Unit One

Foundations for Health Promotion

1. Health Defined: Objectives for Promotion and Prevention
2. Emerging Populations and Health
3. Health Policy and the Delivery System
4. The Therapeutic Relationship
5. Ethical Issues Relevant to Health Promotion
Chapter 1

Health Defined: Objectives for Promotion and Prevention

objectives

After completing this chapter, the reader will be able to:

- Analyze concepts and models of health as it has been used historically and as they are used in this textbook.
- Evaluate the consistency of Healthy People 2010 goals with various concepts of health.
- Analyze the progress made in this nation from the original Healthy People document to the foci in Healthy People 2010 and the developing Healthy People 2020.
- Differentiate between health, illness, disease, disability, and premature death.
- Compare the three levels of prevention (primary, secondary, and tertiary) with the levels of service provision available across the lifespan.
- Critique the role of research and the nurse’s role in the research process for the promotion of health for individuals and populations.

key terms

Adaptive model of health  Eudaimonistic  Qualitative studies
Applied research  Eudaimonistic model of health  Quality of life
Asset planning  Evidence-based practice  Quantitative studies
Clinical model of health  Functional health  Racism
Community-based care  Health  Role performance model of health
Cultural competence  Health disparities  Well-being
Disease  Health promotion  Wellness
Ecological model of health  Healthy People 2010  Wellness-illness continuum
Empathy  High-level wellness
Epidemiology  Illness
Ethnocentrism  Levels of prevention

website materials

These materials are located on the book’s website at http://evolve.elsevier.com/Edelman/.

- WebLinks
- Study Questions
- Glossary
- Website Resources
  1A: Twenty-One Competencies for the Twenty-First Century
Use of Complementary and Alternative Therapies

One of the biggest challenges to health care providers is the blending of Western medicine and health practices with the health practices from other cultures and ethnic groups. The federal government formed the National Center for Complementary and Alternative Medicine (NCCAM) [http://nccam.nih.gov/] to conduct and support basic and applied research and training and to disseminate information on complementary and alternative medicine to practitioners and the public. As demographics of the United States shift, more people use a combination of therapies in self-care and for the treatment of specific illnesses.

1. What questions should the student ask to obtain information from people about their use of nontraditional therapies?

Health is a core concept in society. This concept is modified with qualifiers such as excellent, good, fair, or poor, based on a variety of factors. These factors may include age, gender, race or ethnic heritage, comparison group, current health or physical condition, past conditions, social or economic situation, or the demands of various roles in society. In addition, there is growing recognition that larger societal and environmental concerns determine health outcomes. This chapter will discuss health as a concept and related concepts such as wellness, illness, disease, disability, and functioning. These concepts are frequently embedded in theories, such as theories of health behavior (Pender et al., 2006) or health planning (Issel, 2004). Some motivating factors behind the move to disease prevention and health promotion in society will be examined with an introduction to Healthy People 2010, the federal government’s health objectives for the nation. The implementation of these concepts as nursing actions will also be addressed from ideal and pragmatic standpoints. Research supporting these concepts and recommendations for further research will be presented.

Nurses understand the pivotal role they play in promoting health and preventing disease, the important role of research in the knowledge of what is “healthy”, and the central role of epidemiology (the study of health and disease in society) and public health theories in the everyday practice of nursing.

EXPLORING CONCEPTS OF HEALTH

Newman (2003) states that definitions of health in the nursing literature can be classified broadly within two major paradigms. The first paradigm is the wellness-illness continuum, a dichotomized portrayal of health and illness ranging from high-level wellness at the positive end to depletion of health at the negative end. High-level wellness is further conceptualized as a sense of well-being, life satisfaction, and quality of life. Movement toward the negative end of the continuum includes adaptation to disease and disability through various levels of functional ability.

The wellness-illness conceptualization was the focus of early research and is consistent with some of the categories Smith (1983) identified in her philosophical analysis of health. Research based on this paradigm conforms primarily to scientific methods that seek to control contextual effects, provide the basis for causal explanations, and predict future outcomes.

The second paradigm characterizes health as a perspective developmental phenomenon of unitary patterning of the person-environment. The developmental perspective of health has been present in the nursing literature since 1970, but it was not identified clearly with health until the late 1970s and early 1980s. It has been conceptualized as expanding consciousness, pattern or meaning recognition, personal transformation, and, tentatively, self-actualization. This shift toward a developmental perspective has had clear implications for the way in which health is conceptualized (Newman, 2003). Although not endorsing the developmental perspective to the extent of Rogers (1970) and Reed (1983), Pender et al. (2006), Allen & Warner (2002), and Gryzwacz & Fuqua (2000) state that health is an outcome of ongoing patterns of person and environment interaction throughout the lifespan. Research within this paradigm seeks to address the dynamic whole of the health experience through behavioral and social mechanisms over time. Health can be better understood if each person is seen as a part of a complex, interconnected, biological, and social system. A more recent and comprehensive developmental approach is the ecological model of health (IOM, 2003), which is useful for promoting health at individual, family, community, and societal levels. In this way, the ecological model of health is more compatible with Smith’s descriptions of health as adaptation and eudemonia (self-actualization). Each of these ideas will be examined in more detail throughout this chapter.

People involved in health promotion should consider the meaning of health for themselves and for others. Recognizing differences in the meaning of health can clarify outcomes.
and expectations in health promotion and enhance the quality of health care. Because health is used to describe a number of entities, including a philosophy of care (health promotion and health maintenance), a system (health care delivery system), practices (evidence-based health practices), behaviors (personal health behaviors), costs (health care costs), and insurance (uninsured health care), the reason that confusion continues regarding the use of the term “health” becomes clear. People's use of the term “health”, and its incorporation into these various entities, has also changed over time.

Americans born before 1940 have experienced the greatest changes in how health is defined. Because infectious diseases claimed the lives of many children and young adults at that time, health was viewed as the absence of disease. The physician in independent practice was the primary provider of health care services, with services provided in the private office. The federal government was just establishing its role in working with states to address public health and welfare issues (Barr et al., 2003).

As the national economy expanded during and after World War II in the 1940s and 1950s, the idea of role performance became a focus in industrial research and entered the health care lexicon. Health became linked to a person's ability to fulfill a role in society. Increasingly, the physician was asked to complete physical examination forms for school, work, military, and insurance purposes as physician practice became linked more directly to hospital-based services. The federal government expanded its role through funding for hospital expansion and establishment of a new Department of Health, Education, and Welfare (DHEW), currently the Department of Health and Human Services (DHHS) (Barr et al., 2003). It was recognized that a person might recover from a disease yet be unable to fulfill family or work roles because of residual changes from the illness episode. The work or school environment was viewed as a possible contributor to health or illness.

From the 1960s to the present, there have been incredible changes in the health care delivery system as federal and state governments have attempted to control spending and health care costs have escalated (Barr et al., 2003). Primary care providers, including nurse practitioners and other advanced practice nurses, now attempt to involve individuals and their families in the delivery of care, and teaching individuals about individual responsibilities and lifestyle choices has become an important part of their job. Health care has become an interdisciplinary endeavor even as managed care companies limit the health promotion options available under insurance plans. During this time, the idea of adaptation had an important influence on the way Americans view health. Increasingly, health became linked to individuals’ reactions to the environment rather than being viewed as a fixed state. Adaptation fit well with the self-help movement during the 1970s and with the progressive growth in knowledge from research about disease prevention and health promotion at the individual level.

More recently, emphasis is being placed on the quality of a person's life as a component of health (USDHHS, 2000). Research on self-rated health (Cano et al., 2003; Idler & Benyamini, 1997) and self-rated function (Greiner et al., 1999) indicates that there are multiple factors contributing to a person's perception of his or her health, sometimes referred to as functional health or health-related quality of life (Andresen et al., 2003; Gordon, 2006).

Models of Health
Throughout history, society has entertained a variety of concepts of health (David, 2000). Smith (1983) describes four distinct models of health in her classic work:

Clinical Model
In the clinical model health is defined by the absence, and illness by the conspicuous presence, of signs and symptoms of disease. People who use this model may not seek preventive health services or they may wait until they are very ill to seek care. The clinical model is the conventional model of the discipline of medicine.

Role Performance Model
The role performance model of health defines health in terms of individuals' ability to perform social roles. Role performance includes work, family, and social roles, with performance based on societal expectations. Illness would be the failure to perform roles at the level of others in society. This model is the basis for occupational health evaluations, school physical examinations, and physician-excused absences. The idea of the “sick role,” which excuses people from performing their social functions, is a vital component of the role performance model. It is argued that the sick role is still relevant in health care today (Shilling, 2002).

Adaptive Model
In the adaptive model of health, people's ability to adjust positively to social, mental, and physiological change is the measure of their health. Illness occurs when the person fails to adapt or becomes maladaptive to these changes. As the concept of adaptation has entered other aspects of American culture, this model of health has become more accepted. For example, spirituality can be useful in adapting to a decreased level of functioning in older adults (Haley et al., 2001).

Eudaimonistic Model
In the eudaimonistic model exuberant well-being indicates optimal health. This model emphasizes the interactions between physical, social, psychological, and spiritual aspects of life and the environment that contribute to goal attainment and create meaning. Illness is reflected by a derangement or languishing, a lack of involvement with life. Although these ideas may appear to be new when compared
with the clinical model of health, aspects of the eudaimonistic model predate the clinical model of health. This model is also more congruent with integrative modes of therapy (NIH/NCCAM, 2007), which are used increasingly by people of all ages in the United States and the world. In this eudaimonistic model, a person dying of cancer may still be healthy if she is finding meaning in her life at this stage of development.

These ideas of health provide a basis for how people view health and disease and how they view the role of nurses, physicians, and other health care providers. For example, in the clinical model of health, a person may expect to see a health care provider only when there are obvious signs of illness. Personal responsibility for health may not be a motivating factor for this individual because the provider is responsible for dealing with the health problem and returning the person to health. Therefore attempts to teach health-promoting activities may not be effective with this person. On the other hand, those who adopt a eudaimonistic model of health may find that practitioners working under a clinical model do not address their more comprehensive health needs. They may instead seek out a practitioner of alternative medicine or the council of a priest, rabbi, or minister to complement the services of the more traditional health provider.

**Wellness-Illness Continuum**

The wellness-illness continuum, as stated earlier, is a dichotomous depiction of the relationship between the concepts of health and illness. In this paradigm, wellness is a positive state in which incremental increases in health can be made beyond the midpoint (Figure 1-1). These increases involve improved physical and mental health states. The opposite end of the continuum is illness, with the possibility of incremental decreases in health beyond the midpoint. This depiction of the relationship of wellness and illness fits well with the clinical model of health.

**High-Level Wellness**

From a dichotomous representation of health and illness as opposites, Dunn (1961) developed a health-illness continuum that assessed a person not only in terms of his or her relative health compared with that of others but also in terms of the favorability of the person's environment for health and wellness (see Figure 1-1). Adding this second dimension to the health-illness continuum created a matrix in which a favorable environment allows high-level wellness to occur and an unfavorable environment allows low-level wellness to exist.

With this addition, it became possible to combine the clinical model of health with models based on social and environmental parameters. The concept demonstrates that a person can have a terminal disease and be emotionally prepared for death, while acting as a support for other people and achieving high-level wellness. High-level wellness involves progression toward a higher level of functioning, an open-ended and ever-expanding future with its challenge of fuller potential and the integration of the whole being (Ardell, 2007). This definition of high-level wellness contains ideas similar to those in the eudaimonistic model of health. Additionally, high-level wellness emphasizes the interrelationship between the environment and the ability to achieve health on both a personal and a societal level.

**Health Ecology**

An evolving view of health recognizes the interconnection between people and their physical and social environments. Newman (2003) expressed this interconnection within a developmental framework, and the work of Gordon (2006) applies this interconnection to functional health patterns as presented in subsequent chapters. Health from an ecological perspective is multidimensional, extending from the individual into the surrounding community, and including the context within which the person functions. It incorporates a systems approach within which the actions of one portion of the system affect the functioning of the system as a whole (IOM, 2003). This view of health expands on high-level wellness by recognizing that there are social and environmental factors that can enhance or limit health and healthy behaviors. For example, most people can benefit from physical activity such as walking, and people are more likely to walk in areas where there are sidewalks or walking paths and where they feel safe. Nurses can encourage people to walk, but may also need to advocate for safe areas for people to walk and work with others to plan for people-friendly community development.
FUNCTIONING

One of the defining characteristics of life is the ability to function. Functional health can be characterized as being present or absent, high level or low level, and influenced by neighborhood and society. Functioning is integral to health. There are physical, mental, and social levels of function, and these are reflected in terms of performance and social expectations. Function can also be viewed from an ecological perspective, as in the example of walking used previously. Loss of function may be a sign or symptom of a disease. For example, sudden loss of the ability to move an arm or leg may indicate a stroke. The inability to leave the house may indicate overwhelming fear. In both cases, the loss of function is a sign of disease, a state of ill health. Loss of function is a good indicator that the person may need nursing intervention. Research in older adults indicates that decline in physical function may predict future loss of physical function and death (Greiner et al., 1996).

HEALTH

Health, as defined in this text, is a state of physical, mental, spiritual, and social functioning that realizes a person’s potential and is experienced within a developmental context. While health is, in part, an individual’s responsibility, health also requires collective action to ensure a society and an environment in which people can act responsibly to support health. The culture and beliefs of people can also influence health action. This definition is consistent with the World Health Organization (WHO) definition of health as the state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity (2004), but moves beyond this definition to encompass spiritual, developmental, and environmental aspects over time. This broader definition is applicable across the lifespan, as well as in situations where illness may be a chronic state. For example, in this broader definition of health, a person with diabetes may be considered healthy if she is able to adapt to her illness and live a meaningful, spiritually satisfying life.

ILLNESS, DISEASE, AND HEALTH

It is easy to think of health or wellness as the lack of disease and to consider illness and disease as interchangeable terms. However, health and disease are not simply antonyms and disease and illness are not synonyms. Disease literally means “without ease.” Disease may be defined as the failure of a person’s adaptive mechanisms to counteract stimuli and stresses adequately, resulting in functional or structural disturbances. This definition is an ecological concept of disease, which uses multiple factors to determine the cause of disease rather than describing a single cause. This multifactorial approach increases the chances of discovering multiple points of intervention to improve health.

Illness is made up of the subjective experience of the individual and the physical manifestation of disease (Hollingsworth & Didelot, 2005). Both are social con- structs in which people are in an imbalanced, unsustainable relationship with their environment and are failing in their ability to survive and create a higher quality of life. Illness can be described as a response characterized by a mismatch between a person’s needs and the resources available to meet those needs. Additionally, illness signals to individuals and populations that the present balance is not working. Within this definition, illness has social, psychological, spiritual, and social components. A person can have a disease without feeling ill (e.g., asymptomatic hypertension). A person can also feel ill without having a diagnosable disease (stress). Our understanding of disease and illness within society, overlaid with our understanding of the natural history of each disease, creates a basis for promoting health.

PLANNING FOR HEALTH

Public health has always had the prevention of disease in society as its focus. However, over the past 30 years, the promotion of health has moved to the forefront within public health and has become a driving force in health care.

A key milestone in promoting health was the advent of Healthy People (U.S. Department of Health, Education, and Welfare [USDHEW], Public Health Service, 1979), the first Surgeon General’s report on health promotion and disease prevention issued in the later years of President Carter’s administration. This document identified five national health goals addressing the reduction of death in adults and children and the reduction of sick days in older adults.

1. To continue to improve infant health, and, by 1990, to reduce infant mortality by at least 35 percent, to fewer than 9 deaths per 1000 live births
2. To improve child health, foster optimal childhood development, and, by 1990, reduce deaths among children ages 1 to 14 years by at least 20 percent, to fewer than 34 per 100,000
3. To improve the health and health habits of adolescents and young adults, and, by 1990, to reduce deaths among people ages 15 to 24 by at least 20 percent, to fewer than 93 per 100,000
4. To improve the health of adults, and, by 1990, to reduce deaths among people ages 25 to 64 by at least 25 percent, to fewer than 400 per 100,000
5. To improve the health and quality of life for older adults, and, by 1990, to reduce the average annual number of days of restricted activity due to acute and chronic conditions by 20 percent, to fewer than 30 days per year for people 65 and older

Further, the document identified three causes of the major health issues in the United States as careless habits, pollution of the environment, and permitting harmful social conditions (e.g., hunger, poverty, and ignorance) to persist that destroy health, especially for infants and children. Healthy People was a call to action and an attempt to set health goals for the United States for the next 10 years by issuing 226 health objectives. Unfortunately, a change in
political leadership, a lack of political and social willpower, and the spiraling costs of hospital-based health care caused this document to be placed on the back burner for seven years. The need to report on progress toward the national objectives led to a larger, renewed effort in the form of The 1990 Health Objectives for the Nation: A Midcourse Review (USDHHS, Public Health Service, 1986). This midcourse review noted that, although many goals were achievable, the unachieved goals were hindered by current health status, limited progress on risk reduction, difficulties in data collection, and a lack of public awareness.

**Healthy People 2000 (USDHHS, Public Health Service, 1990)** and its Midcourse Review and 1995 Revisions (USDHHS, Public Health Service, 1996) were landmark documents in that a consortium of people representing national organizations worked with U.S. Public Health Service officials to create a more global approach to health. Additionally, a management-by-objectives approach was used to address each problem area. These two documents became the blueprints for federal programs and the data flowed back into the system to form the revisions set in 1995. The core of these health objectives remained: that is, prevention of illness and disease was the foundation for health. *Healthy People 2000* set out three broad goals:

1. Increase the **span of healthy life**.
2. Reduce **health disparities**.
3. Create easy to read ventilation routes.

Additionally, the work included 22 specific areas for achievement, with objectives in each area based on age, health disparities, and health needs. By 1995, progress was made on 70% of these objectives. However, on 30% of the objectives, movement on goals was either in the wrong direction, had experienced no change, or could not be determined because the data were insufficient.

**Healthy People 2010**

*Healthy People 2010* (USDHHS, Public Health Service, 2000), the latest of the *Healthy People* documents, sets out 2 overarching goals, with 28 specific areas for health improvement and 467 objectives.

**Healthy People 2010 Goals**

The two main goals of *Healthy People 2010* are to:

1. Increase the **span of healthy life**.
2. Eliminate health disparities.

Each goal is important. The first goal addresses the issues of longevity and quality of life. Increasing the years of healthy life addresses the concern that people are living longer, but frequently with numerous chronic health problems that interfere with the quality of their lives. However, quality of life is also an issue for people who are unable to achieve a long life. Combining these two ideas places an emphasis on both longevity and quality of life as areas that need improvement. The second goal, eliminating health disparities, addresses the continuing problems of access to care; differences in treatment based on race, gender, ability to pay; and related issues such as urban versus rural health, insurance coverage, Medicare and Medicaid reimbursement for care, and satisfaction with service delivery.

Together, these two goals set out the territory in which health promotion and disease prevention efforts take place. Research in a variety of areas has clearly indicated that health disparities are directly and indirectly linked to longevity and quality of life issues. For example, it is known that Black men and women live fewer years than do White men and women. Recent research from the Agency for Health Care Research and Quality demonstrates that Black men and women are also provided with less invasive and less expensive interventions for cardiac disease than are White men and women (Canto et al., 2000). By choosing not to offer reperfusion therapy to one racial group when it is warranted and to offer the same therapy to another group, it contributes to the racial disparity in health and health care in this country and to the increased mortality of Blacks as compared with Whites (see Multicultural Awareness box).

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### Selected National Health Promotion and Disease Prevention Objectives for Nutrition and Overweight

1. **19-1. Increase the proportion of adults who are at a healthy weight.**
2. **19-2. Reduce the proportion of adults who are obese.**
3. **19-3. Reduce the proportion of children and adolescents who are overweight or obese.**
4. **19-4. Increase the proportion of persons aged 2 years and older who consume at least two daily servings of fruit.**
5. **19-5. Increase the proportion of persons aged 2 years and older who consume at least three daily servings of vegetables, with at least one third being dark green or deep yellow vegetables.**
6. **19-6. Increase the proportion of persons aged 2 years and older who consume at least three daily servings of grain products, with at least three being whole grains.**
7. **19-7. Increase the proportion of persons aged 2 years and older who consume less than 10 percent of calories from saturated fat.**
8. **19-8. Increase the proportion of persons aged 2 years and older who consume less than 10 percent of calories from saturated fat.**
9. **19-9. Increase the proportion of persons aged 2 years and older who consume no more than 30 percent of calories from fat.**
10. **19-10. Increase the proportion of persons aged 2 years and older who consume 2400 mg or less of sodium daily.**

The Healthy People 2010 focus areas and objectives are the road map for this territory and a guide for health care research, practice, education, policy, and communications. They should allow the health care community to measure progress on the broader goals.

The detailed objectives can be found on the Internet at www.healthypeople.gov. The 28 specific focus areas are listed alphabetically in Box 1-1. A quick look through these focus areas indicates of the scope of the Healthy People 2010 areas compared with earlier Healthy People documents. These focus areas span age categories from conception to death and incorporate prevention, access, treatment, and follow-up at the individual, family, provider, work site, and community levels. Healthy People 2010 is centered on 10 leading health indicators that “reflect the major public health concerns in the United States and were chosen based on their ability to motivate action, the availability of data to measure their progress, and their relevance as broad public health issues” (USDHHS, Public Health Service, 2000, p. 11) (Box 1-2). One example is used here for illustration of the scope of this project.

Objective 22-2. Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day. This objective directly addresses the first two leading health indicators: physical activity and weight (obesity). Arguably, other indicators such as tobacco and substance abuse and mental health are indirectly related to this objective. A person who smokes or uses drugs regularly is limited in the ability to meet this objective. Nevertheless, physical activity can contribute to positive mental health through stress reduction and physical fitness. Access to health care to obtain a complete physical examination before starting to exercise and the quality of the work or neighborhood environment available for exercise can contribute to success or failure of this objective. This objective is related to other objectives such as nutrition and control of high blood pressure.

Additionally, current knowledge about physical activity and specific populations was considered when creating the Healthy People 2010 objectives. Women, low-income populations, Black and Hispanic peoples, people with disabilities, and those over the age of 75 exercise less than do White men with moderate-to-high incomes. These health disparities can influence the number of people in these groups who develop high cholesterol or high blood pressure, which further increases their risk of heart disease and stroke. Although this objective addresses adults, other objectives address the need for beginning exercise activities at an early age and encouraging young adults to be actively engaged in exercise. How might this objective be adjusted to the needs of an older adult population?
Another important feature of *Healthy People 2010* is its emphasis on responsibility. Individuals need to accept responsibility for their lifestyle choices and behaviors. This emphasis on personal responsibility gives each individual a role in the quality of his or her life and the length of healthy life each may have.

Health care providers need to be responsible for offering health promotion, preventive health services, and monitoring behaviors. Unfortunately, many of the financial incentives for providers are to do tasks and procedures rather than to counsel and help individuals choose between various behaviors. Providers need to take the time to discuss...
behaviors that may improve the quality of life and extend years of life. For example, the addictive nature of tobacco and its effect on the development and course of a variety of chronic health conditions is now well recognized. Providers should be asking every person if they use tobacco and should be providing them with ways to quit smoking, including economic and social incentives.

Providers also need to look for partnership in the community through which they can better serve the needs of individuals. Healthy People 2010 emphasizes the efforts of partnerships and partnership building as essential to health promotion. One approach to partnerships is the development and use of community nursing centers (http://fncc.uaf). The Health Promotion Center (HPC) operated by Fairfield University School of Nursing in Fairfield, Connecticut, is one example. The nurses and nursing students who provide health education, screening, and referral services at the HPC work with existing community organizations to better meet the health care needs of underserved people. The HPC works with senior housing and senior centers to provide comprehensive cardiovascular screenings and medication review. As an extension of this work, funding was secured for a program called Step Up to Health, a project to increase physical activity in this population through interactive planning and consumer ownership of the activities. The project was part of the National Blueprint Project supported by the Robert Wood Johnson Foundation (www.agingblueprint.org). The project engaged older adults in walking programs, line dancing, gardening, and low impact exercise programs, including the People with Arthritis Can Exercise (PACE) program from the National Arthritis Foundation (www.arthritis.org/events/getinvolved/ProgramsServices/PACE.asp).

Another approach to partnerships is to have providers serve as active participants on community boards and advisory committees, which enables providers to become more aware of the service needs in the community and the resources available to help meet those needs.

Work sites and communities need to become partners in providing opportunities for people to lead healthy lives through flexible work schedules, work site wellness programs, safe parks, and the availability of exercise facilities. Converting empty lots into community gardens provides beautification of the area, an opportunity for exercise in caring for the garden, and a source of fresh vegetables.

Churches, temples, and mosques can be a vital partner in meeting Healthy People 2010 objectives. Faith communities can cut across economic, social, racial, and gender barriers, making them an excellent source for sharing information on health promotion and disease prevention. Parish nurses are becoming increasingly prevalent and they incorporate Healthy People 2010 objectives into their activities (Berry, 2004).

Public health officials at all levels are necessary partners in meeting Healthy People 2010 objectives. As part of the core public health functions of assessment, policy development, and assurance, the U.S. Public Health Service and all state, county, and local health departments need to collect data, make information available to the public, create policies that support Healthy People 2010 objectives, and ensure that needed services are available from a competent workforce.

Healthy People 2010 can form the basis for planning, service delivery, evaluation, and research in every aspect of the health care system. The nurse needs to be familiar with this document and its intent. Nurses should compare their practices with the objectives in Healthy People 2010. Additionally, the nurse needs to be aware of the research and practice changes that occur as a result of the work toward these objectives.

Healthy People 2010 Update
The Mid-Course Review of Healthy People 2010 came out in 2006. It is available at www.healthypeople.gov/data/midcourse/pdf/ExecutiveSummary.pdf. The mid-course review uses data available in 2005 as the basis for decision making about progress on each of the 467 objectives and subobjectives. Only 6% (29) of the objectives were met during the mid-course review period. Another 30% (138) demonstrated some movement toward meeting the objectives. A total of 31% (114) of the objectives had no change from baseline, mixed changes (some positive and some negative), or negative movement from the baseline. Approximately 158 objectives could not be assessed, of which 28 objectives were dropped from the list. This leaves 439 objectives and subobjectives with continuing measurement for 2010. Only 36% of the objectives demonstrated consistent and positive movement in the past 5 years measured. While this accounts for only 5 of the 10 years in the assessment period, it does reflect the limited amount of funding that supports health promotion activities and the focus of our health care system on illness care.

The comments about progress on Healthy People 2010 objectives are organized around the two primary goals: Increase Quality and Years of Healthy Life and Eliminate Health Disparities.

With regard to the first goal, Increase Quality and Years of Healthy Life, life expectancy continues to improve, with women living longer than men and Whites living longer than Blacks. Total life expectancy is now 77.2 years, with life expectancies of 79.8 years for women, 74.5 years for men, 77.7 years for Whites, and 72.2 years for Blacks. While these figures show overall improvement, they also demonstrate health disparities related to life expectancies by gender and race. In addition, the three measures selected for measuring health, activity limitations, and chronic disease demonstrate similar trends, with women doing better than men and Whites doing better than Blacks. All groups, however, decreased in the measure of “Expected years free of selected chronic diseases,” indicating an increasing concern about developing chronic diseases.

For the second goal of Eliminating Health Disparities, the results at mid-course were decidedly mixed. Trend data indicated that, overall, disparities have not changed significantly. Specifically, the disparities between men and women...
improved for 25 objectives, but got worse for 15 objectives. There was no change on 83% of the objectives. Some may look at these data and see a positive trend in that health disparities are not getting worse. However, the goals were set for realistic improvement, so the expectation was for movement away from the baseline, not maintenance of that baseline. For example, the overall percentage of people with health insurance did not change significantly from the 1997 benchmark data. This result may be due to the stable nature of employment from 2000 to 2005, since having health insurance is linked directly to employment. Viewed through the first perspective, the stable nature of the percentage of people with health insurance may indicate a reversal of the trend of fewer people without health insurance. However, the objective was to increase the number of people with health insurance, not to maintain the status quo. Therefore, the lack of progress in insuring people against health problems is problematic. There were similar changes in disparities across racial and ethnic groups. Most striking is that disparities among education groups showed the most negative change. The group with the highest level of education did better than those groups with lower levels of education. These disparities have yet to be reflected in income and geographic variables, although people with higher incomes continued to do better than those with lower incomes in this area. Data suggest that disparities by education groups will eventually be demonstrated in income and racial/ethnic categories, thus maintaining the disparities seen at the beginning of data collection in 2000.

Even though some progress is demonstrated on about 70% of the objectives and subobjectives and the life expectancy in the United States continues to improve, our life expectancy continues to be less than the life expectancy in other developed countries. In addition, there is little evidence to indicate reductions in health disparities in the United States. These data from the Mid-Course Review (USDHHS, 2006) and the data being analyzed for Healthy People 2020 (both at www.healthypeople.gov) support the need for increased effort and more targeted funding for health promotion and disease prevention, particularly among men, racial/ethnic groups, and those with high school or less education.

CASE STUDY

Refer to the Case Study that appears at the end of this chapter along with the Care Plan. Read carefully, because some of the concepts covered in those boxes are applied in the following sections.

Problem Identification

How many problems does Frank's situation present? The answer depends on who is asked the question and his or her position in relation to Frank. Each point of view focuses on different aspects of Frank's life. His physician, using a clinical model of health, might say that Frank has coronary heart disease with an acute myocardial infarction, hypertension, hyperlipidemia, chronic bronchitis, and obesity. But Frank's problems also represent a failure to meet several of the Healthy People 2010 objectives on a personal level. His nurse can add that he has paid little attention to his lifestyle, even after changes were recommended. He continues to overeat, drink too much, smoke, not exercise, and live a stressful life. Frank's employer sees a man who has potential, but who is now too disabled to take on new responsibilities and perhaps unable to continue performing his previous duties. Frank's children might feel that he can no longer take them on jaunts or play with them. His wife, Sada, knows that their plans for educating their children, and for travel and enjoyment, might suffer. The human resource personnel who manage Frank's health insurance and pension programs would say that he has an expensive disease, and the state health planner would point out that Frank's problem is only one of a growing number of disabling illnesses that result from preventable causes. A reviewer planning for Healthy People 2020 might see Frank as part of the aggregated data on heart disease, indicating a continuing increase in heart disease among Black non-Hispanic men.

To Frank, his health problems are multidimensional. His initial fear of dying, pain, dependence, and frustration decreased as he began to feel better, but his realization that he might never be able to achieve his dreams for himself and his family haunt him. Although theoretically in his prime, Frank suddenly sees himself as far older than his years, both in body and in social achievement. He believes he has reached his limit and that he will never again have the freedom to choose his future. He and his family needed to evaluate their situation and make alternative plans based on asset planning. A care plan has been developed based on the situation of Frank and his family. (See Care Plan at the end of this chapter.)

Planning Interventions

Rather than emphasizing the chronic health issues and related problems, the nurse can begin with asset planning within the family. Asset planning is a planning approach that, given the realities of the present, helps focus the family and their providers on the building blocks for their future. It focuses on the assets or strengths of the individual, the family, and the community, applying those assets to improve or maintain the current level of functioning.

Frank's physician and nurse can begin with the fact that Frank survived his first myocardial infarction. The coronary damage resulting from this event becomes the baseline for determining future change in the lives of Frank and his family. Earlier, Frank's physician had taken a broader time perspective when he advised Frank to cut down on smoking, which was contributing to both his bronchitis and his hypertension, and to change his high-fat diet and sedentary habits, which contributed to his weight problem and aggravated his high blood pressure. These lifestyle changes now become tools for Frank's recovery and for change within his family. His cardiac event also becomes a risk factor for heart disease in the lives of his children.
Looking at the immediate future, Frank’s employer saw the effect of the event on Frank’s position within the company. Frank would have a long recovery that could be successful if he adhered to his cardiac rehabilitation program. Asset planning at this level means examining how to move Frank back into his work role without further jeopardizing his health. Frank and Sada also need to examine if he could continue in this position, given its potential effect on his health.

Frank and his family used a broader perspective than the medical personnel or the corporation. They knew that to achieve the family’s economic and educational goals and still spend time together, they had to make decisions that would ultimately affect Frank’s health. Similar to many Americans, they had been willing to live with Frank’s job pressures and stressful lifestyle. The family members were aware of their impoverished roots and had no wish to go back to them. However, they also recognized that the strength of their family, their ability to work together to achieve goals, and their faith were assets that were missing in some families.

Frank’s social network of friends, relatives, and church members became an additional asset. They helped the family through the difficult initial weeks at home by providing meals, taking care of the yard work and laundry, and providing companionship so Sada could shop and have time alone. As Frank recovered, they would provide support for the social and lifestyle changes that Frank and his family needed to make.

The nurse-led cardiovascular rehabilitation group played a vital role in Frank’s recovery. As the physician continued to monitor Frank’s cardiac status, the nurse began the long process of working with Frank to change his habits. He had stopped smoking while in the hospital, but with more free time than usual, he was craving to smoke again. Using an asset planning approach and Gordon’s functional health patterns (2006), the nurse identified the changes that Frank needed to make to decrease the risk of a second heart attack. A plan was developed to help Frank begin to take control of his life through behavior changes. These changes included relaxation techniques, diet modification, smoking cessation, and mild chair exercises. The support of the family was enlisted to reinforce the changes Frank was willing to make, since social support and environmental changes are shown to enhance personal decision making. His employer was contacted and agreed to a plan enabling Frank to work from home using a computer while the workplace became smoke free. Frank became an asset to the workplace, serving as a spokesperson for the benefits of lifestyle change. He had been enlisted to talk with other employees about stress management, exercise, weight reduction, and smoking cessation based on his personal experiences.

Health planners and public health officials used the broadest perspective in asset planning by viewing Frank as an example of a person whose potential shifted as a result of a preventable, disabling illness. The planners looked to public and private community patterns and policies that increase healthful habits and living conditions. Work schedules and work load; stress and safety in work environments; affirmative action programs for jobs and wages; availability of public transportation systems, recreational facilities, and economically accessible housing; farm price subsidies for food and tobacco crops that affect buying patterns; excise taxes and regulation of health-damaging drugs such as alcohol and nicotine were all taken into consideration (Grzywacz & Fuqua, 2000). The asset planning approach emphasized the positive actions that could be made at the personal, employment, community, and societal levels to minimize the effects of Frank’s illness and related diseases, thereby addressing all levels of the ecological model of health.

What was the Actual Cause of Frank’s Problem?

It is not possible to separate one cause from another because heart disease is a multifactorial disease. In Frank’s case, the sources of illness were found in the many interrelationships in his life. Attempting to treat or change each factor as a separate entity can have but a limited effect on the improvement of overall health. Frank’s health problems were numerous. In addition to a poor diet, weight gain, lack of exercise, and smoking, his hyperlipidemia, an adaptive biological response to the pressures in his life, further debilitated him. It eventually clogged his coronary vessels and they became maladaptive. His hypertension, resulting from his diet and time-constrained lifestyle and complicated by the buildup of plaque secondary to hyperlipidemia, was also a biological attempt to adjust to a situation that contributed to an imbalance between his personal resources and the demands of his family and the economic world. Frank’s smoking was a psychosocial means to help him relieve some of the emotional pressures. It may have served this short-term purpose, but only at a silently rising cost to his health. Cigarette use by persons who have hypertension or high serum cholesterol levels multiplies their risk of coronary heart disease (Izzo & Black, 2003).

Evaluation of the Situation

The health status of an individual or population depends on a sustainable balance of the complex responses between physiological, psychological, and social and environmental factors. Health was initially conceived as a biological state, with genetic endowment as the starting point. However, health involves psychological and social aspects and is interpreted within the context of the immediate environment.

The interconnections between biophysical, psychological, and environmental causes and consequences did not end with Frank’s heart attack. His heart attack was only the most dramatic sign that health-damaging responses outweighed health-promoting ones. The “tip of the iceberg” analogy is frequently used to illustrate the importance of identifying individuals with subclinical symptoms. High blood lipid levels, high blood pressure, obesity, smoking, and persistent worrying were no less important than the infarction in shaping the status of Frank’s health. To repair the damage to Frank’s heart without changing his lifestyle, habits, and
work environment would only buy a brief amount of time before further damage would occur.

The infarction and resulting disability also permanently reshaped Frank's environment. After a few months of working full time, Frank realized that he needed to find a less stressful job. He recognized that his sales administration skills were an asset and began interviewing in the nonprofit sector. Ultimately, he landed a job at half his previous salary, but with excellent benefits and a flexible work environment. His reduced income meant that his children's educational opportunities were more limited than they were before his heart attack, but his family responded by writing for tuition support from community organizations. Frank found that his contacts in both the corporate and the nonprofit sectors increased his value to his new employer. Frank's entire life, internal and external, had changed. He had learned to adapt to his health problems and had developed a more eudaimonistic approach to health and life.

Frank's situation illustrates how causes and effects in life and health tend to merge into constant, inseparable interconnections between individuals and their worlds. A person's health status is a reflection of a web of relationships that characterize that person's life. Health is not an achievement or a prize, but a high-quality interaction between a person's inner and outer worlds that provides the capacity to respond to the demands of the biological, psychological, and environmental systems of these worlds.

After reviewing the list of Healthy People 2010 Focus Areas listed in Box 1-1, which of the focus areas apply to the promotion of Frank's health? Clearly, the area of heart disease and stroke is most applicable. The Healthy People 2010 website (www.healthypeople.gov) has a number of objectives that relate directly to the prevention of heart disease, hypertension, and hyperlipidemia, including objectives that relate to treatment options and training the public to recognize and respond to heart attacks and stroke. Based on the information about Frank and his experience, determine what his children should be taught based on the Healthy People 2010 objectives in this focus area.

**LEVELS OF PREVENTION**

Prevention, in a narrow sense, means averting the development of disease in the future. In a broad sense, prevention consists of all measures, including definitive therapies, that limit disease progression. Leavell and Clark (1965) defined three levels of prevention: primary, secondary, and tertiary (Figure 1-2). While the levels of prevention are related to the natural history of disease, they can be used to prevent disease and provide nurses with starting points in making effective, positive changes in the health status of their clients. Within the three levels of prevention, there are five steps. These steps include health promotion and specific protection (primary prevention); early diagnosis, prompt treatment, and disability limitation (secondary prevention); and restoration and rehabilitation (tertiary prevention).

Some confusion exists in the interpretation of these concepts; therefore, a consistent understanding of primary, secondary, and tertiary prevention is essential. The levels of prevention operate on a continuum, but may overlap in practice. The nurse must clearly understand the goals of each level to intervene effectively in keeping people healthy.

**Primary Prevention**

Primary prevention precedes disease or dysfunction. However, primary prevention is therapeutic in that it includes health as beneficial to well-being, it uses therapeutic treatments, and, as a process or behavior towards enhancing health, it involves symptom identification when teaching stress reduction techniques. Primary prevention intervention includes health promotion, such as health education about risk factors for heart disease, and specific protection, such as immunization against hepatitis B. Its purpose is to decrease the vulnerability of the individual or population to disease or dysfunction. Interventions at this level encourage individuals and groups to become more aware of the means of improving health and the things they can do at the primary preventive health level and the optimal health level. People are also taught to use appropriate primary preventive measures. However, primary prevention can also include advocating for policies that promote the health of the community and electing public officials who will enact legislation that protects the health of the public.

**Health Promotion**

The health promotion definitions vary. O'Donnell (1987, p. 4) has defined health promotion as “the science and art of helping people change their lifestyle to move toward a state of optimal health.” Kreuter and Devore (1980) propose a more complex definition in a paper commissioned by the U.S. Public Health Service. They state that health promotion is “the process of advocating health in order to enhance the probability that personal (individual, family, and community), private (professional and business), and public (federal, state, and local government) support of positive health practices will become a societal norm” (Kreuter & Devore, 1980, p. 26).

The Theoretical Basis of Health Promotion

The theoretical underpinnings for health promotion have evolved since the early 1980s. Most of these theories are behaviorally based, derived from the social sciences, and extensively researched. These theories include the theory of reasoned action by Ajzen & Fishbein (1980), theories of behavior by Bandura (1976, 1999, 2004), the health belief model by Rosenstock (Jan et al., 2002), Pender's Health Promotion Model (Pender et al., 2006), and stages of change theories by Prochaska (Prochaska et al., 2004). Internet searches on each of these theories will provide numerous sites where more detailed information is available.

The Social Nature of Health Promotion

Health promotion goes beyond providing information. It is also proactive
Primary Prevention

Health Promotion
- Health education
- Good standard of nutrition adjusted to developmental phases of life
- Attention to personality development
- Provision of adequate housing, recreation, and agreeable working conditions
- Marriage counseling and sex education
- Genetic screening
- Periodic selective examinations

Specific Protection
- Use of specific immunizations
- Attention to personal hygiene
- Use of environmental sanitation
- Protection against occupational hazards
- Protection from accidents
- Use of specific nutrients
- Protection from carcinogens
- Avoidance of allergens

Secondary Prevention

Early Diagnosis and Prompt Treatment
- Case-finding measures: individual and mass screening surveys
- Selective examinations to:
  - Cure and prevent disease process
  - Prevent spread of communicable disease
  - Prevent complications and sequelae
  - Shorten period of disability

Disability Limitations
- Adequate treatment to arrest disease process and prevent further complications and sequelae
- Provision of facilities to limit disability and prevent death

Tertiary Prevention

Restoration and Rehabilitation
- Provision of hospital and community facilities for retraining and education to maximize use of remaining capacities
- Education of public and industry to use rehabilitated persons to fullest possible extent
- Selective placement
- Work therapy in hospitals
- Use of sheltered colony

Figure 1-2 The three levels of prevention developed by Leavell and Clark. (Data from Leavell, H., & Clark, A. E. [1965]. Preventive medicine for doctors in the community. New York: McGraw-Hill.)
decision-making at all levels of society as reflected in the Healthy People (www.healthypeople.gov) objectives. Health promotion holds the best promise for lower-cost methods of limiting the constant increase in health care costs and for empowering people to be responsible for the aspects of their lives that can enhance well-being. Based on the need for health promotion activities within the health care system, efforts must be made to identify the multiple determinants of health, identify relevant health promotion strategies, and delineate issues relevant to social justice and access to care. Individuals, families, and communities must be active participants in this process so that the actions taken are socially relevant, economically feasible, and supportive of changes at the individual level.

The Active and Passive Nature of Health Promotion

Health promotion efforts, unlike those efforts directed at specific protection from certain diseases, focus on maintaining or improving the general health of individuals, families, and communities (see Health Teaching box). These activities are carried out at the public level (government programs promoting adequate housing), at the community level (Habitat for Humanity), and at the personal level (voting for improved low-income housing). Nursing interventions are actions directed toward developing people’s resources to maintain or enhance their well-being—a form of assets-based planning.

Two strategies of health promotion involve the individual and may be either passive or active. Passive strategies involve the individual as an inactive participant or recipient. Examples of passive strategies are public health efforts to maintain clean water and sanitary sewage systems to decrease infectious diseases and improve health, and efforts to introduce vitamin D in all milk to ensure that children will not be at high risk for rickets when there is little sunlight. These passive strategies must be used to promote the health of the public when individual participation might be low.

Active strategies depend on the individual becoming personally involved in adopting a proposed program of health promotion. Two examples of lifestyle change are daily exercise as part of a physical fitness plan and a stress-management program as part of daily living. A combination of active and passive strategies is best for making an individual healthier. Reexamine the Case Study to determine when Frank could have incorporated some of these strategies to decrease his risk of heart disease.

This text is concerned almost entirely with active strategies and the nurse’s role in these strategies. Some passive strategies are presented, but they are presented with the implicit belief that each individual must take responsibility for improving health. It is undeniable that passive strategies also have a valuable role, but they must be used within a context of encouraging and teaching individuals to assume more responsibility for their health.

An Application of Theory to the Practice of Health Promotion

The Transtheoretical Model (TTM) is an excellent example and can be applied to this case study. TTM incorporates Stages of Change (readiness to take action), Decisional Balance (benefits to and detractors from changing a behavior), Self-Efficacy (personal confidence in making a change), and Processes of Change (cognitive, affective, and behavioral activities facilitating

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**HEALTH TEACHING**

**Process for Assessing, Evaluating, and Treating Overweight and Obesity in Adults**

Overweight and obesity are major concerns in public health because they contribute to other health problems such as high cholesterol, high blood pressure, Diabetes Mellitus, heart disease, functional limitations, and disability. As part of the National Heart, Lung, and Blood Institute’s (NHLBI) Obesity Education Initiative, titled Aim for a Healthy Weight, nurses have an important role to play in health education related to obesity prevention and control. Complete information can be retrieved from: www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/index.htm.

**Make the Most of the Client Visit and Set an Effective Tone for Communication:** Nurses need to be able to ask individuals about their weight history, weight-related health risks, and desire to lose weight. The approaches used need to be respectful of a person’s lifestyle, habits, and cultural influences. Discussions need to be nonjudgmental and goal directed.

**Assess Client’s Motivation/Readiness to Lose Weight:** Nurses need to be able to explain body mass index and why it is the preferred method of determining overweight and obesity in adults. They need to understand the methods of data collection and measurement of height and weight, as well as waist circumference, risk factors, and comorbidities. Nurses need to develop skill in determining readiness and motivation to lose weight in their clients.

**Build a Partnership with an Individual:** Nurses should work with individuals to determine what each person is willing to do to achieve a lower weight. This approach includes knowing the best practices in weight management and weight loss. Fad diets, dietary supplements, and weight loss pills may be inappropriate for most people, and formal weight loss programs may be too expensive for low- and moderate-income families. Use recommended diets that restrict caloric intake, set activity goals with your clients, encourage the person to keep a Weekly Food and Activity Diary, and provide information on diet and activity. Be sure to record individual goals and the treatment plan, including a health education plan. Nurses are knowledgeable about current treatment options and their success. Holistic approaches are needed, since food behaviors are influenced by many factors. Listen to the individual stories about food and its role in their lives. Therapies should fit the individual’s goals and lead to lifestyle change.
Health Defined: Objectives for Promotion and Prevention

change). The bases of TTM are the stages of change—six stages that people spiral through on a path toward making and sustaining a behavioral change to promote health. These stages are:

- **Precontemplative**: Not considering change
- **Contemplative**: Aware of but not considering change soon
- **Preparation**: Planning to act soon
- **Action**: Has begun to make behavioral change (recent)
- **Maintenance**: Continued commitment to behavior (long-term)
- **Relapse**: Reverted to old behavior

Each stage provides opportunities for the nurse to provide information and support behavioral change. Encouraging people and suggesting changes to their environment that support behavioral change can increase their self-efficacy and their chances of maintaining a change. This model also recognizes that people need multiple opportunities to make behavioral change before achieving success and that relapse should be expected (Prochaska et al., 2004).

Although health promotion would seem to be a practical and effective mode of health care, the major portion of health care delivery is geared toward responding to acute and chronic disease. Preventing or delaying the onset of chronic disease and adding new dimensions to the quality of life are not as easy to implement because they take time to implement and evaluate and require personal action. These actions are more closely associated with everyday living and the lifestyles adopted by individuals, families, communities, and nations. Habits such as eating, resting, exercising, and handling anxieties appear to be transmitted from parent to child and from social group to social group as part of a cultural, not a genetic, heritage. These activities may be taught in subtle ways, but they influence behavior and have as much of an influence on health as does genetic inheritance. Although the public may not appreciate the causal relationships between behavior and health, it should be apparent to health professionals. Arguably, the concept of risk is the most basic of all health concepts, since health promotion and disease protection are based on this concept.

Health promotion strategies have the potential of enhancing the quality of life from birth to death. For example, good nutrition is adjusted to various developmental phases in life to account for rapid growth and development in infancy and early childhood, physiological changes associated with adolescence, extra demands during pregnancy, and the many changes occurring in older adults. Good nutrition is known to enhance the immune system, enabling individuals to fight off infections that could lead to disabling illnesses. Other individual activities are adapted to the person’s needs for optimal personality development at all ages. As seen in Unit Four, much can be done on a personal or group basis, through counseling and properly directed parent education, to provide the environmental requirements for the proper personality development of children. Community participation is also an important factor in promoting individual, family, and group health (see Chapters 6, 7, and 8).

Personal health promotion is usually provided through health education (see Chapter 10). An important function of nurses, physicians, and allied health professionals, health education is principally concerned with eliciting useful changes in human behavior based on current research. The goal is to inculcate a sense of responsibility in individuals for their own health and a shared sense of responsibility for avoiding injury to the health of others. For example, encouraging child-rearing practices that foster normal growth and development (personal, social, and physical) addresses both the individual parent and the needs of society. Health education nurtures health-promoting habits, values, and attitudes that must be learned through practice. These must be reinforced through systematic instruction in hygiene, bodily function, physical fitness, and use of leisure time. Another goal is to understand the appropriate use of health services. For example, a semiannual visit to a dentist may teach a child better oral health habits and to visit the dentist regularly, although this is not the primary purpose of the visit. Parents, teachers, and caregivers play a vital role in health education. In addition to teaching individuals, nurses need to develop skills in group teaching and in providing education within community organizations.

Available research clearly shows an increase in longevity, a decrease in mortality and morbidity, and an improvement in the quality of life for individuals who have been involved in health promotion activities such as physical activity and avoidance of smoking. It must be emphasized that health promotion requires lifestyle change. Once a lifestyle change has been adopted, vigilance is needed to ensure that the lifestyle change is maintained and modified to fit developmental and environmental changes.

Empirical data linking risk factors, health promotion activities, and outcomes are sufficient to drive the development of the Healthy People 2010 objectives and to be incorporated into quality improvement measures in managed care. One of the challenges posed in Healthy People 2010 is the development of measurable outcome objectives that are based on more realistic economic models.

Health promotion is an important concept for nursing because it embodies many other concepts that nursing is concerned with today. As stated earlier, much of the nursing role is involved with health teaching. Standard 5B of the Nursing: Scope and Standards of Practice document (ANA, 2004, p. 28) requires nurses to promote health and a safe environment” through health teaching and evaluation of teaching effectiveness in clinical practice (Hot Topics box). Health education is clearly a nursing role.
Specific Protection

This aspect of primary prevention focuses on protecting people from injury and disease, for example, by providing immunizations and reducing exposure to occupational hazards, carcinogens, and other environmental health risks. These hazards and risks include work-related injuries ranging from back injuries for nurses to dismemberment for machinists, exposure to chemicals in boat repair to inhaled sawdust by carpenters, and exposure of children to diesel emissions to damage to a fetus due to radiation.

Primary prevention interventions are considered health protection when they emphasize shielding or defending the body (or the public) from specific causes of injury or disease. Implementing nursing interventions that prevent a specific health problem may seem easier than promoting well-being among individuals, groups, or communities because: (1) the variables are delineated more clearly in prevention than in promotion and (2) the potential influences are less diverse.

Examples Two examples may help demonstrate these differences. Immunization for influenza is quite popular and has become a regular activity for people at risk each autumn. Nurses can participate in this specific protection role by giving the influenza injections in clinics and offices. Another example is creating nut-free schools to protect hypersensitive children from life-threatening allergic reactions to peanut products. Such initiatives have largely been the result of grassroots parent organizations working with formal community organizations to adopt policies that protect the health of these children. Nurses may be involved in the parent organizations or the school or public health boards that review the proposed policies. Additionally, nurses must be able to address the need to protect portions of the population at risk.

Secondary Prevention

Although primary prevention measures have decreased the hazards of chronic diseases such as cardiovascular disease, conditions that preclude a healthy quality of life are still prevalent. Secondary prevention ranges from providing screening activities and treating early stages of disease to limiting disability by averting or delaying the consequences of advanced disease.

Screening is secondary prevention because the principle goal is to identify individuals in an early, detectable stage of the disease process. However, screening provides an excellent opportunity to offer health teaching as a primary preventative measure. Screening activities now play an important role in the control of diseases such as heart disease, stroke, and colorectal cancer. Additionally, screening activities provide early diagnosis and treatment of nutritional, behavioral, and other related problems. Nurses play an important role in screening activities because they provide clinical expertise and educationally sound health information during the screening process.

Delayed recognition of disease results in the need to limit future disability in late secondary prevention. Limiting disability is a vital role for nursing since preventive measures are primarily therapeutic and are aimed at arresting the disease and preventing further complications. The paradox here is that health education and disease prevention activities are similar to those used in primary prevention, but applied to a person or population with an existing disease. Modifications to the teaching plan must be made based on the individual’s current health status and ability to modify behavior. In the case study, Frank needed secondary prevention after his heart attack. The lifestyle changes needed to prevent a second heart attack were similar to the steps he could have taken to prevent his initial heart attack, but with a recognition that his coronary status was now compromised. As a result, exercise had to be increased gradually as part of a cardiac rehabilitation program and diet modifications had to be made with support from a registered dietitian to ensure adequate nutrition and weight loss.
Tertiary Prevention

Tertiary prevention occurs when a defect or disability is permanent and irreversible. The process involves minimizing the effects of disease and disability by surveillance and maintenance activities aimed at preventing complications and deterioration. Tertiary prevention focuses on rehabilitation to help people attain and retain an optimal level of functioning regardless of their disabling condition. The objective is to return the affected individual to a useful place in society, maximize remaining capacities, or both. The responsibility of the nurse is to ensure that persons with disabilities receive services that enable them to live and work according to the resources that are still available to them. When a person has a stroke, rehabilitating this individual to the highest level of functioning and teaching lifestyle change to prevent future strokes are examples of tertiary prevention.

THE NURSE’S ROLE

Evolving demands are placed on the nurse and the nursing profession as a result of changes in society. Emphasis is shifting from acute, hospital-based care to preventive, community-based care, which is provided in nontraditional health care settings in the community. This demand for community-based services, with the home as a major community setting for care, is closely related to the changing demographics of the U.S. As the home and community become the existing sites for care, nurses must assume more blended roles, with a knowledge base that prepares them to practice across settings using evidence-based practice. Within these roles, nurses assume a more active involvement in the prevention of disease and the promotion of health. Nurses can be more independent in their practice, place a greater emphasis on promoting and maximizing health, and more than ever, are accountable morally and legally for their professional behavior.

Nursing Roles in Health Promotion and Protection

Although nurses often work with persons on a one-to-one basis, they seldom work in isolation. Within today’s health care system, nurses collaborate with other nurses, physicians, social workers, nutritionists, psychologists, therapists, individuals, and community groups. In this collaborative capacity, nurses play a variety of roles.

Advocate

As advocates nurses help individuals obtain what they are entitled to receive from the health care system, try to make the system more responsive to individual and community needs, and help persons develop the skills to advocate for themselves. In the role of advocate, the nurse strives to ensure that all persons receive high-quality, appropriate, and cost-effective care. The nurse may spend a great deal of time identifying and coordinating resources for complex cases. Other examples of advocacy will be seen in subsequent chapters.

Care Manager

The nurse acts as a care manager to prevent duplication of services and to reduce costs. Information gathered from reliable data sources enables the care manager to help individuals avoid care that is unproven, ineffective, or unsafe. Reliable sources of information on best practices, evidence-based practices, and standard protocols are available from Internet sites sponsored by the federal government (e.g., www.nih.gov, www.cdc.gov), specialty organizations (e.g., www.arthritis.org, www.nursingworld.org, www.caremanager.org), and private foundations (e.g., www.nuff.org, www.hartfound.org). Successful care management depends on a collaborative relationship among the care manager, other nurses and physicians, the individual and his or her family, the payer, and other care providers who work with the person. The wishes of the individual and family need to be clear to the care manager. Facilitating communication among parties is one of the care manager’s most important functions.

Consultant

Nurses may provide knowledge about health promotion and disease prevention to individuals and groups as a consultant. Some nurses have specialized areas of expertise or advanced practice standing, such as in gerontology, women’s health, or community/public health, and they are equipped to provide information as consultants in these areas of specialization (ANA, 2004). For example, a gerontological nurse specialist might be on a community planning board offering advice about what types of health promotion activities should be considered in planning a new senior housing development. In contrast to independent consultation, all nurses need to develop consultation skills that can be integrated into practice and allow the individual nurse to take advantage of opportunities to provide support on an individual level or for future development at the organizational level (Norwood, 2003).

Deliverer of Services

The core role of the nurse is the delivery of direct services such as health education, flu shots, and counseling in health promotion. Visible, direct delivery of nursing care is the foundation for the public image of nursing. The public demands that nurses be knowledgeable and competent in their delivery of services. This role is clearly expressed in the Nursing’s Social Policy Statement (ANA, 2003) and in the ANA Code of Ethics (ANA, 2008).

Educator

Health practices in the United States are derived from the theory that health components such as good nutrition, industrial and highway safety, immunization, and specific drug therapy should be within the grasp of the total population. Even with its rich resources, society falls far short of attaining the goal of maximal health for all. The problem is not a lack of knowledge, but rather the lack of application; therefore it is incumbent on nurses to be excellent health
educators. To teach effectively, the nurse must know essential facts about how people learn and the teaching-learning process (see Chapter 10).

In addition to their storehouse of scientific knowledge, nurses who are committed to their teaching role know that individuals are unique in their response to efforts to change their behavior. Teaching may range from a chance remark by the nurse, based on a perception of desirable individual behavior, to structurally planned teaching according to individual needs. Selection of the methods most likely to succeed involves the establishment of teacher-learner goals. Health promotion and protection rely heavily on the individual's ability to use appropriate knowledge. Health education is one of the primary prevention techniques available to avoid the major causes of disability and death today and is a critical role for nurses.

**Healer**

The role of healer requires the nurse to help individuals integrate and balance the various parts of their lives (McKivergin, 2004). Healing resides in the ability to glimpse or intuit the “interior” of an individual, to sense and identify what is important to that other person, and to incorporate the specific insight into a care plan that helps that person develop his or her own capacity to heal. It requires a mindful blending of science and subjectivity (Siegel, 2007). Nurses have a special ability to help people heal. The art of nursing is the extraordinary ability to manage a broad array of information to create something meaningful, sensible, and whole (see Chapter 14).

**Researcher**

In today's health care environment, nurses are constantly striving to understand and interpret research findings that will enhance the quality and value of individual care. To provide optimal health care, nurses need to use research findings as their foundation for clinical decision-making. When nurses or other clinicians use research findings and the best evidence possible to make decisions, the outcome is termed evidence-based practice. Evidence-based practice is defined as the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individuals. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research (ANA, 2004).

The National Institute of Nursing Research (NINR) serves as the focal point in developing research themes for the future of the profession. NINR supports research to establish a scientific base for the care of individuals throughout the lifespan, from management of individuals during illness and recovery to the reduction of risks for disease and disability. The four themes NINR has identified are: (1) promoting health and preventing disease, (2) improving quality of life, (3) eliminating health disparities, and (4) setting directions for end-of-life research (NINR Strategic Plan, 2006). Notice that health promotion is the basis for all of these themes.

Evidence-based practice involves tracking down the best evidence with which to answer clinical research questions. Research evidence can be gathered from quantitative studies that describe situations, correlate different variables related to care, or test causal relationships between variables related to care. Such studies become incorporated into screening and treatment standards such as those from the U.S. Preventive Services Task Force (2007). Research evidence can also be gathered from qualitative studies that describe phenomena or define the historical

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### Update on Health Literacy

- People change their behavior when presented with information on the benefits of change and/or the harm done if changes are not made. Key to this process is the ability of people to obtain, process, and understand basic health information to make appropriate health decisions, known as health literacy. The most comprehensive research on this topic comes from the U.S. Department of Education, National Center for Educational Statistics, National Assessment of Adult Literacy, *The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy* (Kutner et al., 2006). Why is health literacy important? Research into this issue demonstrates the following:
  - 36% of all adults have health literacy at or below the basic level.
  - 66% of Hispanic adults have health literacy at or below the basic level.
  - 58% of Black adults have health literacy at or below the basic level.
  - Those adults who have less than a high school education score, on average, below the basic level of health literacy.
  - 63% to 69% of those adults who rate their health as fair to poor have health literacy at or below the basic level.
  - 55% to 60% of those adults who have Medicare, Medicaid, or no insurance have health literacy at or below the basic level.

In all situations where the nurse is attempting to educate about health behavior, assessment of health literacy is important. Cloonan (2004) found that few schools of nursing include health literacy in their curricula. More recently, Riley et al. (2006) examined the scope of the health literacy problem and its impact in the critical care environment. Given the importance placed by the federal government on health promotion and health literacy, nurses need to incorporate health literacy into health promotion protocols as research is expanded in this area.

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nature, cultural relevance, or philosophical basis of aspects of nursing care. Applied research is done to directly affect clinical practice (Burns & Grove, 2003). Sackett and colleagues (1996) stressed the use of the best evidence available to answer clinical questions and explore the next best evidence when appropriate. The next best evidence may include the individual clinical judgment that nurses acquire through clinical experience and clinical practice and other qualitative approaches to research.

Nurses need to recognize research is important as a basis of evidence for their practice and that they often participate in the research process. For example, both home health nurses and nurses in long-term care facilities are required to collect extensive data on the cognitive and physical functioning of their clients through the OASIS and MDS assessment tools. These data are used as part of the quality improvement process to indicate areas for improvement in care, thereby contributing to nursing protocols.

Chapters 16 to 24 contain specific health promotion research studies. Time should be taken to review these studies and explore the relationship between behavior and disease, to identify which populations groups are at risk, and to discover what types of health promotion programs work and why they work. Through knowledge of research, nurses can strengthen their confidence in making daily decisions about quality care.

**IMPROVING PROSPECTS FOR HEALTH**

**Population Effects**

Cultural and socioeconomic changes within the population unequivocally influence lay concepts of health and health promotion. Currently there are areas of the United States where the Hispanic population is larger than any other population group. By the year 2050, it is predicted that the majority of people in the United States will not be of White European descent. Taken together as a portent for the future, such changes are involved require the adoption of a new set of skills by people who will need the assistance of nurses to make those changes. Approximately one fifth of the population in the United States is faced with the problem of getting the basic necessities of food and shelter. The other four fifths, whose basic needs are met, must overcome problems resulting from affluence (U.S. Department of Health and Human Services, 2006).

In addition to changes in the ethnic and racial distribution within the population, the projected changes in age distribution will affect health promotion practice. Considerable growth is expected in the proportion of the population that is 25 years of age and older. For example, the post–World War II baby boom will increase the number of persons in the 65-and-older age group between the years 2010 and 2030. While there was a drop in births after 1960, this decrease has been offset by an increase in immigration, both legal and illegal. More restrictive immigration rules related to Homeland Security have limited legal immigration since 2002 (U.S. Department of Homeland Security, 2003). Analysis of these population trends and projections helps health professionals determine changing needs. Additionally, analysis of the social environment is necessary for social policy concerning health.

**SHIFTING PROBLEMS**

The provision of personal health services must be informed by environmental health. Environmental pollution is a complex and increasingly hazardous problem. Diseases related to industry and technology, including asthma and trauma, have also become important threats to health.

The physical and psychological stresses of a rapidly changing and fast-paced society present daily problems, such as psychosocial and spiritual poor health habits. Obesity, for example, partly attributed to a lack of exercise and increasing food portion size, is a growing health issue. The ingestion of potentially toxic, non-nutritious, high-fat foods is another contributing factor (see Chapter 11). The abuse of tobacco, drugs, and alcohol also negatively affects health.

The emphasis on treating disease through the application of complex technology is not only costly, but it also contributes minimally to the improvement of health. An orientation toward illness clearly focuses on the effects rather than the causes of disease.

A substantial change in wellness patterns is occurring. Infectious and acute diseases were the major causes of death in the early part of the twentieth century, whereas chronic conditions, heart disease, cerebrovascular accident (stroke), and cancer are the major causes today. An emphasis on the diagnosis and treatment of disease, which were highly successful in the past, are not the answers for today’s needs, which are closely related to and affected by the individual’s biochemical functioning, genetics, environment, and personal choices.

**MOVING TOWARD SOLUTIONS**

Solutions are neither simple nor easy, but they can be focused in two major directions: individual involvement and government involvement. The first direction concentrates on actions of the individual, especially actions related to lifestyle choices across the lifespan. The learning and the inherent changes that are involved require the adoption of a new set of skills by people who will need the assistance of nurses to make those changes. Approximately one fifth of the population in the United States is faced with the problem of getting the basic necessities of food and shelter. The other four fifths, whose basic needs are met, must overcome problems resulting from affluence (U.S. Department of Health and Human Services, 2006).

Motivational factors play a large role in influencing attitudinal change. As discussed in Chapter 10, programs for health promotion and health education are only part of the answer. Financial incentives for prevention may be another motivating factor, and health advocacy by professionals in the health field is critical. Additionally, private and public action at all levels is needed to reduce social and environmental health hazards. Toxic agents in the environment such as particles from diesel emissions and social conditions such as school overcrowding can present health hazards that may not be detected for years; therefore, it is necessary for individuals and government to play a role.
Legislation and financing that relate to primary prevention are discussed in Chapter 3. Government activity, in the form of legislation, is currently increasing in this area. For example, bicycle safety, seat belts, and a graduated tax on cigarettes are specific areas for governmental intervention. Health ecology and planning are important areas for governmental involvement in the future. The redirection of the existing health care delivery system, putting more emphasis on primary prevention, is probably the most difficult and the most far-reaching goal; however, an emphasis on a wellness system is necessary to improve the health of the U.S. population.

**SUMMARY**

The ways individuals define health and health problems are important because definitions influence attempts to improve health and care delivery. In the case study, Frank Thompson’s health was affected by obvious, immediate, and personal factors, such as his diet and employment pressures. Nevertheless, his problems had their roots in the social and economic conditions of his parents; in his own early history of illness, education, and work; and in his and his family’s hopes and aspirations. His physician defined Frank’s prob-

**CASE STUDY**

**Health Assessment: Frank Thompson and Family**

Frank Thompson’s large brick home is located off a sparsely traveled country road. A few yards away stands the uninhabited shack where Frank was born during World War II. Frank was raised knowing the odds that he faced as a poor tenant farmer. He helped his father, Ben, with their small tobacco and corn crops. They were unaware that the hazardous chemicals in the pesticides they used would later affect Ben’s life. As his father often reminded him, Frank had to do better than others in school so he would not be doomed to the tenant farmer’s life. However, Frank’s school attendance was erratic because it was interrupted by the frequent demand of tending field crops. Thin and often tired, he had recurrent infections. The school nurse helped the Thompson family obtain the necessary medication for Frank’s initial infection, but the family was never able to afford the penicillin that was necessary to prevent recurrent infections.

Inspired by the early work of Martin Luther King, Jr., Frank was intent on helping at home and building something better for his future. Frank managed to more than make up for his lost time at school. He passed his college entrance examinations and was awarded one of the new equal opportunity grants, which offered him a choice of attending any of the Ivy League schools in the Northeast. Instead, he chose the prestigious Southern University and eventually earned a Masters of Business Administration (MBA) degree. He married Sada, his longtime girlfriend, and the two planned their future.

With a good job in a large local sales firm, Frank built his house and started a family. He moved from a salesman to a division head and often traveled to regional meetings, sometimes accompanied by Sada and their three children. Frank’s dream of sharing his success with his family included using part of his earnings to help his brothers and sisters with their education.

This new way of life meant little time for relaxation and frequent attendance at business luncheons and career-promoting social occasions. He kept late hours and worked long weekends. Good food, drinks, and cigarettes helped him relax before and after important business and social encounters; these softened the edges of hard bargaining and were status symbols.

Not surprisingly, Frank gained weight. He had a persistent cough, which was probably a result of the smoking habit that developed during the early years of his career. Frank’s physician, with whom Frank visited regularly at the corporation’s health maintenance organization (HMO), said Frank’s blood pressure and serum lipid levels were both higher than normal and that he had chronic bronchitis. The physician urged Frank to do what Frank already knew: cut down on smoking, drinking, saturated fats, and calories; get more exercise; and find ways to relax. However, Frank’s life was too busy for exercise. He had to work harder as he moved up in his company, but he also had to appear relaxed, which was an essential characteristic for a prospective vice president. To meet these goals, he tended to drink and smoke more. He also refused to take medication for problems he could not see. Without the outward signs of disease, Frank believed he was out of shape, but generally healthy. Then Sada pointed out that his chance for promotion might actually improve if he lost some weight; therefore, he registered for a physical fitness program for executives that he could attend on Sunday mornings and before work during the week. At his first workout, the classic sharp pain gripped his chest and Frank had a massive heart attack.

Weeks later, Frank was convalescing at home after being released from the university’s coronary care facility. He was lucky to survive the heart attack, and he was also lucky to have most of the services covered by his medical insurance plan and 80% of his earnings were protected by the company’s disability pension. (Most people in the United States do not have this protection.)

However, Frank’s dreams of promotion were shattered. For many months he could go to the office only two or three times a week at most, simply to deal with routine matters. He could not travel, for business or otherwise, for a long time. He was also skeptical about his cardiac rehabilitation program because his heart attack happened during exercise.

**Reflective Questions:**

1. As a nurse, how would you explain to Frank that his heart attack was not caused by his exercise?
2. How might a family approach to diet and exercise work with this family, given its structure and background?
3. Are there negative behaviors in your life that you see as status symbols?
Public health planners, who saw Frank’s problem on a longer-term population basis, sought policy solutions to the problem of preventing cardiovascular disease.

The view taken in this text is that a broad and longer-term perspective of health is the best guide to promoting health more effectively, even as nurses deal with individual problems on a day-to-day basis. Health is a sustainable balance between internal and external forces. Health allows people to move through life free from the constraints of illness and allows healing to take place.

Illness represents an imbalance that human choices (intertwined social, political, spiritual, professional, and personal choices) create. In the United States, communities may yet have time to slow the onslaught of chronic disability and shift the direction, slow the pace, and humanize the scope of economic and social life.

To shift directions in today’s health care patterns may be possible only when nurses and other health professionals do what is expected of them as leaders in the care of health: to work with others through open processes; to provide leadership in finding the vision and the path; and to inform, educate, and reeducate themselves, their colleagues, the media, and the general public using research findings and evidence-based practice methods. Website Resource 1A presents 21 competencies for health professionals in the twenty-first century developed by the Pew Health Professions Commission.

The responsibility of nurses as health professionals today is to see the health problem in new ways and help others to do the same. Responsibility means developing new roles and looking at the problem through others’ eyes, including the eyes of individuals, the public, other professionals, and other nations. Responsibility also means evaluating the social and individual consequences, the long-term and short-term effects, and the public and private interests that are involved when deciding on the set of tools to use in the care of the ailing.

**CARE PLAN**

**Health Assessment: Frank Thompson and Family**

**Nursing Diagnosis:** Risk for Ineffective Coping Due to Change in Role Performance and Self-Esteem

**DEFINING CHARACTERISTICS**
- Inability to complete tasks
- Lack of focus on needs
- Feelings of inadequacy
- Inability to make decisions
- Sense of being overwhelmed
- Rest and sleep disturbance
- Frequent stress-related headaches
- Emotional fragility
- Assessment of situations does not match assessments of others

**RELATED FACTORS**
- Unexpected life changes
- Diagnosis of chronic disease
- Stressful life events
- Unsure of family supports
- Unrealistic expectations of self
- Unpredictable future
- Need to reassess abilities
- Insecure job status

**EXPECTED OUTCOMES**
- The person will develop realistic expectations of capabilities based on rehabilitation potential.
- The nurse and person will set mutually agreeable milestones for resuming functions.
- The person will develop a revitalized sense of self.
- The person and family will use available resources to examine social and role shifts that affect the family.
- The person and spouse will express to each other their hopes and fears about the future.

**INTERVENTIONS**
- Listen to the concerns of the person and spouse regarding job, social, family, and medical concerns.
- Counsel the individual and spouse about realistic goals and expectations of cardiac rehabilitation.
- Assist the individual in setting realistic and reachable short-term goals.
- Assist the individual in developing more effective problem-solving skills.
- Provide support and positive feedback as short-term goals are met.
- Explore available community services that match the goals of the family.
- Facilitate family access to needed services through advocacy and supportive guidance.
- Supervise and teach about the use of prescribed and other medications.
- Coordinate communications between providers, employers, and other organizations to meet coping needs of the individual and his or her family.


