

6

Community Health Practice

Community health practice provides the organizational structure, health care resources, and interdisciplinary collaboration to promote healthy people and communities.

Community health providers focus on individuals, families, populations, and the community using public health science.

Community health practice involves the identification of needs, and improvement of health, for people in communities.

Community health principles promote the positive connections between populations, their environment, and health of the community.

Community Health Clients

1. Individuals
2. Families
3. Populations are composed of people who occupy or live in a certain area, but can also include those with similar attributes or characteristics. The homeless and frail elders are examples of vulnerable populations.
4. Aggregates are groupings of individuals who are loosely associated with one another by characteristics such as by age, gender, race, risk factors, or health problems. Women with heart disease and people who smoke cigarettes are examples of aggregates.

Types of Communities

1. Geographic communities are defined by the boundaries of towns, cities, or neighborhoods.
2. Common interest communities are collections of people with similar interests or goals that are usually health related, such as smoking cessation or 911 emergency care for acute coronary syndromes.
3. Community of solution is a group of people who come together to solve a problem, such as the lack of health care for indigent populations.

Building a Healthy Community

People work together in a group to identify the needs of the community. The group identifies and agrees on goals.

The group reaches consensus on the strategies to achieve the goals.
The group collaborates on the actions to attain the desired outcomes.

Levels of Prevention

1. Primary prevention includes actions used to keep an illness from occurring.
 - a. Altering the susceptibility of people to illness.
 - b. Decreasing exposure to substances that may cause disease.
 - c. Examples are public education on risk factors for coronary heart disease (CHD) or strategies for smoking cessation.
2. Secondary prevention includes those actions that are used in the early detection and treatment of health problems. These actions may include hypertension or cholesterol screening, for example.
3. Tertiary prevention includes actions to decrease the severity of health problems that have occurred.
 - a. The goals are to minimize disability and to preserve or restore function.
 - b. These actions may include treatment and rehabilitation for those people who are recovering from a stroke, for example.

Components of Community Health Practice

Health Promotion

1. Health promotion involves efforts to promote optimal health in individuals, families, populations, and communities to:
 - a. Increase the period of healthy living for people of all age groups.
 - b. Decrease health disparities in groups of people, especially for those at high risk for health problems, such as cardiovascular diseases.
 - 1) For example, black women have a higher risk for stroke than white women. A program directed specifically to black women might be used to reduce this disparity.
 - c. Increase access to clinical preventive services for all people to decrease the incidence, or increase early detection, of health problems.

Disease Management (DM)

This component of community health practice focuses on disease and illness.

1. Treatment of usually chronic diseases, according to clinical guidelines that have been shown to be effective for a majority of the people with the disease.
 2. Goal of DM is to prevent medical crises through education, monitoring, and early intervention.
 3. DM has demonstrated benefit in populations with diabetes, hypertension, CHD, and heart failure.
 4. DM may be accomplished in several ways.
 - a. Nursing and other health care services may be provided to people with the disease such as home visits from a health care agency, clinics at a homeless shelter or mobile van, or screening, education, counseling, and referrals offered at neighborhood health centers.
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- b. People may be offered assistance to obtain treatment such as nutritional counseling for those affected by elevated cholesterol or appointments with cardiologists for problems such as hypertension.

Rehabilitation

This component focuses on reducing disability and restoring function for individuals, families, populations, and communities.

1. Interventions include cognitive and functional assessment, realistic goal setting, counseling and intensive education, physical occupational and speech therapy, environmental modification, and outcome evaluation.
2. Health care organizations involved in rehabilitation include subacute hospitals, long-term care facilities, and home care agencies.
3. For some people and their families, participation in groups such as “The Mended Hearts” provides needed support and guidance as they recover from cardiovascular procedures.

Program Development

1. Community health providers develop programs for individuals, families, populations, and communities. Programs may also be aimed at the people involved with building healthy communities such as the lay public, interdisciplinary health care providers, and administrators of health care agencies.
2. These programs may focus on screening people for health problems, educating people about risk factors or diseases that may impact their health, and teaching community health providers about changes in care delivery or community issues. For example, a community education program that highlights the symptoms of myocardial infarction and emergency care may be developed to increase the public’s awareness of this health problem and to improve survival by prompt treatment.

Practice Evaluation

1. Practice evaluation involves the analysis of community health practice and, if indicated, the identification of need for change.
2. There are several types of evaluation that may be used for this process.
 - a. Outcome evaluation involves analysis of the impact of community health practice on patient/family knowledge, incidence of disease, recovery from illness, health care visits, and complications. This process can be used to evaluate the quality of care based on the numbers of positive and negative outcomes.
 - b. Structure and process evaluation involves the formation and operation of a treatment plan with established performance standards.
 - 1) Structures include the resources to meet the identified needs of the community or goals of the plan. Structures include provider qualifications, licensing, certification, and program funding.
 - 2) Process is the way in which services are delivered.

Community Health Nursing

1. Community health nursing synthesizes theories from public health science, nursing science, and community health practice to address the needs of communities and vulnerable populations.
2. Community health nurses use the nursing process to identify client, family, and group needs, set goals, plan and provide services, and evaluate the impact of their care.
 - a. They formulate health promotion strategies for clients, families, and groups.
 - b. Community health nurses encourage client and family self-care and independence.
 - c. They use aggregate data and analysis to guide and evaluate their work with groups and populations.
3. Community health nurses work collaboratively with health care providers from other disciplines to manage the care of clients.

Roles of Community Health Nurses

1. The clinician role includes the care that is provided to individuals, families, groups, and populations. Health care services are focused on holistic practices that integrate principles of health promotion, disease management, and rehabilitation.
2. The educator role includes the instruction and counseling of individuals, families, groups, and populations. Community health nurses incorporate principles of adult learning into the educator role. They evaluate the effect of their teaching through program evaluation.
3. The collaborator role includes working with health care providers from other disciplines and with different groups of people to meet the needs of individuals, families, groups, and populations.
4. The researcher role involves examining community health problems by collecting and analyzing data. Data collection and analysis may be for continuous quality improvement or to answer a research question.
5. The leadership role focuses on initiating healthful change with different groups within the community. Community health nurses facilitate the achievement of goals by guiding the work of the group. Additionally, community health nurses have a leadership role beyond the community by influencing health policies at the state and federal levels.

Practice Settings

1. Homes.
 2. Ambulatory care sites such as outpatient departments of hospitals, clinics, neighborhood health centers, day care centers, senior centers, health departments, migrant camps, and homeless shelters.
 3. Public and private schools (e.g., preschool, elementary, middle, secondary vocational, technical, specialized schools, and colleges).
 4. Occupational health sites, such as clinics in industry.
 5. Residential settings including hospice, halfway houses, camps, assisted living, and long-term care facilities.
 6. Parishes.
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Emerging Needs of Aggregates

1. Aging of the population will have a major impact on community health nursing.
 - a. The number of people age 65 years and older in the US will more than double to 70 million by the year 2030, while the numbers of centenarians will increase from 65,000 to 381,000 people.
 - b. Many elderly have at least one chronic health problem that requires monitoring by health care providers.
 - c. The increased acuity of illness in the elderly, together with the shortened length of hospital stays, will continue to impact community health practice.
2. Increasing cultural diversity of the population is having a significant influence on community health nursing.
 - a. The US is becoming more racially and ethnically diverse. The number of minorities living in the US has been projected to increase to 22% by 2020.
 - b. Community health nurses and other clinicians need to be culturally competent to meet the needs of the growing African-American, Hispanic, Asian, and other populations.
3. The community mental health movement will continue to affect the responsibilities of community health nurses.
 - a. There will be increasing numbers of people needing mental health and substance abuse services in diverse community health settings such as clinics, halfway houses, and residential facilities.
4. Communicable diseases will have a substantial effect on the practice of community health nurses as treatment changes occur. Additionally, there exists the possibility of the emergence of new diseases and the increased virulence of existing health conditions that will affect community health practice.
5. Bioterrorism is a renewed area of concern for the US.
 - a. The exact risks associated with the use of biochemical weapons are not known.
 - b. Bioterrorism could result in epidemics with the potential to infect large segments of the population because of the delayed onset of symptoms for certain diseases and the increased mobility of people.

Healthy People 2010

This document identifies goals and objectives that target changes specific to age, gender, and race to improve the health of the US over the next decade. *Healthy People 2010* incorporates previous initiatives such as the 1979 Surgeon General's Report, and *Healthy People and Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. *Healthy People 2010* is available online at www.health.gov/healthypeople.

Goals

Increase quality and years of healthy life
Eliminate health disparities

Focus Areas

Approximately 467 objectives were formulated within 28 focus areas. The objectives include interventions intended to achieve the goals by the year 2010.

The focus areas of interest for cardiac and vascular nurses include diabetes, heart disease and stroke, physical activity and fitness, and tobacco use.

Leading Health Indicators

1. Reflect the major health concerns in the US at the beginning of the 21st century.
2. Will be used to measure the health of the US over the next decade.
3. The leading health indicators are:
 - a. Physical activity
 - b. Overweight and obesity
 - c. Tobacco use
 - d. Substance abuse
 - e. Responsible sexual behavior
 - f. Mental health
 - g. Injury and violence
 - h. Environmental quality
 - i. Immunization
 - j. Access to health care

People, communities, professional organizations, and federal agencies are involved with *Healthy People 2010* and with measuring the improvement in the health of the people of the US.

Community Initiatives

National Organizations

1. The American Heart Association (AHA), a national voluntary organization, has sponsored several national campaigns to reduce the risk of cardiovascular disease (CVD) for individuals and communities.
 - a. “My Heart Watch” is a community education program for preventing heart attack and stroke that includes risk assessment tools, cardiovascular health information, and chat rooms.
 - b. “Take Wellness to Heart” is an initiative that is focused on increasing the awareness of women about their risk for heart disease and stroke.
 - c. “Operation Heartbeat” is a community education program designed to increase community knowledge and support for emergency care related to cardiac arrest.
 2. The National Heart, Lung, and Blood Institute sponsors several national initiatives that are focused on the goals of *Healthy People 2010* and community education.
 - a. “Act in Time to Heart Attack Signs” is a public education campaign to increase awareness about emergency care of heart attack victims.
 - b. “National High Blood Pressure Education Program” is to increase public awareness of hypertension and its treatment.
 - c. “Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III)” is a national cholesterol education program to decrease the morbidity and mortality associated with CHD by lowering blood cholesterol.
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- d. “Obesity Education Initiative” is to decrease the incidence of obesity and physical inactivity, thus reducing the risk for CVD and diabetes.
- e. “Developing a Woman’s Heart Health Education Action Plan” is a new cardiovascular education program for women, especially those at high risk.

State and Local Initiatives

State and local chapters of voluntary organizations such as the AHA promote cardiovascular initiatives through public and professional involvement in community education programs.

Other organizations, such as schools and health care agencies, are involved with community education programs to reduce the risk of cardiovascular diseases by increasing the public’s awareness and by implementing screening initiatives.

Many state governments are using *Healthy People 2010* as a framework for building healthy communities. They are using the leading health indicators and objectives to promote healthy living for the people in their respective states and to reduce disparities in health. Another focus of the *Healthy People 2010* initiative is to make the community a healthier place to live.

