A policy pathway: Nursing’s role in advancing diversity and health equity

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\textbf{ABSTRACT}

\textbf{Purpose:} The aim of this manuscript is to embolden nurses to engage in policy that promotes diversity, equity, inclusion, and belonging to advance health equity.

\textbf{Background:} It uses the Future of Nursing Report 2020\textsuperscript{2030} to acknowledge the impact of structural racism and the need for a more equitable, just, and fair society. It also recognizes that nurses must harness their power and political will, to change and strengthen policies, so all nurses can practice to the full extent of their education and license.

\textbf{Conclusion:} A case study of the response to COVID-19 in one underserved community is included to illustrate policy in action.


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“When you see something that is not right, not just, not fair... you have a moral obligation to say something. To do something. Never, ever be afraid to make some noise and get in good necessary trouble.” – John Lewis, civil rights activist, and former U.S. congress representative, December 2019

\textbf{Introduction}

A policy pathway for nurses that advances diversity and health equity must include a commitment “to do something.” It must leverage nursing science, research, education, and practice in order to promote social justice within health and health care and to uphold health care as a human right. This manuscript aims to embolden nurses to engage in policy that promotes diversity, equity, inclusion, and belonging to advance health equity. It uses the Future of Nursing Report 2020–2030 to acknowledge the impact of structural racism and the need for a more equitable, just, and fair society (NASEM, 2021). The authors recognize that nurses must improve their diversity, equity, inclusion, and belonging literacy and fluency so that they may harness their power and political will to change and strengthen policies, payment models, and eliminate regulations and laws that restrict their scope of nursing practice. Such changes will promote nurses’ abilities to work more in line with their education and training to address health disparities.

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Diversity and the Nurses’ Role

Richard-Eaglin (2021) broadly defined diversity as “differences in thoughts, cultural norms among organizational departments, communication styles and preferences, values systems, and work styles” (p. 90). In addition, the Office of Disease Prevention and Health Promotion [ODPHP], U.S. Department of Health and Human Services (Office of Disease Prevention and Health Promotion, 2022a, 1a) defined health equity as “the attainment of the highest level of health for all people” and notes that achieving health equity requires valuing everyone equally; addressing avoidable inequalities, historical and contemporary injustices; and eliminating health care disparities. Growing evidence reveals a clear association between inequities in both health and access to health care and the social determinants of health (SDOH)—the conditions in which people live, learn, work, play, worship, and age—that affect a wide range of health, functioning, and quality-of-life outcomes and risks (National Academies of Sciences, Engineering and Medicine, National Academies of Sciences, Engineering, and Medicine NASEM, 2021). Indeed, SDOH—physical, built, social, and policy environments—can impact health outcomes more than individual-level factors.

Knowing about SDOH is not enough, however, nurses must “do something” to impact health outcomes and health disparities by addressing discrimination, social cohesion, access to health services, and poverty.

Nurses—on the frontline as caregivers, educators, researchers, and scientists, protecting the health and well-being of individuals, communities and populations—must hold themselves accountable for assessing, implementing, and analyzing policies that discourage bias in health care practices and standards. Using a Social Determinants of Health and Social Needs Model (Castrucci & Auerbach, 2019), nurses must seek justice and confront and mitigate structural racism when serving all of society.

The Future of Nursing 2020–2030 report also acknowledges the essential contribution of the nursing workforce but poignantly asks to what end the workforce’s capacity will address health disparities and the complex health and social issues that surround them (NASM, p. xv). The Office of Disease Prevention and Health Promotion [ODPHP], U.S. Department of Health and Human Services US Department of Health and Human Services defines a health disparity as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage” and notes that disparities “adversely affect groups of people who have systematically experienced greater obstacles to health.”Office of Disease Prevention and Health Promotion, 2022b (Office of Disease Prevention and Health Promotion, 2022a). It lists a broad range of groups, based on race or ethnicity, socioeconomic status, gender, and sexual orientation or gender identity, among many others. Health disparities are data points that compare health outcomes between populations of people, and they can be considered the consequences of health inequities. Health inequities are systemic, avoidable, and unjust social and economic policies and practices that create barriers to health (Braveman & Gruskin, 2003; Whitehead, 1992). Jones (2014) explained, “achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustices, and providing resources according to need. Health disparities will be eliminated when health equity is achieved” (p. S74). Recently, COVID has brought these disparities into sharp focus.

The COVID-19 pandemic uncovered severe public health challenges, calling attention to structural racism and exacerbated comorbidities associated with preexisting conditions on disadvantaged groups of people who have poorer health outcomes and increasing health inequities.

COVID-19 & Health Inequities: Taking Action in Nursing Practice

The COVID-19 pandemic has typified the complex social and political issues of both the nursing profession and greater society. It has pulled and pushed nursing and nurses’ influence, impact, and image in an unprecedented way and has been described as a “syndemic”, a synergistic set of problems associated with a “perpetuating configuration of noxious social conditions” that combine to damage health and increase health inequalities (Bambra, Riordan, Ford, & Matthews, 2020). The rates of infection, hospitalization, and death by COVID-19 in Black, Indigenous, and People of Color (BIPOC) communities were higher in all categories compared to White, non-Hispanic persons (CDC, 2021). The long-standing issues of structural racism, chronic disease burden, and health inequities among BIPOC communities directly influence poorer outcomes from COVID-19 infection (Flagg & Campbell, 2021).

Early in the pandemic, the public health response focused on stopping the spread of the virus, and mandatory lockdowns (mobility restrictions) inherently changed the normal daily functioning of most individuals. While this approach was well intentioned to stop or slow viral transmission, it had unintended consequences that most often affected minority communities.

Initially, the emergency approval of COVID-19 vaccines gave renewed hope in reducing the spread and deadly outcomes of the virus. Initial vaccine efforts yielded large quantities of individuals becoming fully vaccinated. However, early national data revealed that Whites were being vaccinated at alarmingly higher rates than racial minorities, despite worse health outcomes among minority groups (Ndugga, Pham, Hill,
Artiga, & Mengistu, 2021). Structural barriers, mistrust in health systems and government, vaccine safety, and lack of representative BIPOC health care professionals all contributed to lower vaccination rates among these groups (Marcelin et al., 2021). Structural barriers contributing to vaccine distribution inequities include convenience, language, immigrant status, transportation, computer accessibility, and lack of accessible and trusted point of access (Njoku, Joseph, & Felix, 2021). Regional and local statistics revealed similar findings with Whites getting vaccinated at twice the rate of Black and Hispanic populations (Yi, 2021). This required the early development of new models for community-based vaccination to augment large scale efforts to reach individuals who are disproportionately affected by COVID-19.

Engendering trust and confidence with vaccination requires a collaborative approach driven by the community. Breaking down organizational silos presented opportunities to leverage strengths, identify trusted relationships, and examine implicit structural racism. Collaboration between local and state health departments, health systems, nursing schools, community organizations, and faith-based organizations among others created a foundation for a community-based vaccination program. During the development of initial vaccination programs,

The Rutgers University School of Nursing-Camden approached local health officials and communicated the value of integrating nursing into the planning and implementation, conveying the message that nursing is not a subset of care providers within organizations, but rather is a driving force for change that can provide value insight into community-based and public health, is imperative.

Thus, addressing structural barriers to vaccination improved success with increased vaccination rates among racial minorities. Efforts included bringing the vaccine to where people live, work, and “hang out.” County busses and ride share vouchers were provided for people who needed transportation. Elimination of computer registration through development of reverse registration—wherein public health team members contacted community member and provided in person registration or phone call registration—removed technology barriers. Language interpretation services, multiple language information pamphlets, and a “no mandatory ID” policy decreased issues related to communication and fears of immigration status. Mobile pop-up sites at trusted community locations like churches, community centers, local organization, parks and schools, and home visits all increased vaccination rates.

However, while vitally important, these strategies fail to address the historical exploitation and contemporary racism of BIPOC communities. Corbie-Smith (2021) cautions using the term “vaccine hesitancy” as it places the focus on the individual. A fundamental shift must be made from blaming racial minorities of being vaccination hesitant to building trustworthiness of clinicians, public health systems, health care institution, researchers, and pharmaceutical companies (Best, Fletcher, Kadono, & Warren, 2021 & Warren, Forrow, Hodge, & Truog, 2020). Building partnerships that are trustworthy requires bidirectional communication, capacity building, and reciprocity (Quinn & Andrasik, 2021). The aforementioned experiences are congruent with these principles. Authentic partnerships with local leaders, community health workers, and ambassadors who are respected and trusted, and who reflect the racial diversity of the community, have improved vaccination rates. Although not every person agrees to vaccination, the mutual sharing of stories, information, and respectful conversation have provided valuable insights that inform relationship building. While “shots in arms” will have an impact on COVID-19 morbidity and mortality, they will not address the underlying causes of structural racism and health disparities. The experiences of nurses during the pandemic should motivate others to address structural racism and SDOH by engaging in all levels of public policy.

Yearby (2020) developed a framework for SDOH in which structural discrimination (race, sexism, ableism, and classism) is the root cause of racial health disparities. This model bridges the gap between health policy and practice to advance health equity. Yearby proposes that racism is not limited to one of the five domains of SDOHs (social and community context), but rather that it is the root cause of racial health disparities. In this model, law (policy) is a tool between structural discrimination and the SDOH domains that influence health outcomes. Considering this model, nurses have an obligation to actively engage in policy that addresses structural racism to improve health outcomes. Additionally, public health is an integral factor in racial health disparities, and it should be reflected as one of the SDOH domains. The Future of Nursing 2020–2030 report describes the critical importance of nursing in public health. Critical analysis of the public health response to COVID-19 and the well documented poor health outcomes for racial minorities, affirms Yearby’s recommendations.

Nurses across the care continuum have felt the pandemic’s strain, and nurses in community and public health roles have witnessed the pandemic amplify the consequences of historical racial health disparities in BIPOC communities. For example, mobility restrictions among low-income Black, Hispanic, and women of all racial/ethnic groups put them all at higher risk for unemployment, class cancellations with no distance learning, food insecurity, and mental health problems (Chakrabarti, Hamlet, Kaminsky, & Subramanian, 2021). Disparities extended into occupational settings with increased work exposure and prevalence rates of COVID-19 in BIPOC compared to White workers (Goldman, Pemble, Lee, Andrasfay, & Pratt, 2021). Positive COVID-19 screening resulted in job loss, time away from
work, and loss of income; therefore, policies addressing economic empowerment are necessary for equity among low-wage workers (Egede & Walker, 2020).

COVID-19 Case Study

The second author’s personal experience during the pandemic provides a microcosmic exemplar of public health, structural racism, and the perpetuation of racial health disparities. In the height of the pandemic, The Rutgers University School of Nursing-Camden provided executive level leadership at one alternative care site (ACS) designed from federal and military manuals to decompress overwhelmed health systems due to COVID-19 related-illness. Those admitted to the ACS were exclusively representative of racial minorities, persons experiencing homelessness, uninsured, non-English speaking, and/or undocumented; in other words, minority and disenfranchised populations were moved from the acute care setting to a location not designed to address complex social issues and discharge barriers.

For example, available emergency response manuals were technically detailed and designed for structure and process, but they were devoid of guidance on addressing health equity that directly inform health outcomes. Lessons from such public health disasters as Hurricane Katrina in 2005 and the H1N1 pandemic in 2009 appear not to have permeated ground level practice (Andrulis, Siddiqui, Purtle, & Cooper, 2012).

While not the initial intent of ACS, community needs shifted from decanting hospitals to developing a plan for the isolation and quarantining of migrant and seasonal farm workers, who are considered an essential work force as the national food supply chain is dependent on low wage workers. Often living in crowded housing (such as pole barns located on the farm), they are inherently at higher risk for communicable diseases like COVID-19. Consequences of COVID-19 illness and isolation can be catastrophic for both farm workers and farm owners.

The inherent make up of a large-scale public health response team created cultural competence and functioning issues within the nuances of caring for diverse populations. For example, Guard and Reserve military personnel in uniform supplemented the operations, but the undocumented persons were uneasy and reluctant to remain among them for fear of arrest or deportation. While this was easily addressed by requiring all personnel in care areas to be in scrubs. It illustrates the fundamental mistrust of the military and inadequate planning for the response. No processes existed addressing or even anticipating issues of equity and health disparities. The influence for change required real-time planning, spearheaded by nursing, to address cultural humility, language interpretation, culturally appropriate food, housing after discharge, cost of medications, and issues of long-term health conditions.

A Call to Action: Antiracism

Antiracism must first be addressed in health care and in nursing. Bailey et al. (2017) argued that focusing on structural racism is key to advancing health equity because it offers concrete and feasible approaches to improving the SDOH. Structural racism refers to the interconnected impact of discriminatory laws, policies, and institutions such as in education, health care, housing, food, employment, incarceration, and transportation that continue to produce disparate outcomes based on race and ethnicity (Bailey et al., 2017). The combination of these inequities, collectively and over time, results in structural violence. Structural violence was described by Farmer, Nizeye, Stulac, and Keshavjee (2006) as social arrangement that puts individuals in harm’s way.

Structural racism is also a source of structural violence because it causes injury in the form of both morbidity and mortality as measured by health disparities. One measure of structural violence is life expectancy. The national difference in life expectancy between White and Black populations is 3.6 years; however, in some locations—like Washington, DC—it can be up to 17.23 years (Roberts, Reither, & Lim, 2020).

Understanding approaches and solutions in health disparities targets health equity where “wicked” and “complex” problems must have the full engagement of interprofessionals to create innovative problem-solving and social justice policy changes. Eliminating disparate outcomes in health care is “a wicked problem,” i.e., a social or cultural problem that is difficult or seemingly impossible to solve (Kolko, 2012). Some of the factors that make a problem wicked include (a) incomplete or contradictory knowledge, (b) the number of people and opinions involved, (c) a significant economic burden, and (d) the interconnected nature of these problems with other problems.

Another lens of health disparity is complexity theory, which provides insight into the nature and difficulty of reducing disparate health outcomes. This framework views complexity as a multi-faceted, interconnected, and ever-changing system. Thompson, Fazio, Kustra, Patrick, and Stanley (2016) noted that because system behavior is often changing and unpredictable, it can be challenging to trace back to a specific cause. Complex health care problems have no singular solution, and solutions cannot be pre-determined; however, policy changes and solutions can emerge through collaborative, interdisciplinary, and community-based processes. This allows for open, transparent communication for interprofessional collaborative approaches and outcomes for the reduction in health disparities.

Page (2019) emphasized, through mathematical models, that the value of diversity is not only rooted in social justice but offers a knowledge “bonus” through cognitive diversity. Cognitive diversity refers to the
differences in the way individuals interpret, reason, and problem-solve, which can be beneficial in addressing high dimensional and complex issues. This source of diversity can come from the natural ways individuals think, learn, and process information, but it can also be experiential diversity and diversity of identity. However, the cognitive potential of diversity does not automatically occur, and mere proximity of diverse thinkers is not enough, especially in a society or within organizations that have been structured to favor some groups over others. Page pointed out that talent and diversity are lost when environments are not inclusive and not accountable to each other.

Ackerman-Barger, Valderama-Wallace, Latimore, and Drake (2016) described “inclusion” as a connective force for diversity which lays the foundation for the interprofessional teamwork and collaboration needed to improve quality patient care outcomes. They further defined inclusion as an environment where individuals see themselves as active members of a community in which their background, insights, and contributions are valued as part of the group’s creativity and productivity. Inclusion must be an organizational expectation, woven through policies and operationalized by the human resources that comprise the organization. In addition to considering cognitive diversity, nurses must also consider compositional diversity, which examines demographics to determine whether the diversity of a subset is representative of the whole.

In nursing, for example, the question posed is, “Does the composition of the nursing workforce represents the patients?” To achieve healthy lives for all people and prepare the next generation nursing workforce, nursing education must address deep-seated health care disparities and social inequities and overcome discrimination and implicit bias in the academy.

Nursing Education

To produce generations of nurses with the knowledge, skills, and desire to achieve health equity, nurses must be educated. Per Recommendation seven of the Future of Nursing Report 2020–2030, “Nursing education programs, including continuing education, and accreditors and the National Council of State Boards of Nursing should ensure that nurses are prepared to address social determinants of health and achieve health equity” (NASEM, p. 13). The report recommends that nursing education be strengthened to prepare nurses to identify and act on complex social, economic, and environmental factors that influence health and well-being.

To graduate equity-minded nurses, nursing schools must embed concepts like health equity, social justice, antiracism, and cultural humility into their curricula. Nurse faculty must ask themselves whether their course materials include learning objectives, course activities, and learning assessments related to deep thinking about health equity and social justice. As the next generation of nurses are prepared, educated, and informed, students must discover for themselves how to take actions that mitigate inequities and promote health equity. Learning materials must reflect diverse, inclusive, and representative groups without stereotyping. When classifying groups of individuals, course materials should acknowledge the wisdom and expertise of underrepresented communities, including the strengths and challenges experienced by those individuals.

One approach to ensure the voices and scholarship of diverse, underserved, and underrepresented faculty are seen and heard is to encourage and promote role models and mentors to be key informants on diversity, equity, and inclusion (DEI). The knowledge and perspectives of faculty of color are deeply underrepresented in academic nursing (Beard and Volci, 2013; Hamilton & Haozous, 2017), and Hamilton and Haozous (2017) noted that over the past decade, the percentage of full-time tenure track nurses of color has remained below 13%. Additionally, Taffe and Gilpin (2021) noted that Black scientists are less likely to receive National Institute of Health (NIH) grant funding than their White, Hispanic/Latinx, and Asian counterparts. Scholars of color have historically experienced exclusion and devaluing of their research, especially on DEI issues (Dotson, 2014; McFarlin, 2021). Perspectives from diverse, underserved, and underrepresented faculty will expand the scope of education and training to include researched and new knowledge in the discipline, and faculty of color can help guide what is being taught and how it is taught in undergraduate and graduate nursing programs.

As nursing education promotes and becomes equity-minded, it must also ensure that inclusive teaching and learning approaches reflect the varied learning experiences, perspectives, and styles of a diverse and representative student body. Finally, faculty may need to be trained in topics of social determinants of health and health equity and learn how to facilitate uncomfortable questions about racism and inequities. This process will require faculty to acknowledge that the wisdom and inquiries of students are valuable and essential for creating robust learning related to health equity.

Nursing Practice

Nursing has always been centered on humanistic caring and science, it is this ethos of empathy, compassion, trust, and respect that ensures people’s physical, emotional, and social needs are equitably met. The public trusts nurses and believes that they protect their rights and dignity. Gaines (2022) notes nursing as America’s most significant health profession, and it continues to be ranked the most trusted profession for the 20th year in a row, according to the Gallup poll in 2021.

The newly revised definition of nursing released in Nursing Scope and Standard of Practice by the American Nurses Association (2021) speaks to the
importance of advocacy in caring and connecting to society.

Nursing integrates the art and science of caring and focuses on the protection, promotion, and optimization of health and human functioning; prevention of illness and injury; facilitation of healing; and alleviation of suffering through compassionate presence. Nursing is the diagnosis and treatment of human responses, and advocacy in the care of individuals, families, groups, communities, and in recognition of the connection of all humanity (p. 1).

Nursing’s policy influence in advocating changes within health and health care is the “good necessary trouble” that Lewis calls for when “you see something that is not right, not just not fair,” including enacting injustices, violations of human rights, and health inequity. “There is now deeper evidence and understanding of the differential impact of generations of inequity associated with racism and bias, socioeconomic status, disabilities, financial poverty, and living in areas with decreased health care access that has fueled compromised health status for many of our fellow Americans” (National Academies of Sciences, Engineering, and Medicine NASEM, 2021, p. xiv).

Advocacy, along with the ability to conduct rigorous analysis and effectively communicate evidence, are competencies essential to policy changes. With these skills, nurses can tailor their message delivery and influence towards stakeholders and policymakers. The number of registered nurses employed in the health care workforce nationwide remains above 4 million. This is a sizeable workforce that can promote changes in regulation, legislation, and standards of practice (National Council of State Boards of Nursing [NCSBN], 2020).

Likewise, advancing policy changes requires power and the ability to distinguish the various forms of laws, regulations, and standards governing nursing, health, and public policy. Nurses must leverage their professional position, expertise, and political acumen to achieve health equity and equitable health care policies. If nurses’ concrete guidance and practical policy solutions are scaled to address health disparities, the root causes of inequities will be uncovered.

In fact, Dawes (2020) suggests that the political determinants of health are rooted in the factors influencing the laws and policies that create, perpetuate, or exacerbate the social, behavioral, and environmental impacts on health and wellness. For example, Dawes notes that health inequities are higher for BIPOC communities, where the differences in health care outcomes are issues of structural racism, marginalization, and neglect.

Promoting diversity and equity through policy calls for adoption of DEI role modeling of diversity and mentoring. According to the American Academy of Nursing’s (2021) statement on equity, diversity and inclusion, the Academy envisions “Healthy Lives for All People” and notes it must: Improve health and achieve health equity by impacting policy through nursing leadership, innovation, and science. To the Academy, equity is assuring the right conditions for all people to thrive and achieve their full potential; diversity is affirming how people differ; inclusivity is welcoming and active engagement of all voices within every aspect of the organization and with an intentional emphasis on acknowledging those who experience or have experienced marginalization or disenfranchisement.

Nursing as a Profession

Over the past few decades, nursing professional organizations have focused on policy changes to promote greater diversity in the nursing workforce. Aligning workforce diversity in terms of racial concordance between patients and nurses by ensuring the availability of a representative nursing workforce is critical. This requires reexamining nursing education, research, policy and resource allocation, and knowledge construction to be more DEI focused.

Dotson, (2014) defined epistemic1 oppression as exclusion that hinders one’s contribution to knowledge production. [Epistemic refers to the development and validation of knowledge].

Crear-Perry et al. (2021) note that a shared focus on how policy and practice create health inequities are pivotal in ending them and assert that “by defining the root causes of health inequities, we can move the focus of intervention away from individual blame and misguided theories of the biological basis of race and ethnicity” (p. 234). Ackerman-Barger, London, and White (2020) note that the factors that can exert influence on health laws and practice must be included in solving health disparities and achieving health equity, including current and accurate health disparities data, social determinants of health, historical and structural competencies, as well as a focus on solutions.

Acknowledging that health is often socially or politically determined allows for the development of strategic approaches to change health policy. For far too long, nursing and nurses have observed the negative impact of health inequities and disparate outcomes without seeing themselves as drivers of change. Shim et al., (2015) summed this up when discussing health care providers and mental health,

“[W]e needs to move from a culture of witnessing the negative impact of the social environment on mental health and thinking “someone should do something about this” to “I should do something about this” and, finally, “I can do something about this.” Through community involvement to shift social norms and through engagement with legislative process to improve public policy, we can experience a sense of community-focused agency, promote an equal distribution of opportunity, and
begin to heal an unfair and unwell society.” (pp. 17–18)

Nikole Hannah-Jones reinforced this during an interview with Balch (Nov. 2020).

“‘When we talk about systemic inequality, it kind of alleviates us from acting,’ she said. ‘We can throw our hands up and say, ‘Well, it is too big. It was created a long time ago, and there is nothing I can do personally.’ But that is not true. . . . It was created intentionally, which means it can be intentionally undone. The question is: Are we willing to put the same amount of effort into undoing inequality as we did into creating it?’”

Nurses and the nursing profession are capable of establishing equity-based standards of nursing practice, developing health care initiatives, creating and/ restructuring policy, and deciding resource allocation. Without diverse perspectives to help identify unheard and overlooked communities and offer research-grounded solutions, nurses risk complicity in the structures and mechanisms that create health inequities and disparities.

Conclusion

Professional nursing and nurses are getting into “good necessary trouble” as they tackle issues of social and environmental justice, community engagement, and access to high quality and universal health care for all. Awareness and knowledge in nursing science, education, and practice advanced health equity is not enough to impact policy, however; nurses must ignite their influence and policy activism by leaning in, harnessing the power to request, obtain, and access resources.

We the authors believe that diversity and nurses’ policy influence in advancing health equity and social justice begins with a commitment to addressing structural racism and discrimination in health and health care. In the words of Dr. Martin Luther King Jr. (1967), “We are now faced with the fact that tomorrow is today. We are confronted with the fierce urgency of now.” The future of health care demands that nurses create, promote and encourage policies that ensure diversity, health equity, inclusion, and belonging. Nurses must be unrelenting in their advocacy commitment, and actions towards advancing polices in diversity and health equity.

Authors’ Contributions

Donna M. Nickitas: Conceptualization, Validation, Writing - original draft, Writing - review & editing, Supervision; Kevin R. Emmons: Writing - original draft, Writing - review & editing, Validation; Kupiri Ackerman-Barger: Investigation, Validation, Writing - original draft, Writing - review & editing.

Box 1

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Appendix 1

Figures 1 and 2

Box 1 – Political Determinants of Health – Calls for Political Action.

Begin By Acknowledging Your Own Personal
• Be aware of sources of opinions and values
• Admit to learn from others in this journey
• Be open to conversations to understand others’ collective experiences

Be Aware of Environmental Implicit or Explicit
• Recognize instances or systems that are inherently racist or systematically limiting to people of color, different in sexual orientation, or with disabilities.
• Know your responsibility to address policies or activities that marginalize people who are colleagues or patients

Be Prepared to Act on Behalf of Your Patients, Colleagues or
• Become active in situations that call for your voice in matters of social justice, for each of your patients and for all of them collectively, and for your colleagues when called upon to disrupt a racially unjust situation
• Act with confidence that in matters of equity and inclusion, it is important to institute policies and procedures to move your organization positively

Become an Activist to Create a More Diverse, Equitable & Inclusive
• From the patient’s room, to the unit rounds, to the staff meetings, to the organization meetings, to the community meetings, to the professional organizations meetings to all of the boardrooms, speak up and speak out.
• Become an outspoken champion for DEI in the political arena locally, regionally and nationally.
Figure 1 – Social Determinants of Health and Social Needs Model. Source: Adapted from Castrucci & Auerbach, 2019.
REFERENCES


