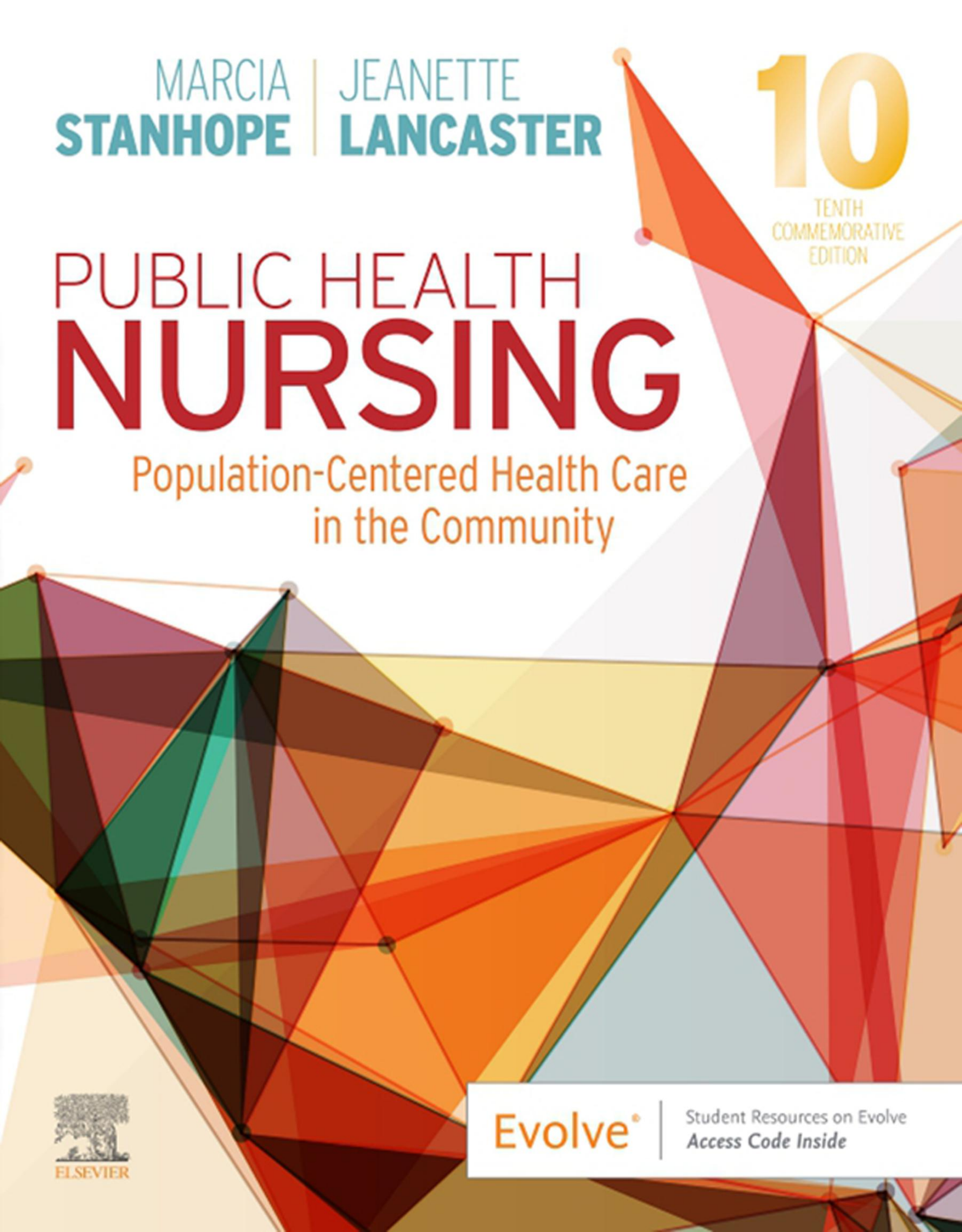
MARCIA STANHOPE | JEANETTE LANCASTER

10

TENTH COMMEMORATIVE EDITION

PUBLIC HEALTH NURSING

Population-Centered Health Care in the Community



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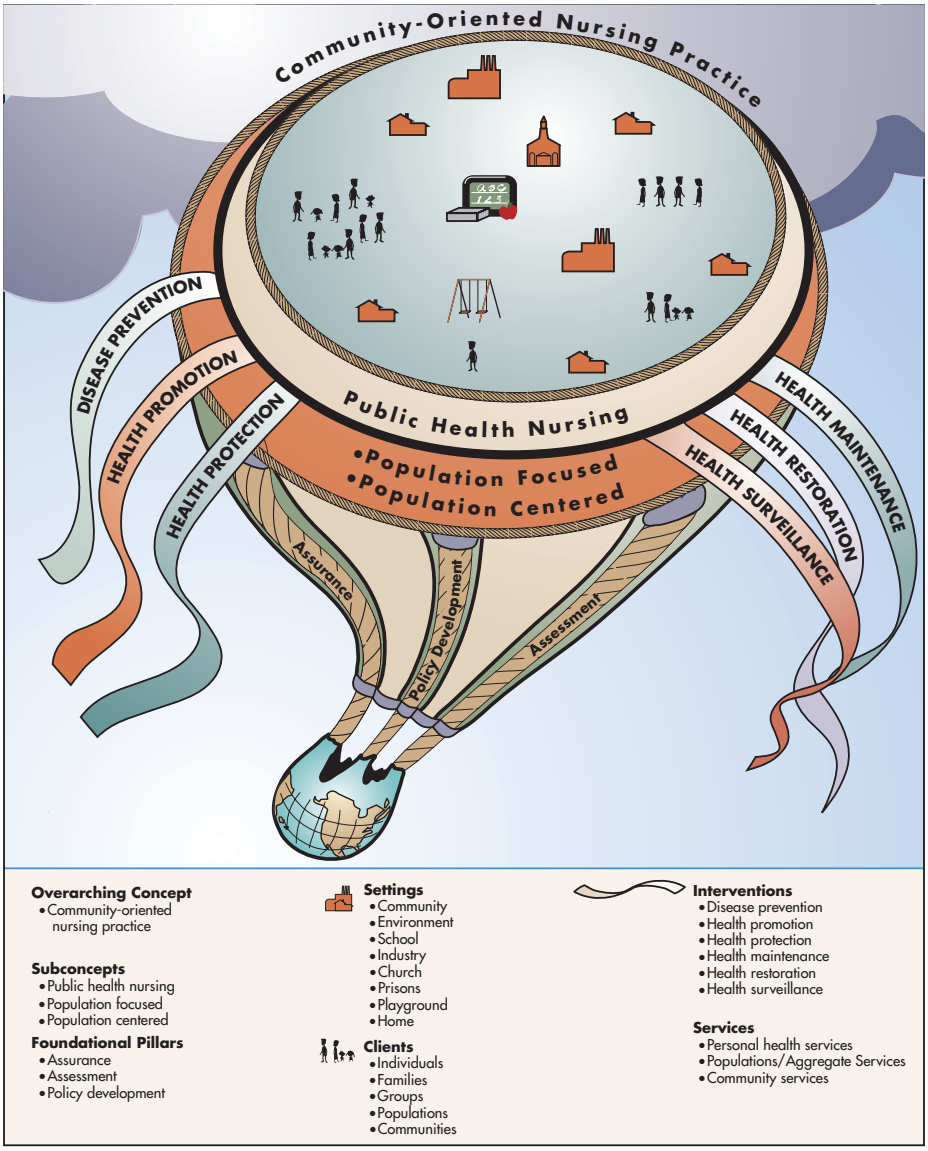

COMMUNITY NURSING DEFINITIONS

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" in order 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 that is 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.

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

	COMMUNITY-ORIENTED NURSING		
	Public Health Nursing: Population Focused/ Population Centered		Community-Based Nursing
Philosophy	PRIMARY focus is on "health care" of communities and populations	SECONDARY focus is on "health care" of individuals, families, and groups in community to unserved clients by health care system	Focus is on "illness care" of individuals and families across the life span
Goal	Prevent disease; preserve, protect, promote, or maintain health	Prevent disease; preserve, protect, promote, or maintain health	Manage acute or chronic conditions
Service context	Community and population health care "the greatest good for the greatest number"	Personal health care to unserved clients	Family-centered illness care
Community type	Varied: local, state, nation, world community	Varied, usually local community	Human ecological
Client characteristics	• Nation • State • Community • Populations at risk • Aggregates • Healthy • Culturally diverse • Autonomous • Able to define problem • Client primary decision maker	• Individuals/families at risk if unserved by health care system • Usually healthy • Culturally diverse • Autonomous • Able to define own problem • Client primary decision maker	• Individuals • Families • Usually ill • Culturally diverse • Autonomous • Client able to define own problem • Client involved in decision making
Practice setting	• Community • Organization • Government • Community agencies	• May be organization • May be government • Community agencies • Home • Work • School • Playground	• Community agencies • Home • Work • School
Interaction patterns	• Governmental • Organizational • Groups • May be one-to-one	• One-to-one • Groups • May be organizational	• One-to-one
Type of service	• Indirect • May be direct care of populations	• Direct care of at-risk persons • Indirect (program management)	• Direct illness care
Emphasis on levels of prevention	• Primary	• Primary • Secondary: screening • Tertiary: maintenance and rehabilitation	• Secondary • Tertiary • May be primary

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

	COMMUNITY-ORIENTED NURSING		
	Public Health Nursing: Population Focused/ Population Centered		Community-Based Nursing
Roles	**Client and delivery oriented: community/ population** • Educator • Consultant • Advocate • Planner • Collaborator • Data collector/evaluator • Health status monitor • Social engineer • Community developer/partner • Facilitator • Community care agent • Assessor • Policy developer/maker • Assuror of health care • Enforcer of laws/compliance • Disaster responder **Population oriented** • Program manager, aggregates • Health initiator • Program evaluator • Counselor • Change agent—population health • Educator • Population advocate	**Client and delivery oriented: individual, family, group** • Individual/family oriented—as needed • Caregiver • Social engineer • Educator • Counselor • Advocate • Case manager **Group Oriented** • Leader, personal health management • Change agent, screening • Community advocate • Case finder • Community care agent • Assessment • Policy developer • Assurance • Enforcer of laws/compliance	**Client and delivery oriented: individual, family** • Caregiver • Educator • Counselor • Advocate • Care manager **Group Oriented** • Leader, disease management • Change agent, managed care services
Priority of nurses' activities	**Community development** • Community assessment/monitoring • Health policy/politics • Community education • Interdisciplinary practice • Program management • Community/population advocacy	**For individual and family clients—as needed** • Case finding • Client education • Community education • Interdisciplinary practice • Case management, direct care • Program planning, implementation • Individual and family advocacy	**Care management, direct care** • Patient education • Individual and family advocacy • Interdisciplinary practice • Continuity of care provider

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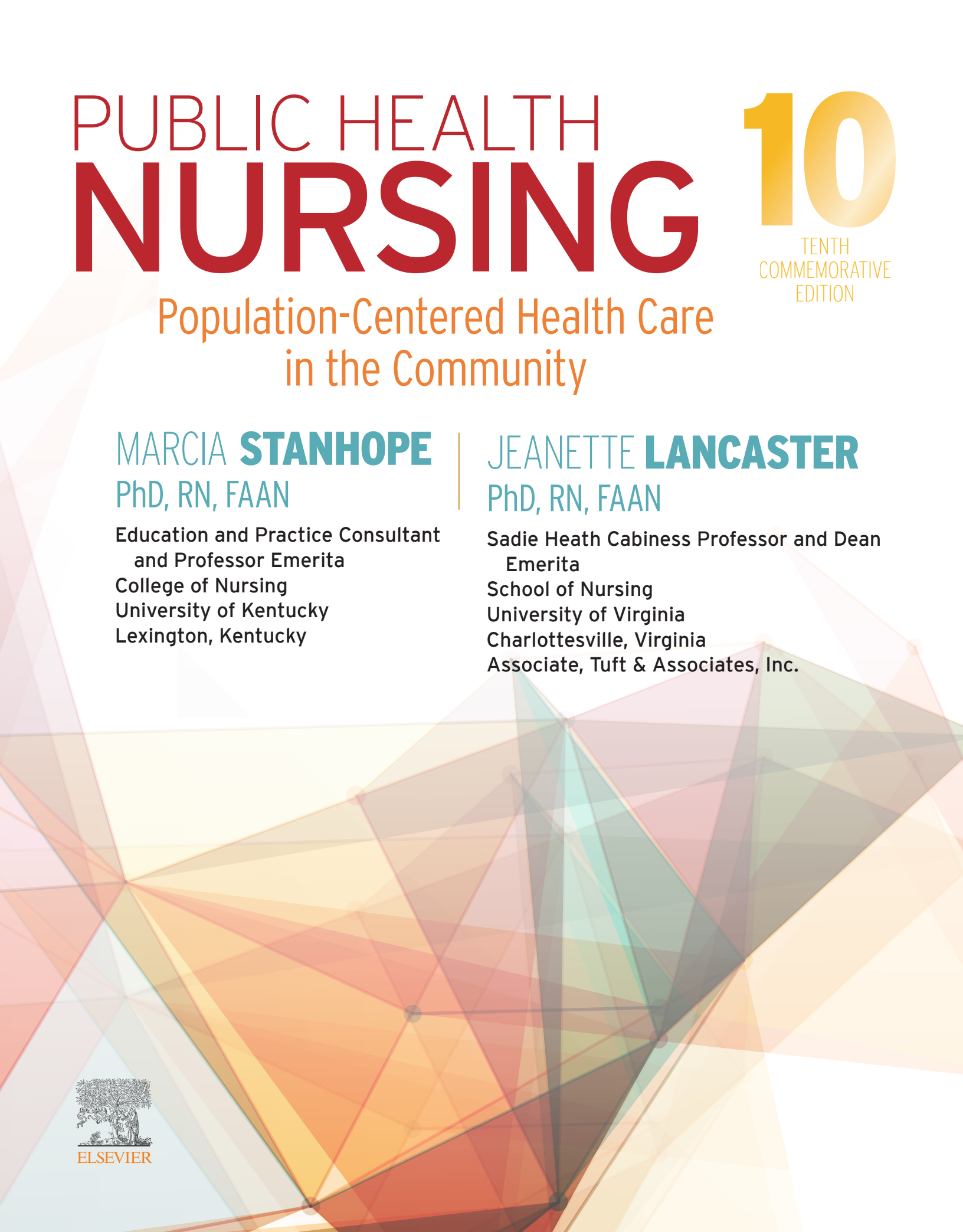
MARCIA **STANHOPE**
PhD, RN, FAAN

Education and Practice Consultant
and Professor Emerita
College of Nursing
University of Kentucky
Lexington, Kentucky

JEANETTE **LANCASTER**
PhD, RN, FAAN

Sadie Heath Cabiness Professor and Dean
Emerita
School of Nursing
University of Virginia
Charlottesville, Virginia
Associate, Tuft & Associates, Inc.



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3251 Riverport Lane
St. Louis, Missouri 63043

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Senior Content Strategist: Jamie Blum
Content Development Manager: Lisa P. Newton
Senior Content Development Specialist: Tina Kaemmerer
Publishing Services Manager: Julie Eddy
Senior Project Manager: Tracey Schriefer
Designer: Amy Buxton

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ABOUT THE AUTHORS

MARCIA STANHOPE, PhD, RN, FAAN

Marcia Stanhope is currently an education consultant, an Associate with Tuft and Associates Search Firm, Chicago, Illinois, and Professor Emerita from the University of Kentucky, College of Nursing, Lexington, Kentucky. In recent years she was a co-developer of the doctorate of nursing practice (DNP) program and co-director of the first DNP program nationally, which began at the University of Kentucky. While at the University of Kentucky she received the Provost Public Scholar award for contributions to the communities of Kentucky. She was also appointed to the Good Samaritan Endowed Chair in Community Health Nursing by the Good Samaritan Foundation, Lexington, Kentucky. She has practiced public health, 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. She has taught community health, public health, epidemiology, primary care nursing, 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, and primary care nursing. 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 PhD in nursing from the University of Alabama, Birmingham. Dr. Stanhope is 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 *Foundations of Community Health Nursing: Community-Oriented Practice.*

Recently Dr. Stanhope was inducted into the University of Kentucky College of Nursing Hall of Fame and was named an outstanding alumni of the University of Kentucky.

JEANETTE LANCASTER, PhD, RN, FAAN

Jeanette Lancaster is Professor and Dean Emerita at the University of Virginia School of Nursing in Charlottesville, Virginia. She served as Dean of the School of Nursing at the University of Virginia from 1989 until 2008. From 2008 to 2009 she served as a visiting professor at the University of Hong Kong, where she taught courses in public health nursing and worked with faculty to develop their scholarship programs and a doctoral program in nursing. She then taught at the University of Virginia from 2010 until 2012. She also taught at Vanderbilt University and is an Associate with Tuft & Associates, Inc., an executive search firm. 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, change, and the significance of nurses to effective primary health care. Since 2009 she has returned to the University of Hong Kong to teach graduate courses in public health nursing, comparative health care systems, and health policy. Dr. Lancaster is a graduate of the University of Tennessee Health Science Center Memphis. She holds a master's degree in psychiatric nursing from Case Western Reserve University and a doctorate in public health from the University of Oklahoma. Dr. Lancaster is the author of another Elsevier publication, *Nursing Issues in Leading and Managing Change*, and the co-author with Dr. Marcia Stanhope of *Foundations for Population Health in Community/Public Health Nursing.*

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Two very important people assisted us in the editing of this edition through their research efforts.

Dr. Sawin is an Associate Professor of Nursing at James Madison University, Harrisonburg, Virginia. She received her MSN from the University of Texas, Austin, and her PhD in nursing from the University of Virginia.

Dr. Turner is an Associate Professor at Berea College, Berea, Kentucky where she holds an endowed chair. She holds a BSN and MSN from the University of Virginia and a PhD from the University of Kentucky.

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Marcia Stanhope and Jeanette Lancaster

Theresa Acquaviva
Swann Adams
Brenda Afzal
Mary Albrecht
Mollie Aleshire
Rena Alford
Jeanne Alhusen
Kacy Allen-Bryant
Debra Anderson
Sandra Anderson
Dyan Aretakis
Sidney Axson
Ellen Bailey
Julie Balzer
Amber Bang
Sara Barger
Eleanor Bauwens
Anne Belcher
Ruth Berry
Virginia T. Betts
Marjorie Glaser Bindner
Patricia Birchfield
Linda Birenbaum
Whitney Bischoff
Kathleen Blomquist
Tina Bloom
Jean Bokinskie
Christine DiMartile Bolla
Joyce Bonick
Nisha Botchwey
Kathryn Bowles
Diane Boyer
Laurel Briske
Hazel Brown
Vivienne Brown
Bonnie Brueshoff
Marjorie Buchanan
Jeanne Bucsela
Angeline Bushy
Jacquelyn Campbell
Catherine Carroca
Ann Cary
Sudruk Chitthathairatt
Laura Clayton
Ann Connor
Marcia Cowan
Erin Cruise
Lois Davis
Sharon K. Davis
Karen Dawn
Cynthia Degazon
Louise Ivanor Dennis
Edie Devers
Nancy Dickenson-Hazard
Janna Dieckmann
Diane Downing
Sadie Elizabeth
Amanda Fallin
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Hartley Feld
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James Fletcher
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Douglas Charles Forness
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Joanna Horn
Patricia B. Howard
Linda Hulton
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Judy Igoe
Janet Ihlenfeld
L. Louise Ivanov
Gerard Jellig
Alicia Jensen
Bonnie Jerome-D'Emilia
Rosemary Johnson
Cheryl B. Jones
Kim D. Jones
Linda C. Jones
Joanna Kaakinen
Lisa Kaiser
Linda Keller
Marjorie Keller
Loren Kelly
Susan Kennel
Ellen Kent
David Kerschner
Katherine Kinsey
Thomas Kippenbrock
Sandra Kirkland
Tammy Kiser

Andrea Knopp
Joyce Krothe
Candace Kugel
Pamela Kulbok
Karen Labuhn
Shirley Laffrey
Wade Lancaster
Karen Landenburger
Peggy Lassiter
Roberta Lavin
Natasha Le
Gwendolyn Lee
Roberta "Bobbi" Lee
Sharon Lock
Jacquelyn Hurbel Logue
Susan Long-Marin
Carol Loveland-Cherry
Myra Lovvorn
Lois Lowry
Max Lum
P.J. Maddox
Karen Martin
Mary Lynn Mathre
Carol Maxwell-Thompson
Natalie McClain
Mary Ann McClellan
Beverly McElmurry
Robert McKeown
Kathleen McPhaul
DeAnne Messias
Mary Ellen Miller
Margaret Millsap
Emma Mitchell
Lillian Mood
Geneva Morris
Carole Myers
Marie Napolitano
Diane Narkunas
Victoria Niederhauser
Cynthia Northrup
Julie Novak
Lisa Onega
Charlene Ossler
Eunhee Park
Susan Patton
Bobbie Perdue
Lynelle Phillips
Paula Pointer
Demetrius Porche
Kristine Qureshi
Mary Riner
Bonnie Rogers
Molly Rose
Cynthia Rubenstein
Barbara Sattler
Erika Metzler Sawin
Linda Sawyer
Marjorie Schaffer
Jennifer Schaller-Ayers
Nancy Scheet
Cheryl Schenk
Juliann Sebastian
Cynthia Selleck
Sharon Shehan
Sallie Shipman
Maria Shirey
Linda Shortridge
George Shuster III
Mary Silva
Ann Sirles
Delois Skipwith
Rebecca Sloan
Donna E. Smith
Kellie Smith
Sherrill Smith
Jeanne Sorrell
Patricia Speck
Sudie Speer
Sharon A.R. Stanley
Patricia Starck
Sharon Strang
Sue Strohschein
Melissa Sutherland
Laura Suzuki
Susan Swider
Francisco Sy
Michele Talley
Esther Thatcher
Karen Thompson
Shirleen Trabeaux
Joan Turner
Lisa Turner
Connie Ulrich
Barbara Valanis
Doris Wagner
Heather Ward
Lynn Wasserbauer
Prapin Watanakij
Jacqueline Webb
Sally Weinrich
Cynthia Wesley
Connie White-Williams
Eileen Wiles
Carolyn A. Williams[a]
Cora Withrow
Judith Wold
Nannette Worel
Elke Jones Zchaebitz
Lisa Zerull

[a]Contributing author for 10 editions.

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Marcia Stanhope

I would like to dedicate my work on this 10th edition to my late husband, I. Wade Lancaster. He supported and encouraged me through the first nine editions of the text, and I am deeply grateful for his love, support, and encouragement.

Jeanette Lancaster

CONTRIBUTORS

Swann Arp Adams, MS, PhD
Associate Professor
College of Nursing
University of South Carolina
Columbia, South Carolina
Chapter 13: Epidemiology

Mollie E. Aleshire, DNP, MSN, FNP-BC, PPCNP-BC, FNAP
Associate Professor
School of Nursing
University of North Carolina at Greensboro
Greensboro, North Carolina;
Family and Pediatric Nurse Practitioner
Greensboro, North Carolina
Chapter 27: Family Health Risks

Jeanne L. Alhusen, PhD, CRNP, RN, FAAN
Associate Professor and Assistant Dean for Research
School of Nursing
University of Virginia
Charlottesville, Virginia
Chapter 38: Violence and Human Abuse

Kacy Allen-Bryant, PhD(c), MSN, MPH, RN
Lecturer
College of Nursing
University of Kentucky
Lexington, Kentucky
Chapter 27: Family Health Risks

Debra Gay Anderson, PhD, PHCNS-BC
Associate Dean for Research
College of Nursing
South Dakota State University
Brookings, South Dakota
Chapter 27: Family Health Risks

Sydney A. Axson, MPH, RN
Hillman Scholar in Nursing Innovation
School of Nursing
University of Pennsylvania
Philadelphia, Pennsylvania
Chapter 7: Application of Ethics in the Community

Amber M. Bang, RN, BSN
Registered Nurse
Grants Pass, Oregon
Chapter 37: Alcohol, Tobacco, and Other Drug Problems

Whitney Rogers Bischoff, DrPH, MSN, BSN
Associate Professor
Nursing
Texas Lutheran University
Seguin, Texas
Chapter 5: Economics of Health Care Delivery

Nisha D. Botchwey, PhD, MCRP, MPH
Associate Professor
City and Regional Planning
Georgia Institute of Technology
Atlanta, Georgia;
Public Health
Emory University
Atlanta, Georgia
Chapter 18: Building a Culture of Health to Influence Health Equity Within Communities

Kathryn H. Bowles, RN, PhD, FAAN
van Ameringen Professor in Nursing Excellence
School of Nursing
University of Pennsylvania
Philadelphia, Pennsylvania;
Director of the Center for Home Care Policy and Research
Visiting Nurse Service of New York
New York, New York
Chapter 41: The Nurse in Public Health, Home Health, Hospice, and Palliative Care

Hazel Brown, DNP, RN
Chief Nursing Officer
Nursing Administration
Cayman Islands Health Services Authority
George Town, Grand Cayman
Cayman Islands
Chapter 29: Major Health Issues and Chronic Disease Management of Adults Across the Life Span

Bonnie L. Brueshoff, DNP, MSN, RN, PHN
Director
Public Health
Dakota County
West St. Paul, Minnesota
Chapter 11: Population-Based Public Health Nursing Practice: The Intervention Wheel

Angeline Bushy, PhD, RN, FAAN
Professor, Bert Fish Chair
College of Nursing
University of Central Florida
Orlando, Florida
Chapter 32: Population-Centered Nursing in Rural and Urban Environments

Jacquelyn C. Campbell, PhD, RN, FAAN
Professor
Anna D. Wolf Chair
National Program Director, Robert Wood Johnson Foundation Nurse Faculty Scholars
Department of Community-Public Health
The Johns Hopkins University
Baltimore, Maryland
Chapter 38: Violence and Human Abuse

Catherine Carroca, MSN, RN
Assistant Professor
School of Nursing
Massachusetts College of Pharmacy and Health Sciences
Worcester, Massachusetts
Chapter 23: Program Management

Ann H. Cary, PhD, MPH, RN, FNAP, FAAN
Dean
School of Nursing and Health Studies
University of Missouri Kansas City
Kansas City, Missouri
Chapter 25: Case Management

Laura H. Clayton, PhD, RN, CNE
Professor
Department of Nursing Education
Shepherd University
Shepherdstown, West Virginia
Chapter 22: Public Health Surveillance and Outbreak Investigation

Erin G. Cruise, PhD, RN
Associate Professor
School of Nursing
Radford University
Radford, Virginia
Chapter 42: The Nurse in the Schools

Lois A. Davis, RN, MSN, MA
Public Health Clinical Instructor
College of Nursing
University of Kentucky
Lexington, Kentucky
Chapter 46: Public Health Nursing at Local, State, and National Levels

Sharon K. Davis, DNP, APRN, WHNP-BC
Clinical Assistant Professor
Nursing
University of Tennessee
Knoxville, Tennessee
Chapter 35: Teen Pregnancy

Karen R. Dawn, DNP, MSN, BSN
Assistant Professor
School of Nursing
George Washington University
Ashburn, Virginia
Chapter 3: Public Health, Primary Care, and Primary Health Care Systems

Cynthia E. Degazon, RN, PhD
Professor Emerita
School of Nursing
Hunter College
New York, New York
Chapter 8: Achieving Cultural Competence in Community Health Nursing

Janna Dieckmann, PhD, RN
Associate Professor
School of Nursing
University of North Carolina at Chapel Hill
Chapel Hill, North Carolina
Chapter 2: History of Public Health and Public and Community Health Nursing

Sherry L. Farra, PhD, RN, CNE, CHSE, NDHP-BC
Associate Professor
Nursing
Wright State University
Dayton, Ohio
Chapter 21: Public Health Nursing Practice and the Disaster Management Cycle

Mary E. Gibson, PhD, RN
Associate Professor
Nursing
University of Virginia
Charlottesville, Virginia
Chapter 17: Community As Client: Assessment and Analysis

Mary Kay Goldschmidt, DNP, MSN, RN, PHNA-BC
Assistant Professor
Family and Community Health
Virginia Commonwealth University School of Nursing
Richmond, Virginia;
Commissioner on Government Relations
Board member
Virginia Nurses Association
Richmond, Virginia;
Co-director
PIONEER NEPQR Grant
Health Resources and Services Administration
Washington, DC
Chapter 33: Poverty and Homelessness

Monty Gross, PhD, MSN, RN, CNE, CNL
Senior Nurse Leader for Professional Development
Nursing Administration
Health Services Authority
George Town, Grand Cayman
Cayman Islands
Chapter 29: Major Health Issues and Chronic Disease Management of Adults Across the Life Span

Melanie Gibbons Hallman, DNP, CRNP, CEN, FNP-BC, ACNP-BC, FAEN
Assistant Professor / Nurse Practitioner
Family, Community and Health Systems
University of Alabama at Birmingham School of Nursing
Birmingham, Alabama
Chapter 39: Advanced Nursing Practice in the Community

Joanna Horn, BA, MS
Senior Genetic Counselor
Center for Human Genetics
University Hospital Cleveland Medical Center
Cleveland, Ohio
Chapter 12: Genomics in Public Health Nursing

Gerard M. Jellig, EdD
School Principal/Leader
KIPP DC WILL Academy
Washington, DC
Chapter 38: Violence and Human Abuse

Tammy Kiser, DNP, RN
Assistant Professor of Nursing
School of Nursing
James Madison University
Harrisonburg, Virginia
Chapter 15: Communicable and Infectious Disease Risks

Andrea Knopp, PhD, MPH, MSN, FNP-BC
Nurse Practitioner Program Coordinator, Associate Professor
School of Nursing
James Madison University
Harrisonburg, Virginia
Chapter 29: Major Health Issues and Chronic Disease Management of Adults Across the Life Span

Candace Kugel, BA, MS, FNP, CNM
Clinical Specialist
Migrant Clinicians Network
Austin, Texas
Chapter 34: Migrant Health Issues

Pamela A. Kulbok, DNSc, RN, PHCNS-BC, FAAN
Professor Emerita
School of Nursing
University of Virginia
Charlottesville, Virginia
Chapter 18: Building a Culture of Health to Influence Health Equity Within Communities

Roberta Proffitt Lavin, PhD, FNP-BC, FAAN
Professor and Executive Associate Dean of Academic Programs
College of Nursing
University of Tennessee
Knoxville, Tennessee
Chapter 21: Public Health Nursing Practice and the Disaster Management Cycle

Natasha Le, BA, BS
Informatics and Quality Coordinator
Home Care and Hospice
Penn Care at Home
Philadelphia, Pennsylvania
Chapter 41: The Nurse in Public Health, Home Health, Hospice, and Palliative Care

Susan C. Long-Marin, DVM, MPH
Epidemiology Manager
Public Health
Mecklenburg County
Charlotte, North Carolina
Chapter 14: Infectious Disease Prevention and Control

Karen S. Martin, RN, MSN, FAAN
Health Care Consultant
Martin Associates
Omaha, Nebraska
Chapter 41: The Nurse in Public Health, Home Health, Hospice, and Palliative Care

Mary Lynn Mathre, RN, MSN, CARN
President and Co-founder
Patients Out of Time
Howardsville, Virginia
Chapter 37: Alcohol, Tobacco, and Other Drug Problems

Natalie McClain, PhD, RN, CPNP
Associate Clinical Professor Visiting Scholar
William F. Connell School of Nursing
Boston College
Chestnut Hill, Massachusetts
Chapter 44: Forensic Nursing in the Community

DeAnne K. Hilfinger Messias, PhD, RN, FAAN
Professor
College of Nursing and Women's and Gender Studies
University of South Carolina
Columbia, South Carolina
Chapter 13: Epidemiology

Emma McKim Mitchell, PhD, MSN, RN
Assistant Professor
Department of Family, Community & Mental Health Systems
University of Virginia School of Nursing
Charlottesville, Virginia
Chapter 4: Perspectives in Global Health Care

Carole R. Myers, PhD, MSN, BS
Associate Professor
College of Nursing
University of Tennessee
Knoxville, Tennessee
Chapter 31: Health Equity and Care of Vulnerable Populations

Victoria P. Niederhauser, DrPH, RN, PPCNP-BC, FAAN
Dean and Professor
College of Nursing
University of Tennessee
Knoxville, Tennessee
Chapter 19: Health Education Principles Applied in Communities, Groups, Families, and Individuals for Healthy Change

Eunhee Park, PhD, RN, APHN-BC
Assistant Professor
School of Nursing
University at Buffalo
Buffalo, New York
Chapter 18: Building a Culture of Health to Influence Health Equity Within Communities

Bobbie J. Perdue, RN, PhD
Professor Emerita
College of Human Ecology
Syracuse University
Syracuse, New York;
Adjunct faculty
Jersey College of Nursing
Tampa, Florida
Chapter 8: Achieving Cultural Competence in Community Health Nursing

Bonnie Rogers, DrPH, COHN-S, LNCC, FAAN
Professor and Director
North Carolina Occupational Safety and Health Education and Research Center
University of North Carolina
Chapel Hill, North Carolina
Chapter 43: The Nurse in Occupational Health

Cynthia Rubenstein, PhD, RN, CPNP-PC
Chair and Professor
Nursing
Randolph-Macon College
Ashland, Virginia
Chapter 28: Child and Adolescent Health

Barbara Sattler, RN, MPH, DrPH, FAAN
Professor
School of Nursing and Health Professions
University of San Francisco
San Francisco, California
Chapter 6: Environmental Health

Erika Metzler Sawin, PhD
Associate Professor
Nursing
James Madison University
Harrisonburg, Virginia
Chapter 15: Communicable and Infectious Disease Risks

Marjorie A. Schaffer, PhD, PHN, RN
Professor Emerita
Nursing
Bethel University
St. Paul, Minnesota
Chapter 11: Population-Based Public Health Nursing Practice: The Intervention Wheel

Cynthia Selleck, PhD, RN, FAAN
Adjunct Professor
University of Alabama at Birmingham School of Nursing
Birmingham, Alabama
Chapter 20: The Nurse-Led Health Center: A Model for Community Nursing Practice

Sallie J. Shipman, EdD, MSN, RN, CNL, NHDP-BC
Clinical Assistant Professor
College of Nursing
The University of Florida
Gainesville, Florida
Chapter 39: Advanced Nursing Practice in the Community

Maria R. Shirey, PhD, MBA, RN, NEA-BC, ANEF, FACHE, FNAP, FAAN
Associate Dean, Clinical and Global Partnerships
Jane H. Brock-Florence Nightingale Endowed Professor in Nursing
University of Alabama at Birmingham School of Nursing
Birmingham, Alabama
Chapter 20: The Nurse-Led Health Center: A Model for Community Nursing Practice

Donna E. Smith, MSPH
Epidemiology Specialist
Epidemiology Program
Mecklenburg County Health Department
Charlotte, North Carolina
Chapter 14: Infectious Disease Prevention and Control

Sherrill J. Smith, RN, PhD, CNE, CNL
Professor
College of Nursing and Health
Wright State University
Dayton, Ohio
Chapter 21: Public Health Nursing Practice and the Disaster Management Cycle

Patricia M. Speck, DNSc, APN, APRN, FNP-BC, DF-IAFN, FAAFS, FAFN, FAAN
Professor
Family, Community, & Health Systems
University of Alabama at Birmingham School of Nursing
Birmingham, Alabama
Chapter 39: Advanced Nursing Practice in the Community

Sue Strohschein, MS, RN/PHN, APRN, BC
Culture of Excellence Project Coordinator
University of Minnesota
School of Nursing
Minneapolis, Minnesota
Chapter 11: Population-Based Public Health Nursing Practice: The Intervention Wheel

Melissa A. Sutherland, PhD, FNP-BC
Professor
Nursing
Binghamton University
Binghamton, New York
Chapter 44: Forensic Nursing in the Community

Laura Suzuki, PhD(c), MPH, BSN, RN
Doctoral student
Connell School of Nursing
Boston College
Boston, Massachusetts
Chapter 44: Forensic Nursing in the Community

Michele H. Talley, PhD, ACNP-BC, FAANP
Assistant Professor and Assistant Dean for Graduate Clinical Education
University of Alabama at Birmingham
Birmingham, Alabama
Chapter 20: The Nurse-Led Health Center: A Model for Community Nursing Practice

Esther J. Thatcher, PhD, RN, APHN-BC
Assistant Nurse Manager
Internal Medicine
University of Virginia Health System
Charlottesville, Virginia
Chapter 17: Community As Client: Assessment and Analysis

Anita Thompson-Heisterman, MSN, PMHCNS-BC, PMHNP-BC
Assistant Professor
School of Nursing
University of Virginia
Charlottesville, Virginia
Chapter 36: Mental Health Issues

Lisa M. Turner, PhD, RN, PHCNS-BC
Associate Professor of Nursing
Department of Nursing
Berea College
Berea, Kentucky
Chapter 10: Evidence-Based Practice
Chapter 40: The Nurse Leader in the Community

Connie M. Ulrich, PhD, RN, FAAN
Professor of Nursing and Bioethics
University of Pennsylvania
Philadelphia, Pennsylvania
Chapter 7: Application of Ethics in the Community

Lynn Wasserbauer, RN, FNP, PhD
Nurse Practitioner
Strong Ties Community Support Program
University of Rochester Medical Center
Rochester, New York
Chapter 30: Disability Health Care Across the Life Span

Jacqueline Webb, DNP, FNP-BC, RN
Associate Professor
School of Nursing
Linfield College
Portland, Oregon
Chapter 26: Working With Families in the Community for Healthy Outcomes

Connie White-Williams, PhD, RN, NE-BC, FAHA, FAAN
Senior Director, Nursing
University of Alabama at Birmingham Hospital
Birmingham, Alabama;
Assistant Professor
University of Alabama at Birmingham School of Nursing
Birmingham, Alabama
Chapter 20: The Nurse-Led Health Center: A Model for Community Nursing Practice

Carolyn A. Williams, RN, PhD, FAAN
Professor and Dean Emerita
College of Nursing
University of Kentucky
Lexington, Kentucky
Chapter 1: Public Health Foundations and Population Health

Lisa M. Zerull, PhD, RN-BC
Director and Academic Liaison
Nursing
Winchester Medical Center-Valley Health System
Winchester, Virginia;
Adjunct Clinical Faculty
School of Nursing
Shenandoah University
Winchester, Virginia
Chapter 45: The Nurse in the Faith Community

Elke Jones Zschaebitz, DNP, APRN, FNP-BC
Family Nurse Practitioner
School of Nursing and Health Science
Georgetown University
Washington, DC
Chapter 12: Genomics in Public Health Nursing

CONTRIBUTOR BIOGRAPHIES

Swann Arp Adams, MS, PhD
Dr. Swann Arp Adams has over 17 years of experience in clinical epidemiology. She holds a PhD in epidemiology and an MS in biomedical sciences. Dr. Adams has previous experience in a variety of research fields, including physical activity, bone marrow transplantation, diabetes, breast cancer, and cancer disparities. She is the Associate Director of the Cancer Prevention and Control Program and is an associate professor with a joint appointment in the College of Nursing and the Department of Epidemiology and Biostatistics at the University of South Carolina. Her current research work focuses on reducing the burden of cancer disparities experienced by African Americans. Past honors include the Doctoral Achievement Award (2004) and the Gerry Sue Arnold Alumni Award (2008) from the Arnold School of Public Health of the University of South Carolina.

Mollie E. Aleshire, DNP, MSN, FNP-BC, PPCNP-BC, FNAP
Dr. Mollie E. Aleshire is a faculty member at the University of North Carolina Greensboro School of Nursing and is certified as a family nurse practitioner and pediatric primary care nurse practitioner. Dr. Aleshire has taught interprofessional health care systems, health promotion, and primary care prevention in both undergraduate and graduate courses. She received a master of science in nursing and a doctor of nursing practice from the University of Kentucky. Dr. Aleshire maintains an active clinical practice in a rural community health center, where she provides collaborative care for diverse patient populations across the life span. Both locally and nationally, Dr. Aleshire serves in leadership roles as well as maintaining active membership in the American Public Health Association (APHA) and its Social Justice and Diversity Committee. Dr. Aleshire's primary clinical and scholarship interests include promoting health and health care access for vulnerable and minority populations with a focus on LGBTQ* populations.

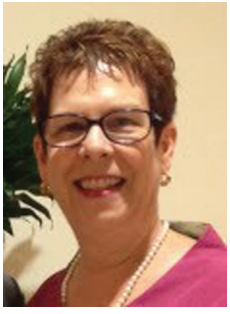
Jeanne L. Alhusen, PhD, CRNP, RN, FAAN
Jeanne L. Alhusen is an associate professor and Assistant Dean for Research at the University of Virginia School of Nursing. Her BSN, MSN, and PhD are from Villanova University, Duke University, and Johns Hopkins University. Dr. Alhusen works as a family nurse practitioner, and her research interests are in maternal mental health and early childhood outcomes, particularly among families living in poverty. She has received funding from the National Institutes of Health (NIH) to conduct research on the impact of domestic violence on early childhood outcomes.

Kacy Allen-Bryant, PhD(c), MSN, MPH, RN
Kacy Allen-Bryant is a lecturer for the University of Kentucky College of Nursing. In that role, Allen-Bryant engages in community outreach to a host of organizations, including homeless shelters, day centers for those with mental illnesses, after-school programs for disadvantaged youth, and the public school system. For the past 18 years she has worked in a variety of community/public health settings such as home health, schools, and worksites. She has been a longtime member of the Lexington-Fayette County Health Department Board of Health and currently serves as its chair. During her time on the board she has been instrumental in such initiatives as the passing of a resolution to add electronic cigarettes to the Lexington-Fayette County smoking ordinance and implementation of the Needle Exchange Program. Ms. Allen-Bryant is also the Director of Occupational Health for KC WELLNESS, INC. and is currently in the University of Kentucky College of Nursing's PhD program. She received a bachelor of science degree in nursing, master of science degree in nursing, master of public health degree, and a graduate certificate in gerontology, all from the University of Kentucky. Her research interest is workplace smoking- and tobacco-related policies.

Debra Gay Anderson, PhD, PHCNS-BC
Dr. Debra Gay Anderson is the Associate Dean of Research at South Dakota State University's College of Nursing. She is certified as a clinical specialist in public/community health nursing and has provided health care for the homeless and other vulnerable populations. Dr. Anderson has taught public health, epidemiology, leadership, and research courses at both the graduate and undergraduate levels. The focus of her program of research, publications, and presentations is social justice, particularly with vulnerable populations, including women who have experienced homelessness, domestic violence, or workplace violence. Dr. Anderson completed her doctoral studies and a family nursing postdoctoral fellowship at Oregon Health Sciences University in Portland, Oregon. Dr. Anderson is an active member of the American Public Health Association (APHA) and has served in various leadership capacities, including Chair of the Public Health Nursing Section of APHA.

Sydney A. Axson, MPH, RN
Ms. Axson is a doctoral student and Hillman Scholar in Nursing Innovation at the University of Pennsylvania School of Nursing.

Amber M. Bang, RN, BSN
Amber Bang graduated from Reed College with a BA in biology, specializing in neuroscience. She then received her BSN at Duke University School of Nursing in 2015. She works as a community health nurse, serving largely unhoused and low-income populations. She has experience in primary care engaging with addictions treatment and currently works in a drug and alcohol detoxification center, as well as a youth correctional facility.



Whitney Rogers Bischoff, DrPH, MSN, BSN
Dr. Whitney Bischoff is retired from the Canseco School of Nursing at Texas A&M International University in Laredo, Texas. She has worked in hospitals, clinics, as a parish nurse, and for 20 years as a nurse educator teaching undergraduate and graduate courses in community health, research, transcultural nursing, public health, health policy, and nursing administration. She has a particular interest in financing of health care. Her presentations and publications have been in the areas of technology in education and practice.

Nisha D. Botchwey, PhD, MCRP, MPH
Nisha Botchwey earned her AB from Harvard University, MCRP and PhD in City and Regional Planning from the University of Pennsylvania, and her MPH from the University of Virginia. She was on the faculty at the University of Virginia in Urban and Environmental Planning and Public Health. She is currently an Associate Professor of City and Regional Planning in the College of Design at the Georgia Institute of Technology and Professor of Public Health at Emory University's School of Public Health. Dr. Botchwey specializes in community engagement, public health, and health equity. She conducts research on healthy communities, youth engagement for health, and data dashboards for evidence-based decision. Dr. Botchwey is Director of the Healthy Places Lab that oversees the work of the Physical Activity Research Center, the Built Environment and Public Health Clearinghouse (www.bephc.gatech.edu), the Atlanta Dashboard, and the Health, Environment and Livability Platform for Fulton County. Botchwey is an NSF ADVANCE Woman of Excellence Faculty award recipient, Georgia Tech Outstanding Faculty, member of the National Academies of Science, Engineering and Medicine Committee on Summertime Experiences and Child and Adolescent Education, Health and Safety, and served on the Advisory Committee to the Director of the Centers for Disease Control and Prevention.

Kathryn H. Bowles, RN, PhD, FAAN
Kathryn H. Bowles is the van Ameringen Professor of Nursing Excellence at the University of Pennsylvania School of Nursing and the Vice President and Director of the Center for Home Care Policy and Research at the Visiting Nurse Service of New York. Her program of research focuses on improving the care of adults using information technology such as decision support for hospital discharge planning and referral decision making, examining the effects of early and intensive home care, as well as testing telehealth technologies in community-based settings.

Hazel Brown, DNP, RN
Dr. Hazel Brown is Chief Nursing Officer for the Health Services Authority, Cayman Islands. She received her BSN from West Indies College in Mandeville, Jamaica, and MSN from the University of Miami, in Miami, Florida. In 2016, she completed her DNP from American Sentinel University. Her clinical background is in primary health care and her leadership expertise has been honed in over 30 years of escalating responsibility in the national health system. She is a passionate advocate of the theory of complex adaptive systems as an explanation of the context of modern health care systems and a guide for leadership development strategies. She is a Rotarian for whom the motto "Service Above Self" is a guide to daily practice and advocacy locally and regionally.

Bonnie L. Brueshoff, DNP, MSN, RN, PHN
Bonnie Brueshoff is the Director for the Dakota County Public Health Department located in West St. Paul, Minnesota. She has been in this position for the past 10 years. In her current role, Brueshoff manages and provides leadership for the public health department, including 100 staff and a budget of $10 million. Her expertise in public health has been sought out at the national, state, and regional levels, having held leadership roles with the National Association of County and City Health Officials (NACCHO) and the Minnesota Local Public Health Association.

Angeline Bushy, PhD, RN, FAAN
Dr. Angeline Bushy, Professor and Bert Fish Endowed Chair at the University of Central Florida College of Nursing, holds a BSN degree from the University of Mary in Bismarck, North Dakota; an MN degree in rural community health nursing from Montana State University in Bozeman; an MEd in adult education from Northern Montana College in Havre; and a PhD in nursing from the University of Texas at Austin; and is a Fellow in the American Academy of Nursing. Dr. Bushy has worked in rural health care facilities located in the north-central and intermountain states; presented nationally and internationally on various rural nursing and rural health issues; published six textbooks and numerous articles on that topic; and is a U.S. Army Reserve Lieutenant Colonel (Ret.).

Jacquelyn C. Campbell, PhD, RN, FAAN
Jacquelyn C. Campbell is the Anna D. Wolf Chair and Professor at the Johns Hopkins University School of Nursing with a joint appointment in the Bloomberg School of Public Health. Her BSN, MSN, and PhD are, respectively, from Duke University, Wright State University, and the University

of Rochester schools of nursing. Dr. Campbell has been the principal investigator on 10 major National Institutes of Health, National Institute of Justice, and Centers for Disease Control and Prevention research grants and has published more than 220 articles and seven books on this subject. She is an elected member of the National Academy of Medicine and the American Academy of Nursing, is on the Board of Directors of Futures Without Violence, and was a member of the congressionally appointed U.S. Department of Defense Task Force on Domestic Violence.

Catherine Carroca, MSN, RN

Catherine Carroca is a community health nurse and nurse educator. She received her bachelor's degree in nursing from the University of Massachusetts, Amherst, and her master's degree in nursing education from Norwich University in Vermont. She is currently an assistant professor at Massachusetts College of Pharmacy and Health Sciences in Worcester, Massachusetts, where she teaches community and home health nursing in an accelerated post-baccalaureate program. She has presented her work on simulation in community health at the St. Anselm's and the Massachusetts/Rhode Island League for Nursing (MARILN) conferences. She is currently pursuing her doctorate in global public health.

Ann H. Cary, PhD, MPH, RN, FNAP, FAAN

Dr. Ann H. Cary began practicing public health nursing as a home health nurse in New Orleans, Louisiana, where she executed case management functions daily. She has served on national workgroups to establish the standards of practice for public health nurses and case managers and organizations that created certification examinations for case managers, authored numerous articles on case management issues, taught baccalaureate and graduate-level courses in case management, and directed graduate programs in case management and continuity of care and care coordination. She is the Dean of the School of Nursing and Health Studies at the University of Missouri, Kansas City, Missouri. In Kansas City, she also serves on a variety of nonprofit and interprofessional foundation, health care systems, and community boards whose missions are to increase access, coordinated care, and quality delivery for clients and to prepare health care leaders of the future to assure population health.

Laura H. Clayton, PhD, RN, CNE

Dr. Clayton earned her PhD from West Virginia University (WVU) in 2007, certificate in health care administration from WVU in 1998, master of science in nursing and family nurse practitioner from WVU in 1993, and bachelor of science in nursing from Alderson-Broaddus College in 1983. Dr. Clayton co-founded the Emmanuel's Table Free Clinic in Martinsburg in 2006, serves on the Eastern Panhandle Medical Reserve Corps Steering Committee, is the peer reviewer for Nursing Education Perspectives by the National League for Nursing, and is the president of the board of directors for the Shenandoah Valley Medical System. In 2010 she received the West Virginia University School of Nursing Golden Graduate Award and received the Nursing Excellence Award in Nursing Education from the West Virginia Center for Nursing in 2007. Dr. Clayton received her certification as a certified nurse educator by the National League for Nursing in 2010.

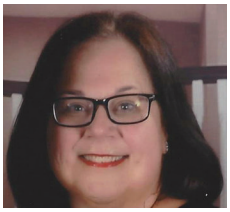
Erin G. Cruise, PhD, RN

Dr. Erin Cruise completed her BSN at Berea College in Berea, Kentucky, where she was first introduced to the concepts of community and public health nursing. Service to the community is a major focus at Berea: nursing students provide health education and screening programs to vulnerable populations, such as seniors, low-income families, and schoolchildren as part of their clinical education. Here, Dr. Cruise learned that poverty and lack of education can lead to poor health and prevent vulnerable populations from achieving their full potential. Dr. Cruise has worked in a variety of inpatient and outpatient settings, but her true passions are public health and school health. Forming relationships with community members helped her understand important influences on her clients' health, illness, or ability to access health care. She was a school nurse supervisor for many years and developed programs and policies in two counties in the Appalachian region of southwestern Virginia. Dr. Cruise completed her MSN in community/public health leadership at the University of Virginia and her PhD in health education/curriculum and instruction from Virginia Tech. Her dissertation research was in the field of school nurse education. Dr. Cruise is an associate professor at Radford University School of Nursing and leads the undergraduate community health nursing course. She also teaches health promotion to DNP students and writes and presents nationally on the subjects of health literacy and school health. Her students work with school nurses in their clinics and provide health education and screening for schoolchildren throughout the region.

Lois A. Davis, RN, MSN, MA

Lois A. Davis began her public health career in 1977 in Eastern Kentucky with the Breathitt County Health Department, where she worked with the Appalachian population in a variety of public health preventive programs. She expanded her role in public health as a school nurse and initiated a program to reduce teen pregnancy in the Breathitt County Schools. She worked in community mental health and understands the importance of community partnerships. Lois spent three years in South America and afterwards fulfilled a desire to assist migrant health populations and the underserved. After 20 years in community/public health nursing, Lois retired in July 2016 from the Lexington–Fayette County Health Department in Lexington, Kentucky, where she served as the Maternal–Child Health Coordinator and directed several community services programs, including Health Access Nurturing Development Services (HANDS), school health, and health equity and education. She has functioned as incident commander for preparedness exercises and as the operations lead for real events, such as special needs shelters during ice storms. At the state level, Lois served on the Nurse Executive Council, where she helped define public health protocols and public health nursing competencies for local health department nurses. Lois served on the board of the Bluegrass Community Health Center, a Health Resources and Services Administration (HRSA) Federally Qualified Health Center, for 10 years. She is currently on the board of the Kentucky CancerLink, a

local nonprofit that provides case management services for cancer victims. Additionally, she has served as an adjunct faculty member and on advisory boards for the University of Kentucky College of Nursing, Eastern Kentucky University, and Midway College. She has precepted numerous nursing students and is passionate about preventive health. Lois currently works as a public health clinical instructor for the University of Kentucky College of Nursing.



Sharon K. Davis, DNP, APRN, WHNP-BC

Sharon K. Davis earned her diploma in nursing from St. Mary's School of Nursing in Knoxville, Tennessee, BSN and MSN from the University of Tennessee, Knoxville, and DNP from the University of Tennessee, Chattanooga. She began her nursing practice in obstetrics and gynecology at a regional hospital and then transitioned to a private practice where she cared for women for over 20 years. In 2010, she entered academia, where she teaches core courses in the doctor of nursing practice program.

Karen R. Dawn, DNP, MSN, BSN

Karen Dawn is a registered nurse with over 30 years' experience in diabetes management, disease prevention, health promotion, and patient education. She completed a DNP from the University of Virginia School of Nursing in March 2014. She is a full-time faculty member at George Washington University school of nursing in the accelerated second-degree program focusing on public health and chronic disease prevention, specifically diabetes.

Cynthia E. Degazon, RN, PhD

Dr. Cynthia E. Degazon is Professor Emerita at Hunter College, City University of New York. She received a BS in nursing from Long Island University and an MA in community health nursing and a PhD in nursing research and theory development from New York University. For 20 years she has prepared undergraduate and graduate nurses to provide culturally competent care to ethnically diverse populations. Dr. Degazon has given many national and international presentations and authored several scholarly publications.

Janna Dieckmann, PhD, RN

Dr. Janna Dieckmann is an associate professor at the University of North Carolina at Chapel Hill. She received her BSN from Case Western Reserve University and her MSN in community health nursing and her PhD from the University of Pennsylvania. She has practiced as a public health nurse with both the Visiting Nurse Association of Cleveland, Ohio, and the Visiting Nurse Association of Philadelphia. She uses written and oral historical materials to research the history of public health nursing and care of the chronically ill and to comment on contemporary health policy.

Sherry L. Farra, PhD, RN, CNE, CHSE, NDHP-BC

Dr. Sherry Farra has practiced nursing for over 30 years and is experienced in emergency and disaster preparedness, response, and recovery. She is an associate professor at Wright State University in Dayton, Ohio, where she is the Director for the National Disaster Health Consortium. Dr. Farra is the Research Consultant to the Chief Nurse of the American Red Cross. As a nurse educator, she has designed, developed, and launched disaster courses for health care providers for nurses and other allied health professionals. She is a certified disaster health care provider and has a research concentration in disaster training, including the use of virtual reality training.

Mary E. Gibson, PhD, RN

Dr. Mary E. Gibson was a public health nurse in Albemarle County, Virginia, early in her career. Since that time, she has practiced in a variety of maternal–child health settings. Mary was involved in the Virginia Department of Health's early initiative to regionalize high-risk pregnancies and has worked as an outpatient nurse, childbirth educator, and perinatal outreach nurse, including systems work with regional hospitals and nurses, and outreach education; and as a labor and delivery and perinatal nurse. She concentrated on community health in her master's program, and her doctoral work at University of Pennsylvania focused on nursing history, and this continues to be her research focus. She currently serves as President of the American Association for the History of Nursing. At the University of Virginia, Mary serves as the Associate Director of the Bjoring Center for Nursing Historical Inquiry and her teaching experience includes graduate-level community assessment, undergraduate obstetrics and neonatal nursing, and clinical undergraduate community health nursing. She is currently a member and past chair of a local nonprofit organization's board that serves at-risk, underserved children and families.

Mary Kay Goldschmidt, DNP, MSN, RN, PHNA-BC

Mary Kay Goldschmidt holds a BSN, an MSN in public health nursing leadership, and a DNP from the University of Virginia in Charlottesville and holds a certificate in advanced public health nursing. She is an assistant professor of nursing at Virginia Commonwealth University School of Nursing. Her research and clinical practice focuses on working with medically underserved populations and health policy. Dr. Goldschmidt completed a fellowship in translational research and public policy at the L. Douglas Wilder School of Government and Public Affairs at Virginia Commonwealth University and currently serves as the Commissioner on Government Relations for the Virginia Nurses Association. Dr. Goldschmidt continues to develop and advocate for health policy which supports the health and well-being of all Virginians. She is the co-director of two HRSA Nursing Education, Practice, Quality and Retention grants, which seek to increase access to health care for medically underserved populations by strengthening the nursing workforce in community-based primary care settings. Dr. Goldschmidt

serves as a volunteer with Remote Area Medical Clinics and Homeward Virginia and continues her work with vulnerable populations such as those living in multidimensional poverty, the homeless, children, and victims of natural disaster.

Monty Gross, PhD, MSN, RN, CNE, CNL

Dr. Monty Gross is Senior Nurse Leader for Professional Development for the Cayman Islands Health Service Authority in Grand Cayman. He received his BS in communications from Clarion University of Pennsylvania and his BSN and MSN from the University of Virginia. His PhD was awarded from Virginia Tech. He has practiced nursing in acute care, critical care, and underserved communities in Latin America. He serves as a Commission on Collegiate Nursing Education (CCNE) nursing program on-site evaluator. He has taught nursing as an associate professor at the undergraduate and graduate levels.

Melanie Gibbons Hallman, DNP, CRNP, CEN, FNP-BC, ACNP-BC, FAEN

Dr. Hallman is an instructor at the University of Alabama at Birmingham School of Nursing in Birmingham, Alabama. Dr. Hallman has provided prehospital and hospital emergency services for more than 39 years. She continues to provide patient care as an emergency nurse practitioner and volunteers with various organizations as a family nurse practitioner, providing access to medically underserved populations locally and internationally. Dr. Hallman has been an active member of the Emergency Nurses Association since 1988, serving in multiple leadership positions at local, state, and national levels.

Joanna Horn, BA, MS

Joanna Horn is a senior genetic counselor in the Center for Human Genetics at University Hospital Cleveland Medical Center. She currently works with both pediatric and oncology populations but has also worked in prenatal genetics. She has over a decade of experience working in academic medical centers. She is dedicated to making the field of genetics accessible to her patients and families and working collaboratively with her health care teams.

Gerard M. Jellig, EdD

Gerard M. Jellig is Head of Secondary Schools and Turnaround Principal for KIPP DC. He is a Turnaround for Children trained team member and has instituted trauma-informed teaching practices on his urban campus, reducing office referrals 80% and suspensions 99%, while dramatically increasing test scores. He has been a teacher, principal, and superintendent over 25 years in public education. Dr. Jellig has a BA in history and secondary education from Providence College, MA from Johns Hopkins University in leadership and literacy practice, and an EdD from University of Pennsylvania, where his research focused on the impact of emotional intelligence on leadership practice in diverse, challenged public schools. He's on the faculty at the University of Pennsylvania and has also taught at Johns Hopkins and Rowan University.

Tammy Kiser DNP, RN

Dr. Tammy Kiser is an assistant professor of nursing at James Madison University, where she teaches community health and faith community nursing courses. Her areas of research interest are vulnerable populations. Dr. Kiser has worked with several community initiatives, including working extensively with the Healthcare for the Homeless Suitcase Clinic in Harrisonburg, Virginia, both on the leadership team and in clinics, since 2009. She received her bachelor's degree in nursing from Eastern Mennonite College, master's degree in nursing from James Madison University, and an MSN certificate and DNP from the University of South Alabama in public health nursing administration.

Andrea Knopp, PhD, MSN, MPH, FNP-BC

Dr. Andrea Knopp is an associate professor of nursing at James Madison University and coordinator of the nurse practitioner program. She received her BSN in nursing from the Medical College of Georgia and her master of science in nursing and master of public health from Emory University. Her PhD was awarded from the University of Virginia. Dr. Knopp stays active as a family nurse practitioner and conducts international research and domestic research focused on disadvantaged and vulnerable populations. In 2013, she received the VCNP Education Award from the Virginia Council of Nurse Practitioners and the March of Dimes Nurse of the Year Educator Award in 2017.

Candace Kugel, BA, MS, FNP, CNM

Ms. Candace Kugel has over 30 years' experience in health care for the underserved. She is a family nurse practitioner and certified nurse-midwife with extensive expertise in training and technical assistance to under resourced communities and working to provide health services to farmworkers, immigrant workers and families, and other underserved populations. She has worked in various clinical settings, including family planning, migrant health, community health centers, and private practice. She currently works as a clinical specialist for the Migrant Clinicians Network and as a clinical consultant for the HRSA Bureau of Primary Health Care.

Ms. Kugel has extensive experience in the United States and internationally with training of community health workers and health education using popular education methodology. She has written and provided continuing education on cultural competency, women's health access, and services in under-resourced settings.

Pamela A. Kulbok, DNSc, RN, PHCNS-BC, FAAN

Pamela A. Kulbok earned her BS and MS at Boston College, her doctorate at Boston University, and did postdoctoral work in psychiatric epidemiology at Washington University in St. Louis. She was on the faculty at St. Louis University, University of Illinois at Chicago, and the Catholic University of America. She is Professor Emerita, University of Virginia School of Nursing. She has taught undergraduate and graduate courses in public health nursing, health promotion research, and nursing knowledge development. Dr. Kulbok is a Robert Wood Johnson Foundation Executive Nurse Fellow (2012 cohort). She was the principal investigator of an interprofessional, cross-institution, community-based participatory research project to design a youth substance use prevention program and of a series of studies of youth nonsmoking behavior. She was chair of the Environmental and Public Health Expert Panel, American Academy of Nursing; co-chair of the American Nurses Association workgroup that revised the Public Health Nursing: Scope and Standards of Practice (2013); a member of the American Public Health Association (APHA) PHN Section taskforce that updated the Definition of Public Health Nursing (2013); president of the Association of Community Health Nursing Educators, and chair of the Quad Council of Public Health Nursing Organizations. In 2016, she was awarded the APHA, Public Health Nursing Section's Ruth B. Freeman Distinguished Career Award.

Jeanette Lancaster, PhD, RN, FAAN

Dr. Lancaster is Professor and Dean Emerita of Nursing at the University of Virginia. She has edited this book with Dr. Marcia Stanhope through its previous nine editions.

Roberta Proffitt Lavin, PhD, FNP-BC, FAAN

Roberta Lavin, Professor and Associate Dean of Academic Programs, spent 20 years as a U.S. Public Health Service (USPHS) officer. She began her career at St. Elizabeths Hospital in Washington, DC, on an acute psychiatric admission unit for those who were homeless. In her work she has coordinated mass migrations in Guatemala, managed health care in an immigration detention center in Batavia, New York, before becoming the Chief of Field Operations of the Division of Immigration Health Services, worked for the Federal Bureau of Prisons in Tucson, Arizona, and spent a few months "tooling around" the South Pacific on a National Oceanic and Atmospheric Administration research vessel. After 9/11 and the anthrax attacks she was selected to be the Director of the Secretary's Command Center for the Department of Health and Human Services and later became the Chief of Staff for the Assistant Secretary for Preparedness and Response. She ended her USPHS career again working with the poor and underserved leading the research and development for a national disaster case management program. Her current research focuses on bringing cultural competency around urban and rural communities to practicing nurses and disaster preparedness. Current projects include infusion and assessment of cultural competency in training DNP students and research of training gaps for health care primary care providers for disaster response. She is developing an interprofessional curriculum around disaster preparedness.

Natasha Le, BA, BS

Natasha Le is a second-degree nurse who received her first degree in public health policy at the University of California, Irvine, and her BSN at the University of Pennsylvania School of Nursing, where she is also a graduate student working towards her MSN. Presently, she works at Penn Medicine's Home Care and Hospice entity as a Quality and Informatics Coordinator and as a temporary research employee at Drexel University College of Nursing and Health Professions. Her research focuses on understanding information requirements, decision-making needs, and workflow of home care nurse in the admission and care planning processes. Of specific interest to her is examining if and how health information technology helps or hinders these needs.

Susan C. Long-Marin, DVM, MPH

Susan Long-Marin developed an interest in infectious diseases and public health while serving as a Peace Corps Volunteer in the Philippines. Training in veterinary medicine further increased her respect for emerging infectious diseases, the ingeniousness of the microbes that cause them, and the importance of primary prevention. Today she manages the Epidemiology Program of the Mecklenburg County Health Department in Charlotte, North Carolina, which serves a rapidly growing and changing population. Dr. Long-Marin earned her doctor of veterinary medicine degree from the Virginia-Maryland College of Veterinary Medicine at Virginia Tech and her master of public health degree in epidemiology from the Norman J. Arnold School of Public Health at the University of South Carolina.

Karen S. Martin, RN, MSN, FAAN

Karen S. Martin is a health care consultant who has been in private practice since 1993. She works with clinicians, managers, administrators, educators, researchers, and software developers nationally and internationally. Her focus is evaluation and improvement of practice, documentation, and information management systems to meet quality, data exchange, and interoperability standards for electronic health records. Karen has been employed as a staff nurse, director of a combined home care/public health agency, and, from 1978 to 1993, the Director of Research of the Visiting Nurse Association of Omaha, Nebraska, where she was the principal investigator of Omaha System research.

Mary Lynn Mathre, RN, MSN, CARN
Mary Lynn Mathre earned the BSN from the College of St. Teresa in Winona, Minnesota, and the MSN from the Frances Payne Bolton School of Nursing at Case Western Reserve University. She has 39 years of experience as an acute care nurse and has worked in the field of alcohol, tobacco, and other drugs for the past 25 years. From 1991 to 2003, she worked as the addictions consult nurse for the University of Virginia Health System and interacted with many community resources to provide appropriate referrals and aftercare for clients. From 2004 to 2007, she worked in an outpatient opioid treatment program as the executive director. Currently she works as an independent consultant on substance abuse prevention and brief interventions. She is an active member of the International Nurses Society on Addictions and serves on the editorial board for the *Journal of Addictions Nursing*.

Natalie McClain, PhD, RN, CPNP
Dr. McClain earned her bachelor's and master's degrees from the University of Texas Health Sciences Center–Houston and her PhD from the University of Virginia. She has worked at the Children's Assessment Center, an advocacy center providing services for child victims of sexual abuse in Houston, Texas. At the assessment center and later in Charlottesville, Virginia, Dr. McClain performed medical forensic exams in cases of sexual assault, testified in both civil and criminal trials, and served as an expert witness for the FBI. Dr. McClain served on the 2012-2013 Committee on Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States. Dr. McClain is currently a visiting scholar at Boston College William F. Connell School of Nursing in Boston, Massachusetts.

DeAnne K. Hilfinger Messias, PhD, RN, FAAN
Dr. DeAnne K. Hilfinger Messias is an international community health nurse, educator, and researcher. She spent more than two decades in Brazil, where she directed a primary health care project on the lower Amazon, taught women's health and community health nursing, and organized women's health initiatives among poor urban populations. Her research and scholarship focus on women's work and health, immigrant women's health, language access, and community empowerment. Her current research involves a community-based intervention trial of a *promotora*-delivered physical activity intervention among low-income Latinas. Dr. Messias was a fellow with the International Center for Health Leadership Development at the School of Public Health, University of Illinois at Chicago (2002–2004) and a Fulbright Senior Scholar in Global/Public Health at the Federal University of Goiás, Brazil (2005). She is the Emily Myrtle Smith Endowed Chair and Carolina Trustee Professor of the University of South Carolina College of Nursing, with a joint appointment in the Women's and Gender Studies Program.

Emma McKim Mitchell, PhD, MSN, RN
Dr. Emma Mitchell is an assistant professor at the University of Virginia School of Nursing and co-directs global initiatives surrounding research, study abroad, and community-based capacity building in rural and remote settings. A public health nurse, her program of research has focused on women's health, health disparities, and particularly on the prevention of cervical cancer as a cancer of disparities globally. Her graduate work at the University of Virginia (MSN and PhD) centered on women's health in global settings. She completed her PhD in nursing at the University of Virginia, where she did extensive fieldwork in her NIH/National Institute of Nursing Research (NINR) funded ethnographic dissertation study with vulnerable women in Nicaragua. Winner of the 2017 Excellence in Education Award from the University of Virginia's Nursing Alumni Association and the 2018 University of Virginia Provost's Excellence in Education Award, Mitchell has developed innovative courses focused on women's health and social entrepreneurship in global settings. Locally, she has fostered a longtime partnership with community health workers trained in Charlottesville, Virginia, and surrounding rural areas, many of whom represent immigrant communities. Her publications support a global perspective on the need for culturally tailored nursing interventions to promote women's health and prevent cervical cancer.

Carole R. Myers, PhD, MSN, BS
Dr. Carole R. Myers is an associate professor at the University of Tennessee with a joint appointment in the College of Nursing and Department of Public Health.

Victoria P. Niederhauser, DrPH, RN, PPCNP-BC, FAAN
Dr. Niederhauser is Professor and Dean at the University of Tennessee Knoxville College of Nursing. Dr. Niederhauser is a board-certified pediatric nurse practitioner, a Robert Wood Johnson Executive Nurse Fellow and a fellow in the American Academy of Nursing. She has received several national awards and currently serves on the board of the Beryl Institute and the National Advisory Council for Accelerating Interprofessional Community-Based Education and Practice Initiative.

Eunhee Park, PhD, RN, APHN-BC
Eunhee Park earned her master's degree in the public health nursing leadership (PHNL) specialty track and her PhD degree at the University of Virginia. Dr. Park is an assistant professor of the School of Nursing at the University at Buffalo. With experience in a variety of community and clinical settings, she has taught undergraduate and graduate public health nursing courses, such as public health nursing practicum, health promotion and epidemiologic methods, informatics in health care, health

behavior and health promotion research, nursing care in the community, public health nursing leadership, etc. Her research focus is on health promotion with the use of technology and community-based approaches to find innovative ways to promote population health particularly for adolescents and vulnerable populations. Therefore her research areas include understanding the factors of health behavior patterns and trajectory development, the development of youth health education programs utilizing interactive technology and health literacy strategies for smoking and substance use prevention, and linking individual health with the community for health promotion via the community participatory approach.

Bobbie J. Perdue, RN, PhD

Dr. Bobbie Perdue is Professor Emerita at Syracuse University. Her teaching career in nursing spans 46 years and includes the teaching of associate degree, baccalaureate, and master's degree nursing students. She received a BSN from Vanderbilt University, an MSN in child-psychiatric mental health nursing from Wayne State University, and a PhD in nursing research and theory development from New York University.

Bonnie Rogers, DrPH, COHN-S, LNCC, FAAN

Bonnie Rogers is a professor of public health and nursing and is Director of the North Carolina Occupational Safety and Health Education and Research Center and the Occupational Health Nursing Program at the University of North Carolina, School of Public Health, at Chapel Hill, North Carolina. Dr. Rogers received her diploma in nursing from the Washington Hospital Center School of Nursing, Washington, DC; her baccalaureate in nursing from George Mason University School of Nursing, Fairfax, Virginia; and her master of public health degree and doctorate in public health, the latter with a major in environmental health sciences and occupational health nursing, from the Johns Hopkins University School of Hygiene and Public Health, Baltimore, Maryland. She holds a postgraduate certificate as an adult health clinical nurse specialist. She is certified in occupational health nursing, case management, legal nurse consulting, and is a fellow in the American Academy of Nursing and the American Association of Occupational Health Nurses. Dr. Rogers completed an academic certificate program in bioethics and health policy at Loyola University, Chicago, is a nurse ethicist, and was invited to study ethics as a visiting scholar at the Hastings Center in New York. She was granted a National Institute for Occupational Safety and Health (NIOSH) career award to study ethical issues in occupational health. In addition to managerial, consultant, and educator/researcher positions, Dr. Rogers has also practiced for many years as a public health nurse, occupational health nurse, and occupational health nurse practitioner. She has published more than 200 articles and book chapters, and two books, including *Occupational and Environmental Health Nursing: Concepts and Practice* and *Occupational Health Nursing Guidelines for Primary Clinical Conditions,* in their third and fifth editions, respectively. She is a member of several editorial panels and has given nearly 500 presentations nationally and internationally on occupational health and safety issues, ethical issues in occupational health, and total worker health. Dr. Rogers has had several funded research grants on clinical issues in occupational health, health promotion, research priorities, hazards to health care workers, and ethical issues in occupational health. She is past editor for the *Journal of Legal Nurse Consulting*. Dr. Rogers is honored to serve as Chairperson of the NIOSH Board of Scientific Counselors. She was elected in 2013 as a fellow in the Collegium Ramazzini. She served two elected terms as Vice President of the International Commission on Occupational Health (ICOH) and completed two terms as Chairperson of the Scientific Committee on Education and Training in Occupational Health, ICOH. Dr. Rogers is past president of the American Association of Occupational Health Nurses and the Association of Occupational and Environmental Clinics and completed several terms as an appointed member of the National Advisory Committee on Occupational Safety and Health. She is a consultant in occupational health and ethics.

Dr. Rogers served as Chairperson of the NIOSH National Occupational Research Agenda Liaison Committee for 15 years and has served on numerous Institute of Medicine/National Academy of Medicine committees.

Cynthia Rubenstein, PhD, RN, CPNP-PC

Cynthia Rubenstein is currently chair of the nursing department and professor at Randolph-Macon College. She has extensive experience in pediatric nursing, including neonatal intensive care unit (NICU), emergency department (ED), home health, and primary care. She has been a practicing pediatric nurse practitioner for 20 years and has collaborated on childhood obesity prevention educational programs for Virginia's youth. She practices clinically through Remote Area Medical (www.ramusa.org) to support youth access to medical, dental, and vision care.

Barbara Sattler, RN, MPH, DrPH, FAAN

Dr. Barbara Sattler has a diploma in nursing from Pilgrim State Psychiatric Center School of Nursing, a BS in political science from the University of Baltimore, and the MPH and DrPH from Johns Hopkins University. She is a professor at the University of San Francisco. She is a founding member of the Alliance of Nurses for Healthy Environments (www.enviRN.org), a national network of nurses who are addressing the integration of environmental health into our nursing education, practice, research, and policy/advocacy efforts. She has been working in the area of environmental health and nursing for over three decades and has been involved in issues associated with air, water, food, and products, as well as climate change and energy policies as they relate to human health.

Erika Metzler Sawin, PhD

Erika Metzler Sawin is a second-degree nurse who received her master's in community health nursing from the University of Texas, Austin, and her PhD in nursing from the University of Virginia. She is an associate professor in the School of Nursing at James Madison University in Harrisonburg, Virginia, where she teaches community health nursing to BSN students. Her research interests are in the areas of domestic violence and culturally aware care. In 2015, she was a U.S. Fulbright-Nehru Scholar, teaching nursing and public health in Puducherry, India. She is currently Project Director for the HRSA NEPQR grant "Undergraduate Primary Care and Rural Education (UPCARE) Project: A Community-Based Nursing Education Collaboration" based in rural Page County, Virginia.

Marjorie A. Schaffer, PhD, PHN, RN
Marjorie Schaffer is Professor Emerita at Bethel University, where she taught public health nursing for 31 years. She consulted on public health nursing education during Fulbright awards in Norway and New Zealand and has published research articles on public health nursing practice and education.

Cynthia Selleck, PhD, RN, FAAN
Dr. Cynthia Selleck is Professor and Associate Dean for Clinical and Global Partnerships at the University of Alabama at Birmingham School of Nursing. In this role, she oversees faculty practice initiatives for the School of Nursing, including the school's nurse-led clinics and Nurse-Family Partnership program. Dr. Selleck also holds an appointment as professor in the Department of Family and Community Medicine at the University of Alabama School of Medicine and serves as Director of the Alabama Statewide Area Health Education Center (AHEC) Program. She received her bachelor's in nursing from Emory University, her master's as a family nurse practitioner from Vanderbilt University, and a PhD from the University of Alabama at Birmingham School of Nursing. Her interests include care of underserved populations, health disparities, social justice issues, team-based care, and the preparation of a primary care workforce for medically needy populations.

Sallie J. Shipman, EdD, MSN, RN, CNL, NHDP-BC
Sallie J. Shipman is a clinical assistant professor at the University of Florida College of Nursing in Gainesville, Florida, and teaches community/population and public health nursing in the undergraduate curriculum. She is board certified as a clinical nurse leader and national healthcare disaster professional. She has been teaching nursing since 2011 and has more than 18 years of experience as a public health nurse at the Alabama Department of Public Health (ADPH) with extensive experience in public health emergency preparedness planning, community/academic partnerships, and prenatal/perinatal outreach. She started her role at the ADPH Center for Emergency Preparedness in 2002 as an area surveillance nurse coordinator, which evolved into a state level position as a hazard vulnerability analysis nurse coordinator. Dr. Shipman serves nationally on the Practice Committee of the Society for the Advancement of Disaster Nursing.

Maria R. Shirey, PhD, MBA, RN, NEA-BC, ANEF, FACHE, FNAP, FAAN
Dr. Maria R. Shirey, professor in the School of Nursing at the University of Alabama at Birmingham, teaches in both the PhD in nursing and doctor of nursing practice programs, focusing on leadership, management, health policy, and scholarly writing. Since 2003 her program of research has focused on building leadership capacity to advance quality, safety, and health care transformation. Since joining the University of Alabama at Birmingham in 2013, Dr. Shirey has extended her funded scholarly work to include leadership for population health through testing of innovative interprofessional collaborative practice (IPCP) models to impact the Quadruple Aim outcomes of enhancing the patient experience, improving population health, reducing the cost of care, and enhancing care team member well-being. As principal investigator of a $1.5 million Health Resources Services Administration grant, "Interprofessional Collaborative Practice Enhancing Transitional Care Coordination in Heart Failure Patients," Dr. Shirey led the creation and sustainability of a medical home at UAB Hospital designed to provide guideline-driven, coordinated care for an uninsured, vulnerable population. The medical home serves as a clinical training site for students (undergraduate, graduate, doctoral) from multiple health professions to engage in both interprofessional education (IPE) and IPCP. Dr. Shirey's "real world" approach to leadership over the last 40 years well integrates her extensive experience as an accomplished nurse clinician, executive, educator, researcher, and scholar.

Dr. Shirey received a bachelor of science in nursing from Florida State University, a master of science in nursing from Texas Woman's University, a master of business administration from Tulane University, and a PhD in nursing science from Indiana University. Dr. Shirey's practice expertise is in executive nursing leadership, and her broad career experience includes roles as staff nurse, clinical nurse specialist, academic faculty, nurse manager, nursing director, hospital vice-president, clinic administrator, and entrepreneur.

Donna E. Smith, MSPH
Donna Smith is an epidemiology specialist with the Mecklenburg County Health Department in Charlotte, North Carolina. She has expertise in the areas of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) research, racial and ethnic health disparities, social determinants of health, and community health assessments. Prior to her work in Charlotte, Ms. Smith served as an epidemiologist with the South Carolina Office of Minority Health, where she researched a broad range of health disparity topics impacting minority populations. She also served as a project coordinator for the South Carolina HIV/AIDS Surveillance Unit, where she led a Centers for Disease Control and Prevention (CDC)-funded initiative researching risk behaviors of persons newly reported with HIV.

Ms. Smith earned her master's degree (MSPH) in epidemiology from the Norman J. Arnold School of Public Health, University of South Carolina in Columbia.

Sherrill J. Smith, RN, PhD, CNE, CNL
Dr. Sherrill Smith is a professor in the College of Nursing and Health at Wright State University in Dayton, Ohio, where she has taught full time since 2008. She served in the United States Air Force Nurse Corps for 26 years, retiring as a colonel in the Air Force Reserves in 2011. She is certified both as a nurse educator and clinical nurse leader. Her scholarship and funding is in the area of nursing education, including the use of virtual reality training for disaster training.

Patricia M. Speck, DNSc, APN, APRN, FNP-BC, DF-IAFN, FAAFS, FAFN, FAAN

Patricia Speck is a professor at the University of Alabama at Birmingham School of Nursing in Birmingham, Alabama, and the coordinator of the advanced forensic nursing program and internationally recognized as a board-certified family nurse practitioner (1984-present) and expert in advanced forensic nursing care of patients experiencing an intersection with the legal system. Her clinical practice with forensic populations globally spans over 35 years, consulting nationally and internationally in Africa, Eurasia, the Caribbean, and Central, South, and North America with governments, universities, institutions, and nongovernmental organizations to evaluate and implement infrastructure change in response to victims of violence. As a family nurse practitioner and forensic nursing practice expert who is a published and funded researcher, she develops policy, evaluates programs, and builds workforce capacity in rural and underserved communities through publication, education, and violence prevention initiatives. She was President of the International Association of Forensic Nurses (2003-2004) and Chair of the American Public Health Association's Family Violence Prevention Forum/Caucus (2011-2013), and her awards include fellow status from the International Association of Forensic Nurses (2001), American Academy of Forensic Sciences (2008), fellow in the Academy of Forensic Nursing (2018), and the premier American Academy of Nurses (2002). She was the first nurse to receive the Professional Impact Award from End Violence Against Women International organization in 2017.

Marcia Stanhope, PhD, RN, FAAN

Dr. Marcia Stanhope is former Associate Dean and is Professor Emeritus, University of Kentucky, Lexington, Kentucky. She has edited this book with Dr. Jeanette Lancaster through its previous nine editions.

Sue Strohschein, MS, RN/PHN, APRN, BC

Sue Strohschein's public health nursing career spans more than 40 years and includes practice in both local and state health departments in Minnesota. She was a generalized public health nurse consultant for the Minnesota Department of Health for 25 years. She provided leadership in the initial development and dissemination of the Public Health Intervention Wheel.

Melissa A. Sutherland, PhD, FNP-BC

Dr. Sutherland earned her bachelor's and master's degrees from Binghamton University in New York, and her PhD from the University of Virginia. She is a board-certified family nurse practitioner and a professor at the Decker School of Nursing, Binghamton University. Her major areas of research and practice are interpersonal violence and women's health. She is a member of the International Association of Forensic Nurses and the American Public Health Association.

Laura Suzuki, PhD(c), MPH, BSN, RN

Laura Suzuki is a public health nurse who has spent most of her career in a large local health department managing maternal and child health services for a diverse population of vulnerable women and families. She has worked for the Centers for Disease Control and Prevention in Atlanta, Georgia, and the World Health Organization in Africa. Dr. Suzuki's practice and research efforts focus on gender-based violence among marginalized women, including immigrants and ethnic minorities. Her dissertation centers on the phenomenon of reproductive coercion and the extent of autonomy in decision making related to sexual and reproductive health among low-income Latina women. She is an active member of the American Public Health Association, Public Health Nursing Section, and serves on the APHA Gun Violence Prevention Workgroup. She is a member of the Massachusetts Public Health Association and Massachusetts Association of Public Health Nurses. She has previously served on the Maternal Child Health Advisory Committee for the National Association of County and City Health Officials (NACCHO). She earned her BSN from the University of Virginia and her MPH from Johns Hopkins University. She currently is a doctoral candidate at the William F. Connell School of Nursing, Boston College.

Michele H. Talley, PhD, ACNP-BC

Dr. Talley, assistant professor at the University of Alabama at Birmingham School of Nursing, serves as the clinic director for a nurse-led clinic founded by the University of Alabama at Birmingham School of Nursing in 2011. This clinic, the Providing Access to Healthcare (PATH), was opened to provide care to uninsured patients with diabetes using an interprofessional model of care delivery. Additionally, in fulfillment of the school's tripartite mission (teaching, service, and scholarship), Dr. Talley serves as an educator, a provider of diabetes care, and a nursing researcher. Currently, she also serves as the master's program director where she leads a team of faculty in 11 different specialty tracks. Likewise, Dr. Talley serves as mentor and preceptor for MSN and DNP students. In her service role, Dr. Talley shares her extensive diabetes management expertise with patients while also addressing the challenges faced by this vulnerable population. Indeed, her research efforts are focused on diabetes self-care management with vulnerable patients. Dr. Talley received her bachelor of science in nursing (BSN) from the University of Alabama Capstone College of Nursing in 1996, her master of science in nursing (MSN) (adult acute care nurse practitioner) in 2005, as well as her doctor of philosophy in nursing in 2015 from the University of Alabama at Birmingham School of Nursing.

Esther J. Thatcher, PhD, RN, APHN-BC

As a BSN nursing student, Dr. Thatcher volunteered in El Salvador several times with a group called Nursing Students Without Borders. After graduating, she continued to work with Latinos as a migrant farmworker outreach nurse in rural Virginia. She then worked in adult internal medicine settings, where she became interested in preventing chronic diseases in underserved populations. Later, as a public health nurse, Dr. Thatcher reignited her interest in how community

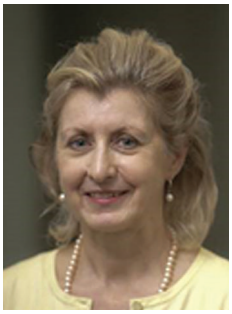
environments affect health outcomes. Her PhD research at the University of Virginia was to describe community influences on healthy food access in rural Appalachia. She completed a postdoctoral fellowship at the University of North Carolina–Chapel Hill, and now works at University of Virginia Health System.

Anita Thompson-Heisterman, MSN, PMHCNS-BC, PMHNP-BC

Anita Thompson-Heisterman earned the BSN, MSN, FNP, and PMHNP degrees and certificates from the University of Virginia. She began practicing community mental health nursing in 1983 as a psychiatric nurse in a community mental health center. Her community practice has included clinical and management activities in a psychiatric home care service, a nurse-managed primary care center in public housing, and an outreach program for rural older adults. Currently she is an assistant professor and assistant department chair in the Division of Family, Community and Mental Health Systems at the University of Virginia School of Nursing and co-director of global initiatives at the school of nursing.

Lisa M. Turner, PhD, RN, PHCNS-BC

Lisa M. Turner felt called to the field of public and community health nursing while obtaining her BSN degree, inspired by the focus on preventing disease and helping underserved populations. Since then, she has provided care for a wide variety of vulnerable populations, including children in the schools, adults who are homeless, low-income families, and elders in long-term care facilities. She served as a nurse and clinic coordinator of the Good Samaritan Nursing Center at the University of Kentucky for 12 years. Her work at the Good Samaritan Nursing Center focused on providing school health services to underserved populations as well as developing a K-12 school health curriculum for a county in rural Kentucky. She has lectured and supervised students studying public health nursing in myriad community settings, including school clinics, homeless shelters, and free clinics for adults and children. She has contributed to several projects to evaluate school health services and has presented at national and international symposia on nursing clinics in the community. Her research interests are in the areas of vulnerable populations, access to health care, and obesity prevention. She is an active member in several nursing organizations, including leadership roles in the Association of Community Health Nurse Educators. Dr. Turner currently serves as an associate professor at Berea College, Berea, Kentucky.



Connie M. Ulrich, PhD, RN, FAAN

Dr. Ulrich is a professor of nursing and bioethics and the Lillian S. Brunner Chair in Medical-Surgical Nursing at the University of Pennsylvania School of Nursing with a secondary appointment in the Department of Medical Ethics and Health Policy, Perelman School of Medicine.

Lynn Wasserbauer, RN, FNP, PhD

Lynn Wasserbauer earned an undergraduate degree in zoology from the State University of New York, Oswego, a BS and MS in nursing from the University of Rochester, and a PhD and FNP certificate from the University of Virginia. She is a nurse practitioner at the University of Rochester Medical Center. Her current practice is in psychiatric nursing.

Jacqueline Webb, DNP, FNP-BC, RN

Dr. Jackie Webb has been a practicing family nurse practitioner for over 25 years, working primarily with underserved populations. She has taught nursing students both at the undergraduate and graduate levels for the past 15 years. Currently she is an associate professor at Linfield College School of Nursing in Portland, Oregon. Her research focus is on community nursing and innovative delivery health care models to deal with chronic pain and health inequities in vulnerable populations. She is the current Oregon Chapter President of the National Association of Hispanic Nurses.

Connie White-Williams, PhD, RN, NE-BC, FAHA, FAAN

Dr. White-Williams is Senior Director of the University of Alabama Hospital Heart Failure Transitional Care Services for Adults (HRTSA) Clinic and the Center for Nursing Excellence and an assistant professor at University of Alabama School of Nursing (UABSON) in the Department of Acute, Chronic, and Continuing Care. She has extensive clinical experience in cardiovascular nursing, especially heart failure and heart transplantation. Dr. White-Williams served as the Clinical Practice Partner in the grant-funded HRSA Heart Failure Clinic for the Underserved. Dr. White-Williams received her BSN from the University of Pittsburgh in 1984, MSN in cardiovascular nursing (clinical nurse specialist) from UABSON in 1991, family nurse practitioner from UABSON in 2000, PhD in nursing from UABSON in 2009, and Post Graduate Certificate in Healthcare Quality and Safety in 2015. She also completed a Health Disparities Research Training Program in 2010 and a Hartford Geriatric Grant Writing Workshop in 2011.

Carolyn A. Williams, RN, PhD, FAAN

Dr. Carolyn A. Williams is Professor and Dean Emerita at the College of Nursing at the University of Kentucky, Lexington, Kentucky. Dr. Williams began her career as a public health nurse. She has held many leadership roles, including President of the American Academy of Nursing; membership on the first U.S. Preventive Services Task Force, Department of Health and Human Services; and President of the American Association of Colleges of Nursing. She received the Distinguished Alumna Award from Texas Woman's University in 1983. In 2001, she was the recipient of the Mary Tolle Wright Founder's Award for Excellence in Leadership from Sigma Theta Tau International, and in 2007 she received the Bernadette Arminger Award from the American Association of Colleges of Nursing. In 2011, she was awarded

an Honorary Doctorate of Public Service from the University of Portland, Portland, Oregon. In 2014, she received the honor of being inducted into the University of Kentucky College of Public Health Hall of Fame for international, national, state, and local contributions to public health and nursing, and in 2017 she was honored by the American Academy of Nursing as a Living Legend.

Lisa M. Zerull, PhD, RN-BC

Dr. Lisa M. Zerull provides leadership for nursing professional development and faith-based services, including faith community nursing and chaplaincy, at Valley Health System in Winchester, Virginia. She is also employed as adjunct clinical faculty at the Shenandoah University Eleanor Wade Custer School of Nursing teaching fundamentals and faith community nursing preparation courses. Since 1996, Dr. Zerull has served as a board-certified and unpaid faith community nurse in her home congregation of Grace Evangelical Lutheran Church. Currently the editor for *Perspectives*, an international publication for faith community nurses, Dr. Zerull is an author and frequent conference presenter. Her research interests include nursing history, outcome measures of faith community nursing, and youth health care career exploration.

Elke Jones Zschaebitz, DNP, APRN, FNP-BC

Elke Jones Zschaebitz is a nurse practitioner who has worked in the fields of student health, pediatrics, and women's health, as well as in a telehealth practice in primary care. She received her BSN from Villanova University, her MSN-FNP from Midwestern State University in Wichita Falls, Texas, and her DNP from Duquesne University in Pittsburgh, Pennsylvania. She currently is employed full time at the University of Virginia Student Health Center in Charlottesville, Virginia, and is part-time adjunct faculty for the family nurse practitioner program at Georgetown University.

PREFACE

Since the last edition of this text, many changes have occurred in society as well as in health care. The news media daily discuss events including violence, man-made disasters, and disasters that are the result of naturally occurring events, including hurricanes, earthquakes, fires, and tornados that destroy homes, lives, businesses, and communities. Many countries around the world are engaged in health care reform, and a major driver propelling this reform is the cost of health care. The need for strong and effective public health care has grown in most countries, yet the reality has been that many countries have not prioritized public health.

A key component of public health is population health. The need for population health has not been greater than it is at present. This 10th edition of the text emphasizes population health as well as preventive services for individuals in the community. Two early and significant proponents of the importance of population health are David Kindig and Greg Stoddart. They have been writing about this concept for over 15 years. The beginning discussions of their work and of population health begin in Chapter 1 of the text. The health of a population is measured by health status indicators including social, economic, and the physical environments of a population, as well as the personal health practices of the members of the population, their biological including genetic makeup, early childhood and development throughout life, and the health care services available to the population. Populations in public health are broad and wide-ranging. They could include a population of ethnic groups or other affinity groups such as employees, disabled persons, prisoners, members of a specific religious affiliation, or those who live in a specific community (Kindig and Stoddart, 2003; Kindig, 2007).

The health outcomes of a population are influenced by a multitude of factors often described as social determinants. These determinants are discussed in chapters throughout the text. Other chapters focus on the myriad of factors that are considered social determinants of health such as economics, policy, the environment, culture, and many others. What is important is to look at population health from a multifaceted approach. Consider all factors that influence the health of a given population.

As is explained in Chapter 1 and discussed in other chapters throughout the text, there are three core functions of public health: assessment, policy development, and assurance. The Centers for Disease Control and Prevention (CDC, 2018, p. 1) has developed 10 essential public health services and aligns these services with the core functions of assessment, assurance, and policy development.

Chapters in this text include all of the critical elements of the public health services and the core functions cited above, as well as guidance in how to deal with other major issues, including the quality of care, the cost of care, and access to care. The growing shortage of nurses and other health care providers will only increase the concerns about these issues. One of the ways in which quality of care could be improved would include new uses of technology to manage an information revolution. Great improvements in quality would require a restructuring of how care is delivered, a shift in how funds are spent, changing the workplace, and using more effective ways to manage chronic illness. There will be costs associated with these quality improvements. However, the future costs of health care may be reduced as a result of improved health of populations and individuals.

The United States' health care spending has slowed in recent years due to the economy. A useful resource that describes health care systems in 19 countries around the world is *International Profiles of Health Care Systems,* edited by Mossiaios et al. and written for the Commonwealth Fund in May 2017. This monograph uses the same format to describe health care systems in large countries like Australia, Canada, India, and the United States, as well as much smaller countries, including New Zealand and Singapore.

In the past two decades, the greatest improvements in population health have come from public health achievements such as immunizations leading to eliminating and controlling infectious diseases, motor vehicle safety, safer workplaces, lifestyle improvements reducing the risk of heart disease and strokes, safer and healthier foods through improved sanitation, clean water and food fortification programs, better hygiene and nutrition to improve the health of mothers and babies, family planning, fluoride in drinking water, and recognition of tobacco as a health hazard. Continued changes in the public health system are essential if death, illness, and disability resulting from preventable problems are to continue to decline.

The need to focus attention on health promotion, lifestyle factors, and disease prevention led to the development of a major public policy about health for the nation. This policy was designed by a large number of people representing a wide range of groups interested in health. The policy, first introduced in 1979, was updated in 1990 and in 2000; it is reflected in the most recent document updated in 2010, titled *Healthy People 2020*. This document includes objectives related to population health. The newest document, *Healthy People 2030*, is being developed. These five documents have identified a set of national health promotion and disease prevention objectives for each of four decades. Examples of these objectives are highlighted in chapters throughout the text.

Healthy People 2020 emphasizes the concept of social determinants of health—that is, the belief that health is affected by many social, economic, and environmental factors that extend far beyond individual biology of disease. This means that improving health requires a broad approach to including the concept of health in all policies and creating environments where the healthy choice is the easy choice. To improve health in the United States individuals, families, communities, and populations must commit to these approaches. Also, society,

through the development of health policy, must support better health care, the design of improved health education, and new ways of financing strategies to alter health status.

Some indicators have been substantially improved since the release of *Healthy People 2000*; *Healthy People 2010 and 2020* highlighted many of the original objectives and added new ones. The *Healthy People 2030* framework has as its purpose to (1) provide context and rationale for the initiative's approach, (2) communicate the principles that underlie decisions about *Healthy People 2030*, and (3) situate the initiative in the five-decade history of Healthy People. Since the framework is general, it is useful to review the foundational principles, overarching goals, and plan of action (www.healthypeople2030.gov). What does this mean for nurses who work in public health? Because people do not always know how to improve their health status, the challenge of nursing is to create change. Nursing takes place in a variety of public and private settings and includes disease prevention, health promotion, health protection, surveillance, education, maintenance, restoration, coordination, management, and evaluation of care of individuals, families, and populations, including communities.

To meet the demands of a constantly changing health care system, nurses must have vision in designing new and changing current roles and identifying their practice areas. To do so effectively, the nurse must understand concepts, theories, and the core content of public health, the changing health care system, the actual and potential roles and responsibilities of nurses and other health care providers, the importance of health promotion and disease orientation, and the necessity of involving consumers in the planning, implementation, and evaluation of health care efforts.

Since its initial publication in 1984, this text has been important in the education of nurses in baccalaureate, BSN-completion, and graduate programs. The text was written to provide nursing students and practicing nurses with a comprehensive source book that provides a foundation for designing population-focused nursing strategies. Content has been added to address the changing aspects of population health, including a section on human trafficking, the use and some cautions of genetic inquiries, and selected content about the health of veterans. There have also been changes where some of the prior appendixes and documents may be found on the book's Evolve website.

The unifying theme for the book is the integrating of health promotion and disease prevention concepts into the many roles of nurses. The prevention focus emphasizes traditional public health practice with increased attention to the effects of the internal and external environment on the health of populations and communities. The focus on interventions for the individual and family emphasizes the aspects of population-centered practice with attention to the effects of all of the determinants of health, including lifestyle, on personal health.

CONCEPTUAL APPROACH TO THIS TEXT

The term *community-oriented* has been used to reflect the orientation of nurses to the community and the public's health. In 1998, the Quad Council of Public Health Nursing composed of members from the American Nurses Association Congress on Nursing Practice, the American Public Health Association Public Health Nursing section, the Association of Community Health Nursing Educators, and the Association of State and Territorial Directors of Public Health Nursing developed a statement on the *Scope of Public Health Nursing Practice*. Through this statement, the leaders in public and community health nursing attempted to clarify the differences between public health nursing and the newest term introduced into nursing's vocabulary during health care reform of the 1990s, *community-based nursing*. The Quad Council recognized that the terms *public health nursing* and *community health nursing* have been used interchangeably since the 1980s to describe population-focused, community-oriented nursing and community-focused practice. They decided to make a clearer distinction between community-oriented and community-based nursing practice. In 2007, the definitions were further refined, and nurses once referred to as *public health nurses* and *community health nurses* are now referred to only as *public health nurses* in the revised standards of practice. The standards were again revised in 2013 by the renamed Quad Council Coalition and can be found in the appendixes of this edition of the text.

In this textbook, two different levels of care in the community are acknowledged: community-oriented care and community-based care. Two role functions for nursing practice in the community are suggested: public health nursing (community health nursing) and community-based nursing. This text focuses only on public health nursing (community health nursing), using the overarching term *community-oriented nursing*, which encompasses a focus on populations within the community context, or *population-centered nursing practice*.

For the fifth edition of this text, with consultation from C.A. Williams (author) and June Thompson (Mosby editor), Marcia Stanhope developed a conceptual model for community-oriented nursing practice. This model was influenced by a review of the history of community-oriented nursing from the 1800s to today. Marcia Stanhope studied Betty Neuman's model intensively while in school, which influenced this model.

The model itself is presented as a caricature of reality—or an abstract—with a description of the characteristics and the philosophy on which community-oriented nursing is built. The *model* is shown as a flying balloon (see inside the front cover of this book). The balloon represents community-oriented nursing and is filled with the knowledge, skills, and abilities needed in this practice to carry the world (the basket of the balloon) or the clients of the world who benefit from this practice. The *subconcepts* of public health nursing with the community and populations as the center of care are the *boundaries* of the practice. The public health foundation pillars of assurance, assessment, and policy development hold up the world of communities, where people live, work, play, go to school, and worship. The ribbons flying from the balloon indicate the interventions used by nurses. These ribbons (interventions) serve to provide lift and direction, tying the services together for the clients who are served. The intervention names and the services are listed with the balloon. The *propositions* (statements of relationship)

for this model are found in the definitions of practice, public health functions, clients served, specific settings, interventions, and services. Many *assumptions* have served as the basis for the development of this model. Community-oriented nursing practice has evolved over time, becoming more complex. The practice of nursing in public health is based on a philosophy of care rather than being setting specific. It is different from community-based nursing care delivery. The development of community-oriented nursing has been influenced by public health practice, preventive medicine, community medicine, and shifts in the health care delivery system. Community-oriented nursing, whether a public health nurse or a community-based nurse, requires nurses to have specific competencies to be effective providers of care.

The definition of community-oriented nursing appears near the inside of the front cover of this book. This practice involves public health nurses. Community-based nurses differ from public health nurses in many ways. These differences are described in the table following the definitions. The differences are described as they relate to philosophy of care, goals, service, community, clients served, practice settings, ways of interacting with clients, type of services offered to clients, prevention levels used, goals, and priority of nurses' activities.

The four concepts of nursing, person (client), environment, and health are described for this model. These concepts appear in many works about nursing and in almost every educational curriculum for undergraduate students. Each of the four concepts may be defined differently in these works because of the beliefs of the persons writing the definitions.

In this text *nursing* is defined as community-oriented with a focus on providing health care through community diagnosis and investigation of major health and environmental problems. Health surveillance, monitoring, and evaluating community and population status are done to prevent disease and disability and to promote, protect, preserve, restore, and maintain health. This in turn creates conditions in which clients can be healthy. The person, or client, is the world, nation, state, community, population, aggregate, family, or individual.

The boundaries of the client *environment* may be limited by the world, nation, state, locality, home, school, work, playground, religion, or individual self. *Health*, in this model, involves a continuum of health rather than wellness, with the best health state possible as the goal. The best possible level of health is achieved through measures of prevention as practiced by the nurse.

The nurse engages in autonomous practice with the client, who is the primary decision maker about health issues. The nurse practices in a variety of environments, including, but not limited to, governments, organizations, homes, schools, churches, neighborhoods, industry, and community boards. The nurse interacts with diverse cultures, partners, other providers in teams, multiple clients, and one-to-one or aggregate relationships. Clients at risk for the development of health problems are a major focus of nursing services. Primary prevention–level strategies are the key to reducing risk of health problems. Secondary prevention is done to maintain, promote, or protect health, whereas tertiary prevention strategies are used to preserve, protect, or maintain health.

Nurses have many roles related to community clients and roles that relate specifically to practice with populations (or population-centered). Public health nurses especially engage in activities specific to community development, assessment, monitoring, health policy, politics, health education, interdisciplinary practice, program management, community/population advocacy, case finding, and delivery of personal health services when these services are otherwise unavailable in the health care system. This conceptual model is the framework for this text.

ORGANIZATION

The text is divided into eight sections:

- **Part 1, Influencing Factors in Public Health Nursing and Population Health,** describes the historical and current status of the health care delivery system and public health nursing practice, both domestically and internationally.
- **Part 2, Forces Affecting Nurses in the Delivery of Public and Population Health Care Delivery,** addresses environmental health, ethics, policy, and cultural issues that affect public health, nurses, and clients.
- **Part 3, Conceptual and Scientific Frameworks Applied to Nursing Practice,** provides conceptual models and scientific bases for public health nursing practice. Selected models from nursing and related sciences are also discussed.
- **Part 4, Community Level Interventions,** looks at promoting healthy communities, looking at the community as a client, and how principles are applied to all populations in community environments.
- **Part 5, Issues and Approaches in Population-Centered Nursing,** examines the management of health care, quality and safety, and populations in select community environments and groups, as well as issues related to managing cases, programs, and disasters.
- **Part 6, Promoting the Health of Target Populations Across the Life Span,** discusses risk factors and population-level health problems for families and individuals throughout the life span.
- **Part 7, Promoting and Protecting the Health of Vulnerable Populations,** covers specific health care needs and issues of populations at risk.
- **Part 8, Nurses' Roles and Functions in the Community,** examines diversity in the role of public health nurses and describes the rapidly changing roles, functions, and practice settings.

NEW TO THIS EDITION

New content and illustrations have been included in the 10th edition of *Public Health Nursing: Population-Centered Health Care in the Community* to ensure that the text remains a complete, current, and comprehensive resource:

- **NEW!** Each chapter has a brief box to check your practice. A brief clinical situation is provided, and the answers can be determined by content in the chapter.

PEDAGOGY

Other key features of this edition are detailed below. Each chapter is organized for easy use by students and faculty.

Additional Resources

Additional Resources listed at the beginning of each chapter direct students to chapter-related tools and resources contained in the book's Evolve website.

Objectives

Objectives open each chapter to guide student learning and alert faculty to what students should gain from the content.

Key Terms

Key Terms are identified at the beginning of the chapter and defined either within the chapter or in the glossary to assist students in understanding unfamiliar terminology.

Chapter Outline

The Chapter Outline alerts students to the structure and content of the chapter.

How To Boxes

How To boxes provide specific, application-oriented information.

Evidence-Based Practice Boxes

Evidence-Based Practice boxes in each chapter illustrate the use and application of the latest research findings in public health, community health, and community-oriented nursing.

Practice Application

At the end of each chapter a case situation helps students understand how to apply chapter content in the practice setting. Questions at the end of each case promote critical thinking while students analyze the case.

Key Points

Key Points provide a summary listing of the most important points made in the chapter.

Clinical Decision-Making Activities

Clinical Decision-Making Activities promote student learning by suggesting a variety of activities that encourage both independent and collaborative effort.

Appendixes

The **Appendixes** provide additional content resources, key information, and clinical tools and references.

EVOLVE STUDENT LEARNING RESOURCES

Additional resources designed to supplement the student learning process are available on this book's website at http://evolve.elsevier.com/Stanhope/community/, including:

- **Additional Resources for Students** in select chapters
- **Audio Glossary** with complete definitions of all key terms and other important community and public health nursing concepts
- **Review Questions** with answers
- **Student Case Studies** with questions and answers
- **Answers to Practice Application Questions**

INSTRUCTOR RESOURCES

Several supplemental ancillaries are available to assist instructors in the teaching process:

- **TEACH for Nurses lesson plans** provided for each chapter, with Nursing Curriculum Standards, Teaching Strategies and Learning Activities, Case Studies, and more
- **Test Bank** with 1200 questions and answers coded for NCLEX Client Needs category, nursing process, and cognitive level
- **PowerPoint Lecture Slides** for each chapter, with current accessibility guidelines incorporated
- **Image Collection** with illustrations from the text

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CONTENTS

1

Public Health Foundations and Population Health

Carolyn A. Williams, RN, PhD, FAAN

OBJECTIVES

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

1. State the mission and core functions of public health, the essential public health services, and the quality performance standards program in public health.
2. Describe specialization in public health nursing and other nurse roles in the community and the practice goals of each.
3. Describe what is meant by population health.
4. Identify barriers to the practice of community and prevention-oriented, population-focused practice.
5. Describe the importance of the social determinants of health to the health of a population.
6. State key opportunities for nurses to provide the leadership in implementing Public Health 3.0.

CHAPTER OUTLINE

KEY TERMS

aggregate, p. 10
assessment, p. 3
assurance, p. 4
capitation, p. 17
community-based nursing, p. 15
Community Health Improvement Process (CHIP), p. 6
community health nurse, p. 15
cottage industry, p. 17
integrated systems, p. 17
levels of prevention, p. 11
policy development, p. 3
population, p. 10
population-focused practice, p. 11
population health, p. 2
population health management p. 8
public health, p. 2
Public Health 3.0, p. 8
public health core functions, p. 3
public health nursing, p. 2
Quad Council, p. 7
social determinants of health, p. 8
subpopulations, p. 11

As the United States approaches the third decade of the twenty-first century, considerable public attention is being given to issues related to the availability of affordable health insurance so individuals are assured that they can have access to health care. The central feature in the Patient Protection and Affordable Care Act (ACA) of 2010 are the mechanisms to increase the number of people with health insurance. Despite initial turbulence in implementation of the legislation, including difficulties with enrollments due to technological problems, there is good evidence that progress was made in enrolling people. The U.S. Census Bureau reported that after the first enrollment period in the fall of 2013 the number of uninsured Americans fell from 41 million to 27 million in 2017 (Berchick, 2017; Census Bureau, 2018). In 2014, Blumenthal and Collins reported that the Urban Institute projected that the proportion of uninsured adults in the United States fell from 18 percent in the third

quarter of 2013 to 13.4 percent in May 2014. The latest data from the Census Bureau put the uninsured rate for the total population at 8.8 percent in 2017 (Census Bureau, 2018). However, Collins et al. reported in May 2018 that, based on the Commonwealth Fund's tracking survey, ACA gains in coverage are beginning to reverse (Commonwealth Fund, 2018). They suggested the factors likely responsible are the lack of federal legislation to improve weaknesses in the ACA and the current administration's deep cuts in advertising and outreach during the open enrollment period, a shorter enrollment period, and other administrative actions that may have confused people about the status of the law. They anticipate further erosion of coverage in 2019 due to repeal of the individual mandate penalty, which was a part of the 2017 tax law; actions to increase insurance policies that are not in compliance with the minimum benefits of the ACA; and support for Medicaid work requirements.

Before the passage of the ACA, many at the national level were seriously concerned about the growing cost of medical care as a part of federal expenditures (Orszag, 2007; Orszag & Emanuel, 2010). The concern with the cost of medical care remains a national issue, and Blumenthal and Collins (2014) argued that the sustainability of the expansions of coverage provided by the ACA will depend on whether the overall costs of care in the United States can be controlled. If costs are not controlled, the resulting increases in premiums will become increasingly difficult for all—consumers, employers, and the federal government. Other health system concerns focus on the quality and safety of services, warnings about bioterrorism, and global public health threats such as infectious diseases and contaminated foods. Because of all of these factors, the role of public health in protecting and promoting health, as well as preventing disease and disability, is extremely important.

Whereas the majority of national attention and debate surrounding national health legislation has been focused primarily on insurance issues related to medical care, there are indications of a growing concern about the overall status of the nation's health. In 2013, the Institute of Medicine (IOM) issued a report, *U.S. Health in International Perspective: Shorter Lives, Poorer Health,* which presented some sobering information. The report concluded that "Although Americans' life expectancy and health have improved over the past century, these gains have lagged behind those in other high-income countries. This health disadvantage prevails even though the United States spends far more per person on health care than any other nation." Why is this so? Bradley and Taylor (2013) undertook a study to try to answer that question and concluded that one answer could be that compared to other high-income countries the United States spends less on social services. The IOM report on Shorter Lives and Poorer Health summarizes their findings with this statement, "The U.S. health disadvantage has multiple causes and involves some combination of inadequate health care, unhealthy behaviors, adverse economic and social conditions, and environment factors, as well as public policies and social values that shape those conditions." Thus it is timely to refocus attention on public health, on the concept of population health, which is emerging as a focal point for improving the health of the population, and the opportunities for nurses to be involved in and provide leadership in population health initiatives.

This chapter and others that follow in this book will present information on many factors, perspectives, and strategies related to the protection, maintenance, and improvement of the health of populations. This chapter is focused on three broad topics: **public health** as a broad field of practice that is the backbone of the infrastructure supporting the health of a country, state, province, city, town, or community; **population health,** which can be viewed as a particularly important set of analytical strategies and approaches that was first used in public health to describe, analyze, and mobilize efforts to improve health in community-based populations and is now being used in initiatives to improve outcomes of clinical populations; and a discussion of **public health nursing** and emerging opportunities for nurses practicing in a variety of settings to be engaged in community-based, population-focused efforts to improve the health of populations.

This is a crucial time for public health nursing, a time of opportunity and challenge. The issue of growing costs together with the changing demography of the U.S. population, particularly the aging of the population, is expected to put increased demands on resources available for health care. In addition, the threats of bioterrorism, highlighted by the events of September 11, 2001, and the anthrax scares, will divert health care funds and resources from other health care programs to be spent for public safety. Also important to the public health community is the emergence of modern-day epidemics (such as the mosquito-borne West Nile virus, the H1N1 influenza virus, the opioid epidemic, and gun violence) and globally induced infectious diseases such as avian influenza and other causes of mortality, many of which affect the very young. Most of the causes of these epidemics are preventable. What has all of this to do with nursing?

Understanding the importance of community-oriented, population-focused nursing practice and developing the knowledge and skills to practice it will be critical to attaining a leadership role in health care regardless of the practice setting. The following discussion explains why those who practice community and prevention-oriented, population-focused nursing will be in a very strong position to affect the health of populations and decisions about how scarce resources will be used.

PUBLIC HEALTH PRACTICE: THE FOUNDATION FOR HEALTHY POPULATIONS AND COMMUNITIES

During the last 30 years, considerable attention has been focused on proposals to reform the American health care system. These proposals focused primarily on containing costs in medical care financing and on strategies for providing health insurance coverage to a higher proportion of the population. As discussed earlier, in the national health legislation that passed in

2010, the ACA, the majority of the provisions and the vast majority of the discussion of the bill focused on those issues. While it was important to make reforms in the medical insurance system, there is a clear understanding among those familiar with the history of public health and its impact that such reforms alone will not be adequate to improve the health of Americans.

Historically, gains in the health of populations have come largely from public health efforts. Safety and adequacy of food supplies, the provision of safe water, sewage disposal, public safety from biological threats, and personal behavioral changes, including reproductive behavior, are a few examples of public health's influence. In 2008, Fielding et al. argued that there is indisputable evidence that public health policies and programs were primarily responsible for increasing the average life span from 47 years in 1900 to 78 years in 2005, an increase of 66 percent in just a little over a century. They asserted that most of that increase was through improvements in sanitation, clean water supplies, making workplaces safer, improving food and drug safety, immunizing children, and improving nutrition, hygiene, and housing (Fielding et al., 2008).

In an effort to help the public better understand the role public health has played in increasing life expectancy and improving the nation's health, in 1999, the Centers for Disease Control and Prevention (CDC) began featuring information on the Ten Great Public Health Achievements in the 20th Century. The areas featured include Immunizations, Motor Vehicle Safety, Control of Infectious Diseases, Safer and Healthier Foods, Healthier Mothers and Babies, Family Planning, Fluoridation of Drinking Water, Tobacco as a Health Hazard, and Declines in Deaths From Heart Disease and Stroke (CDC, 2014). A case can be made that the payoff from public health activities is well beyond the resources directed to the effort. For example, data reported by the Centers for Medicare and Medicaid Services (CMS) showed that in 2012 only three percent (up from 1.5 percent in 1960) of all national expenditures supported governmental public health functions (CMS, 2012). The latest data show that in 2017 such expenditures remained at three percent (CMS, 2018).

Unfortunately, the public is largely unaware of the contributions of public health practice. After the passage of Medicare and Medicaid, federal and private monies in support of public health dwindled, public health agencies began to provide personal care services for persons who could not receive care elsewhere, and the health departments benefited by getting Medicaid and Medicare funds. The result was a shift of resources and energy away from public health's traditional and unique prevention-oriented, population-focused perspective to include a primary care focus (U.S. Department of Health and human Services [USDHHS], 2002).

Time will tell whether the gains in insurance coverage due to the ACA will stabilize or whether the reported indication of a decline mentioned above will continue. What happens will have an impact on the activities of public health organizations. If the majority of the population remains covered by insurance, public health agencies will not need to provide direct clinical services in order to ensure that those who need them can receive them. Public health organizations could refocus their efforts on the core functions and emphasize community-oriented, population-focused health promotion and preventive strategies if ways can be found to finance such efforts. An IOM report, *For the Public's Health: Investing in a Healthier Future,* released in 2012, began with a presentation of data showing that in comparison with other wealthy countries, the United States lags well behind its peers on health status while outspending every country in the world on health care. However, a key message was that health-related spending in the United States is primarily expended on clinical care costs for medical and hospital services; very little spending is for public health activities.

A central conclusion of the report was that "to improve health outcomes in the United States, there will need to be a transforming of the way the nation invests in health to pay more attention to population-based prevention efforts; remedy the dysfunctional manner in which public health funding is allocated, structured, and used; and ensure stable funding for public health departments." Further, the committee recommended that "a minimum package of public health services—those foundational and program services needed to promote and protect the public's health"—be developed. The report concluded by recommending that "Congress authorize a dedicated, stable, and long-term financing structure—a national tax on all health care transactions—to generate the enhanced federal revenue required to deliver the minimum package of public health services in every community" (IOM, 2012a). Unfortunately, the CMS data presented earlier clearly show that in the five years between 2012 and 2017 there has not been any overall increase in government funds directed to public health efforts.

Definitions in Public Health

In 1988, the IOM published a report on the future of public health, which is now seen as a classic and influential document. In the report, public health was defined as "what we, as a society, do collectively to assure the conditions in which people can be healthy" (IOM, 1988, p. 1). The committee stated that the mission of public health was "to generate organized community efforts to address the public interest in health by applying scientific and technical knowledge to prevent disease and promote health" (IOM, 1988, p. 1; Williams, 1995).

It was clearly noted that the mission could be accomplished by many groups, public and private, and by individuals. However, the government has a special function "to see to it that vital elements are in place and that the mission is adequately addressed" (IOM, 1988, p. 7). To clarify the government's role in fulfilling the mission, the report stated that assessment, policy development, and assurance are the **public health core functions** at all levels of government:

- **Assessment** refers to 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 the need to provide leadership in developing policies that support the health of the population,

including the use of the scientific knowledge base in making decisions about policy.

- **Assurance** refers to the role of public health in ensuring that essential community-oriented health services are available, which may include providing essential personal health services for those who would otherwise not receive them. Assurance also refers to making sure that a competent public health and personal health care workforce is available. Fielding, (2009) made the case that assurance also should mean that public health officials should be involved in developing and monitoring the quality of services provided.

Because of the importance of influencing a population's health and providing a strong foundation for the health care system, the U.S. Public Health Service and other groups strongly advocated a renewed emphasis on the population-focused essential public health functions and services that have been most effective in improving the health of the entire population. As part of this effort, a statement on public health in the United States was developed by a working group made up of representatives of federal agencies and organizations concerned about public health. The list of essential services presented in Fig. 1.1 represents the obligations of the public health system to implement the core functions of assessment, assurance, and policy development. The How To box further explains these essential services and lists the ways public health nurses implement them (U.S. Public Health Service, 1994 [updated 2008]; CDC, 2018)

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. (From U.S. Public Health Service: *The core functions project.* Washington, DC, 1994/update 2000, Office of Disease Prevention and Health Promotion. Update 2008, CDC, 2018.)

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 to 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 of health.
   - Recognize multiple causes or factors of health and illness.
   - Participate in case identification and treatment of persons with communicable disease.
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 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 primary prevention and early intervention strategies.
   - 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 development of 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 broader 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 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 disease.
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 clinical guidelines.
9. Evaluate 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 health status of the community.
   - Participate with the community in assessment of services and outcomes of care.
   - Identify and define enhanced services required to manage 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 early identification of factors that are detrimental to the community's health.
    - Formulate and use investigative tools to identify and impact care delivery and program planning.

Public Health Core Functions

The *Core Functions Project* (U.S. Public Health Service, 1994 [updated 2008]); CDC, 2018) developed a useful illustration, the Health Services Pyramid (Fig. 1.2), which shows that

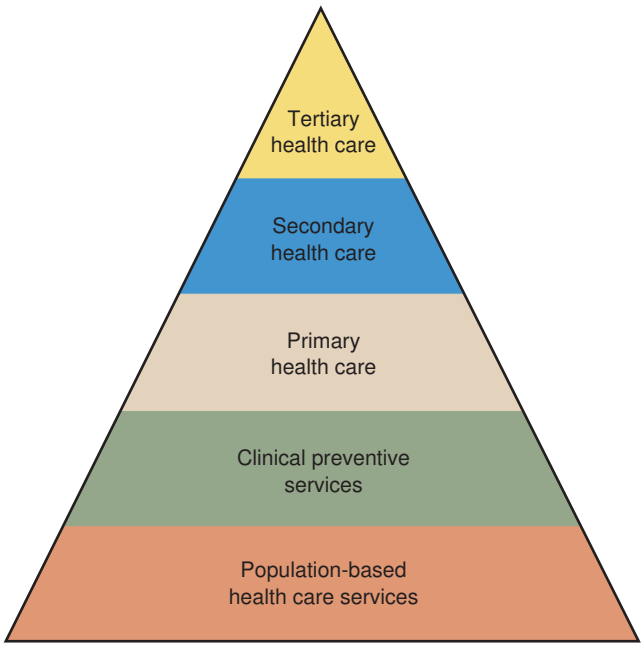

Fig. 1.2 Health Services Pyramid.

population-based public health programs support the goals of providing a foundation for clinical preventive services. These services focus on disease prevention; on health promotion and protection; and on primary, secondary, and tertiary health care services. All levels of services shown in the pyramid are important to the health of the population and thus must be part of a health care system with health as a goal. It has been said that "the greater the effectiveness of services in the lower tiers, the greater is the capability of higher tiers to contribute efficiently to health improvement" (U.S. Public Health Service, 1994 [updated 2008]). Because of the importance of the basic public health programs, members of the Core Functions Project argued that all levels of health care, including population-based public health care, must be funded or the goal of health of populations may never be reached.

Several new efforts to enable public health practitioners to be more effective in implementing the core functions of assessment, policy development, and assurance have been undertaken at the national level. In 1997, the IOM published *Improving Health in the Community: A Role for Performance Monitoring* (IOM, 1997). This monograph was the product of an interdisciplinary committee, co-chaired by a public health nursing specialist and a physician, whose purpose was to determine how a performance-monitoring system could be developed and used to improve community health.

CHECK YOUR PRACTICE

As a student you have been placed on a committee in your community to develop a community health profile. This is being done to focus the public health efforts more on the health of the population. What can you contribute to this committee? Where would you look for data that includes your county's health ranking? What would you do?

The major outcome of the committee's work was the **Community Health Improvement Process (CHIP)**, a method for improving the health of the population on a community-wide basis. The method brings together key elements of the public health and personal health care systems in one framework. A second outcome of the project was the development of a set of 25 indicators that could be used in the community assessment process (see Chapter 17) to develop a community health profile (e.g., measures of health status, functional status, quality of life, health risk factors, and health resource use) (Box 1.1). A third product of the committee's work was a set of indicators for specific public health problems that could be used by public health specialists as they carry out their assurance function and monitor the performance of public health and other agencies.

In 2000, the CDC established a Task Force on Community Preventive Services, which is in place and works to provide evidence-based findings and recommendations about a variety of community preventive services, programs, and policies to prevent morbidity and mortality (CDC, 2014b). The result is *The Community Guide: What Works to Promote Health*, a versatile set of resources available electronically at https://www.thecommunityguide.org that can be used by public health specialists and others interested in a community-level approach to health improvement and disease prevention. A particularly useful interactive Internet-based resource available on the CDC website is the *Community Health Navigator.*

The Navigator can be reached at www.gov. It is an interactive Internet-based resource that allows the user to locate

BOX 1.1 Indicators Used to Develop a Community Health Profile

Sociodemographic Characteristics

- Distribution of the population by age and race/ethnicity
- Number and proportion of persons in groups such as migrants, homeless, or the non–English speaking, for whom access to community services and resources may be a concern
- Number and proportion of persons aged 25 and older with less than a high school education
- Ratio of the number of students graduating from high school to the number of students who entered ninth grade three years previously
- Median household income
- Proportion of children less than 15 years of age living in families at or below the poverty level
- Unemployment rate
- Number and proportion of single-parent families
- Number and proportion of persons without health insurance

Health Status

- Infant death rate by race/ethnicity
- Numbers of deaths or age-adjusted death rates for motor vehicle crashes, work-related injuries, suicide, homicide, lung cancer, breast cancer, cardiovascular diseases, and all causes, by age, race, and sex as appropriate
- Reported incidence of AIDS, measles, tuberculosis, and primary and secondary syphilis, by age, race, and sex as appropriate
- Births to adolescents (ages 10 to 17) as a proportion of total live births
- Number and rate of confirmed abuse and neglect cases among children

Health Risk Factors

- Proportion of two-year-old children who have received all age-appropriate vaccines, as recommended by the Advisory Committee on Immunization Practices
- Proportion of adults aged 65 and older who have ever been immunized for pneumococcal pneumonia; proportion who have been immunized in the past 12 months for influenza
- Proportion of the population who smoke, by age, race, and sex as appropriate
- Proportion of the population aged 18 and older who are obese
- Number and type of U.S. Environmental Protection Agency air quality standards not met
- Proportion of assessed rivers, lakes, and estuaries that support beneficial uses (e.g., approved fishing and swimming)

Health Care Resource Consumption

- Per capita health care spending for Medicare beneficiaries—the Medicare adjusted average per capita cost (AAPCC)

Functional Status

- Proportion of adults reporting that their general health is good to excellent
- Average number of days (in the past 30 days) for which adults report that their physical or mental health was not good

Quality of Life

- Proportion of adults satisfied with the health care system in the community
- Proportion of persons satisfied with the quality of life in the community

AIDS, Acquired immunodeficiency syndrome.

evidence-based interventions depending on a variety of factors: type of risk factor, target population, outcome desired, intervention setting, intervention type, and assets. The information provided, which includes systematic reviews of research, can be used to help make choices about policies and programs that have been shown to be effective.

Core Competencies of Public Health Professionals

To improve the public health workforce's abilities to implement the core functions of public health and to ensure that the workforce has the necessary skills to provide the 10 essential services listed in Fig. 1.1, a coalition of representatives from 17 national public health organizations (the Council of Linkages) began working in 1992 on collaborative activities to "assure a well-trained, competent workforce and a strong, evidence-based public health infrastructure" (U.S. Public Health Service, 1994 [updated 2008]). In the spring of 2010, the Council, funded by the CDC and USDHHS, adopted an updated set of Core Competencies ("a set of skills desirable for the broad practice of public health") for all public health professionals, including nurses. In 2014, the Core Competencies were updated again (Council on Linkages, 2010/2014). The 72 Core Competencies are divided into 8 categories (Box 1.2). In addition, each competency is presented at three levels (tiers), which reflect the different stages of a career. Specifically, Tier 1 applies to entry-level public health professionals without management responsibilities. Tier 2 competencies are expected in those with management and/or supervisory responsibilities, and Tier 3 is expected of senior managers and/or leaders in public health organizations. It is recommended that these categories of competencies be used by educators for curriculum review and development and by agency administrators for workforce needs assessment, competency development, performance evaluation, hiring, and refining of the personnel system job requirements. A detailed listing of the 2014 competencies can be found at www.phf.org.

A coalition of public health nursing organizations initially called the **Quad Council** developed descriptions of skills to be attained by public health nurses for each of the public health core competencies. Skill levels are specified and have been updated for nurses by the Quad Council Coalition in three tiers: the generalist/public health staff nurse (Tier 1); the public health staff nurse with an array of program implementation, management, and supervisory responsibilities, including clinical services, home visiting, community-based, and population-focused programs (Tier 2); and the public health nurse at an executive or senior management level and leadership levels in public health or community organizations (Tier 3) (Quad Council Coalition, 2018).

BOX 1.2 Categories of Public Health Workforce Competencies

- Analytic/assessment
- Policy development/program planning
- Communication
- Cultural competency
- Community dimensions of practice
- Basic public health sciences
- Financial planning and management
- Leadership and systems thinking

Compiled from www.phf.org

Quality Improvement Efforts in Public Health

In 2003, the IOM released a report, "Who Will Keep the Public Healthy?" that identified eight content areas in which public health workers should be educated—informatics, genomics, cultural competence, community-based participatory research, policy, law, global health, and ethics—in order to be able to address the emerging public health issues and advances in science and policy.

Two broad efforts designed to enhance quality improvement efforts in public health have been developed within the last 20 years: the National Public Health Performance Standards program and the accreditation process for local and state health departments. The National Public Health Performance Standards (NPHPS) program is a high-level partnership initiative started in 1998 and led by the Office of Chief of Public Health Practice, CDC. The collaborative partners are the American Public Health Association (APHA), Association of State and Territorial Health Officials, National Association of County and City Health Officials, National Association of Local Boards of Health, National Network of Public Health Institutes, and the Public Health Foundation. The NPHPS "provide a framework to assess capacity and performance of public health systems and public health governing bodies." The program is "to improve the practice of public health, the performance of public health systems, and the infrastructure supporting public health actions" (CDC, 2014). The performance standards, collectively developed by the participating organizations, set the bar for the level of performance that is necessary to deliver essential public health services. Four principles guided the development of the standards. First, they were developed around the 10 essential public health services (see the How To box on p. 5). Second, the standards focus on the overall public health system rather than on single organizations. Third, the standards describe an optimal level of performance. Finally, they are intended to support a process of quality improvement.

States and local communities seeking to assess their performance can access the assessment instruments developed by the program and other resources such as training workshops, on-site training, and technical assistance to work with them in conducting assessments (CDC, 2014a).

Public Health 3.0

The Public Health 3.0 initiative, which represents a call to action for public health to regenerate and refocus to meet the challenges of the twenty-first century, emerged after the growing recognition that there are troubling indicators regarding the health of Americans. For example, the CDC reported in 2014 that the historical gains in longevity had plateaued for three years in a row (Murphy et al., 2014). It is important to note that

more recent data discussed by Woolf in an editorial in the *British Journal of Medicine* (2018) shows that life expectancy in the United States is actually beginning to decline. Other data have shown wide variations in life expectancy between those with the highest incomes and lowest incomes in some communities, while the variation was small in others (National Center for Health Statistics, 2016). Researchers (Chapman et al., 2015–2016) have shown that life expectancy can vary by up to 20 years in areas only a few miles apart. Such information suggests that more attention needs to be given to the environments in which people live, work, play, and age and requires community-based interventions. In discussing Public Health 3.0, DeSalvo et al. argue that in dealing with the challenges presented by such disturbing population data an approach that goes beyond health care is called for and requires community-based interventions. These factors that influence an individual's health and well-being are now commonly referred to as the **social determinants of health**. They include housing, transportation, environments that are safe, access to healthy foods, economic development, and social support.

Two other factors that have contributed to the development of Public Health 3.0 are policy changes in approaches to payment, that is, efforts to move away from the episodic nonintegrated approach to care to value-based approaches and the continuing limitations in resources available for public health initiatives and limited resources to deal with the social determinants of health. The 2008 recession resulted in reductions in many public health services at the state and local levels, and the very small governmental investment in public health discussed above along with the limited investment of the United States (as compared to other wealthy peer countries) in nonmedical determinants of health such as social services, housing, and environmental protection have created a major challenge for those who are concerned about the population's health. These circumstances make putting more emphasis on partnerships and collaborative efforts in addressing community health problems more compelling.

Public Health 3.0 as described by DeSalvo et al. (2017) represents an effort to build on the past and put forth "a new era of enhanced and broadened public health practice that goes beyond traditional public department functions and programs" (p. 4). Key features of the Public Health 3.0 agenda are to focus on prevention at the total population level or community-wide prevention; to improve the social determinants of health; and to engage multiple sectors and community partners to generate collective impact. To accomplish the stated goals a major recommendation is that "Public health leaders should embrace the role of Chief Health Strategists for their communities—working with all relevant partners so that they can drive initiatives, including those that explicitly address 'upstream' social determinants of health" (p. 4).

Population Health

Kindig and Stoddard are credited with publishing the first formal definition of population health in the *American Journal of Public Health* in 2003. Their definition is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (p. 1).

With the growing popularity and use of the term *population health* has come confusion about the meaning of the term. Some of this confusion can be resolved by being descriptive about the type of population whose health is being considered. For example, those in public health primarily focus on community-based populations defined in geographic terms, such as those residing in a particular country, state, county, city, or a specific community. Whereas those working in a health care institution such as a hospital or health care system may define the population as those who are receiving or did receive care in their system or institution, which would constitute a clinical population. An example of a definition that focuses on a geographic population is the consensus definition developed by a group of public health and health care stakeholders convened by the Health Policy Institute of Ohio. Their definition of population health is "The distribution of health outcomes across a geographically defined group which results from the interaction between individual biology and behavior, the social, familial, cultural, economic and physical environments that support or hinder wellbeing; and the effectiveness of the public health and health care systems" (Center for Health Affairs, 2017).

Although the health of community-based populations has historically been the focus of public health practice, specifically defined populations of patients/clients, potential or actual, are increasingly becoming a focus of the "business" of managed care. As a result, managed care executives, program managers, and others associated with health care organizations are joining public health practitioners in becoming population-oriented. They and the consultants they hire are beginning to apply the biostatistical and analytical tools of the field of public health. However, their focus is on using such epidemiologic, statistical, and information science strategies to develop databases and analytical approaches to developing information useful in making decisions for defined populations enrolled in their care delivery organization or those covered by a particular insurance company or Medicare or Medicaid. This focus on clinical populations can be described as **population health management**. A population-focused approach to planning, delivering, and evaluating various interventions, whether they be community-wide or programs of care delivered by a hospital or hospital system, is increasingly being used in an effort to achieve better outcomes in the population of interest and has never been more important.

The concept of population health is relevant to populations defined in a variety of ways beyond those in a geographic jurisdiction or those receiving care from a particular care facility and can be applied to various groups such as workers/employees and students in a school setting. In order to be clear about what population is being considered by indicating that a specific population should be identified and to focus on the health of the population rather than the many factors responsible for that health, Williams proposed in a presentation at the spring 2018 meeting of the Association of Community Health Educators (ACHNE) the following definition, which is adapted from Kindig and Stoddard: "Population Health is the health status of a defined population of individuals, including the distribution of health status within the group" (Williams, 2018).

In a later discussion with doctoral students, Williams suggested that in view of all of the activity and "buzz" around the concept of population health it appears that *population health could also be seen as an emerging field within the health sciences that includes ways of defining health status, determinants of the population's health, policies and interventions that link those factors, and biostatistical and analytical strategies and approaches to describe, analyze, and mobilize collaborative, interdisciplinary, and cross-sector efforts to improve health in a defined population.*

The idea of looking at the health of populations is not new; epidemiologists have been doing this for many years, but what is different now and makes the effort much more feasible, practical, and useful is the use of technology in gathering, processing, analyzing, displaying, and sharing the data. In the not-too-distant past it was necessary to rely on very basic hand counts or paper records that were processed by hand and involved the investment of much time and a considerable lag between when the data were originally obtained and when they could be available for decision making. With the development of information technology—computers, handheld devices, and amazing software—it is now becoming increasing possible to look at population health data in ways that are practical, useful, and actionable.

Examples of Public Accessible Electronic Databases for Assessment of Population Health at the National, State, and County Level

The availability of interactive databases that has made it more feasible for public health practitioners and others to have access to population health data that they can actually use to understand what is happening in their state and community. Two such databases are Healthy People 2020 and County Health Rankings. Healthy People focuses on national level data, but for some of the areas examined state level data are available. In Healthy People 2020 (https://www.healthypeople.gov), 42 topic areas are examined—for each topic area, national objectives to be reached over the period of 10 years (from 2010 to 2020) are stated. In addition, a subset of high-priority topics/metrics referred to as leading indicators have been identified. Several of the leading indicators are infant deaths (under one year) per 1000; suicide per 100,000; obesity among adults per 100; and adolescent cigarette smoking in the past 30 days per 100. A very important part of the Healthy People initiative is the identification of recommended evidence-based interventions that can be used to address each of the objectives. The information on evidence-based recommendations and tools to assess community needs, create and implement program plans, and monitor community progress are also available on the website under the Tools and Resources tab. In January 2017, a midcourse review of data on progress toward the 2020 goals became available. Work is already under way to develop the goals and objectives for Healthy People 2030.

The County Health Rankings and Roadmaps (www.countyhealthrankings.org) is an interactive database that provides information at the state and county levels on Health Outcomes (length of life and quality of life); Health Factors (health behaviors—tobacco use, diet and exercise, alcohol and drug use, and social activity); Clinical Care (access to care and quality of care); Social and Economic Factors (education, employment, income, family and social support, and community safety); and Physical Environment (air and water quality, and housing and transit). In addition, there is a searchable database of evidence-informed policies and programs (road maps) that can make a difference. Other features are the Action Center, which helps users move from data to action at the community level; a Partner Center, which helps users identify possible partners and provides tips for engaging them; and Community Coaches, which can provide guidance to local communities to assist them in their efforts to make change. The user of the website can compare data on a given county with other counties in their state, with data at the state level, and with counties in other states. This website is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

PUBLIC HEALTH NURSING AS A FIELD OF PRACTICE: AN AREA OF SPECIALIZATION

Most of the preceding discussion has been about the broad field of public health. Now attention turns to **public health nursing**. What is public health nursing? Is it really a specialty, and if so, why? It can be argued that public health nursing is a specialty because it has a distinct focus and scope of practice, and it requires a special knowledge base. The following characteristics distinguish public health nursing as a specialty:

- *It is population-focused.* Primary emphasis is on populations whose members are free-living in the community as opposed to those who are institutionalized.
- *It is community-oriented.* There is concern for the connection between the health status of the population and the environment in which the population lives (physical, biological, sociocultural). There is an imperative to work with members of the community to carry out core public health functions.
- *There is a health and prevention focus.* The primary emphasis is on strategies for health promotion, health maintenance, and disease prevention, particularly primary and secondary prevention.
- *Interventions are made at the community or population level.* Target populations are defined as those living in a particular geographic area or those who have particular characteristics in common, and political processes are used as a major intervention strategy to affect public policy and achieve goals.
- *There is concern for the health of all members of the population/community, particularly vulnerable subpopulations.*

In 1981, the Public Health Nursing Section of the American Public Health Association (APHA) developed *The Definition and Role of Public Health Nursing in the Delivery of Health Care* to describe the field of specialization (APHA, 1981). This statement was reaffirmed in 1996 (APHA, 1996). In 1999, the American Nurses Association, with input from three other nursing organizations—the Public Health Nursing Section of the APHA, the Association of State and Territorial Directors of

Public Health Nursing, and the Association of Community Health Nurse Educators—published the *Scope and Standards of Public Health Nursing Practice* (Quad Council, 1999 [revised 2005]). In that document, the 1996 definition was supported. Since 1999, the scope and standards have been revised twice. In the latest version Public Health Nursing continues to be defined as "the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences" (APHA, 1996; and Quad Council, 1999 [revised 2005], 2011), but the following statement was added in 2011: "Public Health Nurses engage in population-focused practice, but can and do often apply the Council of Linkages concepts at the individual and family level" (see Quad Council, 2011, p. 9). In 2018, the Quad Council Coalition (QCC) of Public Health Nursing Organizations, which is comprised of the Alliance of Nurses for Healthy Environments (AHNE), the Association of Community Health Nursing Educators (ACHNE), the Association of Public Health Nurses (APHN), and the American Public Health Association—Public Health Nursing Section (APHA-PHN), published an update of Competencies for Community/Public Health Nurses (Quad Council Coalition, 2018) and adopted the APHA-PHN's 2013 definition of Public Health Nursing, which is "the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences. Public health nursing is a specialty practice within nursing and public health. It focuses on improving *population health* by emphasizing prevention and attending to multiple determinants of health. Often used interchangeably with community health nursing, this nursing practice includes advocacy, policy development, and planning, which addresses issues of social justice" (APHA-PHN, 2013).

Educational Preparation for Public Health Nursing

Targeted and specialized education for public health nursing practice has a long history. In the late 1950s and early 1960s, before the integration of public health concepts into the curriculum of baccalaureate nursing programs, special baccalaureate curricula were established in several schools of public health to prepare nurses to become public health nurses. Today it is generally assumed that a graduate of any baccalaureate nursing program has the necessary basic preparation to function as a beginning staff public health nurse.

Since the late 1960s, public health nursing leaders have agreed that a specialty in public health nursing requires a master's degree. In the future, a Doctor of Nursing Practice (DNP) degree will probably be expected, since the American Association of Colleges of Nursing has proposed that the DNP should be the expected level of education for specialization in an area of nursing practice (AACN, 2004, 2006). The educational expectations for public health nursing were highlighted at the 1984 Consensus Conference on the Essentials of Public Health Nursing Practice and Education sponsored by the USDHHS Division of Nursing. The participants agreed "that the term 'public health nurse' should be used to describe a person who has received specific educational preparation and supervised clinical practice in public health nursing" (USDHHS, 1985, p. 4). At the basic or entry level a public health nurse is one who "holds a baccalaureate degree in nursing that includes this educational preparation; this nurse may or may not practice in an official health agency but has the initial qualifications to do so" (USDHHS, 1985, p. 4). Specialists in public health nursing are defined as those who are prepared at the graduate level, with either a master's or doctoral degree, "with a focus in the public health sciences" (USDHHS, 1985, p. 4) (Box 1.3). The consensus statement specifically pointed out that the public health nursing specialist "should be able to work with population groups and to assess and intervene successfully at the aggregate level" (USDHHS, 1985, p. 11).

BOX 1.3 Areas Considered Essential for the Preparation of Specialists in Public Health Nursing

- Epidemiology
- Biostatistics
- Nursing theory
- Management theory
- Change theory
- Economics
- Politics
- Public health administration
- Community assessment
- Program planning and evaluation
- Interventions at the aggregate level
- Research
- History of public health
- Issues in public health

From *Consensus Conference on the Essentials of Public Health Nursing Practice and Education,* Rockville, MD, 1985, U.S. Department of Health and Human Services, Bureau of Health Professions, Division of Nursing.

The ACHNE reaffirmed the results of the 1984 Consensus Conference (ACHNE, 2003). The educational requirements were reaffirmed by ACHNE (2009) and in the revised *Scope and Standards of Public Health Nursing Practice* and include both clinical specialists and nurse practitioners who engage in population-focused care as advanced practice registered nurses in public health (Quad Council, 1999 [revised 2005]). The latest iteration of the *Scope and Standards of Practice for Public Health Nursing* was published by the American Nurses Association in 2013 (ANA, 2013).

Population-Focused Practice Versus Practice Focused on Individuals

A key factor that distinguishes public health nursing from other areas of nursing practice is the focus on populations, a focus historically consistent with public health philosophy and a cornerstone of population health. Box 1.4 lists principles on which public health nursing is built. Although public health nursing is based on clinical nursing practice, it also incorporates the population perspective of public health. It may be helpful here to define the term *population.*

A **population**, or **aggregate**, is a collection of individuals who have one or more personal or environmental characteristics in common. Members of a community who can be defined in terms of geography (e.g., a county, a group of counties, or a state) or in terms of a special interest or circumstance (e.g., children attending a particular school) can be seen as constituting a population.

BOX 1.4 Eight Principles of Public Health Nursing

1. The client or "unit of care" is the population.
2. The primary obligation is to achieve the greatest good for the greatest number of people or the population as a whole.
3. The processes used by public health nurses include working with the client(s) as an equal partner.
4. Primary prevention is the priority in selecting appropriate activities.
5. Selecting strategies that create healthy environmental, social, and economic conditions in which populations may thrive is the focus.
6. There is an obligation to actively reach out to all who might benefit from a specific activity or service.
7. Optimal use of available resources to assure the best overall improvement in the health of the population is a key element of the practice.
8. Collaboration with a variety of other professions, organizations, and entities is the most effective way to promote and protect the health of the people.

Quad Council of Public Health Nursing Organizations: *Scope and standards of public health nursing practice,* Washington, DC, 1999, revised 2005, 2007, 2013 with the American Nurses Association.

Often there are **subpopulations** or high-risk groups within the larger population, such as high-risk infants under the age of one year, unmarried pregnant adolescents, or individuals exposed to a particular event such as a chemical spill. In **population-focused and community-based practice**, problems are defined (by assessments or diagnoses) and solutions (interventions), such as policy development or providing a particular preventive service, are implemented for or with a defined population or subpopulation (examples are provided in the **Levels of Prevention** box). In other nursing specialties the diagnoses, interventions, and treatments are usually carried out at the individual client level. However, with the adoption of population health strategies by those working with clinical populations—population health management—this is beginning to change. Specifically, in some clinical settings population health management efforts are being developed in which patients with a common set of problems or conditions are defined as a population, and a defined set of services are offered to the entire population or a specific set of services are offered to those at varying levels of risk.

LEVELS OF PREVENTION

Examples in Public Health Nursing

Primary Prevention

Using general and specific measures in a population to promote health and prevent the development of disease (incidence) and using specific measures to prevent diseases in those who are predisposed to developing a particular condition.

Example: 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

Stopping the progress of disease by early detection and treatment, thus reducing prevalence and chronicity.

Example: The public health nurse develops a program of toxin screenings for migrant workers who may be exposed to pesticides and refers for treatment those who are found to be positive for high levels.

Tertiary Prevention

Stopping deterioration in a patient, a relapse, or disability and dependency by anticipatory nursing and medical care.

Example: The public health nurse provides leadership in mobilizing a community coalition to develop a Health Maintenance and Promotion Center to be located in a neighborhood with a high density of residents with chronic illnesses and few health education and appropriate recreation resources. In addition to educational programs for nutrition and self-care, physical activity programs such as walking groups are provided.

Professional education in nursing, medicine, and other clinical disciplines focuses primarily on developing competence in decision making at the individual client level by assessing health status, making management decisions (ideally *with* the client), and evaluating the effects of care. Fig. 1.3 illustrates three levels at which problems can be identified. For example, community-based nurse clinicians, or nurse practitioners, focus on individuals they see in either a home or a clinic setting. The focus is on an individual person or an individual family in a subpopulation (the *C* arrows in Fig. 1.3). The provider's emphasis is on defining and resolving a problem for the individual; the client is an individual.

In Fig. 1.3 the individual clients are grouped into three separate subpopulations, each of which has a common characteristic (the *B* arrows in Fig. 1.3). Public health nursing specialists often define problems at the population or aggregate level as opposed to an individual level. Population-level decision making is different from decision making in clinical care. For example, in a clinical, direct care situation, the nurse may determine that a client is hypertensive and explore options for intervening. However, at the population level, the public health nursing specialist might explore the answers to the following set of questions:

1. What is the prevalence of hypertension among various age, race, and sex groups?
2. Which subpopulations have the highest rates of untreated hypertension?
3. What programs could reduce the problem of untreated hypertension and thereby lower the risk of further cardiovascular morbidity and mortality for the population as a whole?

Public health nursing specialists are usually concerned with more than one subpopulation and frequently with the health of the entire community (in Fig. 1.3, arrow *A:* the entire box containing all of the subgroups within the community). In reality, of course, there are many more subgroups than those in Fig. 1.3. Professionals concerned with the health of a whole community must consider the total population, which is made up of multiple and often overlapping subpopulations. For example, the population of adolescents at risk for unplanned pregnancies would overlap with the female population 15 to 24 years of age. A population that would overlap with infants under one year of age would be children from zero to six years of age. In addition, a population focus requires considering those who may need particular services but have not entered the health care system (e.g., children without immunizations or clients with untreated hypertension).

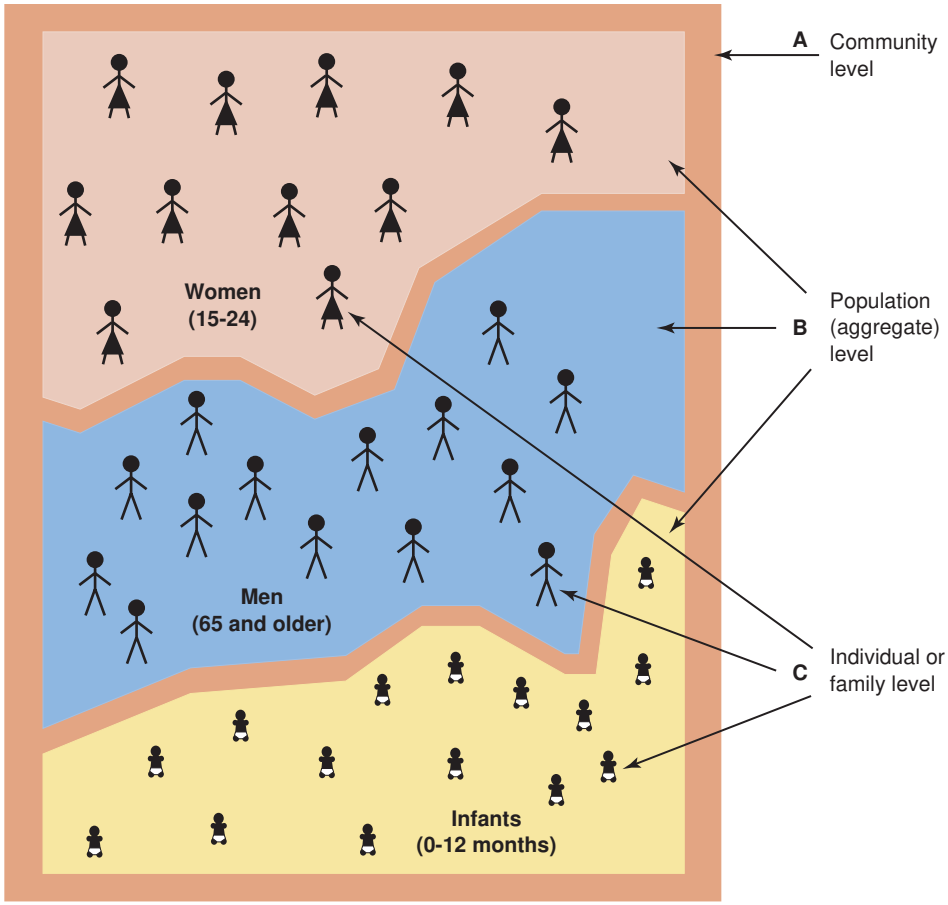

Fig. 1.3 Levels of health care practice.

Public Health Nursing Specialists and Core Public Health Functions: Selected Examples

The core public health function of *assessment* includes activities that involve collecting, analyzing, and disseminating information on both the health status and the health-related aspects of a community or a specific population. Questions such as whether the health services of the community are available to the population and are adequate to address needs are considered. Assessment also includes an ongoing effort to monitor the health status of the community or population and the services provided. As described earlier in this chapter, Healthy People is an excellent example of the efforts of the USDHHS to organize the goal setting, data collecting and analysis, and monitoring necessary to develop the series of publications describing the health status and health-related aspects of the U.S. population. These efforts began with *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* in 1980 and continued with *Promoting Health/Preventing Disease: Objectives for the Nation, Healthy People 2000, Healthy People 2010,* and *Healthy People 2020*, and are now moving forward into the future with *Healthy People 2030* (U.S. Department of Health, Education, and Welfare, 1979; USDHHS, 1980, 1979, 1991, 2000, 2010, 2020; *Healthy People 2030* retrieved from https://www.healthypeople.gov).

In addition to the County Health Rankings described earlier, many states and other jurisdictions have developed publications describing the health status of a defined community, a set of communities, or populations. Unfortunately, it is difficult to find published descriptions of health assessments on particular communities unless they demonstrate new methods or reveal unusual findings about a community. Such working documents and data sets should be available in specific settings, such as a county or state health department, and should be used by public health practitioners to develop services.

EVIDENCE-BASED PRACTICE

This study was a quasi-experimental pre-post design with no control group. The study sample consisted of 21 community institutions (7 hospitals, 8 YMCAs, 4 community health centers, and 2 organizations serving homeless populations). All Boston hospitals were invited to participate because they have an employee base that includes many lower-wage workers who live in the priority neighborhoods. The other settings were selected from priority neighborhoods defined as those with the highest proportion of black and Latino residents and a disproportionate chronic disease burden. The researchers estimated that about 78,000 people were reached by the intervention every week.

The goal was to reduce the percent of prepackaged foods available at the sites with greater than 200 milligrams (mg) of sodium; thus the outcome measure was the change in the percent of prepackaged foods with greater than 200 mg per serving from baseline to follow-up. The intervention consisted of education provided by registered dietitians to the food service directors at the sites, feedback on

EVIDENCE-BASED PRACTICE—cont'd

baseline assessment of levels of sodium in products available at each site and how they compared with other organizations in their sector, an action plan at each site for goal setting, technical assistance that included webinars on how they could support the desired changes, and educational materials to identify healthy, lower-sodium options and to increase consumer awareness of the health effects associated with excess sodium. The intervention period ranged from 1 to 1.5 years. Overall the percent of prepackaged products with greater than 200 mg of sodium decreased from 29.0 percent at baseline to 21.5 percent at follow-up ($P = .003$) Those changes were found to be due to improvements in the hospital cafeterias and kiosks. In the YMCA vending machines the percent of high-sodium products decreased from 27.2 percent to 11.5 percent ($P = .017$). While declines were observed in the vending machines in the community health centers and the organizations serving the homeless, they were not statistically significant due to the small sample sizes. While the study has the limitation of not having a control group, it cannot be said whether the changes were from the intervention or due to secular trends. However, the investigators had documented information that the sites made intentional decisions to produce the outcome. The study also is limited in not including any information on consumption behavior. The study provides information on the feasibility and modest effectiveness of a community-level intervention to increase the availability of lower sodium products in the food supply.

Nurse Use

This study indicates that there is potential to reduce the public's access to high-sodium products by providing options with less sodium, which can be useful in nurse-led public policy advocacy for healthier options in vending machines in schools and public buildings.

Brooks CJ, Barret J, Daly J, et al.: A community-level sodium reduction intervention, Boston, 2013-2015, *Am J Public Health* (12)107:1951-1957, 2017.

Policy development is both a core function of public health and a core intervention strategy used by public health nursing specialists. Policy development in the public arena seeks to build constituencies that can help bring about change in public policy. In an interesting case study of her experience as director of public health for the state of Oregon, Christine Gebbie (1999), a nurse, describes her experiences in developing a constituency for public health. This enabled her to mobilize efforts to develop statewide goals for *Healthy People 2000* as well as to update Oregon's disease-reporting laws. Gebbie's experiences as a state director of public health illustrate how a public health nursing specialist can provide leadership at a very broad level. Gebbie left Oregon to go to Washington, DC, to serve in the federal government as President Clinton's key official in the national effort to control acquired immunodeficiency syndrome (AIDS). Clearly, Gebbie is an example of an individual who has provided leadership in policy development at both state and national levels. Another public health nursing specialist who has provided and continues to provide strong policy leadership is Ellen Hahn, PhD, director of the Kentucky Center for Smoke Free Policy (https://www.uky.edu), which is based at the University of Kentucky's College of Nursing. This website is a treasure trove of information about reducing exposure to tobacco through advocacy and policy. There are fact sheets, videos, and research studies. Through her research Dr. Hahn has developed considerable evidence to support important policy changes (antismoking ordinances) to reduce exposure to tobacco smoke in Kentucky, a state that has a long tradition of a tobacco culture, both in production of tobacco and in use. A number of studies conducted by Hahn and her colleagues can be found on the website above.

The third core public health function, *assurance,* focuses on the responsibility of public health agencies to make certain that activities have been appropriately carried out to meet public health goals and plans. This may result in public health agencies requiring others to engage in activities to meet goals, encouraging private groups to undertake certain activities, or sometimes actually offering services directly. Assurance also includes the development of partnerships between public and private agencies to make sure that needed services are available and that assessing the quality of the activities is carried out. A report suggested that much more attention should be paid by public health officials to the quality of direct care services provided by clinicians in their communities (Fielding, 2009). It is important to point out that when personal services to individuals are offered by public health agencies to ensure that they can get care they might not receive without the intervention of the official agency, the goal is to "promote knowledge, attitudes, beliefs, practices and behaviors that support and enhance health with the ultimate goal of improving … population health" (Quad Council, 1999 [revised 2005]; and see Evidence-Based Practice box).

HEALTHY PEOPLE 2020

In 1979, the surgeon general issued a report that began a 30-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 were 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 percent of the national objectives had been met, and progress on an additional 40 percent of the objectives was noted. In the midcourse review published in 1995, it was noted that significant progress had been made toward meeting 50 percent of the objectives.

In light of the progress made in the past decade, the committee for *Healthy People 2010* proposed two goals. The hope was to reach these goals by 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 cannot be entirely separate 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 (https://www.healthypeople.gov).

PUBLIC HEALTH NURSING VERSUS COMMUNITY-BASED NURSING

The concept of public health should include all populations within the community, both free-living and those living in institutions. Furthermore, the public health specialist should consider the match between the health needs of the population and the health care resources in the community, including those services offered in a variety of settings. Although all direct care providers may contribute to the community's health in the broadest sense, not all are primarily concerned with the population focus—the big picture. All nurses in a given community, including those working in hospitals, physicians' offices, and health clinics, may contribute positively to the health of the community. However, the special contributions of public health nursing specialists include looking at the community or population as a whole; raising questions about its overall health status and associated factors, including environmental factors (physical, biological, and sociocultural); and *working with the community* to improve the population's health status.

Fig. 1.4 is a useful illustration of the arenas of practice. Because most nurses working in the community and many staff public health nurses, historically and at present, focus on providing direct personal care services—including health education—to persons or family units outside of institutional settings (either in the client's home or in a clinic environment), such practice falls into the upper right quadrant (section *B*) of Fig. 1.4. However, specialization in public health nursing is population-focused and focuses on clients living in the community and is represented by the box in the upper left quadrant (section *A*).

There are three reasons, in addition to the population focus, that the most important practice arena for public health nursing is represented by section *A* of Fig. 1.4, the population of free-living clients:

1. Preventive strategies can have the greatest impact on free-living populations, which usually represent the majority of a community.
2. The major interface between health status and the environment (physical, biological, sociocultural, and behavioral) occurs in the free-living population.
3. For philosophical, historical, and economic reasons, prevention-oriented, population-focused practice is most likely to flourish in organizational structures that serve free-living populations (e.g., health departments, health maintenance organizations, health centers, schools, and workplaces).

What roles in the health care system do public health nursing specialists (those in section *A* of Fig. 1.4) have? Options include director of nursing for a health department, director of the health department, state commissioner for health, director of maternal and child health services for a state or local health department, director of wellness for a business or educational organization, and director of preventive services for an integrated health system. Nurses can occupy all of these roles, but, with the exception of director of nursing for a health department, they are in the minority. Unfortunately, nurses who occupy these roles are often seen as "administrators" and not as public health nursing specialists. However, those who work in such roles have the opportunity to make decisions that affect the health of population groups and the type and quality of health services provided for various populations.

Where does the staff public health nurse or nurse working in the community fit on the diagram in Fig. 1.4? That depends on the focus of the nurse's practice. In many settings most of the staff nurse's time is spent in community-based direct care activities, where the focus is on dealing with individual clients and individual families, in which case the practice falls into section *B* of Fig. 1.4. Although a staff public health nurse or a nurse practicing in the community may not be a public health nurse specialist, this nurse may spend some time carrying out core public health functions with a population focus, and thus that part of the role would be represented in section *A* of Fig. 1.4. In summary, the field of public health nursing can be seen as primarily encompassing two groups of nurses:

- Public health nursing specialists, whose practice is community-oriented and uses population-focused strategies

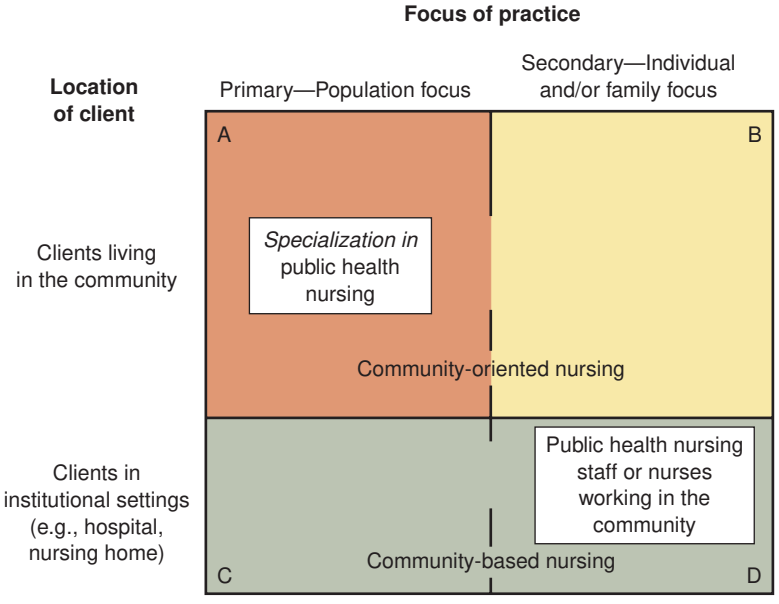

Fig. 1.4 Arenas for health care practice.

for carrying out the core public health functions (section *A* of Fig. 1.4)

- Staff public health nurses or clinical nurses working in the community nurses, who are community-based, who may be clinically oriented to the individual client, and who combine some primary preventive population-focused strategies and direct care clinical strategies in programs serving specified populations (section *B* of Fig. 1.4)

Sections *C* and *D* of Fig. 1.4 represent institutionalized populations. Nurses who provide direct care to these clients in hospital settings fall into section *D*, and those who have administrative/managerial responsibility for nursing services in institutional settings fall into section *C*.

Fig. 1.4 also shows that specialization in public health nursing, as it has been defined in this chapter, can be viewed as a specialized field of practice with certain characteristics within the broad arena of community. This view is consistent with recommendations developed at the Consensus Conference on the Essentials of Public Health Nursing Practice and Education (USDHHS, 1985). One of the outcomes of the historical conference was consensus on the use of the terms *community health nurse* and *public health nurse.* It was agreed that the term *community health nurse* could apply to all nurses who practice in the community, whether or not they have had preparation in public health nursing. Thus nurses providing secondary or tertiary care in a home setting, school nurses, and nurses in clinic settings (in fact, any nurse who does not practice in an institutional setting) could fall into the category of **community health nurse**. Nurses with a master's degree or a doctoral degree who practice in community settings could be referred to as *community health nurse specialists,* regardless of the area of nursing in which the degree was earned. According to the conference statement, "The degree could be in any area of nursing, such as maternal/child health, psychiatric/mental health, or medical-surgical nursing or some subspecialty of any clinical area" (USDHHS, 1985, p. 4). The definitions of the three areas of practice have changed, however, over time.

In 1998, the Quad Council began to develop a statement on the scope of public health nursing practice (Quad Council, 1999 [revised 2005]). The council attempted to clarify the differences between the term *public health nursing* and the term introduced into nursing's vocabulary during health care reform of the 1990s: **community-based nursing**. The authors recognized that the terms *public health nursing* and *community health nursing* had been used interchangeably since the 1980s to describe population-focused, community-oriented nursing practice and community-based practice. However, the Council decided to make a clearer distinction between community-oriented and community-based nursing practice. Community-based nursing care was described as the provision or assurance of personal illness care to individuals and families in the community, whereas community-oriented nursing was the provision of disease prevention and health promotion to populations and communities. It was suggested that there be two terms for the two levels of care in the community: *community-oriented care* and *community-based care* (see the list of definitions presented in Box 1.5).

There is a need and a place for a nursing specialty in the community; the nurse in this specialty is more than a clinical specialist with a master's degree who practices in a community-based setting, as was suggested by the Consensus Conference more than 25 years ago. Although in 1984 these nurses were referred to as community health nurses, today they are referred to as nurses in community-based practice (see definitions in the inside cover of this text). Those who provide community-oriented service to specific subpopulations in the community and who provide some clinical services to those populations may be seen as nurse specialists in the community. Although such practitioners may be community-based, they are also community-oriented as public health specialists but are usually focused on only one or two special subpopulations. Preparing for this specialty includes a master's or doctoral degree with emphasis in a direct care clinical area, such as school health or occupational health, and ideally some education in the public health sciences. Examples of roles such specialists might have in direct clinical care areas include case manager, supervisor in a home health agency, school nurse, occupational health nurse, parish nurse, and a nurse practitioner who also manages a nursing clinic.

BOX 1.5 Definitions of the Key Nursing Areas in the Community

- *Community-oriented nursing practice* is a philosophy of nursing service delivery that involves the generalist or specialist public health and community health nurse. The nurse provides 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.
- *Community-based nursing practice* is a setting-specific practice whereby care is provided for clients and families where they live, work, and attend school. The emphasis of community-based nursing 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.

ROLES IN PUBLIC HEALTH NURSING

In community-oriented nursing circles, there has been a tendency to talk about public health nursing from the point of view of a role rather than the functions related to the role. This can be limiting. In discussing such nursing roles, there is a preoccupation with the direct care provider orientation. Even in discussions about how a practice can become more population focused, the focus is frequently on how an individual practitioner, such as an agency staff nurse, can adopt a population-focused practice philosophy. Rarely is attention given to how nurse administrators in public health (one role for public health nursing specialists) might reorient their practice toward a population focus, which is particularly important and easier for an administrator to do than for the staff nurse. This is because many agencies' nursing administrators, supervisors, or others (sometimes program directors who are not nurses) make

the key decisions about how staff nurses will spend their time and what types of clients will be seen and under what circumstances. Public health nursing administrators who are prepared to practice in a population-focused manner will be more effective than those who are not prepared to do so.

Although their opportunities to make decisions at the population level are limited, staff nurses benefit from having a clear understanding of population-focused practice for three reasons:

- First, it gives them professional satisfaction to see how their individual client care contributes to health at the population level.
- Second, it helps them appreciate the practice of others who are population-focused specialists.
- Third, it gives them a better foundation from which to provide clinical input into decision making at the program or agency level and thus to improve the effectiveness and efficiency of the population-focused practice.

A curriculum was proposed by representatives of key public health nursing organizations and other individuals that would prepare the staff public health nurse or generalist to function as a community-oriented practitioner (Association of State and Territorial Directors of Nursing, 2000). The AACN developed a supplement to the document "The Essentials of Baccalaureate Education for Professional Nursing Practice," which highlights this organization's recommendations for public health nursing (AACN, 2013).

Unfortunately, nursing roles as presently defined are often too limited to include population-focused practice, but it is important not to think too narrowly. Furthermore, roles that entail population-focused decision making may not be defined as nursing roles (e.g., directors of health departments, state or regional programs, and units of health planning and evaluation; directors of programs such as preventive services within a managed care organization). If population-focused public health nursing is to be taken seriously, and if strategies for assessment, policy development, and assurance are to be implemented at the population level, more consideration must be given to organized systems for assessing population needs and managing care. Clearly, public health nurse specialists must move into positions where they can influence policy formation. This means, however, that some nurses will have to assume positions that are not traditionally considered nursing. It also means that some nurses will practice in settings not traditionally considered health organizations, such as nonprofit organizations providing services such as housing, supplemental food, and access to safe physical recreation activities and socialization opportunities.

Redefining nursing roles so that population-focused decision making fits into the present structure of nursing services may be difficult in some circumstances at the present time, but future needs will require that nurses be prepared to make such decisions (IOM, 2010). At this point, it may be more useful to concentrate on identifying the skills and knowledge needed to make decisions in population-focused practice (see Appendix F.1), to define where in the health care system such decisions are made, and then to equip nurses with the knowledge, skills, and political understanding necessary for success in such positions. Although some of these positions are in nursing settings (e.g., administrator of the nursing service and top-level staff nurse supervisors), others are outside of the traditional nursing roles (e.g., director of a health department).

CHALLENGES FOR THE FUTURE

Barriers to Nurses Specializing in Leadership Roles in Population Health Initiatives

One of the most serious barriers to the development of specialists in public health nursing is the mindset of many nurses that the only role for a nurse is at the bedside or at the client's side (i.e., the direct care role). Indeed, the heart of nursing is the direct care provided in personal contacts with clients. On the other hand, two things should be clear. First, whether a nurse is able to provide direct care services to a particular client depends on decisions made by individuals within and outside of the care system. Second, nurses need to be involved in those fundamental decisions. Perhaps the one-on-one focus of nursing and the historical expectations of the "proper" role of women have influenced nurses to view other ways of contributing, such as administration, consultation, and research, less positively. Fortunately, things are changing. Within and outside of nursing, women have taken on every role imaginable. Further, the number of male nurses is steadily growing; nursing can no longer be viewed as a profession practiced by women exclusively. These two developments have opened doors to new roles that may not have been considered appropriate for nurses in the past.

A second barrier to population-focused public health nursing practice consists of the structures within which nurses work and the process of role socialization within those structures. For example, the absence of a particular role in a nursing unit may suggest that the role is undesirable or inaccessible to nurses. In another example, nurses interested in using political strategy to make changes in health-related policy—an activity clearly within the domain of public health nursing—may run into obstacles if their goals differ from those of other groups. Such groups may subtly but effectively lead nurses to conclude that their involvement in political effort takes their attention away from the client and it is not in their own or in the client's best interest to engage in such activities.

A third barrier is that few nurses receive graduate-level preparation in the concepts and strategies of the disciplines basic to public health (e.g., epidemiology, biostatistics, community development, service administration, and policy formation). As mentioned previously, master's-level programs for public health nursing do not give the in-depth attention to population assessment and management skills that other parts of the curriculum receive, such as the direct care aspects. In 1995, Josten et al. noted that, with few exceptions, graduate programs in public health nursing have not aggressively developed the population-focused skills that are needed. After many years of teaching and consulting with graduate programs in public health nursing and DNP programs, it is clear to this writer that the problem Josten et al. pointed out over 20 years ago continues to need attention. For individuals who want to specialize in public health nursing, these skills are as essential as direct care skills, and they should be given more attention in graduate programs

that prepare nurses for careers in public health. There is hope. Fortunately, the curricular expectations for academic programs leading to the DNP degree include serious attention to preparing nurses to develop a population perspective as well as the analytical, policy, and leadership skills necessary to be successful as a specialist in public health nursing (AACN, 2006).

Developing Population Health Nurse Leaders

The massive organizational changes occurring in the health delivery system present a unique opportunity to establish new roles for nurse leaders who are prepared to think in population health terms. In a book that is now viewed as a classic, Starr (1982) described the trend toward the use of private capital in financing health care, particularly institution-based care and other health-related businesses. The movement can be thought of as the "industrialization" of health care, which operated very much like a **cottage industry** or a small business for a very long time. The implications and consequences of this movement are enormous. First, the goal was to provide investors a return on their investment. Other aspects included more attention to the delivery of primary and community-based care in a variety of settings; less emphasis on specialty care; the development of partnerships, alliances, and other linkages across settings in an effort to build **integrated systems**, which would provide a broad range of services for the population served; and in some situations adoption of **capitation**, a payment arrangement in which insurers agree to pay providers a fixed sum for each person per month or per year, independent of the costs actually incurred. Initially with the spread of capitation and now with the development by the CMS of value-based reimbursement, health professionals have become more interested in the concept of populations, sometimes referred to by financial officers and others as *covered lives* (i.e., individuals with insurance that pays on a capitated basis). For public health specialists, it is a new experience to see individuals involved in the business aspects of health care, and frequently employed by hospitals, thinking in population terms and taking a population approach to decision making.

This new focus on populations, coupled with the integration of acute, chronic, and primary care that is occurring in some health care systems, is likely to create new roles for individuals, including nurses, who will span inpatient and community-based settings and focus on providing a wide range of services to the population served by the system. Such a role might be director of client care services for a health care system, who would have administrative responsibility for a large program area. There will also be a demand for individuals who can design programs of preventive and clinical services to be offered to targeted subpopulations and those who can implement the services. Who will decide what services will be given to which subpopulation and by which providers? How will nurses be prepared for leadership in the emerging and future structures for health care delivery and health maintenance?

Physician leaders are recognizing that physicians need to be prepared to use population-focused methods, such as epidemiology and biostatistics, to make evidence-based decisions in the development of programs and protocols. In contrast, the attention being given to preparing nurses for administrative decision making seems to be declining. This may be a result of (1) the recent lack of federal support for preparing nurse administrators and (2) the growing popularity of nurse practitioner programs. However, it is time that nurse leaders give more attention to preparing nurses for leadership in the area of population-focused practice. Perhaps it is time to combine the specialty in public health nursing and nursing administration. As suggested some time ago by Williams (1985), some DNP programs are combining much of the preparation for specialization in public health nursing and administration into a systems-oriented curriculum with differentiation in the application to practice. This is the approach that is being taken in the DNP program in the College of Nursing at the University of Kentucky (www.uky.edu). This makes sense because regardless of how the population is defined, there will be a growing need for nurses with population-level assessment, management, and evaluation skills to assume leadership roles as urged in the IOM's report The Future of Nursing (IOM, 2010).

A primary focus of the health care system of the future will be on community-based strategies for health promotion and disease prevention and on population-focused strategies for primary and secondary care. Directing more attention to developing the specialty of public health nursing as a way to provide nursing leadership may be a good response to the health care system changes. Preparing nurses for population-focused decision making will require greater attention to developing programs at the doctoral level that have a stronger foundation in the public health sciences, while providing better preparation of baccalaureate-level nurses for community-oriented as well as community-based practice.

Some observers of public health have anticipated that if access to health care for all Americans becomes more of a reality, public health practitioners will be in a position to turn over the delivery of personal primary care services to practitioners in accountable care organizations and integrated health plans and return to the core public health functions. However, assurance (making sure that basic services are available to all) is a core function of public health. Thus even under the condition of improved access to care, there will still be a need to monitor subpopulations in the community to ensure that necessary care is available to all and that its quality is at an acceptable level. When these conditions are not met, public health practitioners are accountable for finding a solution.

Shifting Public Health Practice to Address the Social Determinates of Health and More Vigorous Policy Efforts to Create Conditions for a Healthy Population

The growing concern about the role played by the social determinants of health in contributing to negative health outcomes coupled with the Public Health 3.0 call for public health leaders to be health strategists in their communities suggests that public health leaders need to be more active in assuming community level leadership in addressing issues like homelessness, food insecurity, and unsafe physical and social environments. This translates into mobilizing various community constituencies to take collaborative

action within the constraints of current policies and to mobilize for the policy changes necessary to reduce the barriers to healthy conditions. This also means that public health nurse specialists need to be health strategists in their communities.

In 2012, the IOM published a report (IOM, 2012b) on shifting public policy from a primary focus of supporting medical care to creating conditions for a healthy population. A major challenge for the future is the need for public health nursing specialists to be more aggressive in working collaboratively with various groups in the community as well as professional colleagues in institutional settings to deal with barriers to health like the social determinants discussed above. Another challenge is to be more aggressive in their practice of the core public health function of policy development, one of the major ways public health specialists intervene, with the focus on actively engaging in influencing public decisions that will create conditions for a healthy population. This is necessary at the local, state, and national levels, and encompasses a wide range of concerns from the availability of adequate nutrition to the maintenance of a healthy and safe environment in schools, to the reduction of secondhand smoke, to assuring access to needed health services. Policy development is not a solitary activity; it involves working with many groups and coalitions. Also, policy development is not just the responsibility of public health specialists; it is important that all professional nurses become more serious and adept in the process of policy development.

In the IOM's influential report, *The Future of Nursing: Leading Change, Advancing Health* (IOM, 2010), a key message is that "Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States" (IOM, 2010, pp. 1-11). In discussing this message the report states that "to be effective in re-conceptualized roles, nurses must see policy as something they can shape rather than something that happens to them" (IOM, 2010, pp. 1-11). In other words, nurses need to be key actors. However, the report also makes clear that nurses need to be prepared for leadership in that area.

The history of public health nursing shows that a common attribute of leaders is to move forward to deal with unresolved problems in a positive, proactive way. This is the legacy of Lillian Wald at the Henry Street Settlement, the nurse who is credited with founding public health nursing, and others who have met a need by being innovative. Within the context of the core public health functions of assurance and policy making, public health nursing specialists clearly have an opportunity to affect public decisions that will help create conditions for a healthy population and influence the provision of needed health promotion and health maintenance services to populations in the community, particularly those that are most vulnerable. As a specialty, public health nursing can have a positive impact on the health status of populations, but to do so it will be necessary to have broad vision; to prepare nurses for roles in community leadership and policy making and in the design, development, management, monitoring, and evaluation of population-focused health care systems; and to develop strategies to support nurses in these roles. With the focus on quality and safety education for nurses, public health nursing education will want to reflect this renewed focus and assist nurses who are population-focused in developing the competencies noted in the QSEN box.

LINKING CONTENT TO PRACTICE

In this chapter emphasis is placed on defining and explaining public health nursing practice with populations. The three essential functions of public health and public health nursing are assessment, policy development, and assurance. The Council on Linkages' "Core Competencies for Public Health Professionals" revised in 2014 describes the skills of public health professionals, including nurses. In assessment function, one skill is assessment of the health status of populations and their related determinants of health and illness. For policy development, one of the skills is 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 in Fig. 1.1. 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, to support individual and community health efforts. Incorporating ethical standards is done in essential service 3 when informing, educating, and empowering people about health issues.

QSEN FOCUS ON QUALITY AND SAFETY EDUCATION IN NURSES

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	Minimize 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

QSEN, Quality and Safety Education for Nurses.
Prepared by Gail Armstrong, PhD(c), DNP, ACNS-BC, CNE, Associate Professor, University of Colorado Denver College of Nursing.

PRACTICE APPLICATION

Population-focused nursing practice is different from clinical nursing care delivered in the community. If one accepts that the specialist in public health nursing is population-focused and has a unique body of knowledge, it is useful to debate where and how public health nursing specialists practice. How does their practice compare with that of the nurse specialist in community or community-based nursing?

A. In your public health class, debate with classmates which nurses in the following categories practice population-focused nursing and provide reasons for your choices:
   1. School nurse
   2. Staff nurse in home care
   3. Director of nursing for a home care agency
   4. Nurse practitioner in a health maintenance organization
   5. Vice president of nursing in a hospital
   6. Staff nurse in a public health clinic or community health center
   7. Director of nursing in a health department

B. Choose three categories in the preceding list, and interview at least one nurse in each of the categories. Determine the scope of practice for each nurse. Are these nurses carrying out population-focused practice? Could they? How?

Answers can be found on the Evolve site.

KEY POINTS

- Public health is what we, as a society, do collectively to ensure the conditions in which people can be healthy.
- Assessment, policy development, and assurance are the core public health functions; they are implemented at all levels of government.
- *Assessment* refers to systematically collecting data on the population, monitoring of the population's health status, and making available information about the health of the community.
- *Policy development* refers to the need to provide leadership in developing policies that support the health of the population; it involves using scientific knowledge in making decisions about policy.
- *Assurance* refers to the role of public health in making sure that essential community-wide health services are available, which may include providing essential personal health services for those who would otherwise not receive them. Assurance also refers to ensuring that a competent public health and personal health care workforce is available.
- The setting is frequently viewed as the feature that distinguishes public health nursing from other specialties. A more useful approach is to use the following characteristics: a focus on populations that are free-living in the community, an emphasis on prevention, a concern for the interface between the health status of the population and the living environment (physical, biological, sociocultural), and the use of political processes to affect public policy as a major intervention strategy for achieving goals.
- According to the 1985 Consensus Conference sponsored by the Division of Nursing of the U.S. Department of Health and Human Services, *specialists in public health nursing* are defined as those who are prepared at the graduate level, either master's or doctoral, "with a focus in the public health sciences" (USDHHS, 1985). This is still true today.
- Population-focused practice is the focus of specialists in public health nursing. This focus on populations and the emphasis on health protection, health promotion, and disease prevention are the fundamental factors that distinguish public health nursing from other nursing specialties.
- A *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.*

CLINICAL DECISION-MAKING ACTIVITIES

1. Define the following for your personal understanding, and suggest ways to check whether your understanding is correct:
   A. Essential functions of public health
   B. Specialist in public health nursing
   C. Nurse specialist in the community

2. State your opinion about the similarities and/or differences between a clinical nursing role and the population-focused role of the public health nursing specialist. What are some of the complex issues in distinguishing between these roles?

3. Review the model of public health nursing practice of the APHA as described in this chapter. Can you elaborate on the differences between the staff nurse and the specialist nurse?

4. With three or four classmates, identify some nurses in your community who are in an administrative role and discuss with them the following:
   A. The way they define the populations they are serving
   B. Strategies they use to monitor the population's health status
   C. Strategies they use to ensure that the populations are receiving needed services
   D. Initiatives they are taking to address problems

5. Do additional questions need to be asked to determine their views on population-focused practice and the responsibilities of the staff nurse? Elaborate.

ADDITIONAL RESOURCES

EVOLVE WEBSITE

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

- Answers to Practice Application
- Case Study
- Glossary
- Review Questions

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