



Council of Public Health Nursing Organizations

June 24, 2020

Open Letter to the Authors of the Future of Nursing: Campaign for Action's *Building Coalitions to Promote Health Equity: A Toolkit for Action*

To: 1) SDOH Toolkit Authors G. Adriana Perez, PhD, CRNP, FAAN, Kupiri Ackerman-Barger, PhD, MSN, RN, FAAN, Regina Eddie, PhD, RN, Barbara Nichols, MS, RN, FAAN, Claudio Gualtieri, JD, and Jazmine Cooper, MBA; and 2) FON Conveners Pat Polansky, MS, RN, and Winifred Quinn, PhD, FAANP

We are writing in response to the Future of Nursing: Campaign for Action's *Building Coalitions to Promote Health Equity: A Toolkit for Action*, released in November 2019. We are pleased that the authors are open to feedback on the relevance of the toolkit to practice. Having reviewed the Toolkit for Action (TFA) and a webinar led by Dr. Ackerman-Barger in March 2020, we urge the committee to consider revising and renaming it as a handbook in which the resources and frameworks reflect a public health nursing approach that centers on the principle of social justice.

A central assumption inside the TFA is that nurses of **all** specialties can respond to the call for upstream action in promoting health equity. Our caution is that some nurses may be better prepared than others to **lead** nurses in this response by virtue of their backgrounds and expertise in community oriented social justice work. The considerable experience of public health nurses should be central to this call. Our National experiences with egregious inequities exposed by COVID-19 and police violence compel us to re-envision *how* and *who* is involved in the development of such a TFA. As practitioners, educators, researchers, and activists we are viscerally conscious of the persistent inequities and injustices in healthcare and all sectors of society. Our practice demands deep reflection on our own power, privilege, and assumptions, and the centering of these reflections within our decision-making.

Our examination of this TFA comes from a social justice lens informed by our experiences as public health nurses. Some of these perspectives were recently outlined in a November 2019

report submitted to the Future of Nursing initiative by the **Council of Public Health Nursing Organizations**, formerly known as the Quad Council Coalition of Public Health Nursing Organizations. This report covers eight critical “upstream” public health issues¹, specific action steps, and a summary of stakeholder groups specific to each step. As such, this report is our model for addressing the SDOH: the eight issues provide the call to action, the action steps capture our nuanced understanding of the complexities involved with what must be done, and the identification of stakeholders indicates that we are oriented toward *collaborative* styles of leadership in achieving progress.

In the following sections we provide specific critiques of the content of the TFA from our aforementioned perspective. We especially identify where in the document we believe upstream thinking has been replaced by downstream, or individualistic thinking. We conclude with a discussion of the opportunities for revision and a path forward for this important work.

Critique of the TFA

This critique is divided into four sections. We discuss the issue of the audience for this TFA, problematizing the assumption that all nurses can use it. We observe that upstream thinking has been supplanted in some important sections by downstream/individual “lifestyle” thinking. We argue that most conceptualizations do not reflect actual practice and are overly simplistic and linear. We provide detailed feedback on the style, format, and content.

Audience and orientation

The authors use the familiar Assessment Diagnosis Planning Intervention and Evaluation (ADPIE) layout to simplify the process for nurses hoping to address social determinants of health and advance health equity in their communities. There is a strong sense of an “all-nurse-coalition” working to help others facilitate community partnerships in order to create community initiatives that improve health outcomes. However, the importance of community agency, voice, and control over these processes is *absent*. Indeed, there are no commentaries inside this document from any community stakeholder group.

A major shortcoming that we see in this TFA is that the authors seem to assume hospital-based nurses, or even clinic-based nurses in the community, will somehow independently devote time outside of their clinical practice to doing this work (working with community leaders, etc...). Achieving equity can never come to fruition on the back of “volunteerism”, but it does not appear that the authors have considered this issue. Indeed it is ironic that the authors do not question or challenge the structure of a healthcare system workplace that does not invest in population health work. Indeed a recent RWJF Campaign for Action blogpost reifies this

¹ See <http://www.quadcouncilphn.org/documents-3/>. These issues are: Racism; Poverty; Workforce education; Refugee health; Emergency preparedness; Environmental Justice; Population health versus population health management; and Violence

position that nurses *must* (or *should*) volunteer for free to perform this work ([Fishman, 2017](#)). None of this happens *sustainably* without *intentional* % FTE apportionment of nursing positions dedicated to complete this work. Hospitals and healthcare systems are largely not allocating time for acute care nurses to be paid to do this, despite receiving community benefit dollars from the Affordable Care Act.

There is an explicit assumption in the TFA that nurses should take a central role in the work to address SDOH in communities. For example, “Nurses are in a unique position to conduct a community assessment, since they often have first-hand knowledge of the most critical health needs that their patients/communities experience” (p. 9²). From a public health nursing perspective, this assumption is patently ethnocentric. Nurses need to work with humility in community settings, collaborating with community members to generate actions to address SDOH that are determined by community members, and not necessarily based simply on “need”. The focus on need denies the importance of community voice, local knowledge, and power-relations central to the leadership for action that should emanate from authentic experiences of oppression. The TFA focuses on coalition-based organizing as a core strategy but appears to mask that it is the RWJF “Action Coalitions” of nurses in each state that are the vehicles for this organization. This is troublesome in three ways: 1) There is very little peer-reviewed evaluation data on the effectiveness of these Action Coalitions, especially in their accessibility to nurses in general and specifically in their achievements in undoing upstream structural inequities; 2) Coalitions are by nature varied and complex in developing short- or long-range responses to structures of perceived injustice; 3) The nurse role in coalition work is under-described. The TFA glosses over these difficulties, especially with regard to the need for training in community organizing and collaboration. This is a dangerous precedent, especially given the long and troubled history of “expert” interventions in coalition work.

The lack of inclusion of community voice; the assumption that nurses will do this work as volunteers; that nurses are the arbiters of community need and the assumption they have an innate ability to lead coalition organizing are major flaws in the orientation of the TFA. For example, we were especially concerned to read the advice given on determining community priorities: “Decide if the good you can do will be worth the effort it takes” (p.21). This statement implies that addressing the SDOH in a complex environment may not be worth anything.

Downstream versus Upstream thinking

The TFA makes an attempt to describe upstream approaches but becomes hopelessly muddled in differentiating between disparities and inequities (see p.4), devolving to the statement that “inequities...occur on the ...structural/institutional level and individual level”. There is no description of what is meant by a level. Without adequate discussion of the ecological model

² As the TFA in MS.Doc form did not have the pages consistently numbered; we are basing our page numbers in the order they appear in the document (1-33).

there are grave perils in articulating this understanding as a difference in levels (Krieger, 2008).³ The ultimate risk with elevating individual and lifestyle change strategies as a fair target for change encourages the maintenance of the existing status quo in healthcare system action on the SDOH. Indeed, in Table 1, all of the items in the “Health Impact” column are at the individual level. For example, the upstream health impacts of “housing insecurity” are not “chronic disease and poor health” as posited by Table 1; instead, they are crowding, underfunded building maintenance, and segregation.

Furthermore, the terms used for the social determinants of health provided in Table 1 do not reflect the current state of literature, lack contextual grounding, have significant omissions (environmental justice and food justice, for example), and differ from other lists provided in the same document. Upstream thinking is discussed on p.12, but the point is obfuscated by the assertion that addressing social needs is something they call “middle stream” and “upstream from medical interventions” without actually providing an upstream intervention (such as undoing institutional racism).

Moreover, the TFA appears to have an individualistic US health care emphasis in addressing aspects of health with freedom and choice versus a World Health Organization orientation, for example, in their definition of access (“Factors such as lack of insurance; provider availability; fragmented services; and navigating services”) rather than considering access to health as a human right and that access involves physical accessibility, financial affordability, and acceptability.⁴ As a result, an ideal opportunity in the Overview and Purpose section for actually naming the structural inequities that oppress marginalized people (e.g. structural racism) is missed and the thesis is decidedly focused more on individual risk.

Overly simplistic with linear orientation

The orientation of the document, as we discussed, is that all nurses can do this work and that the “Toolkit is designed to provide step-by-step instructions” (p. 3). However, from our experience the work involved in addressing the social determinants of health is anything but a simple straight-forward, clear “step-by-step” recipe. Some particularly dangerous outcomes from this ideology include the glossing over of asset mapping and the conceptualization of community organizing through coalitions; each of these is discussed below.

Asset mapping is a completely different orientation toward nursing practice that is not found in the AACN Essentials. This perspective challenges the hegemonic view of medicine as defined by disease and needs. In our experience it takes considerable training to undo the medical model view in both nursing students and community members. And yet an assets-based approach yields important opportunities for systemic change by ascribing the lens/orientation toward ways to

³ See Krieger, N. (2008). Proximal, Distal, and the Politics of Causation: What's Level Got to Do With It? *American Journal of Public Health*, 98(2), 221.

⁴ See <https://www.who.int/bulletin/volumes/91/8/13-125450/en/>

increase sustainability and resilience in community systems. The TFA unfortunately is oriented toward a needs model and not an assets model: the word “need” is used more often (n=27), compared to the word “asset” (n=5).

As we discussed earlier, the decision to include nurse-centric Action Coalitions as the vehicle for addressing the SDOH through community mobilization is a simplistic notion. Further, the resources and discussion do not begin to describe the methods of community organizing necessary to accomplish coalition work. Incredibly, the only resource provided is the “Crucial Conversations Text”⁵ which would be familiar to acute care nurses but bears no salience to the intricacies and depth needed for cross-cultural and intergenerational community organizing in communities already devastated by colonial forms of oppression and distrustful of the potential impacts of another “well-meaning” nurse.

Thus, when responding to the call to address the SDOH through coalition work, the very political nature of this work is overlooked. Policy work in our experience is intensely political and at times can be dangerous. Yet in this document there is very little serious consideration of the formidable challenges ahead in terms of undoing the intersectional structures of racism, classism, sexism, xenophobia, and ableism that undergird the health inequities we witness every day in America.

Style/Structure/content

As previously described, the document lacks rigor in defining terms and identifying the social determinants of health and structural inequities. The structure of the document to precisely follow the ADPIE process undermines the central importance of community collaboration and organizing for the nurse. Our review of this document found the content to be lacking in a variety of areas, including descriptions of inequities; the processes for in-depth assessment, planning, implementation and evaluation; and the provision of a comprehensive set of resources reflective of the depth and breadth of the field. In particular we recommend:

1. Adopting World Health Organization definitions and language where possible.
2. Include the work of marginalized groups inside the resource HUB.
3. Include a more thorough description of the role of the nurse in community organizing, including collaboration and the role of the outsider; and include community partnership guides such as Alameda County’s Handbook for Participatory Community Assessments.
4. Include the descriptions of environmental justice, including the SDOH of climate change inequities.
5. Include descriptions of reproductive, racial, gender, and economic justice.

⁵ Patterson, K., Grenny, J., McMillian, R., & Switzler, A. (2012). *Crucial conversations: Tools for talking when stakes are high*. (2nd ed.). New York, NY: McGraw Hill.

6. Expand the assessment resources beyond the CVI index (Which was not designed to address SDOH) to include MAPP (NACCHO), EJScreen, and a description of the contents of the Community Toolbox (Kansas).
7. Expand the planning/implementation/evaluation section to include links to Logic Model, PRECEDE-PROCEED, MAP-IT frameworks, CDC Evaluation Matrix, Process Evaluation frameworks, and models of outcome evaluation such as Utilization Focused Evaluation. These are inherently aligned with public health approaches, which are markedly different from using acute care frameworks to accomplish public health work, and depend on public health nursing leadership.

Opportunities for a path forward: Revising the toolkit as a handbook to guide nurse engagement in addressing the SDOH through a Public Health Nursing lens that centers on social justice.

Nursing in general provides a rich and vibrant opportunity for transformative actions to address the social determinants of health. What is missing from this toolkit are perspectives of public health nursing. This particular lens situates the macro perspective of “public health” as upstream research, theory, and practice.

To enact the goals of the TFA, nurses must understand their role as a contributory source of empowerment and leadership for community members seeking to address structural change in their political, social, and economic systems. This perspective orients the necessary work of the public health nurse to address social justice issues at the core of all human endeavors. Coalitions cannot work unless members center conversations about race, class, and gender inside all of their meetings and agreements, guarding space in these conversations for consideration of marginalized voices and indirect impacts of policies and actions.

A public health nursing approach provides a holistic, multilevel perspective for structural change in laws, policies, practices, and culture within communities and promotes inclusionary practices for community organizing, collective decision making, and cultural humility. The wisdom of over a hundred years of research, education, and practice informs our perspective. Furthermore, our ideas are accessible to other nurses who in their daily practice must recognize and respond to the downstream results of health inequities and a broken healthcare system. Significant steps have been taken in the last decade to raise awareness of the need for transformation of nursing education and system practices to bend the arc of justice toward the dismantling of oppression. This TFA, if re-envisioned as a handbook with a public health nursing lens that centers on social justice principles, might generate the needed momentum toward undoing the ongoing and unjust structural violences of racism, poverty, and environmental injustice.

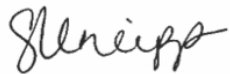
Sincerely,



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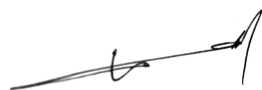
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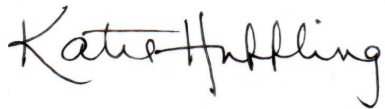
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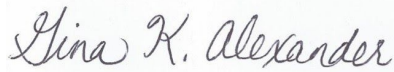
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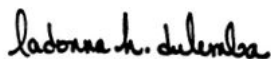
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