Exam 3 Study Guide – Spring 2021

DHW: Ch 9, ATI: CH. 4

1. **What are some primary prevention interventions for communities?**
    a. Education opportunities
    EX: Exercise education, smoking cessation classes,
    Immunization clinics,
    safe sex practices, etc.

2. **Violence in the community: where could you go to identify the mortality rate in your community:**
    a. **local health department vital statistics,**
    autopsy reports/coroners office/police reports.

3. What are SMART goals and objectives and be able to give examples? Pg 201 box 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? Is 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.

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.

4. **What is the WHO's Commission on Social Determinants?**

   The three overall recommendations of the CSDH are to
   (1) improve the conditions under which all people are born, grow, live, work, and age to minimum standards;
   (2) ensure more equitable distribution of power, money, and resources; and
   (3) expand knowledge of the social determinants of health and establish a system to measure and monitor health inequity.

5. **What are the key components of the Logic Model and be able to give examples?**

   It shows the relationships among the inputs and resources available to create and deliver an intervention, the activities the intervention offers, and the expected results .
   A logic model for a community health program illustrates who will receive services **(target population:Diabetic patients or smokers)**,
   what will be done **(activities: glucose management or education on smoking cessation)**,
   when it will happen **(timeline: next week at 12p), where, and why (program theory: To reduce the risk of comorbidities and improve health outcomes)**
   The model is usually a formal process map or flow diagram

6. What are nurse-managed health centers?

Focuses on primary prevention but sometimes has screening for secondary prevention. Designed for specific people such as elderly people, pediatrics, etc. Good venue for nursing students to practice their skills. EX: STD/STI clinics at a health department.

Model of community health services led by advanced-practice nurses. The communities served by NMHCs are usually geographically defined and are most often vulnerable and underserved population aggregates such as the rural poor, migrant farm workers, low-income mothers and children, inner-city neighborhoods, and immigrant communities. The NMHC may offer services in subsidized housing projects, homeless shelters, correctional institutions, schools, faith communities, storefronts, and other locations easily accessible to the population aggregate being served. The NMHCs emphasize health promotion, disease prevention, and health education. They meet the needs of specific population aggregates such as pregnant and parenting women, teens, or homeless people. Primary prevention is a core component of the care provided, and the range of services varies from health promotion programs to a full range of primary care and chronic disease management programs. Many NMHCs are academic nursing centers established by colleges of nursing to provide service to the community as well as clinical practice and research opportunities for students and faculty, and to prepare students with skills to work in medically underserved areas.

7. **What are the stages of the program planning process and be able to identify? examples.**

The planning step of community assessment leads to planning programs for the defined community. Within this planning step, the nursing process is repeated to establish and maintain the program.

- **Preplanning: defining community**
- **Assessment: gathering data and analyze**
- **Diagnosis: what needs done? Nursing diagnosis.**
- **Set a goal: measurable community health goal**
- **Planning**
- **Implementation**
- **Evaluation: Did you meet your measurable goal?**

Eg:

ATI fig. 4.1

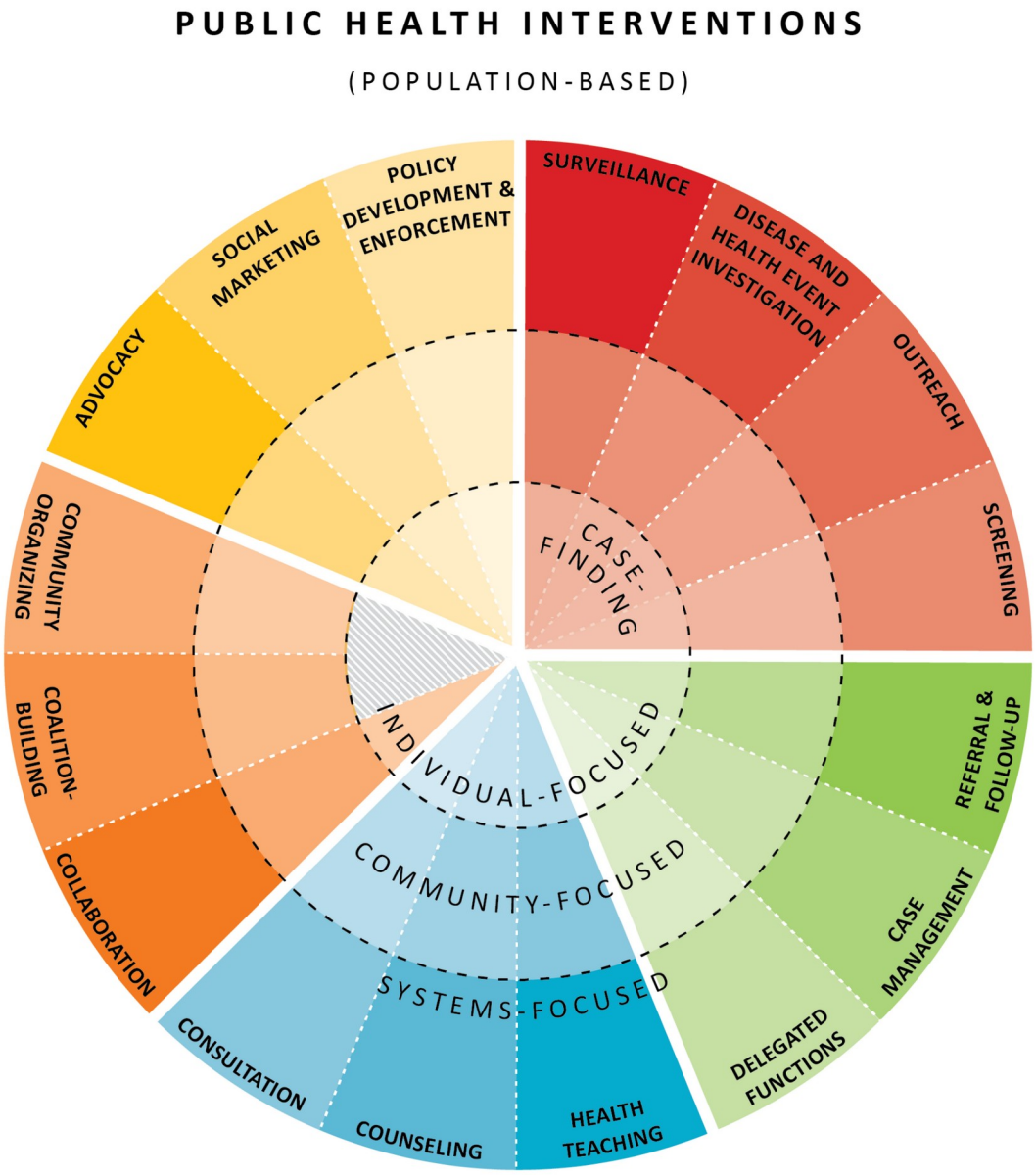
- **Define the community**
- **Collect data**
- **Analyze data**
- **Establish community diagnosis**
- **Plan programs**
- **Implement programs**
- **Evaluate program interventions.**

8. **What do you need to plan and assess for with financial means for a community assessment?**
    a. Looking at local vs big programs available for funding; assess what resources are available in the community. EX: religious organizations, large banks with local outlets, rotary clubs,etc. Think about stakeholders in the community that can help fund events etc.
9. **How do you evaluate the community program?**

    What are the steps that you do in the evaluation? (prioritization goes by the steps – you) pg204

    1. **Develop evaluation questions "focused on what happened, how well it happened, why it happened the way it did, and what the results were" (CDC, n.d., p. 5).**
    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 (CDC, n.d.)**

10. **What is a population aggregate?**
    a. **A defined subset of the population such as ppl with or at risk for a specific health problem or having specific social or demographic characteristics.think of where they come from, why they are at risk.**
    b. **Well defined group of people**
11. **What is a population-focused intervention?**
    https://www.health.state.mn.us/communities/practice/research/phncouncil/wheel.html
    Vaccine clinics, a program to bring vacinenes to a group. A program to bring an intervention to an audience. Or could be an education program on the need of vaccines.



12. What are some stressors that can be identified in a community assessment?

Think social determinants of health

- Conditions in which people live
- **Income**
- Social Status
- Education
- Literacy Level

- Home and Work Environment
- Support Networks
- Gender
- Culture
- Availability of Health Services

EX: high rate of poverty in a community, lack of preventable health care services, lack of affordable nutritional food in a community, unstable economy r/t closure of businesses, food desert, etc.

13. **How do you assure the success of a program?ATI pg35**

Ongoing evaluation is necessary in order to ensure program success and meet the changing needs of the community

Think bigger picture, if you're planning a program, include primary sources such as community members and get their input. Include the community members in the planning process of a program: what time, where at, providing childcare, etc.

14. **How can a community assessment show health disparities?**

Which part of the community assessment will help you see these: look at the social determinants of health in those communities.

15. **What are the steps of the community-based health program?**

The planning step of community assessment leads to planning programs for the defined community. Within this planning step, the nursing process is repeated to establish and maintain the program.

- **Preplanning**

- **Assessment**
- **Diagnosis**
- **Planning**
- **Implementation**
- **Evaluation**

ATI fig. 4.1

- **Define the community**
- **Collect data**
- **Analyze data**
- **Establish community diagnosis**
- **Plan programs**
- **Implement programs**
- **Evaluate program interventions.**

Define the community you're serving with pre planning.

16. **How doe the nurse plan for sustainability of a program when planning**

Developing a strategy for how a program will continue after initial funding ends should begin early in the planning process. (keep evaluating the program and outcomes). Anticipate the support system, involve the members of the community as a partner in the change. Looking at ways to include the people and make sure that you have the resources to continue the program.

17. **How does collaboration between agency personnel who are implementing a program and the target population impact program planning?**

When we plan, we are not the top. Think of the target population we are serving.
Include the population that you're trying to serve with a unified approach. Involve the agency personnel and the targeted population.

DHW: Ch. 11 ATI: CH. 4

1. **What are the steps of the program planning process?**

Develop interventions to meet identified outcomes.

- **Determine possible solutions to meet the health needs.**
- **Compare the resources and interventions required for each solution, and select the best option.**
- **Establish goals and objectives for the selected solution.**
- **Select strategies/interventions to meet the objectives.**
- **Plan a logical sequence for interventions by establishing a timetable.**
- **Identify who will assume responsibility for each intervention**
- **Determine available and needed resources to implement interventions.**
- **Assess the personnel needed and any special training required for screening or providing education.**
- **Determine funding opportunities for needed interventions and develop a budget.**
- **Plan for program evaluation.**

What are the components of a community assessment?

Assess biological, social, and psychological environments:

- **Establish a working group, including community members.**
- **Define the composition of the community.**
- **Identify the information that needs to be collected.**
- **Identify an organizing framework for collecting data.**
- **Use existing data to describe the community's strengths and weakness, assets, and liabilities.**
- **Collect demographic data from national, state, county, and city or town from the internet.**
- **Collect local data from libraries, service organizations, municipal records, newspapers, phonebooks, and other local sources.**
- **Gather new data as necessary.**
    - **Community forums**
    - **Focus groups**
    - **Key informants**
    - **Participant observation**
    - **Surveys**
- **Analyze the data, looking for similarities, differences, and inconsistencies.**
- **Develop a profile of the community.**
- **Identify vulnerable populations, unmet needs, resources, and unique characteristics.**
- **Outline a plan for intervention based on findings.**
- **Prepare a report and disseminate it to others.**

Design, implement, and evaluate a project based on findings

2. What does community as partner focus on?

   The community as partner framework uses a systems approach with a focus on partnerships to effect change. Core = people of community

   Talks about the community aggregate: assessing the needs of the community as a whole. Unity as a whole and collaborate with our resources. Not a one individual approach.

3. What are the core public health functions and give examples of how the steps of the program planning process fit these core functions Ch 2 p 34

   Core public health functions:

   - National consensus on goals (USDHHS, 2017b)
   - Provision of systems of health insurance based on risk, not necessarily on health.
   - Including both governmental & nongovernmental entities in disease prevention and health promotion

   PG 229:

   Core functions: community assessment is an integral function that supports all aspects of nursing practice. The approaches to assessment that will be described provide a foundation to develop and implement interventions that build and maintain healthy communities.

4. Where can you get some information for the community assessment specifically for injuries and violence? police report, death statistic/certificates (health department), coroners office,

5. **Review the Community Assessment process. This is similar to the Nursing Process. 229/190-198**
    - **Define the Community--Assessment**
    - **Collect data--Asssessment: Primary vs secondary sources of data. Past sources of data are secondary, current sources of data that you are gathering are primary sources of data.**
    - **Analyze data**
    - **Establish community diagnoses**
    - **Plan programs**
    - **Implement programs**
    - **Evaluate program interventions**

    In a scenario, during a community assessment process, if you have done this, what is your next step. EX: increased lice outbreaks for the reason of acting on this problem.
6. **What are the steps of analyzing the community assessment data?**
    - **Gathering collected data into a composite database**
    - **Assessing completeness of data**
    - **Identifying and generating missing data**
    - **Synthesizing data an identifying themes**
    - **Identifying community needs and problems**
    - **Identifying community strengths and resources**

    ATI PG 33
7. **Utilizing community assessment data to determine interventions for a community**

    Picking appropriate interventions for problems.

8. **What is the functional health pattern assessment?**

A systematic and deliberate approach to community assessment, evaluating patterns of behaviors of community dwellers that occur sequentially across time.

Designed for individual, family, or community assessment. Involves systematic and deliberate format. What kind of patterns would you see in a family assessment: eating supper together, taking walks together, exercising together, talking about the things that promote the health of the family (physical and emotional health).

9. **Where can you do community assessments? Within the community.**
10. **What are you evaluating in the community assessment? Evaluating the success of the interventions**
    - **Evaluate strengths and weaknesses of the plan/program**
    - **Evaluate the outcomes.**
11. **How do you get primary (direct) and secondary data for community assessments? Which do you get direct data from? Interview with community members for the primary data. Secondary data: 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**

    Primary: community forums, focus groups, observational studies, etc.

    What are health status indicators: data (the rates)

12. **What are the steps in community-based planning process?**

    a. **Initiation**
    b. **Organization of sponsorship**
    c. **Visual goal forming and strategy**
    d. **Recruitment**
    e. **Implementation**
    f. **Evaluation**

13. **How do you predict health status? Statistical measures are used to investigate the degree of relationship b/t events and/or circumstance of illness/disability in cases and cohorts of the population.**

14. **What is the collaborative model and how does this enhance community empowerment?**

    An approach to assessment that begins with planning that includes representative parities of a population, including service organizations, corporations, and government officials.

    This model ensures that members of a population have an active voice in identifying issues and in making decisions about what is needed. Engaging participants with a "we can do it together" approach is more effective than using a "we/they" approach.

    Were looking at both stressors and resources/strengths of the community. This is a part of the collaborative model. Empowers the community to address the needs themselves.

15. **Why should or would you perform a community assessment? 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.**

16. **Who do you choose to perform a community assessment on? Including ppl who work within the community but who do not necessarily live there and could include those living close to community boundaries who visit the communities to purchase goods or use facilities for non-work activities.**

    School population, county, businesses (OSF etc), manufacturing.

https://www.khanacademy.org/test-prep/mcat/social-inequality/social-class/v/health-and-healthcare-disparities-in-the-us

DHW: CH. 13 ATI: CH. 4

1. **What activities are included in the family assessment and what do they provide the nurse? Not sure this one. 280-287**
    a. **Survey and ask questions to the family. Ask how they run their household, how many people reside in the home, what are their methods of living together etc.**

Home visits: provide comprehensive assessment
Seeing the family in a more episodic manner: priority/focused assessment

Who is apart of the family, what do you do as a family, what do you do, moreso daily activities, identify things that will have a longterm impact that people do daily, identify support systems and their importances, geneograms are a tool.

What kind of patterns would you see in a family assessment: eating supper together, taking walks together, exercising together, talking about the things that promote the health of the family (physical and emotional health). 15 minute interview, genogram, etc. Identify strengths/resources/stressors.

2. **What is the purpose of and the questions used for the 15-minute interview?**

   Offers a pragmatic framework for nurses to engage families in a purposeful, therapeutic interaction.

   Key points for a 15-minute family assessment:

   - **Show interest throughout**
   - **Keep body language relaxed**
   - **Face the family member when asking a question**
   - **Try to minimize writing while listening.**
   - **Acknowledge the family's strengths.**
   - **Share any genograms and ecomaps that illustrate relationships with family members.**
   - **Ask family members for their interpretations/impressions (shared b/t the family and clinician)**
   - **Avoid offering advice prematurely**

- **Allow everyone present to voice observation, insights, or concerns before offering how they could change the situation.**
- **Ask the family if they see an area that could be changed.**
- **Plan goals and outcomes with the family**
- **Forge a partnership with the family's full participation**
- **Collaborate with the family to set priorities, plan care, and evaluate goals.**

3. **What are the actions of the functional assessment on a family?** 281

   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.

   Have to be approachable, have the family guide the interview.

   DHW: CH. 6, 7 ATI: CH. 3

1. **Calculation of rates related to community assessment**