

*The Association of Public Health Nurses (APHN) supports strategies in public and private sectors to promote and more closely integrate public health practice as a foundational part of the health care system. APHN specifically supports planning, programs, and policies that strengthen the role of public health nursing as fundamental to interprofessional teamwork. A competent public health nursing workforce is vital to the delivery of public health essential services and successful population-based outcomes.*

***The Public Health Nurse: Necessary Partner for the Future of Healthy Communities  
A Position Paper of the Association of Public Health Nurses  
June 1, 2016***

**\*\*Note:** *Public Health Nurse (Nursing) or PHN(ing) will be used throughout this document to represent population based and community focused nursing practice: focus is on improving the health of groups, populations, and/or communities rather than a focus on an individual's health. In addition, the public health system is considered to include the cumulative resources and relationships necessary to carry out the important processes of population-based health and the clinical health system is used to describe the infrastructure and assets devoted to individual diagnostic, therapeutic, rehabilitative, preventive or palliative procedures and care. When used, health system refers to the inclusion of both the public health system and clinical health system.*

## **Background**

***Public health nursing is the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences (American Public Health Association Public Health Nursing [APHA PHN] Section, 2013).***

Public health nursing (PHNing) practice is founded on specialty knowledge and built within a specific focus (American Nurses Association [ANA], 2013; APHA PHN Section, 2013; Quad Council Coalition of Public Health Nursing Organizations [QCC], 2011). Yet, describing the public health nurse (PHN) specialty or PHNing practice can be difficult for interprofessional healthcare providers including non-public health or community based nurses (i.e., all nurses practicing in the community are not PHNs). That description is often challenging for a public that continues to view a nurse as a ubiquitous provider, one who is most often found in acute care, medical, or diagnostic settings.

Public health nursing practice engages both the public and clinical health systems at multiple levels to produce community changes that undeniably and favorably impact a culture of health (Robert Wood Johnson Foundation [RWJF], 2015a). PHNs have been health advocates positively influencing the environments where people are born, grow, work, live, and age at least since Lillian Wald's Lower East Side New York in the 19<sup>th</sup> Century (World Health Organization [WHO], 2016). Today, PHNs remain the largest discipline in the public health field, consistently providing leadership in an unsettled health system environment. As PHNs continue to move beyond traditional public health settings and integrate their practice with community systems, their value and strength will continue to evolve as well.

## **The Evolution and Future of Health Systems - Clinical and Public Health**

In 2001, the Institute of Medicine's (IOM) landmark report *Crossing the Quality Chasm* presented the U.S. healthcare system as poorly organized, overly complex, and uncoordinated--unprepared to meet the challenges of the public's health care needs. Fifteen years later, a shift in national focus from clinical health care to the *health* of individuals and populations is bridging some of the chasm. The Institute for Alternative Futures' (IAF) *Public Health 2030* report acknowledges the public health system as integral in this shift in focus and discusses four scenarios of what public health agencies might look like by 2030 (IAF, 2014). One key recommendation is to transform public health agencies into health development agencies with dedicated, sustainable, and sufficient funding for community-based programs. Similar to the IAF and IOM recommendations, Robert Wood Johnson Foundation's (RWJF) vision of creating a culture of health aligns with the public health system's work to assure the conditions in which people can be healthy (RWJF, 2015a). The RWJF also supports nurse-led initiatives that include a return on investment, strong partnerships, best practices, and leadership in community settings (RWJF, 2015b).

The Patient Protection and Affordable Care Act (ACA) is also shaping a greater focus on health and prevention. The concept of community benefit dollars for prevention and models such as accountable care organizations and patient-centered medical homes have become reality. In addition, the Centers for Medicare and Medicaid Services changed service reimbursement from guaranteed fee for service payment regardless of outcomes, towards outcome accountability, value based, and episodic bundled payments. These approaches are designed to drive the creation of accountable care communities and patient-centered medical communities (IAF, 2014). In January 2016, the U.S. Department of Health and Human Services announced funding for testing the Accountable Health Communities model, which intends to bridge clinical and community services and focus more on social factors that influence health (Centers for Medicare and Medicaid Services [CMS], 2016). Local health departments already perform functions related to health development agencies.

### **Public Health Nursing Practice as Population Based and Future Ready**

As a result of the evolutionary movement forward in the health system and increasing calls over a decade for the public health system's shift to population-based services, numerous health departments have begun to shift away from their role in individually focused care to one focused on population health as opposed to clinical services. In turn, many hospitals are escalating their efforts to improve the health of their communities, an emphasis fostered by the ACA mandate for nonprofit hospitals to complete triennial community health needs assessments. The IOM's (2012b) groundbreaking report, *Primary Care and Public Health: Exploring Integration to Improve Population Health*, launched a rapid advancement in

integration as evidenced by the *Million Hearts* campaign (Association of State and Territorial Health Officials [ASTHO], 2016).

Central to the success of health system transformation is the PHN. As a health professional, PHNs are uniquely prepared with the knowledge, skills and experience to partner across all components of the health system and within various community sectors. They deliver population based care where people live, work, learn, play, and pray. In a post-ACA environment, the majority of care will be provided in the community (RESOLVE, Public Health Leadership Forum, 2014).

Partnering with communities, populations, and organizations as equal partners is a core principle of PHNing practice (ANA, 2013). The PHN is the natural broker to lead the health system's efforts in developing the innovative public health and clinical health system - - the evolving health system - - integrated intervention models. Such models would align with goals such as the Centers for Disease Control and Prevention's (CDC) accessible, high quality and effective clinical preventive services (Auerbach, 2016). Furthermore, the PHN is the health professional with both the clinical expertise and the public health knowledge and skills to assess the impact of the social determinants of health on disease conditions related to an individual or family, as well as on populations.

The PHN practices within an ecological perspective--understanding the community together with its environment functioning as a unit. This ecologic perspective is key to the PHNs focus on the upstream factors, that while health promotion, disease prevention, or risk reduction activities may be delivered to an individual or family, the scope of practice remains population based (ANA, 2013). The ecological perspective also supports the PHN as the bridge for population health, as the health professional with the expertise to bridge the silos of public health and clinically focused services. For example, the community health needs assessments, which are a requirement for nonprofit hospitals can provide an opportunity to ensure partnerships between public health and clinical health systems, ensuring a need for PHNing expertise (ASTHO, 2014). Partnerships can provide appropriate assessment, data analysis, referral, follow-up and treatment of those most at risk for adverse health events.

Finally, PHNing interventions, such as immunization campaigns, communicable and non-communicable disease screening and management, or home visiting are focused on providing services that are population based. The current *Million Hearts State Learning Collaborative* is an example, where care coordination by PHNs for those with hypertension across the state of Oklahoma is designed to reduce costs associated with hospitalization (ASTHO, 2016). The exemplar of cost effective services provided by PHNs is the Nurse Family Partnership (Olds et al., 1997; 2002), where decades of research documents the benefits of the PHN's unique expertise and the fusion of clinical expertise and with public health knowledge and skills.

The IAF (2014) provides four scenarios with recommendations about the future of the public health system. The PHN can use these practice categories to fully engage and influence

population-based practice in the health system (Table 1). In addition, the Public Health Leadership Forum convened a group of stakeholders in 2013 to further define a minimum package of public health services including foundational capabilities and an array of basic programs no health department can be without (Figure 1). This effort was in direct alignment with four recommendations from *For the Public’s Health: Investing in a Healthier Future* (IOM 2012a). PHNs have an opportunity to shape how public health and healthy communities will advance into the 21<sup>st</sup> century through promising practices that reflect four recommendations of both the IAF document as well as the work around the *Foundational Areas of Public Health Services*.

**Table 1:** Promising Practices for Public Health Nursing Population-Based Practice

Institute for Alternative Futures Recommendation	Examples of Promising Practices for PHNing Related to Foundational Areas of Public Health Services
<p>1: <b>Transform</b> public health agencies into “health development agencies with dedicated, sustainable and sufficient funding.”</p> <ul style="list-style-type: none"> <li>• <b>1A: Develop dedicated, sustainable, and sufficient funding</b></li> <li>• 1B: Implement policies for the systematic use and development of evidence and best practices.</li> <li>• 1C: Build public health agencies’ role in fostering prevention and health promotion strategies.</li> </ul>	<p><b>Sustainability in funding</b> comes from the ability to show evidence of positive health outcomes. The Nurse Family Partnership (NFP) improves <b>maternal/child health</b> through better pregnancy outcomes, prevention of child abuse and neglect, and improved school readiness. Dissemination of research findings began in 1996. The NFP has been funded through a variety of mechanisms including local and state and through Medicaid and the Department of Justice; it has been offered in communities in 37 states (<a href="http://www.nursefamilypartnership.org">www.nursefamilypartnership.org</a>).</p>
<p>2: <b>Partner</b> in health care transformation to facilitate the evolution from a clinical health care system to a health system.</p>	<p><b>Partnerships</b> formed through <b>clinical &amp; community linkages</b> (public health and clinical health systems) are evident within the Association of State and Territorial Health Officials (ASTHO, 2016) Million Hearts State Learning Collaborative. New York’s Dutchess County Health Department and the Beacon Community Health Clinic partnered to institute a new approach to using electronic medical records to better identify and manage those with hypertension and complement primary care services offered to those with hypertension in their community (<a href="http://www.astho.org">www.astho.org</a>).</p>
<p>3: <b>Build the capacity</b> for dialogue about inclusion, opportunity, and equity.</p>	<p>PHNs within the ASTHO Million Hearts State Learning Collaborative are <b>building capacity</b> by partnering with faith community nurses who have established trust and can effectively reach populations at risk for or with <b>chronic disease</b>. Through monitoring, coaching, and referrals, these PHNs are helping to identify those with undiagnosed hypertension and referring them to health care providers while providing a community-based practice to help them make positive lifestyle changes that lower blood pressure (<a href="http://www.astho.org">www.astho.org</a>).</p>

<p>4: <b>Dialogue</b> with other sectors to support innovation.</p>	<p>A school nurse in RI serves on local and national boards to <b>dialogue</b> with other sectors about <b>environmental concerns</b> in the school setting, including the Northeast Board for the American Lung Association (working with RI Department of Health’s Asthma Coalition) and the American Nurses Association’s Healthy Schools Network. Her work has resulted in securing a sponsor to submit Green Cleaning in School legislation. She is also involved with Project CASE (Controlling Asthma in Schools Effectively), a multi-level, multi-component intervention program targeting school-age students in RI who have asthma with one component focused on improving the <b>environmental health</b> of schools. (<a href="http://www.nasn.org">www.nasn.org</a>)</p>
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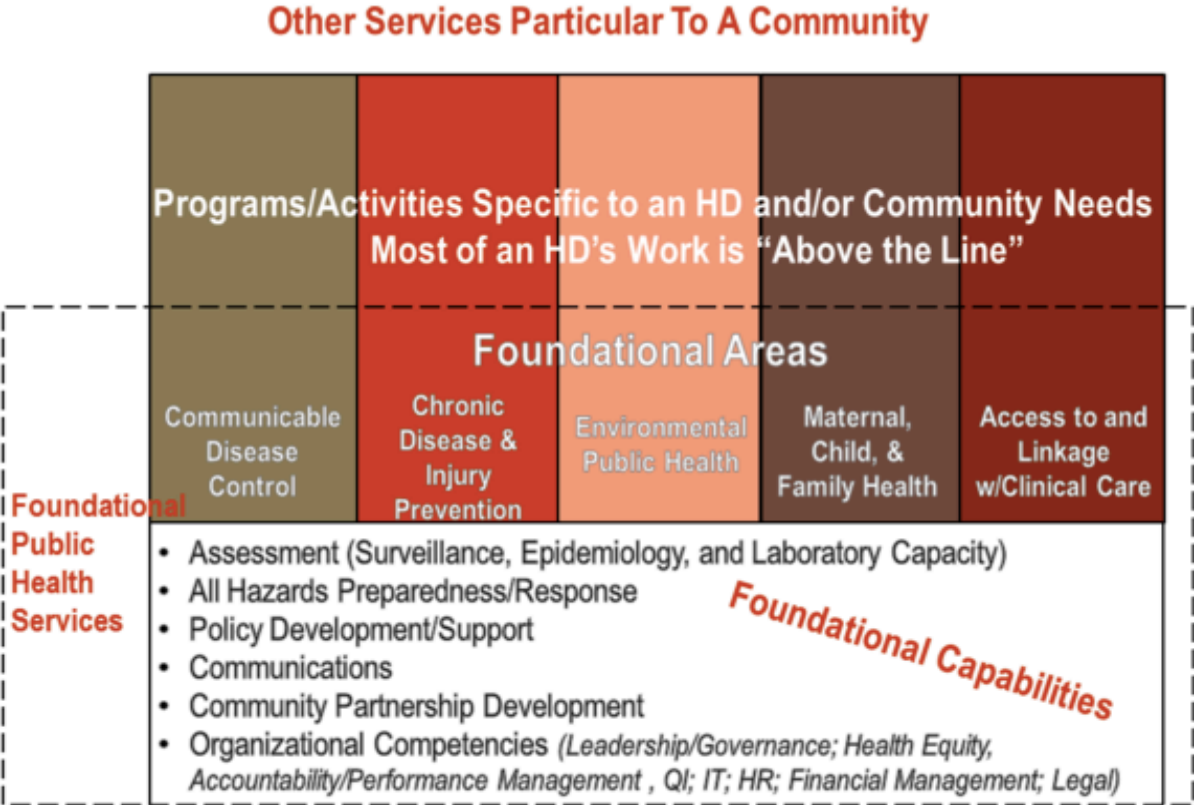
**Conclusion: PHN as a Vital Health Network Partner**

In the changing healthcare landscape, clinicians regardless of practice area are charged with keeping their clients healthy where they live, work and play. This is evident in the changes to reimbursement modality for services by the Centers for Medicare and Medicaid Services. Therefore healthcare systems cannot afford to ignore the built environments that their clients return to once discharged from their facility. As previously mentioned, PHNs clinical knowledge and expertise in ensuring optimal health for communities and populations position them as the ideal professionals to bridge this gap in the continuity of health - - bridging the gap that currently exists between the silos of clinical health and public health.

In 1988, the IOM defined public health as “what we as a society collectively do to ensure the conditions for people to be healthy.” PHNs are equipped to guide and navigate their healthcare colleagues through this evolving health system environment. In upcoming papers, APHN will showcase the vital leadership role of PHNs in realizing measurable outcomes and return on investment in various programmatic areas such as: Chronic Disease, Emergency Preparedness, Maternal and Child Health, and Access as Health System Advocate/Navigator. In 2016, in an environment of increasing fiscal pressure and demand for conditions to assure the hope of public health, public health nurses are an educated, highly skilled and cost effective partner, well able to lead population health strategies into the future.

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Figure 1. Foundational Public Health Services, Public Health Leadership Forum (2013)



**Foundational Capabilities (FCs):** Cross-cutting skills needed in state/local health departments everywhere for health system to work anywhere; essential skills/capacities to support all activities

**Foundational Areas (FAs):** Substantive areas of expertise or program-specific activities in all state/local health departments necessary to protect the community's health

**Programs/Activities Specific to a Health Department or a Community's Needs:** Additional, critical significance to a specific community's health, supported by FAs/FCs; most of a health department's work

**Foundational PH Services (FPHS):** Comprised of the FCs and FAs; a suite of skills, programs/activities that must be available in state/local health departments system-wide

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