POPULATION EXAM 3 STUDY GUIDE

CHAPTER 9:

1. What are some primary prevention interventions? PP. 30, Pg 105, ATI pg. 9

- Flu vaccination/ immunization programs in the community
- Health education (exercise, smoking cessation, family education/ sex education)
- Provide clinical practice for nursing students and faculty
- Offer specialized programs to meet the needs of specific population aggregates
- Driver's safety classes/ seat belt
- Healthy water and air quality
- Health education classes
- Improving safety deigns of equipment
- Fire safety
- Decreasing exposure to sun
- Use of environmentally safe products
- Use ear plugs and safety glasses
- Education about health and hygiene issues to specific groups (day care worker, restaurant workers)
- Prenatal classes
- Advocating for access to health care, healthy environments

2. What are SMART goals and objective? PP. 23, PG. 201

SMART is an acronym for program objectives that are specific, measurable, achievable, relevant, and time bound. Program objectives written in the SMART format help in planning interventions and establishing measurement systems to evaluate programs and outcomes. When planning for change, the objectives need to fit these 5 criteria.

S- Specific, or significant, stretching, stimulating, simple, self-owned, strategic, sensible

M- Measurable, or meaningful, motivating, manageable, maintainable

A- Achievable, or attainable, action-oriented, appropriate, agreed, assignable, ambitious, accepted, audacious

R- Relevant, or rewarding, results-oriented, resourced, recorded, reviewable, robust

T- Time based or time-bound, time- lined, track-able

9.5 Writing SMART Program Objectives

Specific: What behaviors, knowledge, skill, change in health status indicators or outcome will result from the program?
Measurable: How will the outcome be measured and how will one know if the objective is achieved? Are the data available?
Achievable: Is it realistic to reach the desired outcome with the resources and time available to the program?
Relevant: Is the objective related to the program's goals and activities?
Time-bound: When will the objective be achieved?
Not SMART: The program will reduce teen pregnancy.
SMART: The number of births to girls aged 19 and younger in Springfield will be reduced by 20% from 40 births in 2010 to 32 or fewer in 2015.
Not SMART: Fewer teens will start smoking.
SMART: The proportion of high school sophomores in the state of Georgia who report having ever smoked a cigarette on the Youth Behavioral Risk Factor Survey in 2020 will be no more than 7%.
Not SMART: The number of older minority residents of River City receiving a flu shot will double.
SMART: The number of people aged 50 and older who receive a flu shot at a clinic sponsored by RC3-I and who identify themselves as Hispanic or Latino will increase 50% in the fiscal year (FY) 2015 over the baseline number in FY 2012.

3. What is the WHO's Commission on Social Determinants? PP. 14

- Expand knowledge of the social determinants of health
- Ensure more equitable distribution of power, money, and resources
- Improve conditions under which all people are born, grow, live, work, and age

4. What are nurse-managed health centers? PG. 208

- Provide health promotion and primary care services to vulnerable and underserved population, aggregates such as the rural poor, migrant farm workers, low-income mothers and children, inner-city neighborhoods, and immigrant communities, teens, pregnant, and women.
- A unique model of community health services lead by advanced practice nurses and providing a wide range of services and programs to vulnerable and underserved populations.
- May offer services in subsidized housing projects, homeless shelters, correctional institutions, schools and faith communities, storefronts
- Emphasize health promotion, disease prevention and health education
- Primary prevention is a core component of the care provided, and the range of services varies from health promotion to a full range of primary care and chronic disease management programs.
- Academic nursing centers established by colleges of nursing, federally qualified health centers of federally qualified lookalikes or clinics

5. What are the stages of the program planning process? Examples? ATI. 35

For the defined community to establish and maintain the program

- Preplanning
    - Brainstorm ideas
    - Define the community
    - Gain entry into the community and establish trust.
    - Obtain community awareness, support, and involvement.
    - Coordinate collaborations
- Assessment
    - Collect data about the community and its members
    - Complete a needs assessment and identify community strengths and weaknesses.
    - Assess the availability of community resources
    - List potential sources for programs funding (charitable giving, fund-raising, grants)
- Diagnosis
    - Identify and prioritize health needs of the community
    - Work with community members, local health professionals, and administrators to develop priorities and establish outcomes.
- Planning
    - Develop interventions to meet identified outcomes
    - Establish goals and objectives
        - Objectives and behaviorally stated, measurable, and include a target date for achievement.
- Implementation
    - Carry out the plan
    - Initiate interventions to achieve goals and objectives according to the program plan.
    - Monitor the intervention process and the response of the community in terms of values, needs, and perceptions.
- Evaluation
    - Examine the success of the interventions (strengths and weaknesses)
    - Determine achievement of desired outcomes.
    - Examine the adequacy, efficiency, appropriateness, and cost benefit of the program.
    - Recommend and implement modifications to better meet the needs of the community.

6. What do you need to plan and assess for with financial means for a community assessment? PP. 13, PG. 205

- Accountability
    - Includes regular communication about how funds were used, details of program activities, and progress toward achieving program goals
    - Large foundations and government agencies often expect logic models and formal evaluation plans as part of grant proposals
    - Performance in meeting the expectations for regular and meaningful progress, outcome, and financial reports is an important factor in decisions about renewal of grant funding
- Sustainability
    - Most funding agencies expect programs to give a clear and convincing plan outlining how efforts started with grant funding will be continued after the grant ends
- Program Replication
    - What may have succeeded in one location may reflect how ready the community was to change, not how well a program was designed and/or how well it was implemented
    - The ability to replicate or reproduce a successful program within a different community or with a new population aggregate is a test of the strength of the design of an intervention
- Project Funding
    - Government Agencies
        - NIH, CDC, or HRSA
    - Private Foundations
    - Local Resources
        - Local banks and other businesses, faith communities, civic groups such as Rotary International or the Junior league.
- Community Benefit Programs
    - Community benefit programs of local or regional hospitals and HMOs may be valuable partners to the public health department or community health nurse in planning, implementing, and funding programs to improve population health

7. How do you evaluate the community program? ATI 35, PG. 204

- Planning for the evaluation of a program includes, when possible, measuring pre intervention levels of health status or behavior using the same evaluation criteria to establish a baseline for comparison with program results
- The evaluation plan often includes both process and outcome evaluations
    - Process evaluations focus on how well the program was implemented and looks at processes, activities, and capacity building
    - Outcome evaluation focuses on the extent to which the intervention achieved its objectives for changes in knowledge, skills, or health behaviors and for improvement in community health status
    - Measures used for evaluation include both quantitative and qualitative data

What are the steps that you do in the evaluation? ATI 35, PG. 204

1. Develop evaluation questions "focused on what happened, how well it happened, why it happened the way it did, and what the results were"
2. Determine indicators or measures you will use to answer your evaluation questions.
3. Identify where you will find the data you need to measure your indicators and answer your questions.
4. Decide what method you will use to collect data.
5. Specify the time frame for when you will collect data.
6. Plan how you will analyze your data based on the type of data you are using.
7. Decide how you will communicate your results

8. What is a population aggregate? Examples. PG. 190-1,PP 30

Definition: A defined subset of the population such as people with or at risk for a specific health problem or having specific social or demographic characteristics

Examples:

- Adults aged 50 and older for an initiative to increase the rate of screening for color cancer
- Population of adults aged 55 to 74 living in Wisconsin
- The panel of patients served by a large group medical practice
- Families of migrant farm workers in Broward County
- Students in kindergarten through sixth grade in the Chicago public schools (inner city neighborhoods)
- Low-income mothers and children

9. What is a population-focused intervention? Examples. pg. 190 & ATI pg. 31-33

- Planning responses to pandemic influenza programs
- Reduce carbon emission at all levels

10. What are some stressors that can be identified in a community assessment? pg. 190-3

- Social determinants of health
- Poverty/ low income
- Lack of healthcare services
- Lack of access to affordable nutritional food
- Unstable economy/ closure of businesses
- Education/ literacy level
- Home, work and condition where people live
- Gender
- Culture
- Noise, temperature, light, radiation
- Crowding
- Social disorganization
- Racial discrimination
- Violence/ crime
- Economic deprivation
- Resources

11. How can a community assessment show health disparities? PG. 188,

- Uses several approaches (such as interviews, analysis of data on health status and health behavior indicators, observations, and community surveys) to provide resources to address health problem pr need.
- Assessment of a community includes identification of community assets and strengths as well as specific health problems or health needs.
- Assessment of community readiness and community capacity to address the identified health problems is also an important part of the process
- The goal is to identify the community health problems that are the priorities for intervention, as well as community resources available to address each health problem or need.

12. How does collaboration between agency personnel who are implementing a program and the target population impact program planning? PP. 24, pg. 202-203; ATI p 36

- Community health workers can help bridge the gap between the community health nurse and the community, especially when there are cultural and language differences.
- Nurses can play an important role in their professional and personal lives as advocates and champions for health improvement, social justice, and health equity at the local, regional, national, and global levels.
- It is critical to make plans for evaluating a program at the time of initial program planning to ensure the development of the necessary tools and methods for collection of data to measure the impact of the program in advance of the intervention.

CHAPTER 11:

1. What are the components of a community assessment? ATI 31-2

People
- Demographic
  - Distribution, mobility, density, census data
- Biological factors
  - Health and disease status, genetics, race, age, gender and causes of death
- Social factors
  - Occupation, activities, marital status, education, income, crime rates, recreation, and industry
- Cultural factors
  - Ethnohistory, hierarchy and roles, language, religion, spirituality, values, customs, and norms

Place or Environment
- Physical
  - Geography, terrain, type of community, location of health services, housing, animal control
- Environmental
  - Geography, climate, flora, fauna, topography, toxic substances, vectors, pollutants

Social Systems
- Healthy, economic, religious, welfare, education, recreation, legal, communication, transportation, and resources/ services systems

2. What does community as partner focus on? PG. 227, 238

- Within the process of community assessment, considering the expertise of community dwellers as central to the task of understanding the health and well-being of the community
- Demonstrates the equity of the nurse's relationship with the community

3. What are the core public health functions and give examples of how the steps of the program planning process fit these core functions PG. g 189-191, 229 & ATI pg. 32-33

- Provide a foundation to develop and implement interventions that build and maintain healthy communities.
- Goal of the community health assessment is to identify community health problems that are priorities for intervention as well as what community resources are available.
- Assessment of the community includes identification of community assets, as well as specific health problems of health needs.
    - Commitment
    - Assessment
    - Planning
    - Implementation
    - Evaluation

4. Where can you get data and information for the community assessment? Be specific as to what each source has to offer including local, state, national, international and including "health-related" information. DHW pp 188-189 & p 238; ATI Ch 2 p 18 & pp. 32-35

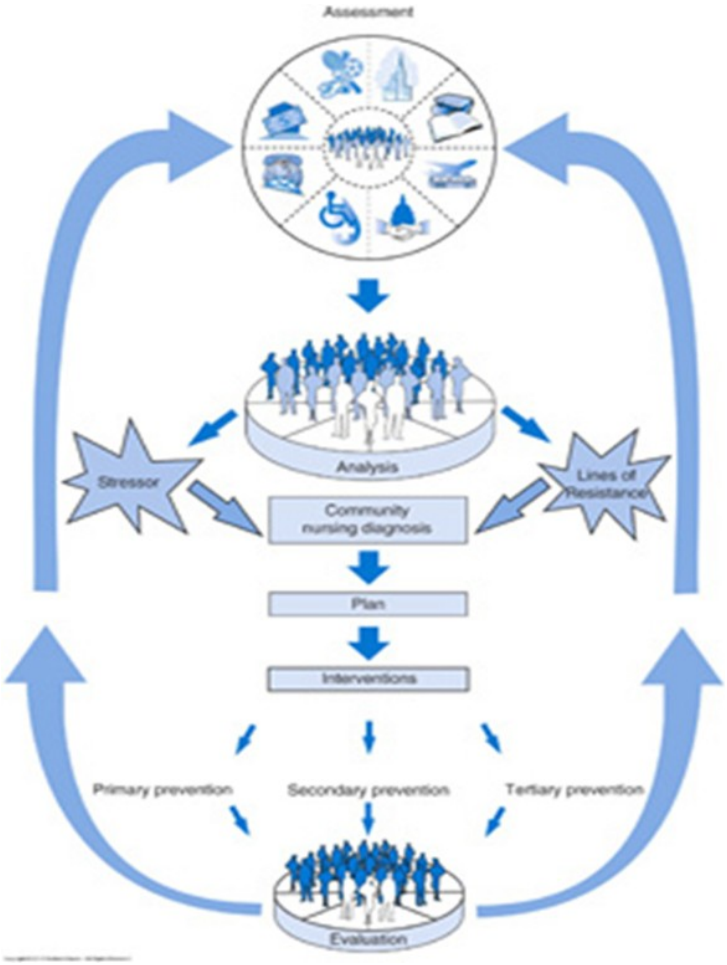
- Windshield Survey, interviews, community forum, participant observation, focus groups, and surveys.
- United States Census Bureau
- The Centers for Disease Control and Prevention
- Local government Websites

Where can you get some information for the community assessment specifically for injuries and violence?

Police report, death statistic/certificates (health department) and coroner's office

5. Review the Community Assessment process and know the sequencing of the steps of the process. DHW Pg 190-198 & ATI pg. 32-34

- Define the community
- Collect Data
- Analyze Data
- Establish Community Diagnosis
- Plan Programs
- Implement Programs
- Evaluate Program Interventions



6. What are the steps of analyzing the community assessment data? PG. 229

- Gathering collected data into a composite database
- Assessing completeness of data
- Identifying and generating missing data
- Synthesizing data and identifying themes
- Identifying community needs and problems
- Identifying community strengths and resources

7. Utilizing community assessment data to determine interventions for a community PG. 229

- Implement interventions that build and maintain healthy communities
- Using both descriptive data and relational data, nurses can develop interventions that can empower communities and effect change.
- These are then evaluated according to the results or outcomes of the interventions.
- Community report cards provide a snapshot of the overall health and well-being of a community through the use of indicators or measurements of local social and health trends.

8. What is the functional health pattern assessment? PG. 228, PG. 239-240

- A systematic and deliberate approach to community assessment, evaluating patterns of behaviors of community dwellers that occur sequentially across time.
- Used for individual, family, or community assessment
- Designed to be used with nursing diagnosis, clinicals are expected to identify defining characteristics from each pattern and assign relevant diagnosis
- Arranged in numerical order, assessment is a guide

9. How do you get primary (direct) and secondary data for community assessments? Which do you get direct data from?

Primary (Direct):

- Informatic interview, community forum, focus groups

Secondary:

- Use of existing data (death, birth statistics; census data, mortality, morbidity data; health records; minutes from meeting; prior health surveys).
- The nurse must evaluate the reliability of secondary data obtained from the Web.
- Generally, websites with .edu, .org, and .gov URLs present reliable information

10. What is the collaborative model and how does this enhance community empowerment? PG. 227, 240

- Definition: an approach to assessment that begins with planning that includes representative parities of a population, including service organizations, corporations, and government officials
- Enhance community empowerment by having public health experts work in partnership and collaboration with the community.
- Engaging participants with a "we can do it together" approach is more effective than using a "we/they" approach.

11. Why should or would you perform a community assessment? PG. 229

Community assessment is a comprehensive evaluation of the status of a community. It identifies vulnerable populations, determines unmet needs, and documents community resources. The data collected during assessment then is used to set goals, plan programs for intervention, and evaluate outcomes. Able to gain more information that require change.

12. Who do you choose to perform a community assessment on?

- People who work or live within the community, vulnerable population, population aggregates
- Community members most affected by the specific area of the community you are assessing
- Seek data about people who funnel in and out of the community. These are often overlooked by students who are trying to understand who constitutes the community. Local town or city employment data may direct you to companies that employ large numbers of people. For example, most of the population from a metropolitan area may work for three or four large corporations. By approaching these corporations, you can find data about employees' residence, interviewing some employees may tell you where they are receiving health care. In addition, you may identify these peoples' concerns related to their health and well-being while working for this particular corporation.

13. How do you use health status indicators in a community assessment? DHW pg. 233-236 & ATI pg. 24, 32-35

Community report cards provide a snapshot of the overall health and well-being of a community through the use of indicators or measurements of local social and health trends.

CHAPTER 13:

1. What activities are included in the family assessment and what do they provide the nurse? PG. 275

Structural Assessment:

- Internal Structure
    - family composition, gender and sexual orientation of the members, birth order of children, subsystems including couple, parent-child, and sibling, and boundaries)
- External Structure
    - Extended family, larger system switch include social and community connections such as schools, work, religious and health care organizations
- Context
    - Culture, race, social class, spirituality and/or religion, environment)

Functional Assessment:

- Emphasizes the interaction among family members, assessing how members actually behave with each other

Developmental Assessment:

- Explores the evolving path the family goes through and the tasks that need to be addressed at key periods.

EX: Survey and ask questions to the family, home visits, working in a clinic setting

- Who is a part of the family, what do you do as a family, what do you do, more so daily activities, identify things that will have a long term impact that people do daily, identify support systems and their importance, genograms are a tool
- Emotional, verbal and nonverbal community, problem solving, roles, influence and power and beliefs
- Helps provides the nurse by combing the elements needed to gain a multilayered understanding of family components.

2. What are the actions of the functional assessment on a family? PG. 281

It focuses on the present, how the family is functioning now, although past history can be considered

- The instrumental aspect includes both activities of daily living (ADLs) and instrumental activities of daily living (IADLs).
- Assess the routines, patterns, behaviors, and interactions related to typical daily activities, such as hygiene, grooming, meal prep, laundry, sleeping, shopping, housework, medication administration, and how the family's current state of health and illnesses are impacting instrumental family functioning.

3. What actions give a positive effect to nurses in Family-Focused home visiting? PG. 282

- Promoting behaviors (new mother and other family members) which positively affect pregnancy outcomes, the child's health and development, and the parents' life course (future pregnancy decisions, education, and work).
- Guiding the women in establishing supportive relationship with family members and friends
- Connecting the women and their family members with needed health, educational, work-related, and social services.
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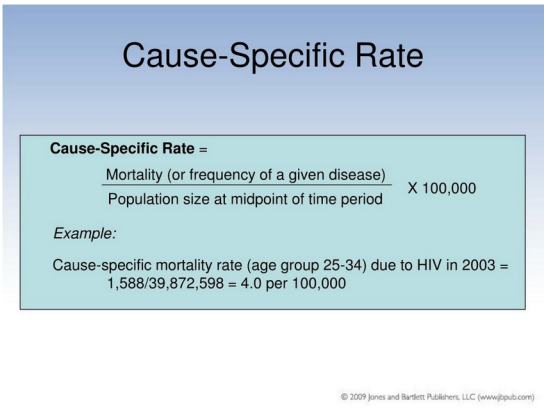
CHAPTER 6 & 7:

1. Calculation of rates related to community assessment

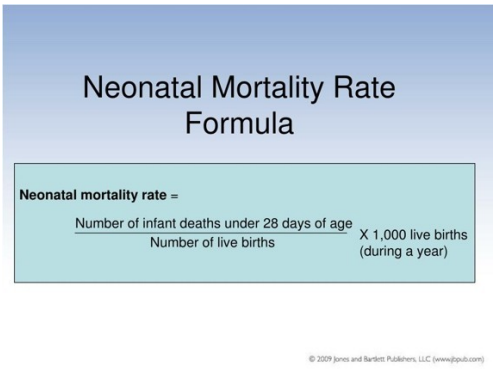
a. Cause-Specific Death (mortality) rate

The number of deaths from a specified cause per 100,000 person-years at risk.



b. Neonatal mortality rate

The neonatal death rate is calculated as the number of infant deaths that occur between 0-27 days of life (often referred to as the 1st month of life) divided by the number of live births, multiplied by 1000.



c. Prevalence Rate

(Measure of existing disease in a population in a specific period/point)/(total population in the same period/point) x 100,000