Sixth Edition

Population and Community Health Nursing

Mary Jo Clark

POPULATION AND COMMUNITY HEALTH NURSING

SIXTH EDITION

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About the Author

Mary Jo Clark, PhD, RN, PHN, has been practicing and teaching population health nursing for 50 years. After completing her BSN degree at the University of San Francisco, she received her introduction to global population health nursing as a U.S. Peace Corps Volunteer in Vita, India, a rural town with a population of about 3,000. Returning to the United States, Dr. Clark employed her cross-cultural expertise as a Public Health Nurse in the Los Angeles County Department of Health Services. In 1973, she became a pediatric nurse practitioner, and later began teaching population health nursing at East Tennessee State University. She completed a master's degree as a community health clinical nurse specialist at Texas Women's University and a PhD in nursing at the University of Texas at Austin. Moving with her army nurse husband to Augusta, Georgia, she taught graduate and undergraduate population health at the Medical College of Georgia. For the past 29 years, Dr. Clark has taught at baccalaureate, master's, and doctoral levels at the University of San Diego, Hahn School of Nursing and Health Science. In addition to her full-time teaching and writing, Dr. Clark has maintained an active population health nursing practice. She is well known in the population health nursing field and has provided consultation and made presentations across the country and overseas. Her many and varied experiences in population health nursing in the United States and abroad form the core of the material presented in this book.

Dedication

This book is lovingly dedicated to Phil the elder, Phil the younger, and Heather, who are the wind beneath my wings, and to my fellow population health nurses and faculty across the country and around the globe. Little by little we are improving the health status of the world's population.

Thank You!

Reviewers

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Preface

This book represents the lessons learned and the progress made in more than 100 years of population health nursing in the United States. The year 1993 marked the 100th anniversary of the founding of the Henry Street Settlement, the acknowledged beginning of modern American population health nursing. Since then, the work of population health nurses and others has led to better health for individuals, families, and population groups. In this book, I have tried to distill the wisdom of early pioneers and present-day practitioners to guide and direct future generations toward nursing excellence.

Locally, nationally, and globally, society is in greater need of population health nursing services than at any time since our beginning. Although expected longevity has increased significantly in the last century, quality of life has not kept pace for a large portion of the world's population. Previously controlled communicable diseases are resurfacing, and new diseases are emerging to threaten the public's health. Malnutrition is a fact of life for many people. Chronic physical and emotional diseases are taking their toll on the lives of large numbers of people. Substance abuse and violence are rampant, and more and more frequently, environmental conditions do not support health. All of these are problems that population health nurses can and do help to solve.

Population health nurses must have the depth and breadth of knowledge that allows them to work independently and in conjunction with clients and others to improve the health of the world's populations. In part, this improvement occurs through care provided to individuals and families, but it must also occur on a larger scale through care provided to communities and population groups. *Population and Community Health Nursing*, Sixth Edition, provides population health nurses with the knowledge needed to intervene at these levels. This knowledge is theoretically and scientifically sound, yet practical and applicable to society's changing demands.

Nursing Excellence Through Advocacy

Like prior editions, this edition focuses on the central facet of population health nursing—advocating for the health of the public. The theoretical concept of advocacy is introduced in Chapter 1 and is based on qualitative research by the author that examines the process of advocacy as it is performed by population health nurses. Practical application of the concept occurs in each of the subsequent chapters.

Advocacy Then and Advocacy Now

The *Advocacy Then* and *Advocacy Now* vignettes that open each chapter showcase the efforts of population health nurses, other health professionals, and members of the lay public to advocate for the health of populations. Some of the *Advocacy Now* vignettes were contributed by population health nurses and are gratefully acknowledged. Other vignettes celebrate the past and present contributions of population health nurses and others to promoting health and addressing health needs in the United States and the world. We offer our appreciation to these contributors for their heartfelt descriptions of nursing in the population and for their generosity in permitting us to tell their stories. The *Advocacy Now* vignette that opens Chapter 2 describes the work of Susie Walking Bear Yellowtail, the first Native American registered nurse and an exemplary population health nurse advocate. The other stories, past and present, are equally inspiring for the population health nurses of today and those in the ages to come.

Population and Community Health Nursing, Sixth Edition, provides students with a strong, balanced foundation for population health nursing practice. The book is designed to help students first achieve excellence in the classroom through the many features and exercises that accompany the narrative. The additional tools and supplemental information will help students succeed at applying those concepts in clinical settings with families, communities, and population groups, with the ultimate goal of preparing nurse generalists who will exhibit nursing excellence in any setting.

The underlying intent of this book is to convey to nursing students at the beginning of the 21st century the excitement and challenge of providing nursing care to populations. As we begin a new era of population health nursing, I believe that well-educated population health nurses can provide a focal point for resolution of the global health problems presented throughout the book. Early population health nurses changed the face of society; we can be a strong force in molding the society of the future by striving for nursing excellence through advocacy.

Organization

This textbook is designed to present general principles of population health nursing and to assist students to apply those principles in practice. It is organized in five units. The first three units address general concepts and strategies of population health nursing practice, and the last two examine the application of those concepts to specific populations, settings, and population health problems.

UNIT I sets the stage for practice by describing population health nursing and the context in which it occurs. Readers are introduced to population health nursing as an area of

specialized practice and to its emphasis on advocacy for the health of individuals, families, and population groups. The attributes and features that make population health nursing unique, standards for practice, and typical roles and functions of population health nurses are addressed. Then, the concept of populations as recipients of nursing care and the historical and theoretical underpinnings and development of population health nursing are presented followed by a discussion of epidemiology as a core content area for population health care.

A unique feature of this book is the consistent use of the Population Health Nursing model to structure the discussion of principles of practice. The model is introduced in Chapter 1. *Further Information* about other theoretical models that may be useful in population health nursing practice is provided in ancillary materials found at www.nursing.pearsonhighered.com. Other relevant models dealing with epidemiology, family nursing, health promotion, and so on, are included in specific chapters.

The population health nursing (PHN) model is used as the organizing framework for most of the chapters in the book, providing students with a systematic approach to determining factors that influence health and relevant strategies designed to promote health, prevent illness and injury, resolve existing health problems, and restore health in individuals, families, communities, and populations. The consistent use of the PHN model permits students to readily identify commonalities and differences among processes, populations, settings, and health problems.

UNIT II examines influences on population health and addresses environmental, cultural, economic, healthcare delivery system, and global influences on population health. Knowledge of the influence of these factors on population health leads to the application of specific strategies to improve population health addressed in **UNIT III**. Strategies addressed include political, empowerment, health promotion and health education, case management, and home visiting approaches to population health nursing as a specialized area of practice. Other aspects of population health nursing practice (e.g., community engagement, referral, delegation, social marketing, group dynamics, and leadership) are integrated into these and other chapters as appropriate.

UNIT IV addresses health care provided to special population groups. In each chapter, students are assisted to apply principles of care to individuals and families, as well as to these populations as aggregates. For example, Chapter 16 emphasizes population health nursing care for children and adolescents as population groups, as well as strategies for improving the health of individual children and adolescents. Similar approaches are taken to other population groups in the unit: families, communities, men, women, the elderly, the GLBT population, and people experiencing poverty and homelessness.

UNIT IV also addresses population health nursing in specialized settings such as the school, work, correctional, and disaster settings. For example, Chapter 22 examines the role of the population health nurse in school settings, whereas Chapter 23 addresses employee health in the work setting. In each chapter in the unit, students are guided in the use of the nursing process and application of the PHN model in the special practice setting. Consideration is given to factors influencing determinants of health in each setting, and population health nursing interventions related to health promotion, illness and injury prevention, resolution of existing health problems, and health restoration are discussed.

UNIT V focuses on population health nursing practice related to the control of common population health problems such as communicable diseases, chronic physical and mental health conditions, substance abuse, and societal violence. Again, students are assisted to apply the nursing process and the PHN model to identify factors contributing to problems in each of these areas and in designing nursing interventions at each of the four levels of health care. Consideration is given to the care of individuals and families with these problems as well as to resolving common health problems at the population level.

How to use this book to foster success in POPULATION HEALTH advocacy

The various features in the sixth edition of *Population and Community Health Nursing* provide tools to help you succeed in the classroom and in practice. They offer opportunities to apply the principles presented in the book in real and virtual practice settings, promoting your ability to be an advocate for health at multiple levels.

Learning Outcomes

Learning outcomes at the beginning of each chapter help you to focus on the outcomes expected of you in relation to your knowledge and application of principles of population health nursing. They highlight the important content for each chapter and assist you in applying the PHN model to specific circumstances and settings.

Key Terms

The list of key terms at the beginning of each chapter alerts you to significant concepts to be addressed in the chapter, concepts with which an effective population health nurse needs to be familiar. At the point of definition within the chapter, each term is set in boldface type.

Healthy People 2020: Objectives for Population Health

These boxes present relevant objectives from *Healthy People 2020* to familiarize you with these important population health goals. You also learn about the current status of objectives here

and sources of further information on the objectives on the Nursing Portal for students at www.nursing.pearsonhighered.com.

Focused Assessments

These boxes present a series of questions that assist you in conducting health assessments focused on a particular client, specific population groups, or particular aspects of care. They are framed in the context of determinants of health included in the PHN model and help you to tailor your nursing assessment to the specific needs of the client population, setting, or health problem addressed in the chapter.

Global Perspectives

This feature presents an international view of population health nursing practice, examining issues that affect health throughout the world. The feature also addresses differences in population health nursing as practiced outside the United States and highlights global solutions to health problems facing mankind.

Evidence-Based Practice

These boxes discuss the evidence base (and sometimes the lack of evidence) that underlies specific aspects of population health nursing practice. They also pose questions that stimulate thinking about the development or critical review of the evidence base for practice.

Client Education

These boxes identify important content for educating clients and the public regarding particular health issues and topics, equipping you for successful clinical encounters as you begin your career.

Highlights

A feature intended to aid your review of content from the chapter; these bulleted summaries of main points or special foci appear periodically in the text.

Case Studies

Each chapter concludes with a case study designed to assist you to apply the principles addressed in the chapter to the real world of population health nursing practice. Many of the case studies foster application of the PHN model in clinical practice with individual, families, and/or population groups. Each case study is followed by questions designed to promote critical thinking in practice.

References

References contained in each chapter present an up-to-date picture of principles and concepts related to the topic presented. References provide a balanced view of population health nursing, exploring a variety of issues from several perspectives, and provide a wide range of supplemental materials, including research reports, for the interested reader.

Additional Student Resources

A variety of supplemental information and assessment tools are provided on the Nursing Portal for students at www.nursing.pearsonhighered.com. The site includes the following features:

- **Testing Your Understanding:** This feature assists you in evaluating your comprehension of concepts and principles presented in each chapter and assessing your achievement of the chapter learning outcomes. Questions are open-ended to facilitate thought and discussion.
- **Clinical Reasoning Questions:** Additional short answer questions are provided to assist readers in applying content from the chapters and to promote clinical reasoning. These questions maintain a balance between application of practice concepts to individuals/families and population groups.
- **Exam Review Questions:** Multiple-choice review questions are provided for each chapter to assist readers in evaluating their comprehension of chapter content.
- **Assessment Guidelines:** The Nursing Portal for students also contains a wide variety of assessment tools and guidelines to assess the health needs of individuals, families, and population groups in a variety of settings. Formerly included in a separate companion text, these tools and guidelines are made available to assist you with the practical aspects of assessing the health needs of various populations as well as individual clients and their families. Most of the guidelines are organized around the elements of the PHN model, making it even easier to apply the model to a variety of client populations, settings, and population health issues. Tools range from comprehensive assessment and intervention guides for care of specific population groups (e.g., children and adolescents, prisoners) or in specific settings (e.g., schools) to more specialized assessments (e.g., fall risk assessment in the elderly or client suitability for case management services). The tools and guidelines can be downloaded for immediate use in practice.
- **Cultural Considerations:** Relevant cultural considerations are provided for each chapter of the book to assist you in developing expertise in caring for a wide variety of culturally and ethnically diverse populations.
- **Further Information:** For some chapters, the Nursing Portal for students contains additional information related to chapter topics that may be of interest to readers. As noted earlier, additional information about other theoretical models for population health nursing is provided in this feature. Similarly, detailed cultural information tables are provided for a wide variety of cultural groups, including ethnic groups, healthcare professionals, and the dominant U.S. culture.
- **Resource Exchange:** This section of the Nursing Portal for students provides resources for further information on a variety of topics addressed in the book.

Instructor Resources

- **Test Bank:** An electronic test generator with questions for each chapter is available for instructors to download from the Instructor Resource Center via the Nursing Portal.
- **Instructor's Resource Manual:** This guide, available in the Instructor Resource Center, provides a wealth of helpful information for planning learning opportunities for students. Included are learning objectives that provide instructors with student goals for each chapter. Suggested classroom activities promote student participation in learning and help bring community health nursing practice to life.
- **Lecture Note PowerPoints**: PowerPoint slides for each chapter are available to instructors in the Instructor Resource Center to help convey key points to students in class and facilitate discussion.

Contents

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UNIT

1

Population Health Nursing: An Overview

Chapters

CHAPTER

1 Population Health and Nursing

Learning Outcomes

After reading this chapter, you should be able to:

1. Define population health and population health nursing.
2. Describe the *Healthy People 2020* national objectives for population health.
3. Describe advocacy as a critical function of population health nurses.
4. Summarize the standards for population health nursing practice.
5. Identify the eight domains of competency for population health nursing.
6. Describe the components of the population health nursing (PHN) model.
7. Describe a systematic process for implementing evidence-based population health nursing practice.

Key Terms

advocacy
aggregates
assessment
assurance
case finding
case manager
clinical practice guidelines
coalition building
collaboration
community
community mobilization
coordination
counseling
education
evidence-based practice
geopolitical community
health determinants
health promotion
liaison
neighborhood
policy advocate
policy development
population health
population health management
population health nursing
populations
prevention
primary prevention
referral
resolution
restoration
role model
secondary prevention
social capital
social marketing
surveillance
tertiary prevention

Advocacy Then

Florence Nightingale and Population Health

Florence Nightingale, considered the founder of modern nursing practice, was also a consummate advocate for population health. In her work in the Crimean War, she was a strong advocate for both the use of statistics to provide a population level of health and of environmental sanitation to improve the conditions of the ill and injured (Lewis, 2010). Ms. Nightingale used her influential media contacts with *The Times* of London to force the British government to support women's involvement in care of the sick and injured soldiers (Simkin, n.d.). Throughout her career, she continued to advocate for social conditions that promoted health and was influential in creating the system of district nursing that was the British version of public health nursing. She also was instrumental in workhouse reform in England (Workhouse, n.d.) and in the establishment of the Indian Sanitary Department to deal with environmental sanitation in India (Bloy, 2010). In a letter to a friend, Nightingale wrote of the need for nursing advocacy, stating "One's feelings waste themselves in words; they ought all to be distilled into actions . . . which bring results" (cited in Hallett, 2010, p. 50).

Advocacy Now

A Picture Is Worth a Thousand Words

Residents of a small community and staff members of local health and social service agencies in a small southern California community were involved in an assessment of community health status and health needs. One of the concerns voiced most often by community members were discriminatory practices by absentee landlords in which tenants, many of whom were newly arrived immigrants, were evicted if they complained about needed repairs and safety hazards. Because many of them had arrived in the United States from countries with repressive regimes, the residents were reluctant to present their concerns to the local housing authority. The local public health nurse, who was well respected in the community and knowledgeable about many housing code violations, took pictures of violations in the homes of many of her clients. Her pictures depicted stoves situated immediately next to walls without adequate ventilation, stairs in poor repair, stairs without handrails, and bars on windows that prevented escape in the event of fire. Armed with her pictures, the Community Collaborative held a town forum to which they invited members of the local housing authority. The pictures graphically reinforced the concerns voiced by community members at the meeting. As a result, the housing authority acted on a number of code violations, which encouraged community members to report other safety issues. In addition, the efforts of the Collaborative resulted in the creation of a city-funded position of housing ombudsman to assist residents in dealing with a variety of housing issues.

Emphasis on the health of populations as a focus for care arose out of growing evidence that individual-oriented health care has only limited effects on improving the health of the general public. A population health focus may occur at a variety of levels, and populations may encompass smaller or larger groups of people.

Defining Populations as a Focus for Care

Populations are groups of people, who may or may not interact with each other, but who have common health concerns and needs. According to the second edition of the American Nurses Association (ANA) *Public Health Nursing: Scope and*

Standards of Practice, a population, in the population health nursing context, refers to the residents of a specific geographic area, but the population health nurse's focus may include specific targeted groups of people with some trait or attribute in common (e.g., a minority group, employees, the elderly) or who "may be at risk for, experience, a disproportionate burden of poor health outcomes" (ANA, 2013, p. 3). Three other commonly used, similar, but different terms for these smaller subgroups are *neighborhood*, *community*, and *aggregate*.

A **neighborhood** is a smaller, frequently more homogeneous group than a community that involves an interface with others living nearby and some level of identification with those others. Neighborhoods are self-defined, and although they may be constrained by natural or man-made factors, they often do not have specifically demarcated boundaries. For example, a major highway may limit interactions between residents on either side, thus creating separate neighborhoods. Or a neighborhood may be defined by a common language or cultural heritage. Thus, non-Hispanic residents of a "Hispanic neighborhood" are not usually considered, nor do they consider themselves, part of the neighborhood.

A community may be composed of several neighborhoods. Some people define communities in terms of specific geographic locations or settings, but most definitions of community go beyond locale as a primary defining characteristic. In addition to location, other potential defining aspects of communities include a social system or social institutions designed to carry out specific functions; identity, commitment, or emotional connection; common norms and values; common history or interests; common symbols; social interaction; and intentional action to meet common needs. A community is described as an "interactional whole" different from the people who comprise it (ANA, 2013, p.65). For our purposes, then, a **community** is defined as a group of people who share common interests, who interact with each other, and who function collectively within a defined social structure to address common concerns. By this definition, geopolitical entities, such as the city of San Diego, a school of nursing, and a religious congregation can be considered communities. A **geopolitical community** is one characterized by geographic and jurisdictional boundaries, such as a city.

Aggregates are subpopulations within the larger population who possess some common characteristics, often related to high risk for specific health problems. School-aged children, persons with human immunodeficiency virus (HIV) infection, and the elderly are all examples of aggregates.

Population health nurses may work with any or all of these population groups—aggregates, neighborhoods, and communities—in their efforts to enhance the health status of the general public or overall population. Population health addresses the health needs of entire groups, and those health needs are affected by factors influencing individuals, families, neighborhoods and communities, as well as the society at large. Issel and Bekemeier (2010) used the *population-patient* to reflect this focus on providing care at the population level.

Defining Population Health

The health of a population goes beyond the health status of the individuals or subgroups that comprise it, but involves the collective health of the group. Several authors have noted the lack of a precise definition of population health, but note that definitions range from health outcomes affecting total populations defined by geography (e.g., a county or state) to "accountability for health outcomes in populations defined by health care delivery systems such as health plans or Accountable Care Organizations" (Stoto, 2013, p. 2). This latter perspective requires health care systems to address "upstream" factors such as health promotion and illness and injury prevention as well management of disease. Both of these perspectives embody a "population health perspective" characterized by conceptualization of the population as a unit separate from its members, incorporation of upstream factors in measures of population health, and the goal of reducing disparities within the population. Other characteristics of a population health perspective include consideration of a broad array of determinants or factors that influence health and recognition that responsibility for population health is shared by many segments of society that must work collaboratively to achieve health, because none of them can do so alone (Stoto, 2013).

Thirty years ago, the World Health Organization conceptualized population health as both a measure of the health status of a given population and "a resource for everyday life, not the object of living. Health is a positive concept, emphasizing social and personal resources as well as physical capacities." (World Health Organization, 1984, p. 1).

The Public Health Agency of Canada (2012) combined these perspectives to describe population health as "the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity, and coping skills, human biology, early childhood development, and health services" (para 2). The Institute of Medicine (IOM) adopted Kindig and Stoddart's (2003) definition of population health as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (p. 380) as the working definition of population health for its *Roundtable on Population Health Improvement* (IOM, 2013). The Institute also noted the distinction between population health as the health status of residents in a geopolitical area versus the clinical health outcomes of a subpopulation served by a given health care system. Notice was also given to Jacobsen and Teutsch's (2012) recommendation that the term "total population health" be used to denote the health status of people within a geopolitical jurisdiction, but the Institute anticipated further refinement of the definition of population health in the work of the Roundtable (2013). The outcome of that work is yet to be realized.

In the interim, for purposes of this book, **population health,** as an outcome of care, can be defined as the attainment of the greatest possible biologic, psychological, and social well-being of the total population as an entity and of its individual members. Population health can also be viewed as a capability or resource that allows members of the population to pursue goals, develop skills, and grow. A population health approach to care focuses on improving the health of the population and decreasing inequities in health status among subgroups within the population. Key elements of a population health approach include the following:

- A focus on the health of the overall population
- Attention to determinants of health and their interactions
- Decision making based on scientific evidence of health status, health determinants, and the effectiveness of interventions
- "Upstream" investment in strategies that maintain and promote health and address root causes of health and illness
- Application of multiple strategies
- Collaboration across sectors and levels of society
- Mechanisms for public participation in health improvement
- Demonstrated accountability for health outcomes (Public Health Agency of Canada, 2013)

Population Health Practice

In the United States, the terms "public health" and "population health" are often used interchangeably, but have the same focus on the health of the overall population. Elements of public or population health practice include core functions and essential services.

Core Public Health Functions

In 1988, the Institute of Medicine (IOM) released a report entitled "The Future of Public Health," which identified three core functions related to public or population health. These core functions of assessment, policy development, and assurance form the foundation for population health practice and population health nursing activities (ANA, 2013). These functions were reinforced in a 2002 revision of the report. The revised report also recommended adoption of a population health approach similar to that described above to address multiple determinants of health (IOM, 2002).

In their assessment function, public health agencies are expected to identify the health needs of the population. The National Public Health Performance Standards Program (n.d.) defined **assessment** as "the systematic collection and analysis of data in order to provide a basis for decision-making" (p. 3).

The **policy development** function of public health practice involves advocacy and political action to develop local, state, and national policies conducive to population health. Policy development has been described as the process of making informed decisions about issues related to the public's health (National Public Health Performance Standards Program, n.d.). The third core function, **assurance**, reflects the responsibility of the public health care system to see that needed services are available to the population through other entities, regulatory processes, or direct provision of care (National Public Health Performance Standards Program, n.d.).

Essential Public Health Services

In 1994, the core public health functions were operationalized in 10 essential public health services delineated by the Public Health Functions Steering Committee (American Public Health Association, 2014). These services and their relationship to the core functions are presented in Table 1-1●.

The statement of the essential functions of public health agencies led in 2001 to the development of core competencies for public health professionals performing these functions. Revised in 2010, the core competencies reflect eight domains of public health practice: analytic assessment skills, knowledge of basic public health sciences (e.g., epidemiology), cultural competence, communication skills, capacity for community-level practice, financial planning and management skills, leadership and systems thinking capabilities, and policy development and program planning skills (Council on Linkages Between Academia and Public Health Practice, 2010). Based on feedback

TABLE 1-1 Core Public Health Functions and Related Essential Services

Core Function	Essential Services
Assessment	• Monitor health status to identify health problems • Diagnose and investigate health problems and hazards in the community • Evaluate the effectiveness, accessibility, and quality of personal and population-based health services
Policy Development	• Develop policies and plans that support individual and community health efforts • Enforce laws and regulations that protect health and ensure safety • Inform, educate, and empower people with respect to health issues
Assurance	• Link people to needed personal health services and assure the provision of health care when otherwise unavailable • Assure a competent public and personal health care workforce • Inform, educate, and empower people about health issues • Mobilize community partnerships to identify and solve health problems • Conduct research into innovative solutions for health problems

from the community of public professionals, the competencies are currently undergoing another revision. The revised competencies will continue to include the same eight domains and three tiers of practice (entry level practice, program management/supervisory practice, and senior management/executive level practice). The revised competencies are expected to be completed by June 2014 (Public Health Foundation, n.d., 2014a, 2014b). The development of these general competencies led, in turn, to the development of specific competencies for population health nursing practice, which are discussed later in this chapter.

Objectives for Population Health

The goals and desired outcomes for population health in the United States have been operationalized in several sets of national objectives. The *Healthy People* initiative began in 1979 with the publication of the *Healthy People: Surgeon General's Report on Health Promotion and Disease Prevention* (Office of Disease Prevention and Health Promotion [ODPHP], n.d.a). A subsequent set of more detailed national objectives was established in 1980 in the publication *Promoting Health/Preventing Disease: Objectives for the Nation* (U.S. Department of Health and Human Services [USDHHS], 1980). Later sets of objectives were published in 1990 and 2000. See the materials provided on the student resources site for a discussion of the changes in the objectives over time.

In 2007, work commenced on a two-phase process for developing the *Healthy People 2020* objectives. Phase I involved the development of the framework and format to be used in the revision and culminated in a report from the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020 in October of 2008 (Advisory Committee, 2008). The committee recommended an interactive, searchable, web-based format for the document rather than the prior print format. The framework consists of a vision, mission statement, overarching goals, four foundation health measures, and a graphic model. The vision is one of a "society in which all people live long, healthy lives" (ODPHP, n.d.b), and the mission statement is as follows:

Healthy People 2020 strives to:

- Identify nationwide health improvement priorities
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress
- Provide measurable objectives and goals that are applicable at the national, state, and local levels
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge
- Identify critical research, evaluation, and data collection needs (ODPHP, n.d.b)

The primary emphasis for *Healthy People 2020* is on achieving health equity and eliminating disparities among segments of the population by addressing the determinants that influence health. Actual delivery of health care services is a secondary emphasis (ODPHP, n.d.a; USDHHS, n.d.). **Health determinants** as defined in *Healthy People 2020* are "the range of personal, social, economic, and environmental factors that influence health status" (USDHHS, 2012a, para 3). Determinants of health addressed by *Healthy People 2020* include policy making, social factors, health services, individual behavior, and biology and genetics (USDHHS, 2012a).

The overarching goals for the *Healthy People 2020* are to:

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages (ODPHP, n.d.b).

The final element of the framework was the development of a graphic model for *Healthy People 2020*. The model is depicted in Figure 1-1●. Within the model, actions, consisting of policies, programs, and interventions, influence determinants of health to achieve the overarching goals. The feedback cycle indicated by the two-way arrow in the model relies on assessment, monitoring, evaluation, and dissemination of best practices to inform action (ODPHP, n.d.b).

Healthy People 2020, released in December 2010, incorporates nearly 600 objectives across the 42 topical areas depicted in Table 1-2●. Objectives were developed by experts from lead federal agencies and then reviewed for comment by multiple constituencies including the Federal Interagency Workgroup as well as the general and professional population. Some objectives focus on specific health conditions, whereas others address broader issues such as health disparities, access to care, dissemination of health-related information, strengthening of public health services, and addressing social determinants of health (USDHHS, n.d.). Figure 1-2● depicts the stakeholders who influenced the development of the 2020 objectives.

Generally, objectives are of two kinds: measurable and developmental. Measurable objectives include the current national baseline status of a health issue derived from existing reliable data sources, as well as the target for achievement by 2020. Developmental objectives do not have available baseline data and are targeted for the development of national data collection systems and processes. Objectives for some of the topical areas are still in development, but each topical area will include an overview of the topic, a list of related objectives to be achieved by 2020, and information on interventions and resources. The interventions and resources information will include clinical recommendations for evidence-based interventions and links to relevant consumer health information (USDHHS, n.d.).

Monitoring progress toward achieving the objectives will be the primary responsibility of a designated lead federal

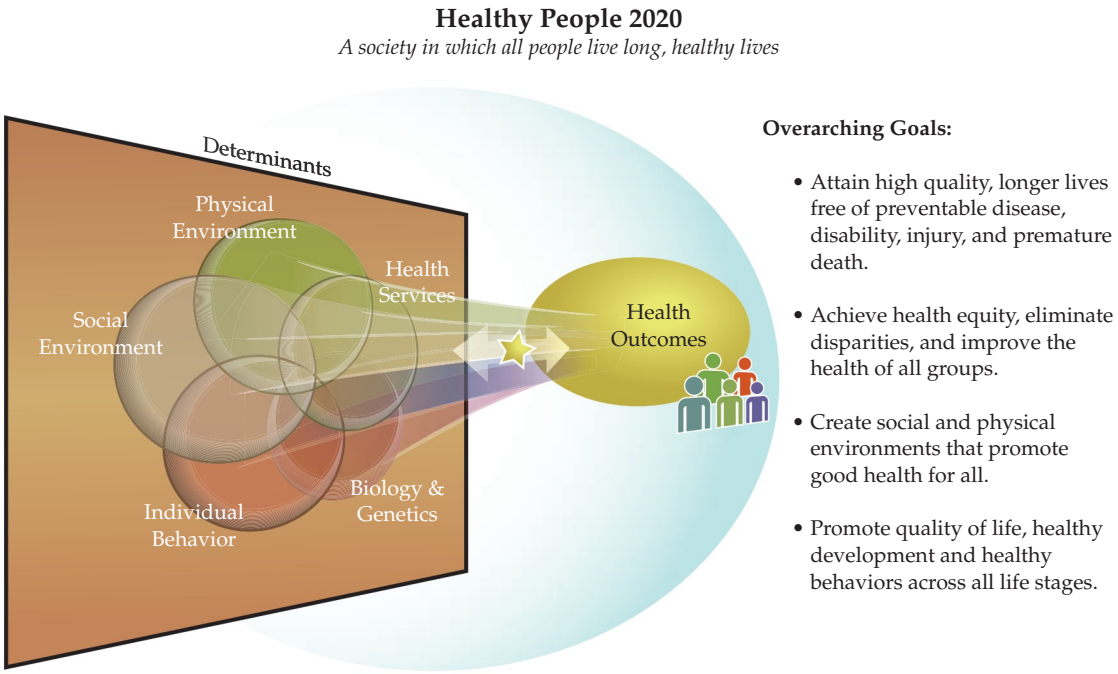

FIGURE 1-1 Model for *Healthy People 2020*

Source: Office of Disease Prevention and Health Promotion. (n.d.a). *Healthy People 2020: A resource for promoting health and preventing disease throughout the nation.* Retrieved from http://www.healthypeople.gov/2020/consortium/HealthyPeoplePresentation_2_24_11.ppt

agency for each topical area. Overall progress will be assessed in terms of four foundation health measures: general health status, health-related quality of life and well-being, determinants of health, and disparities. Specific measures included within each of the general measures are summarized in Table 1-3●. In addition, a revised set of leading health indicators, first established for *Healthy People 2010*, have been established as a focus for assessing goal attainment (USDHHS, 2012b, 2012c). The health indicators consist of 26 objectives addressing 12 topical areas that have been selected as high-priority health issues. The 26 indicator objectives are included in Table 1-4●.

You can access data related to the health indicators through the Healthy People 2020 website. For further information

TABLE 1-2 *Healthy People 2020* Topical Areas

• Access to health services	• Global health*	• Medical product safety
• Adolescent health*	• Health communication and health information technology*	• Mental health and mental disorders
• Arthritis, osteoporosis, and chronic back conditions	• Health care–associated infections*	• Nutrition and weight status
• Blood disorders and blood safety*	• Health-related quality of life and well-being*	• Occupational safety and health
• Cancer	• Hearing and other sensory or communication disorders	• Older adults*
• Chronic kidney disease	• Heart disease and stroke	• Oral health
• Dementias, including Alzheimer's disease*	• HIV	• Physical activity
• Diabetes	• Immunization and infectious diseases	• Preparedness*
• Disability and health	• Injury and violence prevention	• Public health infrastructure
• Early and middle childhood*	• Lesbian, gay, bisexual, and transgender health	• Respiratory diseases
• Educational and community-based programs	• Maternal, infant, and child health	• Sexually transmitted diseases
• Environmental health		• Sleep health*
• Family planning		• Social determinants of health*
• Food safety		• Substance abuse
• Genomics*		• Tobacco use
		• Vision

* Indicates new focus area for 2020, not included in prior sets of objectives.

Based on: U.S. Department of Health and Human Services. (2014). *About Healthy People.* Retrieved from http://www.healthypeople.gov/2020/about/default.aspx

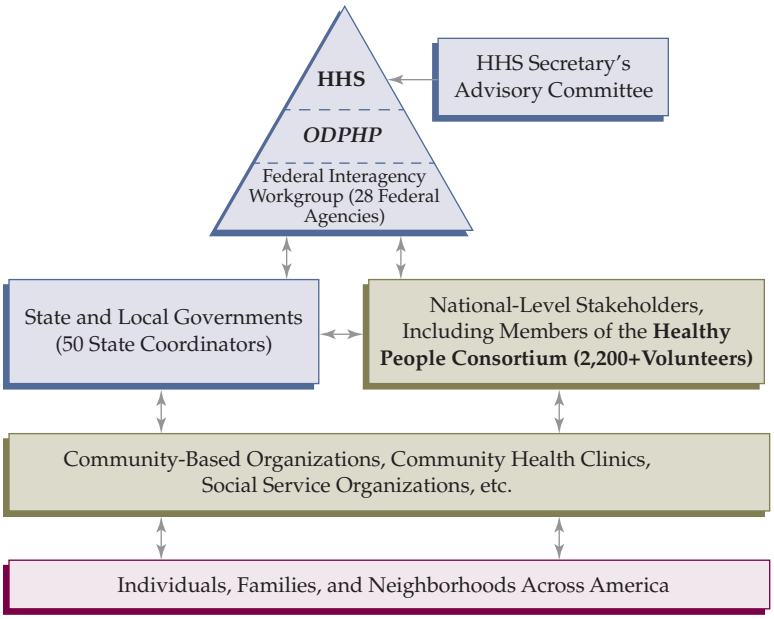

FIGURE 1-2 Stakeholders in the *Healthy People 2020* Development Process

Source: Office of Disease Prevention and Health Promotion. (n.d.a). *Healthy People 2020: A resource for promoting health and preventing disease throughout the nation.* Retrieved from http://www.healthypeople.gov/2020/consortium/HealthyPeoplePresentation_2_24_11.ppt

about the *Healthy People 2020* objectives, see the *External Resources* section of the student resources site.

Population health care is designed to improve the overall health status of the public through modification of factors that influence health either positively or negatively. National health objectives, as exemplified in *Healthy People 2020* and its precursors, guide the design of care delivery systems and serve as a means for evaluating the effectiveness of population health care.

TABLE 1-3 Foundation Health Measures for *Healthy People 2020* and Related Specific Measures

Foundation Measure	Specific Measures
General health status	• Life expectancy • Healthy life expectancy • Years of potential life lost • Physically and mentally unhealthy days • Self-assessed health status • Limitation of activity • Chronic disease prevalence
Health-related quality of life and well-being	• Physical, mental, and social health-related quality of life • Well-being/satisfaction • Participation in common activities
Determinants of health	• A range of personal, social, and environmental factors including biology, genetics, individual behavior, access to health services, and environment
Disparities	Differences in health status based on: • Race/ethnicity • Gender • Physical and mental ability • Geography

Based on: U.S. Department of Health and Human Services. (2014). *About Healthy People.* Retrieved from http://www.healthypeople.gov/2020/about/default.aspx

TABLE 1-4 Leading Health Indicators for *Healthy People 2020*

Topical Area	Leading Health Indicator Objectives	Target
Access to health services	**AHS 1.1** Increase the proportion of persons with medical insurance.	100%
	AHS 3 Increase the proportion of persons with a usual primary care provider.	83.9%
Clinical preventive services	**C-16** Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines.	70.5%
	HDS-12 Increase the proportion of adults with hypertension whose blood pressure is under control.	61.2%
	D-5.1 Reduce the proportion of the diabetic population with an A1c value greater than 9%.	14.6%
	IID-8 Increase the proportion of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines.	80%
Environmental quality	**EH-1** Reduce the number of days the Air Quality Index (AQI) exceeds 100.	10 days
	TU-11.1 Reduce tobacco use by adults.	12%
Injury and violence	**IVP-1.1** Reduce fatal injuries.	53.3/100,000 pop
	IVP-29 Reduce homicides.	5.5/100,000 pop
Maternal, infant, and child health	**MICH-1.3** Reduce infant deaths (within 1 year).	6/1,000 live births
	MICH-9.1 Reduce preterm births.	11.4%
Mental health	**MHMD-1** Reduce the suicide rate.	10.2/100,000
	MHMD-4.1 Reduce the proportion of adolescents who experience major depressive episodes.	7.4%
Nutrition, physical activity, and obesity	**PA-2.4** Increase the proportion of adults who meet the objectives for aerobic physical activity and for muscle-strengthening activity.	20.1%
	NWS-9 Reduce the proportion of adults who are obese.	30.6%
	NWS-10.4 Reduce the proportion of children and adolescents aged 2 to 19 years who are obese.	14.6%
	NWS-15.1 Increase the contribution of total vegetables to the diets of the population aged 2 years and older.	1.1 cup equivalents per 1,000 calories
Oral health	**OH-7** Increase the proportion of children, adolescents, and adults who used the oral health care system in the past 12 months.	49%
Reproductive and sexual health	**FP-7.1** Increase the proportion of sexually active females aged 15 to 44 years who received reproductive health services in the past 12 months.	86.7%
	HIV-13 Increase the proportion of persons living with HIV who know their serostatus.	90%
Social determinants	**AH-5.1** Increase the proportion of students who graduate with a regular diploma 4 years after starting 9th grade.	82.4%
Substance abuse	**SA-13.1** Reduce the proportion of adolescents reporting use of alcohol or any illicit drugs during the past 30 days.	16.5%
	SA-14.3 Reduce the proportion of persons engaging in binge drinking during the past 30 days—Adults aged 18 years and older.	24.3%
Tobacco	**TU-1.1** Reduce cigarette smoking by adults.	12%
	TU-2.2 Reduce cigarette smoking by adolescents.	16%

Based on: U.S. Department of Health and Human Services. (2013). *2020 LHI topics.* Retrieved from http://www.healthypeople.gov/2020/LHI/2020indicators.aspx