A New Perspective on Head Start Health Care

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President Nixon identified child health as a primary concern of Project Head Start when he referred to the program as "a national commitment to provide all American children with an opportunity for health and stimulating development during the first five years of life" (*1*). His stress upon the importance of the program's health emphasis is particularly significant, for while Head Start's creative techniques and unceasing efforts toward greater public awareness have overcome the major part of earlier criticism, there are still those who claim that it has not raised the IQ's of children sufficiently to justify its existence.

Dr. Edward F. Zigler, Director of the Office of Child Development, which operates Head Start for the Department of Health, Education, and Welfare, has forcefully put the matter in perspective. "We are crucifying the children of this country on the cross of IQ," says the former Yale educator. "This society is too IQ conscious, as though IQ is the measure of a person. We are going

to ask rather whether Head Start is raising the quality of life. We are going to look at the child's health, his nutrition, his motivation, his behavior" (*1*).

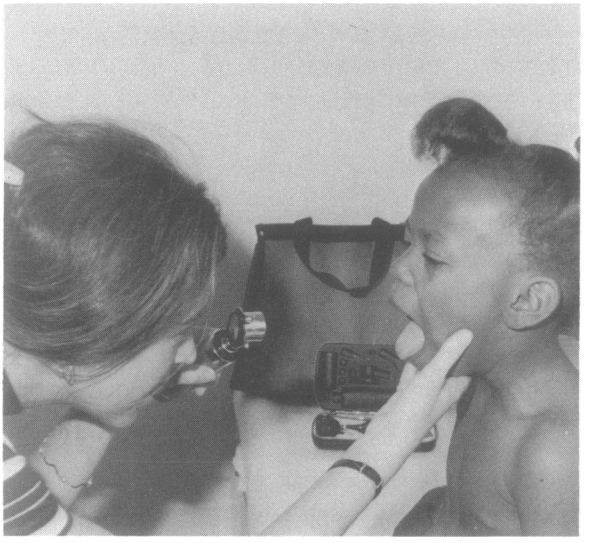
Primary Objective

Thus, without underestimating the crucial importance of the social, mental, and emotional stimulation provided by creative programing, let us look for a moment at the protection and promotion of child health as the very core of Head Start. Unless the small Head Starter is strong and healthy in body and mind, he is unable to take full advantage of the learning and doing opportunities presented to him within the scope of the program. And without a clean bill of health said junior citizen can hardly be expected to begin his school career, and thus his preparation for life, with a genuine "head start." Truly then, child health—painted on a wide screen—is what Head Start is all about.

Head Start's health program does not represent the addition of just one more opportunity for piecemeal assistance to low-income families to the already extensive number of such programs now available. Rather it offers, and insists upon, comprehensive medical and dental care for all preschoolers under its aegis.

The difficulties in the actual delivery of such comprehensive care to this important and high-risk segment of our population obviously stagger the imagination. Making free health care suddenly available to a child for a limited period does not make it automatically desirable to either the child or his parents. In a society characterized by the exorbitant costs of medical and dental care, good health is by necessity a middle-class value. For low-income families, adequate health care is clearly beyond their reach. The adults in this group, who themselves lacked such care as children and who can in no way afford it for their offspring, seldom see good health as a positive state of being, worthy of the expenditure of time and effort as well as money. Of necessity, food, clothing, and housing are given priority over health care. Too often the poverty that necessitates inadequate food and clothing and nonhygienic shelter also precludes the acquisition and maintenance of good health.

Project Head Start thus symbolizes the dilemma faced by all modern public health programs: how can an increasing number and variety of health services be geared to the needs of a growing number of individuals so that these persons can reap the maximum benefit from them? To be effective, such services must reach out to the population they are designed to serve; they must reach not only bodies but minds, and in the case of Head Start, they must reach the minds of both children and parents.



Mary Alexander, pediatric nurse practitioner, conducts a Head Start physical examination

Obviously, success depends upon a coordinated team approach, which in turn depends upon effective team leadership. Who, then, should be the health team leader? Logically, it should be a health professional working full time with the Head Start program who is competent to deal with the social and psychological as well as the physical aspects of health care and who can coordinate the efforts of a wide variety of other health professionals.

The Physician as Leader

Traditionally, the physician has functioned as the health team leader. Contemporary physicians, however, are too scarce, too specialized, and too expensive to be concentrating their time and talents in such a role. Head Start has bowed to expedience by making a nurse the health representative on every local program's staff, but ordinarily it still operates on the premise that the health program itself must be physician-directed—by remote control, if necessary. It is significant that in Head Start's official directive concerning health services (*2*) the initial section on "Administrative Considerations" lists nursing as eighth out of 12 professions that should be involved in the

planning of the various local Head Start programs (following four categories of physicians; local, regional and State health officers; and hospital administrators and dentists). Thus, local Head Start programs usually assume that the major function of the nurse is to carry out physicians' orders.

An increasing number of concerned health professionals recognize, however, that in terms of the burgeoning needs of our population the assumption that the physician must always direct all health care programs and handle most diagnostic and treatment procedures within them is no longer viable. There are two reasons why such a modus operandi is now obsolete. The first is simply supply and demand: too many patients, too few physicians. The second is more subtle. This is the age of specialization—of the expert who "knows more and more about less and less"—and the modern physician is a specialist. This is true even of the general practitioner, if one compares him with the old country doctor.

But, while vastly increased knowledge and improved facilities have given today's physician the advantages of specialization, the physician of yesteryear enjoyed a significant advantage over his modern-day counterpart. Living and working as he did in a community where he frequently supervised his patients from birth to death, he saw health care as a part of a life continuum and developed a wisdom and a perspective based on his experience with the totality of his patients' lives. By contrast, today's physician tends to see his patients in pieces. Even the general practitioner, pressured by an ever-increasing patient load, too often loses track of his patients once he has either cured their diseases of the moment or referred them to a specialist.

Evolving Role of the Nurse

Thus, with physicians trending increasingly toward specialization, the preparation of the nurse is changing—not rapidly enough for the imperatives of the times but rapidly enough so that important trends can be identified. The training school for the nurse is becoming outmoded as hospital-directed nursing programs move in under educational auspices. With university nursing schools as models, nursing education now leans almost as heavily on the social sciences as on the biological. The nurse, therefore, is often better prepared than the physician in dealing with the psychosocial aspects of both health and illness.

Logically then, in terms of her own preparation and interests and society's needs, the nurse is frequently the health professional best suited to supervise health care at the primary level, with the physician available for consultation whenever necessary. But, since many of today's practices are based on yesterday's experience, health programs—including Head Start's—continue to be physician-centered. Society still assumes that only the physician has the overview necessary for the administrator, that only the physician has the training and experience essential for supervision of health care at all levels.

I submit that this is no longer so. I also submit that the nurse is often best qualified to assume the leadership role in planning, directing, and implementing public health programs primarily concerned with health screening, prevention of illness, and overall supervision of physical and mental health. Finally, I propose that Project Head Start, because of its emphasis on the total child, is a logical proving ground for this new nursing role, especially since the most significant pioneering work in expanding the nurse's role has been in pediatrics.

Local Experiment

The 1971 Summer Head Start Program in Laramie, Wyo., was not intended to be a vehicle for the expanded role of the nurse. Based on its 4 previous years of experience, however, the program did begin with a greatly expanded purpose: that of seeking a more effective method of providing complete and continuing health care for its children. Because it succeeded in this purpose far better than anticipated, we who had participated in the program took a new look at the outworn assumptions governing society's use of the health hierarchy.

Since the program's inception in 1967, Laramie's Head Start personnel had annually approached health care in the traditional manner. On the premise that a central objective of Head Start is to acquaint the child and his parent with the physician who will be responsible for the child's continuing health care, every effort was made to route children to the physicians of their parents' choice for a physical examination, as well as for followup care when indicated. As stated in Head Start's official directive (*2*):

> Ideally, each child should be examined by a physician or clinic who will institute corrective treatment for all defects discovered and who will also provide continuing health supervision for the child during the time that he

Diana Maxell, RN, takes a health history on Head Start child, Eva Mendoz, from Eva's mother. Photo by Gene Kimsey, Head Start

is in Head Start and over the years to follow. One of the central goals of the Head Start program is to introduce a child and his parents to a physician or clinic that will be able to meet all of his health needs over an extended period of time.

After 4 years of operating on this philosophy, the staff had to admit failure. True, each child had been seen by a physician and the entire budget allotment had been spent annually, but the degree of health care actually obtained was negligible. In analyzing why this was true we concluded that, while no particular individual or group was to blame for this failure, a variety of circumstances had combined to make the method we had used unproductive.

First, ours was a summer program lasting just 10 weeks, and, despite our efforts to expedite the process, it invariably took the entire 10 weeks simply to get all parents and children to the physicians of their choice for the initial physical examinations. Then, by the time the records were forwarded to the Head Start center, the program was closing and the staff dispersing. Thus, if the physicians had made any followup recommendations, it was then obviously too late to implement them adequately. (While Head Start's national office recommends that local programs hire certain staff that can continue throughout the year to insure followup, many local programs are financially unable to do so.)

Furthermore, many of the participating physicians, flooded by paperwork in addition to their heavy clinical loads, did not fill out the examination forms and return them to Head Start's sponsoring Community Action Agency until months after the program was over. And, while many of these physicians were sympathetic to the aims of Head Start and attempted to do their best with parents and children in the limited time available to them, many were unaccustomed to working with poverty patients and thus were not attuned to their needs. In addition, there was the occasional financial abuse—rare, but costly in terms of the program's limited funds. For example, one physician chosen by a few families inquired whether or not we had funds available for followup care should any of the children require it.

We explained to him that our budget was calculated in terms of a given amount per child ($17 that year—which he insisted upon determining) and that our followup allotment consisted of the differential between the cost of the initial examination and said amount. When this physician's bill arrived, he had raised the price of each of his physical examinations from the $12 he ordinarily charged to exactly $17. Needless to say, he had recommended no followup care for any of his Head Start patients.

The most compelling reason, however, for the discouraging results of Laramie's 1967–70 Head Start health program was that it had failed in its central objective—that of providing each child with a continuing means of health care by formation of a positive relationship with a physician. Because we tended to see the same families over the years as their various children went through the program, we were able to observe their patterns, which remained disturbingly unchanged. And for a very logical reason. No matter how willing parents may have been to take their children back for continuing medical supervision, they were unable to do so simply because, once Head Start could no longer pick up the tab, these parents could not afford to pay for it themselves. Until our society sees fit to make all forms of health care available to all its citizens, through a form of health insurance that does not discriminate against the poor, no antipoverty program can expect its beneficiaries to continue with a health care system they are unable to pay for once they are no longer eligible for Federal assistance.

Before the 1971 program began, our Head Start board and health personnel, with the support of Head Start director, Richard A. Ellerby, concluded that a change in methodology was due if our health care program was to stop marking time. Moreover, we found in Head Start's official directive (*2*) considerable support for innovation in the delivery of health care:

> The improved health and function of the indvidual child is paramount, not any particular method or pattern of organization.

Also, in the February 1965 report entitled "Improving the Opportunities and Achievements of the Children of the Poor," submitted by Dr. Robert Cooke, chairman of Head Start's original Planning Committee, to Sargent Shriver, director of the Office of Economic Opportunity (which originally funded Head Start), the following point was emphasized:

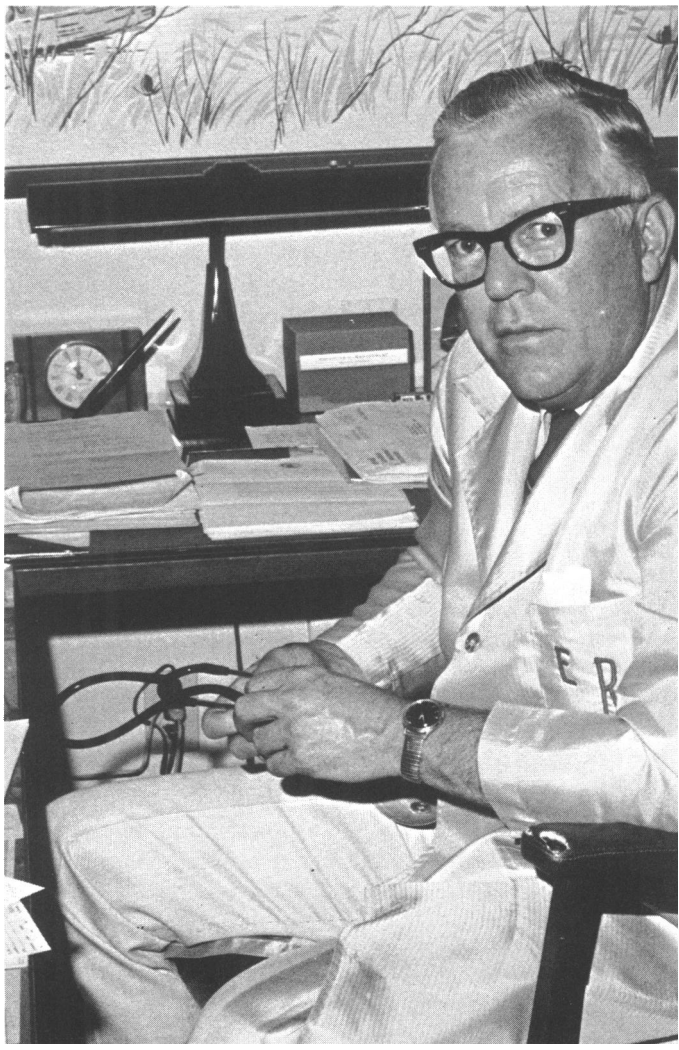
> There should be support for a variety of programs tailored to fit local community conditions. OEO should specifically encourage innovative and experimental ideas.

We thus decided it was time to turn to different health personnel, not only in order to expedite the children's initial care more quickly and efficiently but also for directives in the provision of continuing supervision for these high-risk youngsters at the beginning of their school careers.

The Pediatric Nurse Practitioner

Our decision led us inevitably to a neighboring State which had pioneered in the development of a new category of health personnel. At the University of Colorado the now-famous Pediatric Nurse Practitioner Program, currently used nationwide as a model, had been co-founded by Dr. Henry K. Silver of the school of medicine and Dr. Loretta C. Ford of the school of nursing. The graduates of this program have effectively demonstrated that nurses with the proper additional training in pediatric concepts and techniques can

Dr. Esten W. Ray, Head Start medical consultant. Photo by Gene Kimsey, Head Start



satisfactorily handle 75 percent of the average pediatrician's caseload—the 50 percent that consists of well children who need supervision and preventive care and roughly half of the remaining children presenting varying degrees of pathological conditions (*3*). Furthermore, the emphasis of the pediatric nurse practitioner is on health rather than illness, on prevention rather than cure. She is also primarily interested in the continuous supervision of the child's health as a vital part of his total life continuum.

Head Start contacted Dr. Ford, who offered to help plan and to participate in our physical examinations and the coordinating of ongoing care. Dr. Esten W. Ray, Laramie pediatrician and our Head Start medical consultant, went before the local medical society to interpret our proposed new approach to health care. He gained the approval of its members and their consent to work with Head Start on a referral basis. Dr. Ford and Mary M. Alexander, assistant professor in the Pediatric Nurse Practitioner Program, came to Laramie before Head Start opened to plan the health program with local personnel.

Following this initial meeting, Diana M. Maxell and I, as Head Start's staff nurses, visited the homes of the 52 children (from 49 families) enrolled in Head Start. We took a complete health history on each child.

During the initial week of the program, immunizations and screening tests were begun. Dr. Robert H. Jessen, Laramie's ophthalmologist, tested the vision of all 52 children. Speech and hearing screening was conducted by the University of Wyoming's Language, Hearing and Speech Clinic under the direction of Dr. R. Ramon Kohler. Students from the university's department of psychology, supervised by Dr. Robert C. Tindall, administered the Denver Developmental Screening Test to each child. Blood and urine testing was done by laboratory technicians at the Ivinson Memorial Hospital under the direction of Dr. Masahiro Sakai, pathologist.

July 1, 1971, was physical examination day at Head Start. An examining team, consisting of Dr. Ford and Miss Alexander plus Dr. James A. Hecker, University of Colorado pediatrician, and Dr. Chris J. Ghicadus, Laramie physician, worked in physician-nurse pairs in two rooms, thus expediting the examination of four children simultaneously. Most of the children were accompanied by a parent. Each parent thus had an opportunity to discuss her child's health with the physician or nurse examiner on the basis of the examiner's clinical findings, his observation of both child and parent, and his interpretation of both the health history and the screening tests. The physician and nurse could consult immediately if necessary. And, if a diagnosis needed confirmation or a prescription was required, the physician was there to provide it. During the morning, refreshments were served by the Head Start mothers' cooking class to all attending parents, and transportation to and from the center was arranged for all parents desiring it.

In the afternoon the visiting team joined the Head Start staff for an assessment session, discussing each child in detail and recommending both the type of followup care needed by those with identified problems and where such care might best be obtained. Those children with frank medical problems were referred to the physician of their parents' choice. Those who needed the care of specialists were referred, via their family physician if they had one, to the individuals or agencies best qualified to help them. Often several referrals were made for a child who presented more than one problem. Social agencies as well as those dealing with physical and mental health were utilized in this "total push" approach.

The problems identified or confirmed were many and various: low hemoglobins, urinary tract infections, other acute infections, cerebral dysfunction, a congenital ear anomaly, obesity, mental retardation, malnutrition, an eye defect requiring corrective surgery, speech and hearing problems, orthopedic handicaps, maladaptive behavior, and several suspected cases of child battering. (Dental caries were already under treatment by the local dentists.) In all, 23 children were referred, either to their family physicians or to other therapists or agencies best suited to their needs.

With the screening tests, physical examinations, and child assessments completed during the first half of the summer's program, there remained time to arrange for followup care during the latter part of the Head Start program. For those children needing continuing supervision, referrals were made to school personnel (principal, nurse, or guidance counselor) who could then carry on from an organized beginning. The permanent cumulative record folder used by the public school system was begun for each child, listing the results of the screening tests, the immunization record, and the physical examination findings, with subsequent followup care indicated for those needing it.

Evaluation

Laramie's 1971 Head Start health program achieved a much greater degree of success than it had previously, not simply because of the introduction of the pediatric nurse practitioner but because of the team approach made possible by the use of this new health professional. This was in contrast to previous practice in which followup care had been negligible, because the time limits of the program plus the logistics of getting the children to their various physicians had limited the scope of health care to problem identification only. By assuming the responsibility for planning, coordinating, participating in, and assessing Head Start health care, the pediatric nurse practitioner made optimum use, not only of her own talents but also of those of the physicians, nurses, and other health professionals working with her. Each child was totally assessed before the program was half over, with the result that, for the first time, opportunity remained within the limits of the program to follow through on recommendations made.

While permanent placement of each child within a health care system without cost barriers would have been desirable, it obviously was not possible. The next best thing appeared to be the referral of those children needing continuing health supervision to the school authorities, in the hope that these authorities could either provide help directly or assist parents to obtain it elsewhere when necessary.

The total cost of the summer's program was comparable to that of previous summers. The difference lay in the fact that the money spent in 1971 covered far more comprehensive care. For the first time in its 5-year history, Laramie's Head Start health dollar had bought a full dollar's worth of genuine health care.

Implications of Laramie's Experience

But what happened in Laramie in the summer of 1971 has implications reaching far beyond one small city. By attempting to discover if, by departing from time-honored methods, better continuing health care could be provided for Head Start children, Laramie's staff happened to tune in on the wavelength of the future in terms of both the ends and means of health care in the United States.

For years health professionals have deplored the fact that the individual becomes hopelessly lost in the vast complexities of today's medical machinery. They have noted with alarm the widening gulf between the increasing number of patients and, by comparison, the shrinking number of physicians. They have continued to apply horse-and-buggy logic to an enormous technical system, partly because they rationalize that the public demands it, but mainly because the experts themselves, as guardians of the nation's health, are also members of that public and as such are repositories of the values of their parents and grandparents, unconsciously resisting the imperatives of exploding change.

Only occasionally has society looked toward nursing as an untapped resource. So accustomed is it to thinking of nurses simply in a "fetch and carry" role that it overlooks the fact that an increasing number of nurses have trod the halls of our universities as long as or longer than physicians, while an even greater number have developed clinical expertise far beyond the level at which society has allowed them to function. It is significant that one of the first tentative steps

Dr. Loretta C. Ford (left), co-founder of Colorado's Pediatric Nurse Practitioner Program, discusses Head Start with a public health nurse

toward relief of the medical manpower shortage through the realignment of personnel called for casting the nurse in the "physician's assistant" category—more new wine in old skins.

But Colorado's Dr. Ford and those who have picked up her challenge across the nation have demonstrated by action, not merely words, that the modern nurse can respond to the demands of a rapidly changing society with initiative, not obedience, with an educated mind instead of a trained one, and as an associate to the physician rather than as his assistant. In no way does this new kind of nurse wish to replace the physician at any level; her role is rather a complementary one, for her focus is on preserving health rather than curing illness. Furthermore, her educational background, drawing today as heavily from the social as from the physical sciences, prepares her to be the logical member of the health team to assess the health of the individual at the primary level in terms of his total life continuum, with the physician available for consultation whenever necessary. In this significant manner the nurse assists the physician and he assists her, but far more important, both give optimum assistance to the patient—which is, after all, what health care is all about.

Many Head Start programs throughout the country are undoubtedly finding the traditional system of health care delivery quite satisfactory for their purposes. Furthermore, it will be some time before enough pediatric nurse practitioners will be available for extensive use in Head Start. (Other States besides Wyoming, however, are currently employing them in Head Start programs; for example, Colorado and California.) Regardless of what system individual programs utilize, the pediatric nurse practitioner has effectively demonstrated that nurses can take a far more active part in the planning as well as in the delivery and supervision of pediatric health care. This fact has immediate implications for all public health nurses, physicians, and administrators concerned with improving the level of child care in their respective programs.

Project Head Start has proved unique in that, rather than fragmenting the individual as innumerable mass programs have done, it has provided a multifaceted approach to the whole child. Because it attempts to help the child integrate himself into a world organized by adults, it is essential that the approach of adults to the child be a fully integrated one. Such an approach can best be accomplished by a responsible team effort in which increasingly the health component is implemented by a nurse who acts as catalyst, coordinator, and equal participant in Head Start health care. The healthy, happy child will continue to be the hallmark of the program's success.

Summary and Conclusions

With the establishment of child health as a major emphasis of Project Head Start, the choice of leadership for Head Start's health program has become a matter of primary importance. The modern nurse, with her focus on the preservation of health (rather than the physician, who must concentrate on the diagnosis and treatment of disease) is often the person best suited for the leadership role in public health programs primarily concerned with screening, prevention, and health supervision.

Assisted by Dr. Loretta Ford of pediatric nurse practitioner fame, Laramie's 1971 Summer Head Start Program achieved a genuine breakthrough in its child health care. Because of the team approach made possible by the use of pediatric nurse practitioners, Laramie's Head Starters received health care that was coordinated, complete, and continuing. With the city's physicians, health agencies, and schools working with Head Start on a referral basis, it became possible to provide total care for each child, including continuing supervision through the schools and the public health nursing service for all children requiring it.

In an era marking the shift of health care from hospitals and physicians' offices to the community, such a breakthrough has compelling implications. Our citizenry now has available to it a task force of "new professionals"—nurse practitioners prepared to take an active role in the supervision of community health. Project Head Start, through its total approach to the child, can be instrumental in making possible a total approach to child health by the continued use of these nurse practitioners.

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