Community & Public Health Nursing

Promoting the PUBLIC'S HEALTH

Judith Ann Allender • Cherie Rector • Kristine D. Warner

Wolters Kluwer Health | Lippincott Williams & Wilkins

COMMUNITY & PUBLIC HEALTH NURSING

Promoting the Public's Health

8th EDITION

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In memory of my husband, Gilbert F. Allender (1937–2009)—in my heart and thoughts forever.
—Judy Allender

To my husband—my greatest supporter—and to my children and grandchildren, who make it all worthwhile. This book is dedicated to them and to my parents, who always encouraged me to keep learning and growing.
—Cherie Rector

To my son Sean and his family, my daughters Erin and Kathleen Whalen, and the best mom in the world Dolores Warner—thank you for your unwavering love and support.
—Kris Warner

ACKNOWLEDGEMENTS

We are grateful for the feedback we have received from nursing faculty and students, and have worked to incorporate many of your suggestions into this new edition. For the most part, feedback has been positive, but we appreciate all comments and suggestions. We hope that this textbook meets your needs, and we encourage your continued feedback.

We appreciate the efforts of many people who have assisted us in writing this textbook. We are grateful to have such talented contributors and thank them for sharing their knowledge and expertise. We also want to acknowledge the work of former contributors whose work may remain, in part.

To our hardworking editors, Katherine Burland, Hillarie Surrena, and Christina Burns, along with other staff at Lippincott Williams & Wilkins (Wolters Kluwer), we express our thanks.

We are indebted to our family and friends who provided support throughout this experience.

We look forward to the new generation of public health nurses, and hope that this book may inspire students to consider this exciting nursing specialty!

ABOUT THE AUTHORS

Dr. Judith A. Allender has been a nurse since 1963. For 30 years she taught nursing—first at Good Samaritan Hospital in Cincinnati, Ohio, and later at California State University, Fresno, where she retired as a Professor Emeritus. Her nursing practice experiences were varied. She worked with surgical patients, in intensive care units, as a school nurse, in-patient hospice, home care, and community health nursing. She has authored five nursing textbooks in addition to this one. During her long career, she received several awards. The fourth edition of this textbook received a Robert Wood Johnson award for the end-of-life care content in 2001. She was voted RN of the Year in Education for the Central Valley of California in 1998. In 2005 she was inducted into the Central San Joaquin Valley Nursing Hall of Fame. Presently, Dr. Allender consulted for a nonprofit immigrant and refugee center called Stone Soup of Fresno until 2010. She wrote a weekly health column for a local newspaper from 2002 to 2010. Her undergraduate nursing degree is from the State University of New York in Plattsburgh, master's in guidance and counseling from Xavier University in Cincinnati, Ohio, master's in nursing from Wright State University, Dayton, Ohio, and a doctorate in education from the University of Southern California. When not busy at home, she can be found traveling around the world. She and her late husband have a blended family with 7 children, 14 grandchildren, and 3 great grandsons.

Dr. Cherie Rector is a native Californian who is an Emeritus Professor at California State University, Bakersfield, Department of Nursing. She served as lead faculty in community health nursing, Director of the School Nurse Credential Program and the RN to BSN Program there, and formerly was the Coordinator of the School Nurse Credential Program at California State University, Fresno, where she also taught community health nursing, health teaching, and leadership. She has served as the Director of Allied Health and the Disabled Students Program at College of the Sequoias. She has consulted with school districts and hospitals in the areas of child health, research, and evidence-based practice, and has practiced community health and school nursing as well as neonatal nursing in the acute care setting. She currenty consults with a local Magnet hospital on evidence-based practice and research. She has taught graduate-level courses in community health, vulnerable populations, research, family theories, interprofessional development, and school nursing. Her grants, research, publications, and presentations have focused largely on child and adolescent health, school nursing, public health nursing, nursing education, and disadvantaged students. She earned an associate degree in nursing from College of the Sequoias over 40 years ago and, later, a bachelor of science in nursing degree from the Consortium of the California State Universities, Long Beach. She completed a master's degree in nursing (Clinical Nurse Specialist, Community Health) and a school nurse credential from California State University, Fresno. Her PhD in educational psychology is from the University of Southern California. She is an active

member of the American Public Health Association, the Western Institute of Nursing, and the Association of Community Health Nursing Educators. Dr. Rector and her husband have three grown sons, seven grandsons, and two granddaughters.

Dr. Kristine Warner, also a native Californian, is a Professor at California State University, Stanislaus, with a specialization in Public/Community Health Nursing. With over three decades in the field of Public/Community Health, she has taught in nursing programs in both Pennsylvania and California. Undergraduate and graduate courses she has taught include community health nursing, nursing research, program planning and development, and health policy. Her nursing career began in adult and pediatric acute care, and she has practiced home care and public health in rural and urban settings. Her current professional interests include evidence-based practice, nursing education, emergency preparedness, and health needs of vulnerable populations. Her grants, research, publications, and presentations have focused on emergency preparedness, poverty, chronic illness, and nutrition. Dr. Warner is a retired Navy Nurse Corps Captain, ending a 29-year career of both active and reserve service in 2002. She was recalled to active duty and stationed in the Saudi Arabian desert during the First Gulf War as Assistant Charge Nurse of a 20-bed medical unit. She received her BSN from Harris College of Nursing, Texas Christian University, MPH (Community Health Nursing) and MS (Community Health Nursing & Nursing Education) from the University of South Florida, and PhD in Nursing from the University of Pennsylvania. Dr. Warner has three grown children and two grandchildren.

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PREFACE

Continuing a rich tradition initiated by Barbara Spradley with the first edition of this book in 1981, the eighth edition of *Community and Public Health Nursing: Promoting the Public's Health* introduces undergraduate nursing students to population-focused nursing in community settings (e.g., public health agencies, schools, and other community health organizations). We are passionate about public health nursing and the immense power for good it can bring about for individuals, families, and communities. We recognize that most nursing students remain focused on acute care and will seek employment in hospital settings. To that end, throughout the book, we have endeavored to provide students with examples and information that will broaden their knowledge of their patients and enable them to provide more effective nursing care wherever they may be. When a patient is discharged, it is important for the nurse to understand the patient's unique circumstances and how to best work with the patient and the family to prevent further illness and promote better health. Population-focused tools and interventions are needed in acute care, as infection rates continue to rise and nurse-sensitive outcome indicators are closely monitored. In the process of learning about public health nursing, we hope to light a spark in those nursing students interested in this nursing specialty and its rich history. Public health nurses often work in a more autonomous practice setting and can have a real impact on the general health status of their communities through large-scale interventions and political advocacy. Nurses working in the community are important role models for social justice and are on the front line of communicable disease prevention and control.

The book is designed to give students a basic grounding in the principles of public health nursing and introduce them to key populations they may engage while working in the community setting. Entry-level public health nurses may also find it a helpful resource as they begin to familiarize themselves with their unique practice settings and target populations. The nexus of public health nursing lies in the utilization of public health principles along with nursing science and skills in order to promote health, prevent disease, and protect at-risk populations. Throughout this book, we use the term *community health nurse* interchangeably with *public health nurse* to describe the practitioner who does not simply "work in the community" (physically located outside the hospital setting, in the community), but rather one who has a focus on nursing and public health science that informs their community-based, population-focused nursing practice.

ABOUT THE EIGHTH EDITION

We have continued to try to keep this textbook user-friendly for nursing students, who are entering the world of public health nursing for the first time. We strive to write in an accessible style with little use of jargon or long passages of dry narrative. Also, we seek to have a more conversational quality and highlight student, practitioner, and instructor perspectives on common issues and problems. We use pertinent examples and case studies to convey real-life situations and interventions in order to aid students in applying the concepts and principles of public health nursing practice. Storytelling has been shown to be very effective in nursing education. We feel that these client stories can greatly influence learning, as the student strives to grasp the art and skill of working with clients in a community setting. Our goal is also to provide the most accurate, pertinent, and current information for students and nursing faculty. We have sought out experts in various fields and specialty areas of public health nursing in order to provide a balanced and complete product. With the addition of over 30 contributors from across the country and countless reviewers, the content reflects a broad spectrum of views and expertise. But, we have also carefully edited material to make this a cohesive textbook with a common voice.

ORGANIZATION OF THE TEXT

For the eighth edition, we have strongly emphasized *Healthy People 2020* goals and objectives throughout the text, and have also included more examples of evidence-based practice. We have added more visual interest, with photos and graphics highlighting written content. We have maintained the changes made to chapter and unit organization in the seventh edition, but have added more emphasis on population health and prevention/health promotion strategies.

Unit I, Foundations of Community Health Nursing, covers fundamental principles and background about public health nursing. Chapter 1 discusses basic public health concepts of health, illness, wellness, community, aggregate, population, and levels of prevention. Leading Health Indicators are introduced in this chapter, along with *Healthy People 2020* goals and objectives. In Chapter 2, public health nursing's rich and meaningful history is examined, along with social influences that have shaped our current practice. Educational preparation, and the roles and functions of public health nursing, are discussed in both Chapters 2 and 3. Core

Public Health Functions are described in Chapter 3, and common settings for public health nursing are introduced. Chapter 4 considers values, ethical principles, and decision making unique to this nursing specialty. Evidence-based practice and research principles relating to community health nursing are also discussed, along with the nurse's role in utilizing current research. Community-based participatory research is highlighted. Cultural principles are defined and the importance of cultural diversity and sensitivity in public health nursing are explained in Chapter 5 as well as cultural assessment and folk remedies.

Unit II, Public Health Essentials for Community Health Nursing, covers the structure of public health within the health system infrastructure, and introduces the basic public health tools of epidemiology, communicable disease control, and environmental health. Chapter 6 examines the economics of health care and compares U.S. outcomes with those of other countries, while also introducing the Affordable Care Act (health care reform). It also examines official health agencies and landmark legislation related to public health, as well as basic information on different types of health insurance. Different methods of epidemiologic investigation and research are explored in Chapter 7, along with population-focused communicable disease control in Chapter 8. The concepts vital to environmental health are covered in Chapter 9, along with public health nursing's role in researching and intervening to promote a healthier environment for all. Prevention is emphasized and an ecological approach used to address issues of environmental health and safety.

Unit III, Community Health Nursing Tool Box, includes tools used by the public health nurse to ensure effectiveness in his or her practice. Chapter 10 covers communication and collaboration, as well as contracting with clients. Incorporating technology and social media to promote population health and prevent disease, important for all nurses, are also included in this chapter. Health promotion is the focus of Chapter 11, with an emphasis on helping clients and aggregates achieve behavioral change through the application of educational and theoretical models. In Chapter 12, the focus is on planning and developing community health programs including the contribution of the Quality and Safety Education for Nurses (QSEN) project to community/public health nursing practice. Designing interventions and evaluating outcomes, along with social marketing approaches and grant funding, are examined. Chapter 13 concludes this unit with an explanation of the public health nurse's role in political advocacy and policy making, highlighting examples of successful political action campaigns and client empowerment strategies.

Unit IV, The Community as Client, further expands the focus of the public health nurse. Chapter 14 examines common theories and models used in public health nursing practice, and Chapter 15 applies the well-known nursing process to communities as clients (contrasted to its use with individual patients, as done in acute care settings). Different types of assessments are discussed, along with sources of data, community diagnoses, and community development. Global health and international nursing are considered in Chapter 16. International agencies and health problems/practices are discussed, highlighted by real-life case examples and perspectives. Preparedness is examined in Chapter 17, with a closer look at disasters and terrorism. The public health nurse's role in emergency preparedness, disaster management, preventive measures against terrorism, and *Healthy People 2020* objectives are also included in this chapter.

Unit V, The Family as Client, introduces the family as an aggregate, and Chapter 18 provides theoretical frameworks that promote better family health and provide a means for nurses to better understand and work with families experiencing dysfunction. Applying the nursing process to families and family assessment are covered in Chapter 19. Helpful tools are provided, and case studies help to emphasize concepts. In Chapter 20, family violence, child and spousal abuse, and effective interventions are examined, along with educational strategies and resources.

Unit VI, Promoting and Protecting the Health of Aggregates with Developmental Needs, provides information about client groups as often aggregated by public health departments. Chapter 21 covers common issues, concerns, and interventions for maternal child clients and their infants. Health problems affecting children and adolescents are examined in Chapter 22, and the prevention concerns of adult women and men are highlighted in Chapter 23. Unique issues facing the older client can be found in Chapter 24. These chapters build upon the content presented in Unit V, and can be very helpful in tailoring public health nursing efforts for these select population groups.

Unit VII, Promoting and Protecting the Health of Vulnerable Populations, deals with how to best address the needs of the most vulnerable clients. In Chapter 25, the concept of vulnerability is addressed along with theoretical frameworks and effective methods of working with vulnerable clients and populations. In Chapter 26, clients with chronic illnesses and disabilities are discussed, and Chapter 27 covers clients and populations with behavioral health problems, such as mental health issues and substance abuse. The homeless population is addressed in Chapter 28, along with factors contributing to homelessness and the role of the community health nurse. Chapter 29 addresses the unique challenges of rural and urban populations. It also explores issues of social justice, migrant populations, and frontier nursing.

Unit VIII, Settings for Community Health Nursing, examines public (Chapter 30) and private (Chapter 31) settings in more depth. Practice options in government-sponsored agencies, such as state and local public health departments, public schools, or prisons, are described. Nurse-managed clinics, faith-based nursing, and occupational health are included in the chapter on private organizations. These chapters provide overviews of a number of practice options available to both new and experienced nurses. Finally, the important roles of home health and hospice nursing are discussed in Chapter 32. With the aging of our population, these nursing roles will continue to be in demand.

KEY FEATURES

The eighth edition of *Community and Public Health Nursing: Promoting the Public's Health* includes key features from previous editions as well as new features.

Features continued from previous editions include:

- **Evidence-Based Practice**—this feature incorporates current research examples and how they can be applied to public/community health nursing practice to achieve optimal client/aggregate outcomes.
- **From the Case Files**—presentation of a scenario/case study with student-centered, application-based questions. Emphasizing nursing process, students are challenged to reflect on assessment and intervention in typical, yet challenging examples.
- **Perspectives**—this feature is included in most chapters and provides stories (viewpoints) from a variety of sources. The perspective may be from a nursing student, a novice or experienced public health nurse, a faculty member, a policy maker, or a client. These short features are designed to promote critical thinking, reflect on commonly held misconceptions about public/community health nursing, or to recognize the link between skills learned in this specialty practice and other practice settings, especially acute care hospitals.
- A **Summary** of highlights at the end of each chapter provides an overview of material covered and serves as a review for study.
- **References** at the end of each chapter provide you with classic sources, current research, and a broad base of authoritative information for furthering knowledge on each chapter's subject matter.
- **Learning Objectives** and **Key Terms** sharpen the reader's focus and provide a quick guide for learning the chapter content.
- **Activities to Promote Critical Thinking** at the close of each chapter are designed to challenge students, promote critical-thinking skills, and encourage active involvement in solving community health problems. They include Internet activities.
- **Levels of Prevention Pyramid** boxes enhance understanding of the levels of prevention concept, basic to community health nursing. Each box addresses a chapter topic, describes nursing actions at each of the three levels of prevention, and is unique to this text in its complexity and comprehensiveness.
- Additional assessment tools are provided throughout the chapters. They are added to enhance assessment skills with individuals, families, or aggregates/populations.

FEATURES NEW TO THIS EDITION

- *Healthy People 2020*—highlights pertinent goals and objectives to promote health and is applied to specific populations or problems noted in each of the chapters. Evaluation of select *Healthy People 2010* goals and objectives is also provided.
- Enhanced art program to appeal to today's learner.

RESOURCES FOR INSTRUCTORS

A set of tools to assist you in teaching your course is available on *thePoint* at thepoint.lww.com/allender8e. *thePoint* is a Web-based system that allows you to manage your course and content and provides every resource instructors need in one easy-to-use site.

Available resources include:

- Audio Podcasts covering key points from each chapter
- Videos on Vulnerable Populations
- Guided Lecture Notes and PowerPoint Presentations
- Student Quiz Bank
- Journal Articles
- Assignments, Discussion Topics, Case Studies, and Pre-Lecture Quizzes
- Test Generator
- Learning Objectives
- Image Bank
- Selected Readings and Internet Resources

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UNIT 1

FOUNDATIONS OF COMMUNITY HEALTH NURSING

CHAPTER

1

The Journey Begins: Introduction to Community Health Nursing

"For a community to be whole and healthy, it must be based on people's love and concern for each other."

—***Millard Fuller*** **(1935 to 2009) Founder, Habitat For Humanity**

KEY TERMS

Aggregate
Collaboration
Community
Community health
Community health nursing
Continuous needs
Epigenetics
Episodic needs
Genomics
Geographic community
Global health
Health
Health continuum
Health literacy
Health promotion
Illness
Leading health indicators
Pharmacogenomics
Population
Population-focused
Primary prevention
Public health
Public health nursing
Secondary prevention
Self-care
Self-care deficit
Tertiary prevention
Wellness

LEARNING OBJECTIVES

Upon mastery of this chapter, you should be able to:

- Define community health and distinguish it from public health.
- Explain the concept of community.
- Diagram the health continuum.
- Name 3 of the 10 leading health indicators.
- Discuss ways that public health nursing (PHN) practice is linked to acute care nursing practice.
- Discuss the two main components of community health practice (health promotion and disease prevention).
- Differentiate among the three levels of prevention.
- Describe the eight characteristics of community health nursing.

Opportunities and challenges in nursing are boundless and rapidly changing. You have spent a lot of time and effort learning how to care for individual patients in medical–surgical and other acute-care–oriented nursing specialties. Now you are entering a unique and exciting area of nursing—community/public health.

As one of the oldest specialty nursing practices, public health nursing offers unique challenges and opportunities. A nurse entering this field will encounter the complex challenge of working with populations rather than just individual clients and the opportunity to carry on the heritage of early public health nursing efforts with the benefit of modern sensibilities. There is the challenge of expanding nursing's focus from the individual and family to encompass communities and the opportunity to affect the health status of populations. There also is the challenge of determining the needs of populations at risk and the opportunity to design interventions to specifically address their needs. There is the challenge of learning the complexities of a constantly changing health care system and the opportunity to help shape service delivery. Public health nursing is community-based and, most importantly, it is population-focused. Operating within an environment of rapid change and increasingly complex challenges, this nursing specialty holds the potential to shape the quality of community health services and improve the health of the general public.

You have provided nursing care in familiar acute care settings for the very ill, both young and old, but always with other professionals at your side. You have worked as part of a team, in close proximity, to welcome a new life, reestablish a client's health, or comfort someone toward a peaceful death. Now, you are being asked to leave that familiar acute care setting and go out into the community—into homes, schools, recreational facilities, work settings, parishes, and even street corners that are commonplace to your clients and unfamiliar to you. Here, you will find few or no monitoring devices, charts full of laboratory data, or professional and allied health workers at your side to assist you. You will be asked to use the nontangible skills of listening, assessing, planning, teaching, coordinating, evaluating, and referring. You will also draw on the skills you have learned throughout your acute care setting experiences (e.g., behavioral health nursing; women's, children's, adult health nursing), and begin to "think on your feet" in new and exciting situations. Often, your practice will be solo, and you will need to combine creativity, ingenuity, intuition, and resourcefulness along with these skills. You will be providing care not only to individuals but also to families and other groups in a variety of settings within the community. Talk about boundless opportunities and challenges! (see "Perspectives: Student Voices.")

You may feel that this is too demanding. You may be anxious about how you will perform in this new setting. But perhaps, just perhaps, you might find that this new area is a rewarding kind of nursing—one that constantly challenges you, interests you, and allows you to work holistically with clients of all ages, at all stages of illness and wellness; one that absolutely demands the use of your critical-thinking skills. And you may decide, when you finish your public health nursing course, that you have found your career choice. Even if you are not drawn away from acute care nursing, your community health nursing experience will give you a deeper understanding of the people for whom you provide care—where and how they live, the family and cultural dynamics at play, and the problems they will face when discharged from your care. You will also discover myriad community agencies and resources to better assist you in providing a continuum of care for your clients. Finding out begins with understanding the concepts of community and health.

This chapter provides an overview of the basic concepts of community and health, the components of public health practice, and the salient characteristics of contemporary public health nursing practice, so that you can enter this specialty area of nursing in concert with its intentions. The opportunities and challenges of community health nursing will become even more apparent as the chapter progresses. The discussion of the concepts and theories that make public health nursing an important specialty within nursing begins with the broader field of community health, which provides the context for public health nursing practice.

COMMUNITY HEALTH

Human beings are social creatures. All of us, with rare exception, live out our lives in the company of other people. An Eskimo lives in a small, tightly knit community of close relatives; a rural Mexican may live in a small village with hardly more than 200 members. In contrast, someone from New York City might be a member of many overlapping communities, such as professional societies, a political party, a religious group, a cultural society, a neighborhood, and the city itself. Even those who try to escape community membership always begin their lives in some type of group, and they usually continue to depend on groups for material and emotional support. Communities are an essential and permanent feature of the human experience.

The communities in which we live and work have a profound influence on our collective health and well–being (Edwards & Tsouros, 2008). And, from the beginning, people have attempted to create healthier communities. Here are three recent examples:

- Before the historic Surgeon General's *Report on Smoking and Health*, it was common to see people smoking on television, at work, in restaurants, and even in physician offices (*Morbidity and Mortality*

PERSPECTIVES STUDENT VOICE

I was really terrified when I got to my community health rotation and found that I had to go to people's homes and knock on their doors! I was going to graduate in a few months, and I felt really comfortable in the hospital.... I knew the routines and the machines well. Now, I had to actually find houses and apartments in an area of the city I would normally never venture into! And, it wasn't clear to me what I was supposed to do! I didn't have much equipment—a baby scale, a blood pressure cuff, a stethoscope, a thermometer, and a paper tape measure—that was all! I was told to go visit this 16-year-old mother who had a 4-month-old baby, and to monitor the baby's progress. I don't even have children! What can I tell her? And, besides, she is a teenager who "knows it all." My clinical instructor told me to "build a relationship with her" and to "gain trust and rapport." That is hard to do when you are scared to death! I was afraid of her responses, of being out in that part of the city alone, and of trying to answer questions without anyone there to turn to. But, I wanted to get through nursing school, so I drove over there and knocked on her door. I was shocked to see the condition of the apartment building in which she lived. Peeling paint, loud music, trash everywhere, and strange characters at every turn. When she answered the door, she seemed uninterested—or maybe a little defensive. I told her who I was and why I was there, and she motioned me inside and pointed toward the baby, propped up on the tattered couch. I spent the next 15 weeks visiting Anna and her baby: weighing and measuring the baby, doing a Denver II and sharing the results with Anna, helping her schedule appointments for immunizations, listening to Anna's story of abuse and abandonment, and realizing that what I was doing was actually exciting and rewarding. By the end of my rotation, I was truly going to miss Anna and little José! He always smiled at me, and I enjoyed "playing" with him as I instructed her about baby-proofing her apartment, finding resources for food and clothing, and getting birth control. We even talked about how she could finish high school. I thought about Anna and José occasionally, when young mothers would bring their babies into the emergency department, where I worked after graduation. I learned from my community health nursing rotation that I needed to look beyond the bravado of a teenage mother and try to "connect" with her in order to assure that she would follow through with the antibiotics and antipyretics we were prescribing for her baby's dangerously high fever and serious infection. A year and a half after I graduated, one day when it had been particularly hectic but was now calming down, I glanced up to see Anna and José. She looked so relieved to see me! She was frantic with worry about the serious burn José had on his right hand. The other nurses were mumbling about "child abuse" and how "irresponsible teen mothers always were." I learned that Anna had left José with a neighbor for an hour while she visited a nearby high school to see about getting her GED. The older neighbor was not used to dealing with a busy toddler, and she had left the handle of a pan of refried beans where José could reach it. The team treated José's burn, and I gave Anna instructions for follow-up care. The bond we had developed was still there. She trusted me, and I knew that she would follow through with the instructions. I also knew that the other nurses who were making comments about her did not know Anna's circumstances. I feel that I am a more effective ER nurse because of the things I learned in community health. Someday, when I get tired of the hospital, I may try working as a Public Health Nurse. You never know!

Courtney, Age 25

Weekly Report [MMWR], 2004). Since that report linked tobacco to disease and death more than 40 years ago, much has changed in our living spaces. In most states, it is now uncommon to see smoking in public places, and smokers are often relegated to outdoor smoking areas. With the assistance of the Master Settlement Agreement negotiated by state attorneys general and the tobacco industry in 1999, $206 billion has been given to states to promote smoking cessation; create smoke-free environments in the workplace, restaurants, and bars; and develop antismoking public information campaigns (Curley, 2010; *Milestones in Public Health*, 2006). Along with policy changes and settlements, public awareness has been raised about the harmful effects of secondhand smoke (Public Health Institute, 2010a). However, smoking still causes around 443,000 deaths annually in the United States, and over 46 million Americans continue to smoke cigarettes (Curley, 2010). Smoking has been shown to triple the risk of dying from heart disease among middle-aged men and women (Centers for Disease Control & Prevention [CDC], 2009). While total U.S. consumption of tobacco products has dropped, states with the lowest incidence of smoking (around 14%), like California, New Jersey, and Maryland, have been successful in implementing strategies suggested by the CDC (e.g., raising prices of tobacco products, enacting laws for smoke-free public spaces, limiting tobacco advertising while utilizing antismoking campaigns, limiting access to tobacco vending machines or sales to minors, smoking cessation programs) (Curley, 2010). California has documented fewer deaths from heart disease and incidences of lung cancer since implementing these strategies (Curley, 2010). Other states that

have not uniformly implemented these strategies, like West Virginia, Kentucky, and Missouri, have smoking rates between 25% and 26% (Curley, 2010). Even though only 22% of Americans now report that they are current smokers, as a whole, they generally oppose an outright ban on smoking (81% per a 2009 Gallup poll), leaving a toehold for tobacco companies to promote the individual's right to choose smoking over the public's right to the health benefits of banning tobacco (Gallup, 2011).

- More than 20 million American children and adults live with asthma (Asthma & Allergy Foundation of America [AAFA], n.d.). Evidence of a connection between asthma attacks and community environments has been demonstrated both in the United States and abroad. In Harlem, 25% of the children were reported to have asthma—twice the expected rate. Public health officials note chronic environmental factors as a possible cause for increased asthma cases: pollution from high-traffic areas, secondhand smoke in homes, as well as poor living conditions characterized by dust mites, mold, industrial air pollution, mouse and cockroach droppings, and animal dander (Krisberg, 2006; Wisnivesky et al., 2008). For 2010, the city named "asthma capital" of the United States was Richmond, Virginia (AAFA, 2010, p. 1). Over half of the asthma capitals were in the South, largely due to the lack of smoke-free legislation in many tobacco-producing states, along with poor air quality and high pollen counts. To further make the case for a connection between environment and asthma, in Atlanta, the 1996 Olympics brought an unexpected benefit: a 42% reduction in asthma-related emergency room visits. With the Olympic congestion downtown, Atlanta restricted traffic and thus improved air quality. The same outcomes were experienced with the Beijing Olympics. Internationally, Singapore also noticed a reduction in emergency room visits for asthma after it restricted automobile traffic in its central business district (Li, Wang, Zhang, Lin, & Yang, 2011; *Milestones in Public Health*, 2006).
- In a local effort to address the problem of childhood obesity, Santa Clara county—where one in four children are obese or overweight—passed an ordinance that sets standards for toys included with children's restaurant meals. It simply requires that the meals that include the toys meet basic nutritional standards. It does not ban toys (Baxter, 2010). However, the fast food industry has opposed this effort, as they spend over $360 million on toys that encourage kids and parents to purchase 1.2 billion kid's meals annually. Second only to television advertising targeted to children, the toys given away with kid's meals are a substantial expenditure by the fast food industry. And, interestingly, 10 of 12 meals with the highest calorie levels were found to include toys—indicating that these toys are used to market meals to children that may promote obesity (Public Health Institute, 2010c). So, lawmakers counter that toys should only be used as an incentive for kids to purchase meals with lower sugar, sodium, fat, and calories (Baxter, 2010). The community of Santa Clara, California took a stand to improve their environment in order to address a serious health problem that is affecting their population.

Systems theory, advanced by biologist Ludwig von Bertalanffy in the 1940s and modified by Ross Ashby in the 1950s, proposes that systems are "open to and interact with their environments" (Heylighen & Joslyn, 1992, para. 1). As systems theory reminds us that a whole is greater than the sum of its parts, the health of a community is more than the sum of the health of its individual citizens. A community that achieves a high level of wellness is composed of healthy citizens, functioning in an environment that protects and promotes health. Public health, as a specialty of nursing practice, seeks to provide organizational structure, a broad set of resources, and the collaborative activities needed to accomplish the goal of an optimally healthy community.

When you work in hospitals or other acute care settings, your primary focus is the individual patient. Patients' families are often viewed as ancillary. Public health, however, broadens the view to focus on families, aggregates (see p. 8), populations, and the community at large. The community becomes the recipient of service, and health becomes the product. Viewed from another perspective, public health is concerned with the interchange between population groups and their total environment, and with the impact of that interchange on collective health. The narrow view of the solitary patient, so common in acute care nursing, is expanded to encompass a much wider vista.

Although many believe that health and illness are individual issues, evidence indicates that they are also community issues, and that the world is a community. The spread of the human immunodeficiency virus (HIV) pandemic, nationally and internationally, is a dramatic and tragic case in point, having spread across the globe with 2.7 million new infections annually (Hitt, 2010). Other community, national, and global concerns include the rising incidence and prevalence of tuberculosis (Poltzer, 2008), the "critical and urgent international public health problem" of cardiovascular disease (McDermott, 2007, p. 1254), the rise in antibiotic resistance that has led to calls for global treaties to combat resistant strains (Anomaly, 2010), terrorism, and pollution-driven environmental hazards. While the United States and other developed nations fight rising rates of obesity, many countries in Africa battle malnutrition and starvation. Communities can influence the spread of disease, provide barriers to protect members from health hazards, organize ways to combat outbreaks of infectious disease, and promote practices that contribute to individual and collective health (American Nurses Association [ANA], 2007; Institute of Medicine [IOM], 2002; County Health Rankings, 2010).

Many different professionals work in community health to form a complex team. The city planner designing an urban renewal project necessarily becomes involved in community health. The social worker providing counseling about child abuse or working with adolescent substance abusers is involved in public or

community health. A physician treating clients affected by a sudden outbreak of hepatitis and seeking to find the source is engaged in public health practice. Prenatal clinics, meals for the elderly, genetic counseling centers, and educational programs for the early detection of cancer all are part of the public health effort.

The professional nurse is an integral member of this team, a linchpin and a liaison between physicians, social workers, government officials, and law enforcement officers. Public health nurses work in every conceivable kind of community agency, from a state public health department to a community-based advocacy group. Their duties range from examining infants in a well-baby clinic, to teaching elderly stroke victims in their homes, to carrying out epidemiologic research or engaging in health policy analysis and decision making. Despite its breadth, however, public health nursing is a specialized practice. It combines all of the basic elements of professional clinical nursing with public health and community practice. Together, we will examine the unique contribution made by community health nursing to our health care system.

Community health and public health share many features. Both are organized community efforts aimed at the promotion, protection, and preservation of the public's health. Historically, as a practice specialty, public health has been associated primarily with the efforts of official or government entities—for example, federal, state, or local tax-supported health agencies that target a wide range of health issues. In contrast, private health efforts or nongovernmental organizations (NGOs), such as those of the American Lung Association or the American Cancer Society, work toward solving selected health problems. The latter augments the former. Currently, community health practice encompasses both approaches and works collaboratively with all health agencies and efforts, public or private, which are concerned with the public's health. In this text, community health practice refers to a focus on specific, designated communities. It is a part of the larger public health effort and recognizes the fundamental concepts and principles of public health as its birthright and foundation for practice.

In the IOM's landmark publication, *The Future of the Public's Health* (1998), the mission of public health is defined simply as "fulfilling society's interest in assuring conditions in which people can be healthy" (p. 7). (See "Perspectives: Public Health Nursing Instructor.") Winslow's classic 1920 definition of **public health** still holds true and forms the basis for our understanding of community health in this text:

> Public health… is the science and art of preventing disease, prolonging life, and promoting health and efficiency through organized community efforts for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of the social machinery to insure everyone a standard of living adequate for the maintenance of health (Clinton County Health Department, n.d., p. 1).

PERSPECTIVES
PUBLIC HEALTH NURSING INSTRUCTOR

When I first introduce the topic of public health, I ask students "Why do people end up in the hospital?" Many of them give the usual answers—"They need surgery," "They get in accidents," and the like. Then I tell them the *Story of Jason*:

"Why is Jason in the hospital? (Because he has a bad infection in his leg.)

But why does he have an infection? (Because he has a cut on his leg and it got infected.) But why does he have a cut on his leg? (Because he was playing in the junkyard next to his apartment building and there was some sharp, jagged steel there that he fell on.)

But why was he playing in a junkyard? (Because his neighborhood is kind of run-down. A lot of kids play there, and there is no one to supervise them.)

But why does he live in that neighborhood? (Because his parents can't afford a nicer place to live.)

But why can't his parents afford a nicer place to live? (Because his Dad is unemployed and his Mom is sick.)

But why is his Dad unemployed? (Because he doesn't have much education and he can't find a job.) But why…?" (Public Health Agency of Canada, 1999. *Toward a Healthy Future: Second Report on the Health of Canadians*, p. vii.)

And, they suddenly become more aware of the complex social and economic issues that affect health.

More recent and concise definitions of public health include "an effort organized by society to protect, promote, and restore the people's health" (Trust for America's Health, 2006, p. 27) and "the health of the population as a whole rather than medical health care, which focuses on treatment of the individual ailment" (Public Health Data Standards Consortium, 2006, p. 120). A Web site sponsored by the Association of Schools of Public Health with support from Pfizer Public Health, *What is Public Health?* (www.whatispublichealth.org, n.d.), provides some interesting videos and a quiz about this topic and also proffers this definition:

> Public health is the science and art of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention.
>
> Public health helps improve the health and wellbeing of people in local communities and across our nation.
>
> Public health helps people who are less fortunate to achieve a healthier lifestyle.
>
> Public health works to prevent health problems before they occur.
>
> Public health professionals achieve true job satisfaction by knowing they are making the world a better place (para. 1).

The core public health functions have been delineated as assessment, policy development, and assurance. These are discussed in more detail in Chapter 3.

Given this basic understanding of public health, the concept of community health can be defined. **Community health** is the identification of needs, along with the protection and improvement of collective health, within a geographically defined area.

One of the challenges public health practice faces is to remain responsive to the community's health needs. As a result, its structure is complex; numerous health services and programs are currently available or will be developed. Examples include health education, family planning, accident prevention, environmental protection, immunization, nutrition, early periodic screening and developmental testing, school programs, mental health services, occupational health programs, and the care of vulnerable populations. The Department of Homeland Security, for example, is a community health and safety agency developed in the aftermath of the terrorist attacks on New York City and Washington, DC, on September 11, 2001.

Community health practice, a part of public health, is sometimes misunderstood. Even many health professionals think of community health practice in limiting terms such as sanitation programs, health clinics in poverty areas, or massive public awareness campaigns to prevent communicable disease. Although these are a part of its ever-broadening focus, community health practice is much more. To understand the nature and significance of this field, it is necessary to more closely examine the concept of community and the concept of health.

THE CONCEPT OF COMMUNITY

The concepts of community and health together provide the foundation for understanding community health. Broadly defined, a community is a collection of people who share some important feature of their lives. In this text, the term **community** refers to a collection of people who interact with one another and whose common interests or characteristics form the basis for a sense of unity or belonging. It can be a society of people holding common rights and privileges (e.g., citizens of a town), sharing common interests (e.g., a community of farmers), or living under the same laws and regulations (e.g., a prison community). The function of any community includes its members' collective sense of belonging and their shared identity, values, norms, communication, and common interests and concerns (Anderson & McFarlane, 2012). Some communities—for example, a tiny village in Appalachia—are composed of people who share almost everything. They live in the same location, work at a limited type and number of jobs, attend the same churches, and make use of the sole health clinic with its visiting physician and nurse. Other communities, such as members of Mothers Against Drunk Driving (MADD) or the community of professional nursing organizations, are large, scattered, and composed of individuals who share only a common interest and involvement in a certain goal. Although most communities of people share many aspects of their experience, it is useful to identify three types of communities that have relevance to community health practice: geographic, common interest, and health problem or solution.

Geographic Community

A community often is defined by its geographic boundaries and thus is called a **geographic community**. A city, town, or neighborhood is a geographic community. Consider the community of Hayward, Wisconsin. Located in northwestern Wisconsin, it is set in the north woods environment, far removed from any urban center and in a climatic zone characterized by extremely harsh winters. With a population of approximately 2,200, it is considered a rural community. The population has certain identifiable characteristics, such as age and sex ratios, and its size fluctuates with the seasons: summers bring hundreds of tourists and seasonal residents. Hayward is a social system as well as a geographic location. The families, schools, hospital, churches, stores, and government institutions are linked in a complex network. This community, like others, has an informal power structure. It has a communication system that includes gossip, the newspaper, the "co-op" store bulletin board, and the radio station. In one sense, then, a community consists of a collection of people located in a specific place and is made up of institutions organized into a social system.

Local communities such as Hayward vary in size. A few miles south of Hayward lie several other communities, including Northwoods Beach and Round Lake; these three, along with other towns and isolated farms, form a larger community called Sawyer County. If a nurse worked for a health agency serving only Hayward, that community would be of primary concern; however, if the nurse worked for the Sawyer County Health Department, this larger community would be the focus. A public health nurse employed by the State Health Department in Madison, Wisconsin, would have an interest in Sawyer County and Hayward, but only as part of the larger community of Wisconsin.

Frequently, a single part of a city can be treated as a community. Cities are often broken down into *census tracts*, or neighborhoods. In Seattle, for example, the district near the waterfront forms a community of many transient and homeless people. In New York City, the neighborhood called Harlem is a community, as is the Haight-Ashbury district of San Francisco.

In community health, it is useful to identify a geographic area as a community. A community demarcated by geographic boundaries, such as a city or county, becomes a clear target for the analysis of health needs. Available data, such as morbidity and mortality figures, can augment assessment studies to form the basis for planning health programs. Media campaigns and other health education efforts can readily reach intended audiences. Examples include distributing educational information on safe sex, self-protection, the dangers of substance abuse, or where to seek shelter from abuse and violence. A geographic community is easily mobilized for action. Groups can be formed to carry out intervention and prevention efforts that address needs specific to that community. Such efforts might include more stringent policies on day care, shelters for battered women, work site safety programs in local hazardous industries, or improved sexuality education in the schools. Furthermore, health actions can be enhanced through the support of politically powerful individuals and resources present in a geographic community.

On a larger scale, the world can be considered as a global community. Indeed, it is very important to view the world this way. Borders of countries change with political upheaval. Communicable diseases are not aware of arbitrary political boundaries. A person can travel around the world in <24 hours, and so can diseases. Children starving in Africa affect persons living in the United States. Political uprisings in the Middle East have an impact on people in Western countries. Floods or tsunamis in Southeast Asia or volcano eruptions in Iceland have meaning for other national economies. The world is one large community that needs to work together to ensure a healthy today and a healthier and safer tomorrow. **Global health** has become a dominant phrase in international public health circles. Globalization raises an expectation of health for all, for if good health is possible in one part of the world, the forces of globalization should allow it elsewhere (Skolnik, 2008). Governments need to work together to develop a broader base for international relations and collaborative strategies that will place greater emphasis on global health security. We learn more about global health issues and the global community in Chapter 16.

Common-Interest Community

A community also can be identified by a common interest or goal. A collection of people, even if they are widely scattered geographically, can have an interest or goal that binds the members together. This is called a *common-interest community*. The members of a church in a large metropolitan area, the members of an international nursing professional organization, and women who have had mastectomies are all common-interest communities. Sometimes, within a certain geographic area, a group of people may develop a sense of community by promoting their common interest. Disabled individuals scattered throughout a large city may emerge as a community through a common interest in promoting adherence to federal guidelines for wheelchair access, parking spaces, toilet facilities, elevators, or other services for the disabled. The residents of an industrial community may develop a common interest in air or water pollution issues, whereas others who work but do not live in the area may not share that interest. Communities form to protect the rights of children, stop violence against women, clean up the environment, promote the arts, preserve historical sites, protect endangered species, develop a smoke-free environment, or provide support after a crisis. The kinds of shared interests that lead to the formation of communities vary widely.

Common-interest communities whose focus is a health-related issue can join with community health agencies to promote their agendas. A group's single-minded commitment is a mobilizing force for action. Many successful prevention and health promotion efforts, including improved services and increased community awareness of specific problems, have resulted from the work of common-interest communities. MADD is one example. In 1980, after a repeat drunk-driving offender killed her 13-year-old daughter Cari, Candace Lightner gathered with a group of outraged mothers at a restaurant in Sacramento, California. Across the country, another mother was soon touched by a similar tragedy. Cindi Lamb's five-and-a-half-month-old infant daughter became a quadriplegic at the hands of a repeat drunk driver. Within a short time, the two women joined forces to form MADD, and 2 years later, President Ronald Reagan organized a Presidential Task Force on drunk driving and invited MADD to participate. With media attention and perseverance, MADD quickly grew to over 100 chapters across the United States and Canada and worked to establish a federal legal minimum drinking age and standard blood alcohol levels of 0.08%, as well as to defend sobriety checkpoints before the Supreme Court. The National Highway Transportation and Safety Administration credited MADD when they released the 1994 figures showing a 30-year low in alcohol-related traffic deaths. Even though our U.S. numbers have dropped considerably, still, every 45 minutes someone is killed by a drunk driver, and every minute of every day, one person is injured (Morris, 2010). MADD now claims more than 3 million members worldwide, and is one of the largest and most successful common-interest organizations (*Milestones in Public Health*, 2006; Morris, 2010).

Community of Solution

A type of community encountered frequently in community health practice is a group of people who come together to solve a problem that affects all of them. The shape of this community varies with the nature of the problem, the size of the geographic area affected, and the number of resources needed to address the problem. Such a community has been called a *community of solution*. For example, a water pollution problem may involve several counties whose agencies and personnel must work together to control upstream water supply, industrial waste disposal, and city water treatment. This group of counties forms a community of solution focusing on a health problem. In another instance, several schools may collaborate with law enforcement and health agencies, as well as legislators and policy makers, to study patterns of substance abuse among students and

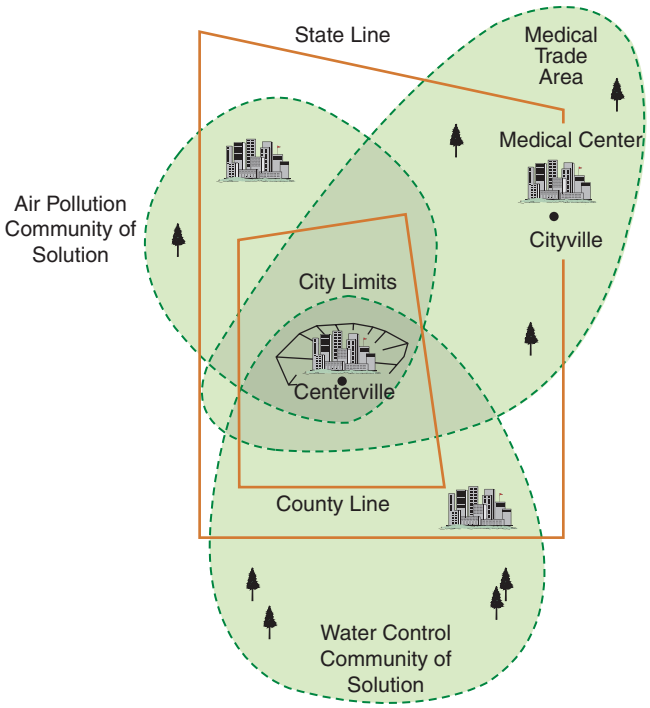

FIGURE 1-1. A city's communities of solution. State, county, and city boundaries (*solid lines*) may have little or no bearing on health solution boundaries (*dashed lines*).

design possible preventive approaches. The boundaries of this community of solution form around the schools, agencies, and political figures involved. Figure 1-1 depicts some communities of solution related to a single city.

In recent years, communities of solution have formed in many cities to attack the spread of HIV/AIDS, and have worked with community members to assess public safety and security and create plans to make the community a safer place in which to live. Public health agencies, social service groups, schools, and media personnel have banded together to create public awareness of dangers that are present and to promote preventive behaviors (e.g., childhood obesity). Former President Bill Clinton organized the Alliance for a Healthier Generation in partnership with the American Heart Association, and they recently announced an agreement with beverage companies such as Coca-Cola and PepsiCo. Vending machines that once stocked calorie-laden sodas now have supplies of low-calorie soft drinks and sports drinks, juices with no added sugar, tea, low or fat-free milk, and water (American Cancer Society, 2008). The American Academy of Pediatrics issued a policy statement about the health effects of soft drink consumption and urged school districts to restrict sales in 2004, reaffirming it in 2009 (Committee on School Health, 2009). Although soft drinks are not the only culprit in the childhood obesity epidemic, this is an important step in helping kids make healthier choices (Engelhard, Garson, & Dorn, 2009; Public Health Institute, 2010b). And the efforts are bearing fruit. In 2008, 63% of schools limited carbonated soft drinks—up from 38% in 2006. The amount of sodas purchased by students dropped from 12 to 8 ounces a week (Reuters, 2010). A community of solution is an important conduit for change in community health.

Populations and Aggregates

The three types of communities just discussed underscore the meaning of the concept of community: in each instance, a collection of people chose to interact with one another because of common interests, characteristics, or goals. The concept of population has a different meaning. In this text, the term **population** refers to all of the people occupying an area, or to all of those who share one or more characteristics. In contrast to a community, a population is made up of people who do not necessarily interact with one another and do not necessarily share a sense of belonging to that group. A population may be defined geographically, such as the population of the United States or a city's population. This designation of a population is useful in community health for epidemiologic study and for collecting demographic data for purposes such as health planning. A population also may be defined by common qualities or characteristics, such as the elderly population, the homeless population, or a particular racial or ethnic group. In community health, this meaning becomes useful when a specific group of people (e.g., homeless individuals) is targeted for intervention; the population's common characteristics (e.g., the health-related problems of homelessness) become a major focus of the intervention.

In this text, the term **aggregate** refers to a mass or grouping of distinct individuals who are considered as a whole, and who are loosely associated with one another. It is a broader term that encompasses many different-sized groups. Both communities and populations are types of aggregates. The aggregate focus, or a concern for groupings of people in contrast to individual health care, becomes a distinguishing feature of community health practice. Community health nurses may work with aggregates such as pregnant and parenting teens, elderly adults with diabetes, or gay men with HIV/AIDS. Unit 6 discusses public health nursing with aggregates and Unit 7 discusses vulnerable populations.

Most registered nurses (RNs) in the United States work in hospitals, and although that number had dropped, a 6% jump was noted between 2004 and 2008. These nurses most often work with individuals, not aggregates