UNIT 1

# The Context

**CHAPTER 1** Opening the Door to Health Care in the Community
*Karen Saucier Lundy, Sharyn Janes, and Sherry Hartman*

**CHAPTER 2** Community and Population Health: Assessment and Intervention
*Karen Saucier Lundy and Judith A. Barton*

**CHAPTER 3** History of Community and Public Health Nursing
*Karen Saucier Lundy and Kaye W. Bender*

**CHAPTER 4** Epidemiology of Health and Illness
*Angeline Bushy and Gail A. Harkness*

## COMMUNITY-FOCUSED NURSING

WHAT DOES IT MEAN to take care of a community? Community-focused nursing care is often difficult to define and even more difficult to practice. Baccalaureate nurses are educated to practice nursing in all healthcare settings. Community health nurses care for populations. Since the late 1800s, professional public health nurses have cared for communities. Those communities have changed over time, and the practice of community health nursing has changed as well. Community health nursing has evolved into a complex, multifaceted nursing specialty that is constantly challenged by rapidly changing delivery systems, including the passage of the Affordable Care Act (ACA, or "Obamacare") of 2010. While reading about the history of community and public health nursing, both similarities and differences in today's community health nursing practice will emerge. Community health nursing, which evolved from public health nursing and is accountable to the public for meeting the population's healthcare needs, has responded to changes in society to include the care of such diverse populations as schoolchildren, women with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), and the homeless. Unit 1 introduces the student to the world of the community health nurse: the focus, the settings, and the historical issues relevant to today's community health practice. As a broadly based specialty, community health nursing practice is more affected by structural changes in society than are other nursing specialties. The community health nurse must be aware of the healthcare system, social trends, economics, and culture to deliver effective care to the public. Unit 1 assists the student in understanding the uniqueness of community health nursing and the structural influences that must be considered when delivering effective care for an entire community.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

## CHAPTER FOCUS

**A Closer Look at Health**
- Historical Insights

**Nursing in the 21st Century**
- Educating Nurses for Community Health Nursing Practice

**Community-Based, Population-Focused, Community Health Nursing: What's in a Name?**
- Communities and Populations
- Acute Care Versus Community Health Nursing

**Reform and the Reinvention of Systems of Care**
- *Nursing's Agenda for Health Care Reform*
- Managed Care and the Future of Nursing

**Back to the Future: From Hospital to Community, from Cure to Prevention**
- Home Health Care
- Cure and Prevention: Can We Really Do It All?
- Benefits Versus Costs
- *Healthy People 2020:* Goals for the Nation
- Influences on a Community's Health: Culture, Environment, and Ethics

**Epidemiology: The Science of Public Health**

**Measuring a Community's Health: How Do We Know When We Get There?**

## QUESTIONS TO CONSIDER

After reading this chapter, you will know the answers to the following questions:

1. How does the definition of health affect the way we care for populations?
2. How have settings and opportunities in the health-care system changed in recent decades?
3. What implications does the ACA have for nurses?
4. What is healthcare reform and prevention, and how do these changes influence health policy in the U.S. care system?
5. What is the significance of *Nursing's Agenda for Health Care Reform*?
6. What is *Healthy People 2020,* and how does it influence the healthcare system related to a policy of prevention?
7. What are the distinctions between the concepts of community health, population-focused care, and acute care?
8. What is a community, and what is a population?
9. What are the three major influences on community health?
10. What is epidemiology?
11. What is the relationship between the natural history of disease and the three levels of prevention?
12. How is a population's health measured?

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

CHAPTER 1

# Opening the Door to Health Care in the Community

Karen Saucier Lundy, Sharyn Janes, and Sherry Hartman

## KEY TERMS

Affordable Care Act (ACA)
care management
community
community-based nursing
community health nursing
culture
environment
epidemiology
ethics
Florence Nightingale
health
healthcare reform
*Healthy People 2020*
home health care
managed care
*Nursing's Agenda for Health Care Reform*
Patient Protection and Affordable Care Act
population
population-focused care
populations of interest
primary prevention
public health nursing
secondary prevention
tertiary prevention
World Health Organization (WHO)

> We hear much of 'contagion and infection' in disease. May we not also come to make health contagious and infectious?
>
> —Florence Nightingale, 1890

> It is cheaper to promote health than to maintain people in sickness.
>
> —Florence Nightingale, 1894

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

## REFLECTIONS

Firefighters Responding to 9/11 at Increased Cancer Risk
Coffee Linked to Lower Cancer Risks
Allergens Found High in Daycare Centers
Moderate Alcohol Consumption Appears to Slow Cognitive Decline in Older Women
States Wrestle with How to Accommodate Children Born in the U.S. to Illegal Immigrants
Dull, Low-Level Jobs Linked to Heart Problems
Teens Say Oral Sex Not Really Sex
Cosmetic Surgeons Focus More on Teen Set
Proximity to Power Lines at Birth May Increase Leukemia Risk
Middle-Age Obesity Predicts Old-Age Dementia
Obamacare Website Malfunctions Limit Access to Patient Enrollment in Insurance Marketplaces
The Robot Will See You Now: Is Your Doctor Becoming Obsolete?
Are Extended Work Hours for Nurses Worth the Health Risks?
Results from Harvard Nurses' Health Study Show That 70 Percent of Nurses Are Either Overweight or Obese
Cyberbullying Leads to Female Teen's Suicide
WHO Just Says No to Tanning Beds for Teens
Days Off in Fine Weather Linked to Melanoma-Courting Behavior
Energy Drinks and Adderall Use Results in Increase in Emergency Room Visits
TB Has Small Presence in America, But Remains Huge Worldwide
Is Your Desk Making You Sick? Computer Keyboards and Office Equipment Swarm with Germs
Cruise Ships May Be Hazardous to Your Health
Few Americans Following "Big Four" Healthy Lifestyle
Obesity in U.S. at Pandemic Level, May Decrease Life Expectancy for Younger Generations
Autism Linked to Allergic Disease During Pregnancy
Mental Disorders Strike Nearly Half of All Americans
Experts: AIDS Vaccine Years Away
Most Prescription Bottles Difficult for Elders to Read
Majority of Elders Do Not Take Drugs as Prescribed
Methamphetamine Now "Drug of Choice" in Rural U.S.
Drug Safety Fears Prompt Some Patients to Seek Alternative Pain Remedies
Aging in Brain Found to Hurt Sleep Needed for Memory
Antibiotics, Sex Hormones and Tranquilizers Found in Major U.S. Cities' Drinking Water
Women's Rights Linked with AIDS Epidemic in Africa
Security Concerns Hampering Polio Eradication Efforts in Pakistan

These headlines are all recent from media throughout the world. Sometimes it may seem that larger social issues are unrelated to nursing practice. As you will see in this text, however, community health nurses define health very broadly so that the connections between and among these headlines and our work in the community will become clearer. Almost every problem cited in the news can be linked to larger issues in public health.

After reading these headlines, think about the following questions:

- Why are illness and disease the focus of most health care in the U.S. healthcare system?
- Are you more interested in the "drama of trauma" in health care than community health nursing, such as educating people about prevention of disease and injury? If you are, you are not alone! Most student nurses and the public are more impressed with high-tech health care than with prevention.
- Think about why nurses might find self-care and prevention to be less interesting. Why do you?
- What do you know about the ACA (or "Obamacare") of 2010? Are you confused about how the new healthcare reform will affect you as a nurse?

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

THE WORLD OF NURSING and the nurse's role are always changing, but it is probably safe to say that those who choose nursing in the early decades of the 21st century are caught in unprecedented currents of change: revolutionary changes in healthcare delivery, changes in settings of care, and changes resulting from historical healthcare reform at the national level. Although bachelor of science in nursing (BSN)–prepared nurses have always been prepared and functioned to some degree within a community health framework, understanding the importance of population-focused and community health nursing practice knowledge and skills is critical to assuming a leadership role in the current healthcare system, regardless of setting. The passage of the **Patient Protection and Affordable Care Act**, also simply called the **Affordable Care Act** or ACA, on March 23, 2010—along with the confirmation of the Act's constitutionality by the U.S. Supreme Court on June 28, 2012—has been the most significant and sweeping healthcare reform legislation in the history of the U.S. healthcare system (American Academy of Nursing [AAN], 2010).

The ACA was created to increase access to affordable and accessible health care for millions of uninsured and underinsured Americans, with an emphasis on preventive health care, as well as protections for citizens from insurance companies denying coverage due to preexisting conditions and high-risk health conditions. The ACA's purpose is twofold: (1) to increase the number of Americans covered by health insurance and (2) to decrease the cost of health care. Prevention of illness and promotion of health are common threads throughout the ACA. The ACA most significantly reforms the way health insurance is purchased, requiring that all Americans purchase a private healthcare plan or pay a tax penalty. Americans who cannot afford private health insurance will either qualify for Medicare or Medicaid, or get assistance in the form of tax credits or tax breaks, among other types of financial support. The ACA has also resulted in one of the most debated and divisive pieces of federal legislation in recent years (Gable, 2011).

As student nurses, you will have varying opinions about the ACA, but as this text is published, ACA is the law, and it has already begun implementing dramatic and far-reaching changes within many facets of society. So, "What does that have to do with nursing?" you may be asking. Throughout the text, you will learn how the ACA will be implemented by the proposed timelines and the impact such reforms will have for all nurses.

The U.S. healthcare system has been challenged like never before to respond to bioterrorist threats unknown to nurses just a few years earlier. Following September 11, 2001, our world was forever changed. The loss of security in our communities remains a serious threat to our wellbeing. The unprecedented "disaster of disasters," Hurricane Katrina, forced us as a society to question our ability to respond to natural threats as well. Many of us watched in shock, and some of us experienced firsthand, the disintegration of an entire region along the Mississippi Gulf Coast and New Orleans. How could this happen in the United States? Even more importantly, how can we respond more efficiently and effectively to future disasters? The decade-long military conflict in the Middle East has resulted in thousands of disabling health conditions for veterans, increasing human and economic costs of a postwar society, and affecting veterans and their families.

These changes and other health crises have left us as a nation questioning our ability to respond to present and future public health needs. In this climate of disillusionment, Americans feel even more vulnerable than ever in terms of their safety, despite living in one of the most advanced nations in the world.

**NOTE THIS!**

Common Definitions in Community Health Nursing

**Community health nursing** is a systematic process of delivering nursing care to improve the health of an entire community (Nehls, Owen, Tipple, & Vandermause, 2001, p. 305).

**Community-based nursing** refers to the setting and the practice of the nursing role. The focus of community-based nursing care is primarily at the individual and family levels, which contribute to the health of the community. Community-based nursing often refers to nursing care provided outside of acute care settings.

**Population-focused care** refers to interventions aimed at health promotion and disease prevention that shape a community's overall health status.

**Public health nursing** is the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences. The practice is population-focused, with the goals of promoting health and preventing disease and disability for all people through the creation of conditions in which people can be healthy (American Public Health Association, Public Health Nursing Section, 1996; American Nurses Association, 2013).

These forces for change have been developing for some time now, engulfing all healthcare professionals in the shifting sands of practice. In response to new demands, new opportunities, new possibilities, and a more complex healthcare environment, current nursing students pursue

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

a curriculum that their predecessors would not recognize. The nurse's place in the healthcare system is at the patient's side, not just in the hospital, but in any setting and in a myriad of roles where people work, play, learn, worship, shop, explore the Internet, or call a hotline. The nurse has an opportunity to educate and promote health for people in broad and diverse communities. Further, travel nursing has emerged as a career choice that provides nurses with opportunities to work in different cultures, settings, and locales, not only in the United States, but throughout the world. In essence, every BSN nurse is a community health nurse: The degree to which this is true varies only in the specific demands of the nursing role and setting.

**ART CONNECTION**

This feature will present a well-known art piece that contains a brief description of the significance of art to understanding the complexity of health, healing, and suffering. Select one of your favorite paintings and write a brief summary of how this art relates to health and healing.

As health care moves toward a more community-driven system, a change in focus becomes vital as we embrace a growing mindfulness to form partnerships with those served by community health nurses. New directions in health care are also occurring internationally, with community-based partnerships between healthcare providers and communities (Nehls & Vandermause, 2004). Even if the world around us appears to remain chaotic and complex, as some suggest, nursing ideals and commitments will fulfill the promise of the dreams that bring most nurses to the profession.

With the headlines often heralding hospital closures, insurance costs, patient access to ACA, mergers, and downsizing, where does that leave nurses? What is the story behind where we are today? What kind of job will there be for you after graduation? When you graduate from nursing school, you will join the more than 2.7 million registered nurses (RNs) in the United States? The good news is that the federal government predicts that RN will be one of the top careers with the most job openings in the future. Employment of RNs is expected to grow 26% from 2010 to 2020, faster than the average for all occupations (Bureau of Labor Statistics, 2012).

Rapid growth in this job market will be driven by technological and innovative advances in patient care and the ACA, which permit a greater number of health problems to be treated outside the traditional clinical/acute care setting. These changes, coupled with an increasing emphasis on preventive care as we learn more about what keeps people healthy, further expand the healthcare market (AAN, 2010).

A critical nursing shortage exists today in all areas of nursing and is projected to extend into the coming decades, especially for positions requiring a BSN. Travel nursing positions are in great demand in the United States and throughout the world. Nurses who can respond to different cultures and practice settings and adjust quickly to diverse care situations requiring community health and population-based skills will be in the greatest demand. In addition, the number of older people, who are much more likely than younger people to need nursing care, is projected to grow rapidly during the 21st century.

Although 61% of RNs still work in hospitals, that percentage has dropped more than five percentage points since 1992, and about 20% work part time, according to the Bureau of Labor Statistics (2012). The greatest changes have been an increase in the percentage of nurses who work in community-ambulatory care, home health, public health, and other community-based settings (U.S. Department of Health and Human Services [HHS], 2000). Dramatic changes in the way health care is delivered—and will be delivered in the future as the ACA continues to reshape the U.S. healthcare system—have led to the discharge of sicker patients to their homes. As managed care continues

**BOX 1-1 Cornerstones of Public Health Nursing**

Public health nursing practice:

- Focuses on entire populations
- Reflects the community's priorities and needs
- Establishes caring relationships with the community, families, individuals, and systems that comprise the populations public health nurses (PHNs) serve
- Is grounded in social justice, compassion, sensitivity to diversity, and respect for the worth of all people, especially the vulnerable
- Encompasses mental, physical, emotional, social, spiritual, and environmental aspects of health
- Promotes health through strategies driven by epidemiological evidence
- Collaborates with community resources to achieve those strategies, but can and will work alone if necessary
- Derives its authority for independent action from the Nurse Practice Acts

*Source:* Minnesota Department of Health Center for Public Health Nursing. (2004). *Cornerstones of public health nursing.* Retrieved from http://www.health.state.mn.us/divs/opi/cd/phn/docs/0710phn_cornerstones.pdf

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

## A DAY IN THE LIFE

### Working as a Nurse and Family Nurse Practitioner in Alaska: Just Another Day in a Frozen Paradise

***Amanda Traver, FNP, MSN***

The first word that comes to my mind after taking a job as a nurse in Alaska as a new BSN graduate is diversity—diversity in opportunities, diversity in the people I worked with, diversity in the type of injuries and illnesses, and diversity in my patients. I first came to Alaska as an Army nurse and functioned primarily in medical-surgical roles in military healthcare facilities. I saw more than my share of frostbite victims and all types of injuries related to living in this frigid environment. Once I completed my Army obligation, I realized just how even more diverse nursing could be. My options were numerous and diverse: working at the Army hospital as a civilian nurse, working in the local hospital, doing Medevac flights from rural villages in Alaska to regional medical centers such as Fairbanks or Anchorage, or working in the regional medical centers with Medevac flights from Fairbanks to Anchorage. What amazing choices! I eventually chose to work in the emergency room (ER) in the Fairbanks hospital.

As an ER nurse in Fairbanks, I was challenged with many diverse and complex patients. I will mention here only a few of my unique cases. There was the man who ran out to his outhouse "real quick" without his shoes at 30 degrees below zero and locked himself out of his house; he suffered severe frostbite on his feet. There was the man who was working for the forest service chopping down trees, when he turned around and looked straight into the eyes of a grizzly bear. He endured massive claw marks on his back and four deep teeth marks in his thigh before he could get his gun out of his pocket to shoot the bear. One of the highlights of my ER time was getting to know all the local alcoholics by name and their "drinks of choice." There were the usual gunshot wounds, car accidents, and domestic violence cases, but even with these typical ER cases, many were unique to Alaska's culture and environment, such as moose-versus-car accidents and harpoons impaled in patients' chests and limbs.

I returned to nursing school and successfully completed a family nurse practitioner (FNP) program. As I write this, I am in King Cove, Alaska, a small fishing village on the Aleutian chain, working as an FNP. Last night we had a tsunami warning. Recent patients included a man who had fallen, had a neck and head injury, and needed to be transported to a regional hospital. The wind was blowing at 35 miles per hour, with gusts up to 65 miles per hour, and snow squalls that made driving even more treacherous than usual. Only small, six-seater planes can land on the runway in King Cove, and that is in good weather. No planes can land on the runways at night. We had to request a Coast Guard helicopter to fly the patient across the bay to a town with a larger, lighted runway. A fishing boat was standing by to take the patient across the bay in case the helicopter could not get in. Fortunately, the Coast Guard helicopter was able to land. As we loaded the patient into the helicopter, the snow was blowing hard in our faces and the wind was howling. He was flown by helicopter to Fairbanks, where a plane picked him up and flew him to the larger medical center in Anchorage. Yes, I am a community health nurse, no matter where I practice. The community is my patient.

My next assignment will be in Nome, where I will work in the clinic and ER at the hospital for 5 months. My next assignment will be in Fairbanks for 6 months. Such is the life of a traveling FNP in Alaska—never a dull moment!

Even my time off in Alaska is diverse. I have learned to mountain bike and have been chased by a bear on a mountain biking trip. It was so close I could see the bear in my peripheral vision, feel her breath on my leg as I was pedaling, and feel the ground shaking as the bear ran. Fortunately, the bear left me alone.

I have learned to ice climb and mountain climb; I have backpacked in amazing, treacherous landscapes; and cross-country skiing is as close as my front yard. There are more pilots in Alaska per capita than anywhere else, and many places in Alaska are accessible only by plane. So I am now a licensed pilot and look forward to even more adventures in the remote, frozen wilderness. Who knows, perhaps one day I will be working as a nurse and a pilot transporting patients in the wild and beautiful state I now call home!

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

## MEDIA MOMENT

View an episode of a current medical or health-related show on television, such as *Dr. Oz*, *Nurse Jackie*, *Grey's Anatomy*, or *Scrubs*. Can you identify a situation on the show where preventive interventions, such as patient or family education by a community health nurse, could have reduced or prevented the occurrence of a featured injury or disease? Why are these shows so popular with audiences when the worst-case scenario tends to occur?

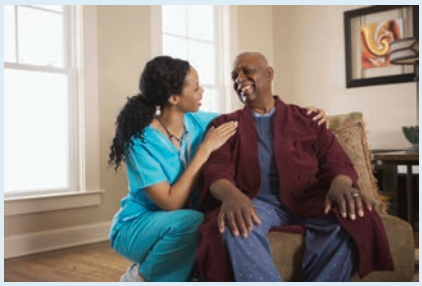
## A DAY IN THE LIFE

### *Martha Rogers, PhD, RN, FAAN, 1966*

Nursing's story is a magnificent epic of service to mankind. It is about people: how they are born, and live and die; in health and in sickness; in joy and in sorrow. Its mission is the translation of knowledge into human service.

Nursing is compassionate concern for human beings. It is the heart that understands and the hand that soothes. It is the intellect that synthesizes many learnings into meaningful administrations.

For students of nursing, the future is a rich repository of far-flung opportunities around this planet and toward the further reaches of man's explorations of new worlds and new ideas. Theirs is the promise of deep satisfaction in a field long dedicated to serving the health needs of people.



to result in fewer hospitalizations, nurses in acute care settings are facing assignments on a daily basis to different units and in diverse settings, including outpatient, home health, and other community-based agencies housed in or associated with their own facility (Gable, 2011).

As the patient census (the number of occupied beds in a hospital on a daily basis) fluctuates, nurses must be flexible, willing, and competent in multiple settings. So, no matter where you ultimately choose to work as a nurse, community health will be an influence on your choice of position, your role, and on your patients' lives. According to Gebbie (1996), the U.S. vision of public health is that of healthy people in healthy communities, because individual health can be fully realized only if the community itself is in good shape as well. (For a closer look at how much our health is influenced by public health measures, see the "Think About This" feature later in the chapter.)

Public health measures, such as immunizations, clean water, safe food, building working environments, sewage disposal, and disease surveillance and intervention, are virtually invisible and often of little interest to citizens and nurses alike *because of their success*. Florence Nightingale would be stunned at the accomplishments in society; during her lifetime, life expectancy was close to half what it is today in the United States. In the United States, we have experienced an extraordinary rise in life expectancy to 78.3 years in the second decade of the 21st century (U.S. Census Bureau, 2012). The gains in life expectancy have primarily come from public health interventions above, based on epidemiology, knowledge, and education of the population and research-based practices of health professionals and the public. The 1970s and 1980s saw a move toward an increase in population-focused research and practice, resulting in healthier communities. Examples of these interventions include anti-smoking campaigns to reduce tobacco use, hypertension and cardiac risk factor prevention and control, improved nutrition, auto and other transportation safety restraints for adults and children, and injury prevention. A reduction in childhood deaths of 40% and close to a 50% decline in cardiovascular-related deaths in adults have also contributed to the present health status and costs of our nation. Medical treatment alone can prevent only about 10% of "early" deaths (prior to expected life expectancy); however, population-based public health interventions (risk reduction of unhealthy lifestyle behaviors, such as sedentary lifestyle, diet, stress, occupational hazards, and substance abuse) have the potential to reduce approximately 70% of these early deaths (HealthyPeople.gov, 2013).

In this chapter, the history, context, and setting for nursing practice are discussed, as well as some of the current controversies and confusions specific to the new move to the patient's side in the community. So many things influence health: In this century we continue to find out through research how much in the environment, in our own behavior, and in the kind of health care we deliver affects whether we are healthy or ill. Why some people get sick and why some people do not have intrigued healthcare providers for centuries. This chapter introduces health as a concept, presents the historical insights we have learned, and reveals what we can expect nursing and health care to look like in the 21st century.

Sometimes the ways in which we use terms can confuse and obscure the focus of community and public health nursing. In this chapter the terms related to community, population, and nursing roles are discussed in the context of healthcare delivery. The ways in which a population's

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

health is determined are introduced as are concepts related to disease and illness prevention and health promotion.

The term *community health nursing* will be used throughout this text to represent care directed toward improving the health of communities and population groups through prevention and risk reduction in all settings.

## A Closer Look at Health

Before we can talk in more detail about the U.S. healthcare system and nursing roles in today's healthcare arena, we need an understanding of what health is. That seems simple; after all, everyone knows what health is. However, there are many definitions and descriptions of health depending on one's perspective and purpose.

The most well-known and widely cited description of health is the **World Health Organization's (WHO)** definition of **health** as a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity (WHO, 1958). When this definition was first drafted in 1948, it began a trend that has persisted for more than 50 years to define health more broadly, including social terms in addition to medical terms.

In 1986, the WHO definition of health was expanded to include a community concept of health. WHO now defines health as the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs, and, on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living; it is a positive concept emphasizing social and personal resources, in addition to physical capacities (WHO, 1986). An individual or community then must be able to attain and use resources effectively and exhibit resilience when facing change.

Although WHO's definition of health is the most widely accepted, many other definitions also imply a social or community focus. Health has been defined as a purposeful and integrated method of functioning within an environment (Hall & Weaver, 1977, p. 7), and as the common attainment of the highest level of physical, mental, and social wellbeing consistent with available knowledge and resources at a given time and place (Hanlon & Pickett, 1984). Even Florence Nightingale's definition of health as not only to be well, but also to use well every power that we have, can be used to describe health for both individuals and communities (Nightingale, 1860).

Many social issues surround the concept of health, making it difficult to limit it to only one definition and perspective. Health is defined by the society and culture in which we live. How individuals, families, and communities perceive what health means is often determined by social, cultural, and economic conditions that limit health choices (Kuss, Proulx-Girouard, Lovitt, Katz, & Kennelly, 1997). Put another way, health is highly dependent on where and how we live. A 20-year-old man may consider himself healthy only if he can run up the stairs at work. For an 80-year-old woman, retrieving her own mail at the mailbox may be her idea of health.

Nurses differ in their perception of health and are influenced by their own background, age, and experiences. In a study that explored the perceptions of community health nurses about health, the nurses interviewed described health as an "interactive vision" between nurses and patients (Leipert, 1996). This vision of health varies with each nurse–patient relationship, depending on the values and characteristics of the nurse, the patient, and the setting where the interaction occurs. Some of the characteristics that can greatly affect the vision of health are age, culture, social environment, and economic status. Patients in this context include individuals, families, groups, and communities.

### Historical Insights

Sickness and suffering have always been a part of human existence. As a result, from the beginning there have been men and women who served as caregivers to the sick and injured. Early on, most care was provided by family members. As human society evolved, moral consciousness became formalized into religious codes, and religious groups assumed more responsibility for the ill. Although their efforts were commendable, they were limited because so little was known about disease causation or prevention.

**Florence Nightingale** is recognized as the founder of modern professional nursing, and for developing the first school of nursing at London's St. Thomas Hospital in 1860. Although her initial efforts focused on preparing nurses to care for the sick in hospitals and infirmaries, she continued throughout her life to promote well nursing in the community. Nightingale's directive was to manipulate the patient's environment to allow nature to take its course in the healing process.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

Through scientific inquiry during the 19th century, causes of the devastating communicable diseases of these earlier centuries began to emerge and professional intervention became possible. During the mid- to late 1800s, public health measures were established as the process of contagion between human hosts, and the environment became better understood.

Throughout the 20th century, medical science grew in leaps and bounds, and the manipulation of nature became the drive that resulted in significant medical discoveries and inventions. The United States experienced unprecedented growth in technology and medical science in this century. We learned more about the causes of diseases and generated a broad knowledge base about disease and injury detection, treatment, and prevention. The resulting healthcare system, which early on was divided into public and private sectors, focused on the diagnosis and treatment of disease in the highly specialized and centralized setting of the hospital. For most individuals, health care was synonymous with the local hospital.

During the 20th century, most nurses were employed in hospital settings as skilled caregivers for the acutely ill; nursing education was mostly focused on care of the sick. Nursing students gained experience almost exclusively in hospitals.

Nevertheless, even as the United States was credited worldwide with having the most advanced health technology for treating disease, and while healthcare spending vastly increased during the 1960s and 1970s, health professionals and the public increasingly expressed a growing concern that the healthcare needs of all citizens were not being met. As the 20th century came to a close, we came to realize that as a society our obligation is to provide an environment in which achievement of good health for all is not only possible but expected. Yet there are population groups—such as the homeless, the elderly, and the poor—whose illness and death rates exceed those of the general population and may require additional resources to achieve good health.

Healthcare costs in the United States already amount to more than 17% of the gross domestic product (GDP), more than twice that of other countries that can boast better health statistics. Americans would probably be willing to live with the high price tag of health care if it made us all healthier than people in other countries. However, that is not the case. In the United States, where the healthcare system is heralded as the most sophisticated in the world, when compared with similar countries such as the United Kingdom, Germany, or France, we are lagging behind in the following:

- The United States has high infant mortality rates relative to other highly developed industrialized nations.
- The United States ranks 25th in the world in life expectancy, behind Japan, Italy, France, and the Scandinavian countries.
- Prior to the passage of the ACA of 2010, at least one-third of the U.S. population had limited access to basic health services and one-third of the uninsured were children.
- Prior to the passage of the ACA of 2010, the United States was the only industrialized nation in the world without guaranteed access to basic healthcare services.

> "It is from quiet places like this all over the world that the forces accumulate which presently will overbear any attempt to accomplish evil on a large scale. Like the rivulets gathering into the river, and the river into the seas, there come from communities like this streams that fertilize the consciences of men, and it is the conscience of the world that we are trying to place upon the throne which others would usurp."
>
> *—U.S. President Woodrow Wilson, address in Carlisle, England, December 29, 1918*

Much must be done in this country for many to achieve levels of health that are acceptable and equitable (AAN, 2010). Many deaths and disabilities could be reduced by environmental improvements and lifestyle changes. One hundred years ago, most deaths were caused by infectious diseases; today, the leading causes of death are related to societal influences, lifestyle, and behavioral choices. Progress in technology, while making our everyday lives easier and safer, has created and built environmental threats to our air, water, products, and food. Health problems such as addiction and violence have emerged as serious threats to our wellbeing and even survival. As Keck (1994) contends, "Good health cannot be achieved without a social concern for ethical, humane decision-making … a just and caring society does not withhold health care from its citizens; sickness, after all, is never something people deserve" (p. 4).

Beyond looking at our own country's struggle with internal decisions about healthcare delivery and connecting it with the broader determinants of health, there has been a concurrent recognition of the global connectedness and importance of concerns for health. The achievement of world health has increasingly become a global expectation. Although nurses are still needed as skilled caregivers who improve the health of individual patients, a broader perspective has evolved as population health interventions are realized to be at least equally, if not more, significant in the attainment of health for all. Solutions to the health problems of populations worldwide now exceed the resources and control of any one individual (Gostin, 2004; McKenzie & Pinger, 1997).

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

## Nursing in the 21st Century

Hospitals in the early part of the new millennium are relinquishing their role as the recognized hub of care delivery, while delivery of healthcare services at home, at work, at play, in schools and churches, online, and on the telephone continues to increase. Who delivers health care, what is provided, and when and where patients are seen have changed. Trends related to cost containment, managed care systems, technology, societal expectations, and politics have all influenced these changes. Patients stay less often in the hospital, and when they do, they stay for fewer days. Patients are generally sicker both when they are admitted and when they are discharged than they have been in the past. There has not been a significant decrease in patient numbers, but rather the settings for care have changed; with this shift, population health issues have become more of a focus.

There are greater demands on the healthcare system now than ever before, including evidence-based practice, as health care becomes more focused on efficiency and quality in patient care (Ferguson & Day, 2007). Nurses, as the translators and caregivers for patients with more complex needs, are needed more than ever. Nurses, as always, continue to meet the needs of patients; we move to care for populations in whatever setting they are found.

### GOT AN ALTERNATIVE?

Research indicates that at least 62% of the U.S. public uses some form of nontraditional or alternative medicine—yet few patients mention such measures when visiting their healthcare providers. Why do you think people are reluctant to share their use and interest in alternative health practices with nurses and physicians?

*Source:* Barnes, P. M., Powell-Griner, E., McFann, K., & Nahin, R. L. (2004). Complementary and alternative medicine use among adults: United States, 2002. *Advance Data, 343*, 1–19.

In a study conducted by the American Nurses Association's (ANA) Department of Labor Relations and Workplace Advocacy, nurse executives from acute, home health, extended, and managed care settings reported on the skills seen as most important for the next generation of nurses. According to this study, nurses should possess skills of self-reliance, independence, flexibility, and decision making, as well as a systems-thinking approach to health care, patient education, critical thinking skills, and computer skills. The conclusion of the study was that nurses need to be prepared to provide the four "rights" of nursing practice: give the *right* care, in the *right* setting, at the *right* time, and at the *right* cost (Canavan, 1996).

Trossman (1998), in *American Nurse*, stated:

> Hospitals will still be a major place of employment for nurses. The type of work will slowly change, though, as these hospitals become the care zones for the nation's oldest and sickest individuals. At the same time, other settings, such as home health and community based care, will provide increased opportunities for RNs with a BSN degree. (p. 1)

### Educating Nurses for Community Health Nursing Practice

The *Essentials of Baccalaureate Nursing Education for Entry Level Community/Public Health Nursing*, a document revised and endorsed by the Association of Community Health Nursing Educators (ACHNE) in 2009, provides recommendations regarding the baccalaureate educational content essential for entry level in community health nursing practice. ACHNE is the only organization that represents community health nurse educators throughout the United States and many other parts of the world. The original purpose of the *Essentials*, as put forth in the first edition in 1990, was to "delineate the essentials of education for entry level community health nursing practice." This remains a core purpose of the subsequent updates of the document. Changes in the healthcare system and the corresponding emergence of issues in community/public health nursing (C/PHN) education and practice necessitate an ongoing revision of entry-level C/PHN essentials. The objectives of the document are (1) to provide a framework for nursing educators in planning and implementing baccalaureate nursing curricula relevant to 21st century healthcare systems, and (2) to communicate to nursing, public health, and other communities the theoretical and clinical practice underpinnings necessary for C/PHN education and practice. For nursing to survive as a profession, ACHNE (2009) recognizes that nursing must evolve along with the changing healthcare system. Nurses of the future will practice in a more complex healthcare system that involves care of individuals outside of acute care and traditional hospital settings (community-based care) and care of populations (community-focused care). This text uses the ACHNE document as the basis for its content and organization (The full text of the ACHNE *Essentials of Baccalaureate Nursing Education for Entry Level Community/Public Health Nursing* can be accessed at http://www.achne.org/files/EssentialsOfBaccalaureate_Fall_2009.pdf).

One of the most intriguing and challenging aspects of the health problems that we face in the 21st century is that we already know about effective interventions for many diseases and conditions in our society. According to Salmon and Vanderbush (1990), never before have we known as much about health as we do now; what we don't know is how to put this knowledge into action (p. 192).

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

## Community-Based, Population-Focused, Community Health Nursing: What's in a Name?

What does it mean that health care is moving to the community? Why are there so many terms to describe nurses who work with a community focus? Much of the confusion over the title of a nurse who focuses on prevention in nonacute populations reflects the diversity that has created new roles for nurses in the community. Both the terms *public health nursing* and *community health nursing* are used to describe a nurse who works with populations and toward goals associated with improving the health of communities, families, and individuals. The primary difference may mean little to you as a student nurse at this point. Community health nursing has been the accepted title for the past few decades. In recent years, public health nursing has reemerged as an accepted title for nurses who work with the entire public and populations with an emphasis on prevention, not just in an official public health agency, to improve the health of populations. Various groups representing all community and public health nurses in the United States through the Quad Council of Public Health Nursing Organizations continue to debate the appropriate title for the nurse who works with a community focus (ANA, 2013; American Public Health Association, 1996; ACHNE, 2009). The term *community health nursing* will be used throughout this text.

### RESEARCH ALERT

Is aspirin a disease-preventing wonder drug for women? The answer to that question is a moving target. In 2005, a 10-year study of nearly 40,000 women, at the time the biggest and best such study yet undertaken, provided the first authoritative assessment of whether women could improve their long-term cardiovascular health by taking regular aspirin—a practice many had already begun based largely on data from studies of men.

The 2005 study, however, was disappointing to many women and their healthcare providers. It found that aspirin does not reduce the risk of a first heart attack for middle-aged women, as it does for men, but it does cut the risk of strokes, which is not the case for men. For women 65 and older, aspirin does lower the chances of having a heart attack, and its stroke-preventing benefits appear to be the greatest.

The findings suggested that the benefits of aspirin may not outweigh the risks for healthy women in their 40s and 50s, but once they hit their 60s, the balance shifts enough to make it worthwhile. Aspirin's major risk is of bleeding, which can cause serious problems including rare but deadly bleeding strokes. Women with high blood pressure and problems with stomach bleeding may be at particular risk.

As a result of that study and similar evidence, the U.S. Preventive Services Task Force issued a recommendation in 2009 that suggested that while preventive aspirin therapy was of benefit to men 45 and older, in women, it should not be initiated until age 55, and should only be considered if its potential benefits outweighed the risk of gastrointestinal bleeding. In other words, for women, the scenario was much more complicated.

Now a new set of data suggests that daily low-dose aspirin offers another potential benefit for women: a reduced risk of ovarian cancer. Researchers from the National Cancer Institute (NCI) reviewed data accrued between 1992 and 2007 from 12 population-based case–control studies of ovarian cancer, including 7,776 case patients and 11,843 control subjects. Their findings showed that aspirin use was associated with a reduced risk of ovarian cancer, especially among women who took low-dose aspirin daily. These findings suggest that the same aspirin regimen originally recommended to women for cardiovascular health could instead reduce the risk of ovarian cancer by 20% to 34%, depending on frequency of use and dose. Their findings were published February 4, 2014, in the *Journal of the National Cancer Institute*.

"Our study suggests that aspirin regimens, proven to protect against heart attack, may reduce the risk of ovarian cancer as well," said Britton Trabert of NCI's Division of Cancer Epidemiology and Genetics, one of the study's authors. However, she cautioned that the results, though "intriguing," were not enough to change the way clinicians advise women. "Additional studies are needed to explore the delicate balance of risk-benefit for this potential chemopreventive agent, as well as studies to identify the mechanism by which aspirin may reduce ovarian cancer risk," Trabert noted.

What can women take away from all this back and forth about whether they should or shouldn't take daily aspirin?

For one thing, they can recognize that there's now a strong body of data showing that men and women differ in fundamental ways on various aspects of health, and that research on men does not necessarily translate directly to women.

"This truly underscores the importance of studying medical therapies among women as well as men," said Julie Buring of the Brigham and Women's Hospital in Boston, who led the 2005 study. "We can't assume studies involving men apply to women."

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

It remains unclear why women respond differently, although some researchers have speculated that it may be due to hormonal differences or the fact that women tend to develop heart disease later in life.

"Age 50 in men is biologically about age 60 in women in terms of their risk of cardiovascular disease," Buring said.

Aspirin, an ancient medicine known for a century mainly as a way to alleviate headaches and fevers, became a key player in the fight against cardiovascular disease—the nation's leading killer—after doctors discovered its powers to prevent and help dissolve blood clots and reduce inflammation. These anti-inflammatory properties may be part of what enables it to stifle cancer, but the 2014 study suggests that there is more to aspirin's cancer-preventing capacity than that: Women who used other nonsteroidal anti-inflammatory drugs (NSAIDs) daily or weekly also saw a slight decline in ovarian cancer incidence, but it was considerably less than that seen with aspirin (about 10%) and was not statistically significant.

What these conflicting findings boil down to, in the end, is that prevention is not one-size-fits-all. "We know millions of people take aspirin thinking it will prevent them from having a heart attack," said Scott M. Grundy of the University of Texas Southwestern Medical Center in Dallas. "But there are risks, and there might be a huge number of women who might be taking aspirin who shouldn't be, because the risks may outweigh the benefit. We just hadn't had the data."

In the 2005 study, about half of a group of 39,876 women age 45 and older took 100 milligrams of aspirin every other day, while the other half took a placebo. After 10 years, the researchers found that aspirin did not reduce the overall risk of heart attacks. But aspirin did reduce by 17% the overall risk of strokes, which tend to strike women more than men, and cut the risk for the most common type of strokes by 24%. When the researchers did a separate analysis of women 65 and older, however, they found that those taking aspirin were 34% less likely to suffer heart attacks, and that the protection against strokes increased as well.

At the time that study was released, clinicians greeted the findings with relief. "This is the definitive trial that we've been waiting for," said Lori Mosca, a women's heart expert at Columbia University. "This answers a big question about whether healthy women have benefits from taking low-dose aspirin." Yet, with the newest evidence on the table, many healthcare providers will need to re-weigh the argument all over again—this time with patients' ovarian cancer risk in mind as well.

*Sources:* Ridker, P. M., Cook, N. R., Lee, I. M., Gordon, D., Gaziano, J. M., Manson, J. E., … Buring, J. E. (2005). A randomized trial of low-dose aspirin in the primary prevention of cardiovascular disease in women. *New England Journal of Medicine, 552*(13), 1293–1304; Trabert, B., Ness, R. B., Lo-Ciganic, W. H., Murphy, M. A., Goode, E. L., Poole, E. M., . . . Wentzensen, N. (2014). Aspirin, nonaspirin nonsteroidal anti-inflammatory drug, and acetaminophen use and risk of invasive epithelial ovarian cancer: A pooled analysis in the Ovarian Cancer Association Consortium. *Journal of the National Cancer Institute, 106*(2), djt431. doi: 10.1093/jnci/djt431; National Institutes of Health. (2014). Press release: NIH study finds regular aspirin use may reduce ovarian cancer risk. Retrieved from http://www.nih.gov/news/health/feb2014/nci-06.htm

## Communities and Populations

When we think of the word "community," we may have many pictures in our mind, because the word has a variety of meanings. Andy Griffith lived in the community of Mayberry, and *Mr. Rogers' Neighborhood* is also a community. Most television situation comedies revolve around a community, such as the television shows *Seinfeld*, *Sesame Street*, or even *The Simpsons* and *South Park*. In this text, the word **community** is defined as a group of people who share something in common and interact with one another, who may exhibit a commitment with one another and may share a geographic boundary. A **population** is defined as a group of people who have at least one thing in common and who may or may not interact with one another. See **Box 1-2**.

Examples of communities include the following:

- Lesbians in a communal living setting
- The town of Golden, Colorado
- The faculty at Florida State University School of Nursing
- The Devil's Own neighborhood urban gang
- Sunshine Heights Retirement Village
- Elders with disabilities living in urban high-rise apartments

Examples of populations include the following:

- Teens who remain sexually abstinent
- Sexually active teenagers
- Nurses who work the night shift

**BOX 1-2 Terms To Know**

**Community**

A *community* is a group of people who share something in common and interact with one another, who may exhibit a commitment with one another, and who may share a geographic boundary.

**Population**

A *population* is a group of people who have at least one thing in common and who may or may not interact with one another.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

- Female long-distance runners
- Teenagers with Down syndrome
- First-time mothers older than age 35
- People who text while driving

According to Schultz (1994), *interaction* is essential in a community, whereas members of a population may or may not interact with one another. To put it another way, communities are usually aware of their "communityness," which binds them into a collective entity and to which they give a name (Cottrell, 1976, pp. 114–115). Some populations evolve into communities over time. Elderly women who participate in a water aerobics class, for example, may develop into a cohesive interactive community that shares other common activities and interests.

> "Small communities grow great through harmony, great ones fall to pieces through discord."
>
> *—Gaius Sallustius Crispus (c. 86–35/34 B.C.), Roman historian*

The average lifespan of Americans increased from 45 years to 75 years during the 20th century, but it is interesting to note that only five of those years are attributable to individual preventive or curative interventions such as cardiac surgery. Twenty-five of the additional years of life expectancy have resulted from public health efforts to provide for safe water, effective waste disposal, adequate housing, and other improvements in the overall health of communities (Bunker, Frazier, & Mosteller, 1994; Centers for Disease Control and Prevention [CDC], 2002).

There are many ways in which nurses are moving into new settings and expanding their application of community health nursing skills. Although these nurses are bringing expertise of acute care and technology to community settings, they are often lacking in their knowledge of community dynamics and public health concepts (Gebbie, 1996). If nurses are to continue to be a dynamic part of health care in the future, we must be able to understand the complex and community-focused nature of health promotion, illness prevention, recovery from illness and injury, and health restoration (Kurtzman, Ibgui, Pogrund, & Monin, 1980). We need to expand our knowledge and expertise in the care of individuals and our skills in hospital-based clinical management of illness and injury to include care of individuals in community settings (Hall & Stevens, 1995; Keller, Strohstein, Lia-Hoagberg, & Shaeffer, 2004). By using our expert knowledge and experience in medical–surgical, maternal–child, and psychiatric nursing, we can assist individuals, families, and groups to make choices that promote health and wellness (Smith, 1995).

## Acute Care Versus Community Health Nursing

Let's compare acute care and community health nursing to more fully understand how these nursing roles differ both in setting and practice focus. In the acute care setting, there is the issue of provider control. Patients are well aware of who is in control in the hospital setting—the healthcare professional. The patient is in a subordinate position to the nurse, who remains the ultimate authority regarding when to go to sleep, what to wear, when and how much to urinate, what kind of diet to eat and when, and whether visitors are allowed. Treatments and interventions are done to the patient and scheduled at staff and hospital convenience. Patients, who are often identified by their condition (e.g., "the gallbladder in room 214"), are isolated from friends, family, and pets, who are excluded from the healthcare setting. Little individualized care that takes into consideration the patient's lifestyle and preferences is given. When a person changes into a hospital gown, the role of patient is assumed. Personal items such as medications, glasses, and false teeth are often relinquished, and self-care is limited, with permission often required from nurses for activities taken for granted at home. Many questions are asked, sometimes over and over by different health professionals, and most often these questions are of a very personal and intimate nature. Rarely does the patient receive any explanation for why information is needed, for to question is to risk being labeled a "difficult" patient—and we know what that means (Armentrout, 1998)! Refer to **Table 1-1** for differences in nursing interventions by setting.

The controlled environment of the acute care setting, however, has many benefits for the nurse:

- Predictable routine
- Maintenance of hospital policy
- Predictability of nursing and medical goals
- Resource availability, both human and material
- Collegial collaboration and consultation
- Controlled patient compliance with the plan of care: the patient takes correct medicine and treatment on time
- Standardization of care

The community setting is very different from acute care, especially in regard to the nurse–patient relationship.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

**TABLE 1-1 Differences in Nursing Interventions by Setting**

| Health Problem | Acute Care Setting: Hospital | Community-Based Setting: Home Health |
|---|---|---|
| Osteoporosis resulting in degenerative hip disease | Treatment | Teach patient how to walk after surgery. |
| | Surgery and recovery (total hip replacement) | Involve family with encouraging activity and flexibility exercises. |

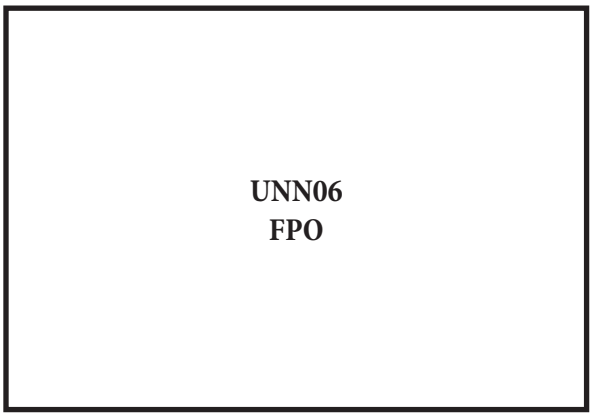
Nurses tend to be dependent on patients' willingness to share health information and to adhere to the plan of care, and patients on their own turf act very differently than they do in the acute care setting. A significant advantage is that the nurse is able to assess environmental conditions, food and other critical resources, lifestyle influences, and the social support system, such as friends, family, and pets. Transportation issues, which may affect the ability to adhere to medical and nursing goals, often become overriding concerns that are not even considered in the hospital setting.

In a community-based setting such as a school clinic, the nurse is dependent on the child's willingness to share information about his or her health concerns and on the teacher regarding any relevant learning issues that may affect the child's health. Educational goals are the primary concerns of the school, and the nurse must consider health in this total context.

The lack of colleagues to consult about problems and challenges encountered in community settings is often a cause of stress among new graduates and nurses who have never worked outside the controlled environment of the hospital and acute care settings (Armentrout, 1998).

Benefits for the community-based patient include the following:

- Familiar and comfortable environment
- Routine that is less determined by the nurse or health professional
- Diverse resources, including friends, family, and pets, available for support and comfort
- Autonomy and choice in health decisions




## Reform and the Reinvention of Systems of Care

Our healthcare system is but one of the many overlapping and interacting systems created by society. Societies create systems that reflect the commonly held values of that society. This is the realm of policy, politics, and power. For example, since the September 11, 2001 terrorist attacks on the United States, U.S. priorities have changed dramatically regarding safety and wellbeing. Bioterrorism and threats such as anthrax require public officials to use resources previously earmarked for other health priorities. Nurses have functioned in situations with increased stress, coping with the effects of national diseases themselves while still helping others deal with the ongoing trauma of a post-9/11 world (Davidhizar, Eshleman, & Wolff, 2003).

Healthcare reform initiatives have arisen in this realm of competing and conflicting values. Groups that advocate values related to protection, wellbeing, sustenance, quality of life, equity, fairness, and justice must often compete with other values related to economic self-interest. Even when values do not seem to be in conflict, the methods recommended to act on those values often cannot be agreed upon.

The capitalist values of the healthcare delivery system in the United States have also been questioned by healthcare leaders and policymakers in other countries (Moon, 1993; Morse, 2003). They often do not understand how the United States can consider itself a highly industrialized and civilized country and not provide basic, essential health care for all. A caring society would not allow individuals (especially children) to be deprived of health care. Many find our non-systems approach to health care confusing. In a post-9/11 world, these chaotic times require even more thoughtful and prioritized planning to meet the critical population health needs of the most vulnerable groups in our society (Gostin, Boufford, & Martinez, 2004; Morse, 2003).

Indeed, few Americans would not argue that, although the health–illness system has changed with more vulnerable populations covered under the ACA, it still needs improvement. Many of the authors throughout this text make reference to **healthcare reform**. Enacted reforms, proposed reforms, and preferred reforms all have actual and possible effects on the populations for which nurses provide care and the conditions under which they provide it. Reform is not

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

new, nor is it controlled; rather, it is episodic, responding to multiple forces for change. Reform implies some major change in the process of the delivery of health care. We often refer to reform as change that originates at the national level but is implemented by the states, by payers, or by provider systems. When change is not a "broad" and "sweeping" reform, it is considered an "incremental change," meaning smaller adjustments occur over time. This is the type of healthcare reform that occurred during the 1990s.

Historically, there have been numerous reform proposals. Major healthcare reform was attempted following World War II—in 1948, President Harry Truman proposed national health insurance. What many thought were the beginnings of broad health coverage were introduced in the 1960s as Medicaid and Medicare. In the 1970s, Senator Edward Kennedy (D-Massachusetts) was one of the major supporters of nationwide reform. The presidential campaigns of 2008 and 2012 were marked by passionate disagreements over health reform issues. Many such disagreements specifically focused on the ACA, which has been a key political issue since its passage in 2010 (even after the subsequent ruling by the Supreme Court in 2012 that the ACA is constitutional).

## Nursing's Agenda for Health Care Reform

The failed effort of the 1990s to redesign the U.S. healthcare system had at least one positive consequence for nursing. In an unprecedented collaboration, more than 75 nursing associations endorsed the document jointly developed by the ANA and the National League for Nursing (NLN), ***Nursing's Agenda for Health Care Reform***. This document was significant in terms of its expression of nursing's values and in furthering an understanding of the profession itself. Values such as health services for all, illness prevention, and wellness were identified as prominent concerns. Many nurses played influential and visible roles during the healthcare reform attempts. Nursing supported the need for cost containment but wanted assurance of quality of care, reduced barriers to advanced practice nursing, and promotion of nursing care as the link between consumers and the healthcare system. According to the document, "the cornerstone of nursing's plan for reform is the delivery of primary healthcare services to households and individuals in convenient, familiar places" (ANA, 1991, p. 9).

## Managed Care and the Future of Nursing

With the passage of the ACA, the controversial issues most debated are expanding federal coverage (access), controlling costs, and moving to evidence-based practice. Evidence-based practice directs care through verifiable research (Ferguson & Day, 2007). Many policy and regulation changes within the ACA, however, have had a significant impact on healthcare delivery systems and providers already. **Managed care** and a market approach based on "managed competition" have emerged as major strategies to control costs in the United States. These connected strategies have together transformed the organization and methods of care delivery.

**Care management** is a growing practice arena for nurses. Within the managed care environment, care management attempts to provide more timely and coordinated care for individuals. Individuals move among the following possible states: being well and promoting that state, having acute care needs, needing outpatient surgery, needing follow-up home care, and so on.

Healthcare organizations now see the economic and quality outcome benefits of caring for patients and managing patient care over a continuum of possible settings and needs. Traditional health care was episodic, with individuals moving with little connection from one episode of need to the next (often waiting until the need for care was acute) and one facility to another. When care is managed, the term *discharge planning* is now more accurately referred to as *transition planning* (Ferguson & Day, 2007). The patient does not leave the system, but merely requires another type of care, including wellness care or health promotion. Patients are followed much more closely both during illness care and with follow-up care when well. Care managers can practice from a base in many settings, including the offices of a payer. To more clearly conceptualize this change in thinking, instead of a patient being discharged from the hospital, he or she is described as being admitted *back* to the community.

When the healthcare providers in a system have the responsibility for all types of care for the plan's enrolled population, they have a financial incentive to coordinate or manage that care efficiently. The goal is to provide the best value in the most efficient way to be competitive in the healthcare market. A market economy with the addition of the ACA for healthcare delivery dramatically changes healthcare services and incentives. For nurses who are historically committed to doing whatever it takes for their patients, cost-consciousness is an unfamiliar and often resisted viewpoint.

Nurses in today's healthcare system must remain informed about the complexities of managed care if they are to sustain their professional identity and to assist patients in navigating this market system. The continued growth of managed care and the implementation of the ACA, as a system for health financing and delivery, provide unique challenges and opportunities for nurses, especially those prepared in community health. Nurses remain the only healthcare professionals who are specifically educated to assess health status and risks, unhealthy lifestyles, and health education needs for patients and families—who provide support and reassurance while caring for present and potential health problems and who act as advocates for primary and

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

preventive care services. Managed care organizations, as well as all agencies that provide healthcare services in a managed care environment, have come to value quality and recognize the importance of prevention, wellness, and early intervention. The community health nurse is especially well prepared to provide managed care with the direction needed to focus on providing a full range of quality, cost-effective services in the promotion of a population's health.

> Money would be better spent in maintaining health in infancy and childhood than in building hospitals to cure diseases.
>
> —*Florence Nightingale, 1894*

## Back to the Future: From Hospital to Community, from Cure to Prevention

As we have learned from the history of health care, early attempts to improve health, treat disease, and prevent disability occurred primarily in the home. The primary characteristic of the emerging system has been the move back to the community practice setting. Perhaps the major force behind much of the change has been economic, with efforts to contain what many see as the exploding costs of the U.S. healthcare system. The ACA came about primarily due to spiraling healthcare costs, which continue to delay economic recovery in the United States from the 2008 financial crisis. The stated purpose of the ACA is to "increase the number of Americans covered by health insurance and decrease the cost of health care." One cost-related factor encouraging a community focus has been the movement of patients out of expensive acute care facilities and into community settings, where many of their illness needs can be adequately met at a much lower cost. This movement has encouraged the growth of home care, hospice care, medical homes (coordinated and accessible care in a central home base for the patient through ACA legislative policies), nurse-managed clinics, outpatient treatment clinics, and outpatient surgeries. Another among the many results of cost-containment efforts has been the recognition of the connection between prevention and keeping populations healthy. Healthy populations have lower morbidity (disease rates) and mortality (death rates).

> My view, you know, is that the ultimate destination of all nursing is the nursing of the sick in their own homes. . . . I look to the abolition of all hospitals and workhouse infirmaries. But no use to talk about the year 2000.
>
> —*Florence Nightingale, 1867*

### A DAY IN THE LIFE

**Melanie C. Dreher, PhD, RN, FAAN**

I am more convinced than ever that the major health problems in this and future decades—chronicity, aging, the personal and public health problems generated by social and economic dislocations, the prevention of illness, and the promotion of healthy communities—are all within the nursing genius to address and ameliorate. These are the very things that we are known for. They are the things we do best and we are the best to do them. . . . I truly believe that we are at a place in nursing that we will never see again. This is our big chance. . . . We cannot wait for anybody to let us do anything. . . . We have more capacity to play in the healthcare game, we have the obligation to take charge, to endorse professional values, and improve health outcomes.

### Home Health Care

**Home health care** is the fastest growing community-based nursing role outside of the acute care setting. It is just one of many roles available in community health and is covered in depth in this text. Home health nursing is an example of an emerging role that has resulted from changes in the way health care is delivered and paid for.

One attempt at major healthcare cost containment in the early 1980s was the shift from cost reimbursement to prospective payment for hospital care, which means that payment is based on standard disease categories. Because of this change, hospitals could make money if they were efficient in taking care of patients' problems and could discharge them more quickly. Home health boomed as patients were discharged while still needing nursing care in their homes. Home health continues to grow and present new and challenging opportunities for nursing, with the implementation of the ACA and its emphasis on providing care in the most efficient environment to improve patient health outcomes and reduce hospitalizations.

### Cure and Prevention: Can We Really Do It All?

Most people—even nurses—spend little time thinking about or planning for their own good health or the community's health. Research tells us that our health is

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

influenced more by our social and biological environment, lifestyle choices, and self-care initiatives than by our inherited traits, yet we continue to pour money into newer and better treatments rather than into learning about what we can do to promote health and prevent illness from the beginning. We are discovering that we have overemphasized cure with a disease-based medical model for health care.

As early as 1977, the CDC reported an analysis of the proportional contributions to mortality in the United States of four health field elements: lifestyle, human biology, environment, and health care. Its conclusions were that approximately 50% of premature mortality in the United States is due to lifestyle, 20% to human biology, 20% to environment, and only 10% to inadequacies in health care. Seventy percent of the potential for reducing premature mortality lies in the areas of health promotion and disease prevention, but only about 3.5% of the healthcare dollar is spent in those areas. Therefore, although the health status of a population is related more to the determinants of health than it is to the causes of disease, we have developed a system that pays for illness care rather than a system designed to create the healthiest population possible.

Certainly, access to competent and skilled health practitioners and technologies related to the diagnosis and treatment of disease is important, but no more so than having clean water to drink, safe food to eat, meaningful and safe employment with an adequate wage, adequate housing and child care, a good education, a life free of discrimination, and a safe environment. Such insights are leading to a "reinvention" of health services organizations at all levels—from single facilities organized to serve sick patients to complex networks organized to serve populations of mostly well people in the community (Friedman, 2013; Shortell & Gilles, 1995).

Prevention activities and population-focused care are often contrasted with the more immediately gratifying and exciting acute care. Community-focused care is long term, often behind the scenes, taken for granted, and largely unseen unless something goes amiss. Nurses have always promoted the welfare and health of those in their care. Wolf (1989) contends that nursing has difficulty being visible because much of the work of nursing goes unnoticed. Healthcare reform and the move to health promotion and illness prevention may provide the opportunity for nursing to shine as a profession. Public health's success literally makes it invisible to most of us.

Despite the excitement of acute care, many economic, social, and political factors suggest that the future focus of health care will be on health promotion and disease prevention in a health-based model with a community orientation (Friedman, 2013; Proenca, 1998). These areas and such networking have traditionally been the domain of the less visible and less financially supported practice of public health. Mechanic (1998) has pointed out that an alignment of public health with the growing managed care health plans would be a logical and potential benefit to the mission of the U.S. public health system. The vision of public health for more than a century has been one of health promotion and disease prevention that depends on a community perspective to activate identification of risks and protective and restorative interventions.

Healthcare providers in managed care plans are increasingly subject to competition and are evaluated on their successes in improving outcomes for their plan's enrollees. They have become more interested in the population activities and methods long carried out by public health. Acknowledging the economic value of population health promotion and disease prevention activities within the ACA and private healthcare marketplaces encourages the adoption of these approaches. Thus, for many nurses caring for individuals, the focus on community health nursing roles represents a transition to the community in practice setting.

Nurses have been optimistic about the trends in healthcare practice and reform. With the increasing impetus for health promotion, nurses seem well poised as a result of their long-standing commitment to and expertise in keeping people healthy. In the past, when nurses have made claims about the benefits of health promotion and disease prevention strategies, the thoughts have been on benefits to the individual, not on any financial benefit or loss. Now we as nurses are beginning to embrace the possibilities of teaming up with a market-driven business world to also realize financial benefits and improved health for populations.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

### Benefits Versus Costs

Anderson (1997) cautions against a naive understanding of what we take for granted. Indeed, she describes the case of smoking cessation programs, which have been proven to have economic benefits. However, a potential financial loss scenario is possible for preventing cardiopulmonary disease in middle-aged individuals. Prevention may actually increase managed care costs by prolonging a person's life and thus incurring greater costs for the complex medical problems of old age. Similarly, early detection of HIV in at-risk populations should permit early drug treatment to prevent costly AIDS-related illnesses. For a managed care organization, early detection would imply antiviral treatment costing thousands of dollars annually. Nondetection and an early death would actually save money for a private healthcare provider and increase its profits. Nurses are socialized to value life; healthcare companies are in business to make a profit first.

**RESEARCH ALERT**

Research has shown that children wearing Heelys sustain the same types of injuries as those wearing inline skates or riding skateboards or scooters. According to Vincent Iannelli, MD, two medical studies reported that children wearing Heelys had injuries ranging from "distal radius fractures and elbow injuries to a head injury that required surgery."

Although the manufacturer recommends wearing safety gear such as a helmet, wrist guards, and kneepads, very few children wear safety gear with Heelys. To prevent injuries, children should wear safety gear, remove the wheels when using Heelys in shoe mode, and avoid using the Heelys in skate mode in traffic, on stairs, or on uneven surfaces. Children should also avoid crowded areas and rolling faster than they can walk.

Many public places, including schools, ban the use of Heelys in skate mode and require children to take the wheels out of the Heelys before entering. Heelys should not be used in skate mode indoors. Falling into such indoor hazards as a table or display case can cause serious injury.

Parents should also know that W.A.T.C.H. (World Against Toys Causing Harm) included Heelys on their "10 worst toys" list.

With such dire warnings, nurses must realize the competing values often at work in the healthcare arena. Community-focused health promotion strategies also can face ideological, political, and religious differences that cause conflict. Much-needed sex education to prevent teenage pregnancy has long met with resistance from some groups. Strategies must be developed at the individual and societal levels to bring about change that aligns with all interested parties' goals and needs.

In the case of smoking cessation, for example, other community groups could be approached to encourage health promotion interventions and policies. Employers could be motivated to realize the financial gain of less employee illness and fewer workdays lost. They would then negotiate for managed care plans that cover health promotion activities (Friedman, 2013).

### *Healthy People 2020:* Goals for the Nation

Even before the more recent reform efforts and regulations encouraged increased use of prevention practices, it became obvious in the 1970s, based on the CDC's study of premature deaths, that health promotion and disease prevention could save lives and perhaps reduce healthcare costs. In 1980, the federal government issued a set of national health objectives that were evaluated to measure the progress of U.S. health goals and healthcare services. The process proved valuable and was repeated with the issuing of a new set of objectives to guide the 1990s; that plan was titled *Healthy People 2000*: *National Health Promotion and Disease Prevention Objectives*.

The process was again repeated, culminating in the release of a *Healthy People 2010* document in October 2000. Two overarching goals—increase years of healthy life and eliminate health disparities—were proposed. Four enabling goals provided support; they were concerned with promoting healthful behaviors, protecting health, achieving access to quality health care, and strengthening community prevention. ***Healthy People 2020*** has been revised to focus on creating a society in which all citizens live long lives through an interactive website.

These objectives provide a tool that the creators envision for public health policymakers at the national, state, and local levels. Meeting these objectives requires that all healthcare providers move toward a community-based practice or focus. That is, providers must move from a focus on illness and cure to a focus on health promotion and illness prevention not only for populations at risk, but also for **populations of interest**—those people who are essentially healthy but whose health status could be improved or protected (Friedman, 2013; Keller et al., 2004).

> "Preventable disease should be looked on as a social crime."
>
> —*Florence Nightingale, 1894*

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

## HEALTHY PEOPLE 2020

### Introducing *Healthy People 2020*

*Healthy People 2020* continues in this tradition with the launch on December 2, 2010 of its ambitious, yet achievable, 10-year agenda for improving the nation's health. *Healthy People 2020* is the result of a multiyear process that reflects input from a diverse group of individuals and organizations. For the first time, *Healthy People 2020* has an interactive website and database which provides statistical information about specific health issues and is searchable, making it accessible to citizens and health professionals, alike.

### Vision

A society in which all people live long, healthy lives.

### Mission

*Healthy People 2020* strives to:

- Identify nationwide health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.
- Provide measurable objectives and goals that are applicable at the national, state, and local levels.
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
- Identify critical research, evaluation, and data-collection needs.

### Overarching Goals

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

Four foundational health measures will serve as indicators of progress toward achieving these goals:

- General health status
- Health-related quality of life and wellbeing
- Determinants of health
- Disparities

*Source:* Healthy People 2020. Available at http://www.healthypeople.gov/2020/about/default.aspx

The topic areas and objectives of the *Healthy People 2020* agenda are available in interactive format online at http://www.healthypeople.gov/2020/topicsobjectives2020/.

### Graphic Model of *Healthy People 2020*

The Federal Interagency Working Group developed a graphic model to visually depict the ecological and determinants approach that *Healthy People 2020* will take in framing the national health objectives. This particular graphic was designed to emphasize this new approach, and is not meant as a comprehensive representation of all public health issues and societal domains. The graphic framework attempts to illustrate the fundamental degree of overlap among the social determinants of health, and to emphasize their collective impact and influence on health outcomes and conditions. The framework also underscores a continued focus on population disparities, including those categorized by race/ethnicity, socioeconomic status, gender, age, disability status, sexual orientation, and geographic location.

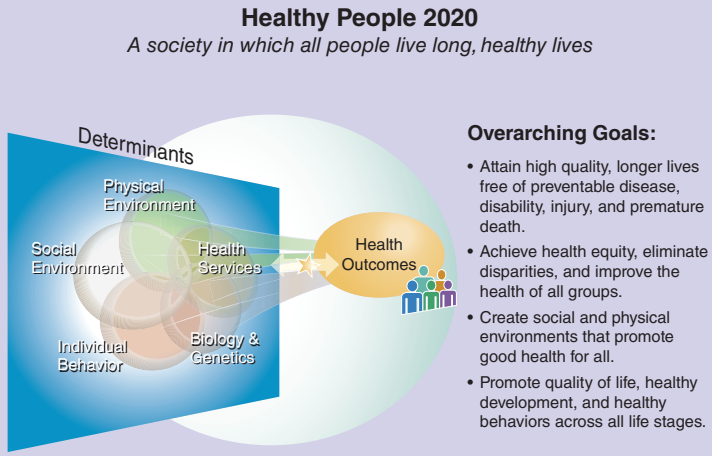



**Figure 1-1** *Health People 2020 Graphic* Model

*Source:* Healthy People 2020. Available at http://www.healthypeople.gov/2020/about/default.aspx

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

## Influences on a Community's Health: Culture, Environment, and Ethics

Many different factors influence health care, making it difficult to decide which are the most important. For the nurse to isolate any one factor for assessment and intervention with both individuals and communities is like the captain of a ship seeing only the tip of the iceberg and not looking for the real threat to the ship's safety that lies underneath. However, three major components of health care are addressed in this chapter because they have a profound effect on all aspects of patient care: culture, environment, and ethics.

### Culture

The numerous global, social, demographic, economic, and political changes in recent years have alerted healthcare professionals to the need to provide attention to the increasing diversity in our society and the effect of that diversity on people's health (Meleis, 1996). International travel and advances in communication through the Internet, cell phones, and cable and satellite television make it essential for today's nurses to develop the skills needed to provide care that recognizes complexities and differences among patients (Janes & Hobson, 1998).

The United States is the most culturally diverse nation in the world. In fact, in 1994, *Time* magazine designated the United States the first universal nation (Grossman, 1994). In the 2010 U.S. Census, almost 30% of Americans were members of ethnic minority groups, including 13.1% African American, 16.9% Hispanic/Latino, 5.3% Asian/Pacific Islander, 1.2% American Indian and Alaska Native, and 2.4% identified themselves as two or more races.

Nurses must be sensitive to cultural differences to be able to provide the best possible care to individuals, families, and communities. But what, exactly, do we mean by the term *culture*? According to Leininger (1995), **culture** refers to the learned and shared beliefs, values, and lifeways of a designated or particular group that are generally transmitted intergenerationally and influence one's thinking and action modes. Giger and Davidhizar (1995) say that culture is a patterned behavioral response that develops over time as a result of imprinting the mind through social and religious structures and intellectual and artistic manifestations.

Purnell and Paulanka (2003) define culture as the totality of socially transmitted behavioral patterns, art, beliefs, values, customs, lifeways, and all other products of human work and thought characteristics of a population of people that guide their worldview and decision making. Obviously, culture is more than just ethnicity. Culture is language, religion, food, traditions, customs, clothing, and everything that makes one group of people unique and distinguishes it from other groups. Cultural values, beliefs, and behaviors can also be related to age, gender, sexual orientation, socioeconomic status, and profession. There is a culture of nursing that all nurses belong to, with its own language, values, and traditions that often clashes with patients whose cultural beliefs about health care differ from those of their nurses. Further, nursing as a profession struggles with a lack of cultural diversity itself, which presents yet another population that must be considered as we promote a holistic and representative profession.

When considering cultural issues, we need to look beyond the borders of our own country. Those who hold privileged and recognized positions in societies by virtue of specialized expertise, such as nursing, have an obligation to give back to those societies (Vilschick, 2003). To make such contributions, nurses should become "global citizens" holding a broad vision of international health. In today's connected world, no profession can be truly effective without interactions and viewpoints that include international perspectives. Community health nurses, especially, who by definition practice within a broad systems perspective, must incorporate understandings from international health efforts in their own interventions. Comparing and drawing insights from methods and successes of nurses in delivering care in other countries hold the promise of improving the care to U.S. patients. In addition, there is a need to understand and support collaborating agencies at the international level. Principles of pluralism, consultation, coherence, consensus, compassion, partnership, and cooperation are the hallmarks of nurses who practice and embrace global citizenship (Neufield, 1992). For example, control measures for effectively reducing HIV/AIDS have involved the active cooperation of most countries worldwide.

**CULTURAL CONNECTION**

After reviewing the section on culture in Chapter 1, why do you think nursing has had difficulty recruiting minorities and males into the profession?

### Environment

The environment has been a concern for nursing since the days of Florence Nightingale. In *Notes on Nursing* (1860), Nightingale emphasizes the fact that recovery from illness can occur only in a bright, clean, well-ventilated environment. She states:

> The very first canon of nursing, the first and the last thing upon which a nurse's attention must be fixed, the first essential to a patient, without which all the rest you

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

can do for him is nothing, with which I had almost said you may leave all the rest alone, is this: TO KEEP THE AIR HE BREATHES AS PURE AS THE EXTERNAL AIR, WITHOUT CHILLING HIM.

When Nightingale spoke of the patient's environment, she meant the room in the hospital or home in which the patient stayed during the course of illness. In more recent years, the public health definition of **environment** has come to mean all the surroundings and conditions that affect the health of individuals, families, and communities, including the built environment. The environment has many different components, including social, cultural, political, economic, and ecological factors.

Environmental issues have been in the forefront of many political campaigns during the last several years and seem to be gaining momentum, with many governmental and private community groups supporting legislation to protect the environment (Graham, 1997). Most of this activity has been focused on the ecological component of environmental health—primarily clean air and water and a safe food supply. The created or built environment has only recently gained attention as another part of the environment, which affects a population's health. An example of the built environment is toxic workplaces with occupational hazards and homes with radon poisoning.

Nurses are beginning to take a more active role in promoting environmental health, reducing environmental health risks, and protecting Earth's resources. In fact, several nursing organizations, such as the American Holistic Nurses Association and the International Council of Nurses, have developed position statements to delineate the nurse's role in promoting environmental health. A specialty organization called Nurses for Environmental and Social Responsibility has been formed specifically to educate nurses and the public about environmental health hazards.

**ENVIRONMENTAL CONNECTION**

The work we are speaking of has nothing to do with nursing disease, but with maintaining health by removing the things which disturb it … dirt, drink, diet, damp, draughts, and drains.

—Florence Nightingale, 1860

## Ethics

Since the time of Florence Nightingale, the nursing profession has been addressing **ethics** concerns related to patient care issues. The ANA's (2008) *Code of Ethics for Nurses with Interpretive Statements* provides guidance for ethical decisions made by nurses in the clinical setting.

**RESEARCH ALERT**

**How Safe Is Airline Drinking Water?**

The Environmental Protection Agency (EPA) is the federal agency responsible for safe drinking water in communities, in public places, and on airplanes. In the summer and fall of 2004, the EPA tested drinking water aboard hundreds of randomly selected domestic and international passenger aircraft. The summer data showed that 13% of tested aircraft water failed to meet EPA standards; the fall 2004 testing showed that 17% failed the standards. Coliform bacteria, usually harmless, indicate that harmful organisms could be present and were found in unacceptable levels.

In response to these findings, the EPA embarked on a process to tailor the existing regulations for aircraft public water systems. In 2008, the EPA proposed the Aircraft Drinking Water Rule for public review and comment. The EPA will now have domestic airlines test themselves and submit results to the agency to see if the trend continues. Some self-sampling has begun, and airlines are adapting their routine disinfections to meet EPA guidance. Airlines now must disinfect water systems every 3 months and water carts and hoses leading to aircraft monthly.

Passengers with compromised immune systems should request canned or bottled beverages and avoid drinking coffee, tea, and other drinks prepared with tap water while on board airplanes. In the interim, to further protect the traveling public, the EPA placed 45 air carriers under Administrative Orders on Consent (AOCs), which will remain in effect until tailored aircraft drinking water regulations are final. These protocols will protect the public while existing regulations are being reviewed and data are being collected and analyzed from the aircraft drinking water. The air carrier AOCs combine sampling, best management practices, corrective action, public notification, and reporting and recordkeeping.

Ethical dilemmas have traditionally included such issues as informed consent and individual freedom of choice, autonomy, truth telling, protection of privacy and confidentiality, and discrimination. In addition, public health nurses have had to make ethical decisions related to the dual obligation to protect the public's welfare while respecting

> "Where justice is denied, where poverty is enforced, where ignorance prevails, and where any one class is made to feel that society is an organized conspiracy to oppress, rob and degrade them, neither persons nor property will be safe."
>
> *—Frederick Douglass (1818–1895), address on the 24th anniversary of emancipation, Washington, DC, 1886*

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

the rights of individual patients (Folmar, Coughlin, Bessinger, & Sacknoff, 1997). According to Sorrell (2012), all nurses must consider healthcare reform and the public's health as a part of their ethical responsibility. Sorrell states that all health professionals should consider how "the implementation of the ACA relates to their role in understanding and trying to rectify conditions of injustice in health care. Changes in social attitudes and resources may require the combined efforts of different disciplines to identify the originating problem and find a way to remediate it."

### BOX 1-3 About *Healthy People*

*Healthy People* provides science-based, 10-year national objectives for improving the health of all Americans. For more than 3 decades, *Healthy People* has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across communities and sectors.
- Empower individuals toward making informed health decisions.
- Measure the impact of prevention activities.

*Source:* HealthyPeople.gov. (2012). About Healthy People. Retrieved from http://www.healthypeople.gov/2020/about/default.aspx

### ETHICAL CONNECTION

"Every community is an association of some kind and every community is established with a view to some good; for everyone always acts in order to obtain that which they think good. But, if all communities aim at some good, the state or political community, which is the highest of all, and which embraces all the rest, aims at good in a greater degree than any other, and at the highest good."

—Aristotle (384–323 B.C.)

Public health is concerned with ensuring the safety of the public's "good"—for example, through protection from hazards such as known infectious diseases where the administration of vaccinations ensures population and public protection. Such public interventions often inspire highly politicized legal debates, where the delicate balance between individual rights and freedom of choice is sacrificed for the sake of the community's right to good health. One such debate is over smoking bans in public places versus the right of individual tobacco users to exercise their rights to smoke in public places. How do you think Aristotle would respond to such a debate?

Today's changing healthcare delivery system brings with it additional ethical dilemmas for nurses. We are now concerned with problems related to equity in healthcare delivery, implementation of the ACA to improve

### THINK ABOUT THIS

The first rays of sunlight peek through your bedroom curtains, accompanied by the fresh air of a new day. You breathe deeply and enjoy the clean air that public health protects by monitoring radiation levels and developing strategies to keep them low.

Rousing the children, you usher them into the bathroom for their showers. You brush your teeth, knowing the water won't make you sick because safe drinking water is the responsibility of public health.

You check your smile in the mirror. You can't remember your last cavity, thanks in part to the fluoride public health helps add to the water. Through similar programs, public health has always sought to promote good health by preventing disease altogether.

The family clambers to the table just as you finish pouring the milk, which is safe to drink because the State Department of Health checks and monitors it from the dairy to the grocery store.

After breakfast, you call your sister, who is pregnant with her first child, and find out her routine doctor's visit went perfectly. Even in the small town where she lives, your sister can visit a local doctor. Public health recognized the need for doctors in rural areas and helped place one there.

Your sister tells you her doctor suggested she visit the county health department and enroll in the Women, Infants, and Children (WIC) program, another public health service that ensures children get the proper nutrition to prevent sickness later in life.

You walk outside and guide the children into the car. You buckle their seatbelts without realizing it. Seatbelts have become a habit now, because public health has explained how proper seatbelt use has greatly reduced automobile-related deaths nationwide.

Playmates greet your children at the childcare center with yelps of youthful joy. As you watch the children run inside to play, you know they'll stay safe while you're away at work. Public health has licensed the center and made certain the staff knows the proper ways to avoid infectious disease outbreaks that can occur among young children.

And thanks to the immunizations your children have received, you know they'll be safe from life-threatening diseases like polio and whooping cough. In fact, public health has eliminated the deadly smallpox virus worldwide, so your children will never catch it. Maybe your children's children won't have to worry about polio or whooping cough.

You arrive at work and find a flyer for a new exercise program tacked to the bulletin board. You decide to sign up, remembering the public health studies that show you can reduce the risks of chronic disease by staying physically active.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

The morning goes well, and you feel good because your company became a smoke-free workplace this month. Science shows that tobacco can cause cancer and other ailments in those who use tobacco and among those who breathe second-hand smoke. Public health encourages people and organizations to quit smoking so that all people can live more healthful lives.

Walking to a nearby fast-food restaurant for lunch, you pass a bike rider with a sleek, colorful helmet—another example of a public health message that can influence healthy behaviors. Inside, you order a hamburger and fries.

You notice the food service license signed by the State Health Officer on the wall, and you know the food is sanitary and free of disease-causing organisms. Still, a State Department of Health public service announcement from TV rings in your head, and you make a mental note to order something with a little less cholesterol next time.

You finish your day at work, pick up the kids, and head to the community park to let the children play. You watch the neighborhood children launch a toy sailboat into the park pond, knowing public health protects lakes and streams from dangerous sewage runoff.

At home, your spouse greets you at the door. You sort the mail and discover a letter from your uncle. He's doing fine after his surgery in the hospital and will head back to the nursing home in 2 days. You know he's getting quality care at both facilities because public health monitors and licenses them to ensure a commitment to quality standards. Even the ambulance that transported him to the hospital met public health standards for emergency medical services.

After dinner, you put the children to bed and sit to watch the evening news. The anchor details a new coalition dedicated to preventing breast and cervical cancer. A representative of the State Department of Health issues an open invitation for members from all walks of life. You jot down the telephone number and promise yourself you'll call first thing tomorrow.

As you settle into bed, you decide that public health is more than a point-in-time recognition. Without even realizing it, you'll rely on public health every day for an entire lifetime.

*Source: Mississippi State Department of Health Annual Report* (1997), pp. 2–3.

population health, environmental safety, politicization of healthcare interventions, euthanasia, elder abuse in nursing homes, provider–patient relationships, and community partnerships. Recent advancements in science and technology are presenting ethical dilemmas that Florence Nightingale could not have envisioned in even her wildest fantasies—for example, physician-assisted suicide, living wills, stem cell research, gene therapy, in vitro fertilization, and human cloning. All nurses would do well to follow Spicer's (1998) advice to nursing students in an editorial in *Imprint*: "As you prepare for your careers, remember your professional commitment to place your patient first in all decisions. Take time to establish your ethical boundaries. . . . Base your decisions from your head and your heart."

## Epidemiology: The Science of Public Health

**Epidemiology** is the science that provides community and public health with a framework for addressing the primary, secondary, and tertiary health needs for a population and directs community health nursing practice. Whether a person is healthy or ill results from numerous constantly changing interacting forces. The actual occurrence of disease results from a triad of factors, referred to as the epidemiological model or triangle. This triad is composed of the host, the agent, and the environment. The *host* is the human body influenced by such variables as gender, age, race, and behavior. The *agent* is a physical, chemical, or biological element that can cause illness or injury. Examples might include tubercle bacilli or nicotine. The *environment* is perhaps the most complex component. As we learn more about health and its determinants, the environment holds more and more keys to explaining health risks to our human hosts. The environment not only includes the physical environment, such as climate and terrain, but also the sociocultural–political environment, such as poverty, racism, and other stressors that influence health.

Prevention strategies are made up of measures that protect people from disease and take the form of efforts that we use to protect ourselves and others from specific diseases and conditions and their resulting consequences. There are three levels of prevention: primary, secondary, and tertiary. Nurses in all settings use all three levels of prevention as a basis for practice. The nurse caring for patients in an acute care setting may primarily use secondary and tertiary interventions, whereas the occupational health nurse may use primary and secondary interventions in his or her role. These levels of prevention were originally conceptualized by Leavell and Clark in 1953 and were tied to what these authors described as the natural history of disease. Their assumption was that disease in humans is a process: The conditions that promote either health or disease are present in the human's biological, physical, emotional, and social environments as well as in the human host itself.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

**GLOBAL CONNECTION**

**The Three Ps of Global Health:**

Pollution
Population
Poverty

*Source:* Turnock, 1997.

The relationship between levels of prevention and the natural history of any given disease condition or health state is the basis for community health interventions. Disease occurs in two stages: prepathogenesis and pathogenesis. The intervention strategies or levels of prevention must coincide with predictable events within the stages of prepathogenesis (predisease) and pathogenesis (disease, condition, or injury). One can readily see that applying the levels of prevention requires that the nurse know the natural history of a given disease or condition. The less known about the disease or condition, the greater the likelihood of interventions occurring in secondary or tertiary prevention levels. In other words, the more we learn about disease, disability, and injury, the earlier we can intervene to prevent the illness from occurring. The goal of preventive health, then, is to intervene at the earliest possible stage in the natural history of disease to prevent complications, limit disability, and halt irreversible changes in health status (Leavell & Clark, 1979). The levels of prevention and examples are included as a boxed feature throughout the text (see Box 1-4).

**BOX 1-4 Levels of Prevention**

**Primary Prevention**

Health measures that focus on prevention of health problems *before* they occur.

**Secondary Prevention**

Health measures that begin when pathology is involved and is directed at early detection through diagnosis and treatment.

**Tertiary Prevention**

Health measures that are taken when an illness, injury, or disability is irreversible; interventions are focused on rehabilitation. The goal of these measures is to restore the person to the optimal level of health and function.

**Primary prevention** refers to those measures that focus on prevention of health problems before they occur. Primary prevention is not therapeutic, which means that it does not consist of symptom identification and use of the typical therapeutic skills of the nurse (Shamansky & Clausen, 1980). This level includes both generalized health promotion and specific protection against certain identified diseases or conditions. The purpose is to reduce the person's vulnerability to the illness by strengthening the human host's capacity to withstand physical, emotional, and environmental stressors. An example would be teaching a person about adequate nutrition, exercise, and hygiene. Specific protection includes numerous interventions associated with public health nursing: immunizations, bicycle helmets, automobile seatbelts, safety caps on electrical outlets, handrails on bathtubs, and drug education for children.

**Secondary prevention** begins when pathology is involved and is aimed at early detection through diagnosis and prompt treatment. This level of prevention is aimed at halting the pathological process, thereby shortening its duration and severity and getting the person back to a normal state of functioning. All screening tests, such as breast self-examinations, hypertensive assessments, and Pap smears, are included in this level of prevention. The goal of this level is to identify groups of individuals who have early symptoms of disease so that they may be treated as soon as possible in the natural history of the disease, condition, or injury. If the disease, condition, or injury cannot be cured, further complications and disability move the level of prevention to that of tertiary prevention.

**Tertiary prevention** consists of activities designed around rehabilitation of a person with a permanent, irreversible condition. The goal of tertiary prevention goes beyond halting the disease process to restoring the person to an optimal level of functioning within the constraints of the disability. Nursing strategies at this level might include teaching a stroke patient how to ambulate with assistance or teaching a child with cystic fibrosis how to reduce risks of respiratory infection while maintaining an active lifestyle.

The traditional epidemiological triad has focused on infectious disease as agent, human host, and physical environment. In most developed countries, in the past century there has been an epidemiological transition from infectious to chronic disease, such as cardiovascular disease, cancer, diabetes, asthma, and depression, and the environment has broadened to include the social and psychological environment, such as prejudice, racism, and stress.

The boundaries between secondary and tertiary prevention are often fuzzy and more difficult to identify as either one or the other. One feature that helps in this identification is that tertiary intervention takes place only if the condition results in a permanent disability (Shamansky & Clausen, 1980). This outcome may be influenced by the age or development of the patient rather than by the condition itself. For example, if a 15-year-old high school athlete suffers a simple broken femur during a soccer game, in-

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

tervention would occur at the secondary prevention level. Although the athlete may require extensive physical rehabilitation after the cast is removed, unless there are serious complications, she should eventually be able to return to her normal state of health. Compare this situation with a 75-year-old man who falls from a roof and suffers the identical injury. Most likely, this patient would need both secondary and tertiary intervention strategies because of the aging process, recovery, and the likelihood of permanent disability resulting from this fall.

Shamansky and Clausen (1980) use the following example to illustrate how all levels of prevention are often used with the same patient and family:

> A nurse is conducting a group session with young parents and uses values clarification as a method to discuss issues of parental responsibility for providing a safe yet stimulating environment for the young, curious child. This is primary prevention: Health promotion occurs, because the discussion is general and directed toward nonspecific efforts to ensure the well-being of the young child.
>
> Later, on a home visit, the nurse encourages a mother to use screens on a second-story window, because she perceives the window is dangerously accessible to the active three-year-old. This, too, is primary prevention, an example of specific protection, because the nurse is attempting to remove a risk factor from the environment of a vulnerable child.
>
> If the screen is not used and the child falls out of the window onto a cement driveway below, the mother's and emergency personnel's use of appropriate emergency first aid would be secondary prevention through the use of prompt treatment. If the child sustained a severe head injury, was hospitalized (and secondary measures were used in the hospital), and later released to home care, teaching the mother to turn, feed, and give range-of-motion exercises would represent the disability limitation aspect of secondary prevention.
>
> Several months later, if the child is found to have some permanent brain damage, tertiary prevention would take the form of referrals to special education classes, or physical or speech therapy to increase the child's maximum potential level of functioning, although the damage itself is irreversible. (pp. 106–107)

**NOTE THIS!**

Why are American children getting heavier every year? Each day, most 8- to 18-year-olds spend an average of 4 hours watching television, videos, and DVDs; more than 1 hour on the computer; and about 50 minutes playing video games.

## Measuring a Community's Health: How Do We Know When We Get There?

Outcomes and measurements of community health interventions take the form of health statistics such as birth rates, infant mortality rates, and incidence and prevalence rates for various diseases and age groups. Most threats to health do not occur at random (i.e., by chance). Natural forces influence health threats, but by no means do they dictate the outcome. In this century we have learned through epidemiological research that most threats or risks to our health and wellbeing are associated with patterns of human activity and behavior. It is those patterns that we use to evaluate health interventions and the multitude of influences on people's health (Cohen, 1989).

For example, breast cancer rates in the United States are high compared with other countries such as Japan and China. In other words, breast cancer is not universal among all females, nor is it randomly distributed in the global female population (Cohen, 1989).

> "We allow our ignorance to prevail upon us and make us think we can survive alone, alone in patches, alone in groups, alone in races, even alone in genders."
>
> —*Maya Angelou*

We can see from epidemiological research that individual behavior has a significant effect on a person's chance of developing breast cancer. Breast cancer may be associated with a high-fat, high-protein, high-calorie diet, and with high levels of estrogen (either produced by the woman's own body or ingested in diet and medication). Women who do not have or nurse children or have them later in life also have higher rates of breast cancer. These lifestyle factors clearly influence a woman's chances of contracting breast cancer in her lifetime. The availability of cutting-edge technology, genomic research, and diagnostic interventions cannot prevent women from contracting breast cancer; these measures can improve chances of survival only after cancer is detected (Kolata, 1987; Marx, 1986; Winick, 1980).

In another example, maternal death risk in childbirth plummeted during the 20th century in developed countries as a result of application of prenatal care, use of antibiotics, and infectious disease control. In the United States, a woman has a 1 in 3,700 chance of dying in childbirth. By contrast, in Latin America, a woman's mortality risk is 1 in 130, and women in parts of Africa had an alarming 1 in 16 chance of dying as a result of childbearing (Whaley & Hashim, 1995).

**Table 1-2** provides an illustration of the links among all levels of care. You will learn in this text how these group

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

**TABLE 1-2 A Comparison of Individual, Family, Community, and Global Population-Focused Care**

| Individual Care | Family | Community | Global |
|---|---|---|---|
| Injuries suffered by women in violent spousal domestic relationship | Family dysfunctions, such as inability to provide appropriate behavioral roles and boundaries for conflict resolution | Children unable to function in school setting because of disruptive behavior in classroom | Women and children refugees in war-torn Pakistan and Afghanistan suffering from injuries as a result of acts of war violence |
| | Children exhibiting early and inappropriate use of firearms | Gang violence resulting in neighborhood isolation, decreased population, diminished economic base because of business closure, and decreased funds available for education and family assistance | |

rates of disease, health, injury, and disability reflect more accurately the values of a society and how health professionals measure not only their interventions but the influences of many variables on health.

**APPLICATION TO PRACTICE**

### Community-Based Care: An Example from Practice

A 3-year-old child is brought to a public health department for her first set of immunizations. As the nurse assesses the child, she finds that the child has a generalized red rash all over her body. The mother complains that the child scratches and cries about the rash. She has been using a cortisone skin cream for 3 days, but the rash has worsened.

The nurse attends to the immediate concerns of the mother about home care, comfort measures, and possible causes. The nurse then delivers direct care to the child and to her family, while considering the following community implications:

- Does anyone else in the family exhibit those symptoms?
- Does the child go to day care?
- Have there been any other children in the clinic recently with similar symptoms? If so, how does this case compare with cases in recent months?
- What is the likely pathogen that is causing the rash?
- Are there any pregnant women in the clinic or in the home setting?

Consider the following questions:

1. What are possible conclusions that the nurse can make that have individual implications?
2. Are there community and public health issues that may be present that the nurse must address?

In a report by the Institute of Medicine (IOM, 2010), *The Future of Nursing: Leading Change, Advancing Health*, "nurses must be full partners, with physicians and other health professionals, in redesigning health care in the United States" (pp. 1–9). Public and community health nurses, because of their focus on prevention and health promotion, must lead the way in the evolving healthcare system of the United States in order to improve the public's health.

## Conclusion

Community health and public health nursing care use a preventive focus with patients, communities, and populations, wherever they live, work, or reside. The focus of nurses' practice may be on the individual, but various influences on a community's health and the way in which the healthcare system has organized services around societal needs and expectations must also be considered. Nurses will play a critical role in the future of managed care, which is organized around prevention and a healthy population. Epidemiology is the science that provides community and public health with a framework for

**LEVELS OF PREVENTION**

**Primary:** Teaching elementary school children how to avoid playground accidents.

**Secondary:** Assisting a class of children with how to know when to call parents or caregivers when they are injured

**Tertiary:** Providing education for parents when a child has experienced a serious injury, such as an amputated finger, about adaptation to schoolwork

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

### AFFORDABLE CARE ACT (ACA)

The ACA was passed by Congress and signed into law by President Barrack Obama in March of 2010. The American Academy of Nursing strongly supported this major healthcare reform, along with most of the professional nursing organizations in the United States. The new healthcare reform law was created to bring about major changes to the delivery of health care in the United States, particularly in regard to delivery and financing of health care to the uninsured and underinsured populations in the nation. Nursing plays a critical role in implementing the health reform changes that are often complex and vast in nature, providing wide access to essential healthcare services, preventive health care, improving quality of care, and controlling costs of health care.

addressing the primary, secondary, and tertiary health needs for a population and directs community health nursing practice. The personal wellbeing of individuals is more than an individual matter. Humankind does not live in isolation, unaffected by others. Community health is a dynamic of the community and is influenced by the context of where and how the population lives, works, and addresses healthcare needs. The ACA of 2010 is a challenge and opportunity for nurses to positively affect the health of the population.

### HEALTHY ME

How do you cope with the stresses of nursing school using healthy practices?

## Critical Thinking Activities

1. After reading "Think About This," respond to the following questions:
   - What are three risks described in the essay that were unknown a century ago?
   - What is the responsibility of the individual in creating a safe environment?
   - What are three public safety measures mentioned in the essay that do not exist in underdeveloped countries?
2. How can heart disease be both a personal health problem and a community health problem?
3. For several decades now, nurses have worked primarily in hospitals using a medical model approach to health and illness. Does nursing have a vision of the profession with community at the center, or has nursing become so institutionalized into hospital-based practice over the past decades that we will resist the tremendous opportunities to care for people in a myriad of settings and situations?
4. How has the ethic of caring for a patient's environment changed from Florence Nightingale's era?
5. How will the ACA of 2010 affect the delivery of nursing care services in all settings?

## References


American Academy of Nursing (AAN). (2010). *Implementing health care reform: Issues for nursing*. Washington, DC: Author.

American Nurses Association (ANA). (1991). *Nursing's agenda for health care reform: Executive summary*. Washington, DC: Author.

American Nurses Association (ANA). (2008). *Code of ethics for nurses with interpretive statements*. Washington, DC: Author.

American Nurses Association (ANA). (2013). *Public health nursing: Scope and standards of practice*. Washington, DC: Author.

American Public Health Association, Public Health Nursing Section. (1996). *The definition and role of public health nursing: A statement of the APHA Public Health Nursing Section*. Washington, DC: Author.

Anderson, C. (1997). The economics of health promotion. *Nursing Outlook*, *45*(3), 105–106.

Armentrout, G. (1998). *Community-based nursing: Foundation for practice*. Stamford, CT: Appleton & Lange.

Association of Community Health Nursing Educators (ACHNE). (2009). *Essentials of baccalaureate nursing education for entry level community/public health nursing*. Wheat Ridge, CO: Author. Retrieved from http://www.achne.org/files/EssentialsOfBaccalaureate_Fall_2009.pdf

Bunker, J. P., Frazier, H. S., & Mosteller, F. (1994). Improving health: Measuring effects of medical care. *Milbank Quarterly*, 72, 225–258.

Bureau of Labor Statistics. (2012). *Occupational outlook handbook*, 2012. U.S. Department of Labor. Retrieved from http://www.bls.gov/ooh/Healthcare/Registered-nurses.htm

Canavan, K. (1996). Nursing education on cusp of shift in focus: Faculty grapple with preparing students for changing health care delivery. *American Nurse*, *28*(6), 1, 11.

Centers for Disease Control and Prevention (CDC). (2002). *Public health infrastructure: A status report*. Atlanta, GA: Author.


© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

Cohen, M. (1989). *Health and the rise of civilization*. New Haven, CT: Yale University Press.

Cottrell, K. (1976). The competent community. In B. H. Kaplan, R. N. Wilson, & A. H. Leighton (Eds.), *Further explorations in social psychology*. New York, NY: Basic Books.

Davidhizar, R., Eshleman, J., & Wolff, L. (2003). Living with stress since 9/11. *Caring*, *22*(4), 26–28, 30.

Ferguson, L. M., & Day, R. A. (2007). Challenges for new nurses in evidence-based practice. *Journal of Nursing Management*, *15*(1), 107–113.

Folmar, J., Coughlin, S. S., Bessinger, R., & Sacknoff, D. (1997). Ethics in public health practice: A survey of public health nurses in southern Louisiana. *Public Health Nursing*, *14*(3), 156–160.

Friedman, E. (June 2013). Which population: Whose health? *Hospitals and Health Networks*. Retrieved from http://www.hhnmag.com/hhnmag/HHNDaily/HHNDailyDisplay.dhtml?id=460002372

Gable, L. (2011). The Patient Protection and Affordable Care Act, public health, and the elusive target of human rights. *Journal of Law, Medicine and Ethics*, *39*(3), 340–354.

Gebbie, K. M. (1996, November 18). *Preparing currently employed public health nurses for changes in the health care system: Meeting report and suggested action steps*. New York, NY: Columbia University School of Nursing Center for Health Policy and Health Sciences Research. (Report based on meeting in Atlanta, GA, July 11, 1996.)

Giger, J. N., & Davidhizar, R. E. (1995). *Transcultural nursing: Assessment and intervention* (2nd ed.). St. Louis, MO: Mosby.

Gostin, L. O. (2004). Health of the people: The highest law? *Journal of Law, Medicine and Ethics*, *32*(3), 509–515.

Gostin, L. O., Boufford, J. I., & Martinez, R. M. (2004). The future of the public's health: Vision, values and strategies. *Health Affairs*, *23*, 96–107.

Graham, K. Y. (1997). Ethics: Do we really care? *Public Health Nursing*, *14*(1), 1–2.

Grossman, D. (1994). Enhancing your cultural competence. *American Journal of Nursing*, *94*(7), 58–62.

Hall, J. E., & Weaver, B. R. (1977). *Distributive nursing practice: A systems approach to community health*. Philadelphia, PA: Lippincott.

Hall, J. M., & Stevens, P. E. (1995). The future of graduate education in nursing: Scholarship, the health communities, and health care reform. *Journal of Professional Nursing*, *11*(6), 332–338.

Hanlon, J. J., & Pickett, G. E. (1984). *Public health: Administration and practice* (8th ed.). St. Louis, MO: Mosby.

HealthyPeople.gov. (2013). *Healthy People 2020*. Retrieved from http://www.healthypeople.gov/2020/default.aspx

Institute of Medicine (IOM). (2010). *The future of nursing: Leading change, advancing health*. Washington, DC: National Academies Press.

Janes, S., & Hobson, K. (1998). An innovative approach for affirming cultural diversity among baccalaureate nursing students and faculty. *Journal of Cultural Diversity*, *5*(4), 132–137.

Keck, E. W. (1994). Community health: Our common challenge. *Family and Community Health*, *17*(2), 1–9.

Keller, L. O., Strohstein, S., Lia-Hoagberg, B., & Shaeffer, M. A. (2004). Population-based public health interventions: Practice-based and evidence-supported. Part I. *Public Health Nursing*, *21*(5), 453–468.

Kolata, G. B. (1987). Kung hunter-gathers Feminism, diet and birth control. *Science*, *185*, 932–934.

Kurtzman, C., Ibgui, D., Pogrund, R., & Monin, S. (1980). Nursing process at the aggregate level. *Nursing Outlook*, *28*(12), 737–739.

Kuss, T., Proulx-Girouard, L., Lovitt, S., Katz, C. B., & Kennelly, P. (1997). A public health nursing model. *Public Health Nursing*, *14*(2), 81–91.

Leavell, H. R., & Clark, E. G. (1953). *Preventive medicine for the doctor in his community*. New York, NY: McGraw-Hill.

Leavell, H. R., & Clark, E. G. (1979). *Preventive medicine for the doctor in his community: An epidemiologic approach* (3rd ed.). Huntington, NY: RE Dreges.

Marx, J. (1986). Viruses and cancer briefing. *Science*, *241*, 1039–1040.

Leininger, M. (1995). *Transcultural nursing: Concepts, theories, research, and practices* (2nd ed.). New York, NY: McGraw-Hill.

Leipert, B. D. (1996). The value of community health nursing: A phenomenological study of the perceptions of community health nurses. *Public Health Nursing*, *13*(1), 50–57.

McKenzie, J. F., & Pinger, R. R. (1997). *An introduction to community health*. Boston, MA: Jones and Bartlett.

Mechanic, D. (1998). Topics of our times: Managed care and public health. *American Journal of Public Health*, *88*(6), 84–85.

Meleis, A. L. (1996). Culturally competent scholarship: Substance and rigor. *Advances in Nursing Science*, *19*(2), 1–16.

Moon, M. (1993). Health care reform. *Future of Children*, *3*(2), 21–36.

Morse, S. S. (2003). Building academic-practice partnerships: The Center for Public Health Preparedness at the Columbia University Mailman School of Public Health, before and after 9/11. *Journal of Public Health Management & Practice*, *9*(5), 427–432.

National Institutes of Health. (2014). Press release: NIH study finds regular aspirin use may reduce ovarian cancer risk. Retrieved from http://www.nih.gov/news/health/feb2014/nci-06.htm

Nehls, N., Owen, B., Tipple, S., & Vandermause, R. (2001). Lessons learned from developing, implementing and evaluating a model of community-driven nursing. *Nursing and Health Care Perspectives*, *22*, 304–307.

Nehls, N., & Vandermause, R. (2004). Community driven nursing: Transforming nursing curricula and instruction. *Nursing Education Perspectives*, *25*(2), 81–85.

Neufield, V. (1992). Training: A Canadian perspective. In Pan American Health Organization (Ed.), *International health: North–south debate*. (Human Resource Development Series, pp. 95, 193–203). Washington, DC: Pan American Health Organization.

Nightingale, F. (1860). *Notes on nursing: What it is and what it is not*. London, England: Harrison.

Proenca, E. J. (1998). Community orientation in health services organizations: The concept and its implementation. *Health Care Management Review*, *23*(2), 28–38.

Purnell, L. D., & Paulanka, B. J. (2003). *Transcultural health care: A culturally competent approach* (2nd ed.). Philadelphia PA: F. A. Davis.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.

Salmon, M., & Vanderbush, P. (1990). Leadership and change in public and community health nursing today: The essential intervention. In J. C. McCloskey & H. K. Grace (Eds.), *Current issues in nursing* (3rd ed., pp. 187–193). St. Louis, MO: Mosby.

Schultz, P. R. (1994). On the matter of populations, aggregates, and communities. Unpublished manuscript, University of Washington, Seattle, WA.

Shamansky, S. L., & Clausen, C. L. (1980). Levels of prevention: Examination of the concept. *Nursing Outlook*, *28*(2), 104–108.

Shortell, S. M., & Gilles, R. R. (1995). Reinventing the American hospital. *Milbank Quarterly*, *73*(2), 131.

Smith, C. M. (1995). Responsibilities for care in community health nursing. In C. M. Smith & F. A. Maurer (Eds.), *Community health nursing: Principles and practice* (pp. 3–29). Philadelphia, PA: Saunders.

Sorrell, J. (2012). Ethics: The Patient Protection and Affordable Care Act: Ethical perspectives in 21st century health care. *OJIN: The Online Journal of Issues in Nursing*, *18*(1). Retrieved from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/Columns/Ethics/Patient-Protection-and-Affordable-Care-Act-Ethical-Perspectives.html

Spicer, G. (1998). Learning right from wrong. *Imprint*, *45*(3), 4.

Trabert, B., Ness, R. B., Lo-Ciganic, W. H., Murphy, M. A., Goode, E. L., Poole, E. M., … Wentzensen, N. (2014). Aspirin, nonaspirin nonsteroidal anti-inflammatory drug, and acetaminophen use and risk of invasive epithelial ovarian cancer: A pooled analysis in the Ovarian Cancer Association Consortium. *Journal of the National Cancer Institute*, *106*(2), djt431. doi: 10.1093/jnci/djt431

Trossman, S. (1998, March/April). Self-determination: The name of the game in the next century. *American Nurse*, 1.

Turnock, B. (1997). *Public health: What it is and how it works*. Germantown, MD: Aspen.

U.S. Census Bureau. (2012). *Statistical Abstract of the United States: 2012* (131st ed.). Retrieved from http://quickfacts.census.gov/qfd/states/00000.html

U.S. Department of Health and Human Services (HHS), Division of Nursing, Bureau of Health Professions, Health Resources and Services Administration. (2000). *National sample survey of registered nurses*. Washington, DC: U.S. Government Printing Office.

Vilschick, J. (2003, January/February). Lack of minority role models affects nursing shortage. Retrieved from http://minorityhealth.hhs.gov/assets/pdf/checked/Lack%20of%20Minority%20Role%20Models%20Affects%20Nursing%20Shortage.pdf

Whaley, R. F., & Hashim, T. J. (1995). *A textbook of world health: A practical guide to global health care*. Nashville, TN: Parthenon Publishing Group.

Winick, M. (1980). Nutrition in health and disease. New York, NY: John Wiley.

Wolf, Z. R. (1989). Uncovering the hidden work of nursing. *Nursing and Health Care*, *10*(8), 462–467.

World Health Organization (WHO). (1958). *The first ten years of the World Health Organization*. New York, NY: Author.

World Health Organization (WHO). (1986). Health promotion: A discussion document on the concept and principles. *Public Health Reviews*, *14*(3–4), 245–254.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION.