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EDITORIAL

PHN PUBLIC HEALTH NURSING WILEY

A call to action for public health nurses during the COVID-19 pandemic

Public health nurses (PHNs) are on the frontline of the public health crisis the world now knows as the COVID-19 pandemic. They serve on mobile strike teams investigating case-contacts, deliver education on self-isolation and quarantine through hotlines and home visits, and interpret the rapidly shifting guidance from the Centers for Disease Control and Prevention (CDC). They are reliable and proven responders during infectious disease emergencies, providing safe, effective, and nondiscriminatory care to the communities in which they serve. Yet, despite their critical role, PHN positions have been underfunded, left vacant, eliminated, or replaced over the past three decades. Combined with outsourcing services to agencies that lack the public health mandate and institutional experience necessary to provide public health services to communities, the erosion of the PHN workforce has made us all more vulnerable to both chronic disease and emerging infectious disease threats.

National, state (territorial and tribal), and local public health departments have lost 55,000 public health workers since the Great Recession of 2008, and PHNs constitute the largest professional segment of this group (Trust for America's Health, 2019, April). The consequences of this nearly 25 percent reduction in the public health workforce has resulted in years of short staffing in health departments where, now, at a time of intense demand has compromised their ability to both mount an effective response against the coronavirus outbreak and maintain the routine essential functions of a health department (Centers for Disease Prevention & Control [CDC], 2017). In some communities, non-essential public health services unrelated to the prevention and mitigation of COVID-19 are currently suspended, including monitoring of tobacco and electronic nicotine sales and regular inspections of food establishments. Moreover, the skeleton crew our country assigns to primary and secondary preventive services is being diverted. During a well-documented crisis in maternal health care, the Nurse–Family Partnership Project, an evidence-based program that serves over 38,000 of the highest risk moms in 41 states, has seen diversion of their nursing workforce to COVID-19. The impact of the withdrawal of trusted and established care to families who are at highest risk for our most pressing public health problems—maternal and infant mortality, intimate personal violence, child abuse and neglect, mental health and substance use disorders—will scale back any recent progress made in these areas. The collateral harm from withdrawing these services will undoubtedly compound the societal impact of COVID-19. We can anticipate that many of the public health problems that we already faced before the pandemic are going to be exacerbated, and public health nursing will remain part of the solution to address these challenges.

Recognition of the need for a strong nursing workforce is part of our nation's history. After the end of World War II on February 28, 1946, President Truman acknowledged the fundamental capacities of public health nurses to attain health security for all Americans, recognizing them as "one of the most important groups of health workers in the country" (Associated Press, 1946, February 28, p. para.1). He went on to stipulate that adequate public health services will require "more than two new nurses in addition to every one now on duty in local, State, and Federal agencies"—remarks made in connection with the first annual observance of *Know Your Public Health Nurse Week*. Over seventy years later, in 2020, the *Year of the Nurse,* we call for resources to support the national minimum standard of one public health nurse per five thousand people in the United States (Association of State & Territorial Nursing Directors [ASTDN], 2008, September).

Federal financial assistance to support public health and this workforce standard was recently issued. This includes the Coronavirus Aid, Relief, and Economic Security (CARES) act that became Public Law No. 116–136 on March 27, 2020 (Coronavirus Aid, Relief, & Economic Security Act or the [CARES Act], 2020). This aid package contains $1.5 billion to support state and local public health departments and territories and tribes in their efforts to conduct public health activities, including: the purchase of personal protective equipment, surveillance for COVID-19, laboratory testing to detect positive cases, contact tracing to identify additional cases, infection control and mitigation at the local level to prevent the spread of the virus and other public health preparedness and response activities (Centers for Disease Control & Prevention [CDC], 2020, March 11). While beneficial, it is far from the $4.5 billion shortfall in the U.S. public health system estimated prior to the pandemic (Public Health Leadership Forum, 2018, October). Funds will be allocated to local health departments through the Centers for Disease Control and Prevention in the form of cooperative agreements. States and other jurisdictions have previously had flexibility in determining how such funds are appropriated. This includes deciding which sector of the public health workforce has the skills and training needed to carry out the activities allowable under the law. In addition to this bolus of funding from the CDC, state governments have also issued emergency funding earmarked for state and local public health, and more coronavirus-related emergency funding is expected.

This COVID-19 pandemic brings public health to the forefront, and it can serve as a catalyst to financial investment in public health nursing with the potential to bring improvements to population health in the near term and farther into the future. We urge public health nurses to advocate to authorities making funding decisions that the emergency money coming into states be transparently allo- cated. We urge public health nurses to work directly with their state health department, boards of health, county commissions, profes- sional coalitions, and Governor's offices to direct support to public health needs, including PHN positions, stipends, and services. As we have witnessed in the past, state and local officials will look to make the most efficient use of these funds to respond to the challenge that lays before them. However, efficiency goals cannot be met by substituting lower-cost employees for public health nurses, given their preparation, knowledge, clinical decision-making skills, and their ability to flexibly be deployed across a diverse range of activities in response to rapidly evolving public health needs (Campbell, Harmon, Joyce, & Little, 2020). To be sure, these professional skills will be in more demand if we hope to contain the second wave of transmission that will inevitably occur when physical distancing measures are relaxed, while herd immunity remains low.

It is also time to call on new and retired nurses to come into the fold of the public health response. Given the proven history of public health nursing's response during times of crisis and the elimination of PHN positions at the local level over the past several decades, it is time to invite our retired workforce, and soon to be matriculated nursing students alike, to adopt this call to action and enter or re-enter public health nursing practice (Spetz, 2020).

Today, we as public health nursing leaders are issuing a call to action among PHNs to combat this infectious disease pandemic. A central feature of this movement is undertaking advocacy for the profession at the state and local institutional level to develop and maintain a strong public health nursing infrastructure necessary to provide the foundational public health services. Our advocacy for funding the public health nursing infrastructure is not intended to minimize the absolute and critical needs of nursing in acute care settings at this time, but rather, it reflects an equally urgent population health need. We have heard from members of the public across the United States, and they want to see nurses in their neighborhoods, towns and communities, the faces of the country's most trusted profession and information source at this time of uncertainty and fear. This is particularly true for the socioeconomically and under-resourced communities, who will likely suffer the most in the wake of the virus's path, and with consequences that will be worse if appropriate health resources are not made available. Currently, plans for how the first wave of emergency funds from the CARES Act are to be distributed are being finalized. Thus, *now* is the time for advocacy on behalf of the communities and public we serve. To ensure a return of nursing to the core public health workforce, and maintenance of critical services in disadvantaged communities, every nurse reading this editorial must advocate for routing resources to bolster the public health infrastructure with the PHNs necessary to protect the public's health.

Tell us about how you are advocating for public health and nursing. Share your stories and comments with us HERE (https://bostoncollege.co1.qualtrics.com/jfe/form/SV_eh2FqpRubmt3agB). Please share with your colleagues and anyone whose work we can feature.

(The authors are, respectively, the Chair-Elect, Chair and Immediate Past Chair of the Public Health Nursing Section of the American Public Health Association.)

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