Foundations *for* Population Health *in* Community/Public Health Nursing

FIFTH EDITION

Marcia Stanhope • Jeanette Lancaster

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Marcia Stanhope, PhD, RN, FAAN
Education and Practice Consultant and
Professor Emeritus
College of Nursing
University of Kentucky
Lexington, Kentucky

Jeanette Lancaster, RN, PhD, FAAN
Sadie Heath Cabiness Professor and Dean Emeritus
School of Nursing
University of Virginia
Charlottesville, Virginia
Associate, Tuft & Associates, Inc.

ELSEVIER

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3251 Riverport Lane
St. Louis, Missouri 63043

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Publishing Services Manager: Julie Eddy
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ABOUT THE AUTHORS

MARCIA STANHOPE, PhD, RN, FAAN

Marcia Stanhope is currently an education and practice consultant for nursing education programs nationally, an Associate with Tuft & Associates, Inc., an executive search firm in Chicago, Illinois; and Professor Emeritus from the University of Kentucky, College of Nursing, Lexington, Kentucky. In recent years, she received the Provost Public Scholar award for contributions to the communities of Kentucky. She was appointed to the Good Samaritan Endowed Chair in Community Health Nursing and held the position for 12 years. She has practiced community and home health nursing, has served as an administrator and consultant in home health, and has been involved in the development of a number of nurse-managed centers as well as the doctorate of nursing practice program nationally. She has taught community health, public health, epidemiology, primary care nursing, policy, and administration courses. Dr. Stanhope was the former Associate Dean and formerly directed the Division of Community Health Nursing and Administration at the University of Kentucky. She has been responsible for both undergraduate and graduate courses in population-centered, community-oriented nursing. She has also taught at the University of Virginia and the University of Alabama, Birmingham. Her presentations and publications have been in the areas of home health, community health and community-focused nursing practice, nurse-managed centers, primary care nursing, and the doctorate of nursing practice. Dr. Stanhope holds a diploma in nursing from the Good Samaritan Hospital, Lexington, Kentucky, and a bachelor of science in nursing from the University of Kentucky. She has a master's degree in public health nursing from Emory University in Atlanta and a doctorate of science in nursing from the University of Alabama, Birmingham. Dr. Stanhope has been the co-author of four other Elsevier publications: *Handbook of Community-Based and Home Health Nursing Practice, Public and Community Health Nurse's Consultant, Case Studies in Community Health Nursing Practice: A Problem-Based Learning Approach,* and *Public Health Nursing-Population-Centered Health Care in the Community.*

JEANETTE LANCASTER, RN, PhD, FAAN

Jeanette Lancaster often serves as a visiting professor in both Taiwan and Hong Kong. She is an associate with Tuft & Associates, Inc. She served for 19 years as the Sadie Heath Cabaniss Professor of Nursing and Dean at the University of Virginia School of Nursing in Charlottesville, Virginia. When Dr. Lancaster stepped down as dean at the University of Virginia, a professorship, grant program for faculty, office suite, and the street in front of the school were named in her honor. From 2008 to 2009 she served as a visiting professor in the School of Nursing at the University of Hong Kong. In spring 2013 and fall 2014, she served as a professor with Semester at Sea and taught cross-cultural health promotion and nutrition as the students, faculty, staff, and life-long learners sailed around the world for 4 months.

Dr. Lancaster also served as president of the American Association of Colleges of Nursing. She has practiced psychiatric nursing and taught both psychiatric and community health nursing. She formerly directed the master's program in community health nursing at the University of Alabama, Birmingham, and served as dean of the School of Nursing at Wright State University in Dayton, Ohio. Her publications and presentations have been largely in the areas of community and public health nursing, leadership and change, and the significance of nurses to effective primary health care. Dr. Lancaster is a graduate of the University of Tennessee Health Sciences Center, College of Nursing. She holds a master's degree in psychiatric nursing from Case Western Reserve University in Cleveland and a doctorate in public health from the University of Oklahoma. Dr. Lancaster is the author of another Mosby/Elsevier publication, *Nursing Issues in Leading and Managing Change,* and co-author (with Dr. Stanhope) of *Public Health Nursing.*

DEDICATION AND ACKNOWLEDGMENTS

DEDICATION

This edition of the text is dedicated to Amber, Bink, G.B., BeBe, Connie, Sam, and Brendy for the joy and fun we have shared for many years.

Marcia Stanhope

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Lisa Pedersen Turner, PhD, RN, PHCNS-BC

Judy L. Ponder, MSN, DNP, RN

Erika Metzler Sawin, PhD, RN

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CONTRIBUTORS

We gratefully acknowledge the following individuals who wrote chapters for the ninth edition of *Public Health Nursing*, on which the chapters in this book are based.

Swann Arp Adams, MS, PhD
Associate Professor
College of Nursing and the Department of Epidemiology and Biostatistics
Associate Director
Cancer Prevention and Control Program
University of South Carolina
Columbia, South Carolina

Mollie Aleshire, DNP, FNP-BC, PPCNP-BC
Assistant Professor
College of Nursing
University of Kentucky
Lexington, Kentucky

Jeanne Alhusen, PhD, CRNP, RN
Assistant Professor
Department of Community and Public Health
Johns Hopkins University School of Nursing
Baltimore, Maryland

Debra Gay Anderson, PhD, PHCNS-BC
Associate Professor
College of Nursing
University of Kentucky
Lexington, Kentucky

Dyan A. Aretakis, RN, FNP, MSN
Project Director and APN3
University of Virginia Teen Health Center
Charlottesville, Virginia

Sydney Axson, MPH, RN
Hillman Scholar in Nursing Innovation
University of Pennsylvania
Philadelphia, Pennsylvania

Linda K. Birenbaum, PhD, RN[†]
Public Health Program Supervisor
Washington County Health & Human Services
Hillsboro, Oregon

Tina Bloom, PhD, MPH, RN
Assistant Professor and Robert Wood Johnson Foundation Nurse Faculty Scholar
Sinclair School of Nursing
Columbia, Missouri

Kathryn H. Bowles, PhD, RN, FAAN
van Ameringen Professor in Nursing Excellence
Director, Center for Integrative Science in Aging
Beatrice Renfield Visiting Scholar, Visiting Nurse Service of New York
Philadelphia, Pennsylvania

Angeline Bushy, PhD, RN, FAAN, PHCNS-BC
Professor and Bert Fish Chair
College of Nursing
University of Central Florida
Daytona Beach, Florida

Jacquelyn C. Campbell, PhD, RN, FAAN
Professor
Anna D. Wolf Chair
National Program Director, Robert Wood Johnson Foundation Nurse Faculty Scholars
The Johns Hopkins University
Baltimore, Maryland

Ann H. Cary, PhD, MPH, RN
Professor and Dean, School of Nursing and Health Studies
University of Missouri-Kansas City
Robert Wood Johnson Foundation Executive Nurse Fellow
Kansas City, Missouri

Ann Connor, DNP, MSN, RN, FNP-BC
Assistant Professor, School of Nursing
Emory University
Atlanta, Georgia

Lois Davis, RN, MSN, MA
Public Health Nursing Manager
Lexington—Fayette County Health Department
Lexington, Kentucky

Cynthia E. Degazon, PhD, RN
Professor Emerita
Hunter College of the City University of New York
New York, New York

[†]= deceased

Janna Dieckmann, PhD, RN
Clinical Associate Professor
School of Nursing
University of North Carolina at Chapel Hill
Chapel Hill, North Carolina

Amanda Fallin, PhD, RN
Postdoctoral Fellow
University of California San Francisco Center for Tobacco Control Research and Education
San Francisco, California

Sharon L. Farra, PhD, RN
Assistant Professor of Nursing
Wright State University
Dayton, Ohio

Hartley Feld, RN, MSN, PHCNS-BC
Lecturer/Clinical Instructor, Public and Community Health Nursing
College of Nursing
University of Kentucky
Lexington, Kentucky

Mary Gibson, PhD, RN
Associate Professor in Nursing
Assistant Director, Bjoring Center for Nursing Historical Inquiry
University of Virginia School of Nursing
Charlottesville, Virginia

Rosa Gonzales-Guarda, PhD, MPH, RN, CPH
Assistant Professor
Robert Wood Johnson Foundation Nurse Faculty Scholar
University of Miami School of Nursing and Health Studies
Coral Gables, Florida

Monty Gross, PhD, RN, CNE, CNL
Clinical Nurse Educator
Veterans Administration
North Las Vegas, Nevada

Patty J. Hale, RN, FNP, PhD, FAAN
Professor and Graduate Program Director
James Madison University
Harrisonburg, Virginia

Susan B. Hassmiller, PhD, RN, FAAN
Robert Wood Johnson Foundation Senior Advisor for Nursing
Director, Future of Nursing: Campaign for Action
Princeton, New Jersey

DeAnne K. Hilfinger Messias, PhD, RN, FAAN
Professor
College of Nursing and Women's and Gender Studies
University of South Carolina
Columbia, South Carolina

Linda Hulton, PhD, RN
Professor of Nursing
Coordinator of Doctor of Nursing Practice Program
James Madison University
Harrisonburg, Virginia

Susan C. Long-Marin, DVM, MPH
Epidemiology Manager
Mecklenburg County Health Department
Charlotte, North Carolina

Karen S. Martin, RN, MSN, FAAN
Health Care Consultant
Martin Associates
Omaha, Nebraska

Mary Lynn Mathre, RN, MSN, CARN
Addictions Nurse Consultant
President, Patients Out of Time
President, American Cannabis Nurses Association
Howardsville, Virginia

Marie Napolitano, PhD, RN, FNP
Director, Doctor of Nursing Practice Program
University of Portland
Portland, Oregon

Bobbie J. Perdue, RN, PhD
Professor, Nursing
South Carolina State University
Orangeburg, South Carolina

Judy L. Ponder, MSN, DNP, RN
Director, Education and Professional Development
Baptist Health Richmond
Richmond, Kentucky

Bonnie Rogers, DrPH, COHN-S, LNCC, FAAN
Director
North Carolina Occupational Safety and Health and Education and Research Center
Director
Occupational Health Nursing Program
School of Public Health
University of North Carolina
Chapel Hill, North Carolina

Joanna Rowe Kaakinen, PhD, RN
Professor
School of Nursing
Linfield College-Portland Campus
Portland, Oregon

Cynthia Rubenstein, PhD, RN, CPNP-PC
Undergraduate Program Director
Assistant Professor
Department of Nursing
James Madison University
Harrisonburg, Virginia

Barbara Sattler, RN, DrPH, FAAN
Professor, Masters of Public Health Program
School of Nursing and Health Professions
University of San Francisco
San Francisco, California

Erika Metzler Sawin, PhD, RN
Associate Professor
James Madison University
Harrisonburg, Virginia

George F. Shuster, RN, DNSc
Associate Professor
College of Nursing
University of New Mexico
Albuquerque, New Mexico

Sharon A. R. Stanley, PhD, RN, FAAN
Visiting Professor, Wright State University
Robert Wood Johnson Executive Nurse Fellow, 2011-2014
Dayton, Ohio

Sharon Strang, RN, DNP, APRN, FNP-BC
Associate Professor and Graduate Faculty
Department of Nursing
James Madison University
Harrisonburg, Virginia

Francisco S. Sy, MD, PhD
Editor, *AIDS Education and Prevention—An Interdisciplinary Journal*
Director, Office of Extramural Research Administration
National Institute on Minority Health and Health Disparities (NIMHD)
National Institutes of Health
Bethesda, Maryland

Esther Thatcher, PhD, RN, APHN-BC
Postdoctoral Fellow
School of Nursing
University of North Carolina at Chapel Hill
Chapel Hill, North Carolina

Anita Thompson-Heisterman, MSN, PMHCNS-BC, PMHNP-BC
Assistant Professor
University of Virginia School of Nursing
Charlottesville, Virginia

Lisa Pedersen Turner, PhD, RN, APHN-BC
Assistant Professor
Berea College Nursing Program
Berea, Kentucky

Connie M. Ulrich, PhD, MSN, RN
Lillian S. Brunner Chair in Medical and Surgical Nursing
Professor of Bioethics and Nursing
Secondary Appointment, Department of Medical Ethics and Health Policy
Associate Director, NewCourtland Center for Transitions and Health
University of Pennsylvania Schools of Nursing and Medicine
Philadelphia, Pennsylvania

Lynn Wasserbauer, PhD, FNP, RN
Nurse Practitioner
Strong Memorial Hospital
University of Rochester Medical Center
Rochester, New York

Jackie F. Webb, FNP-BC, MS, RN
Assistant Professor
Linfield College School of Nursing
Portland, Oregon

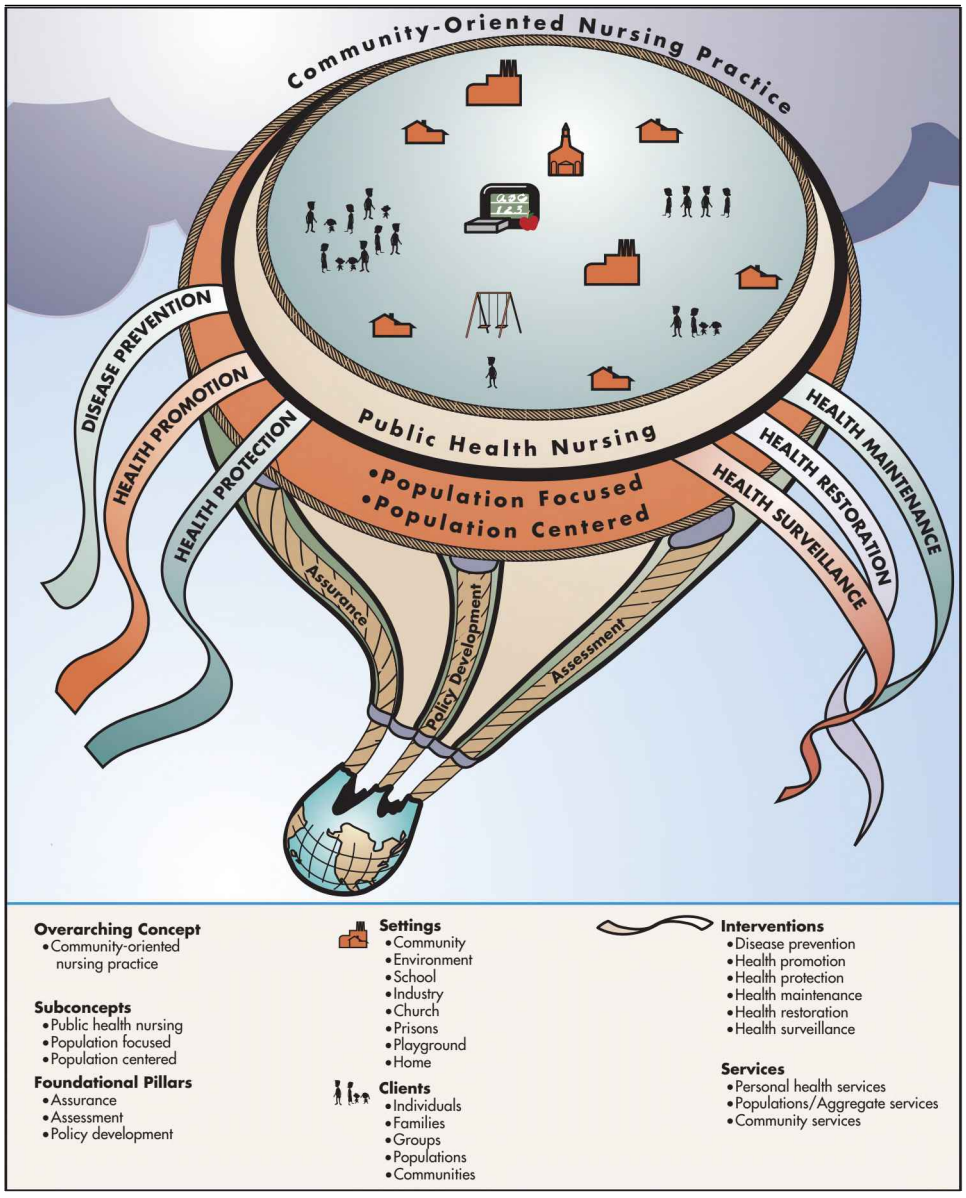
Carolyn A. Williams, PhD, RN, FAAN
Professor and Dean Emeritus
College of Nursing
University of Kentucky
Lexington, Kentucky

Lisa M. Zerull, PhD, RN
Academic Liaison and Program Manager, Wincester Medical Center, Valley Health System
Adjunct Clinical Faculty, Senandoah University (Wincester, Virginia)
Editor, Perspectives out of the Church Health Center (Memphis, Tennessee)

REVIEWERS

Grace Buttriss DNP, RN, FNP-BC, CNL
Assistant Professor of Nursing
Queens University of Charlotte
Nursing Department
Charlotte, North Carolina

Jennifer Wing MSN, RN
Assistant Professor
Upper Iowa University
Nursing Department
Des Moines, Iowa



COMMUNITY NURSING DEFINITIONS

Community-Oriented Nursing Practice is a philosophy of nursing service delivery that involves the generalist or specialist public health and community health nurse providing "health care" through community diagnosis and investigation of major health and environmental problems, health surveillance, and monitoring and evaluation of community and population health status for the purposes of preventing disease and disability and promoting, protecting, and maintaining "health" to create conditions in which people can be healthy.

Public Health Nursing Practice is the synthesis of nursing theory and public health theory applied to promoting and preserving health of populations. The focus of practice is the community as a whole and the effect of the community's health status (resources) on the health of individuals, families, and groups. Care is provided within the context of preventing disease and disability and promoting and protecting the health of the community as a whole. Public Health Nursing is population focused, which means that the population is the center of interest for the public health nurse. *Community Health Nurse* is a term used interchangeably with *Public Health Nurse.*

Community-Based Nursing Practice is a setting-specific practice whereby care is provided for "sick" individuals and families where they live, work, and go to school. The emphasis of practice is acute and chronic care and the provision of comprehensive, coordinated, and continuous services. Nurses who deliver community-based care are generalists or specialists in maternal-infant, pediatric, adult, or psychiatric-mental health nursing.

PREFACE

Health care is in a rapid state of flux. In the early tenure of a new administration in the United States, health care and the many possible changes are at the forefront of the minds of Americans. As we look back at the preface to the fourth edition of this text, it is clear that many of the concerns at that time about health care still exist. In the United States, an increasing amount of money is spent annually on health care, yet not all people get affordable, accessible, and high-quality care. For 27 years, the United Health Foundation has published *America's Health Rankings Annual Report.* In the 2016 report they said that encouraging progress was being made against selected long-standing public health challenges including reducing the prevalence of smoking and the number of people without health insurance (www.americashealthranking.org). However, several significant challenges remain, including rising rates of cardiovascular- and drug- related deaths and an increasing prevalence of obesity. Clearly, drug-related deaths and obesity are preventable, and the incidence of cardiovascular diseases can often be prevented or postponed by healthy behaviors. The findings of this report, which assesses health status annually by individual states, were confirmed in the reflections of former Surgeon General Everett Koop in an editorial in the *American Journal of Public Health* in late 2006. He commented that in nearly six decades of public health work, he was "awed at what has been achieved and shocked at what has not" (Koop, 2006, p. 2090). He commented on the many medical miracles that have saved lives and led to longer lives but that have often failed to make those added years any freer of disability and discomfort. He went on to talk about preventable health problems, including obesity; orthopedic injury; unintentional pregnancies, many of which lead to abortions; and lack of adequate preparation to deal effectively with potential influenza pandemics, bioterrorism, or HIV/AIDS. His comments still reflect the current issues in health and health care today. However, there have been some improvements over time.

For several years, many of us in public health and public health nursing have thought that some national priorities are misaligned. In recent years, we have spent more money on war than on dealing with poverty. We continue to spend more on complex reparative procedures than to spend money on prevention, including health education and health promotion. Despite the fact that many people across the world know that lifestyle plays a large role in morbidity and mortality, only a portion of the people in each country "walk the talk" in terms of their own personal behavior. It is important to remember that numerous deaths each year are still attributed to tobacco, alcohol, and illicit drug use; diet and activity patterns; microbial agents; toxic agents; firearms; sexual behavior; and motor vehicle accidents. Over the years the most significant improvements in the health of the population have come from advances in public health, such as improvements in motor vehicle safety, mandatory helmet use on cycles, food and water sanitation, food pasteurization and refrigeration, immunizations, workplace safety, and emphasis on personal lifestyle and environmental factors that affect health. Changes in the public health system are essential if health in the United States is to improve.

The need to focus attention on health promotion, lifestyle factors, and disease prevention led to the development of a healthy public policy in the United States. This policy was designed by a large number of people representing a wide range of groups interested in health. The policy is reflected in the document *Healthy People 2020,* which identifies a comprehensive set of national health-promotion and disease-prevention objectives. Despite the development of these guidelines for health and the acceptance of the goals and objectives set forth, health indicators are simply not measuring up to expectations.

Public health nurses have a unique view of their "clients." They view the community as the client; they focus on prevention strategies to promote **population health** according to population-based data, and they know to organize resources in the community to address the problems. Public health nurses view health from a broad perspective and include the biology of a person, relationship interactions, genetics, community resources, policies, and the environment in which the population lives, to name only a few.

Specifically, to develop healthy populations, individuals, families, and communities, there must be a commitment to **population level** health goals. In addition, society, through the development of health policy, must support better health care, the design of improved health education, the financing of strategies to alter health status, and the support of alliances and coalitions that truly and consistently work together to improve health care. Of most importance, healthy public policy must be evidence based and outcomes of the policies evaluated. Growing interest in health reform is an opportunity for public health workers to find ways to be involved in charting the future of health care in America.

Our message to you, our readers, is to ask, "How are you going to use the knowledge and skills that you have to make a difference in health care?" We ask you to remember that behind every public health decision, there is a political decision. This means that your role in health care is broad and includes care to individuals, families, communities, and the nation. In late 2008, Bill Foege, MD, MPH, former head of the Centers for Disease Control and Prevention and now with the Bill and Melinda Gates Foundation, offered these comments that have direct usefulness to students of public health nursing, "Leadership in the future will require knowing the rules of coalitions. Most coalitions (however) are formed around an idea. The best will be formed around an outcome" (American Academy of Nursing, 2008 meeting). His words emphasize that public health work is not the work of a soloist and that the work should focus on the outcome versus the process. We hope that this text will provide you with some of

the tools to accomplish the goal Dr. Foege sets forth. It is our belief that nurses are the backbone of public health in both developed and developing countries.

This text focuses on the processes and practices for promoting health principally by the nurse, who is considered to be an ideal person to demonstrate and teach others how to promote health. To be effective, health promotion requires that people cease focusing on how to "fix" themselves and others only when they detect physical and emotional problems and that they instead assume personal responsibility for health promotion. Such a change in emphasis requires that health care providers incorporate health-promotion techniques into their practice.

Because people do not always know how to improve their health status, the challenge of nursing is to initiate change. **Public health nursing focuses on the health of populations to change the health of individuals, families, and groups living, working, and playing within the community as a whole.** The practice takes place in a variety of public and private settings and includes disease prevention, health promotion, health protection, education, maintenance, restoration, coordination, management, and evaluation of care of those populations, as well as the whole of the communities.

To meet the demands of a constantly changing health care system, nurses must be visionary in designing their roles and identifying their practice areas. To do so effectively, nurses must understand concepts and theories of public health, **population health;** the changing health care system; the actual and potential roles and responsibilities of nurses and other health care providers; the importance of a health-promotion and disease-prevention orientation; and the necessity to involve consumers in the planning, implementation, and evaluation of health care efforts.

This text was written to provide nursing students and practicing nurses with a comprehensive source book that provides a foundation for designing nursing strategies **for populations, including the individuals, families and groups within the communities.** The book integrates health-promotion and disease-prevention concepts into all aspects of practice.

REFERENCES

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ORGANIZATION

The text is divided into seven sections:

- *Part 1,* **Perspectives in Health Care Delivery and Nursing,** describes the historical and current status of the health care delivery system and nursing practice in the community.
- *Part 2,* **Influences on Health Care Delivery and Nursing,** addresses specific issues and societal concerns that affect nursing practice in the community.
- *Part 3,* **Conceptual Frameworks Applied to Nursing Practice in the Community,** provides conceptual models for nursing practice in the community; selected models from nursing and related sciences are also discussed.
- *Part 4,* **Issues and Approaches in Health Care Populations,** examines the management of health care and select community environments, as well as issues related to managing cases, programs, disasters, and groups.
- *Part 5,* **Issues and Approaches in Family and Individual Health Care,** discusses risk factors and health problems for families and individuals throughout the life span.
- *Part 6,* **Vulnerability: Predisposing Factors,** covers specific health care needs and issues of populations at risk.
- *Part 7,* **Nursing Practice in the Community: Roles and Functions,** examines diversity in the role of nurses in the community and describes the rapidly changing roles, functions, and practice settings.

PEDAGOGY

Each chapter is organized for easy use by students and faculty. Chapters begin with Objectives to guide student learning and assist faculty in knowing what students should gain from the content. The Chapter Outline alerts students to the structure and content of the chapter. Key Terms, along with text page references are also provided at the beginning of the chapter to assist the student in understanding unfamiliar terminology. The key terms are in boldface within the text. A full Glossary is available in Appendix E as well as on the student Evolve website at http://evolve.elsevier.com/stanhope/foundations.

The following features are presented in most or all chapters:

HOW TO **Provides specific, application-oriented information.**

EVIDENCE-BASED PRACTICE

Illustrates the use and application of the latest research findings in public health, community health, and nursing.

LEVELS OF PREVENTION

Applies primary, secondary, and tertiary prevention to the specific chapter content.

HEALTHY PEOPLE 2020

Selected *Healthy People 2020* objectives are integrated into each chapter.

APPLYING CONTENT TO PRACTICE

Provides highlights and links chapter content to nursing practice in the community.

QSEN FOCUS ON QUALITY AND SAFETY EDUCATION FOR NURSES (QSEN)

Gives examples of how quality and safety goals, competencies, objectives, knowledge, skills, and attitudes can be applied in nursing practice in the community.

CASE STUDY

Real-life clinical situations help students develop their assessment and critical thinking skills.

PRACTICE APPLICATION

At the end of each chapter, this section provides readers with an understanding of how to apply chapter content in the clinical setting through the presentation of a case situation with questions students will want to think about as they analyze the case.

REMEMBER THIS!

Provides a summary in list form of the most important points made in the chapter.

TEACHING AND LEARNING PACKAGE

A website, http://evolve.elsevier.com/stanhope/foundations, includes instructor and student materials.

(a) For The Instructor:

- TEACH for Nurses, which contains:
  - Detailed chapter Lesson Plans containing references to curriculum standards such as QSEN, BSN Essentials and Concepts, BSN Essentials for Public Health, new and unique Case Studies, Critical Thinking Activities, and Critical Analysis Questions and Answers
- Test Bank, with 800 questions
- Image Collection, with all illustrations from the book
- PowerPoint slides

(b) For The Student:

- NCLEX® Review Questions, with answers and rationale provided
- Case Studies, with Questions and Answers
- Answers to Practice Application Questions

CONTENTS

CHAPTER 1

Community- and Prevention-Oriented Practice to Improve Population Health

Carolyn A. Williams

OBJECTIVES

After reading this chapter, the student should be able to:

1. State the mission and core functions of public health and the services generally provided by practitioners of public health.
2. Discuss the role of the public health nurse specialist and how the role influences nursing practice in the community.
3. Contrast community-based nursing practice with community-oriented nursing practice.
4. Describe the role of public health and nursing in population health.

CHAPTER OUTLINE

KEY TERMS

aggregate, 7
assessment, 5
assurance, 5
community, 1
community based, 1
community-based nursing, 1
community health nursing, 1
community-oriented nursing, 1
policy development, 5
population, 7
population focused, 10
population-focused practice, 8
population health, 3
primary health care services, 5
public health, 3
public health core functions, 4
public health mission, 4
public health nursing, 1
secondary health care services, 5
subpopulations, 7
tertiary health care services, 5

Professional nurses must actively participate in developing evidence-based, cost-effective, high-quality, innovative, and useful ways to provide care to citizens. Evidence-based practice is the norm today and simply means that a nurse's practice is based on the use of the best available evidence to provide this care. This evidence may be research, but if research is not available, practice may be based on opinions, case studies, or professional and governmental reports, to name a few examples. Of course it is always the best if research related to a strategy, an intervention, a program, or an application of a model can be found.

Because of the growing costs of hospital care, more services are being provided in **community-based** settings. Increasingly, nurses will engage in what is called **community-based nursing** (CBN). In CBN, the nurse focuses on "illness care" of individuals and families across the life span. The aim is to manage acute and chronic health conditions in the **community,** and the focus of the practice is individual- or family-centered illness care. While providing health care to individuals and families, the nurse maintains an appreciation for the values of the community. CBN is not a specialty in nursing but rather a philosophy that guides care in all nursing specialties when applied in the community.

In contrast, **community-oriented nursing** has as its primary focus the health care of either the community or populations, as in **public health nursing** (PHN), or of individuals, families, and groups in a community. Care of individuals, families, and groups is also referred to as **community health nursing,** although this term was more common in the past. In community-oriented nursing the goal is to preserve, protect,

promote, or maintain health. The key difference between CBN and community-oriented nursing is that community-based nurses deal primarily with illness-oriented care, whereas community-oriented nurses provide health care to promote quality of life. They both may deal with individuals and families, and the community-oriented nurse also typically deals with groups in the community. Table 1.1 lists the similarities and differences between community-oriented nursing and CBN.

As mentioned, community-oriented nursing includes PHN. This is a specialty area whose primary focus is on the health care of communities and populations rather than on individuals, groups, and families. The goal of this specialty is to prevent disease and preserve, promote, restore, and protect health for the

TABLE 1.1 Select Examples of Similarities and Differences Between Community-Oriented and Community-Based Nursing

	Community-Oriented Nursing	Community-Based Nursing
Philosophy	Primary focus is on "health care" of individuals, families, groups, and the community or populations within the community	Focus is on "illness care" of individuals and families across the life span
Goal	Preserve, protect, promote, or maintain health and prevent disease	Manage acute or chronic conditions
Service context	Community health care Population health	Family-centered illness care
Community type	Varied; usually local community	Human ecological
Client characteristics	• Individuals at risk • Families at risk • Groups at risk • Communities • Usually healthy • Culturally diverse • Autonomous • Able to define their own problems • Primary decision makers	• Individuals • Families • Usually ill • Culturally diverse • Autonomous • Able to define their own problems • Involved in decision making
Practice setting	• Community agencies • Home • Work • School • Playground • May be organization • May be government	• Community agencies • Home • Work • School
Interaction patterns	• One to one • Groups • May be organizational	• One to one
Type of service	• Direct care of at-risk individuals • Indirect (program management)	• Direct illness care
Emphasis on levels of prevention	• Primary • Secondary (screening) • Tertiary (maintenance and rehabilitation)	• Secondary • Tertiary • May be primary
Roles	**Client and Delivery Oriented: Individual, Family, Group, Population** • Caregiver • Social engineer • Educator • Counselor • Advocate • Case manager	**Client and Delivery Oriented: Individual, Family** • Caregiver
	Group Oriented • Leader (personal health management) • Change agent (screening) • Community advocate/developer • Case finder • Community care agent • Assessment • Policy developer • Assurance • Enforcer of laws/compliance	**Group Oriented** • Leader (disease management) • Change agent (managed-care services)

TABLE 1.1 Select Examples of Similarities and Differences Between Community-Oriented and Community-Based Nursing—cont'd

	Community-Oriented Nursing	Community-Based Nursing
Priority of nurse's activities	• Case findings • Client education • Community education • Interdisciplinary practice • Case management (direct care) • Program planning and implementation • Individual, family, and population advocacy	• Case management (direct care) • Client education • Individual and family advocacy • Interdisciplinary practice • Continuity of care providers

community and the population within it. The focus is on the public health ethic of "the greatest good for the greatest number." This specialty is built on the blending of nursing and the discipline of public health (American Nurses Association, 2013).

This chapter examines both CBN and community-oriented nursing. It describes the similarities and differences between these two areas of nursing and also discusses public health and the core functions and services included in public health practice. In addition, the essential services of public health nurses are discussed because nurses working from both a CBN and a community-oriented community health nursing framework may use some of these skills. For nurses to work effectively in the community, regardless of their focus, it is useful to know exactly what public health is and how the functions of that discipline work to improve the health of the people in their communities.

WHAT IS PUBLIC HEALTH?

Public health is a scientific discipline that includes the study of epidemiology, statistics, and assessment—including attention to behavioral, cultural, and economic factors—in addition to program planning and policy development. In recent years, efforts in the United States to change the way in which health care is delivered have focused heavily on looking at ways to change the delivery of medical care and on health insurance. Until recently, limited attention has been focused on looking at **population health** or the health of a population as a whole, including the distribution of health outcomes and disparities in the population (Nash et al, 2011).

Although people are excited when a new drug is discovered that cures a disease or when a new way to transplant organs is perfected, it is important to know about the significant gains in the health of populations that have come largely from public health accomplishments. For example, public health has influenced the safety and adequacy of food and water, sewage disposal, public safety from biological threats, and changes in personal behaviors such as smoking. There has been a dramatic increase in life expectancy for Americans in the 21st century compared with the 20th century, from less than 50 years in 1900 to 78.8 years in 2013 (National Center for Health Statistics, 2015). The change is credited primarily to improvements in sanitation, the control of infectious diseases through immunizations, and other public health activities. Population-based preventive programs launched in the 1970s were also largely responsible for the more recent changes in tobacco use, blood-pressure control, dietary patterns (except obesity), automobile safety restraint, and injury-control measures that have fostered declines in adult death rates. A more than 50% decline in stroke and coronary heart disease deaths has occurred (National Center for Health Statistics, 2015, p. 89). Overall death rates for children have declined by approximately 40% (Singh, 2010).

Another way of looking at the benefits of public health practice is to look at how early deaths can be prevented. The US Public Health Service (1994/2008) estimated that medical treatment could prevent only approximately 10% of all early deaths in the United States, whereas population-focused public health approaches could help prevent approximately 70% of early deaths through measures targeted to the factors that contribute to those deaths. Many of these contributing factors are behavioral, such as tobacco use, diet, and sedentary lifestyle. Other factors that affect health are the environment, social conditions, education, culture, economics, working conditions, and housing (US Department of Health and Human Services [USDHHS], 2016).

The passage of the Affordable Care Act of 2010 created the National Prevention, Health Promotion, and Public Health Council and charged it with developing the National Prevention and Health Promotion Strategy to focus on community-oriented approaches to prevention and wellness to "reduce the incidence and burden of the leading causes of death and disability."(prevention.council@hhs.gov.) The strategy identifies the five leading causes of death as heart disease, cancers, stroke, chronic lower respiratory disease, and unintentional injuries. Other noted priorities are behavioral and mental health, substance use, and domestic violence screenings. In addition, the four health-promoting behaviors associated with the underlying causes of death that will be targeted through prevention measures are tobacco use, nutrition, physical activity, and underage and excessive alcohol use (National Prevention Council, 2011).

Public health practice is of great value. In 2014, the Centers for Medicare and Medicaid Services (CMS) reported that only 3% (up from 1.5% in 1960) of all national health expenditures supported population-focused public health functions. Unfortunately, the public is largely unaware of the contributions of public health practice. Federal and private monies were sparse in their support of public health, so public health agencies began to provide personal care services for persons who could not receive care elsewhere. The health departments benefited by receiving Medicaid and Medicare funds. The result was a shift of resources and energy away from public health's traditional and unique population-focused perspective to include a primary-care focus (Levi et al, 2015; Meit et al, 2013). As overall health

needs become the focus of care in the United States, a stronger commitment to population-focused services is emerging. In July 2008, the Trust for America's Health released a study that highlighted the effects of preventive services on improving lives and reducing costs in addition to ways to change the health care system. The threats of terrorism and bioterrorism, highlighted by the events of September 11, 2001, and the anthrax scares, increased awareness for public safety. Important to the public health community is the emergence of modern-day epidemics and infectious diseases, such as the mosquito-borne Zika virus, Ebola, new strains of influenza, and other causes of mortality, many of which affect the very young. Most of the causes are preventable (Bauer et al, 2014).

Public health is best described as what society collectively does to ensure that conditions exist in which people can be healthy (Institute of Medicine, 2003). Public health is a community-oriented, population-focused specialty area. The overall **public health mission** is to organize community efforts that will use scientific and technical knowledge to prevent disease and promote health (Institute of Medicine, 2003). The three **public health core functions** are *assessment, policy development,* and *assurance.*

PUBLIC HEALTH CORE FUNCTIONS DEFINED

Fig. 1.1 describes public health in the United States. The functions provide a framework for defining the services to be

PUBLIC HEALTH IN AMERICA

Vision:
Healthy people in healthy communities

Mission:
Promote physical and mental health and prevent disease, injury, and disability

Public health
- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Ensures the quality and accessibility of health services

Essential public health services by core function

Assessment
1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community

Policy Development
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts

Assurance
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure a competent public health and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services

Serving All Functions
10. Research for new insights and innovative solutions to health problems

FIG. 1.1 Public health in America. (Modified from Public Health Functions Steering Committee: Public Health in America, 1994, US Public Health Service agencies, and U.S. Public Health Service: The core functions project, Washington, DC, 1994 [update 2008], Office of Disease Prevention and Health Promotion.)

provided by the public health system. The core functions are defined as follows:

- **Assessment** involves systematically collecting data on the population, monitoring the population's health status, and making information available about the health of the community.
- **Policy development** refers to efforts to develop policies that support the health of the population, including using a scientific knowledge base to make policy decisions.
- **Assurance** is making sure that essential community-oriented health services are available. These services might include providing essential personal health services for those who would otherwise not receive them. Assurance also includes making sure that a competent public health and personal health care workforce is available.

A working group within the US Public Health Service developed the Health Services Pyramid (Fig. 1.2). In this pyramid, population-focused public health programs with the goals of disease prevention, health protection, and health promotion provide a foundation for **primary, secondary,** and **tertiary health care services.** Each service level in the pyramid is important to the health of the population. The base of the pyramid shows the effective services that support the top tiers and contribute to better health. All tiers of the pyramid need to be adequately financed (US Public Health Service, 1994/2008). The pyramid has been referenced to show how health care services can be offered to specific population groups (Frieden, 2010). In reality, health care in the United States has been organized with the pyramid upside down. That is, more attention, support, and funding are given to tertiary and secondary care than to primary and preventive services, including population-focused care. The How To box on p. 6 lists the 10 essential public health services.

These services need to be implemented to support the base of the pyramid and to support the services offered through the top tiers of the pyramid. Together, all services at all levels contribute to better health in the United States.

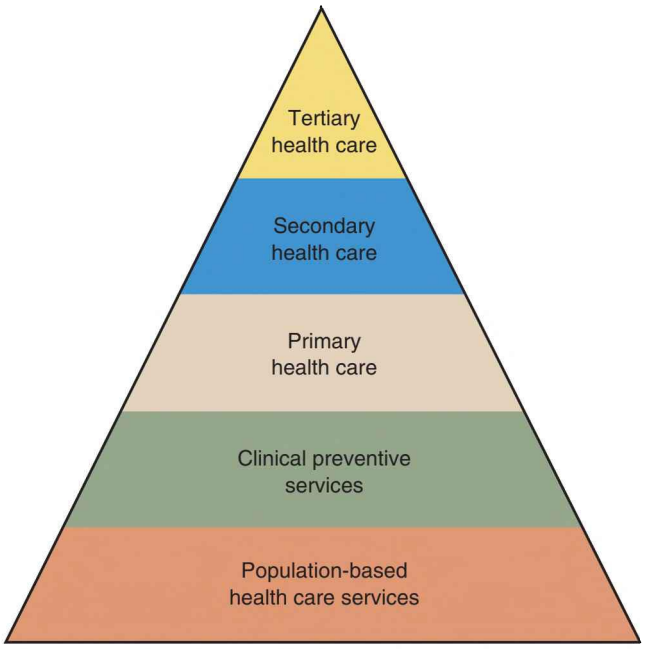

FIG. 1.2 Health services pyramid. (From US Public Health Service: *For a healthy nation: return on investments in public health,* Washington, DC, 1994 [update 2008], USDHHS.)

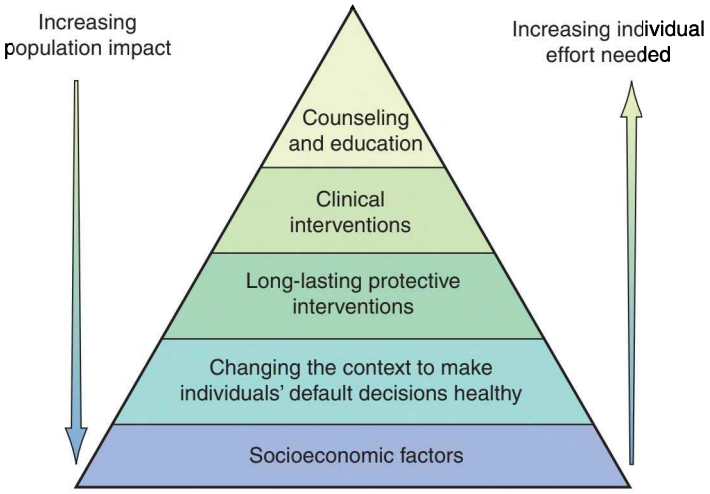

FIG. 1.3 Five-tier health impact pyramid. (From Frieden TR: A framework for public health action: the health impact pyramid, *Am J Public Health,* 100(4): 590–595, 2010.)

Another conceptual framework highlighting the effects of public health action on population health and individual health is the five-tier health impact pyramid (Fig. 1.3). The tiers in this pyramid are as follows:

- *Socioeconomic determinants*, the bottom tier of the health impact pyramid, represents changes in socioeconomic factors (e.g., poverty reduction, improved education), often referred to as social determinants of health, that help form the basic foundation of society.
- *Public health interventions* represents interventions that change the context of health, such as clean water and safe roads.
- *Protective interventions with long-term benefits* represents one-time or infrequent protective interventions that do not require ongoing clinical care, such as immunizations, smoking cessation programs, and male circumcision.
- *Direct clinical care* represents ongoing clinical interventions, such as interventions to prevent cardiovascular disease, that have the greatest potential health impact. Evidence-based clinical care can also reduce disability and prolong life.
- *Counseling and education*, the pyramid's top tier, represents health education (education provided during clinical encounters and in other settings), which is perceived by some as the essence of public health action. It is generally the least effective type of intervention. However, educational interventions are often the only ones available, and when applied consistently over time, they may influence individual health.

Interventions at the top tiers are designed to help individuals, whereas interventions at the bottom tiers help entire populations and thus could have a large population impact if universally and effectively applied (Frieden, 2015). As in the Health Services Pyramid, the greater the emphasis given to the bottom tiers, the greater is the impact on population health.

POPULATION-FOCUSED NURSING PRACTICE

PHN is a specialty with a distinct focus and scope of practice; it requires a special knowledge base. The role of the public

health nurse has changed over the years in response to the following:

- Changes in health care
- Priorities for health care funding
- The needs of the population
- The educational preparation of nurses

As noted in Chapter 2, PHN began more than 100 years ago; early public health nurses provided direct care to people, most often in their homes. The Henry Street Settlement, established in New York City in the late 1800s by Lillian Wald, was an early model for PHN. At Henry Street Settlement the nurses took care of the sick in their homes and also looked at the overall population of low-income people in the community from which their home-care clients came. The primary focus that has differentiated PHN from other specialties is the emphasis on the population rather than on single individuals or families. In the spirit of Lillian Wald, public health nurses have done the following:

- Looked at the community or population as a whole
- Raised questions about the overall population health status and the factors associated with that status, including environmental factors such as physical, biological, social, economic, and cultural aspects
- Worked with the community to improve health status
- Provided health education to individuals, families, and groups to encourage healthier living.

HOW TO Participate as a Public Health Nurse in the Essential Services of Public Health

1. Monitor health status to identify community health problems.
   - Participate in community assessment.
   - Identify subpopulations at risk for disease or disability.
   - Collect information on interventions with special populations.
   - Define and evaluate effective strategies and programs.
   - Identify potential environmental hazards.
2. Diagnose and investigate health problems and hazards in the community.
   - Understand and identify determinants of health and disease.
   - Apply knowledge about environmental influences on health.
   - Recognize multiple causes of or factors in health and illness.
   - Participate in case identification and treatment of persons with communicable diseases.
3. Inform, educate, and empower people about health issues.
   - Develop health and educational plans for individuals and families in multiple settings.
   - Develop and implement community-based health education.
   - Provide regular reports on the health status of special populations within clinic settings, community settings, and groups.
   - Advocate for and with underserved and disadvantaged populations.
   - Ensure health planning, which includes strategies for primary prevention and early intervention.
   - Identify healthy population behaviors, and maintain successful intervention strategies through reinforcement and continued funding.
4. Mobilize community partnerships to identify and solve health problems.
   - Interact regularly with many providers and services within each community.
   - Convene groups and providers who share common concerns and interests in special populations.
   - Provide leadership to prioritize community problems and develop interventions.
   - Explain the significance of health issues to the public, and participate in developing plans of action.
5. Develop policies and plans that support individual and community health efforts.
   - Participate in community and family decision-making processes.
   - Provide information and advocacy for consideration of the interests of special groups in program development.
   - Develop programs and services to meet the needs of high-risk populations as well as other community members.
   - Participate in disaster planning and mobilization of community resources in emergencies.
   - Advocate for appropriate funding for services.
6. Enforce laws and regulations that protect health and ensure safety.
   - Regulate and support safe care and treatment for dependent populations, such as children and frail older adults.
   - Implement ordinances and laws that protect the environment.
   - Establish procedures and processes that ensure competent implementation of treatment schedules for diseases of public health importance.
   - Participate in the development of local regulations that protect communities and the environment from potential hazards and pollution.
7. Link people to needed personal health services and ensure the provision of health care that is otherwise unavailable.
   - Provide clinical preventive services to certain high-risk populations.
   - Establish programs and services to meet special needs.
   - Recommend clinical care and other services to clients and their families in clinics, homes, and the community.
   - Provide referrals through community links to needed care.
   - Participate in community provider coalitions and meetings to educate others and to identify service centers for community populations.
   - Provide clinical surveillance and identification of communicable diseases.
8. Ensure a competent public health and personal health care workforce.
   - Participate in continuing education and preparation to ensure competence.
   - Define and support proper delegation to unlicensed assistive personnel in community settings.
   - Establish standards for performance.
   - Maintain client record systems and community documents.
   - Establish and maintain procedures and protocols for client care.
   - Participate in quality assurance activities, such as record audits, agency evaluation, and adherence to clinical guidelines.
9. Evaluate the effectiveness, accessibility, and quality of personal and population-based health services.
   - Collect data and information related to community interventions.
   - Identify unserved and underserved populations within the community.
   - Review and analyze data on the health status of the community.
   - Participate with the community in the assessment of services and outcomes of care.
   - Identify and define enhanced services required to manage the health status of complex populations and special risk groups.
10. Research for new insights and innovative solutions to health problems.
    - Implement nontraditional interventions and approaches to effect change in special populations.
    - Participate in the collecting of information and data to improve the surveillance and understanding of special problems.
    - Develop collegial relationships with academic institutions to explore new interventions.
    - Participate in the early identification of factors detrimental to the community's health.
    - Formulate and use investigative tools to identify and influence care delivery and program planning.

From the U.S. Public Health Service: *`The core functions project,* Washington, DC, 1994/update 2008, Office of Disease Prevention and Health Promotion.

The primary goal of public health—the prevention of disease and disability—is achieved by ensuring that conditions exist in which people can remain healthy. The How To box on the policy-development process describes ways to distinguish what actually makes up the specialty of PHN.

HOW TO Distinguish the Specialty of Public Health Nursing

- **Population focused:** Primary emphasis on populations of individuals who live in the community, as opposed to those who are institutionalized
- **Community oriented:**
  - Concern for the connection between the population's health status and the environment in which the population lives (e.g., physical, biological, sociocultural)
  - An imperative to work with members of the community to carry out core public health functions
- **Health and disease-prevention focused:** Predominant emphasis on strategies for health promotion, health maintenance, and disease prevention, particularly primary and secondary prevention
- **Interventions at the community and population levels:**
  - The use of political processes to affect public policy as a major intervention strategy for achieving goals
  - Concern for the health of all members of the population or community, particularly vulnerable subpopulations

In 1981 the PHN section of the American Public Health Association (APHA) defined PHN and described how this role contributes to health care delivery. This statement was reaffirmed in 1996 and again in 2013 (APHA, 1996, 2013). PHN is defined as a specialty that brings together knowledge from the social and public health sciences and nursing to promote and protect the health of populations. It is defined by the Quad Council Coalition of Public Health Nursing Organizations as population-focused, community-oriented nursing practice. The goals of PHN are "the promotion of health, the prevention of disease and disability for all people through the creation of conditions in which people can be healthy" (American Nurses Association, 2013, p. 5). Box 1.1 presents the PHN process from the APHA definition.

Public health nurses, like others in public health, engage in assessment, policy development, and assurance activities. These functions are achieved when nurses work in partnerships with others, including nations, states, communities, organizations, groups, and individuals. Public health nurses carry out this mission by participating in the essential public health services described earlier in the chapter.

Although population-focused practice is the central feature of PHN, many of the skills and activities are used when community-oriented nurses and community-based nurses work in the community. For this reason, these practices are described in detail here. A **population** or **aggregate** is a collection of people who share one or more personal or environmental characteristics. Members of a community can be defined in terms of either geography (e.g., a county, a group of counties, or a state) or a special interest (e.g., children attending a particular school). These members make up a population. Generally, there are **subpopulations** within the larger population. Examples of subpopulations within a population of a county are high-risk infants younger than 1 year old, unmarried pregnant adolescents, and individuals exposed to a particular hazardous event (e.g., a chemical spill).

BOX 1.1 The Public Health Nursing Process

Public health nursing is a systematic process of working with the client as a partner that does the following:

- Assesses the health and health care needs of a population in collaboration with other disciplines to identify subpopulations (aggregates), families, and individuals at increased risk for illness, disability, or premature death.
- Develops and plans interventions to meet these needs. The plan includes resources available and activities that contribute to health and its recovery and the prevention of illness, disability, and premature death.
- Implements the plan effectively, efficiently, and equitably.
- Evaluates progress to determine the extent to which these activities have influenced the health-status outcomes of the population.
- Uses the results to influence and direct the delivery of care, the use of health resources, and the development of local, regional, state, and national health policy and research to promote health and prevent diseases.

Data from American Public Health Association, Public Health Nursing Section: *The definition and practice of public health nursing: a statement of the public health nursing section,* Washington, DC, 2013, American Public Health Association; American Public Health Association: *The definition and role of public health nurses: a statement of the American Public Health Association's Public Health Nursing Section,* Washington, DC, 1996, The Association; American Public Health Association: *The definition and role of public health nursing in the delivery of health care: a statement of the Public Health Nursing section,* Washington, DC, 1981, The Association; and American Nurses Association: *Public health nursing: scope and standards of practice,* 2013, ANA.

EVIDENCE-BASED PRACTICE

Kneipp, Kairalla, and Sheely (2013) conducted a study that used a randomized controlled design to evaluate the effectiveness of a public health nursing case-management intervention to address the needs of 432 American women with chronic health conditions who received Temporary Assistance for Needy Families (TANF). This study explored the effect of the PHN intervention on employment outcomes, particularly during the recent economic recession. Previous studies noted the high prevalence of health conditions among US women receiving TANF, thus impeding this population's employment opportunities. The intervention was developed with input from the community and used community members on the research team. Control-group participants received what would be considered usual care in the local Welfare Transition Program (WTP) in north-central Florida. Referral and case-management activities began for the intervention-group participants at their initial visits and focused on ensuring access to and coordination of care, disease management, health education, and disease prevention. Outcomes were assessed at 3, 6, and 9 months. Study findings indicated that outcomes for employment entry (any employment, $p = 0.05$; time to employment, $p = 0.01$) were significantly improved for women in WTPs with chronic health conditions who received a PHN case-management intervention to address their health needs compared with women receiving standard WTP services.

Nurse Use

The results of this study suggest that public health interventions can improve employment outcomes among women receiving TANF. Such improvements were theorized to have occurred because the PHNs working with the intervention group helped the participants "to better manage chronic health conditions and decrease health-related functional limitations" (p. 138).

Data from Kneipp SM, Kairalla JA, Sheely AL: A randomized controlled trial to improve health among women receiving welfare in the U.S.: the relationship between employment outcomes and the economic recession, *Social Science & Medicine, 80*(1): 130–140, 2013.

In **population-focused practice,** problems are defined (assessments/diagnoses) and solutions (interventions), such as policy development or providing a given preventive service, are implemented for or with a defined population or subpopulation as opposed to diagnoses, interventions, and treatment carried out at the individual level. This contrasts with basic professional education in nursing, medicine, and other clinical disciplines, which emphasizes developing competence in decision making at the level of the individual client by assessing health status, making management decisions (ideally with the client), and evaluating the effects of care. The ways in which nurses provide care to people with high blood pressure can demonstrate how population-focused practice differs from the clinical direct-care practice so often used in nursing. Specifically, in a clinical direct-care situation, a nurse practicing in the community might decide that a person is hypertensive based on certain clinical signs. The nurse would evaluate different interventions to find the best one for this person and implement an appropriate intervention, such as a change in diet.

In contrast to the nurse providing direct clinical care, a public health nurse engaged in population-focused practice would ask the following questions related to the population of the center:

- What is the prevalence rate of hypertension among various age, race, and gender groups?
- Which subpopulations have the highest rates of untreated hypertension?
- What programs could reduce the problem of untreated hypertension and decrease the risk for further cardiovascular morbidity and mortality?
- The public health nurse's approach focuses on improving the health of populations in addition to having an effect on the individual.

Public health nurses are typically concerned with more than one subpopulation, and they often deal with the health of the entire community. *Assessment,* one of the public health core functions, is a logical first step in examining a community setting to determine its health status.

The core public health function of assessment includes the following aspects:

- Engaging in activities that involve the collection, analysis, and dissemination of information on both the health and health-relevant aspects of a community or a specific population
- Questioning whether the health services of the community are available to the population and are adequate to address needs
- Monitoring the health status of the community or population and the services provided over time
- Evaluating the social, economic, environmental, and lifestyle characteristics and practices of a population and the health services and capacity available within the community to support good health for the population

The How To box provides a general set of questions that can be used or modified to gather assessment data.

HOW TO Assess: Assessment Questions to Ask

- What are the major health problems in this community?
- Which population groups are at greatest risk?
- How are risks distributed geographically?
- What services are available?
- What services need to be provided but are unavailable?
- What is the level of quality of the available and needed services?
- What do citizens think their most pressing health needs are?
- Are the most pressing health needs considered to be the same by both providers and citizens?
- What is the history of agency collaboration and cooperation in this community?

CHECK YOUR PRACTICE

You have been asked by a local health agency to monitor the health status of the population in a community center that serves older persons living in the area of the center. The problem noted by the center staff is that they would like to know the most prevalent health problem shared by the clients of the center to offer programs based on the primary problem of the total population of the center. What would you do?

Excellent examples of assessment at the national level are the efforts of the USDHHS to organize the goal setting, data collection and analysis, and monitoring necessary to develop the series of publications describing the health status and health-related aspects of the US population. These efforts began with *Healthy People* in 1980 and continued with *Promoting Health, Preventing Disease: 1990 Health Objectives for the Nation, Healthy People 2000,* and *Healthy People 2010* and are now moving forward into the future with Healthy People 2020 (USDHHS, 1979, 1991, 2000, 2016).

In a local health department, public health nurses would participate in and provide leadership for assessing community needs, the health status of populations within the community, and environmental and behavioral risks. They also look at trends in the factors that determine health in the community, identify priority health needs, and determine the adequacy of existing community resources.

Policy development is a core function of public health and one of the core intervention strategies used by PHN specialists. Policy development relies heavily on planning and begins with the identified needs and priorities set by the people involved. It also includes building constituencies that can bring about policy changes. It is important to know what the powerful people in the community think about a specific public health concern. Health and human services providers and the people who will be served or affected must be included. PHN is an approach to planning characterized as "with the people" rather than "to the people" or "for the people." Historically, health care providers have been accused of providing care for or to people without actually involving the recipients in the decisions. The beneficiaries of services in public health need to be included from the very beginning in identifying the need, planning the intervention, and deciding on the format for the evaluation (Box 1.2).

BOX 1.2 Policy Development Process

The policy development function has the following characteristics:

- It is essentially a planning process that uses the assessment data to define health needs; set priorities; identify alternatives; outline a plan, including the determination of available and needed resources; and determine who needs to be involved to ensure some measure of success.
- It serves as a resource or catalyst to help elected officials or heads of community organizations develop population-based health plans.
- It assists people who make policies to do so in such a way that the needs of many people or groups are met. It also advises these individuals and groups about which needs are most important and should be handled first.
- It consistently advocates for better health conditions for the population as a whole.

The third core public health function, *assurance,* focuses on the responsibility of public health agencies to be sure that activities are appropriately carried out to meet public health goals and plans. Not only does PHN include assessment or investigative functions, but the role also requires skill in collaboration, consultation, and cooperation. The assurance function ensures that the activities designed during the policy-development or planning phase are carried out. This is done through collaboration with people in a variety of health and human service organizations to promote, monitor, and improve both the availability and quality of providers and services. PHN is not a good field for people who like to work alone. Although considerable opportunity exists for autonomy in thinking and planning, effective and consistent collaboration is vital to success. Assurance does not always mean to provide something. Rather, another agency may provide the needed service. Assurance means making certain that the services determined to be needed are provided by some agency within the community. Further, assurance includes assisting communities with implementing and evaluating plans and projects. It includes maintaining the ability of both public health agencies and private providers to manage day-to-day operations and ensuring the capacity to respond to critical situations and emergencies.

In PHN, the nurse often reaches out to those who might benefit from a service or intervention. In other forms of nursing, the client is more likely to seek and request assistance. As is discussed in later chapters, the people or populations most in need of public health services are often the least likely to ask for them, such as people who are homeless, poor, or mentally ill. The dominant needs of the population outweigh the expressed needs of one or a few people. Because resources are often limited, careful assessment to identify key needs is important.

However, the contributions of public health nurse specialists include looking at the community or population as a whole; raising questions about its overall health status and factors associated with that status, including environmental factors (e.g., physical, biological, sociocultural); and working *with the community* to improve the population's health status.

HEALTHY PEOPLE 2020

Overview and Goals

In 1979, the Surgeon General issued a report that began a 20-year focus on promoting health and preventing disease for all Americans. The report, entitled *Healthy People,* used morbidity rates to track the health of individuals through the five major life cycles of infancy, childhood, adolescence, adulthood, and older age.

In 1989, *Healthy People 2000* became a national effort of representatives from government agencies, academia, and health organizations. Their goal was to present a strategy for improving the health of the American people. Their objectives are being used by public and community health organizations to assess current health trends, health programs, and disease-prevention programs.

Throughout the 1990s, all states used *Healthy People 2000* objectives to identify emerging public health issues. The success of the program on a national level was accomplished through state and local efforts. Early in the 1990s, surveys from public health departments indicated that 8% of the national objectives had been met, and progress on an additional 40% of the objectives was noted. In the midcourse review published in 1995, it was noted that significant progress had been made toward meeting 50% of the objectives.

Using the progress made in the past decade, the committee for *Healthy People 2010* proposed the following two goals:

- To increase years of healthy life
- To eliminate health disparities among different populations

The committee hopes to reach these goals through such measures as promoting healthy behaviors, increasing access to quality health care, and strengthening community prevention.

The major premise of *Healthy People 2010* was that the health of the individual can rarely be separated from the health of the larger community. Therefore the vision for *Healthy People 2010* was "Healthy People in Healthy Communities."

The vision for *Healthy People 2020* is "A society in which all people live long, healthy lives." The overarching goals for 2020 are as follows:

- To eliminate preventable disease, disability injury, and premature death
- To achieve health equity, eliminate disparities, and improve the health of all groups
- To create social and physical environments that promote good health for all
- To promote healthy development and healthy behaviors across every stage of life

In contrast to previous years, *Healthy People 2020* has a web-accessible database that is searchable, multilevel, and interactive, enhancing its usefulness. The objectives for 2020 are now available online at https://www.healthypeople.gov/2020/topics-objectives.

Data from US Department of Health and Human Services: *Healthy People 2000: national health promotion and disease prevention objectives,* DHHS Pub. No. 91-50212, Washington, DC, 1991, US Government Printing Office; US Department of Health and Human Services: *Healthy People 2010: understanding and improving health,* ed 2, Washington, DC, 2000, US Government Printing Office; US Department of Health, Education, and Welfare: *Healthy People: the Surgeon General's report on health promotion and disease prevention,* DHEW Pub. No. 79-55071, Washington, DC, 1979, US Government Printing Office; and US Department of Health and Human Services: *Healthy People 2020* [Internet], Washington, DC, 2016, Office of Disease Prevention and Health Promotion. Available from https://www.healthypeople.gov/.

PRACTICE FOCUSING ON INDIVIDUALS, FAMILIES, AND GROUPS

As mentioned, community-based nursing practice, with its focus on the provision or assurance of care to individuals and families in the community, is different from **community-oriented practice.** The latter is broader in scope and is a form of care in which the nurse provides health care after completing a community diagnosis to determine what conditions need to be altered for individuals, families, and groups in the community to stay healthy. Although it is hoped that all direct-care providers contribute to the community's health in the broadest sense, not all are primarily concerned with a population health focus, or the "big picture." All nurses in a given community, including those working in hospitals, physicians' offices, and health clinics, contribute positively to the health of the community. Examples of community settings for treating individuals include ambulatory surgery clinics, outpatient clinics, physician and advanced-practice nursing offices and clinics, and employment and school sites, in addition to preschool programs, housing projects, and migrant camps. These sites often provide individual-focused health care services in contrasts to **population-focused** services (i.e., services focused on a large group). A specific example is Head Start, the federally funded program for preschool children. From a community-oriented nursing care perspective, nursing services could be provided to individual children by conducting developmental-level screening tests to evaluate each child's level of cognitive and psychomotor development for comparison with established standards for children of the same age. The community-based nurse could then deliver illness care to the children in the school. In contrast, a public health or population-focused approach would look at the entire group of children being served by the program and the characteristics of the facility and its programs to evaluate whether they are effective in achieving the goals of making the school population healthier.

COMMUNITY-ORIENTED NURSING

Most nurses practicing in the community and many staff public health nurses—both historically and at present—focus on providing direct-care services, including health education, to persons or families outside of institutional settings, either in the home or in a clinic. Historically, the term *community health nurse* applied to all nurses who practiced in the community, regardless of whether they had preparation in PHN. Thus nurses providing secondary or tertiary care in a home, school, or clinic or any nurse who did not practice in an institutional setting could be considered a "community health nurse." To a large extent, the development of what has been called *community health nursing* was influenced by the development of the specialty of community medicine within the medical field. At that time, both community medicine and community health nursing reached out to the community and began doing community assessments to determine more effectively the needs of the people so that disease prevention and health promotion could be targeted to the specific needs in a given community. Specifically, the community health nurse operated from a health care focus based on an understanding of broader community needs. Today, the term *community health nurse* and *public health nurse* are used interchangeably, and both are referred to as *community-oriented nurses.*

The nurse must continually evaluate the community to see if changes are occurring that will influence the health of the people who live there. The accompanying case study provides an example of community-oriented nursing practice. Work through the case study and answer the questions for a better understanding of this specialty area.

The practice of community-oriented nursing involves health promotion, health maintenance, health education, management, coordination, and continuity of care in the management of the health care of individuals, families, and groups in a community. A holistic approach is used, and the goal of this care is to provide personal health services that promote and preserve the health of the community in which the clients live. The community-oriented nurse uses both nursing and public health theory to guide practice.

Evidence that entry-level nurses are practicing effectively in the community includes the following (Babenko-Mould et al, 2016; Joyce et al, 2014):

- Provide quality services that can control costs.
- Focus on disease prevention and health promotion.
- Organize services where people live, work, play, and learn.
- Provide referrals when clients need them.

CASE STUDY

Community Assessment to Identify Population Health Risks

This is Debbie Brown's first year working as a nurse at the local health department in a rural county. Most of her days are spent in the clinic, seeing clients who usually do not have health insurance.

Over the course of a month, several young Hispanic men, all migrant farm workers, come to the health department, and tuberculosis is diagnosed in all of them. Ms. Brown is concerned about what the outbreak of tuberculosis in the migrant workers could mean for the community. Through a community health assessment, Ms. Brown identifies the group of migrant farm workers to be at the highest risk of contracting tuberculosis.

Ms. Brown brings the tuberculosis outbreak to the attention of the health department's communicable disease control department, which in turn contacts the local school system and makes tuberculosis skin testing a requirement for enrollment in school. Ms. Brown also develops an educational program for the migrant workers, their families, and their employers to teach them about tuberculosis and how to prevent its spread.

1. What indicators should Ms. Brown look at when she performs her community health assessment?
2. What is Ms. Brown's nursing area?
   - A. Community-oriented nursing practice
   - B. Public health nursing practice
   - C. Community-based nursing practice
   - D. Home health nursing
3. In this case study, how were the core functions of public health applied?

Answers can be found on the Evolve website.

- Work in partnerships and with coalitions and other health care providers.
- Work across the life span and with culturally diverse populations.
- Work with at-risk populations to promote access to services.
- Participate in epidemiological investigations and disaster services.
- Develop the community's capacity for health.
- Work with policymakers for policy change.
- Work to make the environment healthier.

As can be seen, community-oriented nurses emphasize health protection, maintenance, and promotion; disease prevention; and self-reliance among clients. Regardless of whether the client is a person, a family, or a group, the goal is to promote health through education about prevailing health problems, proper nutrition, beneficial forms of exercise, and environmental factors such as safe food, water, air, and buildings. The nurse is likely to be involved in immunizing individuals and organizing the immunization programs for vaccinating the community for influenza, for example, and educating the community about the value of this service. Other individual and family services include provision of maternal and child health care, treatment of common communicable and infectious diseases and injuries, and provision of basic screening programs for problems such as lice, vision, hearing, and scoliosis.

Nurses have always been involved in providing family-centered care to individuals, families, and groups across the life span; however, they also work to identify high-risk groups in the community. Once such groups are identified, the nurse can work with others to develop appropriate policies and interventions to reduce risk and provide beneficial services. Both community-oriented nurses and community-based nurses must be aware of cultural diversity and provide care that is appropriate to the needs of the recipient. Likewise, both groups of nurses provide care in homes. The Focus on Quality and Safety Education for Nurses box provides the list of competencies a nurse will need to improve the quality and safety of interventions and outcomes in the community. Compare these competencies with the public health nursing competencies noted in Appendix C.3.

COMMUNITY-BASED NURSING

As mentioned, the goal of CBN is to manage acute or chronic conditions while promoting self-care among individuals and families (Kane et al., 2013). In CBN the nursing care is family centered, which means that the nurse works to improve the competencies of families to enable them to take better care of themselves. The nurse pays particular attention to the uniqueness of each family and works to plan the most useful interventions. A "cookbook" approach cannot be used because no single nursing approach will fit each family or individual. Cultural diversity is taken into account, as are the situations and stressors facing the person or the family at a given time. The nurse promotes client autonomy and helps clients learn to do as much as possible for themselves.

QSEN FOCUS ON QUALITY AND SAFETY EDUCATION FOR NURSES

Quality and Safety Education for Nurses (QSEN) Competencies

QSEN Competency	Competency Definition
Client-Centered Care	Recognize the client or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for client preferences, values, and needs.
Teamwork and Collaboration	Function effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision making to achieve quality care.
Evidence-Based Practice	Integrate best current evidence with clinical expertise and client/family preferences and values for delivery of optimal health care.
Quality Improvement	Use data to monitor the outcomes of care processes, and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems.
Safety	Minimizes risk for harm to clients and providers through both system effectiveness and individual performance.
Informatics	Use information and technology to communicate, manage knowledge, mitigate error, and support decision making.

Prepared by Gail Armstrong, DNP, ACNS-BC, CNE, Associate Professor, University of Colorado Denver College of Nursing.

LEVELS OF PREVENTION

Related to Public Health

Primary Prevention
The public health nurse develops a health education program for a population of school-age children that teaches them about the effects of smoking on health.

Secondary Prevention
The public health nurse provides toxin screenings for migrant workers who may be exposed to pesticides.

Tertiary Prevention
The public health nurse provides a diabetes clinic for a defined population of adults in a low-income housing unit in the community.

The nurse practicing CBN is more likely to give direct care to people than are nurses who practice from a community-oriented framework. To plan the most appropriate course of action, the nurse assesses client needs and the services available to meet those needs. Throughout care delivery, the nurse teaches and counsels

BOX 1.3 Definitions of the Three Key Nursing Modes in the Community

Community-Oriented Nursing Practice: A philosophy of nursing care delivery that involves generalist or specialist public health and community health nurses providing "health care" through community diagnosis and investigation of major health and environmental problems, health surveillance, monitoring, and evaluation of community and population health status to prevent disease and disability and promoting, protecting, and maintaining health to create conditions in which people can be healthy.

Public Health Nursing Practice: The synthesis of nursing and public health theory applied to promoting and preserving the health of populations. Practice focuses on the community as a whole and the effect of the community's health status (resources) on the health of individuals, families, and groups. The goal is to prevent disease and disability and promote and protect the health of the community as a whole. *Community health nurse* is a term that is often used interchangeably with *public health nurse.*

Community-Based Nursing Practice: A setting-specific practice in which "illness care" is provided for individuals and families where they live, work, and attend school. The emphasis is on acute and chronic care and the provision of comprehensive, coordinated, and continuous care. These nurses may be generalists or specialists in maternal–infant, pediatric, adult, or psychiatric mental health nursing.

APPLYING CONTENT TO PRACTICE

In this chapter emphasis is placed on defining and explaining public health nursing practice with populations. As the nurse works in the community, the focus of the practice will involve the three essential functions of public health and public health nursing: assessment, policy development, and assurance. The *Core Competencies for Public Health Professionals* developed by the Council on Linkages and revised in 2014 describes the skills of public health professionals, including nurses. It is these skills that the nurse will need to apply in the community setting. In the assessment function, one skill is the assessment of the health status of populations and the related determinants of health and illness. For policy development, one of the skills is the development of a plan to implement policy and programs. For the assurance function, one skill that public health nurses will need is to incorporate ethical standards of practice as the basis of all interactions with organizations, communities, and individuals. These skills can also be linked to the 10 essential services of public health nursing found on page 6. Assessment of health status is a skill needed for implementing essential service 1, the monitoring of health status to identify community problems. Development of a plan for policy and program implementation is a skill needed for essential service 5, supporting individual and community health efforts. Incorporating ethical standards is done in essential service 3 when informing, educating, and empowering people about health issues.

clients so they can more fully develop their own ways of taking care of themselves. Box 1.3 provides definitions of each of the three key modes of nursing practice seen in the community, with discussion of PHN and community health nursing combined.

CHALLENGES FOR THE FUTURE

Over the past few years, the places in which care is given have changed dramatically. In previous decades the majority of care was given in an inpatient setting. At present, the trend is to move more care into community settings and to reduce the number of hospital days for "sick" clients. A variety of reasons explain the change. First, community care is often much less expensive than hospital care. Because the cost of health care in the United States has risen considerably over the past decade, it is increasingly necessary to find new ways to deliver care that are accessible to the recipients, less expensive, and of adequate quality to meet client needs. Also, care in the community is usually more appealing to people who prefer to remain at home rather than be treated in a hospital. Currently, care is given in homes, in schools, at the work site, and in a variety of outpatient clinics. This trend is predicted to grow, and it is expected that the role of the nurse in community settings will likewise grow and continue to change. Many factors will affect the changing role of the nurse in the community, such as new and emerging infectious diseases, the need for emergency preparedness, increases in chronic illness, and the continued reduction of numbers of days in the hospital for serious illnesses. As a result of the Affordable Care Act and other changes in health care delivery, massive changes are occurring in how care is delivered and where. The primary focus of the health care system of the future will likely be on community-oriented strategies for health promotion and disease prevention and on community-based strategies for primary and secondary care. With the focus on quality and safety education for nurses, public health nursing education will likely focus more attention toward assisting nurses to develop competencies focused on population health, as noted in the box on the QSEN competencies.

PRACTICE APPLICATION

Debate with classmates where and how PHN specialists practice and how their practice compares with what has been defined as CBN. Be specific about the differences.

Debate with classmates which of the nurses in the following categories are practicing population-focused nursing:

A. School nurses
B. Staff nurses in home care
C. Director of nursing for a home-care agency
D. Nurse practitioners in a health maintenance organization
E. Vice president of nursing in a hospital
F. Staff nurses in a public health clinic or community health center
G. Director of nursing in a health department

Choose three categories from the previous list, then interview at least one nurse in each category.

1. Determine the scope of their practice.
2. Are they carrying out population-focused practice?
3. Could they?
4. How?
5. Ask them if they would change their roles if this were possible.
6. Inquire whether they believe their role is either community-oriented nursing or CBN practice. Compare and contrast their answers with what you have learned about these roles.

Answers can be found on the Evolve website.

REMEMBER THIS!

- Public health is what members of a society do collectively to ensure that conditions exist in which people can be healthy.
- Assessment, policy development, and assurance are the core public health functions at all levels of government.
- Assessment refers to systematically collecting data on the population, monitoring of the population's health status, and making information available on the health of the community.
- Policy development refers to the need to provide leadership in developing policies that support the health of the population, including the use of the scientific knowledge base in decision making about policy.
- Assurance refers to the way public health practice makes sure that essential community-wide health services are available. This may include providing essential personal health services for those who would otherwise not receive them. Assurance also includes making sure that a competent public health and personal health care workforce is available.
- The setting is frequently viewed as the feature that distinguishes PHN from other specialties. A more useful approach is to use characteristics such as the following: a focus on populations of individuals who live in the community, an emphasis on prevention, concern for the interface between the health status of the population and the environment (e.g., physical, biological, sociocultural), and the use of political processes to influence public policy to achieve goals.
- Specialization in PHN is seen as a subset of community-oriented nursing practice.
- Population-focused practice is the focus of specialization in PHN. The focus on populations in the community and the emphasis on health protection, health promotion, and disease prevention are the fundamental factors that distinguish PHN from other nursing specialties.
- *Population* is defined as a collection of individuals who share one or more personal or environmental characteristics. The term *population* may be used interchangeably with the term *aggregate.*

EVOLVE WEBSITE

http://evolve.elsevier.com/Stanhope/foundations

- Case Study, with Questions and Answers
- NCLEX® Review Questions
- Practice Application Answers

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CHAPTER 2

The History of Public Health and Public and Community Health Nursing

Janna Dieckmann

OBJECTIVES

After reading this chapter, the student should be able to:

1. Discuss historical events that have influenced how current health care is delivered in the community.
2. Trace the ongoing interaction between the practice of public health and that of nursing.
3. Explain significant historical trends that have influenced the development of public health nursing.
4. Examine the contributions of Florence Nightingale, Lillian Wald, and Mary Breckinridge and the influence these three nursing leaders had on current public health and nursing.
5. Examine the ways in which nursing has been provided in the community, including settlement houses, visiting nurse associations, official health organizations, and schools.
6. Discuss the status of public health nursing in the 21st century, including the major organizations that have contributed to the current state of public health nursing.

CHAPTER OUTLINE

KEY TERMS

American Association of Colleges of Nursing (AACN), 26
American Nurses Association (ANA), 26
American Public Health Association (APHA), 21
American Red Cross, 20
Breckinridge, Mary, 22
district nursing, 17
district nursing association, 18
Frontier Nursing Service (FNS), 22
instructive district nursing, 18
Metropolitan Life Insurance Company, 21
National League for Nursing (NLN), 26
National Organization for Public Health Nursing (NOPHN), 20
Nightingale, Florence, 17
official health agencies, 24
Rathbone, William, 18
settlement houses, 18
Shattuck Report, 17
Social Security Act of 1935, 24
visiting nurse associations, 18
visiting nurses, 18
Wald, Lillian, 18

One of the best ways to understand today and plan for tomorrow is to examine the past. This is certainly true for public health and public health nursing. Nurses use historical approaches to examine both the profession's present and its future. Questions are asked: What worked in the past? What did not work? What lessons can be learned about health care, nursing, and the communities in which care is provided? During times of rapid social change, it is important to examine history and try to learn from the events of the past and build on the events and actions that were effective. This chapter serves as an introduction to an examination of the past in terms of both public health and nursing.

For nearly 125 years, public health nurses in the United States have worked to develop strategies to respond effectively to public health problems. Public health is an interdisciplinary specialty that emphasizes prevention. Nurses have worked in communities to improve the health status of individuals, families, and populations, especially those who belong to vulnerable groups. This work has not been easy for many reasons. One reason is that it is more difficult to measure the effects of prevention than it is to measure the effects of treatment. In recent years, as health care costs have grown, it has become increasingly important to emphasize prevention.

Many varied and challenging public health nursing roles originated in the late 1800s, when public health efforts focused on environmental conditions such as sanitation, control of communicable diseases, education for health, prevention of disease and disability, and care of aged and sick persons in their homes.

Although the threats to health have changed over time, the foundational principles and goals of public health nursing have remained the same. Many communicable diseases, such as diphtheria, cholera, and typhoid fever, have been largely controlled in the United States, but others, such as HIV, tuberculosis, and hepatitis, continue to affect many lives around the world. Emerging communicable diseases, such as the varying types of influenza, illustrate the global nature of health threats. Even though environmental pollution in residential areas has been reduced, communities are now threatened by emissions from the many vehicles on their roads, overcrowded garbage dumps, and pollutants in the air, water, and soil. Natural disasters continue to challenge public health systems, and bioterrorism, natural disasters, and the many human-made disasters threaten to overwhelm existing resources. Research has identified means to avoid or postpone chronic disease, and nurses play an important role in helping implement strategies to modify individual and community risk factors and behaviors. Finally, with the increased numbers of older adults in the United States and their preference to remain at home, additional nursing services are required to sustain the frail, the disabled, and the chronically ill in the community.

Nurses who have worked in the community have done so to improve the health status of individuals, families, and populations. They have spent time, energy, and effort working with high-risk or vulnerable groups. Part of the appeal of public health nursing has been its autonomy of practice and independence in problem solving and decision making, in addition to the interdisciplinary nature of the specialty. This chapter describes the beginnings of public health, the role of nursing in the community, the contributions made by nurses to public health, and the influence of nurses on community health.

EARLY PUBLIC HEALTH

People in all cultures have been concerned with the events surrounding birth, illness, and death. They have tried to prevent, understand, and control disease. Their ability to preserve health and treat illness has depended on their knowledge of science, the use and availability of technologies, and the degree of social organization. For example, ancient Babylonians understood the need for hygiene and had some medical skills. The Egyptians in approximately 1000 BCE (before the Common Era) developed a variety of pharmaceutical preparations and constructed earth privies and public drainage systems. In England, the Elizabethan Poor Law of 1601 guaranteed assistance for poor, blind, and "lame" individuals. This minimal care was generally provided in almshouses supported by local government. The goal was to regulate the poor and provide a refuge during illness.

The Industrial Revolution in 19th-century Europe led to social changes while making great advances in technology, transportation, and communication. Previous caregiving structures, which relied on families, neighbors, and friends, became inadequate because of migration, urbanization, and increased demand. During this period, small numbers of Roman Catholic and Protestant religious women provided nursing care in institutions and sometimes in the home. Many lay women who performed nursing functions in almshouses and early hospitals in Great Britain were poorly educated and untrained. As the practice of medicine became more complex in the mid-1800s, hospital work required a more skilled caregiver. Physicians and community advocates wanted to improve the quality of nursing services. Early experiments led to some improvement in care, but it was because of the efforts of Florence Nightingale that health care was revolutionized when she founded the profession of nursing.

PUBLIC HEALTH DURING AMERICA'S COLONIAL PERIOD AND THE NEW REPUBLIC

In the early years of America's settlement, as in Europe, the care of the sick was usually informal and was provided by women. The female head of the household typically supervised care during sickness and childbirth and also grew and gathered healing herbs to use throughout the year. This traditional system of care became insufficient as the number of urban residents grew in the early 1800s.

British settlers in the New World influenced the American ideas of social welfare and care of the sick. Just as American law is based on English common law, colonial Americans established systems of care for the sick, poor, aged, mentally ill, and dependents based on England's Elizabethan Poor Law of 1601. Early county or township government was responsible for the care of all dependent residents but provided almshouse charity carefully, economically, and only for local residents. Travelers and people who lived elsewhere were returned to their native counties for care. Few hospitals existed and then only in the larger cities. Pennsylvania Hospital was founded in Philadelphia in 1751 and was the first hospital in what would become the United States.

Early colonial public health efforts included the collection of vital statistics, improvements to sanitation systems, and control of any communicable diseases brought in at the seaports. The colonists did not have a system to ensure that public health efforts were supported or enforced. Epidemics often occurred and strained the limited local organization for health during the 17th, 18th, and 19th centuries (Rosen, 1958).

After the American Revolution, the threat of disease, especially yellow fever, led to public support for establishing government-sponsored, or official, boards of health. By 1800, New York City, with a population of 75,000, had established public health services, which included monitoring water quality, constructing sewers and a waterfront wall, draining marshes, planting trees and vegetables, and burying the dead (Rosen, 1958).

Industrialization attracted increasing numbers of urban residents, leading to inadequate housing and sanitation complicated by epidemics of smallpox, yellow fever, cholera, typhoid, and typhus. Tuberculosis and malaria were always present, and infant mortality was approximately 200 per 1000 live births (Pickett and Hanlon, 1990). American hospitals in the early 1800s were generally unsanitary and staffed by poorly trained workers. Physicians had limited education, and medical care was scarce. Public dispensaries, similar to outpatient clinics, and private charitable efforts tried to provide some care for the poor.

The federal government focused its early public health work on providing health care for merchant seamen and protecting seacoast cities from epidemics. The Public Health Service, still

the most important federal public health agency in the 21st century, was established in 1798 as the Marine Hospital Service. The first Marine Hospital opened in Norfolk, Virginia, in 1800. Additional legislation to establish quarantine regulations for seamen and immigrants was passed in 1878.

In the first half of the 1800s, some agencies began to provide lay nursing care in clients' homes, including the Ladies' Benevolent Society of Charleston, South Carolina (Buhler-Wilkerson, 2001); lay nurses in Philadelphia; and visiting nurses in Cincinnati, Ohio (Rodabaugh and Rodabaugh, 1951). Although these programs provided useful services, they were not adopted elsewhere. Table 2.1 presents milestones of public health efforts that occurred during the 17th, 18th, and 19th centuries.

During the mid-1800s, national interest increased in addressing public health problems and improving urban living conditions. New responsibilities for urban boards of health reflected changing ideas of public health as the boards began to address communicable diseases and environmental hazards. Soon after it was founded in 1847, the American Medical Association (AMA) formed a hygiene committee to conduct sanitary surveys and develop a system to collect vital statistics. The **Shattuck Report,** published in 1850 by the Massachusetts Sanitary Commission, was the first attempt to describe a model approach to the organization of public health in the United States. This report called for broad changes to improve the public's health: the establishment of a state health department and local health boards in every town; sanitary surveys and collection of vital statistics; environmental sanitation; food, drug, and communicable disease control; well-child care; health education; tobacco and alcohol control; town planning; and the teaching of preventive medicine in medical schools (Kalisch and Kalisch, 1995). It took 19 years for these recommendations to be implemented in Massachusetts, and they were added in other states much later.

TABLE 2.1 Milestones in the History of Community Health and Public Health Nursing: 1600–1865

Year	Milestone
1601	Elizabethan Poor Law written
1617	Sisterhood of the Dames de Charité organized in France by St. Vincent de Paul
1789	Baltimore Health Department established
1798	Marine Hospital Service established; later became Public Health Service
1812	Sisters of Mercy established in Dublin, Ireland, where nuns visited the poor
1813	Ladies Benevolent Society of Charleston, South Carolina, founded
1836	Lutheran deaconesses provided home visits in Kaiserwerth, Germany
1851	Florence Nightingale visited Kaiserwerth, Germany, for 3 months of nurse training
1855	Quarantine Board established in New Orleans; beginning of tuberculosis campaign in the United States
1859	District nursing established in Liverpool, England, by William Rathbone
1860	Florence Nightingale Training School for Nurses established at St. Thomas Hospital in London
1864	Beginning of Red Cross

In some areas, charitable organizations addressed the gap between known communicable disease epidemics and the lack of local government resources. For example, the Howard Association of New Orleans, Louisiana, responded to periodic yellow fever epidemics between 1837 and 1878 by providing physicians, lay nurses, and medicine for the sick. The Howard Association established infirmaries and used sophisticated outreach strategies to locate cases (Hanggi-Myers, 1995).

NIGHTINGALE AND THE ORIGINS OF TRAINED NURSING

Even with the growth of technology during this time, cities lacked important public health systems, such as sewage disposal, and also depended on private enterprise for water supply. Previous caregiving structures, which relied on the assistance of family, neighbors, and friends, became inadequate in the early 19th century because of human migration, urbanization, and changing demand. During this period, a few groups of Roman Catholic and Protestant women provided nursing care for the sick, poor, and neglected in institutions and sometimes in the home. For example, Mary Aikenhead, also known by her religious name Sister Mary Augustine, organized the Irish Sisters of Charity in Dublin, Ireland, in 1815. These sisters visited the poor at home and established hospitals and schools (Kalisch and Kalisch, 1995).

Florence Nightingale's vision of trained nurses and her model of nursing education influenced the development of professional nursing and, indirectly, public health nursing in the United States. In 1850 and 1851, Nightingale studied nursing "system and method" during an extended visit to Pastor Theodor Fliedner at his Kaiserwerth, Germany, School for Deaconesses. Her work with Pastor Fliedner and the Kaiserwerth Lutheran deaconesses, with their systems of **district nursing,** later led her to promote nursing care for the sick in their homes.

During the Crimean War (1854–1856), the British military established hospitals for sick and wounded soldiers in Scutari in Asia Minor. The care of soldiers was poor, with cramped quarters, poor sanitation, lice and rats, not enough food, and inadequate medical supplies (Kalisch and Kalisch, 1995; Palmer, 1983). When the British public demanded improved conditions, Florence Nightingale asked to work in Scutari. Because of her wealth, social and political connections, and knowledge of hospitals, the British government sent her to Asia Minor with 40 women, 117 hired nurses, and 15 paid servants. In Scutari, Nightingale progressively improved the soldiers' health using a population-based approach that improved both environmental conditions and nursing care. Using simple epidemiology measures, she documented a decreased mortality rate from 415 per 1000 at the beginning of the war to 11.5 per 1000 at the end (Cohen, 1984; Palmer, 1983). Like Nightingale and her efforts in Scutari, public health nurses today identify health care needs that affect the entire population. They then mobilize resources and organize themselves and the community to meet these needs.

After the Crimean War, Nightingale returned to England in 1856. Her fame was established. She organized hospital nursing practices and nursing education in hospitals to replace untrained

lay nurses with Nightingale nurses. Nightingale thought that nursing should promote health and prevent illness, and she emphasized proper nutrition, rest, sanitation, and hygiene (Nightingale, 1894, 1946).

In 1859 British philanthropist **William Rathbone** founded the first **district nursing association** in Liverpool, England. His wife had received excellent care from a Nightingale nurse during her terminal illness. He wanted to provide similar care to poor and needy people. Together the work of Nightingale and Rathbone led to the organization of district nursing in England (Nutting and Dock, 1935).

During the last quarter of the 1800s, the number of jobs for women rapidly increased. Educated women became teachers, secretaries, or saleswomen, and less-educated women worked in factories. As it became more acceptable to work outside the home, women were more willing to become nurses. The first nursing schools based on the Nightingale model opened in the United States in the 1870s. The early graduate nurses worked as private duty nurses or were hospital administrators or instructors. The private duty nurses often lived with the families for whom they cared. Because it was expensive to hire private duty nurses, only the well-to-do could afford their services. Community nursing began in an effort to meet urban health care needs, especially for the disadvantaged, by providing visiting nurses. In 1877 in New York City, trained nurse Francis Root was hired by a New York City mission to visit and care for the sick poor in their homes.

Visiting nurses took care of several families each day (rather than attending to only one client or family as the private duty nurse did), which made their care more economical. The visiting nurse became the key to communicating the prevention campaign, through home visits and well-baby clinics. Visiting nurses worked with physicians, gave selected treatments, and kept temperature and pulse records. Visiting nurses emphasized education of family members in the care of the sick and in personal and environmental prevention measures, such as hygiene and good nutrition (Fig. 2.1). The movement grew, and **visiting nurse associations** were established in Buffalo (1885), Philadelphia (1886), and Boston (1886). Wealthy people interested in charitable activities funded both settlement houses and visiting nurse associations. Wealthy upper-class women who were freed at this time from social restrictions were instrumental in doing charitable work and in supporting the early visiting nurses.

The public wanted to limit disease among all classes of people, partly for religious reasons, partly as a form of charity, but also because the middle and upper classes were afraid of diseases that were prevalent in the large communities of European immigrants. During the 1890s in New York City, about 2,300,000 people were packed into 90,000 tenement houses. The environmental conditions of immigrants in tenement houses and sweatshops were familiar features of urban life across the northeastern United States and upper Midwest. From the beginning, community nursing practice included teaching and prevention (Fig. 2.2). Community interventions led to improved sanitation, economic improvements, and better nutrition. These interventions were credited with reducing the incidence of acute communicable disease by 1901.

In 1886 in Boston, two women, to improve their chances of gaining financial support for their cause, coined the term **instructive district nursing** to emphasize the relationship of nursing to health education. Support for these nurses was also secured from the Women's Education Association, and the Boston Dispensary provided free outpatient medical care. In February 1886 the first district nurse was hired in Boston, and in 1888 the Instructive District Nursing Association was incorporated as an independent voluntary agency (Brainard, 1922).

Other nurses established **settlement houses** and neighborhood centers, which became hubs for health care and social welfare programs. For example, in 1893 trained nurses **Lillian Wald** (Fig. 2.3) and Mary Brewster began visiting the poor on

FIG. 2.1 Public health nurse demonstrating well-child care during a home visit. (Courtesy Visiting Nurse Service of New York.)

FIG. 2.2 Teaching well-child care was a significant public health nursing role. (Courtesy Instructional Visiting Nurse Association of Richmond, Virginia.)

FIG. 2.3 Lillian Wald. (Courtesy Visiting Nurse Service of New York.)

New York's Lower East Side. They established a nurses' settlement that became the Henry Street Settlement and later the Visiting Nurse Service of New York City. By 1905, public health nurses had provided almost 48,000 visits to more than 5000 clients (Kalisch and Kalisch, 1995). Lillian Wald emerged as a prominent leader of public health nursing during these decades (Box 2.1). Lillian Wald demonstrated an exceptional ability to develop approaches and programs to solve the health care and social problems of her times. We can learn much from her that can be applied to today's nursing practice.

Jessie Sleet (Scales), a Canadian graduate of Provident Hospital School of Nursing (Chicago), became the first African American public health nurse when she was hired in 1900 by the New York Charity Organization Society. Although it was hard for her to find an agency willing to hire her as a district nurse, she persevered and was able to provide exceptional care for her clients until she married in 1909. At the Charity Organization Society in 1904 to 1905, she studied health conditions related to tuberculosis among African American people in Manhattan using interviews with families and neighbors, house-to-house canvassing, direct observation, and speeches at neighborhood churches. Sleet reported her research to the Society board, recommending improved employment opportunities for African Americans and better prevention strategies to reduce the excess burden of tuberculosis morbidity and mortality among the African American population (Buhler-Wilkerson, 2001; Hine, 1989; Mosley, 1994; Thoms, 1929).

BOX 2.1 Lillian Wald: First Public Health Nurse in the United States

Public health nursing evolved in the United States in the late 19th and early 20th centuries largely because of the pioneering work of Lillian Wald. Born on March 10, 1867, Lillian Wald decided to become a nurse after Vassar College refused to admit her at 16 years of age. She graduated in 1891 from the New York Hospital Training School for Nurses and spent the next year working at the New York Juvenile Asylum. To supplement what she thought had been inadequate training in the sciences, she enrolled in the Woman's Medical College in New York (Frachel, 1988).

Having grown up in a warm, nurturing family in Rochester, New York, her work in New York City introduced her to an entirely different side of life. In 1893, while conducting a class in home nursing for immigrant families on the Lower East Side of New York, Wald was asked by a small child to visit her sick mother. Wald found the mother in bed after childbirth, having hemorrhaged for 2 days. This home visit confirmed for Wald all of the injustices in society and the differences in health care for poor persons versus those persons able to pay (Frachel, 1988).

She believed poor people should have access to health care. With her friend Mary Brewster and the financial support of two wealthy laypeople, Mrs. Solomon Loeb and Joseph H. Schiff, she moved to the Lower East Side and occupied the top floor of a tenement house on Jefferson Street. This move eventually led to the establishment of the Henry Street Settlement. In the beginning, Wald and Brewster helped individual families. Wald believed that the nurse's visit should be friendly, more like a visit from a friend than from someone paid to visit (Dolan, 1978).

Wald used epidemiological methods to campaign for health-promoting social policies to improve environmental and social conditions that affected health. She not only wrote *The House on Henry Street* to describe her own public health nursing work, but she also led in the development of payment by life insurance companies for nursing services (Frachel, 1988).

In 1909, along with Lee Frankel, Lillian Wald established the first public health nursing program for life insurance policyholders at the Metropolitan Life Insurance Company. She advocated that nurses at agencies such as the Henry Street Settlement provide complex nursing care. Wald convinced the company that it would be more economical to use the services of public health nurses than to employ its own nurses. She also convinced the company that services could be available to anyone desiring them, with fees scaled according to the ability to pay. This nursing service designed by Wald continued for 44 years and contributed several significant accomplishments to public health nursing, including the following (Frachel, 1988):

1. Providing home nursing care on a fee-for-service basis
2. Establishing an effective cost-accounting system for visiting nurses
3. Using advertisements in newspapers and on radio to recruit nurses
4. Reducing mortality from infectious diseases

Lillian Wald also believed that the nursing efforts at the Henry Street Settlement should be aligned with an official health agency. She therefore arranged for nurses to wear an insignia that indicated that they served under the auspices of the Board of Health. Also, she led the establishment of rural health nursing services through the Red Cross. Her other accomplishments included helping to establish the Children's Bureau and fighting in New York City for better tenement living conditions, city recreation centers, parks, pure food laws, graded classes for mentally handicapped children, and assistance to immigrants (Backer, 1993; Dock, 1922; Frachel, 1988; Zerwekh, 1992).

Data from Backer BA: Lillian Wald: connecting caring with action, *Nurs Health Care* 14:122-128, 1993; Dock LL: The history of public health nursing, *Public Health Nurs* 14:522, 1922; Dolan J: *History of nursing,* ed 14, Philadelphia, 1978, Saunders; Frachel RR: A new profession: the evolution of public health nursing, *Public Health Nurs* 5:86-90, 1988; and Zerwekh JV: Public health nursing legacy: historical practical wisdom, *Nurs Health Care* 13:84-91, 1992.

The **American Red Cross,** through its Rural Nursing Service (later the Town and Country Nursing Service), initiated home nursing care in areas outside larger cities. Lillian Wald secured the initial donations to support this agency, which provided care to the sick, instruction in sanitation and hygiene in rural homes, and improved living conditions in villages and farms. These nurses dealt with diseases such as tuberculosis, pneumonia, and typhoid fever. By 1920, 1800 Red Cross Town and Country Nursing Services were in operation. This number eventually grew to almost 3000 programs in small towns and rural areas.

The emphasis of community nursing has varied and changed over time. In recent years, federal and state financing has influenced the growth. In addition to visiting nurse associations and settlement houses, a variety of other organizations sponsored visiting nurse work, including boards of education, boards of health, mission boards, clubs, churches, social service agencies, and tuberculosis associations. With tuberculosis then responsible for at least 10% of all mortality, visiting nurses contributed to its control through gaining "the personal cooperation of patients and their families" to modify the environment and individual behavior (Buhler-Wilkerson, 1987, p 45). Most visiting nurse agencies depended financially on the philanthropy and social networks of metropolitan areas. As today, fund-raising and service delivery in less densely populated and rural areas were challenging. Learning about the history of a practice agency, such as a visiting nurse association, can provide important perspectives on current agency values, decision-making structures, funding, clinical priorities and service areas, and obstacles to success.

Occupational health nursing, originally called industrial nursing, grew out of early home visiting efforts. In 1895 Ada Mayo Stewart began work with employees and families of the Vermont Marble Company in Proctor, Vermont. As a free service for the employees, Stewart provided obstetrical care, sickness care (e.g., for typhoid cases), and some postsurgical care in workers' homes. However, she provided few services for work-related injuries. Although her employer provided a horse and buggy, she often made home visits on a bicycle. Before 1900 a few nurses were hired in industry, such as in department stores in Philadelphia and Brooklyn. Between 1914 and 1943, industrial nursing grew from 60 to 11,220 nurses, reflecting increased governmental and employee concerns for health and safety at work (American Association of Industrial Nurses, 1976; Kalisch and Kalisch, 1995).

School nursing was also an extension of home visiting. In New York City in 1902 more than 20% of children might be absent from school on a single day because of conditions such as pediculosis, ringworm, scabies, inflamed eyes, discharging ears, and infected wounds. Physicians began to make limited inspections of school students in 1897. They focused on excluding infectious children from school rather than on providing or obtaining medical treatment to enable children to return to school. Familiar with this community-wide problem from her work with the Henry Street Settlement, Lillian Wald introduced the English practice of providing nurses for the schools. Lina Rogers, a Henry Street Settlement resident, became the first school nurse. She worked with the children in New York City schools and made home visits to teach parents and to follow up on children absent from school. The school nurses found that many of the children were absent because they did not have shoes or clothing; many were hungry, and others had to take care of the younger children in the family (Hawkins, Hayes, and Corliss, 1994). School nursing was a success; New York City soon added 12 more nurses. School nursing was soon implemented in Los Angeles, Philadelphia, Baltimore, Boston, Chicago, and San Francisco. The scope of school nursing remains highly variable in the United States in the 21st century, and most school nurses are employed directly by a board of education.

CONTINUED GROWTH IN PUBLIC HEALTH NURSING

The *Visiting Nurse Quarterly,* begun in 1909 by the Cleveland Visiting Nurse Association, initiated a professional communication medium for clinical and organizational concerns. Also in 1909, the University of Minnesota began the first continuing nursing program given on a university campus. In 1911 a joint committee of existing nurse organizations convened, under the leadership of Wald and Mary Gardner, to standardize nursing services outside the hospital. They recommended the formation of a new organization to address public health nursing concerns. Their committee invited 800 agencies involved in public health nursing activities to send delegates to an organizational meeting in Chicago in June 1912. After a heated debate on its name and purpose, the delegates established the **National Organization for Public Health Nursing (NOPHN)** and chose Wald as its first president (Dock, 1922). Unlike other professional nursing organizations, the NOPHN membership included both nurses and their lay supporters. The NOPHN, which worked "to improve the educational and services standards of the public health nurse, and promote public understanding of and respect for her work" (Rosen, 1958, p 381), soon became the dominant force in public health (Roberts, 1955).

The NOPHN sought to standardize public health nursing education. At that time, newly graduated nurses often were unprepared for home visitation because the diploma schools emphasized care of hospital clients. Thus public health nurses needed education in how to care for the sick at home and to design population-focused programs. In 1914 Mary Adelaide Nutting, working with the Henry Street Settlement, began the first course for postdiploma school training in public health nursing at Teachers College in New York City (Deloughery, 1977). The American Red Cross provided scholarships for graduates of nursing schools to attend the public health nursing course. Its success encouraged the development of other programs, using curricula that might seem familiar to today's nurses. During the 1920s and 1930s, many newly hired public health nurses had to verify completion or promptly enroll in a certificate program in public health nursing. Others took leave for a year to travel to an urban center to obtain this further education. Correspondence courses (distance education) were

even acceptable in some areas, for example, for public health nurses in upstate New York.

Public health nurses were also active in the **American Public Health Association (APHA),** which was established in 1872 to facilitate interprofessional efforts and promote the "practical application of public hygiene" (Scutchfield and Keck, 1997, p 12). The APHA focused on important public health issues, including sewage and garbage disposal, occupational injuries, and sexually transmitted diseases. In 1923 the Public Health Nursing Section (PHNS) was formed within the APHA to provide nurses with a national forum to discuss their concerns and strategies within the larger context of the major public health organization. The PHNS continues to serve as a focus of leadership and policy development for public health nursing.

Public health nursing in voluntary agencies and through the Red Cross grew more quickly than public health nursing supported by local, state, and national government. In the late 1800s, local health departments were formed in urban areas to target environmental hazards associated with crowded living conditions and dirty streets and to regulate public baths, slaughterhouses, and pigsties (Pickett and Hanlon, 1990). By 1900, 38 states had established state health departments, following the lead of Massachusetts in 1869; however, these early state boards of health had limited impact because only three states—Massachusetts, Rhode Island, and Florida—annually spent more than 2 cents per capita for public health services (Scutchfield and Keck, 1997).

The federal role in public health gradually expanded. In 1912 the federal government redefined the role of the US Public Health Service, empowering it to "investigate the causes and spread of diseases and the pollution and sanitation of navigable streams and lakes" (Scutchfield and Keck, 1997, p 15). The NOPHN loaned a nurse to the US Public Health Service during World War I to establish a public health nursing program for military outposts. This led to the first federal government sponsorship of nurses (Shyrock, 1959; Wilner, Walkey, and O'Neill, 1978).

During the 1910s public health organizations began to target infectious and parasitic diseases in rural areas. The Rockefeller Sanitary Commission, a philanthropic organization active in hookworm control in the southeastern United States, concluded that concurrent efforts for all phases of public health were necessary to successfully address any individual public health problem (Pickett and Hanlon, 1990). For example, in 1911 efforts to control typhoid fever in Yakima County, Washington, and to improve health status in Guilford County, North Carolina, led to the establishment of local health units to serve local populations. Public health nurses were the primary staff members of local health departments. These nurses assumed a leadership role on health care issues through collaboration with local residents, nurses, and other health care providers.

The experience of Orange County, California, during the 1920s and 1930s illustrates the growing importance of the nurse in the community. Based on the work of a private physician, social welfare agencies, and a Red Cross nurse, the county board created the public health nurse's position in 1922. Presented with a shining new Model T car sporting the bright orange seal of the county, the nurse began her work by dealing with the serious communicable disease problems of diphtheria and scarlet fever. Typhoid became epidemic when a drainage pipe overflowed into a well, infecting those who drank the water and those who drank raw milk from an infected dairy. Almost 3000 residents were immunized against typhoid. At weekly well-baby conferences, the nurse weighed infants and gave them immunizations and taught mothers how to care for the infants. Also, children with orthopedic disorders and other disabilities were identified and referred for medical care in Los Angeles. The first year of this public health nursing work was so successful that the Rockefeller Foundation and the California Health Department provided funds for more public health professionals.

PUBLIC HEALTH NURSING DURING THE EARLY 20TH CENTURY

The personnel needs of World War I in Europe depleted the ranks of public health nurses, even as the NOPHN identified a need for second and third lines of defense within the United States. Jane Delano in 1909 was appointed both as superintendent of the Army Nurse Corps and chairman of the National Committee on Red Cross Nursing services. She was instrumental in preparing nurses to serve in the military, and she also supported the need for public health nurses to stay at home and serve the needs of those not serving in the military. Over 3 weeks in 1918 the worldwide influenza pandemic swept across the United States. A coalition of the NOPHN and the Red Cross worked to turn houses, churches, and social halls into hospitals for the immense numbers of sick and dying. Some of the nurse volunteers died of influenza.

Limited funding during the early 20th century was the major obstacle to extending nursing services in the community. Most early visiting nurse associations relied on contributions from wealthy and middle-class supporters. Consistent with the goal of encouraging economic independence, poor families were asked to pay a small fee for nursing services. In 1909 with encouragement from Lillian Wald in collaboration with Dr. Lee Frankel, the **Metropolitan Life Insurance Company** began a program using visiting nurse organizations to provide care for sick policyholders. The nurses assessed illness, taught health practices, and collected data from policyholders. By 1912, 589 Metropolitan Life nursing centers provided care through existing agencies or visiting nurses hired directly by the company. In 1918 Metropolitan Life calculated an average decline of 7% in the mortality rate of policyholders and almost a 20% decline in the mortality rate of policyholders' children under the age of 3 years. The insurance company attributed this improvement and its reduced costs to the work of visiting nurses.

Nurses also influenced public policy by advocating for the Children's Bureau and the Sheppard-Towner Program. Wald and other nursing leaders urged that the Children's Bureau be established in 1912 to address national problems of maternal and child welfare. Children's Bureau experts conducted extensive scientific research on the effects of income, housing, employment, and other factors on infant and maternal mortality. Their research led to federal child labor laws and the 1919

BOX 2.2 Mary Breckinridge and the Frontier Nursing Service

Born in 1881 into the fifth generation of a well-to-do Kentucky family, Mary Breckinridge devoted her life to the establishment of the Frontier Nursing Service (FNS). Learning from her grandmother, who used a large part of her fortune to improve the education of Southern children, Breckinridge later used money left to her by her grandmother to start the FNS (Browne, 1966).

Tutored in childhood and later attending private schools, Mary Breckinridge did not consider becoming a nurse until her husband died. At that time she wanted to have more adventure in her life and to find opportunities to do something useful for others (Hostutler et al, 2000). In 1907 she enrolled at St. Luke's Hospital School of Nursing in New York. She later married for a second time and had two children. Her second marriage ended after her daughter died at birth and her son died at age 4. From the time of her son's death in 1918, she devoted her energy to promoting the health care of disadvantaged women and children (Browne, 1966).

After World War I and work in postwar France, she returned to the United States, passionate about helping the neglected children of rural America. To prepare herself for what would become her life's work, she studied for a year at Teacher's College, Columbia University, to learn more about public health nursing (Browne, 1966).

Early in 1925 she returned to Kentucky. She decided that the mountains of Kentucky were an excellent place to demonstrate the value of community health nursing to remote, disadvantaged families. She thought that if she could establish a nursing center in rural Kentucky, this effort could then be duplicated anywhere. The first health center was established in a five-room cabin in Hyden, Kentucky. Establishing the center took not only nursing skills but also the construction of the center and later the hospital and other buildings; it required extensive knowledge about developing a water supply, disposing of sewage, getting electric power, and securing a mountain area in which landslides occurred (Browne, 1966). Despite many obstacles inherent in building in the mountains, six outpost nursing centers were established between 1927 and 1930. The FNS hospital was built in Hyden, Kentucky, and physicians began entering service. Payment of fees ranged from labor and supplies to funds raised through annual family dues, philanthropy, and the fund-raising efforts of Mary Breckinridge (Holloway, 1975).

The FNS established medical, surgical, and dental clinics; provided nursing and midwifery services 24 hours a day; and served nearly 10,000 people spread over 700 square miles. Baseline data were obtained on infant and maternal mortality before beginning services. FNS services are especially remarkable considering the environmental conditions in which rural Kentuckians lived. Many homes had no heat, electricity, or running water. Often physicians were located more than 40 miles from their patients (Tirpak, 1975).

During the 1930s, nurses lived in one of the six outposts, from which they traveled to see clients; they often had to make their visits on horseback. Like her nurses, Mary Breckinridge traveled many miles through the mountains of Kentucky on her horse, Babette, providing food, supplies, and health care to mountain families (Browne, 1966).

Over the years, several hundred nurses have worked for the FNS. Although Mary Breckinridge died in 1965, the FNS has continued to grow and provide needed services to people in the mountains of Kentucky. This service continues today as a vital and creative way to deliver community health services to rural families.

Data from Browne H: A tribute to Mary Breckinridge, *Nurs Outlook* 14:54-55, 1966; Goan MB: *Mary Breckinridge: the frontier nursing service and rural health in Appalachia,* Chapel Hill, NC, 2008, The University of North Carolina Press; Holloway JB: Frontier Nursing Service 1925-1975, *J Ky Med Assoc* 73:491-492, 1975; Hostutler J, Kennedy MS, Mason D, et al: Nurses: then and now and models of practice, *Am J Nurs* 100:82-83, 2000; Tirpak H: The Frontier Nursing Service: fifty years in the mountains, *Nurs Outlook* 33:308-310, 1975.

White House Conference on Child Health. The Sheppard-Towner Act of 1921, which focused on maternal and infant health, was credited with saving many lives. This act provided federal matching funds to establish maternal and child health divisions in state health departments. Education during home visits by public health nurses emphasized promoting the health of the mother and child and encouraged mothers to seek prompt medical care during pregnancy. Although credited with saving many lives, the program ended in 1929 in response to charges by the AMA and others that the legislation gave too much power to the federal government and too closely resembled socialized medicine (Pickett and Hanlon, 1990). Just as we see today, there has long been an inability to provide public health services because of the lack of funds.

Some nursing innovations were the result of individual commitment and private financial support. In 1925 **Mary Breckinridge** established the **Frontier Nursing Service (FNS).** This creative service was based on systems of care in Scotland (Box 2.2 and Fig. 2.4). The pioneering spirit of the FNS influenced the development of public health programs to improve the health care of the rural and often inaccessible populations in the Appalachian region of southeastern Kentucky (Browne, 1966; Tirpak, 1975). Breckinridge introduced the first nurse-midwives into the United States when she deployed FNS nurses trained in nursing, public health, and midwifery. Their efforts

FIG. 2.4 Mary Breckinridge, founder of the Frontier Nursing Service. (Courtesy Frontier Nursing Service of Wendover, Kentucky.)

led to reduced pregnancy complications and maternal mortality and to one-third fewer stillbirths and infant deaths in an area of 700 square miles (Kalisch and Kalisch, 1995). Today the FNS continues to provide comprehensive health and nursing services to the people of that area and sponsors the Frontier Nursing University.

AFRICAN AMERICAN NURSES IN PUBLIC HEALTH NURSING

African American nurses seeking to work in public health nursing faced many challenges. Nursing education was absolutely segregated in the South until at least the 1960s and elsewhere was also generally segregated or rationed until the mid-20th century. Even public health nursing certificate and graduate education programs were segregated in the South; study outside the South for Southern nurses was difficult to afford, and study leaves from the workplace were rarely granted. The situation improved somewhat in 1936 when collaboration between the US Public Health Service and the Medical College of Virginia (Richmond) established a certificate program in public health nursing for African American nurses for which the federal government paid nurses' tuition. Discrimination continued during nurses' employment: African American nurses in the American South were paid lower salaries than their white counterparts for the same work. In 1925 only 435 African American public health nurses were employed in the United States, and in 1930 only six African American nurses held supervisory positions in public health nursing organizations (Buhler-Wilkerson, 2001; Hine, 1989; Thoms, 1929).

African American public health nurses significantly influenced the communities they served (Fig. 2.5). The National Health Circle for Colored People was organized in 1919 to promote public health work in African American communities in the South. One strategy adopted was providing scholarships to assist African American nurses in pursuing university-level public health nursing education. Bessie M. Hawes, the first recipient of the scholarship, completed the program at Columbia University (New York) and was then sent by the Circle to Palatka, Florida. In this small, isolated lumber town, Hawes's first project was to recruit schoolgirls to promote health by dressing as nurses and marching in a parade while singing community songs. She conducted mass meetings, led clubs for mothers, provided school health education, and visited the homes of the sick. Eventually she gained the community's trust, overcame opposition, and built a health center for nursing care and treatment (Thoms, 1929).

FIG. 2.5 A New Orleans nurse visiting a family on the doorstep of their home. (Courtesy New Orleans Public Library WPA Photograph Collection.)

ECONOMIC DEPRESSION AND THE IMPACT ON PUBLIC HEALTH

The economic depression of the 1930s affected the development of nursing. Not only were agencies and communities unprepared to address the increased needs and numbers of the impoverished, but decreased funding for nursing services reduced the number of employed nurses in hospitals and in community agencies. Federal funding led to a wide variety of programs administered at the state level, including new public health nursing programs; as a result of NOPHN's enormous efforts, public health nursing was included in federal relief programs.

The Federal Emergency Relief Administration (FERA) supported nurse employment through increased grants-in-aid for state programs of home medical care. FERA often purchased nursing care from existing visiting nurse agencies, thus supporting more nurses and preventing agency closures. The FERA program focus varied among states; the state FERA program in New York emphasized bedside nursing care, whereas in North Carolina, the state FERA prioritized maternal and child health and school nursing services. The public health nursing programs of the FERA and its successor, the Works Progress Administration (WPA), were sometimes later incorporated into state health departments.

In another Depression-era initiative, more than 10,000 nurses were employed by the Civil Works Administration (CWA) programs and assigned to official health agencies. "While this facilitated rapid program expansion by recipient agencies and gave the nurses a taste of public health, the nurses' lack of field experience created major problems of training and supervision for the regular staff" (Roberts and Heinrich, 1985, p 1162).

A 1932 survey of public health agencies found that only 7% of nurses employed in public health were adequately prepared for that role (Roberts and Heinrich, 1985). Basic nursing education emphasized the care of individuals, and students received little information on groups and the community as a unit of service. Thus in the 1930s and early 1940s, new graduates required considerable remedial education when they were hired into public health work (NOPHN, 1944).

During this period the tension persisted between preventive care and care of the sick and the related question of whether nursing interventions should be directed toward groups and communities or toward individuals and their families. Although each nursing agency was unique and services varied from region to region, voluntary visiting nurse associations tended to emphasize care of the sick, and official public health agencies provided

more preventive services. Not surprisingly, this splintering of services led to a rivalry between "visiting," or community, and "public health" nurses and interfered with the development of comprehensive community nursing services (Roberts and Heinrich, 1985). For example, one household could receive services from several community nurses representing different agencies, with separate visits for a postpartum woman and new baby, for a child sick with scarlet fever, and for an elderly bedridden person. This was confusing and costly, with duplicated services.

One solution was to establish the "combination service," which merged sick-care services and preventive services into one comprehensive agency by combining visiting nurse and official public health agencies. However, in contrast to visiting nurse organizations, public health nurses in **official health agencies** often had less control of the program because physicians and politicians determined services and the assignment of personnel. The "ideal program" of the combination agency was hard to administer, and many of the combination services implemented between 1930 and 1965 later reverted to their former, divided structures of visiting nurse agencies and official health departments.

Expansion of federal government programs during the 1930s affected the structure of community health resources and led to "the beginning of a new era in public nursing" (Roberts and Heinrich, 1985, p 1162). In 1933 Pearl McIver became the first nurse employed by the US Public Health Service. In providing consultation services to state health departments, McIver was convinced that the strengths and ability of each state's director of public health nursing would determine the scope and quality of local health services. Together with Naomi Deutsch, director of nursing for the federal Children's Bureau, and with the support of nursing organizations, McIver and her staff of nurse consultants influenced the direction of public health nursing. Between 1931 and 1938 over 40% of the increase in public health nurse employment was in local health agencies. Even so, nationally, more than one-third of all counties still lacked local public health nursing services (Fig. 2.6).

The **Social Security Act of 1935** was designed to prevent reoccurrence of the problems of the Depression. Title VI of this act provided funding for expanded opportunities for health protection and promotion through education and employment of public health nurses. In 1936 more than 1000 nurses completed educational programs in public health. Title VI also provided $8 million to assist states, counties, and medical districts to establish and maintain adequate health services, as well as $2 million for research and investigation of disease (Buhler-Wilkerson, 1985, 1989; Kalisch and Kalisch, 1995).

In the late 1930s and especially in the late 1940s, Congress supported categorical funding to provide federal money for priority diseases or groups rather than for a comprehensive community health program. In response, local health departments designed programs to fit the funding priorities. This included maternal and child health services and crippled children (1935), venereal disease control (1938), tuberculosis (1944), mental health (1947), industrial hygiene (1947), and dental health (1947) (Scutchfield and Keck, 1997). This pattern of funding continues today.

World War II increased the need for nurses both for the war effort and at home. Many nurses joined the US Army and Navy Nurse Corps. US Representative Frances Payne Bolton of Ohio led Congress to pass the Bolton Act of 1943, which established the Cadet Nurses Corps. This legislation supported increased undergraduate and graduate enrollment in schools of nursing. Funding became more available to educate nurses by providing financial support for them to go to school, with many focusing on public health.

FIG. 2.6 A public health nurse talks with a young woman and her mother about childbirth as they sit on a porch. (US Public Health Service photo by Perry. Images from the History of Medicine, National Library of Medicine, Image ID 157037.)

Because of the number of nurses involved in the war, civilian hospitals and visiting nurse agencies shifted care to families and nonnursing personnel. "By the end of 1942, over 500,000 women had completed the American Red Cross home nursing course, and nearly 17,000 nurse's aides had been certified" (Roberts and Heinrich, 1985, p 1165). By the end of 1946, more than 215,000 volunteer nurse's aides had received certificates. During this time, community health nursing expanded its scope of practice. For example, more community health nurses practiced in rural areas, and many official agencies began to provide bedside nursing care (Buhler-Wilkerson, 1985; Kalisch and Kalisch, 1995).

After the war the need increased for services from local health departments to respond to sudden increases in demand for care of emotional problems, accidents, alcoholism, and other responsibilities new to official health agencies. Changes in medical technology improved the ability to screen and treat infectious and communicable diseases. Penicillin, which was developed during the war, became available to treat civilians with rheumatic fever, venereal diseases, and other infections. Job opportunities for public health nurses increased, and nurses were a major portion of health department staff. More than 20,000 nurses worked in health departments, visiting nurse associations, industry, and schools. Table 2.2 highlights significant milestones in community and public health nursing from the mid-1800s to the mid-1900s.

TABLE 2.2 Milestones in the History of Community Health and Public Health Nursing: 1866–1944

Year	Milestone
1866	New York Metropolitan Board of Health established
1872	American Public Health Association established
1873	New York Training School opened at Bellevue Hospital, New York City, as first Nightingale-model nursing school in the United States
1877	Women's Board of the New York Mission hired Frances Root to visit the sick poor
1885	Visiting Nurse Association established in Buffalo
1886	Visiting nurse agencies established in Philadelphia and Boston
1893	Lillian Wald and Mary Brewster organized a visiting nursing service for the poor of New York, which later became the Henry Street Settlement; Society of Superintendents of Training Schools of Nurses in the United States and Canada was established (in 1912 it became known as the National League for Nursing Education)
1896	Associated Alumnae of Training Schools for Nurses established (in 1911 it became the American Nurses Association)
1902	School nursing started in New York; Lina Rogers was the first school nurse
1903	First nurse practice acts
1909	Metropolitan Life Insurance Company initiated the first insurance reimbursement for nursing care
1910	Public health nursing program instituted at Teachers College, Columbia University, in New York City
1912	National Organization for Public Health Nursing formed, with Lillian Wald as the first president
1914	First undergraduate nursing education course in public health offered by Adelaide Nutting at Teachers College
1918	Vassar Camp School for Nurses organized; US Public Health Service (USPHS) established division of public health nursing to work in the war effort; worldwide influenza epidemic began
1919	Textbook *Public Health Nursing* written by Mary S. Gardner
1921	Maternity and Infancy Act (Sheppard-Towner Act)
1925	Frontier Nursing Service using nurse-midwives established
1934	Pearl McIver becomes the first nurse employed by USPHS
1935	Passage of the Social Security Act
1941	Beginning of World War II
1943	Passage of the Bolton-Bailey Act for nursing education; Cadet Nurse Program established; Division of Nursing begun at USPHS; Lucille Petry appointed chief of the Cadet Nurse Corps
1944	First basic program in nursing accredited as including sufficient public health content

FROM WORLD WAR II UNTIL THE 1970s

Between 1900 and 1955, the national crude mortality rate decreased by 47%. Many more Americans survived childhood and early adulthood to live into middle and older ages. Although in 1900 the leading causes of mortality were pneumonia, tuberculosis, diarrhea, and enteritis, by midcentury the leading causes had become heart disease, cancer, and cerebrovascular disease. Nurses helped reduce communicable disease mortality through immunization campaigns, nutrition education, and provision of better hygiene and sanitation. Additional factors included improved medications, better housing, and innovative emergency and critical care services.

Increasing numbers of older adults also increased the population at risk for increasing prevalence of chronic diseases. Nurses now dealt with challenges related to chronic illness care, long-term illness and disability, and chronic disease prevention. In official health agencies, categorical programs focusing on a single chronic disease emphasized narrowly defined services, which might be poorly coordinated with other community programs. Screening for chronic illness was a popular method of both detecting undiagnosed disease and providing individual and community education.

Some visiting nurse associations adopted coordinated home-care programs to provide complex, long-term care to the chronically ill, often after long-term hospitalization. These home-care programs established a multidisciplinary approach to complex client care. For example, beginning in 1949, the Visiting Nurse Society of Philadelphia provided care to clients with stroke, arthritis, cancer, and fractures using a wide range of services, including physical and occupational therapy, nutrition consultation, social services, laboratory and radiographic procedures, and transportation. During the 1950s, often in response to family demands and the shortage of nurses, many visiting nurse agencies began experimenting with auxiliary nursing personnel, variously called housekeepers, homemakers, or home health aides. These innovative programs provided a substantial basis for an approach to bedside nursing care that would be reimbursable by commercial health insurance (such as Blue Cross) and later by Medicare and Medicaid.

During the 1930s and 1940s, more Americans chose to obtain care in hospitals because this was where physicians worked and where technology was readily available to diagnose and treat illness. Health insurance programs now allowed middle-class people to pay for care in hospitals. In 1952 the Metropolitan Life Insurance Company and the John Hancock Life Insurance Company ended their support of visiting nurse services (Fig. 2.7) for their policyholders, and the American Red Cross ended its programs of direct nursing service.

Nursing organizations also continued to change. The functions of the NOPHN, the National League for Nursing Education, and the Association of Collegiate Schools of Nursing were

FIG. 2.7 A nurse from the Visiting Nurse Association demonstrates proper infant care and bathing techniques to the parents.

distributed to the new National League for Nursing (NLN) in 1952. The American Nurses Association (ANA) continued as the second national nursing organization, after merging with the National Association for Colored Graduate Nurses in 1951.

In 1948 the NLN adopted the recommendations of Esther Lucile Brown's study of nursing education, *Nursing for the Future,* and this considerably influenced how nurses were prepared. She recommended that basic nursing education take place in colleges and universities. In the 1950s, public health nursing became a required part of most baccalaureate nursing education programs. In 1952 nursing education programs began in junior and community colleges. Louise McManus, a director of the Division of Nursing Education at Teachers College, Columbia University, wanted to see if bedside nurses could be prepared in a 2-year program. The intent was to prepare nurses more quickly than in the past to ease the prevailing nursing shortage (Kalisch and Kalisch, 1995). This would also move more nursing education into American higher education. Mildred Montag, an assistant professor of nursing education at Teacher's College, became the project coordinator. In 1958, when the 5-year study was completed, this experiment was determined to be a success.

EVIDENCE-BASED PRACTICE

Nursing has a long and rich past, yet this is rarely conveyed to undergraduate nursing students; as a result, nurses devalue the achievements of earlier nurses. This chapter argues that studying the history of nursing has benefits for undergraduate students and the profession at large. It provides students with a realistic understanding of nursing and what has influenced past developments to bring us to the present situation. Thus it provides students with the context of nursing practice and a firm foundation on which other nursing courses can build. Introducing students to the history of nursing introduces them to a heritage of working in the community and in institutions; of working independently and interdependently; and of ongoing struggles to forge a professional status based on philanthropy, ethics, and, later, education. Studying the history of nursing, especially at the beginning of the undergraduate program, allows students to understand the factors that have influenced past events and how these factors continue to have an impact on nursing today and into the future.

In addition to the contextual benefits gleaned from the study of the history of nursing, fundamental critical thinking skills can be developed by encouraging students to question the evidence before them and seek influencing factors or the "bigger picture." Additional benefits include the ability to debunk some well-known myths that have affected nursing over the years, the ability to explore gender roles in nursing and discuss how gender affects today's practice, and the ability to understand the unwritten rules of the clinical environment.

Nurse Use

The influence of nursing should be valued and understood within the context of the time it was being practiced. Students who have an appreciation of nursing's past have a better understanding of nursing and who nurses are. With knowledge of the history of nursing, students can better understand that they are entering a profession with a rich and diverse past and that this can provide a firm platform on which to base their other studies. By studying the history of nursing, they also develop their critical thinking skills, which allows them to question and evaluate information that is presented to them on a daily basis.

From Madsen W: Teaching history to nurses: will this make me a better nurse? *Nurs Educ Today* 28:524-529, 2008.

Currently, associate degree nursing (ADN) programs educate the largest percentage of nurses. Both health care and ADN education have changed; both have moved away from a heavy focus on inpatient care to community-based care. Curricula in ADN programs often include content and clinical experiences in management, community health, home health, and gerontology. These clinical areas have typically been key components of baccalaureate education. The American Association of Colleges of Nursing (AACN) was founded in 1969 to respond to the need for an organization that would further nursing education in American universities and 4-year colleges, including establishing essentials of nursing education for baccalaureate and higher-degree programs.

New personnel also added to the flexibility of the public health nurse to address the needs of communities. Beginning in 1965 at the University of Colorado, the nurse practitioner movement opened a new era for nursing involvement in primary care that affected the delivery of services in community health clinics. Initially, the nurse practitioner was often a public health nurse with additional skills in the diagnosis and treatment of common illnesses. Although some nurse practitioners chose to practice in other clinical areas, those who continued in public health settings made sustained contributions to improving access and providing primary care to people in rural areas, inner cities, and other medically underserved areas (Roberts and Heinrich, 1985). As evidence of the effectiveness of their services grew, nurse practitioners became increasingly accepted as cost-effective providers of a variety of primary care services.

PUBLIC HEALTH NURSING FROM THE 1970s TO THE PRESENT

During the 1970s, nurses made many contributions to improving the health care of communities, including participation in the new hospice movement and through the development of birthing centers, daycare for elderly and disabled persons, drug-abuse treatment programs, and rehabilitation services in long-term care. Adequate funding for population health remained difficult to secure. Health care costs grew during the 1980s. Growing costs of acute hospital care, medical procedures, and institutional long-term care reduced funding for health promotion and disease prevention programs. The use of ambulatory services, including health maintenance organizations, was encouraged, and utilization of nurse practitioners (advanced-practice nurses) increased. Despite unstable reimbursement, home health care increased its role in the care of the sick at home. By the 1980s, individuals and families assumed more responsibility for their own health, and health education—always a part of community health nursing—became more popular. Consumer and professional advocacy groups urged the passage of laws to prohibit unhealthy practices in public, such as smoking and driving under the influence of alcohol. However, reduced federal and state funds led to decreases in the number of nurses in official public health agencies.

The Division of Nursing of the US Public Health Service conducted and sponsored nursing research beginning in the late 1930s. This expanded in the late 1940s (Uhl, 1965).

The National Center for Nursing Research (NCNR) was established in 1985 within the federal National Institutes of Health. The NCNR focused attention on the value of nursing research and promoted the work of nurses. With the effort of many nurses the NCNR attained institute (rather than center) status in 1993 and became the National Institute of Nursing Research (NINR), reflecting the continued growth in nursing research.

By the late 1980s the public health initiative had declined in its ability to implement its mission and influence the health of the public. The disarray resulting from reduced political support, financing, and effectiveness was clearly described by the Institute of Medicine (IOM) in *The Future of Public Health* (IOM, 1988). Although many people agreed about what the mission of public health should be, there was much less agreement about how to turn the mission of public health into action and effective programs. The IOM report emphasized the core functions of public health as assessment, policy development, and assurance.

The *Healthy People* initiative has influenced goals and priority setting in public health and in public health nursing. In 1979 *Healthy People* proposed a national strategy to improve the health of Americans significantly by preventing or delaying the onset of major chronic illnesses, injuries, and infectious diseases. Specific goals and objectives were established, and the goals were to be evaluated at the end of each decade. Implementation of these strategies has considerably influenced the work of nurses, through their employment in health agencies and through participation in state or local *Healthy People* coalitions (*Healthy People 2020* box). The most recent initiative, the development of *Healthy People 2020* (US Department of Health and Human Services, 2010) objectives, has built on the work of *Healthy People 2010* (US Department of Health and Human Services, 2000). Some objectives in *Healthy People 2010* have been met; others are being retained in *Healthy People 2020,* and new ones have been added. *Healthy People 2020* objectives and intervention strategies are included in each chapter of this text.

Since the 1990s, public concerns about health have focused on cost, quality, and access to services. Despite widespread interest in universal health insurance coverage, neither individuals nor employers are willing to pay for this level of service. The core debate of the economics of health care—who should pay for what—has emphasized the need for reform of medical care rather than comprehensive reform of health care. In 1993 a blue-ribbon group assembled by President Clinton, with First Lady Hillary Rodham Clinton serving as chair, proposed the American Health Security Act. This proposal led to broad discussion of the key issues and concerns in health care, especially the organization and delivery of medical care, with an emphasis on managed care. When Congress failed to pass the American Health Security Act, considerable change followed in health care financing, and the private sector assumed even greater control. As managed care grew, costs were contained, but constraints increased in terms of how to access care and how much and what kind of care would be reimbursed. Throughout these debates, public health was generally ignored. Little attention was given to ensuring that populations and the communities in which they lived were healthy. This omission reflected the large gap between the proposal and actual comprehensive health care reform.

In 1991 the ANA, AACN, NLN, and more than 60 other specialty nursing organizations joined to support health care reform. The coalitions of organizations emphasized the key health care issues of access, quality, and cost. Improved primary care and public health efforts would help build a healthy nation. Professional nursing continues to support revisions in health care delivery and extension of public health services to prevent illness, promote health, and protect the public (Table 2.3). Chapters 3 (The Changing US Health and Public Health Care Systems) and 8 (Economic Influences) describe the current work to change the way health is provided and who pays for the care.

TABLE 2.3 Milestones in the History of Community Health and Public Health Nursing: 1946–2013

Year	Milestone
1946	Nurses classified as professionals by US Civil Service Commission; Hill-Burton Act approved, providing funds for hospital construction in underserved areas and requiring these hospitals to provide care to poor people; passage of National Mental Health Act
1950	25,091 nurses employed in public health
1951	National nursing organizations recommended that college-based nursing education programs include public health content
1952	National Organization for Public Health Nursing merged into the new National League for Nursing; Metropolitan Life Insurance Nursing Program closed
1964	Passage of the Economic Opportunity Act; public health nurse defined by the American Nurses Association (ANA) as a graduate of a bachelor of science in nursing (BSN) program
1965	ANA position paper recommended that nursing education take place in institutions of higher learning; Congress amended the Social Security Act to include Medicare and Medicaid
1977	Passage of the Rural Health Clinic Services Act, which provided indirect reimbursement for nurse practitioners in rural health clinics
1978	Association of Graduate Faculty in Community Health Nursing/Public Health Nursing (later renamed Association of Community Health Nursing Educators)
1980	Medicaid amendment to the Social Security Act to provide direct reimbursement for nurse practitioners in rural health clinics; both ANA and the American Public Health Association (APHA) developed statements on the role and conceptual foundations of community and public health nursing, respectively
1983	Beginning of Medicare prospective payments
1985	National Center for Nursing Research (NCNR) established within the National Institutes of Health (NIH)
1988	Institute of Medicine published *The Future of Public Health*

Continued

TABLE 2.3 Milestones in the History of Community Health and Public Health Nursing: 1946–2013—cont'd

Year	Milestone
1990	Association of Community Health Nursing Educators published *Essentials of Baccalaureate Nursing Education*
1991	More than 60 nursing organizations joined forces to support health care reform and published a document entitled *Nursing's Agenda for Health Care Reform*
1993	American Health Security Act of 1993 was published as a blueprint for national health care reform; the national effort, however, failed, leaving states and the private sector to design their own programs
1993	NCNR became the National Institute for Nursing Research, as part of the National Institutes of Health
1993	Public Health Nursing section of the American Public Health Association updated the definition and role of public health nursing
1996	Passage of the Health Insurance Portability and Accountability Act
2001	Significant interest in public health ensues from concerns about biological and other forms of terrorism in the wake of the intentional destruction of buildings in New York City and Washington, D.C., on September 11
2002	Office of Homeland Security established to provide leadership to protect against intentional threats to the health of the public
2003–2005	Multiple natural disasters, including earthquakes, tsunamis, and hurricanes, demonstrated the weak infrastructure for managing disasters in the United States and other countries and emphasized the need for strong public health programs that included disaster management
2007	An entirely new *Public Health Nursing Scope and Standards of Practice* released through the ANA, reflecting the efforts of the Quad Council of Public Health Nursing Organizations
2010	Patient Protection and Affordable Care Act signed by President Barack Obama; *Healthy People 2020* realized by the US Department of Health and Human Services
2011	The Quad Council of Public Health Nursing Organizations published *Competencies for Public Health Nursing*
2013	The American Nurses Association published the second edition of *Public Health Nursing: Scope and Standards of Practice*
2013	The Quad Council of Public Health Nursing Organizations updated *Competencies for Public Health Nursing Practice*

HEALTHY PEOPLE 2020

History of the Development of Healthy People

In 1979 the groundbreaking *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* noted "the health of the American people has never been better" (US Department of Health, Education and Welfare, 1979, p 3). But this was only the prologue to deep criticism of the status of American health care delivery. Between 1960 and 1978, health care spending increased 700%—without striking improvements in mortality or morbidity. During the 1950s and 1960s, evidence accumulated about chronic disease risk factors, particularly cigarette smoking, alcohol and drug use, occupational risks, and injuries. But these new research findings were not systematically applied to health planning and to improving population health.

In 1974 the Canadian government published *A New Perspective on the Health of Canadians* (Lalonde, 1974), which found death and disease to have four contributing factors: inadequacies in the existing health care system, behavioral factors, environmental hazards, and human biological factors. Applying the Canadian approach, in 1976, US experts analyzed the 10 leading causes of US mortality and found that 50% of American deaths were the result of unhealthy behaviors, and only 10% were the result of inadequacies in health care. Rather than just spending more to improve hospital care, clearly, prevention was the key to saving lives, improving the quality of life, and saving health care dollars.

A multidisciplinary group of analysts conducted a comprehensive review of prevention activities. These analysts verified that the health of Americans could be significantly improved through "actions individuals can take for themselves" and through actions that public and private decision makers could take to "promote a safer and healthier environment" (p 9). Like Canada's *New Perspectives,* in the United States Healthy People (1979) identified priorities and measurable goals. *Healthy People* grouped 15 key priorities into three categories: key preventive services that could be delivered to individuals by health providers, such as timely prenatal care; measures that could be used by governmental agencies, organizations, and industry to protect people from harm, such as reduced exposure to toxic agents; and activities that individuals and communities could use to promote healthy lifestyles, such as improved nutrition.

In the late 1980s, success in addressing these priorities and goals was evaluated, new scientific findings were analyzed, and new goals and objectives were set for the period from 1990 to 2000 through *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (US Public Health Service, 1991). This process was repeated 10 years later to develop goals and objectives for the period from 2000 to 2010 and for 2010 to 2020. Recognizing the continuing challenge of the use of emerging scientific research to encourage modification of health behaviors and practices, *Healthy People 2020* (US Department of Health and Human Services, 2010) addresses health equity, elimination of disparities, and improved health for all groups across the life span through disease prevention, improved social and physical environments, and healthy development and health behaviors.

Like the nurse in the early 20th century who spread the gospel of public health to reduce communicable diseases, today's population-centered nurse uses *Healthy People* to reduce chronic and infectious diseases and injuries through health education, environmental modification, and policy development.

During the late 20th and early 21st centuries, challenges continued to trigger growth and change in nursing in the community. Nurse-managed centers now provide a diversity of nursing services, including health promotion and disease and injury prevention, in areas where existing organizations have been unable to meet community and neighborhood needs. These centers provide valuable services but typically face many challenges in securing adequate funding. As population needs also continue to grow and change, schools of nursing, health departments, rural health clinics, migrant health centers, and other community agencies are challenged to provide the range of services necessary to meet specific needs. Transfer of official health services to private control has sometimes reduced professional flexibility and service delivery. A nursing shortage reduces staffing when community nurses

look to employment in acute-care facilities that often pay higher salaries. The Association of Community Health Nurse Educators recommends increased graduate programs to educate public health nurse leaders, educators, and researchers. Natural disasters (e.g., floods, hurricanes, and tornados) and human-made disasters (including explosions, building collapses, airplane crashes, and toxic ingredients added to food) have required rapid, innovative, and time-consuming responses. Preparation for future disasters and possible bioterrorism requires well-prepared nurses. Some states hear new calls to deploy school nurses in every school; a new recognition of the link between school success and health is making the school nurse as essential as in Lillian Wald's era. Many of these topics are detailed in the chapters that follow.

The Affordable Care Act of 2010 has been controversial, and many compromises have been made between the House of Representatives and the Senate in the final crafting of this health care act. Much of the Affordable Care Act deals with changes in insurance plans and coverage. See http://www.healthcare.gov/news/factsheets/index.html for details about the Affordable Care Act.

Public health nursing, historically and at present, is characterized by reaching out to care for the health of people in need and providing safe and high-quality care where needed. Currently, many nurses work in the community. Some bring a public health population-based approach and have as their goal preventing illness and protecting health. Other nurses have a community-oriented approach and deal primarily with the health care of individuals, families, and groups in a community. Still other nurses bring a community-based approach that focuses on "illness care" of individuals and families in the community. Each type of nurse is needed in today's communities. It is important that we learn from the past and use time and resources carefully and effectively. Regardless of the level of education of the nurse who provides care in the community, including population-based care, all nurses need to provide care that is safe and of high quality. The accompanying box below describes the history of the Quality and Safety Education for Nurses (QSEN) initiative, which aims to include quality and safety knowledge, skills, and attitudes in all levels of nursing education.

QSEN FOCUS ON QUALITY AND SAFETY EDUCATION FOR NURSES

Although the scope and responsibilities of public health nurses have changed over time, the commitment to quality and safety has remained constant. Since the beginning of population-centered nursing in the United States, the nurses involved in this specialty have been committed to preserving health and preventing disease. They have focused on environmental conditions such as sanitation and control of communicable diseases, education for health, prevention of disease and disability, and, at times, care of the sick and aged in their homes. This long-standing commitment to quality and safety is consistent with the work of the QSEN, a national initiative designed to transform nursing education by including in the curriculum content and experiences related to building knowledge, skills, and attitudes for six quality and safety initiatives (Cronenwett, Sherwood, and Gelmon, 2009). The QSEN work, led by Drs. Linda Cronenwett and Gwen Sherwood at the University of North Carolina, has made great progress in bridging the gap between quality and safety in both practice and academic settings (Brown, Feller, and Benedict, 2010). The six QSEN competencies for nursing are as follows:

1. **Patient-centered care:** Recognizes the client or designee as the source of control and as a full partner in providing compassionate and coordinated care that is based on the preferences, values, and needs of the client.
2. **Teamwork and collaboration:** Refers to the ability to function effectively with nursing and interprofessional teams and to foster open communication, mutual respect, and shared decision making to provide quality client care.
3. **Evidence-based practice:** Integrates the best current clinical evidence with client and family preferences and values to provide optimal client care.
4. **Quality improvement:** Uses data to monitor the outcomes of the care processes and uses improvement methods to design and test changes to continually improve the quality and safety of health care systems.
5. **Safety:** Minimizes the risk of harm to clients and providers through both system effectiveness and individual performance.
6. **Informatics:** Uses information and technology to communicate, manage knowledge, mitigate error, and support decision making (Brown et al, 2010, p 116).

Of the six QSEN competencies, all but safety were derived from the IOM report *Health Professions Education* (2003). The QSEN team added safety because this competency is central to the work of nurses. Articles have been published to teach educators about QSEN, and national forums have been held. In addition, the AACN has hosted faculty-development institutes for faculty and academic administrators using a train-the-trainer model, and safety and quality objectives have been built in the AACN essentials for nursing education. Similarly, the NLN has incorporated the "NLN Educational Competencies Model" into its educational summits. The six QSEN competencies are integrated throughout the text to emphasize the importance of quality and safety in public health nursing today. *Note:* The terms *patient* and *care* will be changed to *client* and *intervention* to reflect a public health nursing approach.

Specifically related to the history of nursing, the following targeted competency can be applied:

Targeted Competency: Safety—Minimizes the risk of harm to clients and providers through both system effectiveness and individual performance.

Important aspects of safety include the following:

- **Knowledge:** Discuss potential and actual impact of national client safety resources initiatives and regulations
- **Skills:** Participate in analyzing errors and designing system improvements
- **Attitudes:** Value vigilance and monitoring by clients, families, and other members of the health care team

Safety Question

Updated definitions around client safety include addressing safety at the individual level and at the systems level. The history of public health nursing demonstrates the myriad ways that public health nurses have addressed client safety in their evolving practice. Public health nurses support safety by caring for individuals and providing care for communities and groups. Historically, how have public health nurses addressed safety at the individual client level? How have public health nurses addressed client safety at the systems level? How have public health nurses been involved in system improvements?

Answer: *Individual level: A rich part of public health nursing's history has been the development of home visitation, in which clients are cared for in their own environment. Similarly, public health nurses have improved client outcomes by pioneering new models of interventions for maternal–child health and individuals in rural communities.*

Systems level: *Through their work with communities, public health nurses were an integral part of reducing the incidence of communicable diseases by the mid-20th century. More recently, public health nursing has contributed to health care system improvements through the development of the hospice movement, birthing centers, daycare for elderly and disabled persons, and drug-abuse and rehabilitation services. These initiatives have updated the health care system to provide targeted care for previously overlooked populations.*

Prepared by Gail Armstrong, PhD, DNP, ACNS-BC, CNE, Associate Professor, University of Colorado College of Nursing.

Today, nurses look to their history for inspiration, explanations, and predictions. Information and advocacy are used to promote a comprehensive approach to addressing the multiple needs of the diverse populations served. Nurses will seek to learn from the past and to avoid known pitfalls, even as they seek successful strategies to meet the complex needs of today's vulnerable populations. The How To box describes how to conduct an oral history interview. This is one effective way to learn from the successes and failures of our predecessors.

HOW TO Conduct an Oral History Interview

1. Identify an issue or event of interest.
2. Gather information from written materials.
3. Find a person to interview.
4. Get permission from the person to do the interview, and make an appointment to do so.
5. Gather information about the person's background and the period of interest.
6. Write an outline of your questions. Use open-ended questions because they usually give you more information.
7. Meet with the person being interviewed; use a recording device.
8. Conduct the interview by asking only one question at a time and allowing adequate time for the reply.
9. Clarify points when needed; ask for examples; remember, most people like to talk about themselves.
10. After the interview, write it up as soon as possible when your recall is best.
11. Compare your written report with the audio recording. There may be times when you can ask the person interviewed to read your report for accuracy.

As plans for the future are made, as the public health challenges that remain unmet are acknowledged, it is the vision of what nursing can accomplish that sustains these nurses. Nurses continue to rely on both nursing and public health standards and competency guides to help chart their practice.

The ANA's (2013) *Scope and Standards of Public Health Nursing Practice,* the Council on Linkages' (2010) *Domains and Core Competencies,* and the Quad Council's (Swider et al, 2013) *Competencies of Public Health Nurses* each include the processes of assessment, analysis, and planning. Each also incorporates the importance of communication, cultural competency, policy, and public health skills in its recommendations for effective public health nurse practice. Specific to this chapter, the Council on Linkages (2014, p. 17) features a core competency under the domain of public health sciences skills: "Identifies prominent events in the history of public health." Moreover, the Quad Council (Swider et al, 2013) builds on this competency with an application to nursing under Domain 6 that a public health nurse "Describes the historical foundation of public health and public health nursing" (p 533).

APPLYING CONTENT TO PRACTICE

Public Health Nursing, a major journal in the field of public health nursing, publishes articles that broadly reflect contemporary research, practice, education, and public policy for population-based nurses. Begun in 1984, *Public Health Nursing* was published quarterly through 1993 and has been a bimonthly journal since 1994.

More than any other journal, *Public Health Nursing* has assumed responsibility for preserving the history of public health nursing and for publishing new historical research on the field. The contemporary *Public Health Nursing* shares its name with the official journal of the NOPHN in the period 1931 to 1952 (earlier names were used for the official journal from 1913 to 1931, which built on the *Visiting Nurse Quarterly,* published 1909 to 1913).

Public Health Nursing presents a wide variety of articles, including both new historical research and reprints of classic journal articles that deserve to be read and reapplied by modern public health nurses. For example, one historical article reprinted in *Public Health Nursing* addressed a nurse's 1931 work on county drought relief that underscores continuing professional themes of case-finding, collaboration, and partnership (Wharton, 1999). Original historical research presented in *Public Health Nursing* is extremely varied, from public health nursing education, to public health nurse practice in Alaska's Yukon, to excerpts from the oral histories of public health nurses. Contemporary nurses find inspiration and possibilities for modern innovations in reading the history of public health nursing in the pages of *Public Health Nursing.*

PRACTICE APPLICATION

Mary Lipsky has worked for a visiting nurse association in a large urban area for 2 years. She is responsible for a wide variety of services, including caring for older and chronically ill clients recently discharged from hospitals, new mothers and babies, mental health clients, and clients with long-term health problems, such as chronic wounds.

Daily when she leaves the field to go home, she finds that she continues to think about her clients. She keeps going over these and other questions in her mind: Why is it so difficult for mothers and new babies to qualify for and receive Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) services? Why must she limit the number of visits and length of service for clients with chronic wounds? Why are so few services available for clients with behavioral health problems? In particular, she thinks about the burdens and challenges that families and friends face in caring for the sick at home.

A. Why might it be difficult to solve these problems at the individual level, on a case-by-case basis?

B. What information would you need to build an understanding of the policy background for each of these various populations?

Answers can be found on the Evolve website.

REMEMBER THIS!

- A historical approach can be used to increase the understanding of public and community health nursing in the past and its contemporary dilemmas and future challenges.
- Public health and community health nursing are products of various social, economic, and political forces and incorporate public health science in addition to nursing science and practice.
- Federal responsibility for health care was limited until the 1930s, when the economic challenges of the Depression highlighted the need for and led to the expansion of federal assistance for health care.
- Florence Nightingale designed and implemented the first program of trained nursing, and her contemporary, William Rathbone, founded the first district nursing association in England.
- Urbanization, industrialization, and immigration in the United States increased the need for trained nurses, especially in public and community health nursing.
- The increasing acceptance of public roles for women permitted public and community health nursing employment for nurses and public leadership roles for their wealthy supporters.
- Frances Root was the first trained nurse in the United States who was salaried as a visiting nurse. She was hired in 1887 by the Women's Board of the New York City Mission to provide care to sick persons at home.
- The first visiting nurse associations were founded in 1885 and 1886 in Buffalo, Philadelphia, and Boston.
- Lillian Wald established the Henry Street Settlement, which became the Visiting Nurse Service of New York City, in 1893. She played a key role in innovations that shaped public and community health nursing in its first decades, including school nursing, insurance payment for nursing, national organizations for public health nurses, and the US Children's Bureau.
- Founded in 1902, with the vision and support of Lillian Wald, school nursing tried to keep children in school so that they could learn.
- The Metropolitan Life Insurance Company established the first insurance-based program in 1909 to support community health nursing services.
- The National Organization for Public Health Nursing (founded in 1912) provided essential leadership and coordination of diverse public and community health nursing efforts; the organization merged into the new National League for Nursing in 1952.
- Official health agencies slowly grew in numbers between 1900 and 1940, accompanied by a steady increase in public health nursing positions.
- The innovative Sheppard-Towner Act of 1921 expanded community health nursing roles for maternal and child health during the 1920s.
- Mary Breckinridge established the Frontier Nursing Service in 1925 to provide rural health care.
- The tension between the nursing roles of caring for the sick and of providing preventive care and the related tension between intervening for individuals and for groups have characterized the specialty since at least the 1910s.
- The challenges of World War II sometimes resulted in extension of community health nursing care and sometimes in retrenchment and decreased public health nursing services.
- By the mid-20th century, the reduced incidence of communicable diseases and the increased prevalence of chronic illness, accompanied by large increases in the population older than 65 years of age, led to a reexamination of the goals and organization of community health nursing services.
- From the 1930s to 1965, organized nursing and community health nursing agencies sought to establish health insurance reimbursement for nursing care at home.
- Implementation of Medicare and Medicaid programs in 1966 established new possibilities for supporting community-based nursing care but encouraged agencies to focus on postacute-care services rather than prevention.
- Efforts to reform health care organization, pushed by increased health care costs during the past 40 years, have focused on reforming acute medical care rather than on designing a comprehensive preventive approach.
- The 1988 *Future of Public Health* report documented the reduced political support, financing, and impact of increasingly limited public health services at the national, state, and local levels.
- In the late 1990s federal policy changes dangerously reduced financial support for home health care services, threatening the long-term survival of visiting nurse agencies.
- The *Healthy People* program has brought a renewed emphasis on prevention to public and community health nursing.
- In 2011 the Quad Council, an alliance of four national nursing organizations that addresses public health nursing issues, finalized its own set of public health nursing competencies. These competencies were revised in 2013.
- The 2000, 2010, and 2020 versions of *Healthy People;* recent disasters and acts of terrorism; and, most recently, the Patient Protection and Affordable Care Act of 2010 have brought a renewed emphasis on the benefits of both public health and nursing.

EVOLVE WEBSITE

http://evolve.elsevier.com/Stanhope/foundations

- NCLEX® Review Questions
- Practice Application Answers

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CHAPTER 3

The Changing U.S. Health and Public Health Care Systems

Marcia Stanhope

OBJECTIVES

After reading this chapter, the student should be able to do the following:

1. Describe the events and trends that influence the status of the health care system.
2. Discuss key aspects of the private health care system.
3. Define public health and the nurse's role.
4. Compare and contrast the current public health system with the model of primary health care.
5. Assess the effects of health care and insurance reform on population health care.

CHAPTER OUTLINE

KEY TERMS

advanced-practice nursing (APN), 36
Affordable Care Act, 38
community participation, 44
Declaration of Alma-Ata, 33
disease prevention, 33
electronic health record (EHR), 37
health, 33
health promotion, 33
managed care, 39
primary care, 39
primary health care (PHC), 44
public health, 39
US Department of Health and Human Services (USDHHS), 39

In September 1978, an international conference was held in the city of Alma-Ata, which at that time was the capital of the Soviet Republic of Kazakhstan. During this conference, the **Declaration of Alma-Ata** and a new concept in health care delivery emerged: the primary health care model. This declaration states that **health** is a human right and that the health of its people should be the primary goal of every government. One of the main themes of this declaration was the involvement of community health workers and traditional healers in a new health system (World Health Organization [WHO], 1978).

Primary health care (PHC) was introduced, defined, and described. In 2008 WHO renewed its call for health care improvements and reemphasized the need for public policymakers, public health officials, primary care providers, and leadership within countries to improve health care delivery. WHO said, "Globalization is putting the social cohesion of many countries under stress, and health systems . . . are clearly not performing as well as they could and should" (WHO, 2008).

As defined by WHO, PHC, which is defined differently than primary care or public health, promotes the integration of all health care systems within a community to come together to improve the health of the community, including primary care and public health.

Therefore PHC provides for the integration of **health promotion, disease prevention,** and curative and rehabilitative

BOX 3.1 Definitions of Selected Terms

- **Disease prevention:** Activities whose goal is to protect people from becoming ill as a result of actual or potential health threats
- **Disparities:** Racial or ethnic differences in the quality of health care, not based on access or clinical needs, preferences, or appropriateness of an intervention
- **Electronic medical record:** A computer-based client medical record
- **Globalization:** A trend toward an increased flow of goods, services, money, and disease across national borders
- **Health:** A state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity (WHO, 1986a)
- **Health promotion:** Activities that have as their goal the development of human attitudes and behaviors that maintain or enhance well-being
- **Institute of Medicine:** A part of the National Academy of Sciences and an organization whose purpose is to provide national advice on issues relating to biomedical science, medicine, and health
- **Primary care:** The providing of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with clients, and practicing in the context of family and community
- **Primary health care:** A combination of primary care and public health care made universally accessible to individuals and families in a community, with their full participation, and provided at a cost that the community and country can afford (WHO, 1978)
- **Public health:** Organized community and multidisciplinary efforts, based on epidemiology, aimed at preventing disease and promoting health (Institute of Medicine, 1988, p 4)

services (WHO, 1978). Because of the changing environment in health care delivery in the United States, the work by WHO in 1978 is becoming increasingly important. Box 3.1 lists selected definitions that will help explain the concepts introduced in this chapter.

HEALTH CARE IN THE UNITED STATES

Despite the fact that health care costs in the United States are the highest in the world and comprise the greatest percentage of the gross domestic product, the indicators of what constitutes good health do not document that Americans are really getting their money's worth. In the first decade of the 21st century there have been massive and unexpected changes in health, economic, and social conditions as a result of terrorist attacks, hurricanes, fires, floods, infectious diseases, and an economic turndown in 2008. New systems have been developed to prevent and/or deal with the onslaught of these horrendous events. Not all of the systems have worked, and many are regularly criticized for their inefficiency and costliness. Simultaneously, new and nearly miraculous advances have been made in treating health-related conditions. Organs and joints are being replaced, and medicines are keeping people alive who only a few years ago would have suffered and died. These advances and "wonder drugs" save and prolong lives, and a number of deadly and debilitating diseases have been eliminated through effective immunizations and treatments. In addition, sanitation, water supplies, and nutrition have been improved, and animal cloning has begun.

However, attention to all of these advances may overshadow the lack of attention to public health and prevention. Several of the most destructive health conditions can be prevented either through changes in lifestyle or interventions such as immunizations. The increasing rates of obesity, especially among children; substance use; lack of exercise; violence; and accidents have alarming repercussions, particularly when they lead to disruptions in health.

This chapter describes a health care system in transition as it struggles to meet evolving global and domestic challenges. The overall health care and public health systems in the United States are described and differentiated, and the changing priorities are identified, with emphasis on integrating public health and primary care. Nurses play a pivotal role in meeting these needs, and the role of the nurse is described.

FORCES STIMULATING CHANGE IN THE DEMAND FOR HEALTH CARE

In recent years, enormous changes have occurred in society, both in the United States and most other countries of the world. The extent of interaction among countries is stronger than ever, and the economy of each country depends on the stability of other countries. The United States has felt the effects of rising labor costs as many companies have shifted their production to other countries with lower labor costs. It is often less expensive to assemble clothes, automobile parts, and appliances and to have call distribution centers and call service centers in a less industrialized country and pay the shipping and other charges involved than to have the items fully assembled in the United States. In recent years the vacillating cost of fuel has affected almost every area of the economy, leading to both higher costs of products and layoffs as some industries have struggled to stay solvent. This has affected the employment rate in the United States. The economic downturn of 2008 left many people unemployed, and many lost their homes because they could not pay their mortgages. When the unemployment rate is high, more people lack comprehensive insurance coverage because in the United States this has been typically provided by employers. In late November 2008, the US unemployment rate was 6.7%. This represented an increase from 4.6% in 2007. In July 2012 the unemployment rate had increased to 8.2%, close to double the rate in 2007. In recent years the economy has begun to recover. In 2014, for example, the unemployment rate decreased to 6.1%—down 2.1 percentage points from 2012 (Bureau of Labor Statistics [BLS], 2014a). Also, health care services and the ways in which they are financed are changing with the continuing implementation of the Patient Protection and Affordable Care Act (ACA), enacted in 2010. Many of the planned changes were implemented by 2016. However, in 2016, with the election of a new president, there were many threats related to the future of the ACA.

EVIDENCE-BASED PRACTICE

It is often said that the states are the laboratories of democracy. One state, Massachusetts, began an experiment in health reform in 2006. Two years after health reform legislation became effective, only 2.6% of Massachusetts's residents were uninsured, the lowest percentage ever recorded in any state (Dorn et al, 2009). However, the program became one of the most successful and a model for the Affordable Care Act. After 5 years approximately 98% to 99% of all of the commonwealth's citizens were covered by the plan.

Although other states have experimented with various programs to decrease the number of uninsured individuals, the Massachusetts plan has had the most success. The health reform plan rests on an individual mandate that requires everyone who can afford insurance to purchase coverage. Those unable to afford insurance receive subsidies that allow low-income individuals and families to purchase coverage. A new state-run program, Commonwealth Care (CommCare), provides benefits to adults who are not eligible for Medicaid but whose incomes fall below 300% of the federal poverty level.

To understand how the state has achieved such success in this effort toward universal coverage, a group of evaluators met with 15 key informants representing hospitals, community health centers, insurance companies, Medicaid, and CommCare. Several factors, it was found, have contributed to the historic level of coverage seen in the state. Rather than requiring consumers to complete separate applications for programs such as Medicaid, the Children's Health Insurance Program (CHIP), or CommCare, a single application system provides entry to all the state programs. If an uninsured client is admitted to a hospital or visits a community health center, his or her eligibility is automatically evaluated; if eligible, the client is automatically converted to CommCare coverage, even without completing an application. A "Virtual Gateway" has been developed through which staff members of community-based organizations have been trained to complete online applications on behalf of consumers and to provide education and counseling about insurance options to underserved communities. Because reimbursement is held back from providers that do not offer staff to help consumers sign up for one of the available insurance options, hospitals and health centers are motivated to dedicate staff to provide education and counseling to the formerly uninsured. The result is that at least half of the new enrollees in Medicaid and CommCare have been enrolled without filling out any forms on their own. In addition to these efforts, shortly after the reform legislation was enacted, the state financed a massive public education effort to inform consumers about their new options.

Nurse Use

As health reform is implemented on the national level, nurses can play a crucial role in driving down the number of uninsured individuals. Nurses should educate themselves so that they can encourage clients to apply and take advantage of all available coverage options. Taking an active role in consumer educational programs is a natural extension of a nurse's role as a client advocate. Nurses can promote legislation to simplify enrollment processes and encourage the development of shared databases for community health care providers, thus preventing consumers from falling through the cracks in our fragmented health care system.

From Dorn S, Hill I, Hogan S: The secrets of Massachusetts' success: why 97 percent of state residents have health coverage: state health access reform evaluation, Romneycare-The truth about Massachusetts health care. 2014, accessed at mittromneycentral.com. 9/25/2014, Robert Wood Johnson Foundation. Available at http://www.urban.org Accessed September 19, 2012.

DEMOGRAPHIC TRENDS

The population of the world is growing as a result of increased fertility and decreased mortality rates. The greatest growth is occurring in underdeveloped countries, and this is accompanied by decreased growth in the United States and other developed countries. The year 2000, however, marked the first time in more than 30 years that the total fertility rate in the United States was above the replacement level. *Replacement* means that for every person who dies, another is born (Hamilton et al, 2010). Both the size and the characteristics of the population contribute to the changing demography.

Seventy-seven million babies were born between the years of 1946 and 1963, giving rise to the often-discussed baby-boomer generation (Office for National Statistics [ONS], 2014) The oldest of these boomers reached 65 years of age in 2011, and they are expected to live longer than people born in earlier times. The impact on the federal government's insurance program for people 65 years of age and older, Medicare, is expected to be enormous, and this population is predicted to double between the years 2000 and 2030, representing 20% of the total population (Centers for Disease Control and Prevention [CDC], 2013a).

In 2016, the US population totaled more than 322 million people, representing the third most populated country in the world. From 1990 to 2012, the US foreign-born immigrant population grew from about 19 million to approximately 41 million, and it is continuing to increase every year (US Census Bureau, 2016).

At the time of the 1990 census, African Americans were the largest minority group in the United States (US Census Bureau, 1996). However, in 2014, the US Census Bureau announced that Hispanic persons outnumbered African Americans, with non-Hispanic whites being the largest single ethnic group in the United States (ONS, 2014). The nation's foreign-born population is growing, and it is projected that from now until 2050 the largest population growth will be attributable to immigrants and their children. The states with the largest percentage of foreign-born populations are California, New York, Texas, and Florida (Migration Policy Institute, 2015).

The composition of the US household is also changing. From 1935 to 2010, mortality for both genders in all age groups and races declined (Hoyert, 2012) as a result of progress in public health initiatives, such as antismoking campaigns, AIDS prevention programs, and cancer screening programs. The leading causes of death have changed from infectious diseases to chronic and degenerative diseases (National Center for Health Statistics [NCHS], 2014). New infectious diseases are emerging, such as the Ebola virus, which affected the United States in 2014, with the first case occurring in Dallas, Texas (CDC, 2014a), and now the Zika virus, which is spread by infected mosquitoes. This virus, which can result in birth defects and Guillain–Barré syndrome, has created a public health emergency throughout the world. All but four states reported cases in 2016 (CDC, 2016).

New treatments for infectious diseases have resulted in steady declines in mortality among children, but such declines depend on parents' participation in immunization programs. A recent measles outbreak in Orange County, California, shows that continuous focus on control of infectious diseases is essential (Orange County Health Care Agency, 2014). The mortality for older Americans has also declined. However, people 50 years of age and older have

higher rates of chronic and degenerative illness than other age groups, and they use a larger portion of health care services.

SOCIAL AND ECONOMIC TRENDS

In addition to the size and changing age distribution of the population, other factors also affect the health care system. Several social trends that influence health care include changing lifestyles, a growing appreciation for the quality of life, the changing composition of families and living patterns, changing household incomes, and a revised definition of quality health care.

Americans spend considerable money on health care, nutrition, and fitness (BLS, 2012) because health is seen as an irreplaceable commodity. To be healthy, people must take care of themselves. Many people combine traditional medical and health care practices with complementary and alternative therapies to achieve the highest level of health. Complementary therapies are those that are used in addition to traditional health care, and alternative therapies are those that are used instead of traditional care. Examples include acupuncture and herbal medications, among others (National Center for Complementary and Alternative Medicine [NCCAM], 2014). People often spend a considerable amount of their own money for these types of therapies because few are covered by insurance. In recent years, some insurance plans have recognized the value of complementary therapies and have reimbursed for them. State offices of insurance are good sources to determine whether these services are covered and by which health insurance plans.

Approximately 65 years ago, income was distributed in such a way that a relatively small portion of households earned high incomes; families in the middle-income range made up a somewhat larger proportion, and households at the lower end of the income scale made up the largest proportion. By the 1970s, household income had risen, and income was more evenly distributed, largely as a result of dual-income families.

From 1970 through 2011, several trends in income distribution emerged. The economic downturn now known as the Great Recession, which began in 2008, resulted in layoffs, outsourcing, and other economic changes, with many families seeing decreases in wages. From 2011 through 2015, the average per-person income in the United States increased. The income of households in the top 1% of earners grew by 200%, compared with growth of 67% for the next 18%, growth of 40% for 60% of middle-income households, and 48% growth for the bottom 20% of households (Congressional Budget Office [CBO], 2016). It is obvious that the gap between the richest and the poorest is widening because of the evident differences in the wage-increase percentages of the higher-income levels. Chapter 8 provides a detailed discussion of the economics of health care and how financial constraints influence decisions about public health services.

HEALTH WORKFORCE TRENDS

The health care workforce ebbs and flows. The early years of the 21st century saw the beginning of what is expected to be a long-term and sizable nursing shortage. Similarly, most other health professionals are documenting current and anticipated future shortages. Historically, nursing care has been provided in a variety of settings, primarily in the hospital. Approximately 63% of all registered nurses (RNs) continue to be employed in hospitals (National Center for Health Workforce Analysis, 2013). A few years ago hospitals began reducing their bed capacities as care became more community based. Now they are expanding, including the construction of new facilities for both acute and longer-term chronic care. This growth is attributable to the factors previously discussed: the ability to treat and perhaps cure more diseases, the complexity of the care and the need for inpatient services, and the growth of the older age group.

The nursing shortage has been discussed in recent years, yet new graduates often have difficulty finding positions when they graduate (American Association of Colleges of Nursing [AACN], 2014a, 2014b, 2014c). Participating in a nurse internship program and holding a bachelor of science in nursing (BSN) degree or higher will provide more opportunities for the new graduate. In 2014, the BLS predicted there would be 527,000 new nursing positions by 2016 (BLS, 2014b). In addition, 55% of nurses reported in a recent survey that they intended to retire between 2011 and 2020, which will open positions for others (National Council of State Boards of Nursing [NCSBN], 2013).

Periodic shortages are especially common in the primary-care workforce in the United States, and nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified nurse-midwives (CNMs), who are considered to be practitioners of **advanced-practice nursing (APN)** specialties, are vital members of primary-care teams. However, as the baby boomers age, there are projections for increasing RN needs in the workforce through 2022 (AACN, 2016)

In terms of the nursing workforce, increasing the number of minority nurses remains a priority and a strategy for addressing the current nursing shortage. In 2013 minority nurses represented approximately 22% of the RN population. It is thought that increasing the minority population will help close the health-disparity gap for minority populations (AACN, 2014b). For example, persons from minority groups, especially when language is a barrier, often are more comfortable with and more likely to access care from a provider from their own minority group.

TECHNOLOGICAL TRENDS

The development and refinement of new technologies such as telehealth have opened up new clinical opportunities for nurses and their clients, especially in the areas of managing chronic conditions, assisting persons who live in rural areas, and providing home health care, rehabilitation, and long-term care. On the positive side, technological advances promise improved health care services, reduced costs, and more convenience in terms of time and travel for consumers. Reduced costs result from a more efficient means of delivering care and from replacement of people with machines. Advanced technology also reduces paperwork; enables providers, clients, and agencies to access accurate information; facilitates care coordination and safety; and provides direct access to health records between agencies and to clients (Health Information Technology, 2013). Contradictory as it may seem, cost is also the most significant negative aspect of advanced health care technology. The more high-technology equipment and computer programs become available, the more

QSEN FOCUS ON QUALITY AND SAFETY EDUCATION FOR NURSES

Targeted Competency: Informatics—Use information and technology to communicate, manage knowledge, mitigate error, and support decision making.

Important aspects of informatics include the following:

Knowledge: Identify essential information that must be available in a common database to support interventions in the health care system.

Skills: Use information management tools to monitor outcomes of intervention processes.

Attitudes: Value technologies that support decision making, error prevention, and case coordination.

Informatics Question: Updated informatics definitions focus on having access to the necessary client and system information at the right time, to make the best clinical decision. In the *Strategic Plan for 2010 to 2015* of the US Department of Health and Human Services (USDHHS), there are five overarching goals.

Goal 1, Objective C focuses on "Emphasizing primary and preventive care linked with community prevention services." Which community data would a public health nurse assess to determine the work that needs to be done in a community related to this USDHHS strategic goal?

Answer: To assess future work that could be done to effectively address Goal 1, Objective C, public health nurses might gather data in the following areas:

- How informed are members of the community about existing community services that support health promotion (e.g., exercise classes, educational classes, self-management training, and nutrition counseling)?
- How relevant are the services offered by health centers to the needs of a community?
- Do payment or insurance barriers exist for individuals to access preventive health services?
- How accessible is entry to care for vulnerable populations such as pregnant women and infants?
- What community-based prevention programs exist for individuals with and at risk for chronic diseases and conditions?
- How available are substance-abuse screening and intervention programs?
- How linked are primary care and health promotions and wellness programs in a community?

Prepared by Gail Armstrong, PhD(c), DNP, ACNS-BC, CNE, Associate Professor, University of Colorado Denver College of Nursing.

they are used. High-technology equipment is expensive, quickly becomes outdated when newer developments occur, and often requires highly trained personnel. There are other drawbacks to new technology, particularly in the area of home health care. These include increased legal liability, the potential for decreased privacy, too much reliance on technological advances, and the inconsistent quality of resources available on the Internet and other sources, like magazines and newspapers (Palma, 2014).

Advances in health care technology will continue. One example of an effective use of technology is the funding provided to health centers by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services so that they can adopt and implement **electronic health records (EHRs)** and other health information technology (HIT) (HRSA, 2008). The HRSA's Office of Health Information Technology was created in 2005 to promote the effective use of HIT as a mechanism for responding to the needs of the uninsured, underinsured, and special-needs populations (HRSA, 2014). Specifically, in December 2012, an award of more than $18 million made available through the Affordable Care Act was announced to expand HIT in 600 health centers (HRSA, 2012). One innovative use of the EHR in public health is to embed reminders or guidelines into the system. For example, the CDC published health guidelines that contain clinical recommendations for screening, prevention, diagnosis, and treatment. To find and keep current on these guidelines, clinicians must visit the CDC website. The availability of an EHR system allows the embedding of reminders so that the clinician can have access to practice guidelines at the point of care. Some additional benefits in public health (and these are some of the uses health centers make of such records) include the following:

- 24-hour availability of records, with downloadable laboratory results and up-to-date assessments
- Coordination of referrals and facilitation of interprofessional care in chronic disease management
- Incorporation of protocol reminders for prevention, screening, and management of chronic disease
- Improvement of quality measurement and monitoring
- Increased client safety and decline in medication errors

Two federal programs, Medicaid and the State Children's Health Insurance Program (SCHIP), have effectively used HIT in several key functions, including outreach and enrollment, service delivery, and care management, in addition to communications with families and the broader goals of program planning and improvement. In early 2009, the Surgeon General's Office reopened a website that had been tried first in 2004 but then closed: My Family Health Portrait, which helps the user to create an electronic family tree (National Institutes of Health [NIH], 2010). This is described as an easy-to-use computer application that allows the user to keep a personal record of family health history (https://familyhistory.hhs.gov/FHH/html/index.html). In addition, the CDC recently began a family history public health initiative through the Office of Public Health Genomics to increase awareness of family history as an important risk factor for common chronic diseases. This initiative had four main activities:

1. Research to define, measure, and assess family history in populations and individuals
2. Development and evaluation of tools for collecting family history
3. Evaluation of the effectiveness of strategies based on family history
4. Promotion of evidence-based applications of family history to health professionals and the public (CDC, 2013b)

CURRENT HEALTH CARE SYSTEM IN THE UNITED STATES

Despite the many advances and the sophistication of the US health care system, the system has been plagued with problems related to cost, access, and quality. These problems are different for each person and are affected by the ability of individuals to obtain health insurance. Most industrialized countries want the same things from their health care system; several give their government a greater role in health care delivery and eliminate or reduce the use of market forces to control cost, access, and quality. Seemingly, there is no one perfect health care system in the world.

COST

Beginning in 2008, a historic weakening of the national and global economy—the Great Recession—led to the loss of 7 million jobs in the United States (Economic Report, 2010). Even as the gross domestic product (GDP), an indicator of the economic health of a country, declined in 2009, health care spending continued to grow and reached $2.5 trillion in the same year (Truffer et al, 2010). In the years between 2010 and 2019, national health spending is expected to grow at an average annual rate of 6.1%, reaching $4.5 trillion by 2019, for a share of approximately 19.3% of the GDP. This translates into a projected increase in per-capita spending.

In Chapter 8, additional discussion illustrates how health care dollars are spent. The largest share of health care expenditures goes to pay for hospital care, with physician services being the next largest item. The amount of money that has gone to pay for public health services is much lower than that for the other categories of expenditures. Other significant drivers of the increasingly high cost of health care include prescription drugs, technology, and chronic and degenerative diseases.

The economic rebound following the Great Recession will likely continue with the increasing Medicare enrollment of the aging baby-boomer population. It is projected that these new Medicare enrollees will increase Medicare expenditures for the foreseeable future. The number of Medicaid recipients can be expected to decline as jobs are added to the economy, and the percentage of workers covered by employer-sponsored insurance rises to reflect that growth. For the first time since 2008, unemployment rates in 2016 dropped to less than 5% of the working population (BLS, 2016).

Although workers' salaries have not kept pace, employer-sponsored insurance premiums have grown 119% since 1999 (Kaiser Family Foundation, 2015a), and the inability of workers to pay this increased cost has led to a rise in the percentage of working families who are uninsured. It will be essential for nurses to keep abreast of any changes in these facts as the **Affordable Care Act** undergoes reevaluation in the years ahead (Cox et al, 2015).

ACCESS

Another significant problem is poor access to health care. The American health care system is described as a two-class system: private and public. People with insurance or those who can personally pay for health care are viewed as receiving superior care; those who receive lower-quality care are (1) those whose only source of care depends on public funds or (2) the working poor, who do not qualify for public funds either because they make too much money to qualify or because they are illegal immigrants. Employment-provided health care is tied to both the economy and to changes in health insurance premiums. One study found that in 2009, 61% of the nonelderly population obtained employer-sponsored health insurance as a benefit; however, employment did not guarantee insurance (Rowland et al, 2009). This became clear when considering that 9 in 10 (91%) of the middle-class uninsured came from families with at least one full-time worker in jobs that did not offer health insurance or where coverage was unaffordable (Rowland et al, 2009).

CASE STUDY

Issues with Childhood Dental Caries

Public health nurses who worked with local Head Start programs noted that many children had untreated dental caries. Although these children qualified for Medicaid, only two dentists in the area would accept appointments from Medicaid patients. Dentists asserted that Medicaid patients frequently did not show up for their appointments and that reimbursement was too low compared with that from other third-party payers. They also said the children's behavior made it difficult to work with them. So, the waiting list for local dental care was approximately 6 years long. Although some nurses found ways to transport clients to dentists in a city 70 miles away, it was very time consuming and was feasible for only a small fraction of the clients. When decayed teeth abscessed, it was possible to get extractions from the local medical center. The health department dentist also saw children, but he, too, was booked for years in advance.

Created by Deborah C. Conway, Assistant Professor, University of Virginia School of Nursing.

In 2012, the total number of uninsured persons in the United States was 48 million. As discussed, there is a strong relationship between health insurance coverage and access to health care services. Insurance status determines the amount and kind of health care people are able to afford and where they can receive care. As a result of the Affordable Care Act, by 2014, the uninsured nonelderly population had dropped to 32 million people, approximately 16% of the total population. During this same time period, 58% of the total population was covered by employer health insurance. Others, such as the elderly and the Medicaid-eligible populations, were covered by government insurance programs (Kaiser Family Foundation, 2015b).

The uninsured receive less preventive care and are diagnosed at more advanced disease states; once diagnosed, they tend to receive less therapeutic care in terms of surgery and treatment options. There is a safety net for the uninsured or underinsured. As discussed later in this chapter, there are more than 1300 federally funded community health centers throughout the country. Federally funded community health centers provide a broad range of health and social services, which are delivered by NPs, RNs, physician assistants, physicians, social workers, and dentists. Community health centers are primarily located in medically underserved areas, which can be rural or urban. These centers serve people of all ages, races, and ethnicities, with or without health insurance.

QUALITY

The quality of health care leaped to the forefront of concern following the 1999 release of the Institute of Medicine (IOM) report *To Err Is Human: Building a Safer Health System* (IOM, 2000). As indicated in this groundbreaking report, as many as 98,000 deaths a year could be attributed to preventable medical errors. Some of the untoward events categorized in this report included adverse drug events and improper transfusions, surgical injuries and wrong-site surgery, suicides, restraint-related injuries or death, falls, burns, pressure ulcers, and mistaken client identities. It was further determined that high rates of errors with serious consequences were most likely to occur in intensive care units, operating rooms, and emergency

departments. Beyond the cost in human lives, preventable medical errors result in the loss of several billions of dollars annually in hospitals nationwide. Categories of error include diagnostic, treatment, and prevention errors and communication, equipment, and other system failures. Significant to nurses, the IOM estimated that the number of lives lost to preventable errors in medication alone represented more than 7000 deaths annually, with a cost of about $2 billion nationwide.

Although the IOM report made it clear that the majority of medical errors were not produced by provider negligence, lack of education, or lack of training, questions were raised about the nurse's role and workload and their effects on client safety. In a follow-up report, *Keeping Patients Safe: Transforming the Work Environment of Nurses,* the IOM (2003) stated that nurses' long work hours pose a serious threat to patient safety because fatigue slows reaction time, saps energy, and diminishes attention to detail. The group called for state regulators to pass laws barring nurses from working more than 12 hours a day and 60 hours a week—even if by choice (IOM, 2003). Although this information is largely related to acute care, many of the patients who survive medical errors are later cared for in the community.

The culture of quality improvement and safety has made providers and consumers more conscious of safety, but medical errors and untoward events continue to occur. As a means to improve consumer awareness of hospital quality, the Centers for Medicare and Medicaid Services (CMS) began publishing a database of hospital quality measures, Hospital Compare, in 2005. Hospital Compare, a consumer-oriented website that provides information on how well hospitals provide recommended care in such areas as heart attack, heart failure, and pneumonia, is available through the CMS website (www.cms.gov). In a further effort, the CMS announced in 2008 that it would no longer reimburse hospitals, under Medicare guidelines, for care provided for "preventable complications," such as hospital-acquired infections. This reimbursement policy was extended to Medicaid reimbursement in 2011 (CMS, 2009; Galewitz, 2011).

The accreditation process for public health is new, and the impact of quality and safety monitoring has not yet been determined. The ability of a public health agency or a community to respond to community disasters is one event that will be monitored in the accreditation process. In May 2016, 135 of 303 local, tribal, and state centralized integration systems and multijurisdictional health departments had received accreditation in this new process. The accredited health departments served 167 million people, amounting to 54% of the total population base. The aims of this process are as follows:

- To assist and identify quality health departments to improve performance and quality and to develop leadership
- To improve management
- To improve community relationships (Public Health Accreditation Board [PHAB], 2016)

ORGANIZATION OF THE CURRENT HEALTH CARE SYSTEM

An enormous number and range of facilities and providers make up the health care system. These include physicians' and dentists' offices, hospitals, nursing homes, mental health facilities, ambulatory care centers, freestanding clinics and clinics inside stores such as drugstores, free clinics, public health agencies, and home health agencies. Providers include nurses, advanced-practice nurses, physicians and physician assistants, dentists and dental hygienists, pharmacists, and a wide array of essential allied health providers, such as physical, occupational, and recreational therapists; nutritionists; social workers; and a range of technicians. In general, however, the American health care system is divided into the following two, somewhat distinct, components: a private or personal care component and a public health component. These components have some overlap, as discussed in the following sections. It is important to discuss primary health care and examine the interest in developing a primary-care system.

PRIMARY-CARE SYSTEM

Primary care, the first level of the private health care system, is delivered in a variety of community settings, such as physicians' offices, urgent-care centers, in-store clinics, community health centers, and community nursing centers. Near the end of the past century, in an attempt to contain costs, the number of managed-care organizations grew. **Managed care** is defined as a system in which care is delivered by a specific network of providers that agree to comply with the care approaches established through a case-management approach. The key factors are a specified network of providers and the use of a gatekeeper to control access to providers and services. This form of care has not become as prominent as the original concept outlined.

The government tried to reap the benefits of cost savings by introducing the managed-care model into Medicare and Medicaid, with varying levels of success. The traditional Medicare plan involves Parts A and B. Part C, the Medicare Advantage program, incorporates private insurance plans into the Medicare program, including health maintenance organization (HMO) and preferred provider organization (PPO) managed-care models and private fee-for-service plans. In addition, Medicare Part D has been added to cover prescriptions (see Chapter 8).

PUBLIC HEALTH SYSTEM

The **public health** system is mandated through laws that are developed at the national, state, or local level. Examples of public health laws instituted to protect the health of the community include a law mandating immunizations for all children entering kindergarten and a law requiring constant monitoring of the local water supply. The public health system is organized into many levels in the federal, state, and local systems. At the local level, health departments provide care that is mandated by state and federal regulations.

THE FEDERAL SYSTEM

The **US Department of Health and Human Services (USDHHS,** or simply HHS) is the agency most heavily involved with the health and welfare concerns of US citizens. The organizational chart of the HHS (Fig. 3.1) shows the office of the secretary, 11

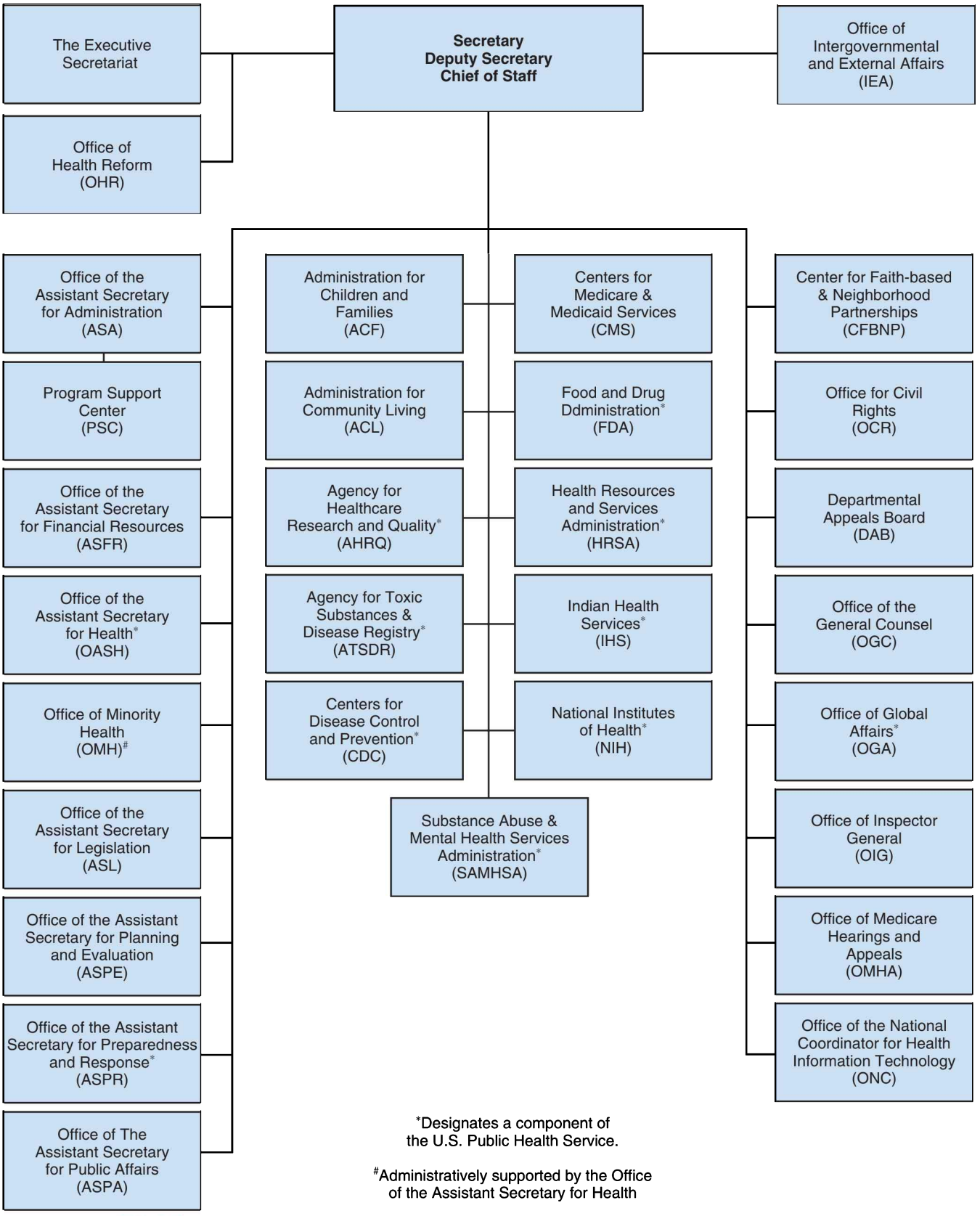

FIG. 3.1 Organization of the US Department of Health and Human Services. (From US Department of Health and Human Services, HHS Organizational Chart, http://www.hhs.gov/about/orgchart/.)

BOX 3.2 USDHHS Strategic Plan Goals and Objectives—Fiscal Years 2010 to 2015*

GOAL 1: Strengthen Health Care	
Objective A	Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured.
Objective B	Improve health care quality and patient safety.
Objective C	Emphasize primary and preventive care linked with community prevention services.
Objective D	Reduce the growth of health care costs while promoting high-value, effective care.
Objective E	Ensure access to quality, culturally competent care for vulnerable populations.
Objective F	Promote the adoption and meaningful use of health information technology.
GOAL 2: Advance Scientific Knowledge and Innovation	
Objective A	Accelerate the process of scientific discovery to improve patient care.
Objective B	Foster innovation to create shared solutions.
Objective C	Invest in the regulatory sciences to improve food and medical product safety.
Objective D	Increase our understanding of what works in public health and human service practice.
GOAL 3: Advance the Health, Safety, and Well-Being of the American People	
Objective A	Promote the safety, well-being, resilience, and healthy development of children and youth.
Objective B	Promote economic and social well-being for individuals, families, and communities.
Objective C	Improve the accessibility and quality of supportive services for people with disabilities and older adults.
Objective D	Promote prevention and wellness.
Objective E	Reduce the occurrence of infectious diseases.
Objective F	Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies.
GOAL 4: Increase Efficiency, Transparency, Accountability and Effectiveness of HHS Programs	
Objective A	Ensure program integrity and responsible stewardship of resources.
Objective B	Fight fraud and work to eliminate improper payments.
Objective C	Use HHS data to improve the health and well-being of the American people.
Objective D	Improve HHS environmental, energy, and economic performance to promote sustainability.
GOAL 5: Strengthen the Nation's Health and Human Service Infrastructure and Workforce	
Objective A	Invest in the HHS workforce to meet America's health and human service needs today and tomorrow.
Objective B	Ensure that the Nation's health care workforce can meet increased demands.
Objective C	Enhance the ability of the public health workforce to improve public health at home and abroad.
Objective D	Strengthen the Nation's human service workforce.
Objective E	Improve national, state, local, and tribal surveillance and epidemiology capacity.

From the US Department of Health and Human Services, 2014.USDHHS Strategic Plan Goals and Objectives—Fiscal Years 2010 to 2015. Retrieved July 2, 2014, from www.hhs.gov.
*In the process of being updated for 2014–2018.

agencies, and a program support center (USDHHS, 2014a). Ten regional offices are maintained to provide more direct assistance to the states. Their locations are shown in Table 3.1. The HHS is charged with regulating health care and overseeing the health status of Americans. See Box 3.2 for the goals and objectives of the HHS strategic plan for fiscal years 2010 to 2015. Newer areas in the HHS are the Office of Public Health Preparedness, the Center for Faith-Based and Neighborhood Partnerships, and the Office of Global Affairs. The Office of Public Health Preparedness was added to assist the nation and states to prepare for bioterrorism after September 11, 2001. The Faith-Based Initiative Center was developed by President George W. Bush to allow faith communities to compete for federal money to support their community activities. The goal of the Office of Global Affairs is to promote global health by coordinating HHS strategies and programs with other governments and international organizations (USDHHS, 2014a). The activities of several key agencies include the following:

1. The US Public Health Service (USPHS, or simply PHS) is a major component of the DHHS. The PHS consists of eight agencies: Agency for Healthcare Research and Quality, Agency for Toxic Substances and Diseases Registry, Centers for Disease Control and Prevention, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, and Substance Abuse and Mental Health Services Administration. Each has a specific purpose (see Chapter 8 for a discussion of the relevancy of the agencies to policy and the provision of health care). The PHS also has a Commissioned Corps, the National Health Services Corp (NHSC), which is a uniformed service of more than 6500 health professionals who serve in many HHS and other federal agencies. The surgeon general of the United States is the head of the Commissioned Corps. The corps fills essential services for public health clinics and provides leadership within the federal government departments and agencies to support the care of underserved and vulnerable populations (USPHS, 2014).
2. An important agency and a recent addition to the federal government, the US Department of Homeland Security (USDHS, or simply DHS), was created in 2003 (USDHS, 2014). The