Proposition 11 and Contemporary Medication in the U.S

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Abstract

Based on the findings obtained in this study, alternatives are proposed relative to service delivery among ambulance companies in California. Indeed, there is a need for California to embrace a unified service area in which ambulance companies may propose services for part of or all of the selected area in which they serve. This alternative exhibits economies of scale and reflects a more innovative approach to response among ambulance companies. By adopting this alternative, the implication is that the most appropriate and closest resource can be deployed to the scene. However, a demerit lies in logistical complexities in which competing firms might end up exhibiting effort duplication or, in some cases, fail to deploy resources on the assumption that other companies are available. Another alternative involves updating the standards of response time to ensure that patterns of California's population are considered. Notably, this option is advantageous because it aligns travel time standards among ambulance companies and, in turn, steer uniformity in service delivery. However, the demerit is that it fails to consider the effects of geographical patterns such as desert, outlying, rural, and urban conditions (and their impact on the realization of the travel time standards).

Introduction

In the U.S., Proposition 11 sought to ensure that the ambulance industry avoids the liability associated with practices that occur past break-time; as it strived to (legally) protect the practices. With EMTs and paramedics denied uninterrupted rest and meal breaks, this health measure (Proposition 11) implies that the ambulance staff ought to remain on duty during those breaks and ensure that they keep their pagers and radios on (even as they get lunch or coffee). The resultant dilemma is to what extent might this initiative shape operations from the perspectives of ambulance companies, the ambulance staff, insurance companies, healthcare organizations, and the federal and state governments?

Methods

One of the provisions of this health measure is that it allows ambulance providers to have their workforces paid at regular rates but remain on-call during breaks (Monterey County Herald, 2018). Also, the measure requires that the employers provide room for the additional training of paramedics and EMTs. Also, the measure calls for the employers to offer paid mental health services to the paramedics and EMTs (Vranjes, 2018). In the context of Proposition 11, the employees' need to remain on-call implies that they ensure that they are reachable via portable communication devices whenever they are on rest breaks and during meals (Matthews, 2018). In situations, where a worker's break is interrupted, the break does not contribute or count as one that the worker may receive. Regarding the provision of training

among ambulance providers, the initiative targets knowledge and skills related to mental health, violence prevention, natural disasters, multiple casualties, and active shooters (Brollini, 2018). It is also worth highlighting that the initiative seeks to have ambulance providers offer up to 10 paid mental health services to their workers (annually). For the case of employers offering health insurance, the initiative requires that the employers provide health insurance plans. These plans are expected to be those offering long-term mental health services (Chronicle Editorial Board, 2018).

Results

Mixed outcomes have been reported regarding the beneficial effects and demerits of this health initiative. For the proponents, the initiative was poised to lower the net operating expenses in such a way that as paramedics and EMTs stay on call even at the time of break, ambulance companies will avoid new ongoing annual costs (Monterey County Herald, 2018). According to Vranjes (2018), these costs are linked to the provision of off-duty breaks. Also, proponents avowed that the health initiative is advantageous because it provides room for the ambulance companies to operate more ambulances in a quest to rest break and meal schedules (Matthews, 2018). However, opponents avow that this decision leads to new costs due to the need for more ambulances.

Indeed, it is imperative to highlight that some paramedics and EMTs have sued the companies claiming that they might have violated the law in the past; yet Proposition 11 holds that the decision by private ambulance companies to advocate for the on-call rest and meal breaks was still allowable (Chronicle Editorial Board, 2018). Therefore, the extent to which the initiative will allow the ambulance companies to avoid the penalties of violating the law (hence avoid the one-time costs) will depend on the court's decision; whether in favor of the companies' past practice of requiring on-call rest and meal breaks or it will be in favor of the paramedics and EMTs, who have sued the ambulance companies (and the lawsuits are active) (Monterey County Herald, 2018).

Lastly, proponents of Proposition 11 avow that it exhibits a fiscal benefit of potentially reducing the net ambulance costs among local governments. According to Vranjes (2018), this assertion is informed by the proponents' position that the health initiative promises lower net costs among ambulance costs and this beneficial effect is likely to trickle down to local governments in which there will be higher revenues (in the wake of lower costs) (Matthews, 2018). Particularly, the reduction in the net costs for ambulance companies (hence local governments) accrues from the assertion that the initiative will relieve the companies of costs linked to the provision of off-duty rest and meal breaks (Brollini, 2018).

Several dilemmas arise from Proposition 11. For instance, the ambulance companies might increase insurance charges for commercial insurance firms (for the patients' trips); leading further to an increase in the peoples' health insurance premiums (Chronicle Editorial Board, 2018). Another dilemma is that the ambulance firms might replace paramedics with EMTs or lengthen the time of response to emergency calls. Notably, EMTs receive generally lower wages than paramedics (Monterey County Herald, 2018). Other scholarly assertions

indicate that the companies might pay counties less for the rights to offer services in their regions and, in areas deemed less profitable, the ambulance firms might not pay for the rights to offer services (Vranjes, 2018). In such cases, Matthews (2018) observed that the counties might be forced to pay ambulance companies to receive services in the perceivably less profitable areas (rather than vice versa).

Based on the findings above, alternatives are proposed relative to service delivery among ambulance companies in California. Indeed, there is a need for California to embrace a unified service area in which ambulance companies may propose services for part of or all of the selected area in which they serve. This alternative exhibits economies of scale and reflects a more innovative approach to response among ambulance companies (Brollini, 2018). By adopting this alternative, the implication is that the most appropriate and closest resource can be deployed to the scene. However, the Chronicle Editorial Board (2018) documented that the demerit lies in logistical complexities in which competing firms might end up exhibiting effort duplication or, in some cases, fail to deploy resources on the assumption that other companies are available. Another alternative involves updating the standards of response time to ensure that patterns of California's population are considered. According to the Monterey County Herald (2018), this option is advantageous because it aligns travel time standards among ambulance companies and, in turn, steer uniformity in service delivery. However, the demerit is that it fails to consider the effects of geographical patterns such as desert, outlying, rural, and urban conditions (and their impact on the realization of the travel time standards) (Matthews, 2018).

Conclusion

The best alternative involves the use of a unified service area model. This model is proposed because it seeks to counter several, potential demerits associated with Proposition 11. For instance, this model will curb the ambulance companies' potential failure to comply with the health initiative via the decision to pay counties less for the rights to offer services in their regions and even withdraw their services from areas deemed less profitable. Also, this alternative seeks to curb the potential negative response of the ambulance companies involving the increase in insurance charges for commercial insurance firms; as the model will specify the expected services, areas served, and the personnel expected to provide the ambulance services. The latter aspect will also aid in shunning the possible negative effect of the companies' decision to replace paramedics with EMTs, who receive generally lower wages than the paramedics. Hence, it is projected that the adoption of this alternative will improve ambulance services while curbing the weaknesses and dilemmas surrounding Proposition 11.

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The Study of Stem Cell Therapy and Implications for Medical Systems

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Abstract

Stem cell therapy has unlimited dental and medical applications. The evolution of the stem cell regeneration concept reflects a shift from the surgical care model to a medical model that has, in turn, paved the way for a biological model of care (through stem cell therapy). However, most of the selected articles affirm that the success of this practice and the ability to achieve the desired goals of stem cell therapy depend on the degree of collaboration and expertise among practicing dental surgeons, matrix biologists, cell biologists, biomaterial scientists, immunologists, and molecular biologists.

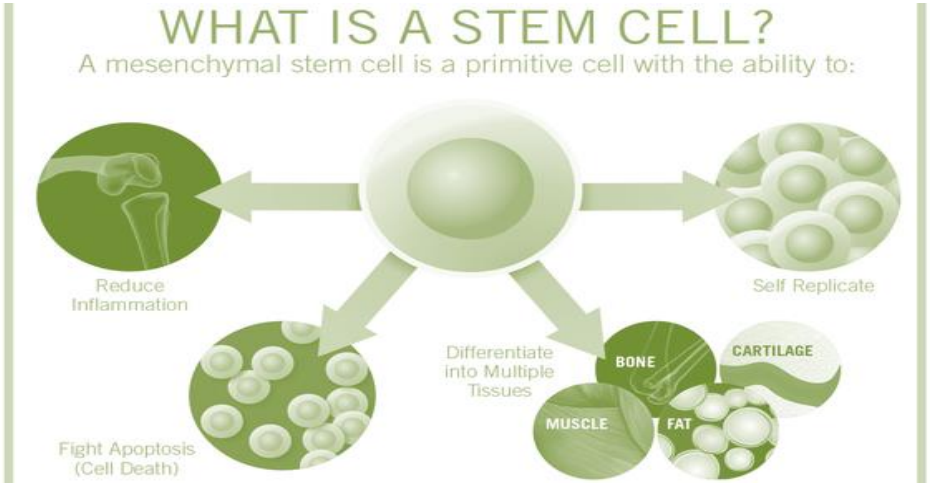
Introduction

Stem cells exhibit the capability to transform into any type of body cell (Poulos, 2018). This feature has paved the way for the cells to be used for purposes of repairing or regenerating diseased organs and tissues (Kim, Mehrazarin & Kang, 2012). This paper provides a literature review of some of the past scholarly studies that have focused on the subject of stem cell regeneration. In so doing, the section is projected to give an issue into subjects such as the current trends in stem cell regeneration, some of the merits and demerits of this practice, and future implications.

Methods

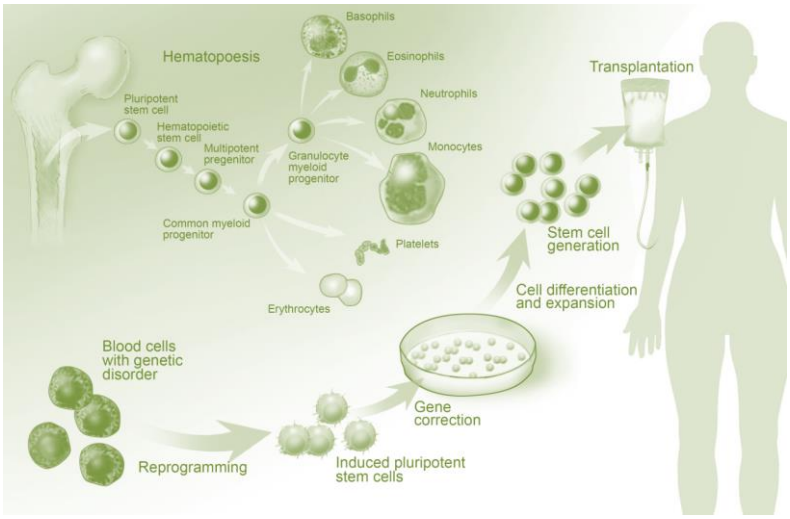
Some studies have focused on the efficacy of stem cell regeneration. In the experiment by Wu, Chiu and Chin et al. (2014), the main aim was to regenerate damaged tissues via the therapeutic use of stem cells. The study employed adult homologous stem cells and strived to determine their efficacy in damaged tissue regeneration. In the findings, the study reported that this therapy, which employs stem cells, is safe. Sudarshan, Annigeri and Vijayabala (2012) concurred that stem cell regeneration as a therapeutic intervention yields significant improvements in pump function and myocardial vascularization. Based on these findings, it can be inferred that the subject of lost tissue regeneration has received in-depth analysis but only recent research has made regenerative dentistry and medicine gain momentum; proving contributory to the subject of molecular biology. This secondary analysis draws information from journals and e-books, with a content analysis technique aiding in analyzing the study's results.

Results



In medicine, chronic debilitating diseases have led to the exploration of stem cells and their possible role in repairing, repopulating, replacing, and rewiring organs and tissues (Sankaranarayanan, Kailasam, Elangovan, Ravi & Sarkar, 2013). According to Kim, Mehrazarin and Kang (2012), the increasing attention in stem cell regeneration is informed by overwhelming success with which the therapy has been reported ─ relative to animal studies. With the animal studies avowing that stem cell regeneration is a promising therapy, several clinical trials have been conducted. In the study by Poulos (2018), the central objective was to find out the role of cell replacement therapy or stem cell regeneration in alleviating symptoms of diseases such as peripheral vascular disease, diabetes, arthritis, and cancer. In a related study, Alpert and Chen (2017) sought to unearth the contribution of stem cell regeneration in addressing heart failure and hematological disease. Findings suggested that stem cell regeneration is a promising therapy due to its promising results. In a related experiment, Nolta (2016) documented that for patients with type-1 diabetes, stem cell regeneration aids in protecting pancreatic islet cells. On the other hand, Horst, Chavez, Jheon, Desai and Klein (2012) observed that for individuals diagnosed with the chronic obstructive pulmonary disease, the cell therapy procedure aids in repairing the lung tissue.

Stem cell regeneration has also gained application in dentistry. For these studies, dental tissues have been used to obtain the stem cells. Some of the areas in which promising results have been reported include the ability to foster whole tooth regeneration, craniofacial defects' bone replacement and repair, and periodontal regeneration (Gasparotto, Landim-Alvarenga and Oliveira et al., 2014). Others include the repair of perforations and regeneration of apical or cervical dentin and resorbed root, as well as regenerations of damaged coronal pulp and dentin (Kim, Mehrazarin & Kang, 2012). In relation to the regeneration of damaged coronal pulp and dentin, stem cell regeneration has been found to facilitate the deposition of physiologic dentin (Wu, Chiu and Chin et al., 2014). According to Sudarshan, Annigeri and Vijayabala (2012), this facilitation has been contributory to medicine and dentistry whereby it has minimized micro-leakage and interfacial failure ─ while ensuring that the structural integrity of the tooth is restored.



In the study by Sankaranarayanan, Kailasam, Elangovan, Ravi and Sarkar (2013), it was acknowledged that in situations, where apexification or apexogenesis is required for young permanent teeth, stem cell regeneration leads to pulp regeneration. As such, it was observed that stem cell regeneration is important because its associated ability to promote pulp regeneration paves the way for the completion of development of lateral and vertical roots. In so doing, Poulos (2018) indicated that long-term prognosis is improved.

As mentioned earlier, stem cell regeneration has also been used in periodontal regeneration. According to Alpert and Chen (2017), some of the techniques that have been embraced to foster the regeneration of the periodontium include the use of alloplastic materials, allografts, and autologous bone grafts. Whereas the techniques have been used widely, Kim, Mehrazarin and Kang (2012) cautioned that the structure of the periodontium, which constitutes soft and hard tissues, has proved complex and too challenging for these methods. As such, cell-mediated regeneration has been employed to counter the limitations with which the techniques highlighted above are associated. In one of such studies, Nolta (2016) indicated that when expanded autologous marrow stromal stem cells (MSCs) are transplanted *ex vivo*, this process leads to the regeneration of new periodontal ligaments, alveolar bone, and cementum. Particularly, the experiment was conducted with dogs experiencing class III periodontal defects. In situations, where *in vitro* cultures of periodontal ligament cells are established, Horst, Chavez, Jheon, Desai and Klein (2012) asserted that the results demonstrate re-implanting into periodontal defects; upon which periodontal regeneration is promoted. Given the degree of concurrence among the scholarly studies and results documented above, it can be inferred that stem cell regeneration is highly contributory to medicine and dentistry because it fosters tissue regeneration in very complex tissues; including the periodontium.

Stem cell regeneration has also gained application in the orofacial region. According to Gasparotto, Landim-Alvarenga and Oliveira et al. (2014), mesenchymal stem cells, which are obtained from dental and non-dental sources, aid in the regeneration of maxillofacial regions. Some of these regions include craniofacial regeneration, the repair of the palate and cleft lip, regeneration of salivary gland, and the production of dentin and enamel (Wu, Chiu and Chin et al., 2014). In experiments where the mesenchymal stem or stromal cells have been used,

prophylactic treatment has been achieved in relation to atrophy or vocal fold scar (Sudarshan, Annigeri and Vijayabala, 2012). For the mesenchymal stems cells that have been transplanted into vocal folds (pre-clinically *in vivo* and *in vitro*), no adverse risks have been reported (Kim, Mehrazarin & Kang, 2012). In studies where focus has been on oral submucosal fibrosis (which is a chronic condition that restricts mouth opening and affects the underlying muscles of mastication, esophagus, pharynx, lips, cheeks, fauces, palate, and the sub-mucosal layer of the pharynx), stem-based therapy has been embraced (Sankaranarayanan, Kailasam, Elangovan, Ravi & Sarkar, 2013). As affirmed by Poulos (2018), the main of stem cell therapy has been to steer neoangiogenesis via the release of growth factors and cytokines. In the findings, stem cell regeneration studies focusing on oral sub-mucosal fibrosis avow that the practice yields promising results (Alpert and Chen, 2017). Particularly, neoangiogenesis, a product of stem cell therapy, has been found to aid in reversing hypoxia and increasing the supply of additional scavenging defenses in diseased issues, upon which the removal of senescent cells has been facilitated (Nolta, 2016). Also, stem cell therapy stimulates resident tissue stem cells, upon which the latter cells are transformed into new fibroblasts. According to Horst, Chavez, Jheon, Desai and Klein (2012), the eventual role of the new fibroblasts lies in the removal of morphologically altered and biochemically disintegrated collagen fibers.

Indeed, most of the current literature suggests that stem cell therapy plays a contributory role in regenerative medicine. This procedure entails the use of undifferentiated cells for purposes of curing diseases. Some of the diseases that have been targeted include autoimmune disease, cardiovascular disease, diabetes, liver disease, and Parkinson's disease; which are neurodegenerative conditions. The selected studies highlight further that one of the specific zones to which the stem cell regeneration procedure has been applied entails the orofacial region. In particular, stem cell therapy has been employed in this region for purposes of alveolar bone regeneration, temporomandibular joint reconstruction, and periodontal and tooth regeneration. From the scholarly affirmations, it is evident that stem cell therapy's curing ability is promising; with the dental pulp and other craniofacial stem cells forming sources from which the required cells have been obtained.

Conclusion

In conclusion, stem cell therapy has unlimited dental and medical applications. The evolution of the stem cell regeneration concept reflects a shift from the surgical care model to a medical model that has, in turn, paved the way for a biological model of care (through stem cell therapy). However, most of the selected articles affirm that the success of this practice and the ability to achieve the desired goals of stem cell therapy depend on the degree of collaboration and expertise among practicing dental surgeons, matrix biologists, cell biologists, biomaterial scientists, immunologists, and molecular biologists.

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Vocational Nursing and Impact on Health Care Service Outcomes

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Abstract

Scope of practice covers what the law allows for specific experience and education; with specified competencies expected to be demonstrated by the affected professionals. In California, the Board of Vocational Nurse and Psychiatric Technicians (BVNPT) regulates the practice and licensure of vocational nurses; with the practice of authorization conducted by the California Business and Professions Code. On the other hand, the case of the state of Washington operates in such a way that the scope of practice for LVNs is governed by the Washington State Department of Health. This comparative case study seeks to unearth the scope of practice for LVNs in the contexts of California and Washington.

Introduction

In California, the scope of practice for registered nurses (RNs) is governed by the Board of Registered Nurses. The role of this board is to determine some of the activities that are likely to overlap medical practice and, in turn, prompt standardized procedures. It is also worth noting that the board defines dependent functions such as the administration of medications, independent functions such as patient care services involving personal hygiene, comfort and safety, and interdependent functions such as observing signs and symptoms of illnesses, general behavior, and reactions to treatment (Corazzini, Anderson, Mueller, McConnell, Landerman, Thorpe & Short, 2011). This study focuses on a comparative analysis of LVN scope of practice in Washington and California, a secondary analysis aimed at predicting the future of the specialty in the selected regions.

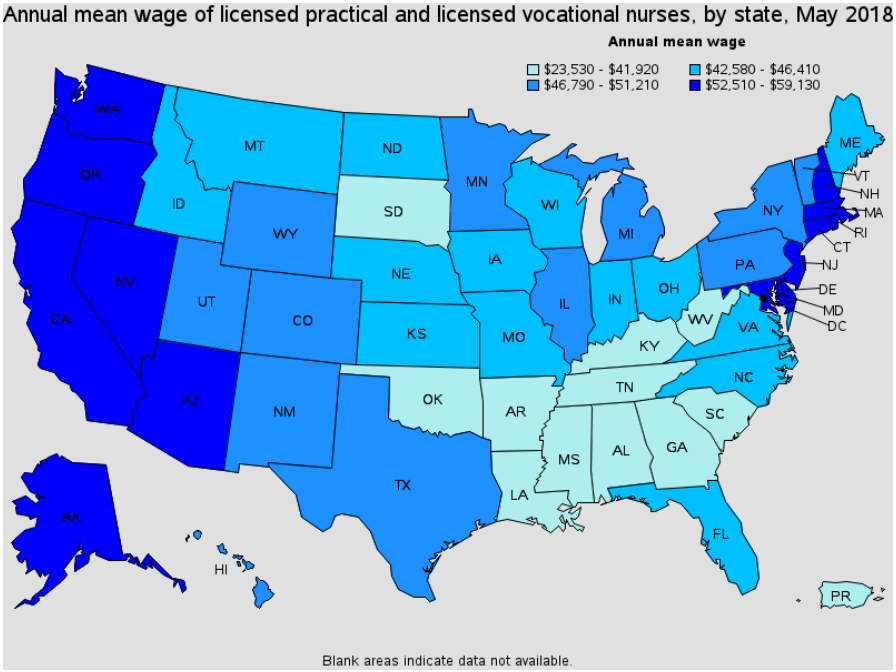
Methods

By understanding the scope of practice, nurses are likely to gain an insight into some of the safe parameters within which they are expected to work. The eventuality is that patients are protected from unsafe and unprofessional nursing practice (Corazzini, Anderson, Mueller, Thorpe & McConnell, 2013). In addition, the knowledge of the scope of practice is important because it aids in avoiding a confusion of roles by specifying the processes, actions and procedures that the RNs are expected or allowed to perform. By providing professional support and guidance to RNs regarding issues relating to clinical practice, the scope of practice is important because it promotes effective decision-making processes (National League for

Nursing, 2010). This study adopts a secondary research approach, gaining and analyzing data from government and institutional reports.

Results

A confusion of roles, which may result from the decision by nurses to perform roles beyond their scope, is likely to compromise the state of patient safety due to the possible incapability of the practitioners to handle what is beyond their levels of qualification (Institute of Medicine, 2011). Besides, defying the scope of practice is likely to cause overlaps or a duplication of effort because operating beyond one's scope implies that the nurses will have "taken over" the roles and responsibilities that may have, otherwise, been meant for other care providers (in the units perceived to be intruded by nurses operating beyond their scope). Lastly, operating beyond one's scope of practice implies that the resources available are likely to be utilized inefficiently and ineffectively; either leading to an underutilization of the resources in the new sections that nurses intrude or an overexploitation of the resources available in one's unit while struggling to meet the needs of patient groups beyond their area of coverage (Corazzini, Anderson, Mueller, McConnell, Landerman, Thorpe & Short, 2011).



LVNs, under the supervision of doctors, can give medication via oral administration and hypodermics injections, draw blood from patients after being instructed by physicians or RNs, and start and continue to give intravenous fluids medications (Corazzini, Anderson, Mueller, Thorpe & McConnell, 2013). Similarly, LVNs can carry out skin tests (such as coccidioidin, histoplasm, and TB tests), give immunizations (after demonstrating the capacity and knowledge of emergency reactions and rededications), help in emergency situations requiring nursing skills, and exercise voluntary work similar to that of religious establishments (National League for Nursing, 2010).

	California	Washington
Similarities	▪ Nurse practitioners and LVNs operate in collaboration with physicians ▪ LVNs in California are restricted to less critical situations such as those involving oral administrations of medication and drawing blood from patients; rather than allow the groups to participate in advanced and physician-related activities	• Similar to California, nurse practitioners and LVNs operate in collaboration with physicians • Similar to the case of California, groups such as LVNs and engaged in less critical medical practices such as oral administrations of medications while advanced skills lied in the hands of physicians
Differences	✓ Within collaborative practice agreements, nurse practitioners engage in the ordering, administration, dispensing, and prescription of medications ✓ In California, nurse practitioners are not allowed to sign death certificates but only permissive regarding parking handicap permits	❖ Nurse practitioners make basic observations, collect information, and help in identifying problems and needs relevant to clients (as directed by supervising persons) ❖ The Washington State law does not define the community member to sign death certificates and allows advanced registered nurse practitioners, physician assistants, and physicians to sign the certificates

LVNs work in structured settings such as private physician offices, clinics, skilled nursing facilities, rehabilitation centers, hospitals, and nursing homes (Institute of Medicine, 2011). Specifically, these nurses aid in determining the mental and physical health needs, statuses, and preferences of socially, ethnically and culturally diverse patients, as well as their families based on the interpretation of health-related information (Corazzini, Anderson, Mueller, McConnell, Landerman, Thorpe & Short, 2011). Upon collecting information, the LVNs recognize changes in conditions before reporting to RN supervisors or other appropriate clinical supervisors for problem identification and goal formulation. Thus, the focused assessments produced by LVNs enable the RNs to form nursing processes (Corazzini, Anderson, Mueller, Thorpe & McConnell, 2013). Licensed vocational nurses are also expected to safeguard the health and safety of patients by documenting care based on professional standards while performing services based on specifications in business and professions codes.

For LVNs, some of the behavioral and ethical standards to which they are expected to adhere include maintaining current skills and knowledge for competent and safe practice, maintaining confidentiality among clients or patients, and maintaining professional boundaries during the practitioner-patient interaction processes (National League for Nursing, 2010).

Other standards include abstaining from substance or chemical abuse and cooperating with state boards during investigations. Whereas a majority of these standards exhibit a commonality in California and Washington, the difference is that the latter state holds the nurses accountable for the clients' safety. Similarly, the case of Washington operates in such a way that the nurses may delegate personal care tasks to other care givers perceived to be qualified.

Conclusion

At the personal level, the knowledge gained is critical and the resultant insights will be applied in future practices. For example, patient safety will be safeguarded in a scenario involving a patient diagnosed with a chronic condition such as asthma but reported to resist medication. The ethical and behavioral standard that will be applied is that which requires care providers to maintain confidentiality among patients and clients. To achieve this objective, I will use the patient's family members, close friends, and other relatives as entry persons to allow the patient express himself or herself regarding medication history. Given that the cause of resistance to medication might be informed by potential tensions that might be present at the initial stage, confidentiality will be assured due to the perceived trust that the patient might have in members of the family, rather than me, the care provider. In turn, the family members will be instructed to explain to the patient about some of the possible adversities that could accrue from failed administration of medication, as well as the expected benefits, should the patient agree to undergo treatment. With a harmonious atmosphere created, I will collect the patient data or medication history with the aid of members of the family and deliver the same to the physician for further processes. Thus, the use of family members as entry persons will demonstrate the maintenance of confidentiality with the patient by allowing the information to flow between the patient and these members 9as well as the care provider), rather than attract the attention of additional groups such as other patients in the unit, members of staff at the healthcare firm, and other authorities. Overall, the insights gained from the study will enable me to examine some of the possible causes of patient resistance to medication and determine the most appropriate channels that could be used without zed groups to access the patient's data or case at hand. This step is predicted to not only enhance confidence and promote trust but also create a harmonious nurse-to-patient relationship or environment.

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Community Windshield Survey in Nursing and Medical Practice: Focusing on Miami's Coral Gables

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Abstract

This paper has provided a summary of a windshield survey that focused on Coral Gables. The city, found in Miami County of Florida, is dominated by groups such as African-Americans, the Hispanics, Asians, Native Americans, and the Pacific Islanders. Recent statistics indicated that Coral Gables has a population of 49,631. In relation to health, some of the factors placing these communities at risk include poverty, sedentary living (that is characterized by little physical exercising), and poor eating habits. It is recommended that nurse practitioners and other relevant healthcare authorities strive to understand the people's state of cultural competence. In so doing, valid and reliable plans might be formulated in a quest to curb healthcare disparities by enhancing accessibility while encouraging physical exercising and healthy eating behaviors.

Introduction

Coral Gables is located in Florida's Miami County. Specifically, the official city is situated on the downtown of Miami. The 2013 census statistics indicated that Coral Gables has a population of 49,631. Demographically, the city is dominated by groups such as African-Americans, the Hispanics, Asians, Native Americans, and the Pacific Islanders. It is also worth noting that Coral Gables is a home to multiracial groups (Williams & George, 2011). In this windshield survey, focus has been to gain an insight into the state of health in the city, with the participant observation technique forming the main approach for collecting and analyzing the data.

Methods

As one drives through Coral Gables on a typical weekend morning, several neighborhoods would be observed to constitute individuals working in their yards. In addition, other people would be observed either grilling or conversing with their neighbors at the yards. Children are also observed to be engaged in play. It is also worth highlighting that a majority of the population constitutes the Hispanics and African-Americans. However, a significant population is evidently overweight. This state of health could be attributed to the predominant dining on fast foods, as well as the presence of the city's relaxation centers that beam with enjoyment.

Results

Relatively, a significant population is observed to live in poverty. This affirmation is indicative of the majority's inability to access healthcare that could address issues such as

obesity at the individual and family levels. The risk to healthcare intervention is also exacerbated by disparities arising from constrained and biased provider-patient communication, as well as health illiteracy. Most of these differences arise from deviations in the residents' ethnicity, socio-economic statuses, and race differences. Whereas developments such as access to preventive care are observed, the city's state of intense healthcare disparities in some of its zones remains unaltered.

In relation to equitable healthcare access, a challenge is presented by the city's health resources. Given that most of the healthcare facilities are located in town, transportation from residential areas, which are miles away, remains challenging. In addition, emergency services are dire, with voluntary emergency departments forming a major player in case of emergencies.

The main health condition observed is obesity, arising from non-healthy eating. One of the reasons accounting for this state is the consumption of food without paying attention to the calorific value. As documented by Flegal, Ogden and Wei et al. (2013), the current society continues to consume most of the McDonald's foods. Specifically, Big Mac contains about 33 grams fat and 500 calories, a significant amount indeed. The survey found out that most of the residents overlook the effect of calories on their state of health. In most parties, the survey revealed that most of the people prefer foodstuff with a lot of salt, fat and sugar. This trend was further evident in restaurants. During free times, a majority of the individuals were observed eating snacks and cookies. Besides, settings such as pubs were dominated by people watching televisions while drinking and eating snacks. Indeed, the trend is worrying because of a lack of adequate exercising while engaging in unhealthy eating behaviors. Overall, the survey indicated that a sedentary lifestyle characterizes a significant number of residents in Coral Gables.

With busy schedules characterizing the community, it was inferred that they are unlikely to get enough time to sleep. According to Marlow and Shiers (2010), mechanization continues to deprive over 60 percent of populations of physical exercising. With the evolution of mechanized transport, concerns have arisen regarding the significant decrease in physical exercising. Domestic technologies have also been introduced to save on labor or the amount of energy used to accomplish tasks. These technologies include the TV remote controls, washing machines, and elevators (Karnik & Kanekar, 2012). In Coral Gables, the level of the children's engagement in physical activities was observed to be low; evidenced by reduced walking. The rest of the age groups were observed to engage in leisure activities that would incorporate few physical activities. In both adults and children, leisure activities involving the Internet and television were evident.

The presented scenario in Coral Gables proves to be challenging to nursing as a practice. Observable issues include the general state of sedentary lifestyles, poor eating habits, and unequal access to care. The implication is that nurse practitioners and other members of the community could engage in various interventions (or initiatives). One of the approaches involves exercising cultural competence. To achieve this objective, there is a need to understand the Coral Gables community's culture. By understanding the cultural assumptions, experiences and perceptions of residents in this region, nurse practitioners are likely to achieve

the objective of attitudinal and behavioral change. It is also worth avowing that nurses may strive beyond care provision to offer additional advice regarding the need for patient groups to exercise healthy eating habits in a quest to curb conditions such as obesity and diabetes. Similarly, the healthcare authorities in Coral Gables and the rest of Miami ought to formulate a plan through which improvements could be made towards enhanced accessibility to healthcare. By increasing healthcare resources, emergency services might be improved while seeking to achieve a healthy population in Coral Gables. Overall, the survey affirmed that physical exercising and poor eating habits form critical predictors of healthcare disparity in Coral Gables. Other potential attributes that complement sedentary living include the considerable amount of time spent on the Internet and television, as well as poverty. By addressing these disparities, it is projected that the state of healthcare access and provision in the city and its environments would be improved to a significant extent.

Conclusion

In conclusion, this paper has provided a summary of a windshield survey that focused on Coral Gables. The city, found in Miami County of Florida, is dominated by groups such as African-Americans, the Hispanics, Asians, Native Americans, and the Pacific Islanders. Recent statistics indicated that Coral Gables has a population of 49,631. In relation to health, some of the factors placing these communities at risk include poverty, sedentary living (that is characterized by little physical exercising), and poor eating habits. It is recommended that nurse practitioners and other relevant healthcare authorities strive to understand the people's state of cultural competence. In so doing, valid and reliable plans might be formulated in a quest to curb healthcare disparities by enhancing accessibility while encouraging physical exercising and healthy eating behaviors.

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