Multiple calls have been issued for academic nursing to prepare students to practice in settings outside the hospital walls. The National Advisory Council on Nurse Education and Practice (2016) outlined specific recommendations for nursing schools to develop innovative curricula that integrate population health competencies. The Josiah Macy Jr. Foundation (2016) concurred that academic nursing should prepare nurses for practice in primary care settings, echoing the call by the Advisory Committee on Interdisciplinary, Community-Based Linkages (2014) that health professionals should have high-quality, interprofessional, team-based community experiences.

Despite these calls, the majority of prelicensure clinical experiences remain in acute care. This staid method of prelicensure clinical education persists for multiple reasons, more likely to do with tradition, regulation, and the licensure examination than health or health care. Ill health frequently occurs long before hospitalization is sought. Health and wellness are greatly influenced by upstream measures, such as housing, neighborhood conditions, socioeconomic status, and lifestyle, more so than downstream measures, such as an acute episode of illness requiring hospitalization. Attention to upstream measures is far more likely to affect health status than hospital care during an acute episode of illness.

So why is it important for students to care for individuals, families, and communities outside of the hospital walls? When will students have experiential learning in interprofessional community-based experiences, if not during the educational process? When will students learn how to address the needs of specific populations and make connections related to the social determinants of health? The social determinants of health can be described as the lived environment or broad determinants of health that include childhood adversities; inadequacies in meeting basic needs related to wages, levels of education, working conditions, and housing; and a multitude of other conditions that have the potential to create environmental stress, addictions and marginalization—all of which affect health (World Health Organization, 2016). Accordingly, the differences in health outcomes at the population level are attributed to and rooted in the environmental contexts in which people live.

Curious to know how this has been addressed in prelicensure curricula, I queried academic colleagues via a national electronic network to ask: “How does your program integrate concepts of population health into the prelicensure curriculum?” I shared the view of primary care as individualized practice in a community-based setting and population-focused practice as encompassing not only the individual but also the aggregate and differentiated from public health. A common distinction is that population health focuses on the drivers of health with attention to the determinants of health, whereas public health focuses on ensuring conditions that promote health and reduce the incidence of illness, such as safe drinking water, vaccinations for preventable disease, and sanitation.

My colleagues expressed a variety of ways students learned about public and population health. The vast majority provided clinical experiences that placed students in communities to conduct assessments with the subsequent design of population-specific community health promotion projects. In general, the population and public health content was limited to coursework that spanned over one or two semesters in the curriculum, supplemented with varied community-based experiential learning opportunities. The communities were geographical or setting based, such as neighborhoods, census tracts, jails, churches, shelters, barbershops, and even fast food restaurants. These experiences certainly afforded students the opportunity to learn about public and population health. However, I still wondered how nurse educators can better facilitate students’ knowledge and experiences with population health and the challenges associated with the social determinants of health, which are often shaped by the distribution of wealth, power, and policy and subsequently affect the quality and length of life (World Health Organization, 2016). How can students be placed in the throes of everyday life to improve health? Many communities express mistrust of university researchers who enter communities to collect and gather data for their research but offer the communities little in return. How might universities create institutional commitment for sustained community engagement that promotes the health of and gives back to the community members and, concurrently, create expanded opportunities for engaging students in the process?

The Patient Protection and Affordable Care Act (ACA) of 2010 was designed to expand health coverage to individu-
als, control rising health care costs, and improve aspects of the health care delivery system (Congressional Budget Office, 2017). In March 2017, there was an unsuccessful effort to replace the ACA with the American Health Care Act. Many policy experts projected that approximately 14 to 24 million individuals would become uninsured had the replacement been successful (Congressional Budget Office, 2017). The future status of the ACA is unknown at this time, but attempts to “repeal and replace” have the potential to leave millions uninsured.

Given the current climate, perhaps now more than ever, nurse educators should make it a priority to provide clinical opportunities that teach students upstream measures to improve the health of populations. This includes structuring clinical experiences that provide students with an appreciable understanding of the Culture of Health, the goals set forth by the Robert Wood Johnson Foundation (n.d.) that lead to improved population health, well-being, and equity. You might ask how this can be accomplished in an already cramped curriculum. Do we really know how many acute care clinical hours are sufficient to prepare an entry-level nurse? Do we know how much repetition of the same task is necessary? Is performance based on the number of clock hours in the acute care clinical setting or mastery of objectives and competencies?

Now is the time to reconsider what we are teaching that perhaps is no longer needed. Is the status quo in the best interest of the health of the populous? How do we move beyond what we’ve always done to ensure relevance and that students are prepared for the future? What curricular innovations and reinventions are needed to prepare today’s students for tomorrow’s practice? I challenge nurse educators to:

- Develop community experiences where students are engaged in the promotion of health outside the hospital walls.
- Redesign the curriculum to facilitate the students’ acquisition of the knowledge, abilities, and values that will enable them to build healthier communities.
- Equip students to engage with underserved communities so they gain intimate knowledge of the effects of the social determinants of health and how those conditions affect health and health care.
- Design community-based learning experiences, ideally in interprofessional teams, that extend through the entire educational experience so students gain an appreciation of complex health issues and challenges and the strategies for addressing them to improve health.

In the Vital Directions for Health and Health Care, published by the National Academy of Medicine, Lipstein et al. (2016) predicted that the future workforce will be oriented toward health promotion and health protection and need skills in assessing and addressing the social determinants of health, knowledge of effective prevention strategies, and comfort working in cooperative interprofessional teams at the interface of health (physical and behavioral) care and the social environment. How will we prepare nursing students for this new reality?

**References**


Teri A. Murray, PhD, APHN-BC, RN, FAAN
Assistant Editor

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