

Preface



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In 2000, when the federal government released the document *Healthy People 2010* [1] one of the two goals for the initiative was to eliminate health disparities that occur by race and ethnicity, gender, education, income, geographic location, disability status, or sexual orientation. With the focus on improving the health of the nation through improvements in the health status of individuals, populations, and communities, one of the leading health indicators identified was access to care. The goal of eliminating disparities and the leading health indicator are intertwined because in order to eliminate health disparities, one must have access to care. The barriers to such access are noted in the document as financial, structural, and personal: lack of health insurance; low income (financial); lack of a health care provider to meet basic and special needs; lack of availability of health care facilities (structural); culture, religion, and language barriers; lack of knowledge about health care seeking behaviors; and concerns about confidentiality and discrimination (personal). When the barriers to care are compared to the population identifiers where disparities are likely to exist, it is easy to see the relationship between the goal and the health indicator and the need to improve access in order to eliminate the disparities in health status, life expectancy, and quality of life for individuals, populations, and communities.

The population identifiers above are often those that are used to describe the concept of vulnerability, or those people most likely to have little or no

access to care and those at risk for poorer health status. Vulnerability is a global as well as a local issue, with the populations and communities who are defined as vulnerable changing depending on geographic location and the individual's, as well as the community's, level of risk for developing particular health problems [2]. Health care initiatives and partnerships targeted at access to care for the most vulnerable are essential to assisting the United States in moving toward eliminating health disparities. In the 2005 Healthy People 2010 midcourse review [3], there are mixed reviews about the health disparity objectives. Much work is needed to make a difference by 2010.

While there are many worthy goals, the 2010 objectives chosen to measure progress toward improving access to care were increased proportion of persons with health insurance (with a specific source of ongoing care) and the proportion of pregnant women who begin prenatal care in the first trimester of pregnancy. While the midcourse review did not have data on access for pregnant women, more recent data indicate that the problem of access as a result of lack of health insurance has worsened. In 2000 there were 40 million uninsured persons in the United States. In 2008 there are 47 million, or 15.6% of the total population. The numbers of uninsured children has risen slightly from 11 million to 11.7 million of all children under age 18. Similarly, in 2000, 40 million persons did not have an ongoing source of health care. This figure included both the insured and uninsured. Today, it is reported that there has been an 11% increase in the numbers of persons with an ongoing source of health care [2].

This issue of *Nursing Clinics of North America* highlights eleven projects that are assisting with improving access to care and an ongoing source of health care to vulnerable populations, some with and some without health insurance. Conceptual models are proposed and tested, application of old and new models of health care delivery are described, and interventions are used or recommended. Often, nurses work with vulnerable populations who do not have access to care, and who have or are at risk for poorer health status than the population at large. These projects emphasize the work of nurses with individuals, populations, and communities. These projects involve those who experience homelessness, who live in poverty, who are pregnant, migrant workers, immigrants, developmentally disabled, abused, victims of violence, or substance abusers. These projects also focus on particular age groups, such as children and the older adult, and particular health problems and life stages, such as chronic disease and death. Geographic locations include inner city, urban, and rural.

The article by Esperat and colleagues presents a new evidenced-based model for conceptualizing, and explaining how to predict and intervene in health behavior management with vulnerable populations. The model is applied with interventions at the individual and community level. Danner and colleagues discuss an intervention aimed at early identification of dementia

in African American clients, a population the authors say may not have equal access to care and may wait longer to seek care when needed.

Involvement with the churches assists in building trust in the community. Eddy and colleagues describe a “town and gown” partnership to address the problem of pregnant women in violent relationships. Kennedy and Floriani describe their work with children and their families, aimed at enhancing healthy lifestyles through an after-school intervention program and an inner city primary care practice. Lashley focuses on the development of interprofessional and community partnerships as a way to address the oral health care needs of an urban homeless population in a faith based inner city shelter.

Education, screening, and improved access are emphasized. Pfeiffer and colleagues offer insights into lessons learned about the essentials of care and the development of resources to provide care to pregnant women and their newborn children during a public health emergency. Community partners and pre-event planning are noted as a must. Robley discusses a community hospital experience in providing palliative and end-of-life care needs for the dying patient. Speck and colleagues address the problem of the overburdened prison system and the positive results of providing a community-based drug court program of rehabilitation for persons accused of drug-related crimes. Because incarceration of the addict involved in petty crime has resulted in relapse (and often additional criminal activity) the authors argue that nurses can provide safety net clinics to assist these persons to a higher level of wellness. Anderson and Riley share the woes of the long haul truck driver, exposed to stress, long working hours, little sleep, lack of a support system, and hazardous road conditions. These risk factors, they say, expose the worker to possible use and abuse of a variety of substances. Riley further describes a statewide project aimed at improving the health status of a total population. This project involves a college of agriculture, five health care colleges, and county extension agents, as but a few of the partners in this endeavor, to address the chronic disease problem in a state that is largely rural and where more than half of the counties are in designated “medically underserved” areas.

Finally, Turner and Stanhope paint a picture of an integrated virtual nurse-managed center that provides primary and community health care services to children and adults of all ages through ten community-based sites located in schools and free clinics, including two clinics for the homeless and one for new babies and their families. A geomap shows the outreach to children in four elementary schools, and the outputs of the center are described over time. Foundation, education, health department, and university partners are highlighted.

While the projects discussed highlight the work of nurses and the impact the nursing profession can have on improving health care access, the articles also highlight the effects that community and interprofessional partnerships have on enhancing and sustaining these projects. At any given time in any

location all of us may become vulnerable. A health condition for which we have been at risk may emerge. Because we are not the gatekeepers of the health care system, as individuals we may be denied access, as one author recently learned through a personal experience. As we can envision through these projects and interventions, nurses can help break the cycle of vulnerability and improve health care access for all, regardless of existing individual, population, and community circumstances.

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