

## CHAPTER OUTLINE

- ▶ Introduction
- ▶ Philosophy of Nursing Care
- ▶ Structure of the Alliance for Health Model
  - The Voice of the Client
  - The Expertise of the Provider (Nurse and Interdisciplinary Team)
  - Community-Based Needs
  - Systems of Care Management
  - Resource Allocation
- ▶ The Alliance for Health Model as a Complement to Evidence-Based Nursing
  - Evidence from Research
  - Evidence from Clinical Practice
  - Evidence from the Client's Perspective
- ▶ Use of the Alliance for Health Model: Two Different Problems in the Community
  - A Problem Emerging with Community-Based Needs
  - A Problem Emerging with Resource Allocation
- ▶ Summary

## OBJECTIVES



1. Consider the importance of the nurse and client sharing responsibility for using the Alliance for Health Model, to solve community-based problems.
2. Identify the role of the nurse in evaluating the effectiveness of completing a community assessment, using the Alliance for Health Model, in each of the model's, five components.
3. Explain why the community health provider team is essential for completing and responding to the findings of a community assessment.
4. Consider how the Alliance for Health Model could be adapted to improve the process of community assessment.

## KEY TERMS



**Advocacy group**  
**Aesthetics**

**Alliance for Health Model**  
**Demographics**

**Interdisciplinary plan of care (IPC)**  
**Morbidity**

**Mortality**  
**Special interest group**



# CHAPTER 3

## The Vision for the Alliance for Health Model

Stephen Paul Holzemer

### VISION

*I am only one, but still I am one. I cannot do everything, but still I can do something; and because I cannot do everything, I will not refuse to do something that I can do.*

—Edward Everett Hale (1822–1909)



## Introduction

This chapter provides a vision for community health assessment—specifically, the **Alliance for Health Model**. A philosophy of nursing care is provided that guides the care of clients, who may present as individuals, families, other groups, aggregates, or communities. The structure of the model consists of five essential components that represent areas of concern central to the three steps in the joint-venture process of seeking health by the community health nurse (CHN) and the client. The Alliance for Health Model is a complement to the idea of evidence-based nursing in care delivery, education, and ongoing research. Using this model, the CHN collects evidence of health (or the lack of health) from established research, from the expertise of professionals “in the field,” and from the lived experiences of the client.

## Philosophy of Nursing Care


Community health assessment is an ongoing process. Community health nurses and other healthcare providers in the community engage in ongoing assessment of the community in an effort to ensure the accuracy of their perceptions of the health of the community. This process guides their interventions with the community so that their interventions remain appropriate. The Alliance for Health Model is a tool to be used in community assessment, albeit from the most general perspective. Obtaining an overall, general perspective allows the CHN to better understand the actual and potential needs of families, groups, aggregates, and the community as a whole.

The Alliance for Health Model represents a philosophy of nursing care in the community—one that is defined as a joint venture between the nurse and the client on their journey toward health. The model provides the professional nurse with a schema for applying the nursing process to actual and potential health problems experienced by families, other groups, aggregates, and communities. **FIGURE 3-1** depicts the evolution of the Alliance for Health Model as occurring in three steps:

1. The voice of the client articulates needs, and is responded to by the nurse (or other provider) with the professional expertise to hear the client.
2. The nurse and the client identify community-based needs and validate the utility of the systems of care management in place (or needing development) to meet community-based needs.
3. The nurse and the community secure the resources needed to resolve threats to the health of the community.

The Alliance for Health Model reflects a larger set of cultural and ethical values and beliefs about health and illness, which is created by the larger collective of various healthcare providers and the communities they serve. This model should evolve with current and changing health-related concerns, like those identified through the national response to health known as *Healthy People 2020* (U.S. Department of Health and Human Services [DHHS], 2010). The usefulness of the Alliance for Health Model unfolds from the relationship between the specialty of community health nursing and the needs experienced by families, other groups, aggregates, and communities—that is, the clients of the community health nurse. The key to success when using the model rests in the therapeutic relationship that develops between nursing and the community.

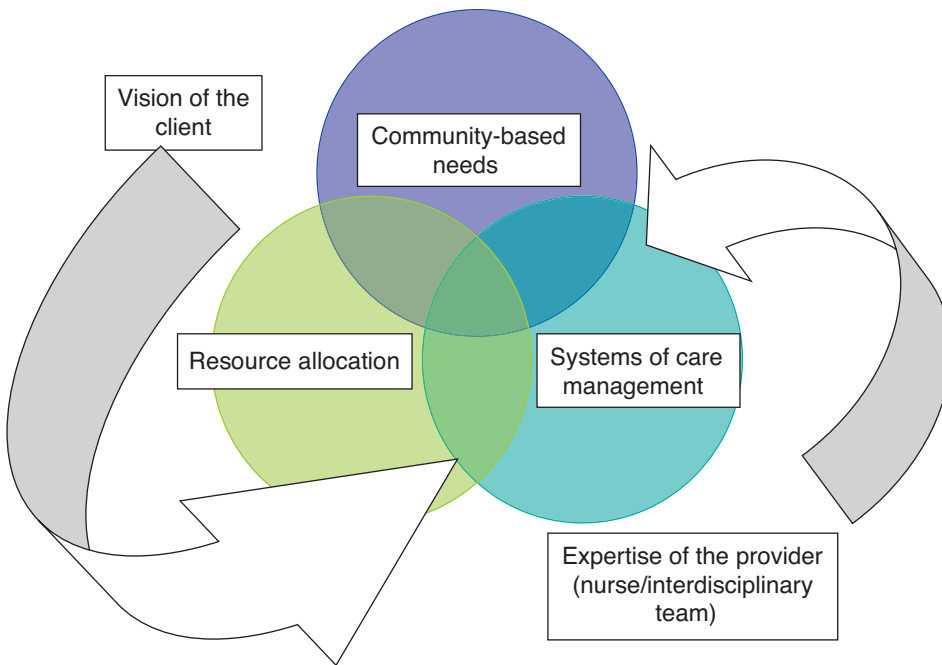
The Alliance Model for Health is intended to serve as a template to inform the CHN and other healthcare providers about the various forces that interact to create a composite picture of health and illness in the community. The client and the nurse navigate the healthcare delivery system together to address the client’s health needs. **FIGURE 3-2** illustrates the basic structure of the Alliance for Health Model; **FIGURE 3-3** examines the various components of the model in further detail.



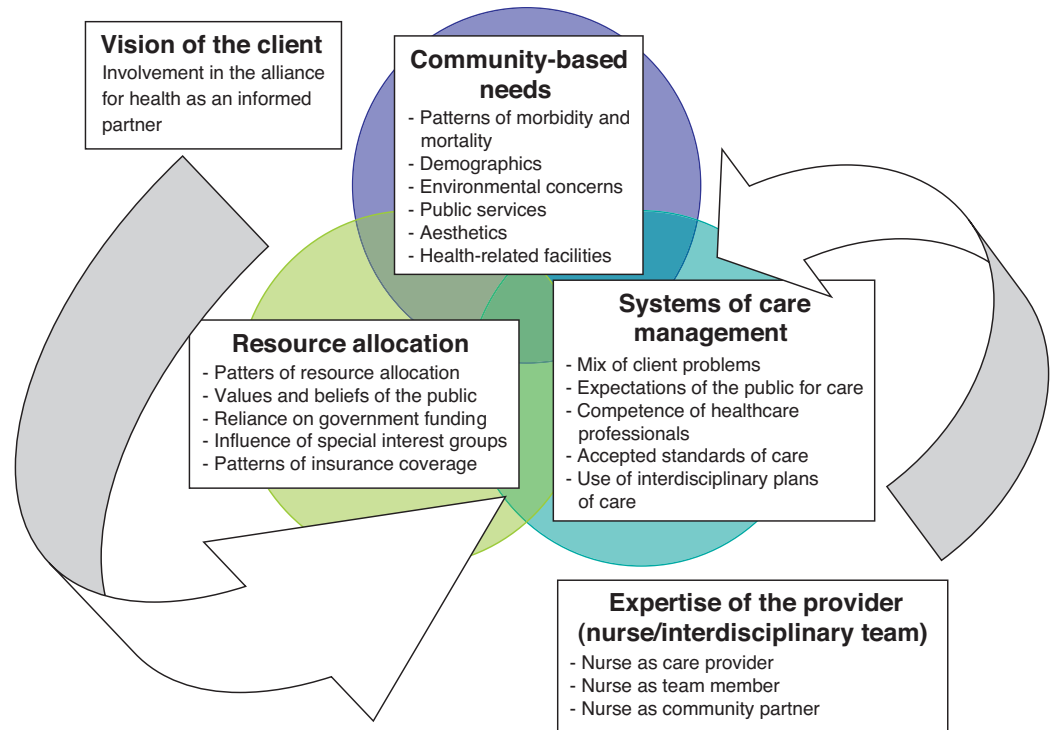
**Alliance for Health Model:** A philosophy of nursing care—a template—to assist the nurse in focusing on the relationship between nursing and the community, so as to resolve problems within the scope of nursing practice. It consists of five essential components that represent areas of concern central to the three steps in the joint-venture process of seeking health by the community health nurse and the client.



**Figure 3-1** The evolution of the Alliance for Health Model.



**Figure 3-2** Alliance for Health Model structure.



**Figure 3-3** Alliance for Health Model in detail.

## Structure of the Alliance for Health Model

The Alliance for Health Model is a template to assist the nurse in focusing on the relationship between nursing and the community, so as to resolve problems within the scope of nursing practice. Such a model resides within a larger model of multidisciplinary and interdisciplinary expertise geared toward meeting national and global health-related concerns.

The Alliance for Health Model includes five components:

1. The voice of the client
2. The expertise of the provider (nurse and interdisciplinary team)
3. Community-based needs
4. Systems of care management
5. Resource allocation concerns

The separateness of these components is, in many ways, artificial. In fact, the Alliance for Health Model should be seen as a dynamic whole of interacting parts or components, not unlike the concept of health itself, with many variables influencing the meaning of health. The parts of the model find meaning only in their relationship to the other aspects of the model. The whole, or picture of health, is altogether different and not limited by the linear aspects of the model. The evolutionary nature of this “picture of health” transcends the ability to capture or diagram it in a meaningful way.

## The Voice of the Client

The voice of the community client articulates, in part, the pressing community-based needs, the preferred systems of care management, and the engagement in resource allocation decisions. The client should be engaged in the Alliance for Health Model as an informed partner; that is, the client needs to be fully informed about the benefits and limitations of the healthcare options at hand. Nurses need to make time to hear the voices of clients who are at times silenced, such as those with mental illness, those with undocumented immigration status, those who speak a non-English language, and those who have a history of not choosing to participate in the available standard of healthcare services (American Nurses Association [ANA], 2001; Dayer-Berenson, 2011; Fowler, 2010).

It is important to recognize that the measurement of health-related outcomes depends on the response of individuals to health-related interventions. The conceptual leap of viewing families, groups, and large aggregates as the clients of nursing care allows for the construction of a more holistic view of nursing care, but complicates the measurement of outcomes. Most assessment tools used today focus on the care delivered to individuals (Allender, Rector, & Warner, 2010; Solberg, 2007; DHHS, 2010).

Families, groups, and larger aggregates, when receiving nursing care, may respond with improved or stabilized health status. The techniques needed to measure aggregate wellness, however, are not always available to nurses or other care providers. For example, a family intervention to assist all members in coping with an unexpected death is intended to improve the functioning of the family unit. The nurse might expect to see improvements in communication as the family copes with the death experience, but a tool to measure improvements in family coping may not be readily available to the community health nurse. Some of the limited areas where the measurement of aggregate health status has been successfully carried out are immunization rates, communicable disease surveillance, and monitoring of prenatal care.

One of the inherent problems with clients negotiating for healthcare services is that they may not necessarily know which services they need. Clients may have unmet or unrecognized healthcare needs because they are unfamiliar with the services that are available. Healthcare services may also be incongruent with their ethical and cultural beliefs and, therefore, not acceptable to the clients (Dayer-Berenson, 2011). It is the responsibility of the healthcare provider to keep the consumer aware of acceptable options in health care, and to create linkages between providers and consumers of health care.

## The Expertise of the Provider (Nurse and Interdisciplinary Team)

The role of the nurse in the community is a prescribed function. That is, this role is generated from the permission society gives to the nursing profession to assist others in their quest for health and wellness, coping with illness and disease, and dealing with the limitations of care and recovery. Nursing has developed a rich reservoir of guidelines that enable the nurse to act from a position of ethical, legal, and cultural competence (ANA, 2010a, 2010b).

Nurses rarely act in the community as sole agents. Rather, the nurse is typically part of an intradisciplinary (within nursing) and interdisciplinary (with other providers) team whose members, acting in concert, assist clients in meeting their healthcare needs. Thus the nurse fulfills three primary roles in the community: care provider, team member, and community partner.

FPO

<INSERT UNN 3-1 NEAR HERE>

- *Nurse as Care Provider.* Nurses provide a wide range of services in the community. For example, they provide advanced acute care interventions in the home as well as health planning services for a whole geographic area. Nurses engage in multiple illness prevention, health maintenance, and health restoration activities as needed by the community.
- *Nurse as Team Member.* Although some nurses work in isolation, the power of community health nursing comes from an articulated intradisciplinary and interdisciplinary plan of care for clients needing services.
- *Nurse as Community Partner.* In the community, nurses work toward establishing partnership status with clients, so as to create success in meeting community-based needs. Nurses must be present in the community—and actually be a part of the community—to be effective in providing nursing care.

Intervention from many health-related disciplines is needed to improve the health of the community. Nursing, as one discipline, is a significant—but not isolated—contributor to the betterment of the public's health. Nurses need to improve their ability to work with other team members continuously so that comprehensive care can be provided to all clients. The skill of healthcare team members in providing comprehensive care should focus on care that is available, accessible, affordable, appropriate, adequate, and acceptable (ANA, 2010a, 2010b). In the community, nurses' skills and knowledge, as well as the skills of other members of the interdisciplinary team, vary from novice to expert. The team is likely to consist of both newly licensed and experienced members who are striving to work collaboratively to solve problems and meet the needs of clients (Buerhaus, Staiger, & Auerbach, 2009).

## Community-Based Needs

The needs of all communities change on an ongoing basis. Continuous assessment of community-based needs is necessary for constructing a useful picture of which needs represent priorities for action. A clear image of community-based needs informs the client and the nurse which systems of care management are necessary to use or develop, and how to direct or redirect resources to make these systems of care management useful. The dynamic nature of community health nursing includes an ever-changing scope of problems and solutions, ranging from emerging pandemics such as the H1N1 influenza to changing demographics of current problems such as HIV/AIDS (National Center for Health Statistics, 2009; DHHS, 2010).

There are six areas of concern related to community-based needs: patterns of morbidity and mortality, demographics, environmental concerns, public services, aesthetics, and health-related facilities.

### *Patterns of Morbidity and Mortality*

The patterns of **morbidity** (illness) and **mortality** (death) are central concerns with community-based needs and significant variables in community health assessment. Knowledge of the causes of death and disability assists in the development of preventive health services as well as in the provision of early treatment and rehabilitation services. Patterns of morbidity and mortality inevitably change in communities. Epidemics, changes in immunization rates in children, and variations in how disease affects certain groups can all affect patterns of morbidity and mortality, with such changes occurring as communities develop, grow, or deteriorate.

### *Demographics*

Information about clients is coded based on characteristics such as age, employment, religious affiliation, and level of education. A community is known by both the visible

**Morbidity:** Illness.

**Mortality:** Death.



characteristics of the people (e.g., age, race, gender, and location of housing) and their invisible characteristics (e.g., level of education, income, and religion). Thus **demographics** represents a way of describing a community statistically. Demographics can describe only those aspects of the community that can be measured. Some parts of the community demographics, such as the homelessness rate, may prove challenging to measure because it is difficult to obtain an accurate count of the number of people living in isolation.

In the United States, the complexity of measuring national demographics, usually through census counts performed every 10 years, results in problems with reporting findings. Some data take years to analyze and present to the public. The community may change while the old picture of a community (findings from the census) is being developed and provided to the public. The massive task of measuring characteristics of the United States makes more frequent measurement unlikely. As a consequence, changes in the population that surface immediately after a census measurement may not be captured until the next census is conducted (U.S. Census Bureau, 2010).

International demographics are difficult to use because different countries use different variables to measure health statistics. Some countries do not record any health-related information, which makes any comparison impossible. Also, exact definitions of what constitutes certain illnesses or syndromes vary from nation to nation.

### *Environmental Concerns*

Environmental concerns relate to the quality of air, water, food, and variables such as the physical and emotional working conditions in which people find themselves. Safety is the key to environmental health regardless of where people live, eat, play, work, and pray (if appropriate). Recreational, employment, and house of worship facilities need to be as safe as where people live (shelter).

The environment is the context in which life is supported on earth. Concern about the global environment is necessary to protect the fragile ecosystem, which serves as a major determinant of health. It is important to advocate for a healthy environment, whether one is concerned about the loss of the atmospheric ozone layer and the resulting increase in harmful, carcinogenic rays from the sun, or the presence of a local chemical dump site that threatens the drinking water of a community. People need to know about the health effects of the environments in which they live, work, play, and pray, and they need to act in a way that conserves resources for future generations.

### *Public Services*

Public services include fire, police, sanitation, and public education services; public utilities (gas, electric, water); and recreation and sports facilities. Every community provides protection from crime and disasters to its residents as well as activities that promote socialization and entertainment. A sign of a healthy community is the availability of adequate public services such that the community members are safe to enjoy life. Large communities or those in certain hubs of the country may offer more public services than other communities. In times of financial constraints, some communities limit access to public services that are not seen as essential.

### *Aesthetics*

**Aesthetics** includes exposure to and participation in the fine arts, music, and spirituality, closely associated with one's cultural experience. The personal joy of seeking beauty in one's home and surrounding environment is augmented by the availability of parks, museums, and houses of worship. Communities express the joys and pains of

**Demographics:** A way of describing a community statistically based on the community members' visible characteristics (e.g., age, race, gender, and location of housing) and invisible characteristics (e.g., level of education, income, and religion).

**Aesthetics:** Exposure to and participation in the fine arts, music, and spirituality, closely associated with one's cultural experience.

FPO

<INSERT UNN 3-2 NEAR HERE>



FPO

&lt;INSERT UNN 3-3 NEAR HERE&gt;

living through the creation of art and beauty. People may define art and beauty as a personal valuing of pottery, paintings, or music. The personal meaning of aesthetics in a multiracial, multiethnic society such as the United States is important to consider, as people may have widely divergent views of what is artistic and beautiful.

A healthy community is one in which people can express what they find to be artistic and beautiful while tolerating the expressions of other groups different from themselves. The appreciation of diversity is key to the aesthetic component of a healthy community. Some of the ways in which communities appreciate aesthetics are by building museums, funding public sculpture, remembering holy days and festivals, and holding ethnic celebrations.

### *Health-Related Facilities*

Although all health-related facilities are located in the community, they vary in terms of what they do and who they serve. Health-related facilities include ambulatory care clinics, hospitals, community-based organizations (CBOs), subacute and custodial care facilities, public health departments, and home care and hospice organizations. These various health-related facilities are built by communities to meet the needs of the public. Contemporary trends are to decentralize healthcare services when possible and to increase the use of CBOs. Rehabilitative services, for example, are moving into communities so that clients can receive services close to where they live.

Individuals and groups can also provide care out of private offices. In addition, health maintenance organizations (HMOs) and preferred provider organizations (PPOs) support health care by linking a number of facilities or practitioners together to provide health care with the intent of lowering costs.

## Systems of Care Management

Systems of care management exist to meet community-based needs within the possibilities and realities of resource allocation. These systems need careful creation, use, and at times termination, so as to maximize the resources available for meeting community-based needs. Understanding systems of care management involves a study of the mix of client problems, expectations of the public for care, competence of healthcare professionals, accepted standards of care, and use of interdisciplinary plans of care. These five variables influence the development of the systems of care management in a number of ways.

### *Mix of Client Problems*

The mix of client problems varies widely according to location, success in resolving existing problems, and identification of new problems as they emerge. It may necessitate an ever-fluctuating level of intensity of needed services. Some individual clients in the community may need total support, whereas others may need only minimal intervention to maintain independence in living. Nurses in the community must make daily assessments of their case loads to decide which clients need a visit, which clients need a supportive phone call, and which clients need a different level of care, perhaps involving referral and coordination.

When the client mix includes families and groups of people as in a support group, care providers have a more diverse case load and confront a wider range of human problems. For example, the community health nurse caring for a family experiencing domestic disputes will likely be managing a complex plan of care. Clients with domestic dispute problems need special intervention services and psychosocial counseling.

The family unit needs a very different type of care from interventions focused on individuals. In domestic violence, the whole family needs care and support. Groups of people meeting for a common reason, such as a 12-step Alcoholics Anonymous group, have common needs, but the group requires a variety of interventions so that all members can participate. Sometimes nursing groups of people is done for economy of time (giving similar instructions to many people at the same time), and sometimes it is done because people are better able to participate in their healing in the midst of group support. Some cancer support groups are founded on the idea that people with similar problems are best able to help other cancer survivors cope with life.

FPO

<INSERT UNN 3-4 NEAR HERE>

### *Expectations of the Public for Care*

The expectations of the public for health care are as complex as the various communities that exist. The desire for healthcare services by the public is a major aspect of how care is ultimately managed. For example, prior to the advent of dialysis, people had fewer expectations about long-term care of clients with renal disease than they do today. Similarly, recent trends that support consumerism and make nutritional counseling and weight-loss information a high priority encourage the public to expect this type of information from their care providers.

Advertising often attempts to inform clients what they should expect from healthcare providers. Competing advertisements often present the idea that a special service is actually the normal service, thereby suggesting that organizations without the special service are actually offering substandard care. Some deluxe maternity services are advertised as a service that a new family should expect, implying that hospitals without such a service are not providing the basic care that the new family needs. In this sense, advertisements may be misleading.

Some people avoid the healthcare system because they fear providers, do not trust that the care they receive is adequate, or have had a poor experience with care in the past. The major problem with this situation is that the client avoids the care system until the illness or problem has progressed so far that little or nothing can be done to correct it.

The challenge for healthcare providers is to assist the public to expect a *reasonable* level of care, given that *unlimited* care is no longer realistic. Even the reliance on the safety net of healthcare services for people who are uninsured or underinsured, living in poverty, or with disabilities is now being called into question. In addition, American society has not yet defined “futile care”; as a consequence, many people continue to receive care that will not help them become healthier or improve their quality of life (Public Health Leadership Society, 2002; DHHS, 2010).

Some clients are kept on high-technology life support equipment long after such care has ceased to be useful, at the expense of others who might benefit from that level of care. Such misdirected care exacts an unknown toll on families, groups, and communities that must pay for the care on both monetary and emotional levels. The focus on curative care, as discussed earlier in this book, creates a scenario in which people always want more care after a health problem emerges, instead of preventing the problem in the first place.

### *Competence of Healthcare Professionals*

The competence of healthcare professionals is both a personal responsibility and a public mandate (ANA, 2010a; Holmes, 2006). The competence of professionals affects how care is managed. Nurses need competence in theoretical as well as technical aspects of care. Care providers need to be skilled in issues related to financial reimbursement, for example, to be fully able to manage care effectively from an economic perspective. In

addition, they need specific skills in negotiation, supervision, and collective bargaining, to name but a few areas. Nurses working to guard the public's health must be skilled in epidemiology, project management, and politics.

Likewise, given the high level of acuity in home care services, nurses need the latest technical skills in areas such as intravenous home infusion therapy, use of respirators, administration of peritoneal dialysis, and managing complex medication regimens to be able to manage care in a safe way. Each member of the interdisciplinary team brings various levels of skill in the physical, emotional, spiritual, and cultural care of clients; together the team is able to provide comprehensive care to the community. The smooth functioning of the interdisciplinary team suggests that the team as a whole, though not necessarily each team member, has the skills and knowledge necessary to manage complex client situations.

### *Accepted Standards of Care*

Effective examination of accepted standards of care requires the input of both professionals and the people whom they serve. Each healthcare discipline performs its work using accepted standards of care. The ANA sets general standards of care for the nursing profession, for example, and the ANA and specialty organizations, such as the Association of Nurses in AIDS Care, collaborate to set standards for specialized and advanced practice (Finkelman & Kenner, 2009). Legally, the state Nurse Practice Act specifies the parameters of accepted nursing care for its jurisdiction. Consortia, such as the Public Health Leadership Society, may establish principles for ethical practice from an interdisciplinary perspective (Public Health Leadership Society, 2002).


Nurses are required to uphold standards for community-based care that are adapted for home care, school health, public health, and private practice. Nurses working in the community have the opportunity to share their concerns about care with their peers and professional associations so that the standards of care reflect contemporary practice. Organizations such as the National League for Nursing and the Public Health Nursing section of the American Public Health Association are involved in solving problems in community-based practice through discussions among their respective memberships.

### *Use of Interdisciplinary Plans of Care*

**Interdisciplinary plans of care (IPCs)**, also known as action plans, are created and used by the various disciplines involved in the process of providing care. They influence care management by setting minimal expectations for client outcomes or responses to care interventions. These care plans are intended to capture the more general or typical response to interventions to accelerate discharge from a more acute level of care to a lesser level of care. For example, an individual client might be discharged from the hospital to home, or the home care nurse might discharge a client from a dependent care level of service to a level of greater self-care and independence.

Standardized IPCs are not useful for every client. People may respond to care in unique or unexpected ways and, therefore, may need a tailored, personal plan of care. It is important to remember that all clients, working together with the nurse, need to continuously evaluate the actual plan of care for its fit with any predetermined IPC. Each provider has the legal responsibility to plan and provide care that meets the special needs of clients.

Interdisciplinary plans of care are conceptually less useful for families, groups, and communities. Standards of care for collectives are difficult to set because of the complexities inherent in more complex, multiple-person clients. Ongoing research is needed to document an interdisciplinary approach to the care of families, groups, and communities.



**Interdisciplinary plan of care (IPC):** An action plan created and used by the various disciplines involved in the process of providing care that set minimal expectations for client outcomes or responses to care interventions.

## Resource Allocation

Resource allocation is a complex construct, with aspects related to local, regional, national, and global availability and use of personal and material resources. Resource allocation comprises more than just cash flow from various private and public sources; it involves the material, time, and energy necessary to construct systems of care management that meet the needs of the community on physical, emotional, and cultural levels. Resource allocation is explored by examining the patterns of resource allocation, values and beliefs of the population, reliance on government funding, influence of special interest groups, and patterns of insurance coverage.

### *Patterns of Resource Allocation*

Patterns of resource allocation include who receives resources in the present and who received them in the past. The pattern of resource allocation is an important variable when one considers who needs resources today as well as tomorrow. Every community has a pattern of how it allocates resources. Retirement communities allocate resources differently than aggregates of young families, for example. One role for nursing and other members of the interdisciplinary team is to keep a community informed about unmet needs of other parts of the community. For example, a community that does not value rehabilitative services may need to be educated about the importance of these services before it decides whether it wants or requires them.

### *Values and Beliefs of the Population*

The values and beliefs of the population relate to concerns about who should and who should not receive resources. These considerations dictate which types of health-related services members of the population want developed. For example, a closed and isolated Amish community has different requirements for health services than a large metropolitan Hispanic community. Some populations with traditional religious beliefs could be expected to have different requisites for family planning services than groups who value various artificial birth control methods.

Populations are diverse and inevitably encompass a variety of cultural values and beliefs. The community health nurse needs to uncover and learn about these various beliefs without supporting negative stereotypes. For example, nurses can learn about beliefs different from their own by reading about other cultures as well as living and working with other groups of people. Diversity is found both between cultural groups and within the groups themselves. Most groups have members who are conservative as well as those who are liberal in how they interpret the values and beliefs held by the overall group.

### *Reliance on Government Funding*

Reliance on government funding occurs on local, state, and national levels. Communities that receive various levels of government funding for health-related programs allocate their resources differently than communities that pay out-of-pocket for all healthcare services. In the United States, public hospitals subsidize approximately 70% of inpatient care and 50% of outpatient or ambulatory care (National Center for Health Statistics, 2009). Changes in government funding could greatly affect the services offered in certain communities that subsidize healthcare costs with public support. Each state varies in how it provides funds or services to the people who cannot pay for them. Local communities provide services after applying taxes on property and goods that are sold. The United States is different from other countries in this respect, because it does not have an integrated national–state–local level of health services guaranteed to

its citizens. As a consequence, the U.S. healthcare system provides services that are not always integrated (Finkelman & Kenner, 2009).

### *Influence of Special Interest Groups*

The influence of **special interest groups** can affect resource allocation in both overt and covert ways. Special interest groups are those that use their influence to get the services that they want. For example, a certain political group may want more acute care cardiac services while limiting reproductive services for women. One concern with special interest groups is that they may advocate for services for one group at the expense of another group's needs.

Healthcare planning can become inconsistent and chaotic when special interests are catered to without regard for the needs of the whole community. Clients from different age groups or with different diagnoses should not have to compete for care resources. Should resources in short supply go to the clients in the neonatal intensive care unit or those in the intermediate geriatric care unit? Does society want to focus on caring for people with AIDS or Alzheimer's disease? There are no easy answers to these questions.

Advocates for the homeless, prisoners, and physically and mentally challenged persons indicate that their needs are often not taken into account when healthcare choices are made by the public. **Advocacy groups**—another type of special interest group—exist to assist less empowered groups to have a voice and get their needs met. The community health nurse advocates for different types of clients at different times in their experience of health and illness. Nurses advocate for other nurses by lobbying politicians to protect professional practice legislation.

### *Patterns of Insurance Coverage*

The influence of third-party payment for health care as it relates to who has access to healthcare services is a complex issue. Increasingly large segments of the U.S. population are now uninsured or underinsured. Insurance coverage is not just a problem for people who do not work; many of the “working poor” cannot afford health insurance either. Patterns of insurance coverage are directly influenced by employment patterns. For example, many people who work are not offered healthcare benefits or are paid per diem wages that do not include healthcare or other benefits. Some workers in the United States are undocumented nonresidents who are impossible to cover with insurance. Insurance coverage is a primary concern of emerging discussions of healthcare reform (DHHS, 2010).

## **The Alliance for Health Model as a Complement to Evidence-Based Nursing**

The use of the Alliance for Health Model complements the evolution of evidence-based nursing in care delivery, education, and ongoing research. This model is unique in requiring the examination of the therapeutic relationship between the nurse and the client, as well as the requisite to address the realities of resource allocation. The nurse and the client—that is, the profession and the public—must do their healing work within the constraints and possibilities of allocating human and material resources. The Alliance for Health Model has a history of utility in relating these core concepts with this healing work in education and care delivery in the community (Holzemer, 1997, 2010; Holzemer, Scaramuzzino, & Kiernan, 2001).

**Special interest group:** A group that uses its influence to get the services that its members want.

**Advocacy group:** A type of special interest group that exists to assist less empowered groups to have a voice and get their needs met.

## Evidence from Research

Evidence from scholarship is central to the work of moving with clients on their journey to health and wellness. Qualitative and quantitative ways of knowing are enriched by the various, respective modes of inquiry. Studies conducted in the community can use large samples to describe, correlate, and predict phenomena of interest in quantitative research. In this sense, the community represents a living laboratory where qualitative questions find meaningful answers in how people live.

## Evidence from Clinical Practice

The realities of using and improving best practices in nursing care begin at the bedside, regardless of the location of care delivery. The expertise of the nurses “in the community” provides new and innovative approaches to care that are pre-research in nature. Point-of-service experience indicates where improvements in care may be generated prior to the formal inquiry involved in quantitative and qualitative research.

## Evidence from the Client's Experience

Clients live their joys and sorrows in a unique way; the result is their story—their experience. It is critical for nurses and other healthcare providers to listen closely to their clients and incorporate their experience into the plan of care. Respect for the health-related experience of the client is not part of their story, but rather the central component of their story. When the story comes from a family, group, aggregate, or other community, it is likely to be complex, and sometimes confusing.

Attention to the client's story is vital, yet it poses a challenge in community health nursing. The evidence from the client's experience is not simply a summation of the evidence from individual members in a family, group, aggregate or other community. Instead, the story of a family in distress comprises the collective ability of the family to function in a healthy way; the story of a community includes the needs of the people and environmental influences that reflect the health and illness of the whole. The client's experience in the community is demonstrated by the community's dynamic and changing behaviors, and it takes vigilance on the part of the nurse to interpret these behaviors correctly.

The concept of vulnerability, specifically related to clients without a voice, is a particular challenge to the community health nurse. Clients who are not heard due to the overwhelming needs of special interest groups, for example, make listening to the client very difficult. The influence exerted by clients of special interest, who may control the systems of care management and resource allocation in the community, make meeting the needs of all clients problematic.

# Use of the Alliance for Health Model: Two Different Problems in the Community

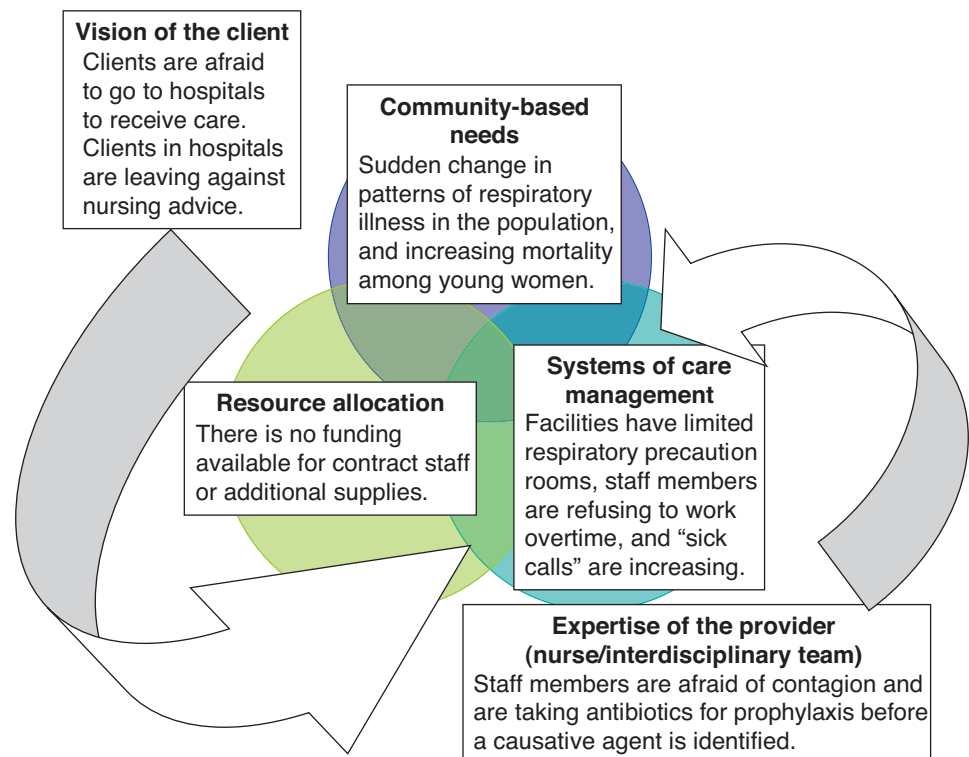
Two case studies are used here as examples of how the various parts of the Alliance for Health Model are related. A problem may begin with any of the primary aspects of the model. In the first example, the problem begins in the area of community-based needs; in the second example, a concern is noted with resource allocation. It is important to understand that the problems in one area influence all other areas of the model. Of interest, a problem emerging in one area may be solved by devoting attention to a related or nested concern in another part of the model.

## A Problem Emerging with Community-Based Needs

**Community-Based Needs.** Community A is a rural community, with a population of 5,000. The public health nurse is working with an epidemiologist to review recent mortality data from the local hospital, nursing home, and emergent care center. The pair notes a rapid rise in the incidence of an influenza-like illness, especially among young women. Phone calls to the local school of nursing and a child care center validate high absentee rates among the women attending or using these facilities. The local news station reports 46 cases of the yet-to-be-named condition, with three unconfirmed deaths. The local community moves into a crisis state (**FIGURE 3-4**).

**Vision of the Client.** The community as a whole (vision of the client) becomes afraid of contagion and avoids care. An increased rate of voluntary discharges from the local hospital occur, against nursing advice. Some families curtail outside activities, and local support and activity groups cancel meetings. Segments of the community with financial means leave the area on “unplanned vacations.” Other segments of the population, whose members were not previously participants in receiving healthcare resources, seem immobilized from acting and isolate themselves.

**Expertise of the Provider.** Nurses and other healthcare providers, as part of the community, also fear contagion. Unlike their lay counterparts, they secure antibiotics before a causative agent can be isolated. Although considered an unsound medical practice, the providers of care take drugs to prevent what



**Figure 3-4** Alliance for Health Model: A problem emerging with community-based needs.

“might occur to them.” They are not responding to the situation like educated professionals.

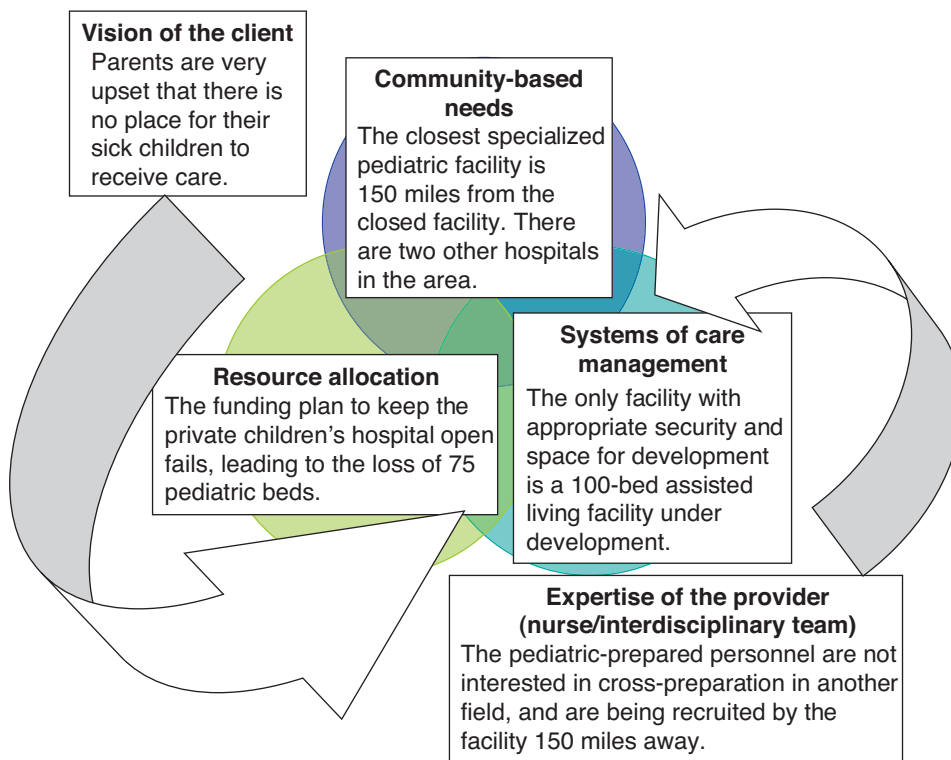
**Systems of Care Management.** The systems to provide care in the local hospital are experiencing problems. The facility was not constructed and is not supplied to cope with a sudden influx of patients with respiratory illness. Families are upset and angry because visiting hours have been curtailed. Even with minimal space and equipment constraints, problems are intensifying because of the number of staff who are not showing up for work. The number of “sick calls” is increasing.

## A Problem Emerging with Resource Allocation

**Resource Allocation.** A funding plan to keep a private children’s hospital fails, leading to the closure of the 75-bed institution (**FIGURE 3-5**). The private, for-profit hospital was part of a regional pediatric care system, and was losing money due to low reimbursement rates for experimental procedures. The hospital is a major source of employment for the geographic area. There are two other hospitals in the area, but the closest pediatric facility is now 150 miles away.

**Community-Based Needs.** Community B is an urban community, with a population of 67,000 people. The public is aware that ongoing political unrest has prevented the passing of the local budget. The “general feel” in the community is that all of the problems will be resolved during the last budgetary session.

**Vision of the Client.** The community as a whole (vision of the client) is very upset because there is no place for their sick children to receive care conveniently.



**Figure 3-5** Alliance for Health Model: A problem emerging with resource allocation.



**Expertise of the Provider.** The pediatric-prepared personnel are not interested in cross-preparation in another field, and are being recruited by the facility located 150 miles away.

**Systems of Care Management.** The only facility with appropriate security and space for development is a 100-bed assisted living facility under development.

## Summary

The Alliance for Health Model represents a philosophy of nursing care in the community, defined as a joint venture between the nurse and the client on their journey toward health. The model provides the professional nurse with a schema for applying the nursing process to actual and potential health problems experienced by families, other groups, aggregates, and communities. There are three steps in the joint venture process of seeking health by the nurse and the client:

1. The voice of the client articulates needs, and is responded to by the nurse (or other provider) with the professional expertise to hear the client.
2. The nurse and the client identify community-based needs and validate the utility of the systems of care management (either in place or needing development) to meet community-based needs.
3. The nurse and the community secure the resources needed to resolve health-related threats to the community.

The Alliance for Health Model should be seen as a dynamic whole of interacting parts or components, which find meaning in their relationship to the other aspects of the model. It includes five components:

1. The voice of the client
2. The expertise of the provider (nurse and interdisciplinary team)
3. Community-based needs
4. Systems of care management
5. Resource allocation concerns

The Alliance for Health Model complements the idea of evidence-based nursing in care delivery, education, and research. Using this model, the nurse collects evidence of health (or the lack of health) from established research, accesses the expertise of professionals “in the field,” and appreciates the lived experience of the client. The Alliance for Health Model can serve as a useful tool to better capture the relationship between the CHN and the client on their search for health.

## Acknowledgments

The development and utility of the Alliance for Health Model is due in great part to Joan Arnold, PhD, RN. Dr. Arnold, a community health nurse scientist, continues to advance the science of community health nursing education—research—care delivery to improve the health of people in need.

## REFERENCES

- Allender, J. A., Rector, C., & Warner, K. D. (2010). *Community health nursing: Promoting and protecting the public's health* (7th ed.). New York, NY: Lippincott Williams & Wilkins.
- American Nurses Association (ANA). (2001). *Code of ethics for nurses with interpretive statements*. Silver Spring, MD: Author.

- American Nurses Association (ANA). (2010a). *Nursing: Scope and standards of practice* (3rd ed.). Silver Spring, MD: Author.
- American Nurses Association. (2010b). *Nursing's social policy statement: The essence of the profession*. Silver Spring, MD: Author.
- Buerhaus, P. I., Staiger, D. O., & Auerbach, D. I. (2009). *The future of the nursing workforce in the United States: Data, trends, and implications*. Sudbury, MA: Jones & Bartlett.
- Dayer-Berenson, L. (2011). *Cultural competencies for nurses: Impact on health and illness*. Sudbury, MA: Jones and Bartlett.
- Finkelman, A., & Kenner, C. (2009). *Teaching IOM: Implications of the Institute of Medicine reports for nursing education* (2nd ed.). Silver Spring, MD: American Nurses Association.
- Fowler, M. D. (Ed.). (2010). *Guide to the code of ethics for nurses: Interpretation and application*. Silver Spring, MD: American Nurses Association.
- Holmes, C. A. (2006). The slow death of psychiatric nursing: What next? *Journal of Psychiatric and Mental Health Nursing*, 13, 401–415.
- Holzemer, S. P. (1997). The Alliance for Health Model: Helping students to understand community health assessment and care delivery. In B. Marckx & E. Tagliareni (Eds.), *Teaching in the community: Preparing nurses for the 21st century*. New York, NY: National League for Nursing Press.
- Holzemer, S. P. (2010). Creating a culture of care for the maturing nurse. In M. Klainberg & K. M. Dirschel, *Today's nursing leader: Managing, succeeding, excelling* (pp. 277–290). Sudbury, MA: Jones and Bartlett.
- Holzemer, S. P., Scaramuzzino, M., & Kiernan, J. (2001). Community-based primary care for children. In C. G. Hernandez, J. K. Singleton, & D. Z. Aronzon (Eds.), *Primary care pediatrics*. Philadelphia, PA: Lippincott.
- National Center for Health Statistics (NCHS). (2009). *Health, United States, 2009: With special feature on medical technology*. Hyattsville, MD: U.S. Government Printing Office. Retrieved from <http://www.cdc.gov/nchs/hus.htm>
- Public Health Leadership Society. (2002). *Principles of the ethical practice of public health* (Version 2.2). Retrieved from <http://www.phls.org>
- Solberg, L. I. (2007). Improving medical practice: A conceptual framework. *Annals of Family Medicine*, 5(3), 251–256.
- U.S. Census Bureau. (2010). *Statistical abstract of the United States: 2010* (129th ed.). Washington, DC: Author. Retrieved from <http://www.census.gov/statab/overview.html>
- U.S. Department of Health and Human Services (DHHS). (2010, July). *Healthy people 2020: The road ahead*. Retrieved from <http://www.healthypeople.gov/hp2020>

## ADDITIONAL RESOURCES

- Centers for Disease Control and Prevention (CDC). (2010, June 25). Summary of notifiable diseases—United States, 2008. *Morbidity and Mortality Weekly Report*, 57(54).
- Milstead, J. A. (2013). *Health policy and politics: A nurse's guide* (4th ed.). Burlington, MA: Jones & Bartlett.



WWW

For a full suite of assignments and additional learning activities, use the access code located in the front of your book to visit the exclusive website: <http://go.jblearning.com/Holzemer/>. If you do not have an access code, you can obtain one at the site.

## LEARNING ACTIVITIES

www

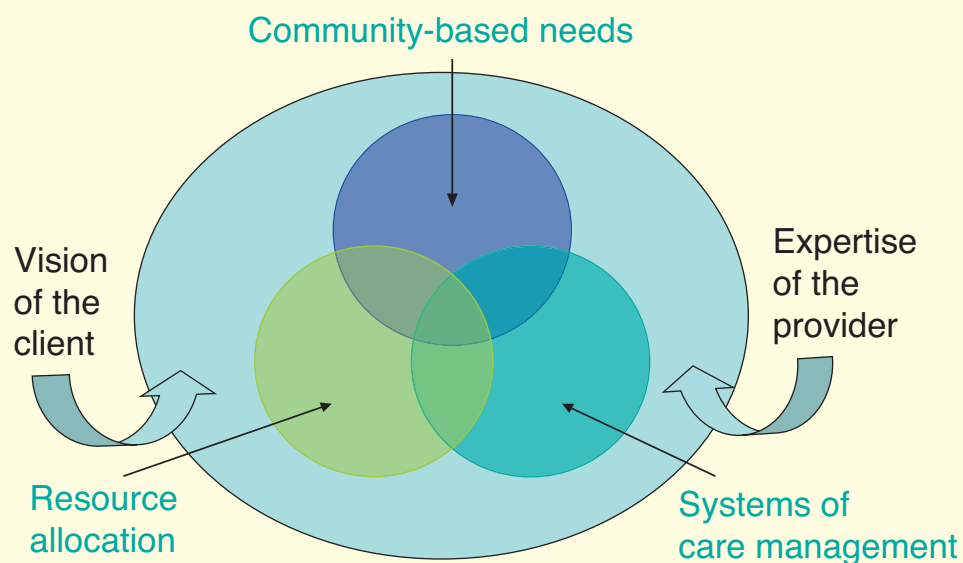
Read the following questions slowly and choose the best answer. Questions that have more than one correct answer are identified with the statement "Choose all that apply."

Using the Alliance for Health Model in **FIGURE 3-6**, match the various sets of data with the five key aspects of the model. The key aspects may be used more than once.

For Questions 1–6, match the following examples with the key aspect of the Alliance for Health Model (A–E) each represents.

- A. Community-based needs
- B. Systems of care management
- C. Resource allocation concerns
- D. Vision of the client
- E. Expertise of the provider

1. Insurance coverage.
2. Creation of special hospital units for respiratory infections.
3. Experience of being a client in the hospital.
4. Availability of sanitation services.
5. A nurse does not make a referral to a physical therapist when such a referral is indicated.
6. A client and family decide to institute a "do not resuscitate" directive.



**Figure 3-6**



7. A nurse is interested in obtaining evidence of the client's perspective of care while developing an evidence-based protocol. Which of the following statements, made by a nurse, reflect an attempt to capture the client's perspective of care? Choose all that apply.
- A. "Contact the Health Department to obtain the latest morbidity data."
  - B. "Reviewing the patient satisfaction data will provide useful information."
  - C. "A new protocol will allow the staff to make follow-up calls to clients."
  - D. "Ask the nurse managers to submit their thoughts on best practices."
  - E. "Interview the financial staff to identify the lowest-cost interventions."
8. A nurse who is working in "high-tech" home care feels that he is not prepared to provide comprehensive care to clients receiving chemotherapy in the home. From which resource would the nurse *initially* seek help to resolve the problem?
- A. The board of nursing in the state where the nurse works
  - B. The specialty organization related to the type of care that is provided
  - C. The school of nursing from which the nurse graduated
  - D. The education department of the employing agency
9. A community health nurse would anticipate using an interdisciplinary plan of care with which of the following clients?
- A. A 12-year-old boy with an arm fracture and of normal weight
  - B. An 87-year-old man with unstable angina and dementia
  - C. A 45-year-old woman with chest trauma and poor health history
  - D. A newborn with failure to thrive after a home delivery
10. A community health nurse working in a large, politically conservative community would expect limitations in which of the following healthcare services?
- A. Coronary care services for men
  - B. Supportive care services for older people
  - C. Women's reproductive health services
  - D. Services for infants and children

## ADDITIONAL QUESTIONS FOR STUDY

The Alliance for Health Model will be greatly influenced by the unfolding of the Patient Protection and Affordable Care Act (Affordable Care Act), which became law in 2010. Although the exact way the law will take effect state by state may be different, the concerns of the five components of the model will be, in some ways, redefined.

Go to the website Health Care and You (<http://www.healthcareandyou.org>), or another similar site, and review the various components of the Affordable Care Act. Discuss with your

classmates the impact of the Affordable Care Act on the following:

1. The voice of the client
2. The expertise of the provider (nurse and interdisciplinary team)
3. Community-based needs
4. Systems of care management
5. Resource allocation concerns (components of the Alliance for Health Model)

## APPENDIX 3-A

# Alliance for Health Model Community Assessment Tool

Name of team (group) members; identify the team leader. (Your instructor may assign any number of people to make up a community assessment team.)

1. \_\_\_\_\_ (Team Leader)

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

Please identify the dates and times of data collection, as well as the sources of information used in all parts of this assessment. Omit the names of the people you interview for the purposes of privacy and confidentiality. Place your original assessment notes where indicated.

## Description of the Community

Use Census Tract or other statistical resources to determine the boundaries of the community. In this description, include pictures, newspaper articles, and direct quotes from residents for the community you select. Write a summary statement in the space provided. Place pictures and other supplemental material in the “Supplemental Data” section. Do not take pictures of residents that can reveal their identity. Distant group shots without identifying information are acceptable.

## Areas of Assessment

### Focus on Community-Based Needs

1. **Patterns of Morbidity and Mortality:** What are the leading causes of death and disability? Why do people seek health care? Are there unusual patterns of illness and death in the community?
2. **Demographics:** What are the characteristics of the community related to age, gender, education level, income and types of housing available? Have the demographics changed over the last 5 to 10 years?

3. **Environmental Concerns:** What does the community look like? Which types of environmental problems could cause accidents or disease? Are there any areas in the community where the movement of people is restricted due to pollution or other barriers?
4. **Public Services:** Which types of public services exist related to fire, police, education, sanitation, recreation, and sports? Has an emergency disaster plan been developed for this community? How do people evaluate the quality of these services?
5. **Aesthetics:** Which types of art, music, cultural, and religious institutions are reflected or available in the community?
6. **Health-Related Facilities:** Describe the various health-related facilities available to the community under study. What is the response rate of the emergency medical services? How do the health-related facilities relate to the characteristics and needs of the community?

## Care Management Techniques

1. How do the patterns of morbidity and mortality of the community relate to the use of resources (e.g., is the local hospital so burdened with trauma cases that other clients do not receive timely emergency care)?
2. Do people in the community want care that is not being provided? Do people perceive inequality in who obtains care?
3. How do healthcare providers define the type of care that is provided to the community? How is the care evaluated?
4. How are standards of care set, followed, and evaluated?
5. Is there evidence of an interdisciplinary plan of care for the community? Which disciplines are involved in providing interdisciplinary care?

## Influences on Resource Allocation Decisions

1. What are the influences on allocation of resources?
2. What are the values and beliefs of the community, as they relate to health and illness? How do you know this?
3. In what ways does the community depend on government funding for its healthcare services? Are there alternative sources of funding?
4. Which special interest groups exist in the community? How do they influence healthcare services?
5. What are the patterns of healthcare insurance coverage?
6. What is the process for involving the consumer in healthcare decisions for the community?
7. How are care providers oriented for their work? Is there continuing education available or required?

## Application: Diagnostic Statement(s) About the Community

Write diagnostic statements that are developed from the assessment *after the entire assessment is completed*. They should be listed in the priority of how your team thinks they should be addressed. Identify whether they represent actual or potential problems. Write the group's rationale for the order in which the diagnoses are listed.



## Evaluation of the Community Assessment Project

1. What were the benefits and limitations of completing this project?
2. Which aspects of the project would you change to improve your learning?

## Assessment Notes

Identify the dates and times of data collection, as well as the sources of information used in all parts of this assessment. Each team member may collect notes separately, and the information for the whole group should be placed in this section.

## Supplemental Data

Place pictures, newspaper articles, fliers, and other supplemental material here. (Do not take pictures of residents that can reveal their identity. Distant group shots without identifying information are acceptable.)