, and the remaining five were graduates of a diploma school of nursing; all five diploma graduates had received some academic credits from a university. Their nursing experience ranged from 12 to 22 years with a mean of 15. All the trainees had considerable nursing experience in pediatric settings.

The trainees were selected by a panel consisting of pediatricians, supervisory nursing personnel, staff nurses, and training experts employed by the Department. Each applicant was interviewed by the panel before she was chosen. For the first training programs, the eligible applicants were limited to nurses who were employed in a neighborhood health center of the Department of Human Resources.

During the discussions regarding the career ladder potentials of the program, it was felt that the projected role of the nurse practitioner should be carefully scrutinized to determine if the newly established position should be reclassified. The personnel staff are currently studying this issue, and it appears that the job may merit a GS–11 or 12 classification (approximately $13,000–$16,000 per annum). This determination would result in a promotion for five of the eight trainees who entered the program at the GS–9 level (approximately $11,000). The other three nurses were receiving pay at the GS–12 level when they were selected for the training program.

The curriculum for the pediatric nurse practitioner is structured to accomplish certain specific objectives:

1. An understanding of the dynamics of physical, psychological, social, and cultural parameters that affect a child's health.
2. Comprehensive well-child care.
3. Problems which may hinder growth and development.
4. The assessment of a child's physical condition to detect the presence of illness and the need for referral to the physician.
5. The management of emergency situations.
6. An understanding of the management of common pediatric problems.

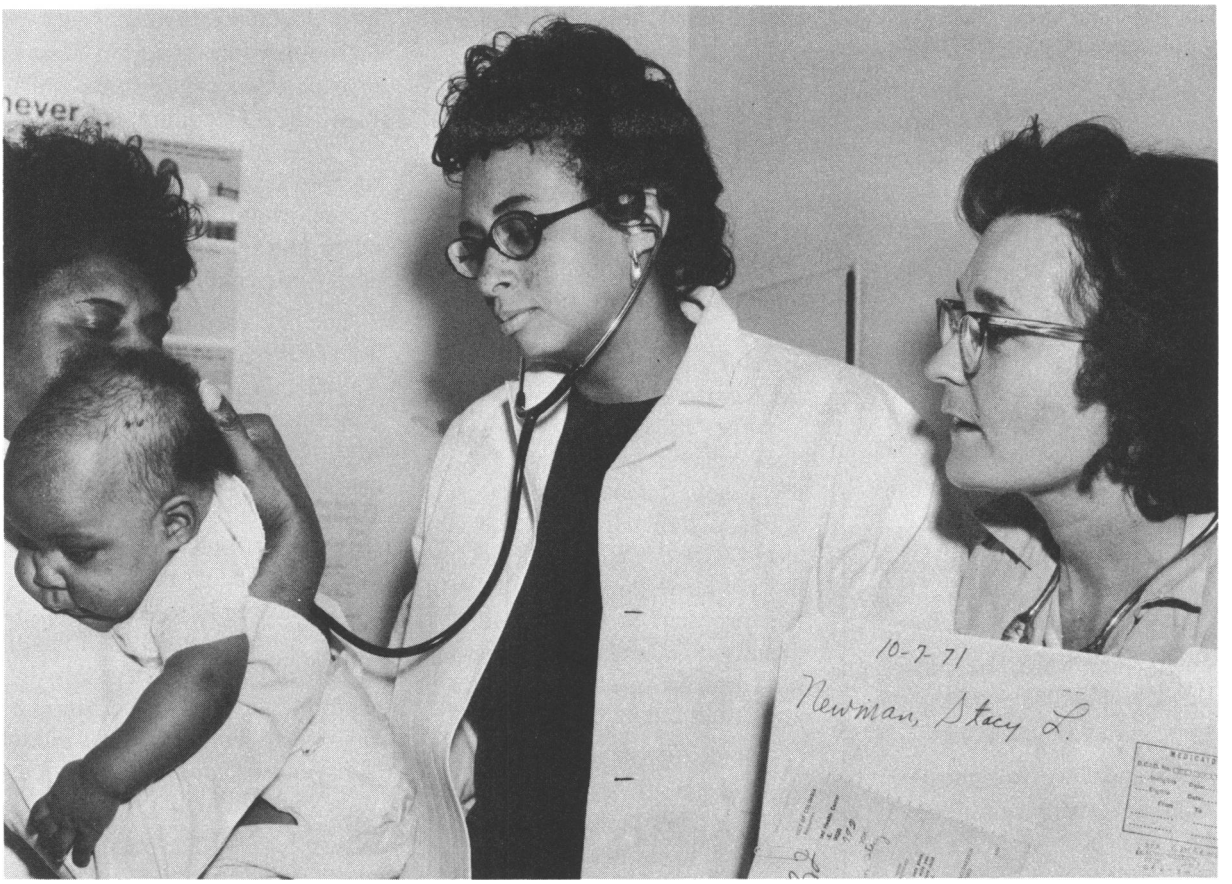
The training is divided into three phases which include both classroom instruction and practical experience.

Three Phases of Training

Phase one consists of 10 weeks of didactic lectures and study time, with a minimum of 8 to 10 hours of clinical experience per week. During these first 10 weeks of training, the curriculum is comprised of 20 hours regarding the sociopsychological development of the child, 60 hours concerning abnormal childhood conditions, 60 hours on child growth and development, 80 hours in independent study, and 120 hours of clinical experience. The intent of these courses is to give the trainee a well-rounded education in all aspects of child health that will allow her to assume a more independent role in patient care.

The second phase of training consists of 6 weeks of concentrated clinical experience in the neighborhood health centers. These neighborhood clinics have been established by the Department to provide comprehensive family health services within a single community facility. Currently, there are eight centers in the District where the pediatric nurse trainee can gain experience. In addition to this clinical training, she spends at least 4 hours per week at the training center. The 4 hours consist mainly of seminars in which there is considerable discussion regarding potential problems in reorienting the role of the nurse.

The third and final phase of training consists of a 6-month



Two of D.C.'s new pediatric nurse practitioners with a departmental pediatrician (right) give quality care to children

internship. During it, each trainee assumes a more independent role in giving well-child care and managing minor illnesses. In phase two, for example, the pediatrician reviews the findings of the trainee following each examination and before the patient is released. In phase three the pediatrician reviews selected cases at the end of the session. The trainee is assigned to the community health center where she will be working after completing training with the pediatrician. At least 8 hours per month is spent in continuing pediatric education. At the end of the internship the trainees are evaluated on written examinations and on practical clinical performance.

The first class was graduated March 31, 1972, with all the eight trainees satisfactorily completing the course. A second class consisting of approximately eight students is planned to begin during the summer of 1972. Nurses who are employed in any program administered by the Department of Human Resources will be eligible to apply for this pediatric training. Since the initial training model seemed quite adequate, only minor revisions are anticipated. Also, it is planned that the 12 hours of academic credit granted the trainees by Federal City College will be available to students in the second class.

Practitioners' Duties

The graduates are able to provide quality medical services in the Department's clinics and other institutions. The pediatric nurse practitioners will perform the following duties: (*a*) conduct initial interviews and examinations, (*b*) record interval medical histories and evaluations on followup visits, (*c*) counsel patients on infant and child development, behavior, and rearing, (*d*) manage minor medical problems, and (*e*) instruct parents on the proper administration of medicines and other nursing procedures.

The planning for continuity of care represents another responsibility of the pediatric nurse practitioner; this task involves participating in community health and social interagency meetings, identifying the need for referral to other community agencies, and

cooperating with other community agencies that provide child or family care.

The physical assessment of the health and developmental status of children affords the pediatric nurse practitioner the opportunity to use basic skills of inspection, palpitation, percussion, auscultation, and ophthalmoscopic examinations. The pediatric nurse practitioner must be able to recognize common illnesses, as well as to assess the developmental level of children and infants.

She will also handle parents' phone calls, mainly to give advice and to differentiate between conditions to be referred to the emergency ward, to physicians, or to be handled by the pediatric nurse practitioner alone.

Perhaps the two most important new responsibilities to be handled by the pediatric nurse practitioner are sharing in total management of well children and minor illnesses and accidents. Minor illnesses may include common communicable diseases, upper respiratory infections, gastrointestinal conditions, and skin irritations of children. The pediatric nurse practitioner will stress preventive measures as well as treating the condition. Examples of minor accidents that she might handle include cuts (except suturing) and ingestions. In the event of an ingestion the practitioner would administer the recommended antidote and, if she deemed necessary, would initiate the evacuation of the contents of the stomach. In assuming these responsibilities, the pediatric nurse practitioner must always be in close communication with the pediatrician in order to maintain viable quality services.

Need for Training Center

At present, a permanent training center has not been established for this program; however, health officials hope that one will be established in the future—with faculty members of some of the local collegiate schools of nursing assuming teaching responsibilities for the academic component of the program. Because such assistance was not available for the initial training program, the didactic lectures were given by Department nursing and medical staff. However, the Federal City College made it possible for the nurse director of the training program to be certified as a faculty member, thereby enabling the trainees to earn 12 hours of academic credit.

Currently, there are five collegiate nursing programs in the District and three diploma programs. Two of these diploma programs—at Freedmen's Hospital and D.C. General Hospital—are being phased out. The D.C. General Hospital School of Nursing will close in 1972 and the Freedmen's Hospital School of Nursing is scheduled to close in 1973. Establishment of a permanent training center in conjunction with a collegiate program would be both beneficial and in keeping with the need to find innovative ways of coping with the health care crisis.

The Program's Rationale

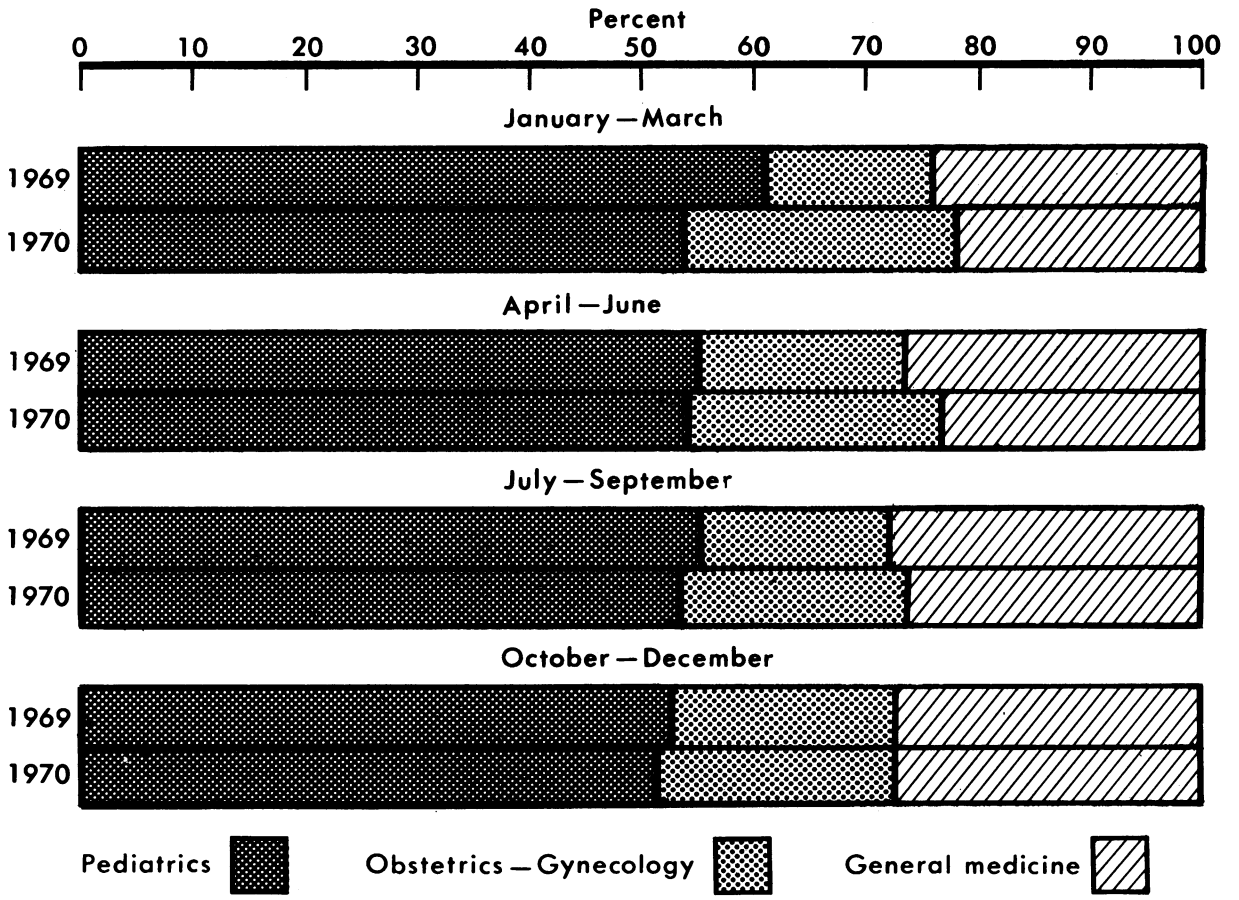
The foremost reason for creating this pilot project is the need to use more efficiently the skills of the physician, a category of health manpower in short supply. It has long been realized that the physician is often occupied with tasks that could be easily performed by other persons who have adequate training. A second reason for the program was to provide the professional nurse with an opportunity to expand her role in direct pediatric care. In this program, the nurse has an opportunity to use more effectively present skills and to apply newly acquired skills.

The pediatric nurse practitioner program can be instrumental in stretching health manpower resources, especially those who treat the city's young. Infants and children through age 14 comprise 29 percent of the city's population, and they comprise the segment of the population most susceptible to the inequities of the health system. The health of the child will affect his behavioral and cultural pattern of day-to-day living, his educational achievements, and his future employment potential.

Services at the neighborhood health centers include pediatrics, general medicine, and gynecology and obstetrics. The largest percentage of these services are rendered to the infants and children of the city. During the last quarter of 1970, more than 50 percent of all clinic visits were for pediatric services (see chart). Because the demand for pediatric services was twice as large as those for general adult medical or for obstetrical-gynecological care, the Department of Human Resources gave priority to developing a program in pediatrics rather than another specialty.

The existing health care delivery system in the District of Columbia is primarily oriented toward the treatment of the acute phase of illness, with little emphasis on prevention of the illness or maintenance of good health. The pediatric nurse practitioner program emphasizes pre-

Percent distribution of patients who visited eight neighborhood health centers of the D.C. Department of Human Resources, by service, according to quarters, 1969–70



ventive measures as well as the treatment of health conditions, and it promotes continuity of patient care through full utilization of all community resources.

Getting additional health manpower into the mainstream of medicine has been and continues to be one of the Department's main concerns. Through the implementation of this program, the Department's need for increased manpower can be partially realized. By accepting some of the responsibilities that were previously handled by the pediatrician, the pediatric nurse practitioner frees him to give comprehensive diagnostic and therapeutic services to additional patients. The pediatric nurse practitioner, in turn, must relinquish some previous duties in order to assume new ones. Reassigning duties to staff at the next lower level of the health ladder allows each professional or paraprofessional to assume more responsibility in the delivery of health care.

Conclusions

The response in the community to the pediatric nurse practitioner program has been extremely favorable. Parents are receptive to the trainees because they can spend more time with parents discussing a child's health, and thus establish deeper rapport. Also, it is felt that the parents appreciate the wider range of care that the nurse is now capable of rendering.

The initial acceptance and success of this program have encouraged the D.C. Department of Human Resources to proceed with other training programs to expand the roles of existing employees or to add new categories of paraprofessionals.