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Chronic health conditions in the disparities population, the impact on practice settings, sociopolitical factors and stakeholders; one US city's solutions to address the issues and how nurses can advocate for change–a DNP nurse reflection

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Introduction

Disparities in healthcare in the United States (US) have been a problem for many years but with the rapid growth of racial and ethnic minorities, from 12.3% in 1970 to 25 % now, the problems have doubled and are expected to get worse as the years go by Modlin.[1] There are multiple underlying factors responsible for the healthcare disparities including low socio-economic status, cultural beliefs and practices, poverty, employment, access to healthy food options, education, poor health literacy, and lack of access to healthcare services (primary care providers). Policy makers have recognized more needs to be done, that providing social support and services, and partnering with healthcare systems are strategies that will decrease the disparities, improve health equity, and reduce healthcare spending. The US Department of Health and Human Services[2] in its efforts to bridge the disparities gap launched Healthy People 2020, a continuation of Healthy People 2010, with a goal to improve the health of all populations. Along with this are a growing number of initiatives and partnerships aimed at addressing the many issues including the social determinants of health to improve population health and well-being. These initiatives outline the actions that cities and communities across the nation in partnership with healthcare systems are taking to deal with the problems.[3]

The City of Cleveland located in Cuyahoga County, Ohio is one of many communities in the nation affected by healthcare disparities. Even more significant is the large number of community members (disparities) afflicted with chronic health problems, poorly managed and controlled. In tackling the problems, Cuyahoga County launched a *Health Improvement Partnership-Cuyahoga* (*HIP-C*)[4] with major area hospitals, county, city and state health departments and government to collaborate on solutions.[4] A community health assessment revealed the high priority health problems include heart failure with frequent readmissions, heart disease, strokes, diabetes, late stage cervical and breast cancers.[4] The purpose of this article is to explore a power dynamic, how chronic health conditions in the disparities population impact practice settings, the impact of legitimate power from the viewpoint of sociopolitical factors, stakeholders, and other interested parties, and how nurses can advocate for and influence change on a broader level, the different levels of healthcare (macro, meso and micro).

Description of the power dynamic

Chronic diseases are the leading causes of death and disability in the US with the disparities population accounting for a significant portion of the statistics.[5] This population compared to the white population boasts a higher incidence of diseases, disabilities, and poorer health outcomes with individuals dying much earlier.[1] Health disparities are often viewed as populations having no access to quality healthcare or because of poverty. However, there are multiple underlying reasons responsible for this complex issue.[1,5] Cuyahoga County in Ohio is home to a large disparities population (racial and ethnic minorities), without health insurance which means healthcare organizations and stakeholders are faced with a myriad of communities' health problems that can no longer be ignored. Adding to the problems is the severity of illnesses seen in the large numbers of disparities patients readmitted within 30 days of discharge notably with poor health outcomes. Furthermore, healthcare organizations and hospitals are burdened with assuming the costs of caring for these individuals adding to an already over-burdened complex health care system.

Social determinants play a key role in the health and wellbeing of the disparities' individual that winds up having a domino effect on communities.[6] There is a significant difference between those with health insurance, better health, and longer life expectancy compared to those afflicted with chronic diseases, no healthcare, and poor health with shortened life expectancy. The disparities populations include members of all ages ranging from infant to the elderly and minority ethnic groups. Addressing this gap in healthcare disparities is essential. However, several power factors (internal and external) influence how a healthcare system is run, the decision-making, policies and procedures, programs and initiatives.

Legitimate power

Legitimate power from a sociopolitical standpoint includes regulatory agencies such as the American Nurses Association (ANA) code of ethics that demands registered nurses (RNs) have a duty and responsibility to provide competent, safe, ethical, and appropriate care for all patients including the appropriate delegation of nursing tasks. Nurses as patient advocates must protect the rights and safety of patients and hospitals and must set goals to support magnet standards for quality outcomes and performance assessment.[6,7] For example, nurses in many organizations participate in shared governance unit

activities by setting the tone, influencing unit based and organizational policies and procedures by using evidence-based practices to guide improvement and quality of care. Abood[8] suggested nurses should move beyond the practice setting, step out of their comfort zone by becoming involved in the legislative arena advocating for and influencing health policies, much needed changes in our healthcare system. This means getting involved beyond the clinical level. For example, nurses can join a professional organization such as the ANA and learn how to participate in legislative activities. With close to three million nurses in the United States, the ANA,[6] already involved in government healthcare legislation, can have a greater impact with the collective voices of all nurses in healthcare policy-making.

Legitimate power from a stakeholders' perspective refers to employees in a healthcare system including doctors, nurses, hospital administrators and leaders, social workers, case managers and specialty services accountable and responsible for providing care to the patient. As healthcare providers (direct and indirect care) stakeholders have an obligation to ensure patients are receiving safe, ethical, high quality cost effective care with good outcomes. How poorly or well employees are performing filters up (impact) the dashboard of organizational performance as measured by such metrics including patient outcomes, quality of care, costs, and patient satisfaction scores. For example, a county hospital and Level I trauma center must provide care for the large percentage of disparities populations ensuring there are no inequities in care. Hospital administrators and leaders must ensure financial and overall operational efficiencies to maintain the financial health of the organization.

Legitimate power from an interested parties' standpoint refers to insurance companies, federal agencies such as Medicare and Medicaid, and regulatory agencies such as the Joint Commission that oversees organizational compliance in the best interest of public safety; organization risk management and education department ensuring standards of practice and guidelines are followed; and clinical staff are up to date on annual education requirement and competencies. For example, Centers for Medicare & Medicaid Services (CMS) changed its reimbursement rules late 2012 to no longer paying for readmissions within 30-days of discharge.[9] With the high rate of heart failure readmissions in Cuyahoga County this chronic very costly health problem forced many health systems to devise strategies and initiatives to try and fix the issues. As well, regulatory agencies are using performance measures such as health outcomes, quality of care, and costs in grading hospitals' performance, the dashboard of which is shared on a public database.

Reflection on the power dynamic

Macro level

The macro level refers to government agencies, healthcare policies, laws, and regulatory agencies. In meeting the federal guidelines of *Healthy People 2020,* the *HIP-C* coalition conducted an assessment of communities with results published in 2013. The assessment identified multiple social, political, economic, environmental, and cultural issues. *HIP-C* is using a multipronged approach partnering with stakeholders, health systems, state, county and city governments with interventions to address the many social, economic, and environmental factors that influence populations' health and well-being. This include unemployment, uninsured, uneducated, poverty, unsafe housing, environmental risk factors, reduce early deaths from drug overdose, violent crimes, improve social and mental health, maternal and child health, rate of communicable diseases, behavioral risk factors, and to make available more health resources. The goal is to improve the overall quality of life. The driving force is *Healthy People 2020*, federal and other levels of government funding this massive project with legislation and regulatory support. Nurses as healthcare givers are an important part of this equation. Nurses spend the most time with patients and have the skills, abilities, training, and critical thinking to deliver holistic care. Nurses know what is required from a holistic viewpoint. Advanced Practice Registered Nurses (APRNs) can bridge the primary care provider gap from a qualification and cost effective standpoint. Restraining factors include lack of funding, lack of primary care physicians to meet the needs of all populations; nurses poor understanding of legislation and health policies; restrictive regulations for APRNs that impact access to healthcare; under-utilizing APRNs training, skills, and expertise.

Meso level

The meso level includes organizations and hospital systems that provide healthcare to different groups of patients, some with similar disease processes or in meeting the needs of populations. The city of Cleveland boasts some of the states' leading healthcare organizations and health systems. Each of the city's four main health partners[4] are focusing initial efforts on preventive care, primary care, improved chronic diseases management, and providing culturally competent and health literacy education targeting the leading chronic diseases (heart failure, heart diseases, stroke, diabetes, and late stage cancers). Realistically, the initiatives require much more than just access to care. Health literacy identified as a nationwide issue in *Healthy People 2020* is an important consideration in healthcare delivery.[10] Patient centered care is the care delivery model in the health systems involved. This means providers must ensure culturally competent care delivery; education and interventions must incorporate such factors as low health literacy, language barriers; the environment - culturally diverse underserved, poor communities where family, cultural beliefs, practices and lifestyle impact self-care, healthcare, and decision-making. Communication is a key factor in healthcare delivery; furthermore, all communication including printed materials must be in plain, simple language that the individual can understand.[11]

Restraining factors at the meso level include lack of funding for the required clinics needed to meet the needs of this large population, provide quality care; meeting the needs of health literacy and culturally diverse communities; staff trained in cultural competence; lack of primary care providers; nurse researchers being utilized, poor quality healthcare leadership; nursing shortage resulting in "missed care"[12] that impact quality outcomes, quality of care; and waste, abuse and fraud of healthcare resources.[13] Driving forces at the meso level include transformational health care leaders who support and influence a healthy work environment, use of APRNs to staff clinics; nurse led clinic initiatives for which Doctor of Nursing Practice (DNPs) are well trained to meet this challenge; nurses as experts advocating for health policy changes, more involvement in policy formulation by explaining issues and situations, utilizing evidence-based concepts to support the changes;[14] decreased readmission rates for heart failure, heart diseases, strokes, diabetes and cancer patients as evidenced by decreased financial losses, and cost savings.[15]

Micro level

An organization is made up of many clinical microsystems, units that function collectively and collaboratively to provide healthcare

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with nurses at the micro system level providing direct bedside care to patients.[16] Nurses use a combination of skills, education, experiences, and knowledge of evidence-based practices to provide individualized holistic care to patients. For example, based on anecdotal accounts, nurses at a Cleveland hospital are accountable for explaining and teaching discharge instructions using verbal and printed education materials to heart failure and other chronic diseases patients using language and methods at the level of the individual's (disparities population) understanding. Teaching methods incorporate social, cultural, and environmental aspects of the individual's life impacting self-care and self-management of their chronic conditions focusing on how important it was to follow the recommended guidelines. This strategy is aimed at increasing patient involvement, compliance in their care at home. The goal is for individuals to make the correct dietary and behavioral choices in managing their condition at home for a better quality of life. This long-standing initiative proved to be successful by decreasing the high rates of 30-day readmissions. However, many forces at the meso and macro levels beyond the control of frontlines staff can impact the micro level and how nurses practice.

Restraining forces that impact practice at the micro level include inadequate staffing; funding issues; unhealthy work environment (bullying, lateral violence, toxic culture); inferior management and poor quality leadership; limited resources and malfunctioning equipment that restrict efficiencies in daily practice posing patient safety risks; poor skill mix of nursing staff; nurse fatigue and burnout with staff not engaged in anything beyond getting the job done; poor, ineffective communication; regulatory restrictive forces; and nurse turnover (lack of retention). Driving forces at the micro level include authentic transformational leadership and management supportive of a healthy therapeutic work environment with programs to support and value nurses, their work, and well-being; adequate staffing; improved retention; nurses involved in policy, practices, and decision-making promoting a culture of safety, culture of enquiry environment consistent with true shared governance models; adequate funding; use of evidence based practices to improve quality, safety, patient outcomes; and well-functioning updated equipment (resources) that assist in getting the job done timely, safely, efficiently, and cost-effectively.

Conclusion

Patient experiences and quality outcomes are key drivers in today's complex healthcare delivery system. Nurses as professionals, the main care providers of patient care are the backbone of healthcare systems and therefore essential to the functioning of the macro, meso, and micro systems level of healthcare. Nurses have a long history of adeptly advocating for patients' care, treatment, and well-being, trained to adapt easily in a dynamic care environment. Nurses as the single largest, most trusted group of direct care providers have the power to influence legislation and policies for much needed changes to improve the nation's complex healthcare system. Nurses have what it takes to work collaboratively with key stakeholders to guide communities, populations to better health, well-being, and outcomes.[17]

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Conflicts of interest

Author declares that there are no conflicts of interest.

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