Chapter Objectives

1. Compare and contrast individual, family, and population-based health care.

2. Apply an ecological lens to identify multiple levels of health risks associated with human health.

3. Identify the relationships between population health and vulnerable populations, health disparities, and social determinants of health.

4. Explore societal health challenges from multiple perspectives.

5. Analyze the evidence that supports the need for population-based care.

Chapter Concepts

- Department of Health and Human Services
- Distributive justice
- Environmental health
- Government regulations
- Health care costs
- Health disparities
- Health equity
- Health Resources and Services Association
- Healthy People
- Indian Health Service
- Medicaid
- Medicare
- Population health
- Prevention
- Social justice
- State Children’s Health Insurance Program
- Surgeon General
- Vulnerability

Chapter Introduction

Modern society often seems primarily focused on individualism and competition; this can make it difficult to see the importance of population health care needs. Population health pertains to the
larger societies are composed of families and individual members. An ecological lens is useful for identifying the interacting and interdependent complexities of population health tied to society. Population health is dynamic and continually affected by environmental risks (e.g., natural hazards, disasters, legislative policies, politics). Things such as distributive justice, government and state regulations, professional guidelines, standards of care, health promotion and prevention, and at-risk groups are also linked with population health. Social determinants of health, culture, vulnerable populations, and disparities are additional topics to consider when broad factors that influence health and illness are viewed from a population perspective. Students need to understand these concepts and know how they affect family households and member health or illness.

While community is not always the first things that come to nursing students’ minds when thinking about nursing practice, the Code of Ethics for Nurses states that nurses collaborate with other health professionals and the public to promote community, national, and international efforts that address health needs (American Nurses Association, 2001). Provisions of the codes implies nurses meet the health, welfare, and safety of all people. Attention to things such as world hunger, environmental pollution, lack of access to human rights, and inequitable distribution of nursing and health resources is expected. In community roles, nurses educate the public, facilitate opportunities for informed choices, identify conditions that contribute to injuries, illness, and disease, and encourage healthy lifestyles. Also, nurses can be involved in things like poverty, homelessness, unsafe living conditions, abuse and violence, and lack of access to health services. Student nurses need to identify personal cultural values and learn not to impose them upon others. They need experiential learning that helps them become reflective,
gain sensitive awareness to broad individual and family unit needs, develop values aligned with culturally diverse populations, and gain respect for human dignity.

Population care is different from individual care that is tailored to meet the unique health needs of each person and generally has cure as its goal. Most medical care is concerned with diagnosis, treatment, and rehabilitative options provided by a physician and health care practitioners. Medical care mainly concentrates on cure and uses pharmaceuticals, medical treatments, radiation, and surgery to achieve results. Much of what nurses learn through a formal education is focused on individual needs. Evaluation of the care generally involves measuring satisfaction levels and determining if an improved health status results from the intervention. While these approaches are useful for individuals, they are not effective for solving larger population-based problems. Currently, most U.S. health care delivery systems provide medical services, a care delivery system based primarily upon reimbursement plans with incentives for disease treatment. This form of health care gives little thought to family, community, or population needs. Yet, 97% of the current health care spending is for medical treatment services, 2% is for clinical preventive care, and only about 1% for population-based public health services (Turnock, 2009).

This chapter explores ways individuals, families, and the larger society intersect. Rather than merely think about individual health and illness, this chapter encourages thoughts about families, groups, communities, and populations. Ecological thinking supports larger perspectives and suggests that broad factors can be sources of illness and disease and solutions. Instead of thinking about health care and nursing practice as merely ‘fixing’ problems, this chapter also considers prevention. Innovative practices to engage groups, families, and communities in targeted education and outreach are identified as ways to extend the reach of healthful practices
Family-Focused Nursing Care: ‘Think Family’ and Transform Nursing Practice
Denham, Eggenberger, Young, & Krumwiede
Faculty Manual Chapter 12 Family Focused Care to Meet Population Needs

to places where people live, learn, work, pray, and play. This introduction to chapter twelve provides some supplementary information to the textbook for use in student activities.

Population Health Perspectives

Students need ways to learn about health from community perspectives so that they do not just view family health and illness as medical problems. Conversations about the interconnectedness among society and its families can be useful ways to engage students in thoughtfully considering the life story and linked needs of those they give care. Active learning activities that engage students in their communities and allow them to interact with people that differ socially from themselves can facilitate opportunities to compare, contrast, and reflect. Development of service learning experiences with students can facilitate learning about culturally diverse people, the elderly, homelessness, single parent families, abuse and violence, or people living with HIV/AIDS. Fettering out ways to engage students in social service agencies, volunteer groups, non-profit work, coalitions, and policy are other ways to help students learn about the diverse connections between health and illness.

Nursing students need to learn about the limits of expensive and marginally effective health care for increasing life expectancy and improving the quality of life for individuals, families, and populations. It is well documented that life expectancy is associated with socioeconomic status and influenced by income, education, and status. Income influences choices about the neighborhood where families live, the types of food bought and eaten, the schools children attend, stress of daily life, and abilities to access health care services. Life expectancy is also affected by a country’s infant mortality rate. In 1960, the U.S. infant mortality ranked 12th among Economic Cooperation and Development (OECD) countries. By 2008, the rank of the U.S. had dropped to 31st among the 34 OECD countries, with only Chile, Mexico,
Despite the revered medical practices of the U.S., problems linked with infant mortality continue. In 2010, the infant mortality rate in the U.S. was 6.14 per 1,000 live births (Murphy, Xu, & Kochanek, 2012). While some explanations for disparities exist (e.g., the recording of what is viewed as a live birth, low birthweight and short gestational age, racial disparities), but factors like geographic variation and health system characteristics (Heisler, 2012). Students need understandings about health disparities and interventions that can make potential differences in outcomes.

**The New Ulm Project**

An example of population-based care that demonstrates the interventions at each level of practice is *The Heart of New Ulm* project, started in 2008 (Hearts Beat Back, 2013). This population focused project was initially led and financed by a hospital health care system in Minnesota that involved many community partnerships. New Ulm, a small city south of Minneapolis, has many residents of German ancestry. Some leaders recognized that beer, brats, and butter were too often on the menu and tables of the community’s families. The mission was to make community health a top priority. This project was designed to reduce the number of heart attacks in the New Ulm area over the next 10 years (Hearts Beat Back, 2013). Initially, health-screening programs were offered throughout the community to identify individuals at highest risk. A variety of community based programs were made available to assist residents in decreasing their heart attack risks by improving their nutritional intake, increasing physical activity, eliminating tobacco use, and addressing other social behaviors.

The project includes community education programs (e.g., cooking classes; sharing recipes; ranking community restaurants by the healthfulness of food preparation and offerings; providing healthy eating resources; using an online eating management tracking sources; and
Family-Focused Nursing Care: ‘Think Family’ and Transform Nursing Practice
Denham, Eggenberger, Young, & Krumwiede
Faculty Manual Chapter 12 Family Focused Care to Meet Population Needs

providing grocery shopping tours, tobacco cessation programs, cholesterol and blood pressure management heart care for diabetes classes, stress management and reduction instruction).

Physical activity is being promoted through opportunities to increase physical activities (e.g., walking/running events and clubs, dance classes, bike riding, aerobic exercise classes). The New Ulm Dance Project (<http://legacy.mnhs.org/sharing-community-stories/projects/new-ulm-dance-project>) provides opportunities for intergenerational interaction as young and old come together to dance and share life stories.

Some environmental changes within the community such as building sidewalks to improve walking opportunities, creating parks, and initiating tobacco use restriction policies are population-based strategies being instituted. Online resources, blogs, and phone applications were created to support local activities and share success stories. Improving overall health is a shared community good that must be viewed as a shared community responsibility. A community preventive care model for other places can be created by planning coordinated activities and initiatives similar to the ones in New Ulm. Engage your students by having them research this community project and then envision how something similar might be done where they live. A group project that looks at various ways health is influenced by things like social, financial, environmental, and political actions can help them identify ways nurses can become actively engaged in the health of their community.

**Individual, Community, and Population Health**

It is important to understand the interactions of nursing at the individual, family, and population levels because health-linked concerns differ at each level. For instance, the historic 2007 flooding in the southeastern corner of the state of Minnesota caused flooding after 15.10 inches of rainfall fell in a 24-hour period (Minnesota Board of Water & Soil Resources, 2011). The
event was the largest 24-hour rainfall ever reported in Minnesota (Minnesota Board of Water & Soil Resources, 2011). Following this flood, hundreds of people were displaced as roads, homes, and businesses were washed away in flash flooding across the area. Southeast Minnesota was declared a disaster area. Individual, family, and population care were all needed as a result of this natural disaster. Individual and family care was provided in emergency shelters with care aimed at meeting needs based on personal health status (e.g., safety, hygiene, nutrition, sleep). Individual care included distribution of things like bottled water, hygiene supplies, emergency food, and delivering medical care to those with acute or chronic health care needs. Family focused care was preserved in the aftermath of the flood through individual medical intervention, family care based upon basic needs, psychological support, and population based health promotion and disease prevention that targeted risks for present and future conditions.

As seen in the Minnesota flood recovery example, health care in the United States is provided through a complex system of human services that targets the interconnected levels of biophysical, social, emotional, and structural health needs (Ervin, Bickes, & Schim, 2006). Using an ecological model, these interconnected levels of need can be depicted as four concentric circles or Environments of Care (Ervin, Bickes, & Schim, 2006). The inner core represents individual determinants of health, a second level represents social determinants of health, a third level can represent environmental determinants of health, and the outmost level represents growing global health determinants (Ervin, Bickes, & Schim, 2006). All of these levels have relevance to health and illness of individuals, families, and the community.

**Vulnerability and Health**

Vulnerability is created through social forces and can only be resolved through social supports and not merely individual means (Shi & Stevens, 2010). Several reasons to focus resources and
research on vulnerable populations exist. First, the prevalence of vulnerable groups in the population is increasing. The national poverty rate has steadily increased since the 1970s and, in 2012, it is the highest since the Great Depression. Growing gaps between ‘haves’ and ‘have nots’ are creating concern. Poverty is often defined as lacking financial resources to live at a standard most view as comfortable or usual in a society. While wealth implies a large amount of money or assets exists. Being at risk for not being able to pay one’s bills, obtain adequate housing or obtain food is something feared by many of the world’s people.

Being rich or poor does not define the character of a life or family. Poverty is not always a result of personal ineptitude, but often a result of social injustices. Big problems can result when scarce resources are unequally distributed among social groups, a situation that occurs nationally and internationally. For example, those with wealth and power faced growing discontent as they were implicated in the 2011 international *Occupy Movements* across the United States with much attention given to social equity (The New York Times, 2012). A disaster such as a flood, Tsunami, or terrorist act can afflict both the rich and the poor. As caregivers, nurses give care to those that come from all backgrounds and are called upon to give similar respect and care to all.

The health of the vulnerable is closely related to a nation’s resources, as well as differences in wealth between the highest and the lowest on the economic scale (Mackenbach, Stirbu, Roskam, Schaap, et al., 2008). Some countries have small gaps between the wealthiest and poorest individuals (e.g., Sweden, Norway, Switzerland). The least wealthy individual, in those nations, have higher rankings on life expectancy and lower rates on national health indicators as infant mortality than the poor in the U.S. While estimates of wealth vary, it is understood that the top 20% of the U.S. population control about 85% of the wealth (Domhoff,
Factors linked with poverty and wealth are social factors worth considering when it comes to understanding the health needs of a nation’s people.

**Family and Community Interventions**

Community wide environmental interventions could help protect vulnerable families from food insecurity and improve access to affordable, healthy foods. Interventions such as fruit and vegetable incentive programs, development of community gardens, and use of community farmers’ markets are ways to improve access to local foods. As nurses consider care for risks linked with eating disorders, things like family functioning, food access, and shopping or eating patterns be examined. Research shows that healthy family mealtime interactions have improved psychosocial wellbeing among adolescents (Eisenberg, Olson, Neumark-Sztainer, Story, & Bearinger, 2004), increased medical adherence in children with chronic diseases such as asthma (Fiese & Everhart, 2006; Fiese & Wamboldt, 2000), and may mediate the effects of asthma-induced anxiety symptoms (Fiese, Winter, Wamboldt, Anbar, & Wambolt, 2010). Nurses who think family, whether in an acute, chronic, or public health setting can talk with individuals and families about the importance of good nutrition (e.g., label reading, planning, shopping and budgets, choosing fresh fruits and vegetables) and regular meal time gatherings of multiple family members. These interventions are often done through community settings rather than medical services. Students learning to become nurses not only need knowledge about social factors associated with communities, but need to be prepared to think critically as they make clinical judgments about coordinated care, health counseling, and health teaching.

**Theoretical Frameworks for Family and Societal Health Care**

Theoretic frameworks and models used in nursing such as those related to resilience (Rew & Horner, 2003), health promotion (Pender, Murdaugh, & Parsons, 2006), and self-efficacy
Family-focused nursing care: ‘think family’ and transform nursing practice
Denham, Eggenberger, Young, & Krumwiede
Faculty Manual Chapter 12 Family Focused Care to Meet Population Needs
(Bandura, 1997) may increase understandings about individuals, but students may need guidance in applying them to families and communities. Many theoretical frameworks used by nurses identify individual responsibility for health status and point to nurse interactions as instrumental efforts to resolve vulnerabilities and subsequent poor health and illness (Adler, 2008; Lantz, 1998; Rogers, 1997).

Frameworks for meeting community needs

A different set of frameworks and models is available to explore community-level determinants of health and vulnerability. An example of a model of care directed at individual and provider interactions to manage disease is the Chronic Care Model (CCM) (Wagner, Austin, & Von Korff, 1996). Research using the CCM demonstrated some improvement in outcomes based on economies of scale. In other words, cost savings may be realized if the model is implemented across multiple practitioners and used to redesign practices and the role of the primary care practitioner (Wallace, 2011). The CCM and other disease management programs are the foundation for the Medical Home movement included in the ACA.

Risks associated with social groups or access to care that reduces risks for morbidity require different forms of thinking. Students need to learn that socioeconomic and environmental challenges are important to a population’s overall health. For example, the Vulnerability Model (Flaskerud & Winslow, 1998) identifies resource availability, relative risk, and health status as factors to evaluate. Thus, things like community unemployment, poverty rates, rates of violence and crime, quality of schools, availability and strength of community organizations, and the presence of grocery stores, farmers’ markets, and fresh produce are factors linked with a community’s health. Community poverty rate has been repeatedly identified as a predictor of morbidity and mortality (Do & Finch, 2008; Erwin, 2008; Kaler & Rennert, 2008). These are not
Students often have ideas that focus on individual versus societal responsibility for health circumstances. For example, when nursing students meet persons that are overweight, obese, or physically inactive they might quickly assume the individual is responsible and fail to identify other explanatory social determinants of health. Family focused nurses not only assess things like personal health circumstances, but also family living environments. Care is then tailored to specific needs. Advocacy includes assuring that false assumptions based on unsupported or inaccurate information are not made. Advocacy involves giving voice to the problems of social structures or inadequate systems that put individuals and families at risk for health problems in their homes and community. It also implies working to make changes that help all multiple families attain an optimum health status and reduce risks due to social or environmental factors.

**Cost Saving Interventions**

Many interventions are primarily focused on realizing cost savings to the health practices, hospitals, insurers, and health care systems (Wallace, 2011). Individuals often have the power to change their health circumstances if they are given adequate education and nursing support (Pender, Murdaugh & Parsons, 2006). However, care models that support individual disease management strategies often provide a rationale and context for blaming the victim at risk for their behaviors, lack of compliance, and vulnerable health status. The phrase “blaming the victim” came into use after Ryan (1971) wrote a book to repudiate the Moynihan Report (1965) where statements blamed chaotic family structure for the ongoing socioeconomic issues African Americans faced in employment, education, and overall financial and social status (Office of Policy Planning and Research, 1965). Ryan countered that the socioeconomic issues of African Americans...
Americans were due to upstream social structural impediments. While Moynihan’s solution was federal programs to strengthen the African American family structure, Ryan’s solution was to tear down the sociocultural, economic, and physical structures that made African American families’ rise from poverty difficult and often impossible.

Lack of available medical services and providers in a community can be another source of health disparities (Wright, Andres, & Davidson, 1996). Medically Underserved Areas (MUAs), Medically Underserved Populations (MUPs), and Health Professional Shortage Areas (HPSAs) can be found in both urban and rural areas. MUAs may be a whole county or a group of connected counties, a group of county or civil divisions, or a group of urban census tracts in which residents have a shortage of personal health services. MUPs may include groups of persons that face economic, cultural, or language barriers to health care. HPSAs are designated by state and county and reviewed annually for inclusion. HPSAs can be urban or rural areas, a population group, or a public or nonprofit public facility that has this official federal designation from the Secretary of Health and Human Services. HPSAs can pertain to primary medical care, dental care, or mental health care. Improvement of population health can be attained most effectively through use of community models rather than individual models. Consequently, poor population health is seen as a geopolitical problem of distribution of wealth and resources, not only an individual issue. As students learn community content from a think family perspective, they can be challenged to think outside the formal medical structures, systems, and practitioners and begin seeing health and illness from other viewpoints.

References


Family-Focused Nursing Care: ‘Think Family’ and Transform Nursing Practice
Denham, Eggenberger, Young, & Krumwiede

Faculty Manual Chapter 12 Family Focused Care to Meet Population Needs


www.heartsbeatback.org/project


Turnock, B. J. (2009). *Public health: What it is and how it works*. Sudbury, MA: Jones and

Family-Focused Nursing Care © 2015
