MARCIA STANHOPE | JEANETTE LANCASTER

FOUNDATIONS *for* POPULATION HEALTH *in* COMMUNITY/PUBLIC HEALTH NURSING

SIXTH EDITION

ELSEVIER

Evolve®

Student Resources on Evolve
Access Code Inside

Evolve®

YOU'VE JUST PURCHASED MORE THAN A TEXTBOOK!

Enhance your learning with Evolve Student Resources.

These online study tools and exercises can help deepen your understanding of textbook content so you can be more prepared for class, perform better on exams, and succeed in your course.

Activate the complete learning experience that comes with each NEW textbook purchase by registering with your scratch-off access code at

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

If your school uses its own Learning Management System, your resources may be delivered on that platform. Consult with your instructor.

If you rented or purchased a used book and the scratch-off code at right has already been revealed, the code may have been used and cannot be re-used for registration. To purchase a new code to access these valuable study resources, simply follow the link above.

Place Sticker Here

REGISTER TODAY!

ELSEVIER

You can now purchase Elsevier products on Evolve!
Go to evolve.elsevier.com/shop to search and browse for products.

2019v1.0

A tailored education experience — *Sherpath book-organized collections*

Sherpath is the digital teaching and learning technology designed specifically for healthcare education.

ELSEVIER

Sherpath book-organized collections offer:

Objective-based, digital lessons, mapped chapter-by-chapter to the textbook, that make it easy to find applicable digital assignment content.

Adaptive quizzing with personalized questions that correlate directly to textbook content.

Teaching materials that align to the text and are organized by chapter for quick and easy access to invaluable class activities and resources.

Elsevier ebooks that provide convenient access to textbook content, even offline.

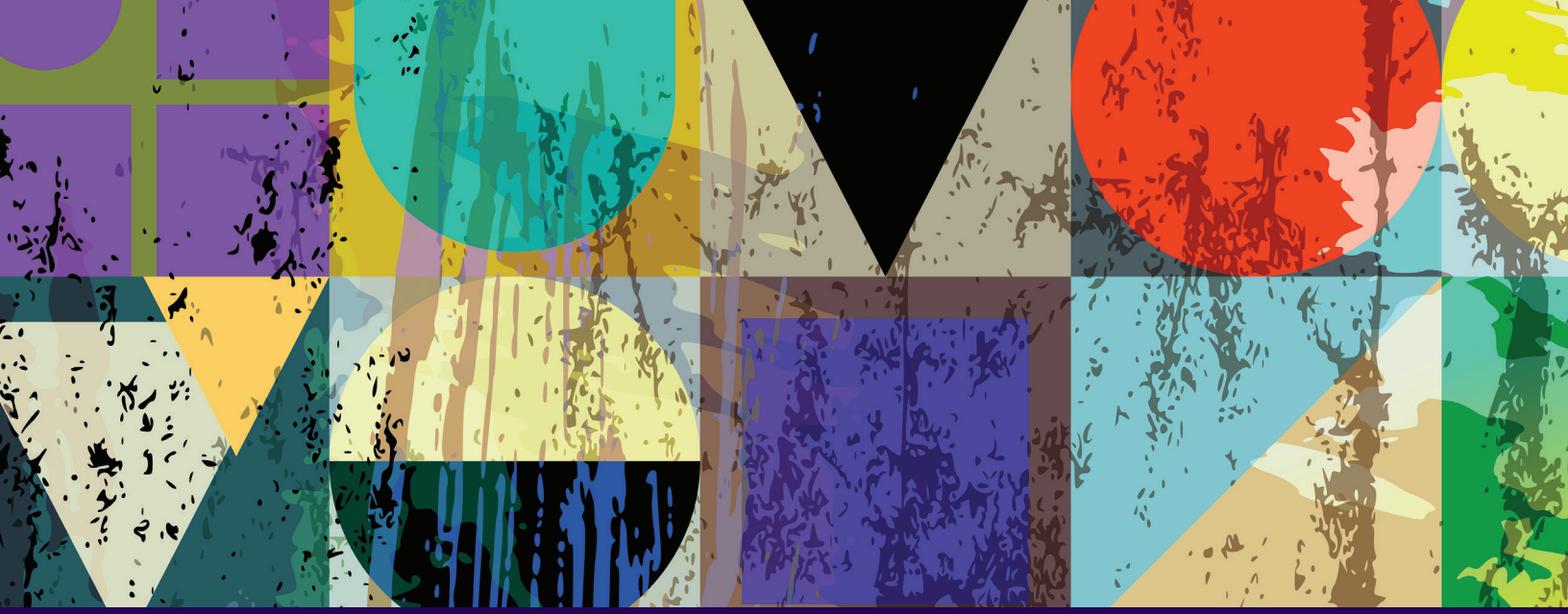
VISIT
myevolve.us/sherpath
today to learn more!

21-CS-0280 TM/AF 6/21

This page intentionally left blank

FOUNDATIONS *for* POPULATION HEALTH *in* COMMUNITY/PUBLIC HEALTH NURSING

This page intentionally left blank



FOUNDATIONS *for* POPULATION HEALTH *in* COMMUNITY/PUBLIC HEALTH NURSING

SIXTH EDITION

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;
Associate, Tuft & Associates, Inc.
Charlottesville, Virginia

ELSEVIER

Elsevier
3251 Riverport Lane
St. Louis, Missouri 63043

FOUNDATIONS FOR POPULATION HEALTH IN COMMUNITY/PUBLIC HEALTH NURSING, SIXTH EDITION ISBN: 978-0-323-77688-2

Notice

Practitioners and researchers must always rely on their own experience and knowledge in evaluating and using any information, methods, compounds or experiments described herein. Because of rapid advances in the medical sciences, in particular, independent verification of diagnoses and drug dosages should be made. To the fullest extent of the law, no responsibility is assumed by Elsevier, authors, editors or contributors for any injury and/or damage to persons or property as a matter of products liability, negligence or otherwise, or from any use or operation of any methods, products, instructions, or ideas contained in the material herein.

Previous editions copyrighted 2018, 2014, 2010, 2006, and 2002

Library of Congress Control Number: 2021934549

Content Strategist: Heather Bays-Petrovic
Senior Content Development Manager: Lisa P. Newton
Senior Content Development Specialist: Tina Kaemmerer
Publishing Services Manager: Julie Eddy
Senior Project Manager: Rachel E. McMullen
Design Direction: Brian Salisbury

Printed in Canada

Last digit is the print number: 9 8 7 6 5 4 3 2 1

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 at 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 in the College of Nursing 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 alumna of the University of Kentucky.

JEANETTE LANCASTER, PhD, RN, FAAN

Jeanette Lancaster is a Professor and Dean Emerita at the University of Virginia, where she served as Dean for 19 years and remained on the faculty an additional 4 years. She served as a Visiting Professor at the University of Hong Kong from 2008–2009, where she taught undergraduate and graduate courses in public health nursing and worked on a number of special projects, including the development of a doctoral program. She also served as a visiting professor at Vanderbilt University and taught and delivered talks in Hong Kong and Taiwan. Dr. Lancaster taught public health courses on Semester at Sea in both 2013 and 2014. She works as an Associate with Tuft & Associates, Inc. an executive search firm. She has practiced psychiatric nursing and taught both psychiatric and public health nursing courses, as well as courses in nursing management. She taught at Texas Christian University; directed the community health master's program; and served as director of all master's programs at the University of Alabama in Birmingham. She was Dean of the School of Nursing at Wright State University in Dayton, Ohio before going to the University of Virginia in 1989. Dr. Lancaster is a graduate of the University of Tennessee Health Sciences 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 authored the Elsevier publication *Nursing Issues in Leading and Managing Change* and is co-author with Dr. Marcia Stanhope of *Foundations for Population Health in Community/Public Health Nursing.* She received outstanding alumni awards from the University of Tennessee Health Sciences Center and the Frances Payne Bolton School of Nursing at Case Western Reserve University and an honorary Doctor of Humane Letters from SUNY Downstate Medical Center's College of Nursing and Related Health Sciences.

I am dedicating this edition of *Foundations* to the memory of my beloved aunt, Betty Lamb. She has been my touchstone to the family and has been my friend and supporter for many years. I do miss her. Also to my Aunt Ruby, who was an integral part of my life from birth. I have also enjoyed the friendship, support, and fun times with my closest friends and colleagues Joann Brashear, Nancy D. Hazard, Carolyn A. Williams, and Jeanette Lancaster, as well as many others through my life and career. I have benefited from the closeness I have shared with their husbands and the children, who are now grown and making their contributions to life, Ronn and Larry Brashear, John B. Hazard, and Anne Hazard Hoblik. Fun with Dusty, Buster, Lilbeth, Clem and Chip, Freckles, Simon, and the Phynx, as well as A.D., L.B., L.O., F.C., P.B., O.B & O.J, has been interesting and challenging for many years.

Marcia Stanhope

I dedicate this edition to my new COVID-inspired rescue cats: Loki and Arlo. They are 8-year-old brothers who have great fun walking across my keyboard when I am working on chapters. Of course, their exercise often causes difficulty since they alter the page on which I am working. Perhaps they have learned a little about public health nursing in their computer travels.

Jeanette Lancaster

ACKNOWLEDGMENTS

We wish to thank the Public Health nurses who work daily to improve the health of populations and to faculty who assist students to understand the importance of population-level health care. Our special thanks to the Elsevier team who make our contributions possible, especially Heather Bays-Petrovic, Tina Kaemmerer, and Rachel McMullen and her staff. A very special thanks to our contributors in *PHN 10* for their outstanding work developing the text content, which supports the updates for *Foundations*, and to Lisa Pedersen Turner, PhD, RN, PHCNS-BC, who has worked with us through several editions of the text. The contributions of this talented group of people make our work easier.

Marcia Stanhope and Jeanette Lancaster

CONTRIBUTORS

We gratefully acknowledge the following individuals who wrote chapters for the 10th edition of *Public Health Nursing*, on which the chapters in this book are based.

Swann Arp Adams, MS, PhD
Associate Professor
College of Nursing
University of South Carolina
Columbia, South Carolina

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

Jeanne L. Alhusen, PhD, CRNP, RN, FAAN
Associate Professor and Assistant Dean for Research
School of Nursing
University of Virginia
Charlottesville, Virginia

Kacy Allen-Bryant, PhD(c), MSN, MPH, RN
Lecturer
College of Nursing
University of Kentucky
Lexington, Kentucky

Debra Gay Anderson, PhD, PHCNS-BC
Associate Dean for Research
College of Nursing
South Dakota State University
Brookings, South Dakota

Amber M. Bang, RN, BSN
Registered Nurse
Grants Pass, Oregon

Whitney Rogers Bischoff, DrPH, MSN, BSN
Associate Professor
Nursing
Texas Lutheran University
Seguin, Texas

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

Hazel Brown, DNP, RN
Chief Nursing Officer
Nursing Administration
Cayman Islands Health Services Authority
George Town, Grand Cayman
Cayman Islands

Angeline Bushy, PhD, RN, FAAN
Professor, Bert Fish Chair
College of Nursing
University of Central Florida
Orlando, Florida

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

Catherine Carroca, MSN, RN
Assistant Professor
School of Nursing
Massachusetts College of Pharmacy and Health Sciences
Worcester, Massachusetts

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

Laura H. Clayton, PhD, RN, CNE
Professor
Department of Nursing Education
Shepherd University
Shepherdstown, West Virginia

Erin G. Cruise, PhD, RN
Associate Professor
School of Nursing
Radford University
Radford, Virginia

Lois A. Davis, RN, MSN, MA
Public Health Clinical Instructor
College of Nursing
University of Kentucky
Lexington, Kentucky

Sharon K. Davis, DNP, APRN, WHNP-BC
Clinical Assistant Professor
Nursing
University of Tennessee
Knoxville, Tennessee

Cynthia E. Degazon, RN, PhD
Professor Emerita
School of Nursing
Hunter College
New York, New York

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

Sherry L. Farra, PhD, RN, CNE, CHSE, NDHP-BC
Associate Professor
Nursing
Wright State University
Dayton, Ohio

Mary E. Gibson, PhD, RN
Associate Professor
Nursing
University of Virginia
Charlottesville, Virginia

Mary Kay Goldschmidt, DNP, MSN, RN, PHNA-BC
Assistant Professor
Family and Community Health
Virginia Commonwealth University School of Nursing;
Co-director
PIONEER NEPQR Grant
Health Resources and Services Administration
Washington, DC

Monty Gross, PhD, MSN, RN, CNE, CNL
Senior Nurse Leader for Professional Development
Nursing Administration
Health Services Authority
George Town, Grand Cayman
Cayman Islands

Gerard M. Jellig, EdD
School Principal/Leader
KIPP DC WILL Academy
Washington, DC

Tammy Kiser, DNP, RN
Assistant Professor of Nursing
School of Nursing
James Madison University
Harrisonburg, Virginia

Andrea Knopp, PhD, MPH, MSN, FNP-BC
Nurse Practitioner Program Coordinator, Associate Professor
School of Nursing
James Madison University
Harrisonburg, Virginia

Candace Kugel, BA, MS, FNP, CNM
Clinical Specialist
Migrant Clinicians Network
Austin, Texas

Roberta Proffitt Lavin, PhD, FNP-BC, FAAN
Professor and Executive Associate Dean of Academic Programs
College of Nursing
University of Tennessee
Knoxville, Tennessee

Natasha Le, BA, BS
Informatics and Quality Coordinator
Home Care and Hospice
Penn Care at Home
Philadelphia, Pennsylvania

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

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

Mary Lynn Mathre, RN, MSN, CARN
President and Co-founder
Patients Out of Time
Howardsville, Virginia

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

Emma McKim Mitchell, PhD, MSN, RN
Assistant Professor
Department of Family, Community & Mental Health Systems
University of Virginia School of Nursing
Charlottesville, Virginia

Carole R. Myers, PhD, MSN, BS
Associate Professor
College of Nursing
University of Tennessee
Knoxville, Tennessee

Victoria P. Niederhauser, DrPH, RN, PPCNP-BC, FAAN
Dean and Professor
College of Nursing
University of Tennessee
Knoxville, Tennessee

Bobbie J. Perdue, RN, PhD
Professor Emerita
College of Human Ecology
Syracuse University
Syracuse, New York;
Adjunct Faculty
Jersey College of Nursing
Tampa, Florida

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

Cynthia Rubenstein, PhD, RN, CPNP-PC
Chair and Professor
Nursing
Randolph-Macon College
Ashland, Virginia

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

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

Donna E. Smith, MSPH
Epidemiology Specialist
Epidemiology Program
Mecklenburg County Health Department
Charlotte, North Carolina

Sherrill J. Smith, RN, PhD, CNE, CNL
Professor
College of Nursing and Health
Wright State University
Dayton, Ohio

Esther J. Thatcher, PhD, RN, APHN-BC
Assistant Nurse Manager
Internal Medicine
University of Virginia Health System
Charlottesville, Virginia

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

Lisa M. Turner, PhD, RN, PHCNS-BC
Associate Professor of Nursing
Department of Nursing
Berea College
Berea, Kentucky

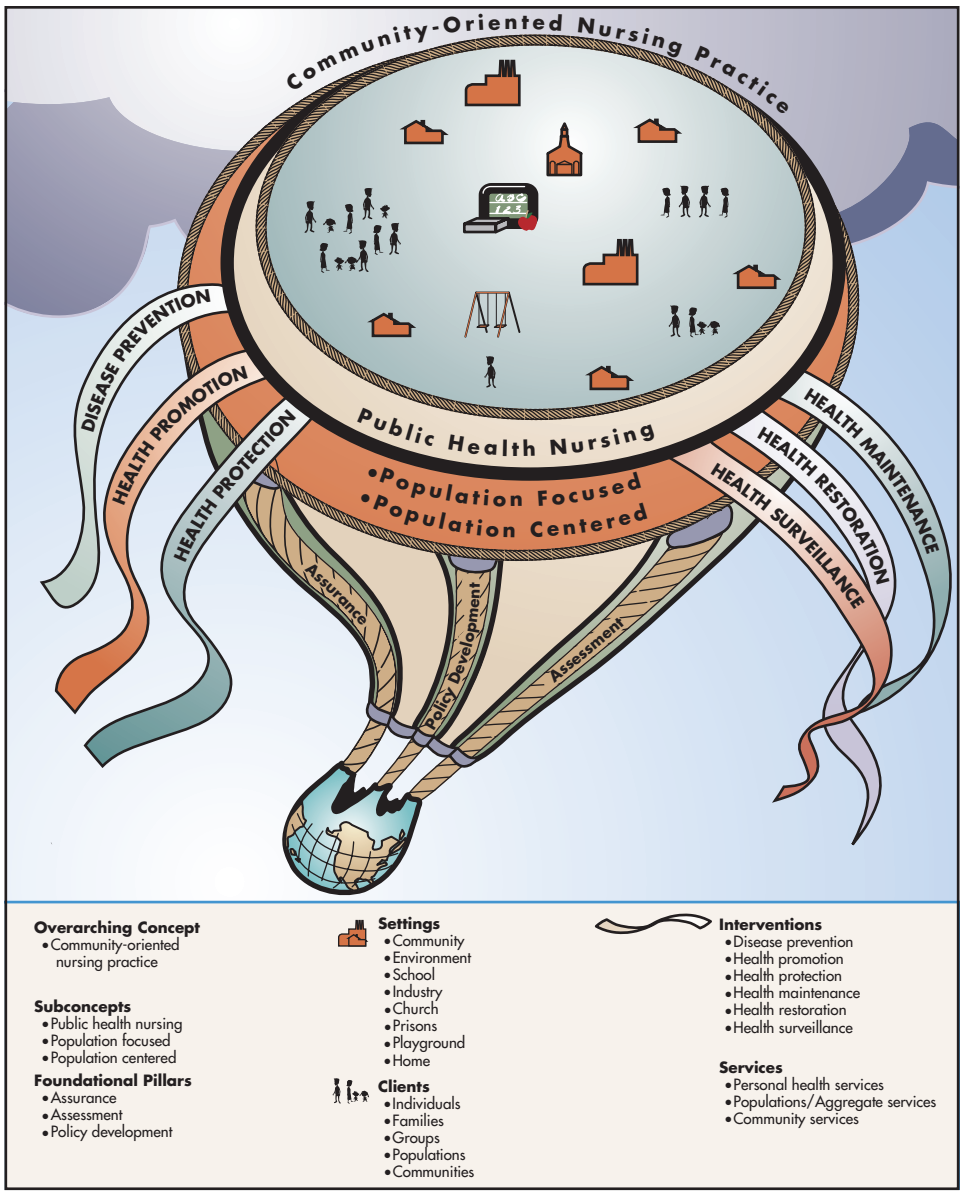
Connie M. Ulrich, PhD, RN, FAAN
Professor of Nursing and Bioethics
University of Pennsylvania
Philadelphia, Pennsylvania

Lynn Wasserbauer, RN, FNP, PhD
Nurse Practitioner
Strong Ties Community Support Program
University of Rochester Medical Center
Rochester, New York

Jacqueline F. Webb, DNP, FNP-BC, RN
Associate Professor
School of Nursing
Linfield College
Portland, Oregon

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

Lisa M. Zerull, PhD, RN-BC
Director and Academic Liaison
Nursing
Winchester Medical Center-Valley Health System;
Adjunct Clinical Faculty
School of Nursing
Shenandoah University
Winchester, Virginia



COMMUNITY NURSING DEFINITIONS

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

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

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

PREFACE

When we wrote the preface to the 5th edition of this text, we said "health care is in a rapid state of flux." Now, the state of health care is in a much greater "flux." In fact, it is called a crisis. We did not expect a new word to dominate our vocabulary and its possible and real effects to dominate our behavior. COVID-19 has had crippling effects on health, the economy, and many aspects of usual life behaviors. In addition to the virus with its several strains and the confusion and difficulties that occurred in getting vaccines to communities, health is affected by unrest in the nation due to killings, protests, and demonstrations, as well as a record-setting hurricane in 2020 and subsequent flooding, and wildfires across many of the Western states.

The American Nurses Association developed five guiding principles for nurses and the COIVID-19 vaccines. These principles are: access, transparency, equity, efficacy, and safety (ANA, 2021). Access has been a significant issue. Unlike some countries, where there was a national plan for vaccine distribution, in the United States, each state determined who was eligible and the priority system for distribution. Transparency has been more fully implemented via written and spoken news media. Equity means that there should be equitable distribution in more than high income countries. The COVID vaccines were developed in record time; however, there appears to be strong efficacy for the safety and effectiveness of the various vaccines.

Nurses, nursing students, patients, and families have been affected by the virus. The education of students has changed remarkably, necessitating that both faculty and students learn new ways of teaching and learning. Regrettably, the United States did not handle the pandemic as effectively as some other nations, which led to an unusually high number of cases of COVID-19 and many deaths. The 72nd World Health Assembly had designated 2020 as the Year of the Nurse and the Midwife (World Health Organization, 2019). At that time, no one knew how much attention would focus on nurses as they cared for COVID patients. This designation was intended to recognize Florence Nightingale's 200th birthday. Due to the state of the world in 2020, the Year of the Nurse and the Midwife continues through 2021.

The Trust for America's Health (TFAH.org) found a chronic pattern of underfunding of vital public health programs in its report "The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations" (April 2020). They concluded that this lack of underfunding puts Americans' lives at risk. This risk occurs at a time when the nation is facing the "ongoing challenges of seasonal flu, vaccine-preventable disease outbreaks, the growing number of Americans who have obesity, risks associated with vaping, rising rates of sexually transmitted infections, and the opioid and other substances misuse and suicide epidemics" (TFAH, 2020, p. 3).

The Centers for Disease Control and Prevention (CDC) is the primary driver for public health funding through its grant programs to states and larger cities. The CDC's overall budget was increased by 9 percent in 2020 from 2019; however, when taking inflation into account, this only represented a 7 percent increase. Also, when adjusting for inflation the 2020 budget was about the same as the CDC's budget in 2008. The COVID-19 crisis led Congress to enact three response bills on each of these dates: March 5: 8.3 billion; March 18: 500 million; and March 27: 4.3 billion (TFAH, 2020, p. 3). The report provides details about each of these funding programs and how funds were allocated. In 2018 public health spending was about $286 per person, and that was only 3 percent of all healthcare spending in the nation. Spending in public health has been demonstrated to have a strong return on investment in high-income countries. Specifically, in a systematic report done in 2017, the authors found a median return on investment of 14 to 1 (Masters, Anwar, Collins et al., 2017). Public health underfunding was highlighted during the pandemic when necessary resources were not available.

According to the CDC, there are five core capabilities of a robust public health system:

- Threats assessment and monitoring: the ability to track the health of a community via data and laboratory testing.
- All-hazards preparedness: the capacity to respond to emergencies of all kinds, from natural disasters to infectious disease outbreaks to bioterrorism.
- Public communication and education: the ability to effectively communicate to diverse public audiences with timely, science-based information.
- Community partnership development: the ability to harness, work with, and lead community stakeholders and to create multisector collaborations to address public health and health equity issues.
- Program management and leadership: applying the best business and data-informed practices to the public health enterprise.

To carry out these activities, you need a well-trained public health workforce, and the numbers have been declining. From 2016 to 2019 the number of state full-time or equivalent people working in public health declined from 98,877 to 91,540, and an estimated 25 percent of the public health workforce was expected to retire in 2020 (TFAH, 2020, p. 7). Also, as will be discussed in Chapter 23, social determinants of health and the creation of health equity need to be addressed to ensure an effective public health system.

Public health workers, nurses, physicians, first responders, and other essential workers have been at the forefront of appreciation from Americans. Nurses who cared for COVID-19 patients have contracted the virus, and many have lost their lives and endangered their families due to the transmission of the virus.

As discussed in Chapter 2, throughout history, public health initiatives have had significant effects on health care in the United States and around the world. However, in recent years, we have seen a continual decline in funding for public health.

What is new is the launch of *Healthy People 2030*. Since 1980, *Healthy People* editions have set measurable goals designed to

improve the health and well-being of Americans. This document is published every decade following review and feedback from a diverse group of individuals and organizations. The goal is to set national objectives to address the nation's most critical health objectives. Some of the key changes in *Healthy People 2030* that differentiate it from prior versions include:

- A reduction in the number of objectives to avoid overlap and to prioritize the most critical public health issues.
- Each objective is clearly labeled as to its relationship to *Healthy People 2020* objectives as: retained, modified, related, or removed.
- There is an increased focus on health equity and the social determinants of health.
- Health literacy is a central focus as reflected in one of the document's overarching goals: "Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all." Health literacy is divided into personal health literacy and organizational health literacy.
- Personal health literacy is "the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others" *(Healthy People 2030)*.
- Organizational health literacy is "the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others" *(Healthy People 2030)*.
- There is also an increased focus on how conditions in the environment where people are born, live, learn, work, play, worship, and age affect health.
- *Healthy People 2030* groups objectives according to health conditions; health behaviors; populations; setting and systems; and social determinants of health.

Each chapter in the text has a box that gives three examples of *Healthy People 2030* objectives that relate to the content of the chapter.

Two other documents to pay attention to are *Core competencies for public health professionalism*, which was updated in June 2014 by the Council on Linkages Between Academia and Public Health Practice (phf.org/corecompetencies) and *Community/Public Health Nursing (C/PHN) Competencies* (http: www.nationalacademies.org/), which was updated in 2018 by the Quad Council Coalition (QCC) of Public Health Nursing Organizations. The QCC was founded in 1988 to address priorities for public health nursing education, practice, leadership, and research, and services as the voice for public health nursing (Quad Council Coalition Competency Review Task Force, 2018): Community/Public Health Nursing Competencies. The Quad Council Coalition of Public Health Nursing Organizations is comprised of these groups:

Association of Community Health Nurse Educators (ACHNE)
Association of Public Health Nurses (APHN)
American Public Health Association (APHA)-Public Health Nursing Section
Alliance of Nurses for Healthy Environments (ANHE).

The Future of Nursing 2020-2030: document was released in May 2020 and has a significant emphasis on health equity and the social determinants of health that affect health equity. The report also recommends that nurses achieve the highest level of nursing education possible. See http://www.nationalalacademies.org/future-of-nursing-2020-2030.

Also, the Public Health Association defines public health nursing as "the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences" (APHA, 2013). Throughout the chapters, you will find information that supports this definition as public health nurses work with individuals, families, groups, and communities to promote health and prevent illness.

The National Council of State Boards of Nursing (NCSBN) determined that the nursing process, which has been the "gold standard" to guide nursing practice for over 50 years did not necessarily use this process to make "clinical judgment." The NCSBN's definition of clinical judgment builds on and expands the nursing process. The definition of clinical judgment is "the observed outcome of critical thinking and decision-making. It is an iterative process that uses nursing knowledge to observe and assess presenting situations, identify a prioritized client concern, and generate the best possible evidence-based solutions in order to deliver safe client care" (NCSBN, 2018, p. 12). The six essential cognitive skills of clinical judgment include:

1. Recognize cues
2. Analyze cues
3. Prioritize hypotheses
4. Generate solutions
5. Take action
6. Evaluate outcomes

These six skills are consistent with the steps of the nursing process as can be seen in the following table, and these are important steps to take in public health nursing (Ignatavicius and Silvestri, 2019, developed for Elsevier).

With the onset of the COVID-19 pandemic, the need for clinical judgment has been intensified. These are important times for nurses and especially so for those who choose public health nursing.

COMPARISON OF NURSING PROCESS STEPS WITH CLINICAL JUDGMENT COGNITIVE SKILLS

Steps of the Nursing Process	Cognitive Skills for Clinical Judgment
Assessment	Recognize Cues
Analysis	Analyze Cues
	Prioritize Hypotheses
Planning	Generate Solutions
Implementation	Take Action
Evaluation	Evaluate Outcomes

(NCBSN, 2019).

These steps are integrated in chapters to help readers make their best clinical decisions.

REFERENCES

American Nurses Association: ANA member news, January 22, 2021. www.NursingWorld.org/.

American Public Health Association, Public Health Nursing Section: *The definition and practice of public health nursing: A statement of*

the public health nursing section. Washington, CD: American Public Health Section.
The Council on Linkages Between Academic and Public Health Practice: *Core competencies for public health professionals,* 2014, Washington, DC, Public Health Foundation, available at phf.org/corecompetencies.
Ignatavicius D, Silvestri L: *Developing clinical judgment in nursing: A primer,* developed for Elsevier, 2019.
Masters R, Anwar E, Collins B et al., Return on investment of public health interventions: a systematic review, *J Epidemiol Community Health,* 71(8):827-834, 2017.
National Council of State Boards of Nursing (NCSBN): *NCLEX-RN Examination: Test plan for the National Council Licensure Examination for Registered Nurses.* Chicago, IL: Author.
National Council of State Boards of Nursing (NCSBN): The clinical judgment model, *Next generation NCLEX News,* Winter: 1-6, 2019.
Quad Council Coalition Competency Review Task Force: *Community/Public Health Nursing Competences,* 2018. Author.
Trust for America's Health: *The impact of chronic underfunding on America's public health system: Trends, risks, and recommendations,* April 2020. http://www.TFAH.org.
USDHHS: *Healthy People 2030,* 2020, Retrieved October 2020 at http://www.health.gov.
World Health Organization. Year of the Nurse and Midwife 2020. Accessed February 2021 at www.WHO.int.

ORGANIZATION

The text is divided into seven sections:

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

PEDAGOGY

Each chapter is organized for easy use by students and faculty. Chapters begin with Objectives to guide student learning and assist faculty in knowing what students should gain from the content. The Chapter Outline alerts students to the structure and content of the chapter. Key Terms, along with text page references, are also provided at the beginning of the chapter to assist the student in understanding unfamiliar terminology. The key terms are in boldface within the text.

The following features are presented in most or all chapters:

HOW TO
Provides specific, application-oriented information

EVIDENCE-BASED PRACTICE
Illustrates the use and application of the latest research findings in public health, community health, and nursing

LEVELS OF PREVENTION
Applies primary, secondary, and tertiary prevention to the specific chapter content

HEALTHY PEOPLE 2030
Selected *Healthy People 2030* objectives are integrated into each chapter

APPLYING CONTENT TO PRACTICE
Provides highlights and links chapter content to nursing practice in the community

QSEN FOCUS ON QUALITY AND SAFETY EDUCATION FOR NURSES (QSEN)
Gives examples of how quality and safety goals, competencies, objectives, knowledge, skills, and attitudes can be applied in nursing practice in the community

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

CHECK YOUR PRACTICE
This box provides a clinical situation and asks questions to stimulate problem solving and application to practice. Some boxes integrate the Clinical Judgment in Nursing process.

PRACTICE APPLICATION

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

REMEMBER THIS!

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

TEACHING AND LEARNING PACKAGE

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

For The Instructor:

- Next-Generation NCLEX® (NGN) Examination–Style Case Studies for Community and Public Health Nursing
- TEACH for Nurses, which contains: Detailed chapter lesson plans containing references to curriculum standards such as QSEN, BSN Essentials and Concepts, BSN Essentials for Public Health, unique Case Studies, and Critical Thinking Activities
- Test Bank with 800 questions
- Image Collection with all illustrations from the book
- PowerPoint slides

For The Student:

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

CONTENTS

1

Public Health Nursing and Population Health

Carolyn A. Williams

OBJECTIVES

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

1. State the mission and core functions of public health, 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 in public health practice.

CHAPTER OUTLINE

KEY TERMS

aggregate, p. 9
assessment, p. 3
assurance, p. 3
capitation, p. 16
community-based nursing, p. 13
Community Health Improvement Process (CHIP), p. 4
community health nurses, p. 13
cottage industry, p. 16
integrated systems, p. 16
levels of prevention, p. 10
policy development, p. 3
population, p. 9
population-focused practice, p. 9
population health, p. 2
public health, p. 2
public health core functions, p. 3
public health nursing, p. 2
Quad Council, p. 6
subpopulations, p. 9
social determinants of health, p. 7

In the year 2019, the United States and the world began experiencing a major public health crisis, a worldwide pandemic—a newly identified coronavirus, now well known as COVID-19. A pandemic is defined as an epidemic spread over several countries or continents, usually affecting a large number of people (www.cdc.gov. retrieved August 2020). The COVID-19 pandemic is identified as one of the 10 worst pandemics to occur since 165 AD.

As the United States endures this pandemic and approaches the third decade of the 21st 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 features in the Patient Protection and Affordable Care Act (ACA) of 2010 are the mechanisms to increase the number of people with health insurance. Difficulties with program enrollments have occurred; however, there is good evidence that identifies progress was made with the increasing numbers of enrollment (Census Bureau, 2018).

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) and Orszag and 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, and the current pandemic. 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 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. But compared to other high-income countries the United States spends less on social services" (Bradley and Taylor, 2013). 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 a combination of inadequate health care, unhealthy behaviors, adverse economic and social conditions, environment factors, public policies and social values that shape those conditions."

It is time 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 especially as the primary need in 2020 is to slow the pandemic crisis occurring.

This chapter and others that follow in this book will present information on many factors, outlooks, 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, which 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 first used in public health to describe, analyze, and mobilize efforts to improve health in community-based populations and 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 US 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 globally induced infectious diseases that result in pandemics and epidemics such as COVID-19, the mosquito-borne West Nile virus, the H1N1 influenza virus, the opioid epidemic, gun violence, avian influenza and other causes of mortality, many of which affect the very young. Most of the causes of pandemics and 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 cost in medical care financing and on strategies for providing health insurance coverage to a higher proportion of the population. 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, for example, (1) safety and adequacy of food supplies; (2) the provision of safe water; (3) sewage disposal; (4) public safety from biological threats; and (5) personal behavioral changes, including reproductive behavior. These are a few examples of public health's influence.

There is indisputable evidence collected over time that public health policies and programs were primarily responsible for increasing the average life span from 47 in 1900 to 78.6 years in 2017, an increase of approximately 60% in just over a century, through improvements in (1) sanitation; (2) clean water supplies; (3) making workplaces safer; (4) improving food and drug safety; (5) immunizing children; and (6) improving nutrition, hygiene, and housing (Fussenich,, 2019).

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, moter vehicle safety, workplace safety, control of infectious diseases, safer and healtier foods, healthier mothers and babies, family planning,, drinking water flouridation,, tobacco as a health hazard, and declines in death from heart disease and stroke (CDC, 2018)

The payoff from public health activities is well beyond the money given for the effort. In 2012 only 3% (up from 1.5% in 1960) of all national expenditures supported governmental public health functions and in 2017 such expenditures remained at 3% (CMS, 2012, 2018).

Time will tell whether the gains in insurance coverage due to the ACA will stabilize or improve. 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, as in the past, in order to assure that those who need them can receive them. Public health organizations could refocus their efforts and emphasize community-oriented, population-focused health promotion and preventive strategies, if ways can be found to finance such efforts.

Unfortunately, the CMS data presented above clearly show that in the 5 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 Institute of Medicine 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 US 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 (US Public Health Service, 1994 [updated 2008]; CDC, 2018).

Public Health Core Functions

The Core Functions Project (US Public Health Service, 1994 [updated 2008]), CDC, 2018) developed a useful illustration, the Health Services Pyramid (Fig. 1.2), which shows that 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" (US Public Health Service, 1994 [updated 2008]). Because of the importance of the basic public health programs, members of the Core Functions

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.*

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 Institute of Medicine published *Improving Health in the Community: A Role for Performance Monitoring* (IOM, 1997) to highlight how a performance monitoring system could be developed and used to improve community health. The outcomes of the work were:

- the **Community Health Improvement Process (CHIP)**, a method for improving the health of the population on a community-wide basis brought together key elements of the public health and personal health care systems in one framework,
- the development of a set of 25 indicators that could be used in the community assessment process to develop a community health profile (Box 1.1), and
- 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.

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 US Public Health Service: The Core Functions Project, Washington, DC, 1994/update 2000, DC, Office of Disease Prevention and Health Promotion. Update 2008, CDC, 2019.)

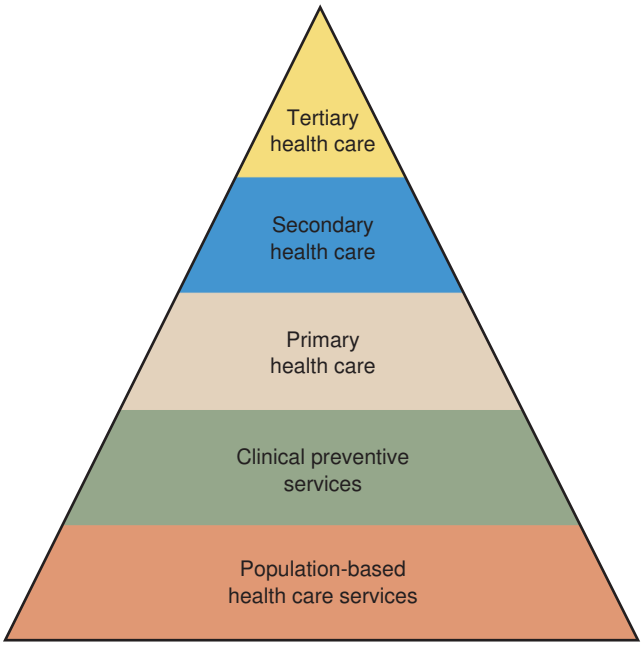


Fig. 1.2 Health Services Pyramid.

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 on the health of the population. What can you contribute to this committee? Where would you look for data that includes your county's ranking? What would you do? See if you can apply these steps to this scenario: (1) Recognize the cues, looking at available data on the community's health status; (2) analyze the cues; (3) state several and prioritize the hypotheses you have stated; (4) generate solutions for each hypothesis; (5) take action on the number one hypothesis you think best reflects the profile of the health of the community; and (6) evaluate the outcomes you would expect for improvements in the community's health as a result of using the profile to change public health services offered in the community.

In 2000 the CDC established a Task Force on Community Preventive Services (CDC, 2014). The result was *The Community Guide: What Works to Promote Health*, a versatile set of resources available electronically at www.thecommunityguide.org (accessed September 15, 2020) that can be used for 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 Improvement Navigator* which outlines a process to identify and address the health needs of the community (accessed at CDC.gov, September 15, 2020).

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" (US Public Health Service, 1994 [updated 2008) (updated by the Council on Linkages, 2010/2014). The 72 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.

- 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.
- 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 for workforce needs assessment, competency development, performance evaluation, hiring, and refining of the personnel system job requirements (www.phf.org/programs/corecompetencies/).

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 3 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 10–17) as a proportion of total live births
- Number and rate of confirmed abuse and neglect cases among children

Health Risk Factors

- Proportion of 2-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 US 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

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 Centers for Disease Control and Prevention: Genomics and disease prevention: Frequently asked questions, 2010. http://www.cdc.gov. Accessed January 11, 2011; Centers for Disease Control and Prevention: Genomics and disease prevention.

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 (QCC) in three tiers:

- Tier 1: the generalist/public health staff nurse
- Tier 2: 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 3: the public health nurse at an executive or senior management level and leadership levels in public health or community organizations (Quad Council Coalition, 2018). (See Appendix C.3 for the Public Health Nursing Core Competencies.)

Quality Improvement Efforts in Public Health

In 2003, the Institute of Medicine 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 (NPHPS) Program and the accreditation process for local and state health departments. 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, 2018b). The performance standards 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. Second, the standards focus on the overall public health system rather than on single organizations. Third, the standards describe an optimal level of performance. Fourth, 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, 2018b).

After this process is completed, the state and local health departments can voluntarily apply to the Public Health Accreditation Board located in Alexandria, Virginia, for recognition as an accredited health department.

Public Health 3.0

Public Health 3.0 as described by DeSalvo, Wang, Harris 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: (1) to focus on prevention at the total population level or community-wide prevention; (2) to improve the **social determinants of health**; and (3) 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 other community leaders."

The Public Health 3.0 initiative represents a Call to Action for Public Health to regenerate and refocus to meet the challenges of the 21st century that emerged after the growing recognition that there are troubling indicators regarding the health of Americans. For example, the Centers for Disease Control reported in 2014 that the historical gains in longevity had plateaued for 3 years in a row (Murphy, Kkochanek, Arias, 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 (Murphy 2014). Researchers (Chapman, Kelley, Woolf, 2015–2016, VCU Center on Society and Health, 2018) 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, Wang, Harris, 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, safe environments, access to health foods, economic development, and social support.

Other factors that require interventions are life expectancy rates, policy changes in payment approaches, moving away from episodic nonintegrated care toward value-based approaches, and more emphasis on partnerships to address community health problems.

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 with the group" (p. 1).

With the growing popularity and usage 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.

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. This has resulted in managed care executives, program managers, and others associated with health care organizations joining public health practitioners in becoming population oriented. This focus on clinical populations can be described as *Population Health Management*. A population-focused approach to planning, delivering, and evaluating various interventions is increasingly being used in an effort to achieve better outcomes in the population of interest and has never been more important whether in the clinical practice or community setting.

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 Nursing 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, 2020. Explore the two definitions and debate the similarities and differences in the definitions.

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 which 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 which 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 increasingly possible to look at population health data in ways that are practical, useful, and actionable.

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

The availability of interactive databases 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 2030* and *County Health Rankings*.

Healthy People focuses on national-level data but on some of the areas examined, state-level data are available.

Healthy People 2030 (www.healthypeople.gov/2030):

- Includes evidence-based objectives organized into user-friendly topics
- Provides resources and data to help health professionals and others address public health priorities and monitor progress toward achieving objectives
- Has an increased focus on health equity and the social determinants of health.

In the document there are five topic areas with 355 national objectives to be reached over the period of 10 years (from 2020 to 2030). The framework includes foundational principles, overarching goals, plan of action, and history and context.

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. In January of 2017, a Midcourse Review of data on progress toward the 2020 goals became available. This review served to influence the development of 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 level 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 (roadmaps) that can make a difference. Other features are the Action Center, which helps users to 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, who 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 and can be assessed at www.countyhealthrankings.org

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 preventive 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 (ANA), 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; 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 updated set 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 the DNP should be the expected level of education for specialization (Box 1.3) in an area of nursing practice (AACN, 2004, 2006).

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, US Department of Health and Human Services, Bureau of Health Professions, Division of Nursing.

The ACHNE reaffirmed the results of the 1984 Consensus Conference on the Essentials of Public Health Nursing Practice and Education sponsored by the USDHHS Division of Nursing (ACHNE, 2003; USDHHS, 1985). 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 ANA 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. Often there are **subpopulations** or high-risk groups within the larger population, such as high-risk infants under the age of 1 year, unmarried pregnant adolescents, or individuals exposed to a particular event such as a chemical spill. In **population-focused 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

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.

From 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

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 1 year of age would be children from 0 to 6 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).

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 US 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,* and *Healthy People 2010, Healthy People 2020*, and are now moving forward into the future with *Healthy People 2030* (US Department of Health, Education, and Welfare, 1979; USDHHS, 1979, 1980, 1991, 2000, 2010, 2020, and *Healthy People* 2030 retrieved at www.healthypeople.gov).

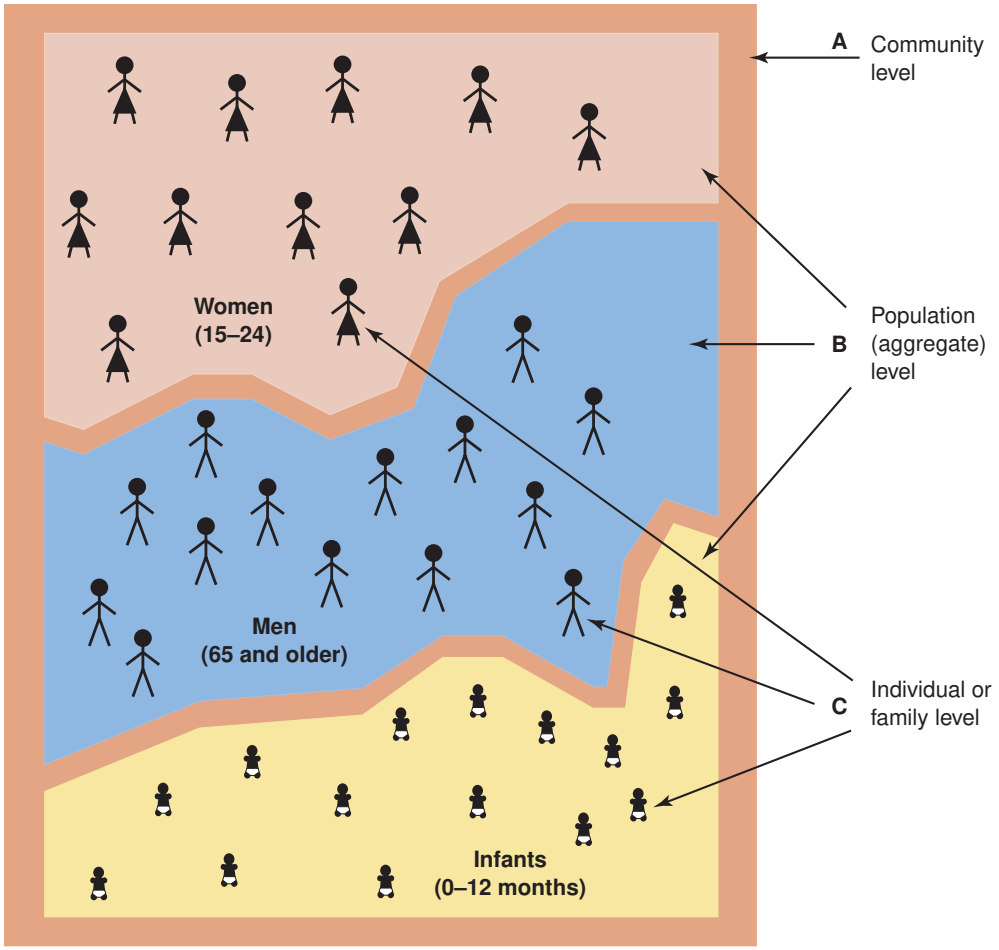


Fig. 1.3 Levels of Health Care Practice.

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 approximately 78,000 people were reached by the intervention every week.

The goal was to reduce the percentage of prepackaged foods with greater than 200 mg of sodium available at the sites, 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 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 which 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% at baseline to 21.5% 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% to 11.5% ($P = .017$). 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 no control group, it is difficult to know 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.

Data from Brooks CJ, Barret J, Daly J, et al: A Community-Level Sodium Reduction Intervention, Boston, 2013–2015, *Am J Public Health* 107(12):1951–1957, December 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. A public health nursing specialist who has and continues to provide strong policy leadership is Ellen Hahn, PhD, director of the Kentucky Center for Smoke Free Policy, which is based at the University of Kentucky's College of Nursing. More information care be found at www.uky.edu/breathe/tobacco-policy/kentucky-center-smoke-free-policy. 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 identified 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. Review the Evidence-Based Practice Box for an example.

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

HEALTHY PEOPLE 2030

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% of the national objectives had been met, and progress on an additional 40% of the objectives was noted. In the mid-course review published in 1995, it was noted that significant progress had been made toward meeting 50% 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* was "A society in which all people live long, healthy lives." (www.healthypeople.gov/2020) HP 2020 tracked approximately 1300 objectives organized into 42 topic areas, each of which represented an important public health area. In addition, HP2020 contained the Leading Health Indicators, a small, focused set of 12 topics containing 26 objectives identified to communicate and move action on high-priority health issues.

Healthy People 2030 emphasizes a vision of a society in which all people can achieve their full potential for health and well-being across the lifespan with a mission to promote, strengthen, and evaluate the nation's efforts to improve the health and well-being of all people. *HP 2030* highlights leading health indicators and social determinants of health, with five major topic areas and 355 objectives.

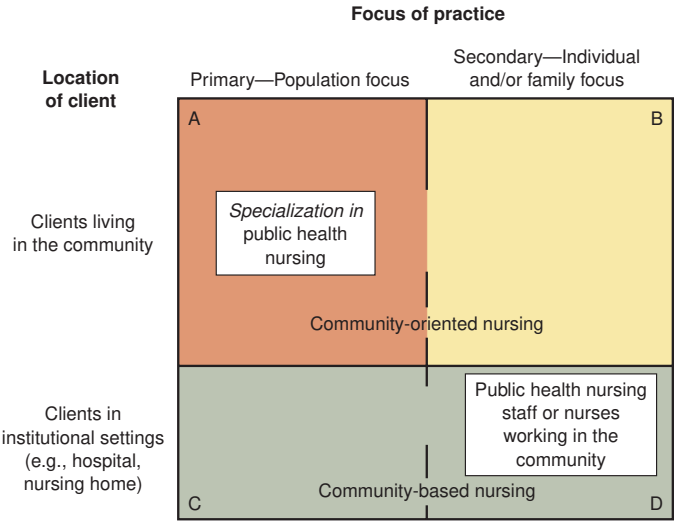


Fig. 1.4 Arenas for Health Care Practice.

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 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, 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. In contrast, 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

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.

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.

Table 1.1 illustrates the similarities and differences between Public Health (Community Oriented) Nursing and Community-Based 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 need to have a broader point of view with an emphasis on the functions of the nurse rather than focusing only on the direct care provider orientation. In other words, what do nurses do and how do they relate to a population rather than individual clients? Discussions will be held about how a practice can become more population focused, for an individual practitioner, such as an agency staff nurse, and nurse administrators in public health (one role for public health nursing specialists). This is particularly important 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.

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 C), 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

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

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

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).

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 doctor of nursing practice (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 Centers for Medicare and Medicaid 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?

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 to finding a solution.

Shifting Public Health Practice to Address the Social Determinants 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 Institute of Medicine published a report (IOM, 2012) 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 to address (1) the availability of adequate nutrition, (2) the maintenance of a healthy and safe environment in schools, (3) the reduction of secondhand smoke, and (4) assuring access to needed health services.

In the Institute of Medicine'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 other words, nurses need to be key actors and be prepared for leadership in that area.

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 to develop the competencies noted in the QSEN box.

QSEN FOCUS ON QUALITY AND SAFETY EDUCATION FOR NURSES

QSEN Competency	Competency Definition
Client-centered care	Recognize the client population or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for population 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 population preferences and values for delivery of optimal health care
Quality improvement	Use data to monitor the outcomes of the assessment, assurance, and policy development functions and use improvement methods to design and test changes to continuously improve the quality and safety of population health care systems
Safety	Minimize risk for harm to populations and providers through both system effectiveness and nurse performance
Informatics	Use information and technology to communicate, manage knowledge, mitigate error, and support decision making

Prepared by Gail Armstrong, ND, DNP, MS, PhD, professor and assistant dean/DNP program, Oregon Health and Sciences University, and updated by Marcia Stanhope (2020).

APPLYING 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 earlier in this chapter. 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.

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 from 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.

REMEMBER THIS!

- 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 and in communities.
- *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 Nursing Division of the US 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 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*.

REFERENCES

American Association of Colleges of Nursing (AACN): AACN Position Statement on the Practice Doctorate in Nursing. Washington, DC, 2004, AACN.

American Association of Colleges of Nursing (AACN): The Essentials of Doctoral Education for Advanced Nursing Practice. Washington, DC, 2006, AACN.

American Association of Colleges of Nursing (AACN): Public Health: Recommended Baccalaureate Competencies and Curricular Guidelines for Public Health Nursing: A Supplement to The Essentials of Baccalaureate education for Professional Nursing Practice" 2013. Accessed at http://www.aacn.nche.edu.

American Nurses Association (ANA): Public Health Nursing: Scope and Standards of Practice. Washington, DC, 2013, ANA.

American Public Health Association (APHA): The Definition and Role of Public Health Nursing in the Delivery of Health Care: A Statement of the Public Health Nursing Section. Washington, DC, 1981, APHA.

American Public Health Association (APHA): The Definition and Practice of Public Health Nursing. 2013. Retrieved on December 28, 2018 at www.apha.org

American Public Health Association (APHA): The Definition and Role of Public Health Nursing: A Statement of the APHA Public Health Nursing Section, *[March 1996 update]*. Washington, DC, 1996, APHA.

Association of Community Health Nursing Educators (ACHNE): Essentials of Master's Level Nursing Education for Advanced Community/Public Health Nursing Practice. Lathrop, NY, 2003, ACHNE.

Association of Community Health Nursing Educators (ACHNE): Essentials of Baccalaureate Nursing Education for Entry Level Community/Public Health Nursing. Wheat Ridge, CO, 2009, ACHNE.

Association of State and Territorial Directors of Nursing (ASTDN): Public Health Nursing: A Partner for Healthy Populations. Washington, DC, 2000, ASTDN.

Blumenthal D, Collins SR. Health care coverage under the Affordable Care Act—a progress report, *N Engl J Med* 371:275–281, 2014.

Bradley EH, Taylor LA. The American Health Care Paradox: Why Spending More is Getting Us Less. Philadelphia, PA, 2013, Public Affairs.

Brooks CJ, Barrett J, Daly J. Lee R, Blanding N, McHugh A, Williams D. A Community-Level Sodium Reduction Intervention, Boston, 2013-2015. Am J Public Health 107, 2017.

Centers for Disease Control and Prevention (CDC). *Ten Great Public Health Achievements in the 20th* Century, 2018. Retrieved November 2020 from: www.cdc.gov.

Centers for Disease Control and Prevention (CDC): *National Public Health Performance Standards Program*, 2018b. Retrieved November 2020 from: www.phf.org.

Centers for Disease Control and Prevention (CDC): *The Community Guide: What Works to Promote Health*, 2014. Retrieved November 2020 from: www.thecommunityguide.org.

Centers for Disease Control (CDC): The public health system and the ten essential services, June 2018c, Atlanta Georgia.

Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group: *The Nation's Health Dollar Calendar Year 2012: Where It Came From, Where It Went*, 2012. Retrieved November 2014 from: http://www.cms.gov.

Centers for Medicare and Medicaid Services (CMS) Office of the Actuary, National Health Statistics Group. *The Nation's Health Dollar Calendar Year 2017* Retrieved December 30, 2018 from www.cms.gov

Chapman DA, Kelley L, Woolf SH: Life Expectancy Maps 2015-2016. VCU Center on Society and Health. Retrieved on December 28, 2018 from http://www.societyhealth.vcu.

Council on Linkages between Academia and Public Health Practice: Core Competencies for Public Health Professionals. Washington, DC, 2010, revised 2014. Retrieved 9/29/2020 from: www.phf.org.

County Health Rankings can be assessed at www.countyhealthrankings.org

DeSalvo KB, Wang YC, Harris A, Auerbach J, Koo D, O'Carroll P. A Call to Action for Public Health to Meet the Challenges of the 21st Century. Perspectives, Discussion Paper, the National Academies. 2017.

Fielding J: Commentary: public health and health care quality assurance—strange bedfellows? *Milbank Q* 87:581–584, 2009.

Koen Füssenich,Wilma J. Nusselder, Stefan K. Lhachimi, Hendriek C. Boshuizen & Talitha F. Feenstra , Potential gains in health expectancy by improving lifestyle: an application for European regions. *Population Health Metrics* **17**:1, 2019.

Institute of Medicine (IOM): Improving Health in the Community: A Role for Performance Monitoring. Washington, DC, 1997, National Academies Press.

Institute of Medicine (IOM): Primary Care and Public Health,: Exploring Integration to Improve Population Health. Washington, DC, 2012, National Academies of Sciences Press.

Institute of Medicine: The future of public health. Washington, DC, 1988, National Academy Press.

Institute of Medicine (IOM): The Future of Nursing: Leading Change, Advancing Health. Washington, DC, 2010, National Academies Press.

Institute of Medicine and the National Research Council, The Academies Press, Washington DC, 2018.

Kentucky Center for Smoke-Free Policy: Retrieved December 27, 2018 from www.uky.edu.

Kindig D, Stoddart G: What is Population Health? *Am J Public Health* 93:380-383. 2003.

Murphy SL, Kochanek KD, Xu J, Arias E: Mortality in the United States 2014. National Center Health Statistics Data Brief 229: 1-8. PubMed.

Orszag PR: Health Care and the Budget: Issues and Challenges for Reform *[Statement before the Committee on the Budget, U.S. Senate]*. Washington, DC, June 21, 2007, Congressional Budget Office.

Orszag PR, Emanuel EJ: Health care reform and cost control. *N Engl J Med* 363:601–603, 2010.

Patient Protection and Affordable Care Act & Health Care and Education Affordability Reconciliation Act of 2010, 2010. Retrieved 9/28/November 2014 from: www.hhs.gov.

Quad Council Coalition Competency Review Task Force: Community/Public Health Nursing Competencies. 2018 Retrieved December 28 from www.quadcouncilphn.org

Quad Council of Public Health Nursing Organizations: Scope and Standards of Public Health Nursing Practice. Washington, DC, 1999 [revised 2005], American Nurses Association.

Quad Council of Public Health Nursing Organizations: Competencies for Public Health Nursing Practice. Washington, DC, 2003 [revised 2009], Association of State and Territorial Directors of Nursing.

Quad Council of Public Health Nursing Organizations: *Quad Council Competencies for Public Health Nurses*, Summer 2011. November 2014 from: www.quadcouncilphn.org.

Quad Council of Public Health Nursing Organizations: Scope and standards of public health nursing practice, Washington, DC, 1999, revised 2003, 2005, 2007, 2013 with the American Nurses Association.

Starr P: The social transformation of American medicine. New York, 1982, Basic Books.

US Department of Health, Education, and Welfare: Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention, *DHEW (PHS) Publication No. 79-55071*. Washington, DC, 1979, U.S. Government Printing Office.

US Department of Health and Human Services: Promoting Health/Preventing Disease: Objectives for the Nation. Washington, DC, 1980, U.S. Government Printing Office.

US Department of Health and Human Services (USDHHS): Healthy People 2000: National Health Promotion and Disease Prevention Objectives, *DHHS Publication No. 91-50212*. Washington, DC, 1991, U.S. Government Printing Office.

US Department of Health and Human Services, Bureau of Health Professions, Division of Nursing: Consensus Conference on the Essentials of Public Health Nursing Practice and Education [APHA Report Series]. Washington, DC, 1985, American Public Health Association.

US Department of Health and Human Services (USDHHS): Healthy People 2010: Understanding and Improving Health, ed 2. Washington, DC, 2000, U.S. Government Printing Office.

US Department of Health and Human Services (USDHHS): National Center for Health Statistics. Washington, DC, 2010.

US Department of Health and Human Services (USDHHS): Healthy People 2020: The Road Ahead. 2010. Retrieved November 2013 from: www.healthypeople.gov.

US Department of Health and Human Services(USDHHS): Healthy People 2030: Building a healthier future for all, Wash DC, 2020, US Government Printing Office.

US Public Health Service: The Core Functions Project. Washington, DC, 1994 [updated 2008], Office of Disease Prevention and Health Promotion.

Williams CA: Population-focused community health nursing and nursing administration: a new synthesis. In McCloskey JC, Grace HK, editors: *Current Issues in Nursing*, ed 2. Boston, 1985, Blackwell Scientific.

Woolf S, Aron L. Eds. US Health in International Perspective: Shorter Lives, Poorer Health.

2

The History of Public Health and Public and Community Health Nursing

Janna Dieckmann

OBJECTIVES

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

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

CHAPTER OUTLINE

KEY TERMS

American Association of Colleges of Nursing (AACN), 31
American Nurses Association (ANA), 30
American Public Health Association (APHA), 26
American Red Cross, 25
Breckinridge, Mary, 27
COVID-19, 21
district nursing, 23
district nursing association, 23
Frontier Nursing Service (FNS), 27
Healthy People 2030, 32
instructive district nursing, 24
Metropolitan Life Insurance Company, 26
National League for Nursing (NLN), 30
National Organization for Public Health Nursing (NOPHN), 25
Nightingale, Florence, 23
official health agencies, 29
Rathbone, William, 23
settlement houses, 24
Shattuck Report, 22
Social Security Act of 1935, 29
visiting nurse associations, 23
visiting nurses, 23
Wald, Lillian, 24

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

Historically public health nurses have worked to develop strategies to respond effectively to public health problems. Public

health is an interdisciplinary specialty that emphasizes prevention. Nurses have worked in communities to improve the health status of individuals, families, and populations, especially those who belong to vulnerable groups. This work has not been easy for many reasons. One reason is that it is more difficult to measure the effects of prevention than it is to measure the effects of treatment. In recent years, as health care costs have grown, it has become increasingly important to emphasize prevention. There is currently an increased emphasis in public health nursing on population health as was discussed in Chapter 1 and throughout the text. Also the **COVID-19** pandemic emphasized the critical role that public health principles and practices play in the health of citizens in the United States and around the world.

Many varied and challenging public health nursing roles originated in the late 1800s, when public health efforts focused on environmental conditions such as sanitation, control of communicable diseases, education for health, prevention of disease and disability, and care of aged and sick persons in their homes. Although the threats to health have changed over time, the foundational principles and goals of public health nursing have remained the same. Many communicable diseases, such as diphtheria, cholera, smallpox, and typhoid fever, have been largely controlled in the United States, but others, such as HIV, tuberculosis, hepatitis, and the emerging virus (flu) strains including the most recent, COVID-19, continue to affect many lives around the world. Certainly with COVID-19, the global nature of the transmission of disease has been evident and frightening. Even though environmental pollution in residential areas has been reduced, communities are now threatened by emissions from the many vehicles on their roads, overcrowded garbage dumps, and pollutants in the air, water, and soil. Natural disasters including hurricanes, tornadoes, floods, and fires continue to challenge public health systems, and bioterrorism and the many human-made disasters threaten to overwhelm existing resources. Research has identified means to avoid or postpone chronic disease, and nurses play an important role in helping implement strategies to modify individual and community risk factors and behaviors. Finally, with the increased numbers of older adults in the United States and their preference to remain at home, additional nursing services are required to sustain the frail, the disabled, and the chronically ill in the community.

Nurses who work in the community have done so to improve the health status of individuals, families, and populations, and they have paid particular attention to high-risk or vulnerable groups. Part of the appeal of public health nursing has been its autonomy of practice, independence in problem solving and decision-making, and the interdisciplinary nature of the specialty. This chapter describes the beginnings of public health, the role of nursing in the community, the contributions made by nurses to public health, and the influence of nurses on community health.

EARLY PUBLIC HEALTH

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

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

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

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

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

Early colonial public health efforts included the collection of vital statistics, improvements to sanitation systems, and control of any communicable diseases brought in at the seaports. The colonists did not have a system to ensure that public health efforts were supported or enforced. Epidemics often occurred

and strained the limited local organization for health during the 17th, 18th, and 19th centuries (Rosen, 1958).

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

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

The federal government focused its early public health work on providing health care for merchant seamen and protecting seacoast cities from epidemics. The Public Health Service, still the most important federal public health agency in the 21st century, was established in 1798 as the Marine Hospital Service. The first Marine Hospital opened in Norfolk, Virginia, in 1800. Additional legislation to establish quarantine regulations for seamen and immigrants was passed in 1878.

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

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

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

NIGHTINGALE AND THE ORIGINS OF TRAINED NURSING

Even with the growth of technology during this time, cities lacked important public health systems, such as sewage disposal, and also depended on private enterprise for water supply. Previous caregiving structures, which relied on the assistance of family, neighbors, and friends, became inadequate in the early 19th century because of human migration, urbanization, and changing demand. During this period, a few groups of Roman Catholic

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

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

and Protestant women provided nursing care for the sick, poor, and neglected in institutions and sometimes in the home. For example, Mary Aikenhead, also known by her religious name Sister Mary Augustine, organized the Irish Sisters of Charity in Dublin, Ireland, in 1815. These sisters visited the poor at home and established hospitals and schools (Kalisch and Kalisch, 1995).

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

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

After the Crimean War, Nightingale returned to England in 1856. Her fame was established. She organized nursing practices and nursing education in hospitals to replace untrained lay nurses with Nightingale nurses. Nightingale thought that nursing should promote health and prevent illness, and she emphasized proper nutrition, rest, sanitation, and hygiene (Nightingale, 1894, 1946). Each of these areas of her early emphasis remains important in the 21st century.

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

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

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

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

Fig. 2.1 New Orleans Nurse Visiting a Family on the Doorstep. (Courtesy New Orleans Public Library WPA Photograph Collection.)

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

Other nurses established **settlement houses** and neighborhood centers, which became hubs for health care and social welfare programs. For example, in 1893 trained nurses **Lillian Wald** (Fig. 2.2) and Mary Brewster began visiting the poor on New York's Lower East Side. They established a nurses' settlement that became the Henry Street Settlement and later the Visiting Nurse Service of New York City. By 1905, public health nurses had provided almost 48,000 visits to more than 5000 clients (Kalisch and Kalisch, 1995). Lillian Wald emerged as a prominent leader of public health nursing during these decades (Box 2.1). Lillian Wald demonstrated an exceptional ability to develop approaches and programs to solve the health care and social problems of her times. We can learn much from her that can be applied to today's nursing practice.

Jessie Sleet (Scales), a Canadian graduate of Provident Hospital School of Nursing (Chicago), became the first African American public health nurse when the New York Charity Organization

Fig. 2.2 Lillian Wald. (Courtesy Visiting Nurse Service of New York.)

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

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

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

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

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

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

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

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

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

Society hired her in 1900. Although it was hard for her to find an agency willing to hire her as a district nurse, she persevered and was able to provide exceptional care for her clients until she married in 1909. At the Charity Organization Society in 1904 to 1905, she studied health conditions related to tuberculosis among African American people in Manhattan using interviews with families and neighbors, house-to-house canvassing, direct observation, and speeches at neighborhood churches. Sleet reported her research to the Society board, recommending improved employment opportunities for African Americans and better prevention strategies to reduce the excess burden of tuberculosis morbidity and mortality among the African American population (Buhler-Wilkerson, 2001; Hine, 1989; Mosley, 1994; Thoms, 1929). Her work laid the foundation for much of what has characterized public health nursing over the years.

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

The emphasis of community nursing has varied and changed over time. In recent years, federal and state financing has influenced the growth or in recent years, the lack of growth. There has rarely been adequate funding to support a comprehensive public health nursing service. In addition to VNAs and settlement houses, a variety of other organizations sponsored visiting nurse work, including boards of education, boards of health, mission boards, clubs, churches, social service agencies, and tuberculosis associations. With tuberculosis then responsible for at least 10% of all mortality, visiting nurses contributed to its control through gaining "the personal cooperation of patients and their families" to modify the environment and individual behavior (Buhler-Wilkerson, 1987, p. 45). Most visiting nurse agencies depended financially on the philanthropy and social networks of metropolitan areas.

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

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

CONTINUED GROWTH IN PUBLIC HEALTH NURSING

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

The NOPHN sought to standardize public health nursing education. At that time, newly graduated nurses often were unprepared for home visitation because the diploma schools emphasized care of hospital clients. Thus public health nurses needed education in how to care for the sick at home and to design population-focused programs. In 1914 Mary Adelaide Nutting, working with the Henry Street Settlement, began the first course for postdiploma school training in public health nursing at Teachers College in New York City (Deloughery, 1977). The American Red Cross provided scholarships for graduates of nursing schools to attend the public health nursing

course. Its success encouraged the development of other programs, using curricula that might seem familiar to today's nurses. During the 1920s and 1930s, many newly hired public health nurses had to verify completion or promptly enroll in a certificate program in public health nursing. Others took leave for a year to travel to an urban center to obtain this further education. Correspondence courses (distance education) were even acceptable in some areas, for example, for public health nurses in upstate New York.

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

Public health nursing in voluntary agencies and through the Red Cross grew more quickly than public health nursing supported by local, state, and national government. By 1900, 38 states had established state health departments, following the lead of Massachusetts in 1869; however, these early state boards of health had limited impact because only three states—Massachusetts, Rhode Island, and Florida—annually spent more than 2 cents per capita for public health services (Scutchfield and Keck, 1997).

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

During the 1910s public health organizations began to target infectious and parasitic diseases in rural areas. For example, in 1911 efforts to control typhoid fever in Yakima County, Washington, and to improve health status in Guilford County, North Carolina, led to the establishment of local health units to serve local populations. Public health nurses were the primary staff members of local health departments. These nurses assumed a leadership role on health care issues through collaboration with local residents, nurses, and other health care providers.

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

PUBLIC HEALTH NURSING DURING THE EARLY 20TH CENTURY

The personnel needs of World War I in Europe depleted the ranks of public health nurses, even as the NOPHN identified a need for second and third lines of defense within the United States. Jane Delano in 1909 was appointed both as superintendent of the Army Nurse Corps and chairman of the National Committee on Red Cross Nursing services. She was instrumental in preparing nurses to serve in the military, and she also supported the need for public health nurses to stay at home and serve the needs of those not serving in the military. Over 3 weeks in 1918 the worldwide influenza pandemic swept across the United States. A coalition of the NOPHN and the Red Cross worked to turn houses, churches, and social halls into hospitals for the immense numbers of sick and dying. Some of the nurse volunteers died of influenza. In 2020 we see the same situations occurring with locations for care increasing outside the hospital and with health care workers contracting COVID-19. As the pandemic that began in 2019 spread, public health departments assumed a key role in administering vaccines to groups in priority areas.

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

Nurses also influenced public policy by advocating for the Children's Bureau and the Sheppard-Towner Program. Wald and other nursing leaders urged that the Children's Bureau be established in 1912 to address national problems of maternal and child welfare. Children's Bureau experts conducted extensive scientific

research on the effects of income, housing, employment, and other factors on infant and maternal mortality. Their research led to federal child labor laws and the 1919 White House Conference on Child Health. The Sheppard-Towner Act of 1921, which focused on maternal and infant health, was credited with saving many lives. This act provided federal matching funds to establish maternal and child health divisions in state health departments. Education during home visits by public health nurses emphasized promoting the health of the mother and child and encouraged mothers to seek prompt medical care during pregnancy. Although credited with saving many lives, the program ended in 1929 in response to charges by the AMA and others that the legislation gave too much power to the federal government and too closely resembled socialized medicine (Pickett and Hanlon, 1990). Just as we see today, there has long been an inability to provide public health services because of the lack of funds.

Some nursing innovations were the result of individual commitment and private financial support. In 1925 **Mary Breckinridge** established the **Frontier Nursing Service (FNS)**. This creative service was based on systems of care in Scotland (Box 2.2 and Fig. 2.3). The pioneering spirit of the FNS influenced the development of public health programs to improve the health care of the rural and often inaccessible populations in the Appalachian region of southeastern Kentucky (Browne, 1966; Tirpak, 1975). Breckinridge introduced the first nurse-midwives into the United States when she deployed FNS nurses trained in nursing, public health, and midwifery. Their efforts led to reduced pregnancy complications and maternal mortality and to one-third fewer stillbirths and infant deaths in an area of 700 square miles (Kalisch and Kalisch, 1995). Today the FNS continues to provide comprehensive health and nursing services to the people of that area and sponsors the Frontier Nursing University.

Fig. 2.3 Mary Breckinridge, Founder of the Frontier Nursing Service. (Courtesy Frontier Nursing Service of Wendover, Kentucky.)

BOX 2.2 Mary Breckinridge and the Frontier Nursing Service

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

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

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

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

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

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

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

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

AFRICAN AMERICAN NURSES IN PUBLIC HEALTH NURSING

African American nurses seeking to work in public health nursing faced many challenges. Nursing education was segregated in the South until the 1960s and elsewhere was also generally segregated or rationed until the mid-20th century. Even public health nursing certificate and graduate education programs were segregated in the South; study outside the South for Southern nurses was difficult to afford, and study leaves from the workplace were rarely granted. The situation improved somewhat in 1936 when collaboration between the US Public Health Service and the Medical College of Virginia (Richmond) established a certificate program in public health nursing for African American nurses, for which the federal government paid nurses' tuition. Discrimination continued during nurses' employment: African American nurses in the South were paid lower salaries than their white counterparts for the same work. In 1925 only 435 African American public health nurses were employed in the United States, and in 1930 only 6 African American nurses held supervisory positions in public health nursing organizations (Buhler-Wilkerson, 2001; Hine, 1989; Thoms, 1929).

African American public health nurses significantly influenced the communities they served (Fig. 2.4). The National Health Circle for Colored People was organized in 1919 to promote public health work in African American communities in the South. One strategy adopted was providing scholarships to assist African American nurses in pursuing university-level public health nursing education. Bessie M. Hawes, the first recipient of the scholarship, completed the program at Columbia University (New York) and was then sent by the Circle to Palatka, Florida. In this small, isolated lumber town, Hawes's first project was to recruit schoolgirls to promote health by dressing as nurses and marching in a parade while singing community songs. She conducted mass meetings, led clubs for mothers, provided school health education, and visited the homes of the sick. Eventually she gained the community's trust, overcame opposition, and built a health center for nursing care and treatment (Thoms, 1929).

Fig. 2.4 A Public Health Nurse Talks with a Young Woman and her Mother About Childbirth as They Sit on a Porch. (US Public Health Service photo by Perry. Images from the *History of Medicine*, National Library of Medicine, Image ID 157037.)

ECONOMIC DEPRESSION AND THE IMPACT ON PUBLIC HEALTH

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

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

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

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

During this period, tension persisted between preventive care and care of the sick and the related question of whether nursing interventions should be directed toward groups and communities or toward individuals and their families. Although each nursing agency was unique and services varied from region to region, voluntary VNAs tended to emphasize care of the sick, and official public health agencies provided more preventive services. Not surprisingly, this splintering of services led to a rivalry between "visiting," or community, and "public health" nurses and interfered with the development of comprehensive community nursing services (Roberts and Heinrich, 1985). For example, one household could receive services from several community nurses representing different agencies, with separate

visits for a postpartum woman and new baby, for a child sick with scarlet fever, and for an elderly bedridden person. This was confusing and costly, with duplicated services.

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

Expansion of federal government programs during the 1930s affected the structure of community health resources and led to "the beginning of a new era in public nursing" (Roberts and Heinrich, 1985, p. 1162). In 1933 Pearl McIver became the first nurse employed by the US Public Health Service. In providing consultation services to state health departments, McIver was convinced that the strengths and ability of each state's director of public health nursing would determine the scope and quality of local health services. Together with Naomi Deutsch, director of nursing for the federal Children's Bureau, and with the support of nursing organizations, McIver and her staff of nurse consultants influenced the direction of public health nursing. Between 1931 and 1938 over 40% of the increase in public health nurse employment was in local health agencies. Even so, nationally, more than one-third of all counties still lacked local public health nursing services (Fig. 2.5).

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

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

World War II increased the need for nurses both for the war effort and at home. Many nurses joined the US Army and Navy Nurse Corps. US Representative Frances Payne Bolton of Ohio led Congress to pass the Bolton Act of 1943, which established the Cadet Nurses Corps. This legislation funded increased undergraduate and graduate enrollment in schools of nursing, and many of the students studied public health.

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

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

Fig. 2.5 A Nurse from the Visiting Nurse Association Demonstrates Proper Infant Care and Bathing Techniques to the Parents.

FROM WORLD WAR II UNTIL THE 1970s

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

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

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

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

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

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

Nursing organizations also continued to change. The functions of the NOPHN, the National League for Nursing Education, and the Association of Collegiate Schools of Nursing were distributed to the new **National League for Nursing (NLN)** in 1952. The **American Nurses Association (ANA)** continued as the second national nursing organization, after merging with the National Association for Colored Graduate Nurses in 1951.

In 1948 the NLN adopted the recommendations of Esther Lucile Brown's study of nursing education, Nursing for the Future, and this considerably influenced how nurses were prepared. She recommended that basic nursing education take

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

EVIDENCE-BASED PRACTICE

Prior to the 20th century, public health nursing emerged from district nursing as described earlier in the chapter. Early in the 20th century the emphasis on preventive care grew. This was a period of growing industrialization and urbanization, considerable immigration, and the growth of infectious diseases. A series of federal programs began that influenced public health nursing. However, despite program expansion, public health nurses still lacked field experience, training, and supervision. The Social Security Act of 1935 strengthened state health organizations and focused on extending services to mothers and children in rural and distressed areas. The next shift was away from direct care to one of education. Following World War II there was an increased need for nurses to meet the needs of families in the community. The health problems of the past took on new forms, and there was a growing body of knowledge that prevention was essential for a healthy nation. The Patient Protection and Affordable Care Act of 2010 was to ensure affordable, accessible, and high-quality health care for the uninsured and those who had inadequate health insurance. This act emphasized preventive care and management of chronic diseases. The relationship between policy, funding, and public health nursing is evident throughout history. The pendulum of what was funded in public health tends to swing from one focus area to another. This article provides detailed information about the changes in public health and public health nursing from 1890 to 1950.

Nurse Use

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

From Kub J, Kulbok P, Glick D: Cornerstone documents, milestones, and policies: shaping the direction of Public Health Nursing 1890–1950, *OJIN: Online J Issues Nurs* 20(2):Manuscript 3, 2015.

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

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

PUBLIC HEALTH NURSING FROM THE 1970s TO THE PRESENT

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

The Division of Nursing of the US Public Health Service conducted and sponsored nursing research beginning in the late 1930s. This expanded in the late 1940s (Uhl, 1965). The National Center for Nursing Research (NCNR) was established in 1985 within the federal National Institutes of Health. The NCNR focused attention on the value of nursing research and promoted the work of nurses. With the effort of many nurses, the NCNR attained institute (rather than center) status in 1993 and became the National Institute of Nursing Research (NINR), reflecting the continued growth in nursing research.

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

The *Healthy People* initiative has influenced goals and priority setting in public health and in public health nursing. In 1979 *Healthy People* proposed a national strategy to improve the health of Americans by preventing or delaying the onset of major chronic illnesses, injuries, and infectious diseases. Specific goals and objectives were established, and the goals were to be evaluated at the end of each decade. Implementation of these strategies has considerably influenced the work of nurses, through their employment in health agencies and through participation in state or local *Healthy People* coalitions (*Healthy People* box). *Healthy People 2020* (US Department of Health and Human Services, 2010) built on the work of *Healthy People 2010* (US Department of Health and Human Services, 2000). Some objectives in *Healthy People 2010* were met; others retained in *Healthy People 2020*, and new ones were added. *Healthy People 2030* built on the work of the previous four editions of *Healthy People*. ***Healthy People 2030*** objectives are included in each chapter of this text.

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

In 1991 the ANA, AACN, NLN, and more than 60 other specialty nursing organizations joined to support health care reform. The coalitions of organizations emphasized the key health care issues of access, quality, and cost. Improved primary care and public health efforts would help build a healthy nation. Professional nursing continues to support revisions in health care delivery and extension of public health services to prevent illness, promote health, and protect the public (Table 2.3). Chapters 3 (Global and U.S. Public Health Systems) and 5 (Economic Influences) describe the current work to change the way health is provided and who pays for the care.

HEALTHY PEOPLE 2030

History of the Development of Healthy People

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

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

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

In the late 1980s, success in addressing these priorities and goals was evaluated, new scientific findings were analyzed, and new goals and objectives were set for the period from 1990 to 2000 through *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (US Public Health Service, 1991). This process has been repeated every 10 years to develop goals and objectives for the period from 2000 to 2010; 2010 to 2020; and 2020 to 2030. Recognizing the continuing challenge of the use of emerging scientific research to encourage modification of health behaviors and practices, *Healthy People 2030* (US Department of Health and Human Services, USDHHS 2020) was released August 18, 2020. This document builds on the knowledge gained over the past 4 decades and addresses the most current public health priorities and challenges. The ways in which *Healthy People 2030* was developed and how it has been changed since *Healthy People 2020* are discussed in the Preface of the text. In brief, *Healthy People 2030* is more concise and has fewer objectives than were in *Healthy People 2020* in order to make it easier for users to find the objectives relevant to their work.

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

TABLE 2.3 Milestones in the History of Community Health and Public Health Nursing: 1946–2021

Year	Milestone
1946	Nurses classified as professionals by US Civil Service Commission; Hill-Burton Act approved, providing funds for hospital construction in underserved areas and requiring these hospitals to provide care to poor people; passage of National Mental Health Act
1950	25,091 nurses employed in public health
1951	National nursing organizations recommended that college-based nursing education programs include public health content
1952	National Organization for Public Health Nursing merged into the new National League for Nursing; Metropolitan Life Insurance Nursing Program closed
1964	Passage of the Economic Opportunity Act; public health nurse defined by the American Nurses Association (ANA) as a graduate of a bachelor of science in nursing (BSN) program
1965	ANA position paper recommended that nursing education take place in institutions of higher learning; Congress amended the Social Security Act to include Medicare and Medicaid
1977	Passage of the Rural Health Clinic Services Act, which provided indirect reimbursement for nurse practitioners in rural health clinics
1978	Association of Graduate Faculty in Community Health Nursing/Public Health Nursing (later renamed Association of Community Health Nursing Educators)
1980	Medicaid amendment to the Social Security Act to provide direct reimbursement for nurse practitioners in rural health clinics; both ANA and the American Public Health Association (APHA) developed statements on the role and conceptual foundations of community and public health nursing, respectively
1983	Beginning of Medicare prospective payments
1985	National Center for Nursing Research (NCNR) established within the National Institutes of Health (NIH)
1988	Institute of Medicine published *The Future of Public Health*
1990	Association of Community Health Nursing Educators published *Essentials of Baccalaureate Nursing Education*
1991	More than 60 nursing organizations joined forces to support health care reform and published a document entitled *Nursing's Agenda for Health Care Reform*
1993	American Health Security Act of 1993 was published as a blueprint for national health care reform; the national effort, however, failed, leaving states and the private sector to design their own programs
1993	NCNR became the National Institute for Nursing Research, as part of the National Institutes of Health
1993	Public Health Nursing section of the American Public Health Association updated the definition and role of public health nursing
1996	Passage of the Health Insurance Portability and Accountability Act
2001	Significant interest in public health ensues from concerns about biological and other forms of terrorism in the wake of the intentional destruction of buildings in New York City and Washington, DC, on September 11
2002	Office of Homeland Security established to provide leadership to protect against intentional threats to the health of the public
2003–2005	Multiple natural disasters, including earthquakes, tsunamis, and hurricanes, demonstrated the weak infrastructure for managing disasters in the United States and other countries and emphasized the need for strong public health programs that included disaster management
2007	An entirely new Public Health Nursing Scope and Standards of Practice released through the ANA, reflecting the efforts of the Quad Council of Public Health Nursing Organizations
2010	Patient Protection and Affordable Care Act signed by President Barack Obama; *Healthy People 2020* realized by the US Department of Health and Human Services
2011	The Quad Council of Public Health Nursing Organizations published *Competencies for Public Health Nursing*
2013	The American Nurses Association published the second edition of *Public Health Nursing: Scope and Standards of Practice*
2013	The Quad Council of Public Health Nursing Organizations updated *Competencies for Public Health Nursing Practice*
2018	The Quad Council of Community/Public Health Nursing updated *Community/Public Health Nursing Competences;* the USDHHS approved the *Healthy People 2030* framework.
2020	Beginning of the COVID-19 virus in Wuhan, China with subsequent spread around the world; declaration of a pandemic by the World Health Organization on March 11, 2020

During the late 20th and early 21st centuries, challenges continued to trigger growth and change in nursing in the community. Nurse-managed centers now provide a range of nursing services, including health promotion and disease and injury prevention, in areas where existing organizations have been unable to meet community and neighborhood needs. These centers provide valuable services but typically face many challenges in securing adequate funding.

The Affordable Care Act of 2010 has been controversial, and many compromises were made between the House of Representatives and the Senate in the final crafting of this health care act. Much of the Affordable Care Act deals with changes in insurance plans and coverage, and it continues to be controversial with continued debate among congressional members.

Public health nursing, historically and at present, is characterized by reaching out to care for the health of people in need

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

QSEN FOCUS ON QUALITY AND SAFETY EDUCATION FOR NURSES

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

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

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

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

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

Important aspects of safety include the following:

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

Safety Question

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

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

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

Prepared by Gail Armstrong, PhD, DNP, ACNS-BC, CNE, professor and assistant dean of the DNP Program, Oregon Health and Sciences University.

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

HOW TO CONDUCT AN ORAL HISTORY INTERVIEW

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

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

The ANA's (2013) *Scope and Standards of Public Health Nursing Practice*, the Council on Linkages' (2014) *Domains and Core Competencies*, and the Quad Council's (Quad Council Coalition Competency Review Task Force, 2018) *Community/Public Health Nursing(C/PHN) Competencies* provide guidance for the practice of community/public health nursing.

APPLYING CONTENT TO PRACTICE

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

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

Public Health Nursing presents a wide variety of articles, including both new historical research and reprints of classic journal articles that deserve to be read and reapplied by modern public health nurses. Original historical research presented in *Public Health Nursing* is varied, from public health nursing education, to public health nurse practice in Alaska's Yukon, to excerpts from the oral histories of public health nurses. Contemporary nurses find inspiration and possibilities for modern innovations in reading the history of public health nursing in the pages of *Public Health Nursing*.

THE ORIGIN AND PROGRESSION OF COVID-19

On December 31, 2019, the government in Wuhan, Hubei Province, China, released the first official report that multiple cases of pneumonia were being treated. On January 12, 2020, it was disclosed that a new virus not seen in humans had been detected. The theory was that the virus originated in a Wuhan market where live fish and animals were sold, and that the virus was transmitted to humans. The first case of the virus in Washington was confirmed January 20, 2020 in a man who had recently traveled there from Wuhan. On March 11, 2020, the World Health Organization declared the virus, which is now known as COVID-19, a pandemic. Since that time, the virus has spread around the world. The countries that have had fewer cases were those that immediately began the three recommended practices to protect a person against the virus: handwashing, social distancing, and wearing a face mask. Some of these countries, despite their best public health practices, have seen up and down surges of the virus. Some countries forced businesses such as restaurants and bars to close; others established distancing rules for these establishments. In the United States, some states imposed a mask rule while others did not do so.

PRACTICE APPLICATION

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

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

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

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

Answers can be found on the Evolve website.

REMEMBER THIS!

- A historical approach can be used to increase the understanding of public and community health nursing.
- Public health and community health nursing are products of various social, economic, and political forces and incorporate public health science in addition to nursing science and practice.
- Federal responsibility for health care was limited until the 1930s, when the economic challenges of the Depression highlighted the need for and led to the expansion of federal assistance for health care.
- Florence Nightingale designed and implemented the first program of trained nursing, and her contemporary, William Rathbone, founded the first district nursing association in England.