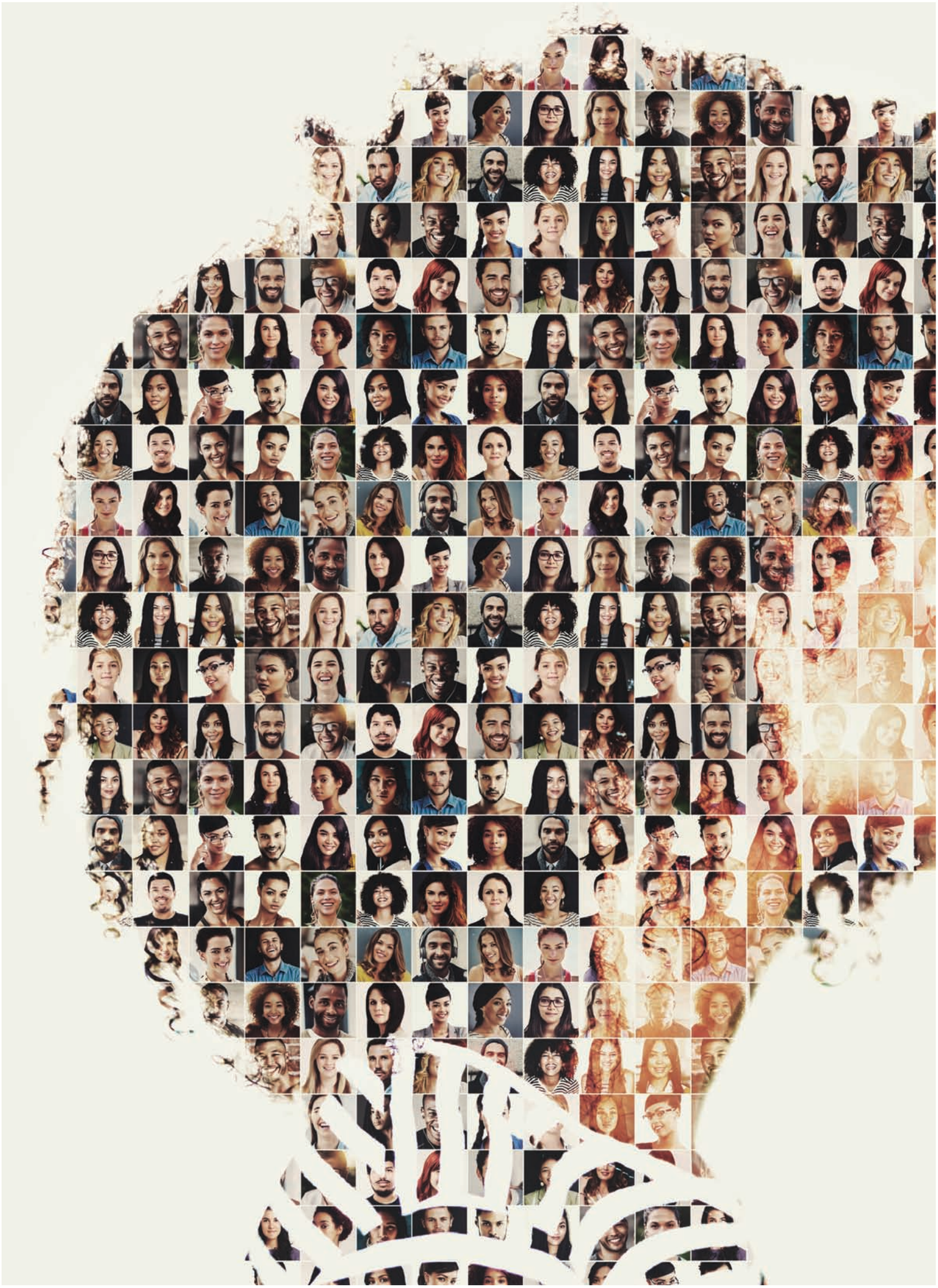


iStock/ PeopleImages

CE 2.5 contact hours

By Breanna Lathrop

When Healthcare Isn't Enough:
A CHRISTIAN RESPONSE TO SOCIAL DETERMINANTS OF HEALTH

ABSTRACT: *Education, employment, housing, neighborhood safety, and traumatic life experiences influence people's health, and poor health as a result of inequities in these areas cannot be remedied by medical care alone. Although social determinants of health threaten the attainment of a healthy life for people across North America, nurses are positioned to be leaders in a movement toward health equity. Nurses can follow the example of Jesus in loving their neighbors as themselves by addressing the social needs of patients, championing health system change, educating their communities, and advocating for Health in All Policies.*

KEY WORDS: *health disparity, health equity, nursing, poverty, social determinants of health*

Nurses, whether working in hospitals, clinics, community health centers, schools, or other facilities, desire to see individuals and those in communities achieve health. Yet, persistent health disparities threaten the attainment of a healthy life for people across North America. Nurses daily encounter examples of the ways in which poverty, racism, inadequate housing, food insecurity, lack of social support, and other social determinants impact health.

Christian nurses also recognize that these persistent disparities in health and longevity are not in line with God's desire for human flourishing. Jesus often healed people physically and opposed social structures that disadvantaged people. With an understanding of social determinants of health (SDOH), openness to personal reflection and change, and desire to demonstrate God's love, nurses can work both within and outside of the healthcare system to improve the lives of their patients.

HEALTH EQUITY AND SOCIAL DETERMINANTS OF HEALTH

Health equity describes the ability for all people to live a healthy life. Health disparities such as maternal mortality, cancer survival, and hospitalization rates remind us that health equity is not yet a reality in the United States. Such disparities are powerfully illuminated by life expectancy gaps of up to 30 years between neighborhoods within the same urban areas (Ducharme & Wolfson, 2019; NYU Langone Health, 2020). Researchers now suggest that ZIP codes

Breanna Lathrop, DNP, MPH, RN, FNP-BC, is a family nurse practitioner and the Chief Operating Officer at the Good Samaritan Health Center in Atlanta, GA. She is the coauthor of *How Neighborhood Make Us Sick: Restoring Health and Wellness to Our Communities* (IV Press).

The author declares no conflict of interest.

The article was accepted by peer review 1/08/2020.

DOI:10.1097/CNJ.0000000000000784

may be a better predictor of life expectancy than genetic code (Graham, 2016). Medical care prevents only 10% to 15% of premature deaths in the United States (Schroeder, 2007). Health behaviors such as smoking, diet, and exercise habits account for another 40% of premature deaths (Mather & Scommegna, 2015).

This begs the question, "What explains the rest of disparities in premature death?" Healthcare simply isn't enough. Social determinants of health are the conditions in which people are born, grow, work, play, and age and that affect health and longevity (World Health Organization, 2019). Education, employment, housing, neighborhood safety, and traumatic life experiences influence our health. These determinants are driven by social problems including racism, classism, and poverty. Christian nurses can recognize that these do not align with God's love for all creation and that nurses can take action to dismantle these social problems.

The impact of SDOH on health status is nuanced and complex. Certainly, social conditions influence the risk of certain health problems. If someone is sleeping outside or in a mold-infested environment, nurses are not surprised to note increased respiratory illness. If a patient has been unable to seek care due to long work hours and lack of health insurance, a nurse is not surprised to find diabetes or cancer at a more advanced state. Yet, social determinants are not only risk factors for health problems; they are directly associated with poor health outcomes (Braveman & Gottlieb, 2014).

People experiencing situations such as repeat evictions, frequent job change with lack of social mobility, food insecurity, and an inability to meet financial needs experience chronic stress. Although the body was designed to manage short-term stress, it was not designed to function optimally under the stress of severe resource disparities. The chronic stress of wondering about where to live, what to eat, and how to survive results in maladaptive coping mechanisms and changes to the neurological and endocrine systems (Steptoe & Marmot, 2002). Incidence of chronic disease such as high blood pressure and diabetes as well as rates of preterm labor are more common among people living in poverty (Akwo et al., 2018; Collins et al., 2019).

The influence of social determinants is also demonstrated through premature aging. Dr. Arlene Geronimus developed the weathering hypothesis in response to her question of why African American women were dying at younger ages than White women. She concluded that the stress African American women experienced was literally wearing down their physical bodies (Geronimus, 1992). Her hypothesis is supported by recent research on telomeres, the projective ends of chromosomes whose length is associated with longevity. Geronimus et al. (2015) found that poverty, education, safety, negative social interactions, neighborhood satisfaction, and hopelessness influenced telomere length. People negatively impacted by social determinants such as poverty and racism are at risk for premature aging.

National and global recognition of the importance of SDOH is increasing. Healthy People 2020 (Office of Disease Prevention and Health Promotion, 2020) now includes SDOH as a topic with objectives aimed at reducing poverty and housing insecurity, increasing educational attainment, and decreasing crime. The Centers for Disease Control and Prevention (CDC) places social determinants at the base of the public health pyramid for the Health Impact in 5 Years initiative, indicating these interventions have the greatest potential impact (CDC, 2018).

At a global level, the World Health Organization (WHO, 2020) has a Social Determinants of Health Unit to support countries in developing initiatives to promote health equity through addressing SDOH. The United Nations (UN) produced 17 sustainable development goals targeting determinants such as poverty, education, and inequality (UN, n.d.). When Jesus' disciples asked why a man was blind, suggesting the cause was his or his parents' sin, Jesus replied, "Neither this man nor his parents sinned" (John 9:1-12, NIV). Health is bigger than individual choices. As nurses, if we address only health behavior, we miss the opportunity to truly improve health.

NURSING AND SOCIAL DETERMINANTS OF HEALTH

Nurses regularly face dilemmas in which patient care is influenced by social factors. Examples include planning discharge for a patient who has no home in which to return, managing diabetes in a patient without a place to store insulin, or strategizing medication assistance options for a patient who cannot afford prescriptions. Addressing the social needs of patients is challenging, but even when done well, does not fully address SDOH.

The Code of Ethics for Nurses (American Nurses Association, 2015) reminds us that nurses' duty to improve the health of patients extends beyond the healthcare system and the individual social needs of patients. Nurses respect the dignity and worth of all people (provision 1), promote human rights (provision 8), and integrate principles of social justice into nursing (provision 9). These ethical directives require nurses to consider factors beyond direct patient care. This might include identifying ways in which policies are beneficial or detrimental to patients' health and educating lawmakers through advocacy. Nurses might partner with educators, such as a school-based health center model, to decrease missed school days due to untreated illness or poorly managed chronic conditions, increasing opportunities for health education. Or they may suggest ways online schooling can be facilitated to overcome barriers such as achievement gaps. Nurses can be members of outcome management and research teams, identifying disparities within their healthcare systems and developing system-level solutions to address them. This type of work is time consuming and difficult, yet necessary to eliminate health disparities and close the life-expectancy gap.

IMPLICATIONS FOR THE CHRISTIAN NURSE

Jesus provided an example of loving people by both meeting individual needs and addressing social issues. Christian nurses seeking to follow

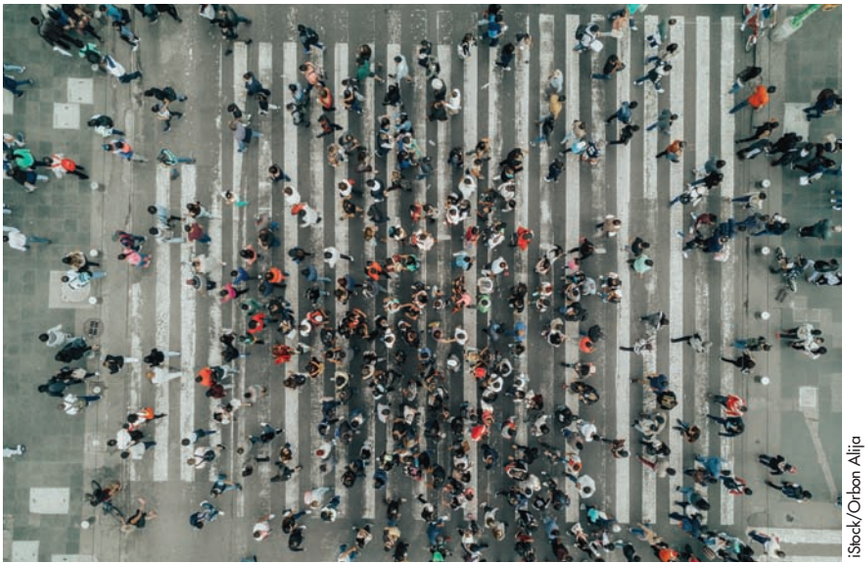
Jesus' teaching may view their work through an ethical lens focused by their faith. Nursing is not only a profession, but also a means of living out the belief that Jesus loves his creation and desires people to be healthy and whole. The Gospels reveal that healing was a central component of Jesus' ministry on earth. Jesus' interactions with society often centered on those most marginalized by society and he regularly disrupted social structures in his healing (Squires & Lathrop, 2019).

Luke 13 records that Jesus was teaching in a synagogue when a crippled woman entered worship. We are not told that she approached Jesus or even asked for help, but he placed his hands on her and healed her. The synagogue leader was outraged that this healing has taken place on the Sabbath. Jesus called out the leader's hypocrisy, challenging him that the woman's freedom from illness as a child of God was much more important than upholding the social rules of not working on the Sabbath (Luke 13:10-16).

In Luke we learn of a woman who desired healing due to a bleeding disorder and grasped the hem of Jesus' cloak as he traveled past. When Jesus asked who touched him, the crowd backed away and the woman fell at his feet. Her 12 years of bleeding rendered her unclean, meaning she had likely gone years without human touch; her uncleanliness and low social status placed her at the bottom of society. The crowd, expecting Jesus to rebuke her, heard him proclaim, "Daughter, your faith has healed you. Go in peace" (Luke 10:48, NIV).

Throughout his ministry, Jesus brought physical healing while offering forgiveness and changing the social status of those he healed. He healed leapers, enabling them to rejoin society (Luke 17:11-14) and restored the blind and the lame, allowing them to escape a life of begging (Mark 8:22-25; John 5:2-9). Jesus was not afraid to challenge social norms and religious structures that prevented people from experiencing this healing. The Gospels reveal a Savior who cares about physical suffering, social conditions, spiritual suffering, and oppression.

Christian nurses can thus reflect on their profession and personal work,



iStock/Orbon Alija

asking, "How can I do likewise?" Jesus commanded us to love our neighbors as ourselves. This neighbor might be the patient who has no home in which to return. The neighbor could be the emergency room (ER) frequent flyer whose drug abuse is self-medication for past trauma. Or this neighbor could be a family living just a ZIP code away whose life expectancy is lower than ours because of the neighborhood in which they live. God deeply cares about the plight of his creation and these inequities are not God's design.

INDIVIDUAL CHANGE

As Christian nurses desiring to love our patients as God loves them and fostering compassion in a world in which health equity is a reality, the work must begin internally. An initial step involves examining personal biases and narratives that can negatively impact interactions with our patients and people groups. The above examples of Jesus' ministry illustrate how Jesus' view of humanity differs from ours. "The LORD does not look at the things people look at. People look at the outward appearance, but the LORD looks at the heart" (1 Samuel 16:7, NIV). Jesus knew the heart of the bleeding woman when society had classified her as unclean. He recognized the ways in which society's boundaries contributed to the suffering of humanity. As people, we are quick to make assumptions without knowing the narratives and circumstances of the people we meet. Examining and challenging our assumptions and biases allows us to love more like Jesus and be more effective in our work as we seek to eliminate inequitable SDOH.

The narrative of poverty. Our understanding of poverty and its causes can shape the way we consider solutions to poverty and the ways in which we interact with people experiencing poverty. Household income—when compared with race, gender, employment, and neighborhood socioeconomic status—is the strongest predictor of lifespan (Signorello et al., 2014). Growing up in poverty causes a lasting impact on the body, from limiting developmental capacity (Jensen et al., 2017) to increasing the risk of cardiovascular disease in adulthood (Barr, 2017). In the United States, poverty is often viewed as an individual condition: People experience poverty often as a result of poor decision-making, mismanagement of resources, or the consequence of poor health behaviors. However, when considering the health impact, poverty is less of a condition and more of a trauma (Jensen, 2018; Sapolsky, 2005).

Squires describes poverty as a dripping faucet on concrete (Squires & Lathrop, 2019). A few drops of water do not damage the concrete, but with continual dripping, the concrete weakens and

Sidebar: Moving Upstream: How Nurses Impact Change

Social determinants of health are complex, covering all sectors of society with roots in racism and other forms of oppression. Considering how to eliminate their negative impact on health can be overwhelming. The notion of moving upstream in approach can be conceptualized by the common analogy in which individuals are drowning in a pool at the end of the stream. The immediate approach for the rescue team involves pulling the drowning individuals from the pool of water.

Next, the rescue team might ask, "Can we pull the individuals out of the stream before they get to the pool?" This approach is helpful. Then someone asks, "Can we stop people from falling in?" "Is something pushing them in?" "Can we move people back from the edge of the stream?" These questions illustrate the concept of moving upstream.

Nurses are unique in that they are involved at all levels of this analogy. Nurses are pulling out drowning people. We are treating those with chronic diseases, cancer, and imminent health threats that are, in part, due to social determinants. This is critical and necessary work. But nurses are also well positioned to move upstream in approach and help their health systems, communities, and nation do the same.

Nurses can start addressing SDOH by talking to patients about the social factors most impacting their health. This can be as simple as asking patients about the features and safety of the place they will return after discharge. Nurses could consider asking all asthmatic patients about mold and bug infestation in their place of residence and their ability (or lack thereof) to address it. Nurses working with patients experiencing high levels of nutrition-related diseases can ask patients about where they purchase food and what strategies they use when money for food runs short.

Conversations like this have several benefits. First, nurses are helping patients understand that their environment and social conditions impact their health. Although patients may not have the ability to change factors such as their living situation or socioeconomic status, these conversations can decrease stigma and shame. Patients may be more honest about their barriers to implementing positive health behaviors if they are not focused on avoiding shame. Strategies that decrease stigma around disease processes can positively impact health-promoting behaviors (Fischer et al., 2019).

These conversations also increase nurses' awareness of the social determinants most significant to their patient population and can focus their efforts on developing resources and referrals to meet these social needs. For example, a nurse working with people experiencing homelessness can learn about housing resources and develop relationships with caseworkers to whom they can refer patients. Although nurses cannot personally solve the social needs for all patients, creating strong referral networks within the community and connecting patients to resources can improve the health of individuals and their families.

cracks. For people living in poverty, daily stressors are like this dripping faucet. Riding two buses to get to the nearest grocery store, the dangerous intersection that never gets addressed, the landlord still hasn't fixed the leaky windows and the power bill keeps increasing, a few days of missed work to care for a sick child means being short on rent. This constant barrage of stress weakens the body physically and biologically.

Understanding poverty as a consequence and individual condition limits our approaches and solutions to addressing poverty. The burden for getting out of poverty lies with the individual currently experiencing it. A brief study of the data or a few conversations with individuals living in poverty quickly challenge this narrative. Only 16% of American children who grow up in poverty are consistently connected to jobs or school and are not poor by their late 20s (Ratcliffe & Kalish, 2017). There is a national shortage of 7.5 million affordable and available rental units for families living at or below the poverty line, and 75% of low-income households are denied federal assistance with housing due to underfunding (Aurand et al., 2018).

Sustaining work and advancing a career without a stable place to live is extremely difficult. Even among people who work, involuntary part-time work and wage stagnation keep workers in poverty. Over 2 million full-time workers and 5.7 million part-time workers live in poverty (Bauer, 2018). What if we consider poverty a social problem, a reminder of the way in which each of us is not living within God's desire for equity? If we approach poverty as a trauma versus a consequence, it expands our compassion and approaches to eliminate it. For nurses, this change can impact both how we consider community and policy interventions as well as our individual interactions with our patients. We can change the question from, "What is wrong with you today?" to "What happened to you?" Jesus modeled a similar approach in his ministry. When people sought his help or healing, Jesus often asked, "What do you want me to do for you?" An all-knowing God demonstrates that people know best what they need.

Implicit bias. As individuals seeking to create health equity, we need to be more knowledgeable of the role of racism in sustaining inequity as well as our potential racial biases. Inequities in SDOH extend from racism and our country's long history of segregation. Racism in the United States is rooted in the belief of the perceived superiority of White people (The People's Institute for Survival & Beyond, n.d.). Segregation, the enforced separation of racial groups, lies at the heart of health disparities, and racial disparities exist across every SDOH (Williams & Collins, 2001). For many, racism is not a consciously chosen belief system, but an unconscious response to living in a race-conscious society. Regardless, nurses must be aware of their implicit bias in order to provide care in a way that advances health equity.

Implicit bias describes negative evaluations against specific groups or categories that affect understanding and action (The Joint Commission, 2016). Most healthcare providers show some level of implicit bias with negative attitudes toward people of color (Hall et al., 2015). As nurses, this is particularly concerning in that bias affects behavior and contributes to health disparities. For example, differences in breast cancer survival between Black and White women have been described as a genetic difference, with Black women having an increased risk of estrogen receptor negative breast cancer. Recent research shows that Black women born in states with legal racial discrimination during the Jim Crow era had greater risk of estrogen receptor negative cancer than those born in states without Jim Crow laws (Krieger et al., 2017). Jim Crow laws legalized segregation in all aspects of society including healthcare. Hospitals

were segregated and, in some states, White nurses could not care for Black patients. Laws denying civil rights have been an important factor in poor health outcomes for Black Americans due to their influence on determinants such as housing, education, and employment as well as their direct affect on access to healthcare (Hahn et al., 2018).

Black Americans have a higher death rate when compared with Whites for 8 of the 10 leading causes of death in this country (Williams & Collins, 2001). Black Americans are not only more likely to experience negative SDOH, they are also more at risk for inadequate treatment within the healthcare system. Implicit bias is not limited to race as healthcare providers also have been shown to have implicit bias related to socioeconomic status, mental health, and drug use (FitzGerald & Hurst, 2017).

Creating strong referral networks within the community and connecting patients to resources can improve individuals' health.

As the definition implies, implicit bias is not intentional and operates on a subconscious level. Racism is uncomfortable and a willingness to choose awareness and change as opposed to a posture of defense is challenging. Yet, creating a safe and loving environment for patients requires nurses who are willing to do just that. Awareness and targeted action to address behavior influenced by bias is effective in creating change (The Joint Commission, 2016). Nurses who actively work to develop empathy can mitigate the impact of their biases. Specific examples of this include listening to patient experiences and taking time to consider patient perspectives. The influence of bias also can be addressed through partnership building, involving patients in the care planning process, and jointly setting health goals (Narayan, 2019).

Personal introspection to illuminate bias and challenge limited narratives is an ongoing process. Just as Christian nurses seek to grow in their relationships with God, they can grow in their understanding and love for the people God created. A lifelong commitment to recognizing social and health disparities and how we often unknowingly contribute is the first step in obtaining health equity.

INFLUENCING HEALTH SYSTEM CHANGE

As nurses become more aware of SDOH and their influence on patients, they can be advocates for change within their health systems. For example, nurses can advocate for their clinic or hospital to develop or adopt an SDOH screening tool. These tools, such as the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE; National Association of Community Health Centers, 2016), the American Academy of Family Physicians (AAFP) Social Needs Screening Tool (AAFP, 2018), and The Accountable Health Communities Health-Related Social Needs Screening Tool (Center for Medicare and Medicaid Services, n.d.), collect information on social determinants in the same way health systems collect vital signs and pain ratings. Most tools can be embedded in the electronic health record and result in reimbursement as well as improved health outcomes. This information can guide patient care as well as inform the health system about the social needs and barriers facing their patients. Health systems can create programing and initiatives focused on meeting these needs.

Knowing the impact of implicit racism on social determinants and health disparities, nurses can also help their health systems implement strategies proven to decrease the effect of bias on healthcare delivery. These strategies include staff training on self-awareness and perspective taking as well as strategies to protect providers from an excess of information, impeding their ability to partner with patients and express empathy (The Joint Commission, 2016). Nurses can assist in creating monitoring systems to collect outcome data based on race and identify disparities and promote hiring processes that ensure diversity at all levels of the organization (The Joint Commission, 2016).

Community education. Although healthcare systems can improve their approaches to addressing SDOH, healthcare alone cannot achieve health equity. As nurses, sometimes our greatest ability to help our patients occurs outside of our clinical work. When we share our stories, we help our community members understand how determinants like poverty, racism, homelessness, underemployment, and food insecurity affect the health of our nation. As nurses speak of their experiences and that of their patients, they illuminate health disparities in a way statistics and data cannot. Through vulnerable and intentional conversation, nurses can challenge their friends, family, and populace to identify biases and consider new solutions to social problems.

For Christian nurses, these conversations can happen in the church. As people united by their love for God and desire to share this love, the church community has immense potential for social change and healing. For example, a local church might post a list of municipal counselors and mental health providers, decreasing stigma and linking parishioners to care. A church group could open a free daycare center to allow low-income parents to work or seek employment. A parish might start a community garden and provide produce to their community or invest in a local school by supplying needed books, snacks, and after-school tutors. Viewing health disparities and inequities in social determinants as social problems that grieve the heart of God changes the way we interact with humanity.

Social system change. Eliminating disparities in SDOH requires changes in policy. Policy can cause generations of disparities as potently illustrated by legal racial discrimination in the Jim Crow era. Conversely, policy is a tool for implementing widespread change. Altering the social landscape requires

us to address the policies, legal codes, and social ideologies that have created concentrations of poverty and wealth and disadvantaged ethnic and racial minorities (Bailey et al., 2017).

Nurses can advocate for the health of their patients at all levels of policy both as healthcare providers and community members. At an institutional level, nurses can promote policies that foster diversity in hiring practices, identify and address discriminatory practices, and create healthy work environments with pathways for increased education and career advancement. At a local level, nurses might work with county commissioners or city officials to increase affordable housing options or improve local transit. Nurses can influence national policy by joining professional organizations, working in tandem with nurses across the country on legislation that address healthcare access, poverty, and social services. As nurses interact with their communities, workplaces, and government, they can evaluate policies and programs through a health lens, recognizing that those policies which most impact health are often unrelated to healthcare delivery.

Health in All Policies describes an approach to addressing SDOH in which public health practitioners, like nurses, collaborate with nontraditional partners to incorporate health considerations into decision-making across diverse sectors (Rudolf et al., 2013). In this approach, decision makers are educated about the health and equity consequences of policy options during the policy development process. Nurses are well equipped to assist in this effort. Through calling, writing an email, attending a school board or community meeting, or testifying at a committee hearing, nurses can emphasize the health impact of policies. Nurses can ask questions like, "What impact will this decision have on the most vulnerable in our community?" "Will this policy change benefit people living in the neighborhood with the lowest life expectancy?" "Does this policy inadvertently further disadvantage those most negatively affected by social determinants of health?" "How can we best demonstrate love for our neighbors in the decision we make?" (See Sidebar: Moving Upstream: How Nurses Impact Change.)

CONCLUSION

Although health equity often seems like a distant and unachievable reality, Christian nurses should remember—and remind others—that God is always working and we are invited to join in that work. Striving toward health equity is both a professional mandate and means of living out our faith. We can and should work within the healthcare system and in our interactions with individual patients, but healthcare alone will not close the life expectancy gaps and health disparities endemic in the United States. Through introspection, personal growth, storytelling, community engagement, and advocacy, nurses can help usher in a new era in which every person has the opportunity to live a healthy life. Christian nurses can support the vision of Jesus who "came that (people) may have life, and have it to the full" (John 10:10, NIV).

Web Resources

- **Health People.gov: Social Determinants of Health**
  https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
- **National Academy of Medicine: The Future of Nursing 2020-2030**
  https://nam.edu/publications/the-future-of-nursing-2020-2030/
- **National Advisory Council on Nurse Education and Practice: Integration of Social Determinants of Health in Nursing Education, Practice and Research**
  https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/nursing/reports/nacnep-2019-sixteenthreport.pdf
- **National League for Nursing: A Vision for Integration of the Social Determinants of Health into the Nursing Education Curricula**
  http://www.nln.org/docs/default-source/default-document-library/social-determinants-of-health.pdf?sfvrsn=2

Akwo, E. A., Kabagambe, E. K., Harrell Jr., F. E., Blot, W. J., Bachmann, J. M., Wang, T. J., Gupta, D. K., & Lipworth, L. (2018). Neighborhood deprivation predicts heart failure risk in a low-income population of blacks and whites in the Southeastern United States. *Circulation: Cardiovascular Quality and Outcomes, 11*(1), e004052. https://doi.org/10.1161/CIRCOUTCOMES.117.004052

American Academy of Family Physicians. (2018). *Social needs screening tool*. https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-form-sdoh.pdf

American Nurses Association. (2015). *Code of ethics with interpretative statements.* (2nd ed.). American Nurses Association.

Aurand, A., Emmanuel, D., Yentel, D., Errico, E., & Pang, M. (2018). *The gap: A shortage of affordable homes.* National Low Income Housing Coalition. https://nlihc.org/sites/default/files/gap/Gap-Report_2018.pdf

Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: Evidence and interventions. *The Lancet, 389*(10077), 1453–1463. https://doi.org/10.1016/S0140-6736(17)30569-X

Barr, D. A. (2017). The childhood roots of cardiovascular disease disparities. *Mayo Clinic Proceedings, 92*(9), 1415–1421. https://doi.org/10.1016/j.mayocp.2017.06.013

Bauer, L. (2018). *Behind the numbers: Millions seeking a path out of poverty.* Spotlight on Poverty & Opportunity. https://spotlightonpoverty.org/spotlight-exclusives/behind-the-numbers-millions-seeking-a-path-out-of-poverty/

Braveman, P., & Gottlieb, L. (2014). The social determinants of health: It's time to consider the causes of the causes. *Public Health Reports, 129*(Suppl. 2), 19–31. https://doi.org/10.1177/00333549141291S206

Center for Medicare & Medicaid Services. (n.d.). *The accountable health communities health-related social needs screening tool*. https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf

Centers for Disease Control and Prevention. (2018). *Health impact in 5 years.* https://www.cdc.gov/policy/hst/hi5/index.html

Collins, J. W., Rankin, K. M., Desisto, C., & David, R. J. (2019). Early and late preterm birth rates among US-born urban women: The effect of men's lifelong class status. *Maternal and Child Health Journal, 23*(12), 1621–1626. https://doi.org/10.1007/s10995-019-02816-2

Ducharme, J., & Wolfson, E. (2019, June 17). Your ZIP code might determine how long you live—and the difference could be decades. *Time*. https://time.com/5608268/zip-code-health/

Fischer, L. S., Mansergh, G., Lynch, J., & Santibanez, S. (2019). Addressing disease-related stigma during infectious disease outbreaks. *Disaster Medicine and Public Health Preparedness, 13*(5–6), 989–994. https://doi.org/10.1017/dmp.2018.157

FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: A systematic review. *BMC Medical Ethics, 18*(1), 19. https://doi.org/10.1186/s12910-017-0179-8

Geronimus, A. T. (1992). The weathering hypothesis and the health of African-American women and infants: Evidence and speculations. *Ethnicity and Disease, 2*(3), 207–221. https://europepmc.org/article/med/1467758

Geronimus, A. T., Pearson, J. A., Linnenbringer, E., Schulz, A. J., Reyes, A. G., Epel, E. S., Lin, J., & Blackburn, E. H. (2015). Race-ethnicity, poverty, urban stressors, and telomere length in a Detroit community-based sample. *Journal of Health and Social Behavior, 56*(2), 199–224. https//doi.org/10.1177/0022146515582100

Graham, G. N. (2016). Why your ZIP code matters more than your genetic code: Promoting healthy outcomes

from mother to child. *Breastfeeding Medicine, 11*(8), 396–397. https://doi.org/10.1089/bfm.2016.0113

Hahn, R. A., Truman, B. I., & Williams, D. R. (2018). Civil rights as determinants of public health and racial and ethnic health equity: Health care, education, employment, and housing in the United States. *SSM - Population Health, 4*, 17–24. https://doi.org/10.1016/j.ssmph.2017.10.006

Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., Eng, E., Day, S. H., & Coyne-Beasley, T. (2015). Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: A systematic review. *American Journal of Public Health, 105*(12), e60–e76. https://doi.org/10.2105/AJPH.2015.302903

Jensen, E. (2018). *The effects of poverty on the brain*. The Science Network. http://thesciencenetwork.org/docs/BrainsRUs/Effetcs%20of%20Poverty_Jensen.pdf

Jensen, S. K. G., Berens, A. E., & Nelson C. A. (2017). Effects of poverty on interacting biological systems underlying child development. *The Lancet. Child & Adolescent Health, 1*(3), 225–239. https://doi.org/10.1016/S2352-4642(17)30024-X

Krieger, N., Jahn, J. L., & Waterman, P. D. (2017). Jim Crow and estrogen-receptor-negative breast cancer: US-born black and white non-Hispanic women, 1992-2012. *Cancer Causes & Control, 28*(1), 49–59. https://doi.org/10.1007/s10552-016-0834-2

Mather, M., & Scommegna, P. (2015). Up to half of U.S. premature deaths are preventable; behavioral factors key. *Population Reference Bureau*. https://www.prb.org/us-premature-deaths/

Narayan, M. C. (2019). Addressing implicit bias in nursing: A review. *The American Journal of Nursing, 119*(7), 36–43. https://doi.org/10.1097/01.NAJ.0000569340.27659.5a

National Association of Community Health Centers. (2016). *PRAPARE: Protocol for responding to and assessing patients' assets, risks, and experiences*. http://www.nachc.org/research-and-data/prapare/

NYU Langone Health. (2020). *City health dashboard*. https://www.cityhealthdashboard.com

Office of Disease Prevention and Health Promotion. (2020). *Social determinants of health*. U.S. Department of Health and Human Services. HealthyPeople.gov. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Ratcliffe, C., & Kalish, E. (2017). *Escaping poverty: Predictors of persistently poor children's economic success*. U.S. Partnership on Mobility from Poverty. https://www.urban.org/sites/default/files/publication/90321/escaping-poverty.pdf

Rudolf, L., Caplan, J., Ben-Moshe, K., & Dillon, L. (2013). *Health in all policies: A guide for state and local governments*. American Public Health Association and Public Health Institute. http://www.phi.org/wp-content/uploads/migration/uploads/files/Health_in_All_Policies-A_Guide_for_State_and_Local_Governments.pdf

Sapolsky, R. (2005). Sick of poverty. *Scientific American, 293*(6), 92–99. https://www.scientificamerican.com/article/sick-of-poverty/

Schroeder, S. A. (2007). Shattuck Lecture. We can do better: Improving the health of the American people. *The New England Journal of Medicine, 357*(12), 1221–1228. https://doi.org/10.1056/NEJMsa073350

Signorello, L. B., Cohen, S. S., Williams, D. R., Munro, H. M., Hargreaves, M. K., & Blot, W. J. (2014). Socioeconomic status, race, and mortality: A prospective cohort study. *American Journal of Public Health, 104*(12), e98–e107. https://doi.org/10.2105/AJPH.2014.302156

Squires, V., & Lathrop, B. (2019). *How neighborhoods make us sick: Restoring health and wellness to our communities*. InterVarsity Press.

Steptoe, A., & Marmot, M. (2002). The role of psychobiological pathways in socio-economic inequalities in cardiovascular disease risk. *European Heart Journal, 23*(1), 13–25. https://doi.org/10.1053/euhj.2001.2611

The Joint Commission. (2016). *Implicit bias in health care*. Division of Health Care Improvement. Quick Safety, 23. https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_23_Apr_2016.pdf

The People's Institute for Survival & Beyond. (n.d.). *Undoing racism fact sheet*. http://www.pisab.org/wp-content/uploads/2018/07/PISAB-Undoing-Racism-Fact-Sheet.pdf

United Nations. (n.d.). *#Envision 2030: 17 goals to transform the world for people with disabilities*. Department of Economic and Social Affairs: Disability. https://www.un.org/development/desa/disabilities/envision2030.html

Williams, D. R., & Collins, C. (2001). Racial residential segregation: A fundamental cause of racial disparities in health. *Public Health Reports, 116*(5), 404–416. https://doi.org/10.1093/phr/116.5.404

World Health Organization. (2019). *About social determinants of health*. http://www.who.int/social_determinants/sdh_definition/en/

World Health Organization. (2020). *Social determinants of health*. https://www.who.int/social_determinants/about/en/

Instructions for Taking the CPD Test Online

- Read the article. The test for this CPD activity can be taken online at www.NursingCenter.com/CE/CNJ. Find the test under the article title. Tests can no longer be mailed or faxed. You will need to create a username and password and log in to your free personal CPD Planner account before taking online tests. Your planner will keep track of all your Lippincott Professional Development online CPD activities for you.
- There is only one correct answer for each question. A passing score for this test is 7 correct answers. If you pass, you can print your certificate of earned contact hours and access the answer key. If you fail, you have the option of taking the test again at no additional cost.
- This CPD test also is available for viewing at www.journalofchristiannursing.com in the table of contents for this issue under CE Test Preview
- Visit www.nursingcenter.com/ce for other CPD activities and your personalized CPD planner tool.
- For questions, contact Lippincott Professional Development: 1-800-787-8985.

Registration Deadline: March 3, 2023.

Disclosure Statement: The authors and planners have disclosed that they have no financial relationships related to this article.

Provider Accreditation:

Lippincott Professional Development will award 2.5 contact hours for this nursing continuing professional development activity.

Lippincott Professional Development is accredited as a provider of continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is also provider-approved by the California Board of Registered Nursing, Provider Number CEP 11749 for 2.5 contact hours. Lippincott Professional Development is also an approved provider of continuing nursing education by the District of Columbia, Georgia, and Florida, CE Broker #50-1223.

Payment and Discounts:

- The registration fee for this test is $24.95 for nonmembers, $17.95 for NCF members.

CE For 20 additional continuing education articles related to faith community nursing, go to NursingCenter.com/ce.