Innovative Teaching Strategy (ITS)

Submission Form

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1. **Title of Teaching Strategy:** Community Health Threading: Teaching Strategies in a Four Semester BSN Program
2. **Date of Submission:** March 17, 2021
3. **Topical Area:**
    - Semester 1 Strategy: Community-Based Care – Home Health. Intervention Wheel – Case Management and Referral
    - Semester 2 Strategy: Community-Based Care to Community-Oriented Care (Assessment). Intervention Wheel - Screening
    - Semester 3 Strategy: Community-Oriented - Community Assessment, Analysis (Nursing Diagnosis), & Planning. Intervention Wheel – Collaboration, Community Organization Building, Advocacy
    - Semester 4 Strategy: Community-Oriented - Community as Partner – Implementation & Evaluation. Intervention Wheel – Outreach and Health Teaching
4. **Public Health Nursing competencies and standards:**
    - **ACHNE Public Health Nursing Core Knowledge and Basic Competencies**

        Semester 1 Strategy

            7- Illness and disease management

            11- Human diversity

        Semester 2 Strategy

            1-Epidemiology and biostatistics

            2-Community/population assessment

            7-Illness and disease management

11-Human diversity

Semester 3 Strategy

1-Epidemiology and biostatistics

2-Community/population assessment

3-Community/population planning

6-Health promotion and risk reduction

7-Illness and disease management

9-Environmental Health

11-Human Diversity

12-Ethics and social justice

Semester 4 Strategy

3-Community/population planning

6-Health promotion and risk reduction

7-Illness and disease management

9-Environmental Health

11-Human Diversity

12-Ethics and social justice

- **ANA PHN Scope and Standards of Practice**

Semester 1 Strategy

1-Assessment

5.a.- Coordination of Care

Semester 2 Strategy

1-Assessment

2-Population and Diagnosis

Semester 3 Strategy

1-Assessment

2-Population and diagnosis

3-Outcomes identification

4-Planning

Semester 4 Strategy

5-Implementation

a.- Coordination of care

b.- Health teaching and health promotion

c.- Consultation

6-Evaluation

- **Quad Council Competencies for Public Health Nurses**

Semester 1 Strategy

1-Analytic and Assessment Skills

4-Cultural Competency Skills

Semester 2 Strategy

1-Analytic and Assessment Skills

4-Cultural Competency Skills

5-Community Dimensions of Practice Skills

Semester 3 Strategy

1-Analytic and Assessment Skills

2-Program Planning Skills

3-Communication Skills

4-Cultural Competency Skills

5-Community Dimensions of Practice Skills

8-Leadership and Systems Thinking Skills

Semester 4 Strategy

1-Analytic and Assessment Skills

2-Program Planning Skills

3-Communication Skills

4-Cultural Competency Skills

5-Community Dimensions of Practice Skills

6-Public Health Sciences Skills

8-Leadership and Systems Thinking Skills

5. **Learner Level(s):** Undergraduate

	Semester 1	**Semester 2**	**Semester 3**	**Semester 4**
6. Learner Setting(s):	Clinical and/or simulation	Clinical	Classroom(Group collaboration)	Classroom(Group collaboration)
7. Strategy Type:	Paper Assignment and/ or debriefing	Paper Assignment (See appendices A, B, C, D)	Paper and field work assignment (See appendices E, F, G, H, I)	Other – health fair/field work (See appendices J, K)
8. Learning Goals/Objectives: At the completion of the activity, participants will be able to:	1. Identify discharge needs for the home setting (community-based) Or – Explore community-based implications for a hospitalized patient. 2. Appraise resources within the community that can be used by the patient post discharge from the hospital. 3. Identify 3 communities or populations the patient belongs to (ie, Native American, diabetic, homeless).	1. Apply an assessment tool to an individual in-patient assessment that includes a Community-based perspective. 2. Describe a community/ population that their patient belongs to (from a completed community-based individual assessment) 3. From the described community/ population, perform a mini community/ population assessment by applying an assessment tool with a Community-Oriented focus.	1. Perform a community assessment for a vulnerable population/ community 2. Analyze community assessment data for a vulnerable population/ community. 3. Plan a health fair or other intervention for a vulnerable population/ community.	1. Implement a plan of care for a vulnerable population/ community 2. Evaluate a plan of care for a vulnerable population/ community
9. Estimated time for the activity:	20-30 minutes of a simulation.	1-3 hours Community-based 2-4 hours Community-oriented	15-20 hours	15-20 hours
10. Strategy Overview:	Introduction of **Community-based.** 3 questions added to the end	Reinforcing **Community-based** and **Community-oriented.**	Application of **Community-oriented** nursing care.	Implementation of **Community-oriented** nursing care.

	of an individual in-patient assessment in a clinical or simulation setting: 1- What are the anticipated needs in the home that the patient has after discharge? (equipment, services) 2- What are some resources in the community that you may need to refer your patient to or educate them about? 3- What are 3 communities or populations your patient belongs to? These questions get the students thinking with a community-based mindset in terms of seeing their hospitalized patients as members of communities/ population.	Work in student pairs. During a current in-patient or a community-based clinical experience, students select a patient/client and perform a community-based assessment on the individual client. From the community-based assessment on the client, the students describe a community or population that the individual belongs to. Next they complete a mini community assessment about the described community or population. No community clinical setting is needed for this community-oriented assessment as this assessment data can be collection of already available data (web, agencies, textbooks, etc) Or, if doing clinicals in a community setting, have students perform a geographical	Work within a groups of 8 students. Faculty identify vulnerable populations/ community agencies that would like an assessment of their community and an intervention from nursing students. Then student groups of 8 select which vulnerable population/ community agency they would like to work with. Students develop a team charter and work together and the agency to provide community nursing care: perform a community assessment, analyze data, and plan an intervention to implement for the vulnerable population/ community agency.	Work within a group of 8 students. Students develop a team charter and work together to implement the intervention decided in previous semester; usually a health fair but can be another significant intervention that 8 students implement. Students are encouraged to recruit other professionals to include in the implementation of the intervention/ fair. Students then evaluate the intervention.

		community assessment.		

11. Detailed Strategy Directions: Provide detailed steps to implement the strategy including faculty/student directions if available. (Attach additional documents as necessary-Be sure document title clearly identifies the content of the file)

Semester 1 Detailed Steps:

- Introduce community based (individual/family care in the community setting)
  - During simulation of female patient, add one Community-based objective to be discussed during debriefing:
    - The female simulation patient is a diabetic and admitted with a lower leg wound. This patient is the second hospitalized patient that the nursing students experience in providing nursing care. Students do this simulation in pairs, while 6 other nursing students watch via video. The patient is controlled by a simulation nurse who is unseen to all. Student pairs spend 15 minutes each providing care then rotate to the video room.
    - Question 1 to ask during simulation and/or debriefing: 1- What are the anticipated needs in the home that the patient has after discharge? (equipment, services). This meets the objective: Identify discharge needs for home setting (equipment, services)
    - Question 2 to ask during simulation and/or debriefing: What are some resources in the community that you may need to refer your patient to or educate them about? This meets the objective: Identify resources within the community that you might refer your patient to (agencies, associations, societies, etc)
    - **Minimal change in curriculum as this would encompass adding two objectives to a current simulation and a 15 minute discussion during simulation or debriefing to get community content integrated at a beginning level.
    - **Can also be used in clinical conference after caring for a live patient in the hospital setting.
    - **Can also be used in the classroom setting as an addition to an unfolding case study
- Introduce community-oriented (care for the community/population as a whole)
  - During the above simulation or continuation of caring for the above patient at a later simulation, add one Community-oriented objective to be discussed during simulation or debriefing:
    - Question 3 to add to simulation and/or debriefing: What are 3 communities or populations your patient belongs to? This meets the objective: Identify 3 communities or populations your patient belongs to (ie, diabetic community, Native American, elderly, homeless, teenage mom)
    - **Minimal change in curriculum as this would encompass adding one objective to a simulation or debriefing and a 15 minute discussion at the end of debriefing to get community content integrated at a beginning level.

- **Can also be used in clinical conference after caring for a live patient in the hospital setting.
- **Can also be used in the classroom setting as an addition to an unfolding case study

Semester 2 Detailed Steps:

- The following 2 activities reinforce community-based and community-oriented
- The first assignment is part of hospital or community clinicals. **Does not have to be community clinicals. The second assignment does not need a clinical experience.
- 1- Students work individually to complete an assessment on an hospitalized or community individual with a community-based focus.
  - Students select a patient from an in-patient hospital or community clinical rotation.
  - Perform an assessment on an individual that incorporates questions with a community-based focus (assessing the patient from a perspective of being an individual within a setting outside of the hospital, in other words, the community).
  - Gordon's Functional Health Patterns (FHP) are used as the assessment tool.
  - See appendix A for template to complete this assignment.
- 2- Students work in **pairs** to complete a **mini** community assessment.
  - Students select one of their patients from their individual community-based assessment above.
  - Based on the individual assessment and diagnosis, students describe one community/population the patient belongs to; for example, diabetic community, homeless, elderly, high school population, Refugee, LGBTQ, Veterans, etc
  - Students take this community/population and perform a community assessment with a community-oriented focus.
  - Gordon's Functional Health Patterns are used as the assessment tool.
  - See appendix B for template to complete this assignment.
  - No individual information is collected but instead a community assessment looking at aggregate data is collected
  - No further clinical site/clinicals needed as this community assessment is completed as part of INDIRECT community nursing; such as reviewing literature, websites, agencies, textbooks, videos, databases, etc. regarding the selected community/population.

Semester 3 Detailed Steps:

- The following activity is an application of **Community- oriented nursing care, specifically assessment, analysis, and planning**.
- A community plan of care will be started this semester. A community or population assessment will be completed in a larger format as compared to the "mini" community assessment in semester 2. Then an analysis and planning will be completed.
  - Students work within a groups of 8 students.
  - Faculty prep work before course begins: identify vulnerable populations/ community agencies that would like an assessment of their community and

an intervention from nursing students. Current and past agencies/populations used have included (but not limited to):
    - Boys and Girls Club
    - Homeless shelters
    - Substance Abuse treatment center and housing
    - Veteran organizations
    - High Schools
    - Pregnant women experiencing homelessness
    - Domestic violence shelters
    - LGBTQ Youth agencies
    - Handicapped adult day centers
    - Elderly day centers
  - Student groups of 8 select which vulnerable population/ community agency they would like to work with.
  - Students develop a team charter. The team charter defines the work that each team member will accomplish since the task is large and the group of 8 students is large.
  - After the team charter, students work together and with the agency to perform a community assessment, analyze data, and plan an intervention to implement for the vulnerable population/ community agency.
  - Gordon's Functional Health Pattern Framework used as the assessment tool.
  - Community/population assessment is an assignment.
  - Community analysis, and planning is an assignment.
  - Implementation and Evaluation occur in Semester 4

Semester 4 Detailed Steps:

- The following activity is an application of **Community- oriented nursing care, specifically implementation and evaluation.**
- From the Community Plan of Care: Assessment, Analysis, and Planning from Semester 3, the group of 8 students now implement and evaluate their intervention/health fair.
  - Students work within a groups of 8 students.
  - The student groups are the same as Semester 3 for continuity. On occasion, students are added to a group for various reasons but all students have had to complete the previous semester before joining a group in Semester 4, so all have learned assessment, analysis, and planning.
  - Students develop a team charter. The team charter defines the work that each team member will accomplish since the task is large and the group of 8 students is large.
  - After the team charter, students work together and with the agency to implement the intervention or health fair for the vulnerable population/ community agency. Examples of implemented interventions include:
    - Health fairs
    - Creation of healing gardens
    - Shoe/sock drive
    - Footcare services
    - Water drive and sun safety education

        - Fashion show for what to wear to an interview
        - Recorded educational series for organizations
        - Virtual health fair
    - Faculty are present for each intervention/health fair. Faculty typically supervise 4-6 groups in this semester.

a. Strategy Materials/Resources: Materials needed to implement the strategy (e.g., PowerPoint files, computer lab, index cards, large paper, videos, etc.)

Semester 1	--A current simulation, clinical, or unfolding case study is needed and these questions are added to the discussion during simulation and/or debriefing, clinical conference, or classroom discussion. --Access to internet via smart phone or computer to look up information on home health and community resources
Semester 2	--Clinical experience, either hospital or community-based. --Community-Based Individual Assessment Template: Functional Health Patterns for individual (Appendix A) --Mini Community-Oriented Assessment Template: Functional Health Patterns for community/population (Appendix B)
Semester 3	--Faculty to provide contact information (address, contact person, phone/email) of community agencies that would like an assessment and intervention/health fair for their population. --PowerPoint of Community Care planning and Community assessment with Functional Health Patterns process as a resource and review (available upon request from author) --Team Charter (Appendix E) --Community Care Plan Template: Assessment (Appendix F). This is a large document due to complexity of assessing the community, but manageable with a team of 8 students. --Community Care Plan Template: Analysis and Planning (Appendix H)
Semester 4	--Team Charter (Appendix J) --Health Fair or Intervention Planning Check Sheet (Appendix K)

b. Website Links: Provide a description of how to use the website in the strategy. Note time needed as appropriate. For example: Students view video prior to simulation activity- 15 minutes.

Semester 1	--If students struggle to anticipate what needs would be needed in the home, faculty can give students a 3-5 minutes to review these sites and apply their simulation, clinical, or case study patient to the home health information. --What's Home Health Care - Medicare https://www.medicare.gov/what-medicare-covers/whats-home-health-care --Types of Home Health Care Services https://www.hopkinsmedicine.org/health/caregiving/types-of-home-health-care-services

Semester 2	None
Semester 3	--Faculty to provide website links of the community agency that the student group will be assessing. If you have a group of 80 students, 10 agencies will be provided for the students to assess (8 students per group). Here is an example of the website and contact information that students will review before contacting the agency and during the assessment as a means of gathering assessment data. Fictitious example: **Crossdoors Women (East Valley) : Team #2** o Addiction Recovery (Women) - o Women who are substance abusers or Women with addictions in Maricopa County Contact: Name_____, (List credentials if applicable) Program Coordinator (or title) Street Address City, State, Zip Code Cell Phone Office Phone Extension Phone Website address
Semester 4	--Event Planning Guide by the Center for Disease Control and Prevention https://www.cdc.gov/traumaticbraininjury/pdf/EventPlanningGuide_FINAL.pdf Students review during week 1. Especially pages 10-13. Approximately 30 min review. This is regarding a traumatic brain injury public event but is to serve as an example for the various health fairs implemented this semester.

c. Methods for evaluating student learning: Examples include but are not limited to: Grading rubric, papers, projects, exam/quiz items, clinical conference discussion questions, student evaluation tool to rate experience.

Semester 1	--Simulation debriefing, clinical conference discussion, or classroom unfolding case study discussion of the 3 questions serve as the evaluation tool. If desired or needed, the following questions can be made into a word document for record of each students' response: 1- What are the anticipated needs in the home that the patient has after discharge? (equipment, services) 2- What are some resources in the community that you may need to refer your patient to or educate them about? 3- What are 3 communities or populations your patient belongs to?
Semester 2	--Rubric Community-Based Individual Assessment (See Appendix C) --Rubric Mini Community-Oriented Assessment (See Appendix D)
Semester 3	--Rubric Community Care Plan Template: Assessment (See Appendix G)

	--Rubric Community Care Plan Template: Analysis and Planning (See Appendix I)
Semester 4	--Implementation of the health fair or intervention is the evaluation measure. At the end of the experience, debriefing occurs.

12. Comment on overall success of this teaching strategy

Semester 1	This teaching strategy is a proposal and it is anticipated that it will be implemented in a future semester
Semester 2	--This assignment has been used since Fall 2019. --In Fall of 2020, this assignment was used in virtual clinicals (due to pandemic) where students reviewed a voice over PowerPoint and worked in pairs virtually in online breakout rooms to complete this assignment. --Challenges are the variety of clinical faculty who might not be well versed in community-oriented and community-based concepts; and the lack of consistent feedback or guidance by clinical faculty. --One faculty for a clinical group of 10 students.
Semester 3	--This assignment has been used since Fall 2017 and every fall, spring, and summer since then. It is estimated that there are 6-16 groups of 8 students, providing community care for 6-16 community agency populations each semester. --100% of the student groups have been successful in passing the assignments and course as there is close guidance by core faculty familiar with the assignment. -One faculty for a cohort of 40-64 students (5-8 groups of 8 students each)
Semester 4	--This assignment has been used since Spring 2018 and every fall, spring, and summer since then. It is estimated that there are 6-16 groups of 8 students, providing community care for 6-16 community agency populations each semester. --100% of the student groups have been successful in passing the assignments and course as there is close guidance by core faculty familiar with the assignment. -One faculty for a cohort of 40-64 students (5-8 groups of 8 students each) --The link below is an ASU Now online article, titled *ASU nursing students learn and teach with the Boys and Girls Club*. This article was written about an implementation of a Health Fair at the Boys and Girls Club that Semester 3 and 4 students developed and implemented: https://asunow.asu.edu/20181015-asu-nursing-students-learn-and-teach-boys-and-girls-club?_ga=2.163923703.998360753.1601894434-1814473769.1558303894 --Another online article was written about an implementation of a health fair by Semester 3 and 4 students at a licensed substance abuse treatment center and housing for women. The article describes what some of the women and nursing students experienced. The article was written by the college of nursing and titled: *Community*

	connections lead to invaluable opportunities for ASU nursing students

13. Additional References: Used in the development of the strategy.

SEE APPENDICES A-K BELOW

Appendix A

Community-Based Individual Assessment Template/assignment

Perform an assessment on the individual patient from your hospital clinicals. This assessment will be a community-based focus and inquire about the patient outside of the hospital, based in the community

Patient Initials_____Age_____Gender_____

Diagnosis(es)_____

_____

Populations the individual belongs to (e.g., Veterans, homeless, LGBTQIA, high school student, physically disabled). List at least 3:

_____

_____

_____

Functional Health Pattern	**Findings for the individual in the community**
Values/Belief • How do you practice your religion or spirituality outside of the hospital? • What do you value about your neighborhood?	
Health Maintenance/management • Do you wear a device to call for help in case you fall or need emergency help? • Do you foresee barriers to managing your health or illness in the home setting/ outside of the hospital? • How do you manage your medications at home (pill box, etc)	
Nutrition • Do you have access to food (Food kitchens, ability to shop at local store, home delivery, Meals on Wheels, food stamps, grocery stores)?	

• What are barriers, if any, to eating healthy?	
Activity/Exercise • Do you have transportation to go to appointments, buy groceries, refill prescriptions, etc? • Do you feel safe outdoors? • What activities do you do outdoors?	
Sleep/rest • Are there any barriers to sleep in your home? • Is your neighborhood quiet or loud at night?	
Sexuality • Do you have sexual concerns outside of the hospital setting? What are they?	
Self Perception/Self concept • How do you feel about yourself and your health situation when in your home setting?	
Role Relationships • Do you live alone or do you have others (e.g., family, significant other, home health aid, etc) live or visit with you? • Do you have pets? • Assistance with care for pets?	
Cognitive/perceptual • Do you have internet and computer access? • Do you have access to a library? Community classes?	
Elimination (Environmental issues) • Where do you live (home, apartment, group setting, homeless shelter, etc)? Running water? Electricity?	
Coping/Stress • Do you receive any services from community	

agencies to help with your illness or stress? • What agencies and types of services?	

Appendix B

Mini Community-Oriented Assessment Template/assignment

From the Community-Based assessment, select ONE community or population that the individual patient belongs to, based on the diagnosis(es), age, culture, race, social economical status, etc. (For example, diabetics, veteran, severely mental ill, truck drivers, LGBTQ, elderly, homeless, impoverished, preschool age, Native American, alcoholics, addicts, nurses, teachers, Mexican Americans, high school students, etc):

_____

Describe the community/population (100-250 words, include at least one citation):

_____
_____
_____

Collect the following data below, based on the community as a whole.

Do not think about your individual patient but instead the characteristics of the entire community/population selected

Obtain information from textbooks, websites, data bases, scientific literature/peer reviewed journals, videos, agencies, professional organizations, etc.

Include citation as to where information obtained as well as a reference page.

Functional Health Pattern	**Findings for the community related to the community/population chosen. Include citation**	**Student collecting data**
Values/Belief • Predominant cultural groups (ethnic or non-ethnic) along with beliefs related to health • Predominant spiritual (inner peace, trust, forgiveness, shame/guilt, fear, caring, etc) beliefs within the community that can influence health. How?		
Health Maintenance/management • Predominant health problems (chronic, acute, physical, and mental) • Available health professionals and health		

resources/referrals for population/community and usage		
Nutrition • What are the nutritional or food intake norms (positive and negative) within your community? • Indicators of nutrient deficiencies (weight gain/loss, dry hair, dry skin, brittle nails, etc)		
Activity/Exercise • What amount and type of exercise is the norm for community members (hikers, exercise restrictions, organized/club sports, none, etc.) • Common activities used for diversion, recreation, or hobbies?		
Sleep/rest • Sleep routines of your community and hours of sleep needed by your community. • Factors affecting sleep (shift work, environment [noise, lights, crowding], consumption of [caffeine, nicotine, alcohol, and drugs], health issues, pain, medication, homework/ extracurricular activities		
Sexuality • Common sexual issues within community (promiscuity, impotence, STDs, monogamy, etc) • Common reproductive issues within community		
Self Perception/Self concept		

• Are the community members' moods, in general: satisfied, happy, fearful, stressed, or feeling down? • Pride indicators within community (caring behaviors, low/high self-esteem, etc)		
Role Relationships • Who are key leaders (formal and informal) within your community? • Vulnerable populations within community? Why are they vulnerable?		
Cognitive/perceptual • Primary language? Lingo/slang? • Communication barrier(s)? • Educational levels?		
Elimination (Environmental issues) • Safety (issues, committee, security guards, badges, locked campuses, fall preventions, personal alarms, neurological issues, etc.) • Diarrhea or constipation issues within community? • Exposure to environmental hazards (noise, bloodborne pathogens, waste, rodents, air pollution, etc)		
Coping/Stress • Stressors within community/population? • Typical coping mechanisms used by community?		

• Stress management resources and community referrals (e.g., hot lines, support groups, etc.)		

Appendix C

Rubric

Community-Based Individual Assessment

Content	Possible Points	Completely Met	Partially Met	Not met	Points awarded
Patient's initials, age, and gender listed	3				
Patient's diagnosis(es) listed	3				
3 populations/communities the patient belongs to listed	6				
Values and Belief findings for the individual in the community	8				
Health Maintenance findings for the individual in the community	8				
Activity/exercise findings for the individual in the community	8				
Nutrition findings for the individual in the community	8				
Sleep/rest findings for the individual in the community	8				
Sexuality findings for the individual in the community	8				
Self-perception/Self concept findings for the individual in the community	8				
Role relationships findings for the individual in the community	8				
Cognitive perceptual findings for the individual in the community	8				
Elimination findings for the individual in the community	8				
Coping/stress findings for the individual in the community	8				
Total points possible = 100	100				

Appendix D

Rubric

Mini Community-Oriented Assessment

Content	Possible Points	Completely Met	Partially Met	Not met	Points awarded
One community/population that patient belongs to is listed	2				
Community/population described in 100-250 words with citation	6				
Values and Belief findings for the community	7				
Health Maintenance findings for the community	7				
Activity/exercise findings for the community	7				
Nutrition findings for the community	7				
Sleep/rest findings for the community	7				
Sexuality findings for the community	7				
Self-perception/Self concept findings for the community	7				
Role relationships findings for the community	7				
Cognitive perceptual findings for the community	7				
Elimination findings for the community	7				
Coping/stress findings for the community	7				
Citations used within each functional health pattern category to show where data obtained from	10				
Reference page to support each citation	5				
Total points possible = 100	100				

Appendix E

Team Charter Template: Semester 3 (Or add course #)

A team charter defines the purpose of the team, and sets ground rules for working together including expectations, communication frequency and methods, how decisions will be made, and how conflicts will be handled. To compete the charter, answer the questions below.

What community/population are you assessing?

Who is on the team (name and defined role)?
To answer this, fill out template at end

What are the ground rules for working together? In other words, what can the team members expect from one another?

How often will the team communicate (daily, weekly, monthly, as needed)?

How will you communicate (describe all the ways—meetings, email updates, phone calls, collaborative software, etc.)?

How will the team make decisions (voting, consensus, single decision maker)?

How will conflicts within the team be handled?

Where will meeting notes, the team charter, and any other documentation related to team communication/collaboration be housed?

Agreement by members (electronic signature)

Adapted from the National Estuarine Research Reserve (NERRA) http://www.nerra.org/

Team Charter: Roles/Duties Template

Team Leaders: Please designate two team leaders

1.

2.

Team Leaders responsible for motivating and leading students during the entire project. Will also be responsible for team meeting attendance.

Section 1: Assessment/FHP topic	**Student: 1 student per slot**
Values/Belief	
Health Maintenance/management	
Nutrition AND **Elimination/environment**	
Activity/ Exercise	
Sleep/rest AND **Sexuality**	
Coping/stress AND *submit the Community assessment FHP group assignment*	
Role/relationships AND *submit the charter assignment*	
Cognitive perceptual AND **Self concept**	
Section 2: Analysis and Planning	**Students: 1 per slot**
Data analysis summary of community assessment FHP	Each student analyzes their FHP category(ies)
Prioritization 3 problems - (this student to coordinate the in-class and online discussion regarding this topic and finalize content)	Student 1-
Outcomes (Goals and 3 outcomes) - (this student to coordinate the in-class and online discussion regarding this topic and finalize content).	Student 2-
Interventions summary - (this student to coordinate the in-class and online discussion regarding this topic and finalize content)	Student 3-
Barriers addressed - (this student to coordinate the in-class and online discussion regarding this topic and finalize content)	Student 4 -
Cost implications - (this student to coordinate the in-class and online discussion regarding this topic and finalize content)	Student 5 -
Implementation mechanisms - (this student to coordinate the in-class and online discussion regarding this topic and finalize content)	Student 6 -
Collaborative Relationships - (this student to coordinate the in-class and online discussion regarding this topic and finalize content)	Student 7 -
Planned evaluation - (this student to coordinate the in-class and online discussion regarding this topic and finalize content)	Student 8-

Appendix F

Community Care Plan Template:

Assessment

Assessment: Functional Health Pattern (FHP) Template

This FHP template is to be used for collecting and organizing community assessment data. Depending on the community/population chosen, you may not answer all questions. You may also add questions that are not captured in this template when conducting Interviews. **This is a guide; *you may need to add and defer as needed*. Please copy and paste this template into a word document and type your answers underneath each bullet in a different color.**

Describe your community/population chosen in terms of characteristics and/or boundaries (for neighborhoods or living communities)

_____
_____
_____
_____
_____

1-Health Perception/Management

Predominant health problems (chronic and acute, physical and mental)
Immunization rates (age appropriate)
Appropriate death rates and causes
Prevention programs commonly used in population or community (exercise, education, dental, fire, fitness, safety, etc.) Participation?
Available health professionals for population/community and usage
Available health resources within the population/community and usage
Common referrals utilized? Or needed and missing or underutilized.
How is community health perceived?
What health services do residents believe they need and have?
What are the cultural (ethnic and/or non-ethnic) patterns influencing health practices?
What languages (ethnic and/or non-ethnic) are spoken?
Do people feel fire, police, and safety programs are sufficient?
What are the population size and age distributions?
What is the sex ratio, racial composition, marital status, and nationality compositions?
What is the education, occupation, and income distributions?
What are the statistics regarding mortality, morbidity, and prevalent infectious diseases?
What are the motor vehicle accident statistics?
What are the currently operating health facilities (types)?
What are the ongoing health promotion and health prevention programs and use rates?
What is the ratio of health professionals to the population?
What are the laws regarding drinking age?
What are the statistics for drug use and for drinking and driving, by age group

2-Nutrition/Metabolic

Indicators of nutrient deficiencies (weight gain/loss, dry hair, dry skin, brittle nails, etc.)
What are the nutritional or food intake norms (positive and negative) within your community?
Obesity rates or percentages
Affordability of food/available discounts or food programs and usage (e.g., WIC, food boxes, soup kitchens, meals on wheels, food stamps, senior discounts, employee discounts)
Availability of water (e.g., number and quality of drinking fountains, public water, wells)
Fast food and junk food accessibility (vending machines, restaurant proximity, etc.)
Evidence of healthy food consumption or unhealthy food consumption (trash, long lines, observations, etc.)
Special diet needs. Provisions for special diets if applicable
Cultural (ethnic and non-ethnic) food staples/norms in community's diet
Supplements or nutrient needs?
Dietary support/programs or referrals?
What shopping facilities are visible?
Are there grocery stores? Kinds and accessibility?
What are the predominant food smells in the area (Asian, Mexican, or other cultures)?
What food purchases are made (observable at food store checkout)?
Are junk food vendors and fast-food establishments near schools and workplaces?
In general, do most people seem well nourished? Children? The elderly?
Are there school lunch programs, elderly feeding programs, and special milk programs?
Is cost of food reasonable in this area relative to income?
Does community housing have adequate kitchen and plumbing facilities?
If appropriate: What is the water usage cost? Any drought restrictions?
What percentage of community housing has no or inadequate kitchen and plumbing facilities?
For schools (in addition to above):

1. Nutritional content of food in cafeteria and vending machines: Compare to ARS 15-242/The Arizona Nutrition Standards
2. Amount of free or reduced lunch

3-Elimination (Environmental Health Concerns)

Common air contaminants' impact on the Community ? Air pollution index ?
Noise exposure
Waste disposal practices, policies, etc.
Pest, rats/rodents, animals? Roaming or on leashes?
Pest control? Is the community notified of pesticides usage?
Hygiene practices (laundry services, hand washing, etc.)
Practices at home: dressing changes, Central line care, etc. Issues?
Bathrooms: Amount, inspect for cleanliness, supplies if possible
Universal precaution practices of health providers, teachers, members (if applicable)
Temperature controls (e.g., within buildings, outside shade structures)
Safety (issues, committee, security guards, crossing guards, badges, locked campuses, fall preventions, personal alarms, neurological issues, etc.)
Diarrhea or constipation issues within community?
Are chemical dumps or disposal dumps visible?
Are they close to waterways or densely populated areas?

Are the community/population members exposed to environmental hazards? (in their home, work, clicks [groups], neighborhoods)
What is visible in the community (waterways, highways, or mountains)?
What is the location of the community?
Is it near a major harbor or desert?
Are major highways evident that allow easy access to community?
Are smells present?
Are noxious chemicals evident?
Are emission controls enforced?
What is the water quality?
What is the population per square mile?
What are the temperature range, humidity range of community?
What plants are observed? Are they poisonous?
Is there evidence of defoliation and deforestation?
What chemicals are used to control mosquitoes and other insects?
Are food plants contaminated?

4-Activity/Exercise

Community fitness programs (gym discounts, P.E., recess, sports, access to YMCA, etc.) Usage?
Fitness norms of community members (hikers, organized/club sports, none, etc.)
Adaptive exercise programs needs/issues
Recreational facilities and usage (gym, playgrounds, bike paths, hiking trails, courts, pools, etc.)
Safety programs (rules and regulations, safety training, incentives, athletic trainers, etc.)
Injury statistics or most common injuries
Evidence of sedentary leisure activities (amount of time watching TV, videos, and computer)
Means of transportation
Common activities used for diversion?
Community Referrals?
Do children play in streets or vacant lots?
Are residents walking, riding bikes, or driving around the community?
Are joggers evident?
Are there cultural programs?
Aids for the disabled?
Residential centers or nursing homes utilized?
What is the general activity level (bustling or quiet)?
Are there transient groups?
Is the population increasing, decreasing, or stable?
Is housing adequate (availability and cost)?
Is public housing available?
Are rehabilitation facilities appropriate for population needs?

5-Sleep/Rest

Indicators of general “restedness” and energy levels
Sleep routines of your community and hours of sleep needed by your community.
Is the area quiet, conducive to sleep? Or are there loud industrial, bus, truck, train, airplane, or construction noises?
Is there movement of residents during certain times of day?

Are noise ordinances enforced? What efforts, if any, are being made to control noise levels?
Factors affecting sleep:

3. Shift work prevalence of community members
4. Environment (noise, lights, crowding, etc.)
5. Consumption of caffeine, nicotine, alcohol, and drugs
6. Health issues, pain, medication
7. Homework/extracurricular activities

6-Cognitive/Perceptual

Primary language? Is there a communication barrier? Are they bilingual?
Educational levels: For geopolitical communities, use http://www.census.gov
School dropout rates?
Opportunities/programs:

8. Educational offerings (specific to community issues, in-services, continuing education, GED, etc.) Usage?
9. School systems? (quality/grading? Dropout rate?)
10. Schools perceived as good or needing improvement?
11. Educational offering community referrals
12. Educational mandates (yearly in-services, continuing education, English learners, etc.)
13. Special education programs (e.g., learning disabled, emotionally disabled, physically disabled, and gifted)

Library or computer/Internet resources and usage
Funding resources - who funds educational offerings, mandates, and programs?
Tuition reimbursement, scholarships, fee waivers, etc.
What are the community's decision-making patterns?
Are decisions made by a few people or a group of leaders?
Are residents heard with regard to health matters, or does evidence show that they are forced to comply?
Do residents believe they have been deceived about health-related issues?
Do community residents believe there is a cooperative effort to achieve community health goals?
What is the community government structure?

7-Self-Perception/Self-Concept

Age levels
Programs and activities related to community building (strengthening the community – like picnics, parades, movie night, etc.)
Community history
Pride indicators: Self-esteem or caring behaviors
Published description about community and/or community agency/services (pamphlets, websites, etc.)
Are community beautification projects evident?
What is the condition of housing and community buildings (in good repair or state of disrepair)?
What is the appearance of streets, sidewalks, and yards? Are they clean or littered?
Is it an old community? Fairly new?
Are people's moods, in general: satisfied, stressed, or feeling down?
Do community residents think it is a good place to live? Or a good community to be a part of?

Do people generally have the kinds of skills needed in this community?

8-Role/Relationship

Interaction of community members (e.g., friendliness, openness, bullying, prejudices, respect, etc.)
Vulnerable populations within community?
14. Why are they vulnerable?
15. How does this impact health?

Power groups (medical personnel, tech savvy, patients, councils [church, student, tribe, etc.], administration, PTA, and gangs)
16. How do they hold power?
17. Positive or negative influence on community?

Harassment policies/discrimination policies
Relationship with broader community
18. Police
19. Fire/EMS (response time)
20. Other clinics/agencies that community utilizes
21. Other (food drives, blood drives, missions, etc.)

Are there newspapers, newsletters, flyers, and bulletins that provide information about community activities and schedules of meetings?
What are the common meeting places (street corners, bars, Laundromats, meeting halls, or parks)?
Do residents seem friendly? Do they stop and talk or walk on?
Do residents seem to get along well together?
Do radio or television stations provide public information announcements?
Are there public meetings to discuss community concerns?
What are the official channels of communication?
What is the organizational structure of community?
Are key leaders (formal and informal) available and easily accessible to residents?
What community systems exchange functions, such as the health department, collaborating with schools for screening or immunizations?
Do people feel they are heard by the government?
Are there enough jobs in the community? Are wages good?
Do people seem to like the work they do, or is there job stress?
Is participation at meetings high or low?
What is the unemployment rate?
What are the rates of riot, violence, and child and elder abuse?
What is the divorce rate?

9-Sexuality/Reproductive

Relationships and behavior among community members
Educational offerings/programs (e.g., sexuality and chronic conditions, growth and development, STD/AIDS education, contraception, abstinence, etc.)
Access to birth control
Birth rates, abortions, and miscarriages? (if applicable)
Access to maternal child health programs and services (crisis pregnancy center, support groups, prenatal care, maternity leave, etc.)

Common sexual issues within community.
Community resources and referrals
What family planning services are available?
What marital, family, and adolescent counseling services are available/visible?
Are abortion services evident?
Are sex-related crimes a problem? Statistics?
Do people feel there is a problem with pornography or prostitution?
Do people support or want sex education in schools and community?
What are the neonatal, infant, and maternal death rates?
What is the average family size and type of household?
What is the male-female ratio?
What is the teen pregnancy rate?
What are the laws and regulations regarding information on birth control?

10-Coping/Stress

Delinquency/violence issues? Statistics?
Crime issues/indicators. Statistics? What is being done to eliminate it?
Poverty issues/indicators
CPS or APS abuse referrals: Compare with previous years (trending up or down)
Drug abuse rates, alcohol use, and physical abuse: Compare with previous years (trending up or down)
Stressors within community/population?
Stress management resources and community referrals(e.g., hot lines, support groups, etc.)
Typical coping mechanisms used by community?
What services does the community have and need to obtain to assist with coping and stress?
Are the services public or private? How are they funded or supported?
Is substance abuse a problem? What is being done to contain it?
Is a type of housing, such as low income, being available? Being opposed?
Is a health facility, clinic, or mental health residence being opposed? Why?
Are specific cultural and ethnic groups valued and maintained? Discriminated?
Prevalent mental health issues/concerns and
    22. How does the community deal with mental health issues?
    23. Mental health professionals within community and usage
Disaster planning? Such as:
    24. Past disasters
    25. Drills (what, how often)
    26. Planning committee (members, roles)
    27. Policies
    28. Crisis intervention plan

11-Value/Belief Pattern

Predominant ethnic and cultural groups along with beliefs related to health
Predominant spiritual beliefs within the community that can influence health
Availability of spiritual resources utilized or available to the community (churches/chapels, synagogues, chaplains, spiritual leaders, Bible studies, sacraments, self-help, support groups, etc.)

Do the community members value health promotion measures? What is the evidence that they do or do not? (e.g., involvement in education, fundraising events, etc.)
What does the community value? How is this evident?
What do the community members spend their money on? Are funds adequate?
What have you read about the history of the community?
How did it come into being?
What are some of its traditions?
What changes were made and valued?
What are the community's priorities?
Is it receptive to new ideas?
What ethnic groups are acceptable?
What health services and programs are acceptable?
What common values and norms are shared?
Are health-promotion and health-protection services available to all groups?
What changes has the community supported?
What are the zoning and conservation laws?
What are contained in the community health committee meeting reports (goals and priorities)?
What is the health budget in relation to total budget?

References

Edelman, C., & Mandle, C. L. (2010). *Health promotion throughout the life span* (7th ed.). St. Louis, MO: Mosby.

Gordon, M. (1994). *Nursing diagnosis process and application* (3rd ed.). St. Louis, MO: Mosby.

Appendix G

Rubric
Community Care Plan Template: Assessment

Content	Possible Points	Completely met	Partially met	Not met	Points awarded
Health Perception/Management	8				
Nutrition/Metabolic	8				
Elimination (Environmental health concerns)	8				
Activity/Exercise	8				
Sleep/Rest	8				
Cognitive/Perceptual	8				
Self-Perception/Self Concept	8				
Role/Relationship	8				
Sexuality/Reproductive	8				
Coping/Stress	8				
Value/Belief	8				
Community/ population data are community oriented and not focused just on the individual or family	4				
Community/ population data is relevant	4				
Data is collected from relevant, reputable sources and cited	4				
Total points awarded	100				

Appendix H

Community Care Plan Template: Analysis and Planning

Individual completion of data analysis of your FHP category

Analyze the Community assessment data analysis (11 FHPs)

Directions to complete:

- Report name, community, and FHP category assigned
- Copy and paste your FHP category(ies) data into the template
- Add a (+) or (-) after each piece of data showing the data is effective/strength/positive (+) or ineffective/weakness/negative (-)
- Select at least three key findings from your FHP category(ies) that you will analyze further as strengths, gaps, or weaknesses; including evidence from the literature- journals, textbook, credible internet sites/agencies, .gov/.edu (See examples below)
- List problems, risks, and strengths at the end

Student name	Community/population	FHP category(ies) assigned

Copy/paste FHP category data here (including [+] or [-] after each piece of data):

Key Findings from community assessment (functional health patterns) **EXAMPLES**	**Strengths**	**Gaps**	**Challenges/ weaknesses**
There are no parks within a mile radius of neighborhood and children seen playing in the streets (Activity/exercise)	N/A	No parks	Lack of nearby parks can contribute to injury, obesity, boredom, violence as no stress outlet
Evidence from literature to support analysis	Parks and trails can improve health by reducing injury- by providing places away from streets and business areas. Parks can be safe places for people to play and exercise. (CDC, 2016) https://www.cdc.gov/healthyplaces/parks_trails/#health		
Syphilis among the AZ teenage population 3 cases per 100,000 population in 2015 and 4 cases per 100,000 population in 2011 (Sexuality)	AZ syphilis rates below the national numbers. Also, AZ cases trending down.	N/A	Syphilis present in the AZ teenage population

Evidence from literature to support analysis	In 2015, Primary &Secondary syphilis were reported in the United States, yielding a rate of 7.5 cases per 100,000 population. This rate represents a 19.0% increase compared with 2014 (6.3 cases per 100,000 population), and a 66.7% increase compared with 2011 (4.5 cases per 100,000 population). (CDC, 2016) https://www.cdc.gov/std/stats15/syphilis.htm		
Key Findings from community assessment (functional health patterns)	**Strengths**	**Gaps**	**Challenges**
1			
Evidence from literature to support analysis			
2			
Evidence from literature to support analysis			
3			
Evidence from literature to support analysis			

What are some summary statements (nursing diagnosis) from your data analysis of the community assessment functional health patterns?

Actual problem(s)

_____
_____
_____

Risk for (potential problems)

_____
_____
_____

Wellness, strengths, positives within the community, good within your community

_____
_____
_____

<u>Group work</u>

Problem Prioritization

What problems or risk for/prevention priorities did your team of 8 decide were priority? List 3

1-

2-

3-

How did your team come to this conclusion?

Planning

From the assessment, analysis, and prioritization, Describe the intervention your team has chosen to address the priority need/problem? (ie, health fair, educational module, policy development, etc) -

_____

What are your team's Goals and Objectives (1 goal and at least 3 objectives):

What are potential Barriers?

What are the Cost implications, if any? And how will this be addressed?

What are your team's implementation mechanisms?

What collaborative relationships with community agencies, advocates and resources need to be addressed for successful implementation of the intervention? Explain. (next semester)

What is your team's planned Evaluation strategy? How will your team evaluate that the goals and objectives have been met (Summative Evaluation)? How will formative/process evaluation be implemented?

Appendix I

Rubric
Community Care Plan: Analysis and Planning

Content	Points	Completely met 100% of points	Partially met	Not met 0 points
Student name/population/FHP assigned listed	5			
FHP data included with (+) and (-) after each data piece showing a strength (+) or weakness (-)	10			
Three key findings from the FHP are listed and analyzed/ explained in terms of strengths, gaps, challenges/weaknesses	15			
Evidence from literature **- journals, textbook, credible internet sites/agencies, .gov/.edu. See examples in template** **to support analysis of the three findings**	15			
An actual problems is listed using the correct formatting for nursing diagnosis (Label, related to, as evidenced by)	5			
Risk for nursing diagnosis listed using the correct formatting (Risk for label, related to)	5			
Wellness nursing diagnosis listed or listing of the strengths	5			
Problem Prioritization Group information added - 3	5			
Intervention described	5			
Goals and 3 outcomes/objectives appropriate	5			
Potential barriers addressed	5			
Cost implications addressed	5			

Implementation mechanisms addressed	5			
Collaborative relationships explained	5			
Formative and Summative Evaluation planned	5			
Total points awarded	100			

Appendix J

Team Charter Template: Semester 4

A team charter defines the purpose of the team, and sets ground rules for working together including expectations, communication frequency and methods, how decisions will be made, and how conflicts will be handled. To compete the charter, answer the questions below.

What community/population are you serving?

Who is on the team (name and defined role)?
To answer this, fill out template at end

What are the ground rules for working together? In other words, what can the team members expect from one another?

How often will the team communicate (daily, weekly, monthly, as needed)?

How will you communicate (describe all the ways—meetings, email updates, phone calls, collaborative software, etc.)?

How will the team make decisions (voting, consensus, single decision maker)?

How will conflicts within the team be handled?

Where will meeting notes, the team charter, and any other documentation related to team communication/collaboration be housed?

Agreement by members (electronic signature)

Adapted from the National Estuarine Research Reserve (NERRA) http://www.nerra.org/

Team Charter Roles/Duties Template*

Designate Team Leader and Co-Leader:

- Leader: _____
- Co-Leader: _____

Duties:

- Motivate successful completion of team project
- Lead/monitor Zoom breakout room meetings
- Communicate with Professors as needed

During class time in Week 3 you will update this charter to:

Briefly describe the health fair or intervention:

_____

_____

Role/activity/task	Student name
Submission of Health Fair Planning Check Sheet and Team Charter	

Adaptable depending on your project.

Appendix K

Health Fair or Intervention Planning Check Sheet

Team to complete this check list regarding the health fair. If another intervention is provided, the team is to adjust the appropriate "item" boxes below and type the appropriate activity that needs to be completed.

Team Name and Members: _____

_____

√	Item	Remarks	Team Member	Date Completed
	Confirm date and location			
	Identify and invite other professionals to assist and/or participate in the health fair			
	Create advertising/publicity for the health fair (date, time, location); e.g., ASU logo, flyers, posters, banner, Email, invitations)			
	Collect or develop educational materials for the health fair			
	Collect or develop screening guidelines and referral criteria (including a referral system)			
	Collect equipment needed (e.g. BP cuffs, scales, etc.)			
	Collect or develop incentives if appropriate			
	Room layout design draft			

	Room logistics (Tables, chairs, electrical outlets, trash cans, audio-visual, etc.)			
√	**Item**	**Remarks**	**Team Member**	**Date Completed**
	Health Fair Coordinator selected (to include confirmation of student roles/stations/tasks)			
	Refreshments if appropriate (including napkins, cups, plates, plastic forks, water, etc.)			
	Plan for set up and clean up			
	Communication to ASU CONHI Marketing staff			
	Thank-you letters to agency and other professionals			
	Contingency plan (Last minute cancellation, unable to obtain equipment, etc.)			
	Lessons learned: Create file with historical information to assist in future events at the selected site, including amount of time involved, agency contact(s), example of letters, publicity, etc.			

1-1-18 Adapted from CDC/ATSDR Association for Professional Women