Chapter 3

Nursing's Role in Building a Culture of Health

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Chapter Objectives

By the end of this chapter, you will be able to:

1. Identify the social determinants of health and explain how where people live, learn, work, and play affects their health.
2. Describe new nursing roles that are promoting health and keeping people healthier.
3. Explain how nurses can build a Culture of Health by taking a leadership role in addressing the social determinants of health within a primary health care perspective.

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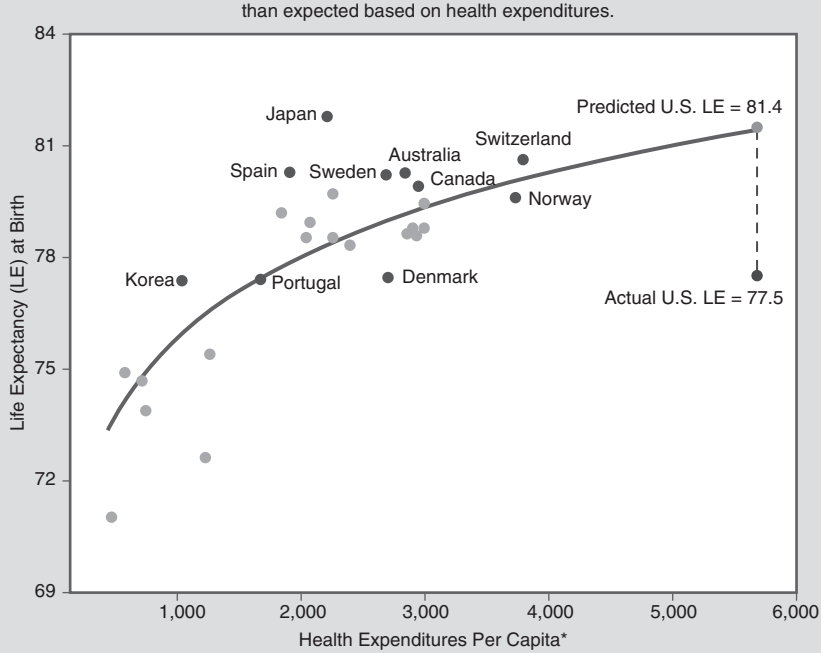
Introduction

The United States is unhealthy, resulting in poorer quality of life and lost productivity compared with other developed countries. On more than 100 measures, health in the United States lags behind other developed nations. People in 26 countries can expect to live longer than Americans (Braveman & Egerter, 2013). U.S. rankings for infant mortality have also fallen relative to other countries, from 18th in 1980 to 26th in 2006 (OECD, 2009). Yet the United States continues to spend more on medical care than any other country (**Figure 3-1**). The United States, in short, is getting poor value for its health care dollar. This chapter provides a way to address the disparities of health

Figure 3-1

America Is Not Getting Good Value for Its Health Dollar

The United States spends more money per person on health than any other country, but our lives are shorter—by nearly 4 years—than expected based on health expenditures.



Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.
Sources: OECD Health Data 2007.
Does not include countries with populations smaller than 500,000. Data are for 2003.
*Per capita health expenditures in 2003 U.S. dollars, purchasing power parity

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care in the United States by changing the way we think in practice, moving toward the idea of primary health care, and developing a culture of health.

Health Disparities

Health varies substantially in the United States across states, cities, and regions and among social and economic groups, and many Americans are substantially less healthy than they could and should be (**Figure 3-2**; Egerter et al., 2009). The landmark Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Nelson, Smedley, & Stith, 2009), concluded that U.S. racial and ethnic minorities are less likely to receive routine medical procedures and experience a poorer quality of health services. The report found that a large body of research underscores the existence of disparities, defined as racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, or appropriateness of intervention (**Figure 3-3**). The mortality rate for Blacks has been 50% higher compared with Whites, and infant mortality for Blacks has been twice as high as that for Whites (National Center for Health Statistics, 2011; Satcher et al., 2005). The Department of Veterans Affairs, which offers patients similar access to care, has documented health disparities in its system, suggesting that disparities take root outside the formal health care system (Saha et al., 2008). Thomas LaVeist and his colleagues (2011) found that eliminating health disparities for minorities would have lowered direct medical care expenditures by $229.4 billion for the years 2003 through 2006.

The Social Determinants of Health

Where people live, learn, work, and play influences the choices Americans have for leading healthy lives. Our health-related behaviors are influenced by factors in our homes, schools, workplaces, and communities. Health disparities across income and education groups are present in many health conditions from the start of life to the end of life (Braveman, Cubbin, Egerter, Williams, & Pamuk, 2010). Each of us needs to take responsibility for making healthy choices about what we eat, how much we exercise, and whether to avoid smoking and other risky habits, but many Americans face obstacles that are too high to overcome on their own—even with great motivation. Black and Hispanic adults, for example, have less wealth, are more likely to have grown up in neighborhoods with fewer socioeconomic advantages, and are more likely to live in neighborhoods with concentrated poverty, insufficient housing, crime, and pollution and lack good schools, medical care, transportation, and jobs (Braveman et al. 2005; Williams & Jackson, 2005).

These factors—the nonmedical social, economic, political, or environmental factors that influence the distribution of health and illness in the population—are known as the social determinants of health (Gollust,

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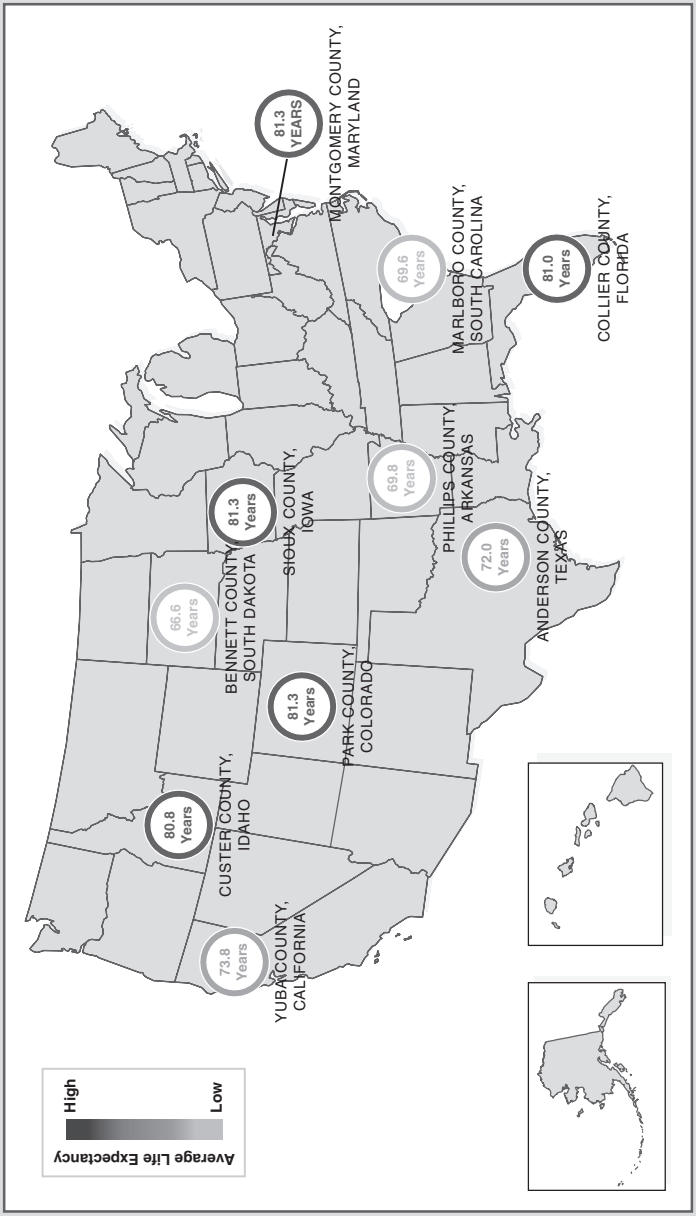
Figure 3-2

Across America, Differences in How Well and How Long We Live



This map shows how life expectancy varies in different regions across the United States. The average life expectancy for people living in Bennett County, South Dakota, is 66.6 years. Just next door, people living in Sioux County, Iowa, can expect to live nearly 15 years longer.

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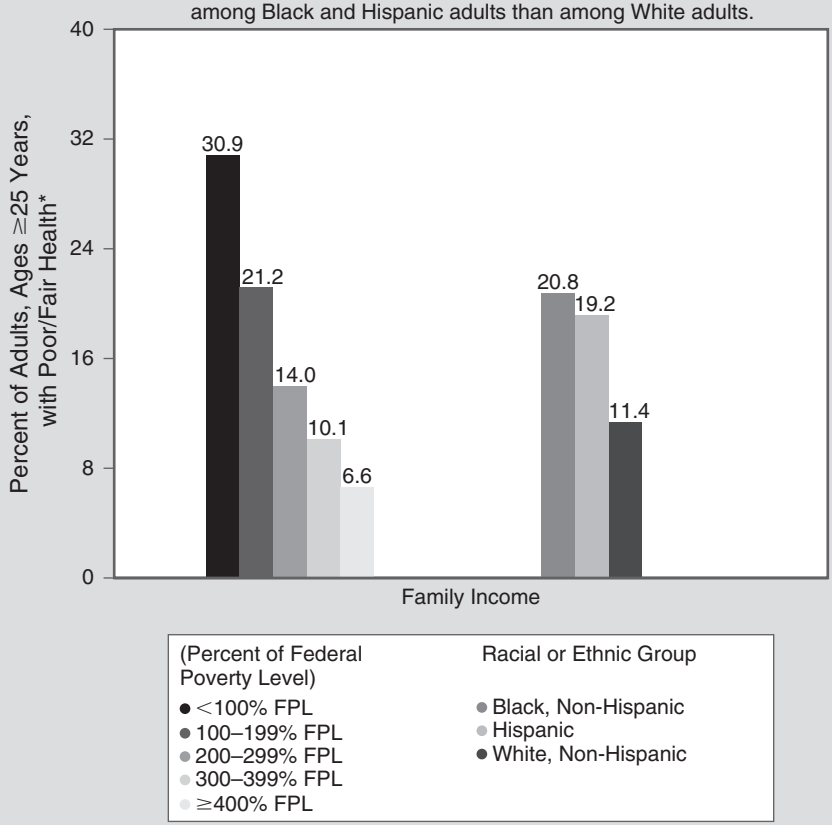
Figure 3-3

Health Varies Across Racial and Ethnic Groups

Lower income generally means worse health. Racial or ethnic differences in health status are also evident: Poor or fair health is much more common among Black and Hispanic adults than among White adults.



Prepared for the Robert Wood Johnson Foundation by the Center on Social disparities in Health at the University of California, San Francisco.
Source: National Health Interview Survey, 2001–2005.
*Age-adjusted

Reproduced from Robert Wood Johnson Foundation Commission to Build a Healthier America. (2008). Health Varies by Income and Across Racial or Ethnic Groups. Retrieved from http://www.commissiononhealth.org/Charts.aspx

Lantz, & Ubel, 2009). Public health advocates have increasingly concluded that addressing the social determinants of health is necessary to improving health and health care in the United States and worldwide. The World Health Organization Commission on the Social Determinants of Health convened in 2006 to identify strategies that could improve health care around the world, reduce differences in health outcomes (Wilensky & Satcher, 2009), and subsequently describes efforts to tackle the social determinants of health as "fundamental" to its work (World Health Organization,

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2015). The United States likewise is placing an increased emphasis on addressing the social determinants of health; they are included in *Healthy People 2020*, the government's 10-year goals and objectives for health promotion and disease prevention (*Healthy People 2020*, 2015).

The social determinants of health recognize that health is much more than health care. Virginia Commonwealth University's Steven Woolf (2009) points out that "perfecting health care is a half answer if the conditions that cause disease prevail" (p. 2). If we are going to address the root causes of disease, primary care professionals need to consider what happens when people leave the provider's office and return home. Do their homes, workplaces, leisure activities, communities, and neighborhoods support ongoing good health (Baum, Bégin, Houweling, & Taylor, 2009)? Efforts that simply inform or encourage individuals to change their behaviors, without also accounting for their physical and social environments, often do not reduce—and may even exacerbate—health inequalities (Glouberman, 2001). Health professionals, including nurses, can lower demand for care services by focusing on prevention and health promotion and considering the following factors.

Where People Live

Neighborhoods influence health in myriad ways, from the air and water quality that residents breathe, to the closeness of companies that produce or store hazardous substances, to whether homes expose residents to lead paint, mold, dust, or pest infestation (Giles-Corti & Donovan, 2002). Access to sidewalks, parks, and grocery stores can determine whether a family is able to exercise and eat healthy food (see **Figure 3-4**; Booth, Pinkston, & Poston, 2005). The availability and quality of schools, transportation, primary health care, and jobs can also influence health by shaping residents' opportunities to earn a living. Schools located in low-income neighborhoods are more likely to serve inexpensive processed foods and rely on income from vending machine contracts that promote soda and high-calorie snacks (Woolf, Dekker, Byrne, & Miller, 2011).

Neighborhoods where residents know and trust each other have been linked to lower homicide rates (Morenoff, Sampson, & Raudenbush, 2001), and less closely knit neighborhoods have been linked to anxiety and depression (Ross, 2000). A person's zip code at birth may be as important as his or her genetic code in predicting how well, and how long, he or she lives. For example, babies born and raised on the Red Line in the Washington, D.C., metro area can expect to live to be 84 years old. Conversely, babies born a few metro stops away in downtown Washington, D.C., can expect to live 7 years less.

Where People Learn

A person's education level affects a person's health. Adults without a high school diploma or equivalent are 3 times as likely as those with a college

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Figure 3-4

Where We Live Affects Our Health

Families with grocery stores in their neighborhoods have more options for eating healthful meals.
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education to die before age 65 (Heron et al., 2009). Men and women who have graduated from college can expect to live at least 5 years longer on average than adults who have not completed high school (Braveman & Egerter, 2008, 2013). Similarly, babies born to mothers who have completed less than 12 years of education are nearly twice as likely to die before their first birthday as babies born to mothers who have completed 16 or more years of schooling (Braveman & Egerter, 2008, 2013).

Where People Work

Poor Americans experience significantly worse health on average than wealthier Americans. In fact, U.S. adults living in poverty are more than 5 times as likely to report being in "fair" or "poor" health as adults with incomes at least 4 times the federal poverty level (Braveman & Egerter, 2008, 2013). People with lower incomes are more likely than people with higher incomes to lack a job, health insurance, and disposable income for medical expenses. Lower-income women are less likely to have access to onsite facilities for breastfeeding, which can promote health for babies. People with lower incomes may live in impoverished neighborhoods with limited employment opportunities and poorer quality schools. They often

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cannot afford to move elsewhere because traveling across town to find a job—or a better one—or to reach a grocery store or doctor may be difficult if public transportation is unavailable or costly (Woolf & Braveman, 2011).

Where People Play

The presence of sidewalks and playgrounds in neighborhoods, afterschool physical activity programs for children and youth, and the safety of a neighborhood can promote health by encouraging healthy behaviors and making it easier for people to adopt and maintain them (see **Figure 3-5**; Braveman, Egerter, & Mokenhaupt, 2011). Parents may want to send their children outside to play, but they may keep them in front of the television or computer because they fear for their safety. Other individuals may wish to bicycle or walk to work, but safe pedestrian routes or bicycle paths may be unavailable (Woolf & Braveman, 2011).

RWJF Commission to Build a Healthier America

The Robert Wood Johnson Foundation (RWJF), the nation's largest health and health care philanthropy, established the RWJF Commission to Build a Healthier America in 2008 to find ways to address the social determinants of health to improve our nation's health. The commission, a national nonpartisan group of leaders from the public and private sectors, issued

Figure 3-5

Where People Play

Children are more likely to be healthy if they have safe places to play.

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10 sweeping recommendations aimed at improving the health of all Americans (see **Figure 3-6**; Miller, Simon, & Maleque, 2009). The commission's work led to a marked increase in collaboration among a wide variety of partners aimed at addressing the social determinants of health.

The commission reconvened in 2014 and issued a subsequent report. It found that to improve the health of all Americans we must:

- Invest in the foundations of lifelong physical and mental well-being in our youngest children;
- Create communities that foster health-promoting behaviors; and
- Broaden health care to promote health outside of the medical system (Robert Wood Johnson Foundation Commission to Build a Healthier America, 2014).

Building a Culture of Health

The commission's report coincided with RWJF's strategic shift to call on all Americans to help build a Culture of Health as the best way to improve health and health care in our nation. Building a Culture of Health is defined as shifting the values—and the actions—of this country so that health and

Figure 3-6

RWJF Commission to Build a Healthier America Recommendations, 2008

1. Fund and design WIC and SNAP (Food Stamps) programs to meet the needs of hungry families for nutritious food.
2. Create public–private partnerships to open and sustain full-service grocery stores in communities without access to healthful foods.
3. Feed children only healthy foods in schools.
4. Require all schools (K–12) to include time for all children to be physically active every day.
5. Become a smoke-free nation. Eliminating smoking remains one of the most important contributions to longer, healthier lives.
6. Ensure that all children have high-quality early developmental support (child care, education, and other services). This will require committing substantial additional resources to meet the early developmental needs particularly of children in low-income families.
7. Create "healthy community" demonstrations to evaluate the effects of a full complement of health-promoting policies and programs.
8. Develop a "health impact" rating for housing and infrastructure projects that reflects the projected effects on community health and provides incentives for projects that earn the rating.
9. Integrate safety and wellness into every aspect of community life.
10. Ensure that decision makers in all sectors have the evidence they need to build health into public and private policies and practices.

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healthy decisions become a part of everything Americans do. RWJF wants to enable all in our society to lead healthy lives, now and for generations to come. Too long our nation has defined being healthy as simply not being sick, and our health is often unduly and unequally influenced by income, education, ethnicity, and where a person lives.

The foundation wants to create a culture that empowers everyone to live the healthiest lives they can, even when they are dealing with chronic conditions or other challenges. RWJF imagines a health care system that couples treatment with care and considers the life needs of patients and caretakers, inside and outside the clinic. See **Figure 3-7** for the characteristics of a Culture of Health.

The Role of Nurses

Nurses are crucial to building a Culture of Health. At 3 million strong, nurses make up the largest segment of the health care workforce and spend the most time with people, families, and communities. Nurses are the glue that binds the system together, and they are vital to the successful transformation of health care. They provide holistic care across acute and community settings, which is increasingly important as care moves out of the hospital setting and into home and community settings. Nurses are at the center of many of the innovations we rely on to expand access, improve quality, and contain costs. And nurses with strong clinical and leadership skills can help to promote wellness, develop new models of care, and manage care coordination to help keep patients from returning to the hospital.

Figure 3-7

Characteristics of a Culture of Health in America

RWJF Vision for an American Culture of Health

1. Good health flourishes across geographic, demographic, and social sectors.
2. Being healthy and staying healthy is valued by our entire society.
3. Individuals and families have the means and the opportunity to make choices that lead to healthy lifestyles.
4. Business, government, individuals, and organizations work together to foster healthy communities and lifestyles.
5. Everyone has access to affordable, quality health care.
6. No one is excluded.
7. Health care is efficient and equitable.
8. The economy is less burdened by excessive and unwarranted health care spending.
9. The health of the population guides public and private decision-making.
10. Americans understand that we are all in this together.

Modified from Robert Wood Johnson Foundation. (2014). Building a Culture of Health: 2014 President's Message. Retrieved from http://www.rwjf.org/en/library/annual-reports/presidents-message-2014.html

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In fact, nurses have a long history of promoting a Culture of Health. Florence Nightingale, the founder of modern nursing, expressed concern with the care of the sick poor in workhouses and workhouse infirmaries, including the quality of life in their homes and in the slums, which had high crime rates and rampant prostitution (see **Figure 3-8**). She sought to address the importance of preventing disease by teaching cleanliness and sanitation (Monteiro, 1985). Nightingale also recognized the importance of good child care to build health. "Money would be better spent in maintaining health in infancy and childhood than in building hospitals to alleviate or cure disease. It is much cheaper to promote health than to maintain people in sickness," she wrote in 1894 (Lundy, Janes, & Hartman, 2001).

Lillian Wald also devoted her life to building a Culture of Health after she was summoned in 1893 to the home of one of her immigrant students to care for the student's mother (**Figure 3-9**). She wrote of being guided through "evil smelling" streets, up slimy steps of a rear tenement into the

Figure 3-8

Florence Nightingale

Florence Nightingale was an early proponent of addressing disease by teaching cleanliness and sanitation, and she recognized the importance of good child care in promoting health.

Courtesy of Library of Congress, Prints & Photographs Division, LC-USZ62-5877.

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Figure 3-9

Lillian Wald

Wald was one of the first nurses to link sickness to a larger set of social problems. She incorporated health, industry, education, recreation, and housing into her work to improve life for residents of the lower-east-side of New York City.

Courtesy of Library of Congress, Prints & Photographs Division, photograph by Harris & Ewing, LC-DIG-hec-19537.

sickroom, where the "sick woman lay on a wretched, unclean bed, soiled with a hemorrhage two days old" (Wald, 1915). Wald recognized that the woman's sickness was part of a larger set of social problems, so she initiated a reform agenda that included health, industry, education, recreation, and housing. She established the Henry Street Settlement, which offered neighborhood residents health care, social services, and instruction in everything from English language to music. Nurses taught infant care to new mothers in their homes. They treated conditions that had previously kept children from entering the classroom. They offered cooking, sewing, music, and dance classes, and they established the city's first municipal playground (Buhler-Wilkerson, 1993).

Nurses have continued to improve health by addressing the factors that affect where people live, learn, work, and play ever since.

The Affordable Care Act

Passage of the Patient Protection and Affordable Care Act (ACA) in 2010 gives nurses new opportunities to deliver care (Hassmiller, 2010) and to help

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build a Culture of Health. With millions of Americans signing up for health insurance—some for the first time—policy makers increasingly are turning to more nurse practitioners and physician assistants to help address the primary care shortage. Compared to physicians, the number of nurse practitioners and physician assistants is expected to be much higher than the projected number of primary care doctors. The Association of American Medical Colleges (AAMC, 2010) estimates a shortfall of 45,000 primary care physicians by 2020. As a result, policy makers anticipate that nurse practitioners who practice with a primary health care perspective will help to alleviate the shortage under new models emphasizing team-based care, such as the patient-centered medical home and accountable care organizations (ACOs), which depend on a team of providers to deliver coordinated primary care across multiple settings. A national survey of primary care nurse practitioners and primary care physicians found that nurse practitioners are more likely to provide primary care in a wider range of settings, and provide proportionally more care to Medicaid recipients, racial and ethnic minorities, and uninsured populations (Buerhaus, DesRoches, Dittus, & Donelan, 2014).

In addition to increasing demand for primary care, the ACA includes provisions to promote wellness (Koh & Sebelius, 2010) and manage more carefully the high costs associated with care provided in hospitals (Berg & Dickow, 2014). Nurses bring traditional competencies such as care management and coordination, patient education, other public health interventions, and transitional care that will be especially valuable as the health system undergoes transformation to emphasize health promotion, illness prevention, risk reduction, and management rather than acute care. The landmark Institute of Medicine (IOM, 2011) report, *The Future of Nursing: Leading Change, Advancing Health*, stressed that nurses have an important contribution to make in "building a health care system that will meet the demand for safe, quality, patient-centered accessible and affordable care" (p. 21).

In many places throughout the United States, nurses are using their skills and competencies to address all of the factors that affect health. By seeking to improve where people live, learn, work, and play, nurses are on the frontlines of helping to build a Culture of Health.

Case Studies: Nurses Promoting a Culture of Health

Nurse-Family Partnership Program

Perhaps the best-known and well-researched example of nurses promoting a Culture of Health is the Nurse-Family Partnership (NFP) program, which takes a broad view of addressing the health and social needs of the individual and family. As part of the program, low-income first-time pregnant women receive home visits by nurses during their pregnancy and the first 2 years of their children's lives. During the home visits, nurses seek to improve prenatal care by ensuring the women receive needed treatment for

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pregnancy-related complications and reduce their use of cigarettes, alcohol, and illegal drugs. After the baby is born, the nurse focuses on improving the child's health by providing responsible and competent care during early childhood. The program also seeks to enhance educational and employment opportunities for the parents and plan future pregnancies (Olds, Sadler, & Kitzman, 2007).

The program has led to improvements in prenatal health-related behaviors; pregnancy outcomes, including reduced preterm delivery and lower rates of pregnancy-induced hypertension; lower rates of child abuse and neglect; lower rates of subsequent pregnancies; and higher employment rates of mothers (Olds, 2002). The program also resulted in improved school performance for the child. By age 19, youths whose mothers received visits from nurses nearly two decades earlier were 58% less likely to have been convicted of a crime (Olds et al., 2007).

The NFP had a high return on investment, with a net benefit to society of $17,180 (in 2003 dollars) per family served, which equates to a $2.88 return per dollar invested in NFP. In fact, the NFP program is being disseminated more broadly under the ACA.

Eleventh Street Family Health Services

The Eleventh Street Family Health Services Center of Drexel University in North Philadelphia prides itself on treating the whole person and creating community; it measures its success by the solid partnerships it shares with its community and the thousands of lives it has helped to change for the better. The nurse-managed health center started in 1996 when the College of Nursing entered into an agreement with the Philadelphia Housing Authority to address health issues of residents in Philadelphia's 11th Street corridor, where most of the 6,000 residents are Black, have low incomes, and are medically underserved. The neighborhood has the largest percentage of unemployed adults and families living in poverty, as well as the highest rate of diabetes within Philadelphia (Drexel University College of Nursing and Health Professions, n.d.).

Director Patricia Gerrity, a public health nurse and Associate Dean for Community Programs in the College of Nursing and Health Professions, stressed the importance of listening to the residents to earn their support. She placed a public health nurse at each of four housing developments in the neighborhood. The nurses responded to residents' immediate concerns, including the need for stop signs, animal control, food assistance, and training in CPR. By gaining trust of the residents, and making the residents' issues the defining issues, a long-term commitment was realized (Drexel University College of Nursing and Health Professions, n.d.).

Around the same time, her colleagues provided health screenings and managed chronic conditions. They went to local schools to teach children about healthy habits (RWJF, 2015). Community residents expressed

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interest for a health care center that they could access, regardless of their ability to pay.

In 1998 the health center opened, and in 2002, it gained status as a federally qualified health center. Nurse practitioners and social workers comprise teams that are enhanced as needed by physicians, nutritionists, and others. The center, which has 53 staff members, offers primary care, dental care, behavioral health care, physical therapy, and a vast array of community programs (**Figure 3-10**). The building includes a fitness center with a full-time personal trainer and a teaching kitchen where cooking classes take place. A community garden enables clients to grow fresh produce. Staff members work with local schools on public art projects, and nurses visit people at home to help them manage complex chronic conditions (RWJF, 2015).

Eleventh Street Family Health Services is an example of one of the more than 250 nurse-managed health clinics across the United States. These clinics, many of which are associated with schools of nursing, serve more than 2.5 million people and have emphasized the importance of addressing

Figure 3-10

Organized neighborhood walks are a chance for families to exercise, socialize, find health information, and connect to community resources as they move through their neighborhood.

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the underlying factors that affect health. They offer accessible, affordable, quality health care and health services to underserved populations while also giving nursing and nurse practitioner students hands-on experience. Nurse-managed health clinics work closely with social workers to link their clients with other social service providers, and they build community by bringing health care to people in a neighborhood.

Transitional Care Model

Building a Culture of Health encompasses creating a culture that empowers every person to live the healthiest life, even when the person is dealing with chronic conditions or other challenges. Approximately 20% of hospitalized Medicare beneficiaries are readmitted within 30 days of leaving the hospital, and 34% return within 90 days, at an estimated cost in 2004 of $17.4 billion of the $102.6 billion in hospital payments from Medicare (Jencks, Williams, & Coleman, 2009). Enabling these people to stay safe in their homes and communities would go a long way toward reducing health care costs and promoting a Culture of Health. It would also benefit their family caregivers, who often have to take time off from work and suffer emotional distress and physical ailments from caring for loved ones (Reinhard, Levine, & Samis, 2012).

One nurse-led model that has overwhelmingly helped frail people to better manage their health is the Transitional Care Model. An advanced-practice registered nurse (APRN) meets with the patient and family caregivers when a patient is hospitalized to devise a plan for managing chronic illnesses. The APRN assists the patient and family in setting goals during the hospitalization, identifies the factors contributing to the patient's hospitalization, designs a care plan that addresses them, and coordinates the various care providers and services. Within the next 2 days, the nurse visits the patient at home and provides telephone and in-person support as often as necessary for up to 3 months. The nurse assesses, counsels, and accompanies the patient to medical appointments to help patients and their family caregivers learn the early signs of a problem that could require immediate help and to better manage the patient's health. The nurse also ensures that a primary care provider is assigned to the patient—as well as the requisite specialists—to keep track of everything affecting the patient (Naylor et al., 2004). The evidence overwhelmingly demonstrates the benefits of the Transitional Care Model. Three randomized controlled clinical trials of Medicare beneficiaries with more than one chronic illness showed that use of the Transitional Care Model lengthened the period between hospital discharge and readmission or death and resulted in fewer rehospitalizations (Naylor et al., 1994, 2004).

The University of Pennsylvania Health System has adopted the Transitional Care Model, and more than 24 health systems and communities are using parts of the model. As with the Nurse-Family Partnership, the ACA contains provisions that will support expansion of the Transitional Care Model.

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Public Health Nursing

Building a Culture of Health will require an emphasis on population health and prevention, opening up a critical role for the nation's 34,500 nurses who work in state and local public health departments (University of Michigan, 2013). Public health nurses serve populations and can play a clear role in engaging communities around health, especially where people live, learn, work, and play. They can contribute to improving population-based health outcomes by offering reliable information on health and safety, and helping to promote early detection of common diseases (Hassmiller, 2014). Public health nurses also protect the public through infection control, emergency response, and health promotion initiatives (RWJF, 2015). In short, public health nurses address the root causes of problems. They use epidemiology and research to develop and test interventions that address poverty, housing, education, racism, adverse childhood experiences, and access to quality health care. A public health nurse could work with a group of neighborhood residents to secure space for a community garden and resources to plant and maintain the garden. He or she could organize a park cleaning event in a low-income neighborhood, or speak at the local planning commission about how safe sidewalks and open spaces promote healthy living. A public health nurse might also help new parents find resources for a child with special needs (Storey, 2013).

A great example of public health nurses working to build a Culture of Health is the Library Nurse Program, a join initiative between the public health department and the public library in Pima County, Arizona (see **Figure 3-11**). A team of public health nurses visits the city's 17 libraries to promote wellness and improve patrons' physical and mental health.

"Because they are perceived as safe and welcoming, public libraries have become shelters for people in need, the mentally ill, battered women, latchkey kids, and new immigrants," says Kathleen Malkin, division manager for Public Health Nursing Services at the Pima County Health Department, "so it makes sense to offer health services in this non-traditional setting" (RWJF, 2015, p. 6). Nurses tour the libraries with stethoscopes around their necks, talk with patrons, and offer health education. Though the program is available to everyone, it specifically targets people with mental health and social service needs. The areas of largest concern include malnutrition and poorly managed acute and chronic diseases. The public health nurses often connect patrons to social services to avoid crises. In the program's first month, behavior incidents were managed better, and the library made fewer nonmedical 911 calls (RWJF, 2015).

The Future of Nursing: Leading Change, Advancing Health

These examples represent nursing at its best and showcase the possibilities of nursing working in a new era of health and health care. However, the IOM

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Figure 3-11

Public Health Nurse Making Rounds in a Library in Pima County, Arizona

Nurse Daniel Lopez attends to the health needs of a man visiting a library in Pima County, Arizona. He works largely with the homeless and working poor. "The full scope of my knowledge, skills, talent, and time is available to all who ask," he says.

Courtesy of the Pima County Health Department.

(2011) report on the future of nursing recognizes that many more nurses will "require more education and preparation to adopt new roles quickly in response to rapidly changing health care settings and an evolving health care system" (p. 4). As a result, the IOM report issued sweeping recommendations to improve the health of the U.S. population through the contributions that nurses can make to the delivery of care (**Figure 3-12**).

The Robert Wood Johnson Foundation believed these recommendations were too important to sit on a shelf, so in 2010 it partnered with AARP, the nation's largest consumer organization, to start a national Campaign for Action to advance the IOM recommendations. The campaign works at both the national level and in the states, engaging with consumers, nurses, other clinicians, insurers, health care systems, employers, educators, funders, and policy makers—all the stakeholders who need to be involved in system change—to advance the IOM's recommendations.

The campaign has established Action Coalitions in all 50 states and the District of Columbia to pave the way for needed changes at the state level. As of January 2015, Action Coalitions collected a total of $11 million in

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Figure 3-12

IOM Recommendations on the Future of Nursing

1. Remove scope-of-practice barriers.
2. Expand opportunities for nurses to lead and diffuse collaborative improvement efforts.
3. Implement nurse residency programs.
4. Increase the proportion of nurses with a baccalaureate degree to 80% by 2020.
5. Double the number of nurses with a doctorate by 2020.
6. Ensure that nurses engage in lifelong learning.
7. Prepare and enable nurses to lead change to advance health.
8. Build an infrastructure for the collection and analysis of interprofessional health care workforce data.

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funding from more than 800 organizations and individuals. Their members include a wide range of health care providers, consumer advocates, policy makers, business, academic, and philanthropic leaders. The campaign's vision is for everyone in America to live a healthier life, supported by a system in which nurses are essential partners in providing care and promoting health.

The campaign seeks to strengthen nursing education, remove scope-of-practice barriers, promote nursing leadership, foster interprofessional collaboration, and promote workforce diversity.

Nursing Education

The campaign strives to advance the IOM recommendation that 80% of the nursing workforce attain a bachelor's degree in nursing or higher by 2020; in 2010, when the report was released, 49% did so (according to data compiled by the American Community Survey Public Use Microdata Sample; Hassmiller & Reinhard, 2015). The campaign also wants to double the number of nurses with doctorates by 2020.

Rationale. Strengthening nursing education is crucial if more nurses are to take on more complex roles in our evolving health system. Nurses are needed to coordinate care for different types of patients; manage transitions across acute, ambulatory, and community settings; engage and educate patients and families; perform outreach and population health management; and connect patients with community-based services. Nurses need to have the competencies required to practice in the community, home, and public health settings.

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In addition, nurses are needed to address the primary care shortage and the faculty shortage. Millions of new Americans now have health insurance through the ACA, and the United States is already struggling to provide primary care. Nurse practitioners can help to fill these roles. More nurses with doctorates are needed to teach the next generation and to design health care delivery innovations. In 2011, nursing schools turned away more than 75,000 qualified candidates, primarily because of a lack of school resources and faculty available to teach them (American Association of Colleges of Nursing [AACN], 2015b).

Progress made. The Action Coalitions have set out to advance nursing education by encouraging strong partnerships between community colleges and 4-year universities to make it easier for nurses to continue their education and earn advanced degrees. In 2014, the campaign showed that the number of nurses with a baccalaureate degree increased to 51%, and there was a 10% rise in the number of nurses with bachelor's degrees, from 1.37 million to 1.52 million. More nurses are enrolling in bachelor's programs, according to the American Association of Colleges of Nursing, and the number of enrollees in RN-to-BSN programs is expanding (Hassmiller & Reinhard, 2015).

Even more exciting, the number of nurses with doctoral degrees has increased substantially. In 2010, only 1% of the nation's 3 million nurses had doctoral degrees (IOM, 2011). From 2010 to 2013, the number of nurses enrolled in doctoral programs jumped 70%, from 11,645 to 19,828. The majority of this growth took place in the doctoral of nursing practice (DNP) programs, but enrollment in research-oriented PhD programs has also grown: in 2013, 5,140 students were enrolled in these programs, up from 4,611 in 2010 (Hassmiller & Reinhard, 2015).

Scope-of-Practice Barriers

Primary care in the United States is struggling to meet demand. Staffing shortages are expected to get worse as millions of newly insured Americans seek care, the population continues to age, and people grapple with more chronic disease. This is particularly true in underserved, rural, and minority communities. Nurse practitioners provide an immediate and cost-effective solution to this problem, enabling physicians to direct their energy to caring for people with complex medical conditions.

However, outdated barriers in many states prevent APRNs from expanding access to care (see **Figure 3-13**). Opponents of lifting restrictions on APRN practice contend that doing so will compromise quality of care and safety. However, the IOM (2011) report found no evidence that care provided in states that require APRNs to work under a physician's authority is better than in states where APRNs have full practice authority.

Progress made. Before the Campaign for Action began in late 2010, only 13 states and the District of Columbia allowed nurse practitioners to provide care to the full extent of their education and training. In the campaign's first

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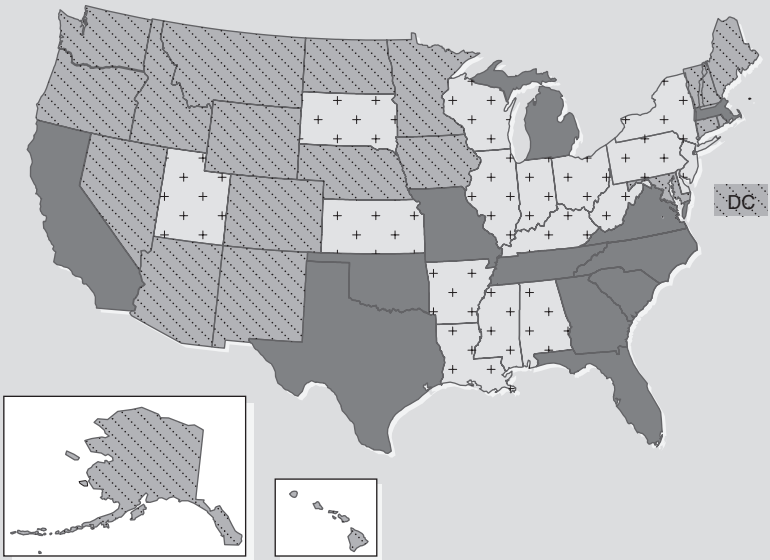
Figure 3-13

Current Practice Environment for Nurse Practitioners



Full Practice
State practice and licensure law provides for all nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribing medications—under the exclusive licensure authority of the state board of nursing. This is the model recommended by the Institute of Medicine and National Council of State Boards of Nursing.

Reduced Practice
State practice and licensure law reduces the ability of nurse practitioners to engage in at least one element of NP practice. State requires a regulated collaborative agreement with an outside health discipline in order for the NP to provide patient care.

Restricted Practice
State practice and licensure law restricts the ability of a nurse practitioner to engage in at least one element of NP practice. State requires supervision, delegation, or team-management by an outside health discipline in order for the NP to provide patient care.

Nineteen states and the District of Columbia allow nurse practitioners to practice to the full extent of their education and training.

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4 years, 7 states (Connecticut, Kentucky, Minnesota, Nevada, North Dakota, Rhode Island, and Vermont) removed statutory barriers to give nurse practitioners full practice and prescriptive authority, bringing the total to 19 states and the nation's capital. Several states have achieved incremental improvements as well (Hassmiller & Reinhard, 2015).

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Nursing Leadership

Nursing is repeatedly ranked the nation's most trusted profession (Rifkin, 2014). Nurses make up the largest group of health professionals, and they spend the most time with people and their caregivers. They provide an important and unique point of view in decision-making, from the boardroom to our communities. They are vital to improving quality by supporting the transition of patients from hospital to home or community and reducing rehospitalizations and medical errors. However, the IOM (2011) report pointed out that nurses seldom sit at leadership and policy-making tables and calls on nurses to take on increasing roles of responsibility in the health care system and society.

Progress made. Action Coalitions throughout the country are establishing programs that train nurses for leadership and board positions. They are also keeping track of open board positions and urging nurses to apply. The Campaign for Action has created the Nurses on Boards Coalition, a group of 21 national organizations that has pledged to place 10,000 nurses on boards by 2020.

Interprofessional Collaboration

As the case studies demonstrated, the future of health care will occur in teams, but it is difficult for professions to work well together if they have limited training and experience in schools. The IOM report called for an end to "educational silos" in which students from one profession are educated separately from other fields. In the 2013–2014 school year, of the 10 nursing schools with graduate health professional schools that were surveyed, 9 required at least one interprofessional course or activity—compared with 4 during the 2010–2011 school year (Hassmiller & Reinhard, 2015).

Workforce Diversity

The nursing workforce historically has been predominately White and female, and remains so today. More than one third of the U.S. population is part of a racial or ethnic minority according to the 2010 census (United States Census Bureau, n.d.), yet nurses from minority backgrounds represent only 19% of the registered nurse workforce, and men comprise 9.6% of all RNs (AACN, 2015). By 2043, minority populations will make up a majority of our population (United States Census Bureau, n.d.). Our profession should reflect the people we serve, and all nurses should be trained to deliver culturally competent services in all settings (**Figure 3-14**).

Progress made. The number of minority nurses in the workforce is gradually rising, and so is the share of the nursing workforce that they represent. Approximately 24% of the nursing workforce self-identified as minorities in 2010; that number is closer to 25% in 2012. Data collection is improving too. In 2011, 34 states collected race and ethnicity data on their nursing workforce; in 2013, 45 states did (Hassmiller & Reinhard, 2015).

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Figure 3-14

Strengthening Workforce Diversity

By 2043, people of color will make up a majority of the population in the United States. The Campaign for Action seeks to improve nurse workforce diversity so that all people can receive culturally competent care.

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Call to Action: The Future of Nursing and You

The Campaign for Action is making substantial progress in preparing the nursing workforce to take on new roles in the health system and to help build a Culture of Health that enables all in our society to lead healthier lives—but much more needs to be done. It will take all of us—health professionals, hospitals and health systems, policy makers, consumer advocates, payers, consumers, businesses, think tanks, long-term care, foundations, and everyone who cares about health care—to make this work. It will also take students.

You can help to build a Culture of Health by continuing your education no matter what your basic degree will be. Consider becoming nurse faculty and teaching the next generation of nursing students or becoming advanced practice registered nurses or public health nurses. You can take on greater roles in primary care to ensure that the Americans who gain access to health insurance under the ACA are able to see a practitioner when they need one and to receive routine preventive care. You can provide care coordination and chronic care management, as well as work in public health and community care.

If you choose to work at the bedside, you need to understand every aspect of your patient's very complex needs. You will need to pursue lifelong learning, as well as an advanced degree. Because of the constant changes in the health care system and patient demographics, an entry level degree is your entry point. It is up to you to stay current through continuous learning—you owe it to the people, families, and communities you serve to provide the most up-to-date care.

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Pursue leadership as you embark on your career. Leadership needs to happen at every level. Speak up at your workplace if you have an idea for improving health. Seek out committees and consider volunteering in the community to broaden your experience. Volunteering also offers a great addition to any resume, especially if you are seeking your first job. Know your areas of expertise and develop your skill set. Strive to serve on boards as your career progresses and enter policy debates. Join professional associations, and volunteer with the Campaign for Action. Go to www.campaignforaction.org to sign up and get involved.

If you choose to get an advanced degree and pursue leadership, you will join the many nurses who are helping to build a Culture of Health. You will have opportunities to address health disparities and make it easier for all people to lead healthier lives, no matter where they live, learn, work, and play. According to Linda Reutter and Kaysi Eastlick Kushner (2010, p. 5), Cathy Crowe, a Toronto street nurse who advocates for the homeless, has summed up nursing's legacy well: "Throughout our history, it has been nurses who, after witnessing injustices, spoke out. They responded with words, with research, with action, with the development of programs, with legal action, and with new policy proposals." You are called to do the same: to help build a Culture of Health to enable all to lead healthier lives, now and for generations to come.

Chapter Activities

1. What are the social determinants of health, and how do they affect a person's health throughout the life span?
2. How can the nursing field use a primary health care perspective to address the social determinants of health?
3. In what ways do you see primary health care supporting a Culture of Health?

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