

Nurse Practitioners in Community Health Settings Today

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During a typical week as a Family Nurse Practitioner, I provide primary care to uninsured immigrant patients on a mobile van, teach an undergraduate nursing course entitled Community and Environmental Health Nursing at the Catholic University of America, screen Hispanic women for breast and cervical cancer through *Celebremos La Vida* (Celebrate Life) at Georgetown University's Lombardi Cancer Center and lead continuing professional education programs for health care providers who work with the poor and underserved through the Association of Clinicians for the Underserved (ACU)'s Pediatric Asthma Prevention Project and Early Childhood Caries Prevention Project.

As a Family Nurse Practitioner, I am trained for a variety of practice settings, including primary care, teaching, research, and management. It is this flexibility and variety of work that I thrive on and that allows me the opportunity to be part of many exciting public health projects, while still having time for my family and community. This varied skill set allows me and other Nurse Practitioners to take on multiple roles in the evolving health system.

The ACU is a non-profit, transdisciplinary organization of clinicians, advocates, and health care organizations united in a common mission to improve the health of America's underserved populations and to enhance the development and support of the health care clinicians serving these populations. The ACU defines transdisciplinary care as a holistic approach to patient assessment and treatment through a highly collaborative team of health care professionals.

This approach only allows health care professionals other than physicians increased decision-making powers in patient care; furthermore, through continuing cross-disciplinary education and regulated overlapping roles, greater efficiency in patient care can be achieved. This collaboration is beneficial to patients and could be a cost-effective way to improve the U.S. health system, and to expand it to treat those who currently go without regular health care. Furthermore, for people living with long-term illnesses such as HIV, hypertension and diabetes, Nurse Practitioners (NPs) can help provide long term patient education and preventive care.

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Training and Roles of Nurse Practitioners

An NP is a registered nurse (RN) with additional training, usually at the masters level (some NPs have certificates, but those programs are being phased out). The graduate training builds on nursing roles in patient advocacy and education, and incorporates physical assessment and diagnostic skills, along with management of acute, chronic and episodic diseases. This includes taking a patient history, performing a physical exam, ordering and interpreting laboratory tests, providing medication, referring to specialists and promoting healthy lifestyles.

The first NP program dates back to 1965 in Colorado where nurses were trained to provide pediatric care to underserved populations. In 1996, it was estimated to be over 40,000 NPs, and by 2000 that number had climbed to over 62,000. Official figures for 2004 are not yet available, but national organizations estimate the number is over 100,000.¹

Some NPs specialize in areas such as women's health, pediatrics, school health, psychiatry, neonatology, and oncology, while others seek a broader focus in family medicine. While NPs work in specialty private practices and in-patient units, this article focuses on roles and opportunities for NPs in the community health setting.

Like members of many other professions, NPs are regulated by the state, in accordance with state laws, and through certification with national credentialing organizations. Some states allow NPs to practice completely independently, others require a collaborative agreement with an MD that defines the scope of practice for that work site, while others do not recognize practice by NPs at all. While the level of prescriptive authority also varies by state, NPs have prescriptive authority in most states, including the opportunity to apply for a Drug Enforcement Agency (DEA) number, allowing them to prescribe controlled substances. One of the many policy issues NP organizations are focusing on is that of allowing managed care patients to choose an NP as their primary care provider.

Nurse Practitioners, along with Physician's Assistants (PAs) and Certified Nurse Midwives (CNMs), are often referred to as midlevel providers or physician extenders. Some NPs and PAs object to these terms, arguing that they imply the NP, PA or CNM occupies a lower position than a physician. However one resolves such concerns, few would disagree that there is a role for every person in the complex health system, including physicians, nurses, social workers, pastoral care ministers, and NPs and PAs. In a recent *Wall Street Journal* article, Ann O'Sullivan, an NP at University of Pennsylvania, is quoted as saying that NPs and doctors collaborating with one another achieve the best outcomes. The example she uses is a patient who needs to stop smoking: the physician explains the physiological problems with smoking while the NP looks at the psychological factors in smoking and the personal barriers to smoking cessation.¹ On a transdisciplinary team such as this, all providers function as equal partners, each with his or her own strengths and skill sets. Patient satisfaction studies have shown NPs to be rated with high favorability.²

The most effective role of the NP in the primary care setting is that of a provider who combines medical knowledge, diagnostic ability, and prescriptive authority with education regarding disease management and lifestyle modifications, and works in a team with others. Nurse Practitioners are in a favorable position to develop an

ongoing relationship and to build on patient strengths, taking into account real life demands of the patient. While medical training focuses on diagnosis and treatment, NP training builds on nursing's foundations in care and prevention. For patients with chronic diseases, on-going education and reinforcement in the management of the disease is important. By empowering patients to take care of themselves, make lifestyle changes, and prevent acute exacerbations of disease, NPs help in the prevention of expensive hospital visits which will be financially beneficial to the medical system and personally beneficial to the patient.

One example of this is in the treatment of patients with elevated cholesterol levels. As an NP, in addition to providing cholesterol-lowering medications to patient, I talk to them about their diet and exercise routines. On the mobile van I primarily treat Latino patients, having become fluent in Spanish and having learned about Latin foods and cooking styles during a 10 year post-college pre-nursing career stay in Central America. This gives me the unique opportunity to discuss the high amount of fat in the diet and make culturally acceptable alternative suggestions. As for exercise, it is unlikely that most of my patients will be able to afford a gym or an exercise machine, yet I know that dancing is a favorite past-time of many patients, and going to church is an important weekly activity. Therefore, I suggest dancing at home to CDs or the radio two or three times per week, and parking far from the church or getting off the bus a few stops early, to increase physical activity. I can usually make dietary suggestions that are culturally acceptable, as well.

Several of my physician colleagues are also adept at providing individualized patient-centered care. I have had the opportunity to work with and learn from many of them. However, the focus on prevention and empowerment through teaching is a particular strength of NP training. Many physicians come to it naturally, but others do not and it is far less strongly emphasized in MD training.

My own path to becoming a Family Nurse Practitioner started when I visited Mexico through an American Friends Service Committee (Quaker) youth project as a college student majoring in political science. I became aware of the serious health needs in the community where I lived, and wanted to gain concrete skills to help prevent disease and malnutrition. Upon graduating from Oberlin College, I wanted to go back to Latin America and work in public health. As a Jew, I was reluctant to work with an organization based in a Christian church, and having seen first-hand the effects of the United States backed wars in Central America, I did not want to work through the U.S. government in the Peace Corps. I eventually landed a job at the National Assembly of Nicaragua during the years of the Sandinista Revolution. While I wasn't working directly in a health capacity, I was able to see how a country could attempt to bring about social changes in health care and education. After several years in an office setting, I started a job at a Nicaraguan non-profit organization that offered participatory education sessions on a variety of subjects including breastfeeding, malaria prevention and family planning to peasant groups throughout the country. Later, I worked with the Department of Maternal-Child Health in the Ministry of Health on women's health projects. After almost a decade of working in a country making clear attempts to improve the health and welfare of its population, in spite of economic and military pressure

against it, it was time for me to return to the United States to figure out which direction to take next.

I considered a variety of options, including public health school, medical school, physicians assistant school, and nursing school. While I knew I wanted to work in a community health setting, either in the United States or Latin America, I didn't know if I wanted to do research, teaching, direct service or management. I chose nursing school, in part because I could add a clinical or a public health degree to my training at a later point.

After receiving my bachelors in nursing degree from Johns Hopkins University, I worked as a labor and delivery nurse, and considered pursuing training as a nurse midwife. By the time I was ready for graduate training, I realized that in order to continue my commitment to the underserved, I wanted to be in a community health setting, and not a hospital. Most of the local birthing centers in my area catered to the wealthier, insured population. Furthermore, I had received a National Health Service Corps (NHSC) Scholarship to fund my graduate education, and I knew that midwifery placements in the two year community service payback were scarce, so I chose to become a Family Nurse Practitioner. I wanted broad skills to work with larger populations and the idea of working with entire families and understanding how an illness in one member affects the entire family appealed to me. During my rotations in NP school at Georgetown University, I sought rotations in local community health settings where I could work with the kinds of populations I would work with after graduation.

I vividly remember working with an internal medicine physician at Upper Cardozo Community Health Clinic in Washington, DC. I kept asking him why he wasn't putting his patients on the drug of choice, as I had learned it in pharmacology. Even in those days, before Personal Desk Accessories were in the pockets of most clinicians, he could spout off the costs of all the major medications he put his patients on; often, the drug of choice according to the pharmacology text book was out of the economic reach of the patients. This was an important lesson in community health medicine for me: the treatment of choice is often limited by the economic situation of the patient.

I completed part of my NHSC payback in a large community health clinic in Baltimore and helped set up a satellite clinic serving the Latino population. The other part of my payback was as Director of Primary Care at the Washington Free Clinic, a free clinic serving the uninsured. In both of these settings, I learned substantial management skills, and became aware of many realities of provision of care where there are limited resources (in addition to short funds, these realities include suboptimal buildings, inadequately trained staff, and the absence of common technological systems, such as computerized scheduling). The transdisciplinary model became key for me in both these settings, as I was usually the only clinician fluent in Spanish, and could work with a physician to convey the treatment and medication regimens for a patient in the patient's primary language.

After the birth of my second child, the demands of work at a clinic with evening hours proved to be too much, so I took a job in the Department of Psychiatry at Georgetown University on a research project to study interventions for depressed

low-income women. I was one of several clinicians, both NPs and psychologists, who worked as a transdisciplinary team with a psychiatrist, treating low-income depressed women with pharmacological agents and cognitive behavioral therapy. The objective of the randomized controlled study was to determine the impact of an intervention to deliver guideline-based care for depression, compared with referrals to community care, for low-income and minority women.³ It was exciting to be working with nationally accepted guidelines and low-income women, instead of offering them the cheaper, but not necessarily best, treatment plan for a problem. In addition, most women I had seen clinically were also suffering from depression, and were not appropriately screened or treated for it. Through this project, I developed primary care skills for treating depression, worked in community-based research, and again was part of a transdisciplinary team.

Presently, working with ACU, I am able to combine all the skills and experiences gained from these positions as an educator to providers who work with the underserved. In ACU-sponsored projects focused on the reduction of early childhood caries and acute asthma attacks, I combine my history of management, teaching, research and clinical experiences to educate other providers who work with the underserved. Additionally, I maintain my clinical skills by working in a variety of community health settings. These broad NP skills allow me great flexibility and job satisfaction.

NPs in the Future

New areas on the horizon for NPs include a growing number of independent NP run practices, increases in the number of health insurance companies that permit NPs to be primary care providers, and the use of NPs in “Minute Clinics” or outpatient rapid clinics houses in department stores where NPs can quickly treat a variety of episodic diseases, such as urinary tract infections and conjunctivitis. The danger in these clinics, though they provide exposure for Nurse Practitioners to the general population, is that patients tend to be referred back to their primary care provider if the NP finds a more complex problem, although often the patients have no primary care provider. The success for patients of these clinics will depend on the local community health resources available to meet their needs, and the NP’s knowledge of those resources.

Additionally, some nursing schools and boards of nursing are looking at a four-year doctor-of-nursing-practice program that would incorporate evaluation clinical studies and setting up independent practices into the NP training. As the baby-boomers age, NPs will play an increasingly important role in geriatric care, as well.

An NP is an essential part of a transdisciplinary health team. The combination of medical skills and nursing care provide a unique role that can fill gaps in many primary care settings, and improve patient outcomes.

Notes

1. Blackman A. Personal Health Treatments—Is there a doctor in the house? Perhaps not as nurse practitioners take on many of the roles long played by physicians. *Wall Street Journal*, October 11, 2004, R4.

2. Mudinger MO, Kane RL, Lenz ER, et al. Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial. *JAMA* 2000; 283: 59–68.
3. Miranda J, Chung JY, Green B, et al. Treating depression in predominantly low-income young minority women: A randomized control trial. *JAMA* 2003; 290:57–65.