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Enhancing nursing competence for future healthcare: Academic, hospital, and community partnerships

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Many countries throughout the world now face new challenges to their health care systems that will demand bold and inclusive action from health practitioners and researchers from several disciplines. A significant threat is the increase of chronic disease rates. For example, the WHO reports that diabetes and asthma are on the rise everywhere. Even low-income countries are seeing shocking increases in obesity, especially in urban areas and frequently among children. Moreover, by 2030, deaths due to cancer, cardiovascular diseases and traffic accidents will together account for about 30 percent of all deaths. A second threat is the increasing proportion of elders in the population. In Japan, for example, the share of 65-85 year old residents is expected to rise from 6% to 15% by 2025. A third challenge arises from the emerging infectious diseases such as MRSA, bird flu, West Nile virus, SARS and HIV.

Traditional medical and technical solutions are not as effective for these problems as health promotion and disease prevention, which take place in community contexts. These challenges present an opportunity for nursing researchers and practitioners to take the lead in their countries to begin a process of reforming health care systems to more completely include family and community sectors of society. One productive avenue for system change is to vastly expand the range of health related partnerships. Partnerships among traditional players such as hospitals, clinics, and public health exist and have been shown to be productive. New relationships need to be established with community organizations and agencies. Such community relationships offer expanded opportunities for nursing practice, education, and research. For example, nursing researchers have greater access to larger and more diverse samples from the community and nursing educators will find more sites for clinical practice.

Why must we work *with* and *in* the community? The most important reason is that everyday life occurs in communities, and both health promotion and disease prevention are directed toward families in communities as they live their lives. In addition, communities are a source of assets that can be harnessed by nurse scientists and practitioners, vastly increasing the reach and effectiveness of health promotion and disease prevention interventions. Working with community assets also promotes project sustainability. Why create partnerships? Partnerships denote working together on joint activities. They imply that each partner will bring its knowledge, skills, and resources to the project. The greater number of resources brought by partners enhances what one partner might have accomplished singly.

The Health Care Partnership Model (Figure 1) depicts a comprehensive system that takes advantage of existing health care resources and skills, as well as existing relationships among institutions and community members. The model proposes new modes of interaction among these players. It is based on existing projects in Japan and the United States and aims to preserve and promote the holistic, and person- and family-oriented strengths that characterize the discipline and profession of nursing. The central feature of the model is the *community coalition*. Coalitions, or other forms of relationships among businesses, community organizations, educational institutions, and public offices, for example, have become a popular way to organize for community action in the United States. Partners from diverse sectors of the community are joined together to address and solve common problems. Coalition members and their projects are not always directly involved with health care. At times such projects address problems in transportation or communications that are essential supports for a healthy society. A second element is the *continuum of care*, the existing relationships of official health care institutions such as hospitals, clinics, long term care, and public health.

The dynamic process that energizes this model is the education of health researchers and practitioners. Health science educational institutions prepare the workforce that populates the health care system, expressed in the model as a continuum from tertiary care to primary care and long term care to public health and home care. In addition, colleges and universities can create partnerships that are not only a source of strength for education, but also for health care and research in health related institutions

and in the community. Our students serve the community as care givers, community resources, and active participants in community change projects. Student participation in community activities provides insight into the lives and attitudes of people who are like the patients they see in the hospital. Practitioner knowledge of clinical science increases their credibility in community settings.

Through our leadership roles, universities influence the ways in which health personnel affect population health status. However, the community has been an overlooked resource until very recently. As we explore the model, I will show how a variety of projects in the U.S. and Japan have used community partnerships for health promotion, and how nursing faculty worked with the projects.

Through this model health science researchers can experience improved abilities to conduct research and to improve research quality. For example, there will be an ease of access to research subjects and populations, opportunities for collaborative relationships with community agencies, the potential to train community members as researchers, and enhanced capability to carry out approaches such as Community-Based Participatory Research. All of this can increase sustainability.

Seattle Partners for Healthy Communities was an urban health coalition (1995 2004) that used Community-Based Participatory Research to structure its variety of projects that ranged from support for African immigrant education and assistance with documenting the plight of people removed from welfare assistance to a participatory study of a domestic violence program for refugees and an experiment to reduce poor children's visits to the emergency room. The coalition included researchers from the university, leaders of grass roots non-profit organizations, and professionals in the public health department, which provided significant intellectual and logistical support. Coalition members worked together to develop projects broadly focused on the social determinants of health. Nursing faculty members were involved with the evaluation of the coalition and consulting on the conduct of the study.

A significant contribution was the development of "Community Collaboration Principles." These provided the coalition and its constituent partners with guidelines for carrying out projects in ways that promoted shared power. They included: a) that the community must be involved in project development at the earliest possible time; b) that community partners have a real influence on Seattle Partners directions and activities; c) the community is involved with specific projects through all aspects of the research; d) The values, perspectives, contributions, and confidentiality of community members are respected; and e) that the research will serve the community through sustaining long-term, beneficial projects and developing community capacity. These guidelines were sometimes difficult for agencies to carry out, but the project demonstrated that community partnerships were an effective way to promote community health.

A second Seattle project was part of a national program for health promotion and disease prevention called Racial and Ethnic Approaches to Community Health (REACH 1999-2007). The REACH coalition included Community Based Organizations (non-profits), community clinics, national voluntary associations such as the American Diabetes Association, a state-wide quality assurance business, the Schools of Nursing and Public Health, one of the university hospitals, and the local health department. Thus the REACH coalition embodied each element of the Health Care Partnership Model.

REACH also used Community-Based Participatory Research, in this case for the secondary prevention of diabetes across a variety of large racial and ethnic groups: African Americans, Latinos, and Asian and Pacific Islander Americans. Three types of small group interventions to assist people to better manage their diabetes were conducted in nine different languages. A key component of this intervention was the use of community health workers—community members who were trained to work with other community members in their own languages. Nursing faculty again carried out research and consulted on design and implementation.

The Seattle REACH project discovered that the use of accepted intervention designs (chronic illness self-management, diabetes education by professionals, and support groups) was successful. All groups were facilitated by community members who shared language and culture with community participants. Therefore the intervention was specifically tailored to the needs and cultural values of the ethnic communities.

Two community-based projects from the U.S. and Japan show how the model fits with nursing education. My community health students and I have been working in South Park, a small diverse neighborhood of Seattle, for thirteen years. Over the years we have created partnerships with about nine different organizations, some of which are extremely complex. This experience has been characterized by a) long-lasting community partnerships, b) rotation of both graduate and undergraduate students through the community site, c) a consistently warm community welcome, and d) a great deal of capacity-building for organizations and groups in the neighborhood.

The Department of Nursing at Shimane University Junior

College of Nursing, Izumo campus has developed "Reformation Toward Community-Based Nursing Education." This is a unique project in which there are two substantial goals: they are building an internet network for education and support among self-help groups in the prefecture. Second, they place their students with the self-help groups. Not only does this project promote health in the community, it also accomplishes three significant goals in student education: 1) increased student understanding of community views, 2) improved student

communication and problem-solving skills; and 3) well-prepared practitioners trained for the prefecture.

Dissertation research on a national sample by a faculty member at Ishikawa Prefectural Nursing University on self help groups for mentally ill people has generated findings that will be helpful for projects like the one in Shimane Prefecture. She has identified requirements for success for self help groups such as adequate administrative and professional support, positive attitudes among members, and the importance of the leader's personality.

A project much broader in scope that has now completed its first five-year funding cycle is "People Centered Care," the 21st Century Center of Excellence Program at St. Luke's College of Nursing in Tokyo. The college has partnerships that support 14 projects throughout Chuo-ko where the college is located. This project is built on the individual partnerships without a central coalition. A few of these are a Geriatric Education Center and Luke-Navi: Public and Health Professional Collaboration for Health Promotion. These projects and others are located in their own building in the heart of the ward. Two others are Kango-Net, Community Health Education Web Site and "Let's Learn About Our Body," a health promotion project for five year old children. Each of the St. Luke's projects has its own independent funding, thus promoting sustainability.

A final example of how the Health Care Partnership Model works is "Yuzawa-town Family Health Plan and Action Plan" in Niigata Prefecture. This coalition is composed of at least 52 partners such as the Chamber of Commerce, the Maternal and Child Health Council, and The Aged Club. The Chairman of the Steering Committee is the representative of the Disabled Persons Organization and the Vice Chairman, from the Diet Improvement Council, is a business woman. This excellent example of the model grew from the engagement of Yuzawa Town public health nurses with the nursing researcher from Saitama Prefectural University. They built a strong coalition that developed the family health plan and now develops new health promotion and disease prevention projects for the town. Nursing students have carried out their graduate research projects with coalition members.

Conclusion

Significant characteristics of the model are nurse researcher and nursing student participation, a focus on health across health conditions and the lifespan, and the development of community partnerships and coalitions to involve communities in their own health. Key requirements for the success of coalitions are:

- Joint problem-solving
- Capacity building
- Meet agency objectives
- Mutually agreed upon decision rules
- Communication and relationships

Factors that sustain such coalitions are Trust, Respect, and the need for Great Organizational Skills.

Figure I, Health Care Partnership Model