Population-Based Nursing
Ann L. Cupp Curley, PhD, RN, is the Nurse Research Specialist at Capital Health in Trenton, New Jersey. In this capacity, she promotes and guides the development of clinical research and facilitates evidence-based practice. Her clinical background includes several years working in community and public health nursing. She has extensive experience teaching undergraduate, MSN, and DNP courses, including the DNP course, Principles of Epidemiology. Dr. Curley has delivered many papers and presentations on Evidence-Based Practice, Evaluation and Motivation for Nurse Educators, Teaching Effectively, Ergonomics, and the Aging Nursing Workforce. Her publications include Urban Health Informatics, An Evidence-Based Approach to Scheduling, and A Nurse’s Perspective on Cuba. She authored a chapter in Fulton et al.’s textbook Foundations of Clinical Nurse Specialist Practice on Population-Based Data Analysis. A specialist for the Institute for Nursing, Foundation of the New Jersey State Nurses Association from 1997 to 2009, she received her BS in nursing at Boston College, an MSN in Community Health/CNS track from the University of Pennsylvania, and a PhD in Urban Planning and Policy Development at Rutgers, The State University of New Jersey.

Patty A. Vitale, MD, MPH, FAAP, holds multiple appointments, including Assistant Professor of Pediatrics and Emergency Medicine at Cooper Medical School of Rowan University and Robert Wood Johnson Medical School, New Jersey; Adjunct Assistant Professor at University of Medicine and Dentistry of New Jersey’s School of Public Health, Department of Epidemiology; and Visiting Clinical Associate in the College of Nursing, Rutgers University. Dr. Vitale is an attending Pediatric Emergency Medicine physician at Cooper University Hospital in Camden, New Jersey. For over 6 years she has taught, Principles of Epidemiology to graduate and doctoral students in public health, nursing, and biomedical sciences at UMDNJ. Dr. Vitale did her residency and post-doctoral training in Pediatrics and Community Pediatrics at the University of California, San Diego. During fellowship, she obtained her master’s in Public Health from San Diego State University. She is certified by the American Board of Pediatrics and has served on National and Statewide Committees for the American Academy of Pediatrics in the areas of epidemiology, government affairs, and young physicians. She also sits on the editorial board for AAP-Grand Rounds a publication of the American Academy of Pediatrics. She volunteered as Team Physician for the U.S. National Gymnastics Team (2003–2008). She is a Junior Olympic National Elite and NCAA Women’s Gymnastics Judge and former gymnastics coach and was inducted into the California Interscholastic Hall of Fame for Sports Officials in San Diego, CA (2009). Her national and local lectures (43) and publications have focused on family violence, pediatric and adolescent health, simulation as an educational tool, and homelessness. She has received many honors including the 2004 AMA Foundation Leadership Award, 2002 Fellows Award for Excellence in Promoting Children’s Health (Academic Pediatric Association), 2002 Pediatric Leaders of the 21st Century (American Academy of Pediatrics), among others.
Population-Based Nursing
Concepts and Competencies for Advanced Practice

Ann L. Cupp Curley, PhD, RN
and
Patty A. Vitale, MD, MPH, FAAP

SPRINGER PUBLISHING COMPANY
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Contributors

Barbara A. Benjamin, EdD, RN  Assistant Clinical Professor, University of North Carolina at Chapel Hill, School of Nursing, Chapel Hill, North Carolina

Ann L Cupp Curley, PhD, RN  Nurse Research Specialist, Capital Health, Trenton, New Jersey

Janna L. Dieckmann, PhD, RN  Clinical Associate Professor, University of North Carolina at Chapel Hill, School of Nursing, Chapel Hill, North Carolina

Susan B. Fowler, RN, CNRN  Nursing Leadership Consultant

Barbara A. Niedz, PhD, RN, CPHQ  Corporate Vice President for Quality Improvement, APS Healthcare, White Plains, New York; Contributing Faculty, Walden University, School of Nursing, Leadership and Management Track RN-MSN Program, Minneapolis, Minnesota

Sonda M. Oppewal, PhD, RN  Clinical Associate Professor and Associate Dean for Clinical Partnerships and Practice, University of North Carolina at Chapel Hill, School of Nursing, Chapel Hill, North Carolina

Patty A. Vitale, MD, MPH, FAAP  Assistant Professor of Pediatrics and Emergency Medicine at Cooper Medical School of Rowan University and Robert Wood Johnson Medical School, New Jersey
Foreword

Gillian Gill claims that Notes Affecting the Health, Efficiency, and Hospital Administration of the British Army (2004) was “probably the best thing that Florence Nightingale ever wrote” (p. 417). Nightingale’s Notes, written in 1857, detailed morbidity and mortality findings related to the Crimean War; her findings were subsequently used by a Royal Commission that advocated reforms in the British Army Medical Department. Using statistical methods to illuminate disease atrocities experienced by her population of interest—soldiers in the British Army—Nightingale provided evidence-based research that basic sanitary measures, fresh food, good latrines, and appropriate clothing decreased the mortality rate of soldiers, a population whose mortality rate, even in peacetime, exceeded the mortality rate noted in the 1665 Great Plague. An early proponent of evidence-based practice embedded in the burgeoning science of statistics, a tool intrinsic to the scientific method; Nightingale’s findings on her population resulted in implementation of dramatic changes in the British Army.

Almost 150 years later, the American Association of Colleges of Nursing (AACN) published its Essentials of Doctoral Education for Advanced Nursing Practice (2006). Crafted in the context of multiple Institute of Medicine reports documenting deficiencies in the U.S. healthcare delivery and health educational systems, and a severely recurrent national shortage of primary care providers, the Essentials offer eight fundamental outcome competencies deemed intrinsic to all advanced practice nurses prepared at the clinical doctoral degree level—that is, the Doctor of Nursing Practice (DNP) program, which is considered nursing’s terminal practice entity. Of paramount importance is Essential Number Eight: Clinical Prevention and Population Health for Improving the Nation’s Health (p. 15). The AACN defines population health to include aggregate, community, environmental/occupational, and cultural/socioeconomic dimensions of health, with aggregates noted as a group of individuals with a shared characteristic (e.g., gender, diagnosis, age, and so forth). In the basic baccalaureate, nursing education broadly addresses health promotion and disease prevention interventions, and clinical DNP programs challenge registered nurses to employ evidence-based clinical prevention and population health services that improve health indices for individuals through direct care provision and for populations through policies and programs grounded in evidence.

Advanced practice nurses in primary care have tools at their readiness to guide individual care management decisions: recommendations of the U.S. Preventive Health Services Task Force (2009), implementation guidelines from Healthy People 2020 (2011), statements and guidelines from a variety of organizations (e.g., American Heart Association, American Academy of Nurse Practitioners, ...
American Cancer Society, and others), and publications of the World Health Organization regarding social determinants of diseases. As a provider matures in practice, the information gleaned from these available resources can be reviewed intelligently, with implications for care management culled efficiently. For the DNP student or novice practitioner, these resources require context, an expansive and detailed overview within which the essential language embedded in the AACN’s emphasis on clinical prevention and population health services *makes sense*. The establishment of a professional practice that integrates current evidence into daily clinical prevention and population health practice mandates a solid, thorough clinical doctoral education, one both practical and theoretical.

Ann L. Cupp Curley, PhD, RN, and Patty A. Vitale, MD, MPH, FAAP, have provided such a foundation in this book, *Population-Based Nursing: Concepts and Competencies for Advanced Practice*, a textbook written for registered nurses in DNP programs and master’s programs in community health nursing. Written in the Nightingale tradition of *Notes* (1857), Curley, Vitale, and their coauthors ground graduate nursing students in the empirical tradition of the health sciences—biostatistics and epidemiology—and relate these sciences to evidence-based advanced nursing practice provided to individuals and populations. Basic constructs are explored in detail, with reference to applicability in practice. Written with a collegial tone, as if in conversation with the authors, the book engages readers to continue on, to turn pages, to learn more. Fast-paced and succinctly thorough, this book will surely find its way as a *must-read* reference on shelves of graduate nursing students. With an emphasis on healthcare disparities, Curley and Vitale provide a practical approach to managing patients suffering from specific diseases viewed as populations. A two-way lens is employed. First, there is focus on populations of individuals with poor health indices; second, there is attendant focus on diseases as populations of interest to be managed through clinical primary and secondary prevention strategies. This pan-dimensional view enables graduate nursing students to integrate individual care within both the broad context of the human population of interest and the index disease of concern. This approach anchors novice practitioners who, up to this point in their careers, have managed the individual only, with somewhat tangential references to management of the broader environments within which the individual resides.

In Chapter 5, Curley leads with a compelling statement: “Nurses in advanced practice have an obligation to improve the health of the population they serve by providing evidence-based care.” Curley’s mandate that advanced practice nurses are *obligated* in their role to use evidence-based care is refreshing. Inherent in this obligation is the centrality of research acumen, a full working knowledge of research tools and methodologies as critical to care delivery as clinical reasoning and physical diagnosis. The authors explicate this centrality in Chapters 3, 4, and 5. Using clinical examples, they address the full integration of research tools in determining if select findings are appropriate for use in providing individual care or in designing a primary or secondary prevention program targeting a disease as a specific population of interest. The various management perspectives
obtained through qualitative and quantitative designs are explored. Beginning with a full explication of a PICO question (population, intervention, comparison, and outcomes), students are guided through the basics of question statement, literature review, and assessment of evidence. Once in practice, DNP graduates will gratefully employ published algorithms giving structure to their management regimens. The pragmatic directions provided by the Adult Treatment Panel III (2004), or those of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (2003), guide management decisions on the basis of evidence. The authors expand on the word evidence as it is used in care delivery and provide readers with steps in how to assess evidence and address questions such as: What are the grading systems used to evaluate evidence? How are levels of evidence ranked? What is best practice evidence? Such questions, although seemingly apparent, are well nuanced from the vantage point of the novice, who is moved along in understanding from the simpler to the more complex constructs. The theme of accountability as related to research skills and to choice of appropriate evidence for guiding specific practice regimens is intermeshed throughout the text.

In Chapter 8, devoted to evaluation of practice at the population level, author Barbara A. Niedz addresses the responsibility of advanced practice nurses to achieve improved clinical outcomes at the population level. The focus on responsibility for quality outcomes, not just the delivery of care appropriate to the disease or community, is fully explicated in Niedz’s discussion of the Centers for Medicare and Medicaid Services’ (CMS) oversight of reimbursement for care delivered, as well as refusal to reimburse for occurrence of “never events”—preventable poor outcomes that contribute significantly to the cost of care delivered. Drilling down on the advanced practice nurse’s accountability for quality individual patient or population outcomes, as well as responsibility for cost-effective care, easily recognized clinical situations is explored as examples. Discussing, for example, congestive heart failure patient discharge instructions, Niedz reviews key quality questions to be asked of such patients; emanating from these questions, quality measurement metrics can be outlined that evaluate effectiveness of care provided to the individual as well as to the population of patients with this disease. As with research tools, quality measurement tools are interwoven as skills as essential as the appropriate use of the stethoscope.

Perhaps one of the most charming and robust discussions is provided by Barbara A. Benjamin in Chapter 9: Community Assessment and Collaboration: The Foundation of a Lasting Relationship. Benjamin speaks of bidirectional communication, a practical tool to be used in improving population health indices. As her predecessors Nightingale, Jane Addams, and Lillian Wald had advocated, Benjamin details the how-to’s of engaging as a partner with communities in efforts to improve that population’s health indices. With meticulous attention to detail, she outlines, step-by-step, how to conduct a community assessment in partnership with community leaders and other key players of systems that interact to affect a community’s health. Transportation, social and welfare systems, religious entities, schools,
housing authorities, and public health departments represent complex systems implicated in communities’ health indices and in care delivery patterns. Benjamin reviews how community evidence is obtained by a variety of methods, such as focus groups, windshield surveys, census and disease reports, and more. As with motivational interviewing, the techniques available to advanced practice nurses for community assessment involve listening carefully to residents and using their perspective as the orientation for further data collection, analysis, and interpretation.

An added bonus with this text is the inclusion of exercises and discussion questions providing students with opportunities for interaction on the constructs essential to the topics presented in each chapter. The exercises are complex, presenting scenarios representative of each chapter’s primary focus. Very importantly, this book is written by seasoned clinicians who have spent significant portions of their careers in the academy. This text also serves as a model of a successful collaboration. Ann L. Cupp Curley, with her rich educational background in urban planning and policy development as well as community health, served in faculty roles in universities in New Jersey. As a core faculty in a newly established DNP program at the University of Medicine and Dentistry of New Jersey, Curley evolved great interest in translating the mandates for accountable, responsible advanced practice nursing in primary care into educational products—courses, books, assignments—easily consumed by the targeted student. Patty A. Vitale brings to the text her extensive experience as a faculty member with a strong clinical practice and public health background. Vitale has mentored many students over the years in their community-based fieldwork projects. She has a long history of working with communities throughout her career including outreach in the areas of domestic violence, child abuse, and violence prevention. Both fine academicians, Ann Curley and Patty Vitale have achieved what Nightingale advocated: educating nurses in the community who would transform the provision of health care and save an untold number of lives. Curley and Vitale’s history of working and teaching together in a DNP program has clearly contributed to the depth and breadth of the material in the book. Accountable, evidence-based practice as detailed in this text affords DNP students the context, skills, and lexicon for novice practice contributing to the improved welfare of individuals and populations. It was a joy to read this book, and I am confident that readers will have the same reaction.

Frances Ward, PhD, RN, CRNP
David R. Devereaux Chair of Nursing
Temple University, Philadelphia, PA
Preface

The inspiration for this book grew out of our experience while co-teaching an epidemiology course for students enrolled in a doctorate in nursing practice (DNP) program. We found it difficult to find a textbook that addressed the course objectives and was relevant to nursing practice. We decided a population-based nursing textbook targeted for use as a primary course textbook in a DNP program or as a supplement to other course materials in a graduate community health nursing program would be of great benefit and value to students enrolled in these programs. This book is the result of that vision.

The chapters address the essential areas of content for a DNP program as recommended by the American Association of Colleges of Nursing (AACN), with a focus on the AACN core competencies for population-based nursing. The primary audience for this text is nursing students enrolled in either a DNP program or a graduate community health nursing program. Each chapter includes discussion questions to help nursing students use and apply their newly acquired skills from each chapter.

This textbook introduces successful strategies that nurses have used to improve population outcomes and reinforces high-level application of activities that require the synthesis and integration of information learned. The goal is to provide readers with information that will help them to identify healthcare needs at the population level and to improve population outcomes. In particular, Chapter 1 introduces the concept of population-based nursing and discusses examples of successful approaches and interventions to improve population health.

In order to design, implement, and evaluate interventions which improve the health of populations and aggregates, APNs need to be able to identify and target outcome measures. Chapter 2 explains how to define, categorize, and identify population outcomes using specific examples from practice settings. The identification of outcomes or key health indicators is an essential first step in planning effective interventions and a requirement for evaluation. The chapter includes a discussion of nursing-sensitive indicators, Healthy People 2020, national health objectives, and health disparities. Emphasis is on the identification of healthcare disparities and approaches that can be used to eliminate or mitigate them. APNs can advocate for needed change at local, regional, state, or national levels by identifying areas for improvement in practice, by comparing evidence needed for effective practice, and by better understanding health disparities. APNs have an important collaborative role with professionals from other disciplines and community members to work toward eliminating health disparities.

Epidemiology is the “basic science” of prevention (Gordis, 2008). Evidence-based practice as it relates to population-based nursing combines clinical practice
and public health together through the use of population health sciences in clinical practice (Heller & Page, 2002). Programs or interventions that are designed by APNs should be evaluated and assessed for their effectiveness and ability to change or improve outcomes. This is true at an individual or population level. Data from these programs should be collected systematically and in such a manner that can be replicated in future programs. Data collection must be organized, clearly defined, and analyzed with clearly defined outcomes developed early in the planning process. Best practice requires that data are not just collected; data must also be analyzed, interpreted correctly, and if significant, put into practice. Understanding how to interpret and report data accurately is critical as it sets up the foundation for evidence-based practice. With that said, it is important to understand the basics of how to measure disease or outcomes, how to present these measures, and know what type of measures are needed to analyze a project or intervention. Chapter 3 describes the natural history of disease and concepts that are integral for the prevention and recognition (e.g., screening) of disease. It also introduces the basic concepts that are necessary to understand how to measure disease and design studies that are used in population-based research. Disease measures such as incidence, prevalence, and mortality rates are covered, and their relevance to practice is discussed. The basics of data analysis including the calculation of relative risk, attributable risk, and odds ratio are presented with examples of how to use these measures. Study design selection is an important part of the planning process for implementing a program. A portion of Chapter 3 is dedicated to introducing the most common study designs, as correct design selection is an essential part of sound methodology, successful program implementation, and overall success.

In order for APNs to lead the field in evidence-based practice, it is critical that they possess skills in analytic methods to identify population trends and evaluate outcomes and systems of care (AACN, 2006). They need to carry out studies with strong methodology and be cognizant of factors that can affect study results. Identification and early recognition of factors that can affect the results or outcomes of a study such as systematic errors (e.g., bias) should be acknowledged as they cannot always be prevented. In Chapter 4, the APN is introduced to the elements of bias with a comprehensive discussion of the complexities of data collection and the fundamentals of developing a database. Critical components of data analysis are discussed including causality, confounding, and interaction.

In order to provide care at an advanced level, nurses must incorporate the concepts and competencies of advanced practice into their daily practice. This requires that APNs acquire the knowledge, tools, and resources to know when and how to integrate them into practice. In Chapter 5, the APN will learn how to integrate and synthesize information in order to design interventions that are based on evidence to improve population outcomes. Nurses require several skills to become practitioners of evidence-based care. In this chapter, they will learn how to identify clinical problems, recognize patient safety issues, compose clinical questions that provide a clear direction for study, conduct a search of the literature,
appraise and synthesize the available evidence, and successfully integrate new knowledge into practice.

Information technologies are transforming the way that information is learned and shared. Online communities provide a place for people to support each other and share information. Online databases contain knowledge that can be assessed for information on populations and aggregates and internet sites provide up to date information on health and health care. Chapter 6 describes how technology can be used to enhance population-based nursing. It identifies Web sites that are available on the World Wide Web and how to evaluate them for quality. It also describes potential ways that technology can be used to improve population outcomes and how to incorporate technology into the development of new and creative interventions. APNs use data to make decisions that lead to program development, implementation, and evaluation. In Chapter 7, the APN will learn how to design new programs using organizational theory. Nursing care delivery models that address organizational structure, process, and outcomes are described.

Oversight responsibilities for clinical outcomes at the population level are a critical part of advanced practice nursing. The purpose of Chapter 8 is to identify ways and means to evaluate population outcomes, evaluate systems’ changes as well as effectiveness, efficiency, and trends in care delivery across the continuum. Strategies to monitor healthcare quality are addressed as well as factors that lead to success. These concepts are explored within the role and competencies of the APN.

In order for APNs to make decisions at the community level, APNs who work in the community need to be part of the higher level of care management and policy decision making in partnership with the community-based consortium of health care policy makers. Chapter 9 describes the tools for successful community collaboration and project development. Emphasis is placed on identifying community needs and assessment of their resources. Specific examples are given in order to guide APNs in developing their own community projects.

Chapter 10 identifies barriers to change within communities and the importance of developing and sustaining community partnerships. Specific strategies for program implementation are discussed, as well as the methods to empower the community to advocate for themselves. Specific examples are given in order to guide APNs in executing a project that has community acceptance and has sustainability.

REFERENCES


Acknowledgments

We would like to express our grateful acknowledgment to those professional colleagues who provided direction, guidance, and assistance in writing this book. We would also like to thank our family and friends for their support throughout this process. Thank you to our publisher, Margaret Zuccarini for her invaluable advice, assistance, and infinite patience. We would also like to acknowledge the following graduates of the DNP program at the University of Medicine and Dentistry of New Jersey: Debbie F. Buck, MSN, APN, BC, Noel Rosner DNP, RN, APN-C, Amy J. Sirkin, DNP, APN-C, Amy R. Weinberg, DNP, MSN, FNP-BC, and especially Margaret Conrad, DNP, MPA, RN, BC, CTN-A. We could not have completed the text without the help of the library staff of the Health Services Library of Capital Health, especially Erica Moncrief, MS, Director of Library Services, and Jennifer Kral, MLS, Capital Health Librarian.
The role of the nurse in healing includes compassionate and quality care not only for the individual, but also the family and the community. Advanced practice nurses (APNs) seek to improve the circumstances that contribute to poor population health by working with community members to modify or change their behaviors that may contribute to poor health outcomes. This type of collaboration has the potential to make or facilitate changes that improve health and reduce morbidity and mortality.

The APN should approach communities with an open mind and a focus on a comprehensive community health assessment (CHA) (see Chapter 9). A CHA helps the APN to gain an understanding of the community, its residents, their diversity, their goals, and aspirations for healthier lives, and the barriers to achieving these goals. People want a better life. They want to be healthier and they want to live longer, happier, and more productive lives. The challenge lies in changing the behaviors and attitudes of individuals and communities. For many, change is uncomfortable or difficult but is a necessary process for communities that want to make improvements. But a process of change is unlikely to be smooth if community members do not buy into this change and are not willing to take a risk or make a sacrifice for the unknown.

LEWIN’S STAGES OF CHANGE

Lewin’s Stages of Change provides a brief but profound approach to change at the aggregate or community level (Allender, Rector, & Warner, 2010). In the role of a change agent, the APN begins by destabilizing the group or community by asking questions to generate hope and visions of something different, something
possibly better. Perhaps the group or community is already experiencing a desire for something different. Disequilibrium in the current moment underscores the relevance and potential of change and of moving out of the current comfort zone.

**Unfreezing**

The first stage of change, *unfreezing*, may arise from the community’s own self-assessment or it may be activated by the APN through motivation, health education, advocacy, or other strategies (Allender et al., 2010; Kurt Lewin, 2011). An APN may initiate unfreezing during the course of usual practice. For example, as part of a primary care practice, an APN may find that many adult patients want to increase their physical activity, but the lack of designated walking or biking trails is a barrier. The APN initiates a conversation with the head of the local farmers’ cooperative and with the director of the county’s agricultural extension office. A community meeting is planned, with broad attendance by local residents and representatives of other community organizations. Many express interest in increased physical activity, but doubt their ability to make changes to their community that will make it more “walker friendly.” This meeting is the first of many opportunities to present the problem to the community and address possible solutions, and begin to build a bridge of confidence between the community and the healthcare provider. Focus groups (see Chapter 9) can also further this goal and provide more individual attention to the barriers while proposing possible solutions to address those concerns.

**Changing, Moving, or Transition**

The second stage in Lewin’s model reflects an understanding that change is not a timed event, but an ongoing process that can be facilitated by the actions of the APN. This stage is known variously as changing, moving, or transition (Allender et al., 2010; Kurt Lewin, 2011). Community members begin individually and as a group to transition to new attitudes and behaviors as they acquire new skills and perspectives.

The combination of destabilizing the present state and the challenge of questioning the status quo of behaviors and attitudes can make the second stage the most difficult. The support role of the APN is very important, as the nurse must accept the community’s attempts at change against the risk of early failures. The APN cannot necessarily direct community change, as community residents benefit from developing their own new patterns of behavior as these emerge from who they are and their past experiences. The APN can motivate and guide community members and help them build upon their experiences to make the changes necessary for success. Using the earlier example, the APN should provide encouragement about the value of change (e.g., an improvement in residents’ physical activity levels leads to improved health—less need for medications, etc.), implement strategies to reduce fears (e.g., educate residents about other successful programs), develop skills to unlock new behaviors (e.g., encourage residents to
work together as a peer support), provide prompts underscoring the importance of change attempts (e.g., use simple outcome measures for residents [i.e., step counters] to track progress and set goals), and remind residents about the benefits of the community’s goal (e.g., a healthier community is a more productive community) (Allender et al., 2010; Kurt Lewin, 2011). As a result of regular community meetings, the rural community raises funds and constructs new walking trails on public land. A picnic shelter is also built to provide families and groups a place to gather after walking.

**Refreezing**

The third stage of *refreezing* (or freezing) reflects the restabilization of the community that follows after making change. This stage can require a period of time, as the change or transition that community members experience can lead to a change in their relationships and in their daily lives as they internalize what is now different. The system adapts to the impact of the change, and the community integrates the change into a newly stable and re-balanced present state. For example, the walking trails that were once seen as improbable are now embraced and accepted by the community. The APN can provide the community with additional tools to stabilize the change and to reinforce and maintain new community behaviors. Family and neighborhood events are encouraged to try out the new walking trail and to use the new picnic area for a healthy meal. Periodic reminders to area residents about the walking trails are included in local print and visual media.

The success of the change process can lead to an enhanced partnership between the nurse and the community with the potential for further collaboration. Ideally, over time, the rural community will increase its physical activity and may seek additional consultation, for example, on how to select and prepare nutritional meals. Two-way communication can identify and address resistance or barriers to change. The APN needs to identify potential problems or doubts, and reinforce the benefits and values of the changed behaviors. The emergence of a new equilibrium signals a potential exit point for the APN’s engagement with the community (Allender et al., 2010; Lewin, 2011).

**COMMUNITY ENGAGEMENT**

**Engagement**

APNs are more likely to succeed in addressing community concerns when communities are prepared to engage in the process of change. *Engagement* is different from wishing or acknowledging that “something” needs to change in order to improve. According to the CDC, community *engagement* is “the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those
Before beginning a community engagement effort, the APN must carefully consider the target community/population. What are the results of the CHA and what is known about the community? What has been the history of this community during and following previous change and engagement efforts? How are the community and its various groups likely to perceive the APN and what is the potential for a successful engagement of community members (CDC/ATSDR Committee, n.d.)? Is the community prepared to engage in change? What about the community’s social or physical environment may facilitate or impede change? During this assessment and initial contact, the APN needs to recognize the core principle of community self-determination and the limits of professional action. It is critical that the APN clearly recognize the principle that “No external entity should assume it can bestow to a community the power to act in its own self-interest” (CDC/ATSDR Committee, n.d., Principle 4). Community members will find their own power when they seek it in themselves and take action for themselves, their families, and their community.

Entering the community is a second important and necessary step in assessing the potential for engagement. The APN needs to establish relationships and build trust through contacts with community leaders and community organizations. As mentioned in earlier chapters, the community leaders are not always the political leaders, but rather can include leaders in the church, schools, charitable foundations, or any member of the community who is trusted as a leader. The successful engagement with the community will depend upon developing these relationships. Each community is distinctively unique; engaging with a community will require acknowledgment and inclusion of the cultures and diversity of that community in all steps of the engagement. Only by taking these steps can the APN fully identify and mobilize community assets and resources and lay the groundwork for building long-term change in the community. With that said, healthcare professionals must recognize the limits of professional control and the need and/or cost of making a long-term commitment with the community and its residents (CDC/ATSDR Committee, n.d.) (Table 10.1).

### TABLE 10.1 Principles of Community Engagement

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<th>Before starting a community engagement effort:</th>
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<td>• Be clear about the purposes or goals of the engagement effort, and the populations and/or communities you want to engage.</td>
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<tr>
<td>• Become knowledgeable about the community in terms of its economic conditions, political structures, norms and values, demographic trends, history, and experience with engagement efforts. Learn about the community’s perceptions of those initiating the engagement activities.</td>
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For engagement to occur, it is necessary to:

• Go into the community, establish relationships, build trust, work with the formal and informal leadership, and seek commitment from community organizations and leaders to create processes for mobilizing the community.

(continued)
• Remember and accept that community self-determination is the responsibility and right of all people who comprise a community. No external entity should assume it can bestow to a community the power to act in its own self-interest.

For engagement to succeed:

• Partnering with the community is necessary to create change and improve health.
• All aspects of community engagement must recognize and respect community diversity. Awareness of the various cultures of a community and other factors of diversity must be paramount in designing and implementing community engagement approaches.
• Community engagement can only be sustained by identifying and mobilizing community assets and by developing capacities and resources for community health decisions and action.
• An engaging organization or individual change agent must be prepared to release control of actions or interventions to the community and be flexible enough to meet the changing needs of the community.
• Community collaboration requires long-term commitment by the engaging organization and its partners.


Gaining the Trust of the Community

When working with a community, population, or aggregate, the APN must include strategies to initiate, develop, and sustain trust between the APN and community leaders, community members, and stakeholders. Trust requires mutual intention and is characterized by reciprocity (Lynn-McHale & Deatrick, 2000). As a key element in social interaction, trust facilitates communication and mutual understanding. Trust is a basis for change, a constant connection that provides support when the change process destabilizes a known situation in favor of an unknown outcome. A focus on developing trust begins with the initial contact with community members (Macali, Galanowsky, Wagner, & Truglio-Londrigan, 2011). The resulting nurse-community relationship is a critical prerequisite to population intervention. Through a trusting relationship, the community member gains the security of the APN’s stable presence as a prerequisite to risking the unknown.

Four categories of trust have been described: calculative, competence, relational, and integrated. In calculative trust, potential members of the community initiative estimate the balance of benefits and costs to be derived from a potential collaboration as well as each members’ assets and linkages. Competence trust hinges on whether group members are capable of doing what they commit to do; this type of trust also underlies the development of mutual respect among the participants. Relational trust reflects the personal relationships that quickly arise among members of any group. Members may express the value of mutual exchanges and develop a sense of commitment to mutual goals. Taken together, these three categories of trust constitute integrated trust, the foundation of an ongoing partnership (Logan, Davis, & Parker, 2010).
Initiating trust is an essential first step in building a bond between the nurse and the community. The nurse’s presence in the community is qualitative evidence of the intent to develop a professional relationship with the community and its members. The community’s willingness to view this presence positively will hinge on the APN’s clear communication of his or her role with the community. The APN should seek to frame his or her presence within the broader outlines of the consensus needs or goals of the community, to the extent that these are known.

Based on knowledge obtained from a CHA, the APN should interact appropriately with community members, for example, in relation to personal demeanor, communication patterns, cultural sensitivity, expressions of interest, and communication of knowledge about the community. Being “liked” by community members can be indefinable in its intent or as a goal, but either way it is nearly essential in practice. Acceptability by the community will lead to acceptance by its members, as the APN should always review and consider what the community needs or wants first. The nurse’s expressions of interest in the community and its members are concrete indications of commitment and, to a certain extent, obligate the APN to the community and to assisting with the community members’ priorities. If there is a specified time frame or funding for the program, the APN needs to share this limitation with the community and provide the community with the tools to sustain or build the program on their own.

**Processes of Developing and Sustaining Trust**

The process of developing trust between the APN and the community and its members will likely emerge from early collaborative efforts. In most cases, selecting small, achievable goals that can be met swiftly is recommended. The success of visible outcomes enhances the nurse’s credibility and increases the community’s willingness and openness to trust. Increasing the breadth and depth of community participation with these goals will also increase the proportion of community members who have had contact with the APN and will be an advantage as the nurse-community collaboration continues. It is likely that the community will embark on testing or probing the nurse’s knowledge, behavior, and character for the sake of better understanding and will withhold open trust until the community’s needs begin to be met. As the nature of the nurse-community relationship is constructed and evolves during this period of role negotiation, the APN must maintain commitment to the initial shared goals, demonstrate professional openness to engagement with the community, and continue visible and concrete participation in the community. As APNs share a community presence with the public health nurse, it is relevant to consider that “The less experience people have with trusting relationships and the less sense of personal power and control they have, the more time public health nurses must spend developing trust and strength” (Zerwekh, 1993, p. 1676).

Sustaining the community’s trust is built on a record of commitment and ongoing interaction with the community and its members. The nurse’s continuing...
presence within the community establishes a sort of continuity that is reinforced by reliable actions. Decisions by APNs that become predictable to the community build the community’s independence in self-management. When community members can predict “what the nurse would do,” they are well on their way to independent decision making for their health. As community members gain independence, the importance of the APN’s leadership becomes less necessary. With increased community competence, the APN may face new challenges in sustaining the community’s trust, and the APN’s role as a leader will change. As a community gains self-efficacy and confidence in self-determination and in their individual perspectives, conflicts become more likely. Mutual participation in thoughtful resolution is essential. Sustaining the community’s continued trust will depend upon the APN’s personal and professional skills to modify relationships with the community and its members, and willingness to accept a new role as defined by a strengthened community.

Building Partnerships

If trust is an essential prerequisite for change, then partnerships are the essential underpinning for negotiating, planning, and implementing change. The long-lasting relationships that characterize some partnerships build on existing strengths even as new capacities are forged and developed. Themes of engagement, autonomy, and self-determination have shaped contemporary ideas of partnership since the mid-20th century. The Alma-Ata Declaration (1978) proposed a social model of health that underscored the need for “citizen’s greater self-reliance and decisional control over their own health” (p. 152), and alerted national health systems to more formally involve citizens in healthcare decisions (Gallant, Beaulieu, & Carnevale, 2002). This is even more salient when addressing 21st century healthcare demands that require individual and community initiative to address and improve health promotion and disease prevention (Courtney, Ballard, Fauver, Gariota, & Holland, 1996).

Agency-Academic Partnerships

One long-standing approach to partnership is the bridging of health agencies and academic institutions through joint ventures. The University Public Health Nursing District (in Cleveland, Ohio, 1917–1962) linked local schools of nursing with an independent nursing agency that provided clinic services, public health services, and nurse home visiting (Farnham, 1964). Nursing students were assigned to the district for their public health nursing experiences. Assignments for diploma school students tended more to observation during a brief few weeks, compared to collegiate nursing students who became fully engaged over a semester in the breadth of public health nursing work. The key structural element was the public health nursing staff of the district who served as clinical educators for students, and direct care providers at other times.
More recently, the nursing center model has advanced a similar strategy. The Clemson University College of Nursing Center, for example, is a partner with the Pickens County Health Department (South Carolina) to place nursing faculty and students at a community-based center. Maternal-child services, acute and chronic disease screening, and home health services are some of the activities that have been provided to community members through this partnership. The exceptional benefits of this model have extended and diversified existing health services in the community (Barger & Crumpton, 1991).

As effective and contributory as these programs are, the agency-academic partnership model of collaboration between a health agency or primary care practice with a school of nursing will have a limited impact when community residents and the wider service-resource network remain uninvolved, and when services are delivered outside a collaborative planning process that includes community participants at the table from the beginning. Agency-academic partnership programs focus on delivering services and improving health, but do not address the critical underlying barriers to improving health. Changes in the community—both change that benefits community members and change that transforms the community’s health—will only occur with the participation of community representatives, both community members and community leaders. One promising approach for successful academic-community partnerships uses the community-oriented primary care model to address the structural inequalities underpinning these challenges by placing a community-based organization in the central coordinating role for the partnership (Cherry & Shefner, 2004).

This discussion of agency-academic partnerships highlights the contrast between the APN as advocate or as catalyst when engaging with a community for health changes. In both the advocate and catalyst roles, the APN respects the community and its self-determination as a basis for developing strategies to assist or complement the community’s efforts for health. The advocate understands “the world view, life circumstances, and priorities of those requesting or receiving care and exploring the possible options with them in light of their preferences” (Walker, 2011, p. 75). While recognizing the community partner’s individuality and self-determination, the nurse advocate takes action on behalf of a community to alert or make change in policy, economic, or social systems affecting the community (Walker, 2011). This approach is closest to the APN role in the agency-academic partnership. In contrast, the APN as catalyst understands the community as containing “all the necessary qualities and resources for change” and focuses the APN role to provide “the spark that will initiate change, as desired by the community and on its terms” (Walker, 2011, p. 75). The catalyst role provides the framework for APN practice in sustainable partnerships and coalitions.

Sustainable Partnerships

Developing long-term relationships between the APN and community representatives and organizations is a necessary component for preparing communities for long-term change. Sustainable partnerships are characterized by a relationship
process through which the nurse and partners “work and interact together” (Gallant et al., 2002, p. 153). Power is shared in a “power-with” approach “emphasizing the positive force created between partners and how this force sustains and propels a relationship forward” (p. 154). Win-win negotiation models are recommended in the clinical nursing context (Roberts & Krouse, 1990), and have value in the APN’s collaborations with community leaders and members. Not only are all parties’ views heard and valued, but also the power to make decisions is shared, leading to “a sense of responsibility and power” (Roberts & Krouse, 1990, p. 33). This is particularly important when establishing a context for the emergence of an empowered community.

Sustainable partnerships are supported by public participation that enhances decision making by reflecting the interests and concerns of partnership members, and by highlighting the underlying values guiding partnership operation. The community that is affected by a decision should be able to participate in influencing the decision, and should be included in a way that enables their full participation. Potential participants should be encouraged to use outreach strategies. Decisions are likely to be more sustainable when the needs, concerns, and interests of all parties are communicated. Communication strategies themselves should be open and negotiated to accommodate representative styles and approaches. Finally, feedback must be provided to all participants and the public about how the decision was made and the role of their input in making the decision (International Association for Public Participation, 2007; Rippke, Briske, Keller, & Strohschein, 2001).

Partnerships can only be characterized as such when certain conditions exist: Each partner must be recognized as having his or her own power and legitimacy, own purpose and goals, and own connection to that locale or community. At the same time, the work of the partnership itself must be or become more than any one partner’s own goals. This is reflected in clear partnership objectives and mutual expectations. Regular patterns of feedback from and among all parties should be planned and shared. And finally, “all partners strive for and nurture the human qualities of open-mindedness, patience, respect, and sensitivity to the experiences of persons” representing every portion of the partnership (Labonte, 1997, p. 101).

**Working With Community Leaders and Members: Building Coalitions**

A coalition-building strategy can establish the groundwork and/or initiate intra-community relationships that contribute to an effective, sustained effort to identify and respond to community challenges and needs. Coalition building “promotes and develops alliances among organizations or constituencies for a common purpose. It builds linkages, solves problems, and/or enhances local leadership to address health concerns” (Keller, Strohschein, & Briske, 2008, p. 204). Coalitions bridge sectors, organizations, and constituencies to provide a benefit to the wider community. Coalitions provide a new means to listen to the community as they open new communication pathways. Coalitions “can be helpful in maximizing
the influence of individuals and organizations, exploiting new resources, and reducing duplication of effort” (Butterfoss, Goodman, & Wandersman, 1993).

Coalitions are used widely in community interventions due to their flexibility and their “democratic appeal” (Parker et al., 1999, p. 182). For example, Healthy People coalitions at the county or city level study their community and develop several health promotion or disease prevention objectives. As these coalitions include health and social service professionals, business people, and religious and social organizations, they contain the expertise and connections that have an impact on a community’s health. Coalitions are useful for many reasons. First, involving a broad range of community groups provides a diverse basis to address local problems and change community expectations. Second, health professionals believe that coalitions develop the capacity of local organizations; skills gained in one effort lead to organizational abilities that will later be applied to solve other problems. Third, coalitions can improve service coordination among community agencies resulting in reduced duplication and more effective use of resources (Parker et al., 1999). For example, when organizations exchange information as part of the coalition’s work, organizational leaders may identify overlapping programs. The cost of duplicate efforts can then be reduced through cooperation across the agencies or consolidation at one host agency. Coalitions can also provide a springboard for community empowerment, “an enabling process through which individuals and communities take control of their lives and their environment” (Rippke et al., 2001, p. 212).

The APN should consider the use of a coalition as it can bring diverse resources together and assist in the community’s recognition and response to health concerns. Even though coalitions have many important characteristics, the APN should consider whether devoting existing resources (such as time, energy, and commitment) to coalition building will lead to the best outcome. The decision also depends upon the availability and willingness of the right members for the coalition. Candidate members for the coalition should represent an organization or constituency, and they should have access to the members and resources of the groups they represent. Coalitions can include 12 to 18 members, but smaller groups are able to address more specialized interests, or more easily gain sufficient trust to permit mutual collaboration (Rippke et al., 2001). Many coalitions may need to add additional members as the coalition’s focus broadens. Based on the coalition’s program, additional groups may need to be added and additional resources may need to be requested from new partners. For example, a coalition meeting to address head injuries among children might refine its focus to promote safety helmet usage in activities such as bicycling and skate-boarding. This coalition might add the expertise of emergency department representatives and the resources of local store owners who sell bicycles or safety helmets.

The intent of a coalition is to assemble around a common interest in which each coalition member has a stake in the outcomes. As in any organization, coalitions require both structure and resources to achieve goals. As coalitions incorporate representatives of diverse organizations who hold diverse perspectives, it is
important to facilitate good interpersonal dynamics and to develop reliable group processes for decision making (Rippke et al., 2001). A community coalition should be able to work together on a broad vision of what needs to be accomplished. A mission statement can be useful in providing formal guidance to the coalition effort, especially when a variety or range of perspectives exist among members. When developed collaboratively, this “common vision” can assist with formalization of the next steps (Wald, 2011).

The Process of Establishing Community Priorities

Most community leaders and members can easily identify a wide range of concerns or issues that reflect their wants or needs to improve their community’s health. In strained economic times, such lists are likely to become even longer. During prioritization the available data and community information are reviewed by the coalition and community members to decide what to address and where resources should be targeted (Issel, 2004). The process of setting priorities includes selecting the most important concerns for attention by the coalition. Making this selection can be difficult or frustrating, because in many cases there are multiple problems that need to be addressed in the community. Some community leaders and members will approach this by advocating for the critical priorities affecting the community, while other coalition members will advocate their own personal priorities. Identifying a consensus priority will facilitate the coalition’s purpose of finding a common vision or goal.

When considering what actions should receive high-priority attention, how can wants and needs be differentiated? Needs reflect an objective assessment or conform to a set of expected requirements, compared to wants that may be personal wishes or aspirations that fail to rise to the level of necessity. But it may be that the dividing line between wants and needs has more to do with who sorts wants from needs, rather than how the sorting is done. Wishes and needs for the same target community may differ based on the perspective of the viewer: Insiders and outsiders to the community may propose quite different lists. Rather than asking how to separate needs and wants, the better question may be: Should needs and wants be separated? Perhaps it is more constructive to view both as important and critical to address. For example, a group of health professionals concluded that the priority intervention for a neighborhood in a small, rural community in North Carolina should be to reduce infant mortality, based on significant epidemiological evidence. However, when neighborhood residents heard about the professionals’ proposal, they insisted that their priority was a safe playground for their children—and it was built. This should not be considered a failure but rather a success. Although, one priority solution was sought another priority was identified and addressed leading to a positive outcome for the community.

The practice of priority setting is not purely quantitative; the highest ranking items do not have to be selected over lower ranked items. The process of decision making is interactive, perhaps even political. For example, the APN may believe
that funding and personnel resources should be directed toward the most common diseases in a community. But what if the most frequent disease in a community is sinusitis? Should sinusitis receive attention above all other chronic diseases? Perhaps severity of illness should be an additional criterion. How should duration of illness be factored in? What about considering the possibility of recovery or rehabilitation as a criterion? And what about the actual cost of illness care? Perhaps immunizations are cost effective because they prevent morbidity and mortality at a very low cost. Through questions such as these and related community and partnership discussion, priority-setting discussions reveal much about the values and beliefs of the community and the coalition members.

Ordinarily, several priorities are selected by a coalition. Several of the selected priorities may require different resources and some priorities may separately seek external grant funding. Priority setting can be helpful in suggesting which items should be addressed first, and which should be discarded from the list due to lack of coalition interest or lack of confidence that the problem is solvable given existing resources (Blum, 1981). On the other hand, the availability of external resources or funding may justify selecting a priority, as it is most likely to be viable. In practice, the availability of funding often guides program decisions (Timmreck, 1995).

If a coalition priority requires financial support that is not immediately available, the coalition could make a decision: (1) to wait for a specified period of time until a funding source is willing to provide financial support; (2) to raise local funding specifically to support the coalition priority; or (3) to down-size the magnitude of the coalition’s planned program by implementing a small pilot program or by initially implementing only a portion of the program. For example, a community seeks to address the low immunizations rates among pre-school children. The coalition’s priority is to ensure adequate immunizations for all pre-school children in their community, but no funding is available for their larger goal. Because the coalition has some resources, they decide to develop a pilot program that focuses on improving influenza immunization for preschoolers. The coalition can begin their program immediately, which reinforces the success of the coalition’s common goals and actions. The coalition will also gain a lot of information, as well as group, organizing, and technical skills through implementing the pilot program. Additionally, information on cost savings and health benefit should be obtained to further justify continuing and/or expanding the program. In some cases, coalitions can work with insurance providers to fund programs such as these to prevent or reduce costs incurred with emergency and hospital admissions. This skill acquisition, as well as the pilot program experiences and outcomes, will provide a strong foundation and justification when applying to fund a broader program to improve childhood immunizations rates.

**Priority-Setting Approaches**

The process of setting priorities is best conducted through a combination of qualitative and quantitative methods. Statistics about the frequency, duration, severity, disability, and mortality of certain health problems tell one story. Social
understandings of health concerns and qualitative estimations of these health problems tell a different story. Priority setting allows for open discussion about perceptions, judgments, and understandings that can be the most valuable part of conducting a priority setting session. When the coalition discusses the community and its priorities, this furthers the coalition’s work.

Criteria that are used to rate priorities can vary. A coalition’s discussion is best served if it first decides which criteria are important to the group, and, second, applies these criteria to rank the community’s issues and concerns. Coalition members will learn much about each others’ preferences from both the first and second parts of the discussion, and subsequent decision making will be enhanced. Community members’ viewpoints should also be incorporated; community forums or focus groups can be an effective means for involving community members. Those unable to attend a forum because of family obligations, work-shift timing, or disability can be contacted directly and their perspectives and opinions can still be included as input. For example, Dallas County, Texas, initiatives directed by Parkland Hospital’s Community-Oriented Primary Care program employed a community prioritization approach that focused on “(1) leadership forums and (2) community advisory boards associated with each health center” (Pickens, Bombulian, Anderson, Ross, & Phillips, 2002, p. 1729).

**Priority Chart**

Several priority-setting approaches use a combination of quantitative and qualitative methods to provide comparative rankings that can highlight community concerns and issues that should receive attention. Tarimo (1991) includes a Priority Chart that incorporates several variables in a brief format suitable for discussion by nonprofessionals. Small groups are formed to evaluate the health problems (preferably no more than seven) or risk factors of concern in a population. The problems or factors are then listed and should relate to a single target population. Ranking is simplified when the list includes either health problems (heart disease, asthma, arthritis, adolescent pregnancy, etc.) or risk factors (tobacco use, high-fat diets, sedentary lifestyles, poor access to birth control methods, etc.). Small group members discuss and rank each health problem or risk factor using the following variables: frequency in the population, mortality in years of potential life lost, morbidity in years of reduced health, costs of solutions, and effectiveness of solutions (Tarimo, 1991, pp. 20–21). The priorities selected by the small groups are reported back to the larger group, tallied, and discussed. This approach can be powerful and instructive in the priority-setting process.

**Problem Priority Criteria**

Schuster and Goeppinger (2003) propose a more complex, mathematical system that shares some of Tarimo’s Priority Chart assumptions. Their Problem Priority Criteria include the following: “(1) community awareness of the problem,
(2) community motivation to resolve or better manage the problem, (3) nurse’s ability to influence problem solution, (4) availability of expertise to solve the problem, (5) severity of the outcomes if the problems are unresolved, and (6) speed with which the problem can be solved” (p. 362). Each criterion is independently rated on a 1 (low) to 10 (high) scale based on two questions: (1) How important is the criterion to problem solution? and (2) Does the partnership have the ability to resolve the problem? (pp. 362–363). In addition, a rationale for rating each parameter is documented. The two resulting numeric ratings (for problem importance and for ability to resolve) are multiplied to yield a problem ranking number (variable from 0 to 600). These steps are repeated for each separate problem that the group seeks to address (Shuster & Goeppinger, 2004). The community problems are then ranked from highest to lowest score. As this system requires detailed knowledge about each separate problem, it works best if those involved are highly familiar with the issues or concerns being prioritized, such as coalition leaders.

A “Skilled Planner” Approach

For setting priorities, Green and Kreuter (2005) recommend a series of key questions for use by “skilled planners” in “a process that balances the perceptions of stakeholder (sic) with objectively constructed descriptions of prevailing health problems and how these are distributed in the target population” (p. 99). Green and Kreuter’s key questions reflect many of the themes of the two previous priority approaches, including comparison of relative mortality, morbidity, costs, and ease of solution. For example, one key question asks: “Which problems are most amendable to intervention?” (p. 99). Added themes included a concern for higher risk subpopulations (such as children, mothers, or ethnic minorities), and the disproportionate burden of the problem on the focus community compared to other communities. For example, a key question here is: “Which problem is not being addressed by other organizations in the community?” (Green & Kreuter, 2005, p. 99). This approach works well when professionals (the “skilled planners”) conduct prioritization comparisons. Although this approach is less helpful in the APN’s work with community coalitions, the “key questions” have the potential to add to or help guide discussions or reflections by coalition members or community residents.

The Hanlon Method and PEARL

The Hanlon Method, also referred to as the Basic Priority Rating System (Pickett & Hanlon, 1990, pp. 226–228; School of Public Health, 2004), is structured “to allow decision makers to identify explicit factors to be considered in setting priorities, to organize the factors into groups that are weighted relative to each other, and to allow the factors to be modified as needed and scored individually” (School of Public Health, 2004, p. 1). Three main components are independently rated on a scale for each candidate priority: (1) size of the problem, (2) seriousness of
the problem, and (3) estimated effectiveness of the solution. The numeric results for each of the three variables are placed into an equation, and the results multiplied by the PEARL factor score to obtain the comparative rating (School of Public Health, 2004).

The PEARL factors are interpreted as strongly influencing whether or not a particular goal can be addressed in a specific community, even though the factors are not directly related to the health problem. Propriety (P) asks whether a proposed problem or program is consistent with the overall mission of the sponsoring organization. Economic feasibility (E) balances the costs of intervening or not intervening, including the economic outcomes of not intervening. Acceptability (A) addresses whether the community or program recipients will accept any intervention to address the goal. Resources (R) are assessed to determine if sufficient resources are available to address this goal? And last, Legality (L) poses the question of whether current laws will permit addressing this goal (School of Public Health, 2004).

The PEARL factors are scored individually as “possible” or “not possible” (i.e., each is rated as “one” or “zero”); given the mathematical formula, if even one of these qualifying factors is rated as “not possible” (i.e., as zero), then the Basic Priority Rating is zero, which indicates that the particular candidate priority should not be considered. At this point, a planning coalition may decide that their first step is to conduct community interventions that modify the PEARL factor rated as “not possible.” For example, if an intervention is currently not acceptable to the population, steps might be taken to educate the population of the potential benefits of the intervention. If population opinion shifts and becomes more accepting of the intervention, it could be reconsidered and implemented (School of Public Health, 2004). Incorporating the PEARL factors into priority setting itself provides a stronger and more complex perspective, as part of the process is deciding which goal or program to select. The PEARL factors may also be an appropriate additional analysis in combination with any priority-setting approach, especially as it addresses the intervention component of a proposed need or program.

Selecting Goals to Address Prioritized Issues and Concerns

As a result of the priority-setting process, the community coalition identifies a ranked group of issues and concerns. The next question is: Should the coalition focus on a single goal or on multiple goals? Single goals do have an appeal of simplicity and require fewer resources. When a coalition focuses on multiple linked goals, it has more of an impact on the underlying causes of the problem, and more opportunity to draw community members into understanding these linkages. In the earlier example of creating walking trails, the combination of increasing physical activity and improving healthy food choices both address achieving an appropriate weight to prevent chronic disease. By linking these two health disease prevention behaviors through the walking trails intervention, it underscores the need for community members to combine several related actions to reduce their risks for poor health outcomes.
In fact, most community health issues and concerns are complex, multifaceted, and challenging to address. Based on the ecological model, multilevel planning models underscore the numerous sources of health problems. The *Multilevel Approach to Community Health* (MATCH) suggests that health problems will only be resolved when they are addressed simultaneously at the individual/family, organization, community, and government level, and this allows for a more effective modification of policy, practice, and behavior. Although this approach requires a potentially vast skill set, it can offer more efficient use of resources at a faster speed (Simons-Morton, Greene, & Gottlieb, 1995; Simons-Morton, Simons-Morton, Parcel, & Bunker, 1988). For example, it is not sufficient for the APN to convince a patient and his family that his sodium intake should be reduced. A broader approach should be taken to address the barriers in the community that make it difficult for an individual to make long-term changes. As in this case, the best patient teaching cannot easily overcome the barriers if local food stores carry only high-sodium food choices. The APN could participate in a community coalition to advocate for local food stores to stock healthier, low-sodium foods. County or state policy changes could persuade food stores that stocking low-sodium foods is to their advantage if, for example, they received a tax credit for the amount of healthier foods they carried and sold. Multilevel approaches provide more effective and sustainable changes, as these modify the underlying causes of current health problems and address the issues at a community and policy level.

The *Transtheoretical Model and Stages of Change* suggests that in any given population, individuals are at different points or stages in considering or implementing personal change (Prochaska, Redding, & Evers, 2008). Patients prescribed a lower-sodium diet will undergo a personal change process in deciding and acting on reducing dietary sodium. When a community coalition plans to modify personal health choices among community members, it will design interventions that simultaneously target residents at each of the stages of change. The intervention design will also support individuals and families in moving stepwise through the stages of change and in assisting backsliders to recommit to engaging in change.

In the *Diffusion of Innovations* model, the members of a population adopt new behaviors, new technologies, and so on, at predictable but very different rates and for very different reasons (Oldenburg & Glanz, 2008). In this case, to reach all members of the community, the coalition should target strategies at early, middle, and late points in the campaign to reduce dietary sodium. Those who are early adopters of the innovation respond to different approaches than those who are late adopters, and specific targeted approaches are employed based on their ability to change and stage of change.

Both the Stages of Change and the Diffusion of Innovations theories underscore the effectiveness of using multiple methods in modifying health-promoting behaviors among diverse community members. As a means to understand these complex relationships and to identify possible interventions, *The Guide to Community Preventive Services* provides intensive, highly developed recommendations for community-targeted health promotion and disease prevention programs (The Community Guide Branch, 2011). Given the complex nature of contemporary
health promotion and disease prevention problems, theoretical and evidence-based approaches are critical in properly framing issues and concerns so that they can be addressed. For example, if an APN is planning a program to reduce dietary sodium, the *Nutrition Guidelines for Americans, 2010* (Center for Nutrition Policy, 2010) is an important resource to assist in this process.

**Sustaining New Programs: Identifying Barriers in the Program Planning and Implementation Process**

One challenge to sustaining new programs arises from existing problems or potential problems at the time the goal or program was selected as a focus by the coalition. Thorough, objective assessment of proposed community goals/programs will often yield doubts about implementation of a program or whether the implementation effort risks serious obstacles. The APN and the coalition’s intervention team must both be carefully analytic and thoroughly honest. When potential problems are revealed, they must be acknowledged and addressed, as a “wait-and-see” approach is not effective. Barriers to program success can also emerge during implementation. Symptoms of potential problems include the following: delays in the implementation timeline, waning resources, disaffected partnerships, or recurring communication difficulties during coalition meetings. These challenges can be detected early by conducting an ongoing program review or formative evaluation. Both symptoms of problems and problems detected during program evaluation require the community intervention team to be honest about the presence of and need to address the barriers, and the importance of taking prompt action to address threats to the coalition’s work. The APN brings problem-solving experience to these situations and should remind the coalition of the normative nature of the challenges to implementing a health promotion/disease prevention program.

Regardless of when in the process a barrier is identified, the characteristics of barriers can be grouped into: (1) characteristics of the goal/program; (2) characteristics of needed resources; (3) characteristics of community members, coalition members, and coalition leadership; (4) characteristics of the APN; or (5) a mismatch between community or coalition partners and the APN.

**Barriers Due to Program Characteristics**

Certain types of programs or goals may not be feasible to study in certain communities. Some goals may receive community support and have the weight of evidence behind their use, but are a violation of law (or illegal). For example, needle-exchange programs are effective in preventing the spread of blood-borne pathogens, but are illegal in some areas (Benjamin, O’Brien, & Trotter, 2002). In another case, the timeline necessary to achieve the stated program or goal may not match community expectations. For example, would the community’s support wane before program goals are achieved? Will the community demand program outcomes immediately, but lack the means or resources to quickly achieve the goals? Air quality is an important quality of life issue, as well as being
a short- and long-term health problem, yet modifying the sources of air pollution are time consuming and challenging (Yip, Pearcy, Garbe, & Truman, 2011). The community might not have patience to wait for change during successive lawsuits and environmental policy interventions over a prolonged period of time. For example, the challenges of sustaining a community coalition to address environmental health problems are illustrated in a case involving the pollution of the Love Canal neighborhood in Niagara Falls, New York (Blum, 2008).

**Barriers Due to Unavailable Resources**

Another barrier that is commonly encountered occurs when goals/programs may lack sufficient resources to succeed, perhaps because of inadequate financing, or because of insufficient, inadequate, or poorly trained leadership. Some groups may proceed to develop programs or goals even after the lack of resources has been recognized in the hope that sufficient personnel or financial resources will be secured. Not only are such programs initiated on unstable foundations, but existing resources that could be dedicated to program development are instead lost to failed attempts to explore and acquire needed resources.

**Barriers Due to Human Factors**

The leadership involved in the coalition can often be a barrier to their own success. Community or coalition partners, who participate in the development of community goals, may be unenthusiastic or disaffected in relation to the focus that was actually selected for implementation. Community partners may simply lack interest in the current priority and may wish to terminate their involvement in the coalition. Partners can also become disengaged or separated from coalition communications; they may disengage in working meetings or miss meetings all together. Given the contrasting possibilities, the APN and other coalition members need to assess the reasons these coalition members appear to be disaffected.

Partners can also become distracted by what is to them a more salient goal or concern, leaving little time and attention for coalition priorities. Reassessment of the goal or program should be carried out if it is deemed unlikely that these partners will change their minds. If they do change their minds, then one of the coalition’s interventions should address recruitment and community awareness about program/goal benefits.

Apparent disinterest in coalition activities may also quietly signal that two or more subgroups in the coalition are unable to collaborate, even though both are necessary to the project’s success. The APN and other coalition leadership should reach out to these subgroups to have a fuller picture of the difficulties and to support and counsel reinclusion of the subgroups. In this serious situation, negotiation between the conflicted subgroups may be possible, but the APN must be extremely diplomatic to avoid the appearance of siding with one group and further damaging the potential for collaboration.
The APN can also experience a lack of sustained interest in the program focus, perhaps because the selected program is only indirectly related to health concerns. Similar to community members or other coalition partners, the APN may find another goal more salient. It is difficult to consider, but important to acknowledge, if the nurse has become disengaged from the community and the coalition, whether because of circumstances in the nurse’s personal life or because working with the community and/or the coalition has become difficult. The APN may find herself/himself overwhelmed with responsibilities that compete with other obligations. It can become difficult for the nurse to agree to a realistic timeline for goal or program implementation if it appears that there may be a prolonged timeline or the potential for a significant time commitment. The APN should acknowledge these personal challenges and seek support from within the coalition, or from elsewhere, to identify the barriers to participation and make a plan to reconstruct linkages with the coalition, or to make a decision to acknowledge the barriers and formally withdraw.

**Barriers Due to the Nurse-Coalition Interface**

Lastly, it may emerge that the community/coalition lacks the skills to partner with the APN. One appropriate step is to delay immediate programmatic work and focus efforts on skill building. This challenge is more likely to be revealed and addressed early if program implementation begins in an incremental way that permits skill and confidence building. In fact, incorporating these necessary elements as a first, planned stage of a larger program implementation is advantageous.

**Preventing Problems in Collaborative Efforts**

In the midst of hard work and complex organizing, some would suggest that some of these barriers could not have been anticipated or prevented. But on the whole, these problems should be foreseen by the coalition leadership and actions taken to prevent a negative impact on developing collaborative efforts. Three steps must be included in any initiative: First, during the planning stage, a coalition should dedicate time to honest reflection, anticipation, and identification of potential problems and barriers to any identified goals. Are coalition members genuinely “buying into” group plans? Is the coalition’s roadmap realistic in its timeline and requirements for community participation? Second, every coalition should periodically reassess its goals and plans. Depending upon the nature and composition of the coalition, this reassessment can be conducted by the leadership (in its broadest, most representative, and diverse sense). In addition, a community meeting will generate an even better understanding of the current status of the coalition’s efforts. The community meeting provides a forum for recognizing and acknowledging success to date, celebrating the success, and focusing/refocusing on next steps. Honest reflection on symptoms and suggestions of problems with goals should lead to specific strategies to further understand and address the issues.
and concerns to minimize negative consequences on the larger coalition and the initiative itself. Third, if issues and concerns are revealed, the coalition leadership should make a judgment about the nature and process of the initiative. Should the initiative continue as currently planned, or should changes be made? Would it be better to modify or eliminate a goal, or would this lead to a coalition member dropping out? Coalition leaders might decide to face a conflict and openly discuss the challenge and its many facets, and by identifying a solution, strengthen the overall initiative and the coalition itself.

In sum, “side-stepping” the problems means that the APN and the coalition can and should be alert to potential challenges. Regular reassessment of the program and early awareness of potential problems are essential for success as is finding a prompt solution. Early success in any effort builds the collaborative and spurs efforts forward. Conflicts and confusion that drain energy from the coalition partners should be prevented if possible or at least minimized. Facing confusion and/or conflicts can strengthen collaborative work and model problem-solving strategies that can result in increasing community capacity to address future challenges.

**Developing Outcomes for Coalition Work**

The priority-setting discussions should identify at least one, but likely several issues or concerns for the APN and the coalition’s project. The next step is to develop outcomes and related means to achieve these outcomes, based on the selected priorities. Identifying outcomes is essential to later work including program evaluation.

The process of defining outcomes or even revising outcomes can be daunting. This process can be a critical step in program development that lays the groundwork for successful and sustainable programs. Even when all of the constituencies in the coalition have previously agreed on the priorities for the community’s health, establishing outcomes for these priorities can lead to unforeseen barriers. First, traditional academic/professional configuration of outcomes may be unfamiliar to community members within the partnership; consideration of alternative means to present these ideas, steps to achievement, and a related timeline can facilitate the process. Outcomes should remain in a contextual format that is appropriate for the target community for the duration of the project. Second, well-defined outcomes that are clearly stated may be the first indication to coalition partners of the extensive work ahead. Presenting the outcomes with a clear timeline and delineation of the steps needed to achieve these goals is a way to demonstrate a well thought out plan that addresses the process that is necessary to achieve these outcomes. It also can facilitate a sense of community efficacy, as it sets up the framework to show these goals are achievable. Generating these steps is an appropriate focus for the coalition at the time the outcome statements are presented to the group.

When the APN and coalition members have agreed on the stated outcomes, the next step is to commit to work toward their resolution. As coalition members
represent their constituencies, these members should take responsibility for communicating with their organizations or neighborhoods about the coalition’s plans. The APN can assist coalition members to design campaigns to involve their constituencies. These campaigns can assist coalition members to facilitate adoption of both the outcomes and the steps to achieve the outcomes among their constituents. Focused organizational or neighborhood meetings/gatherings are useful in accomplishing this. The overall goal is to achieve a “buy-in” and commitment to work on the goals among the constituents and the coalition partners.

To support the coalition members, the APN and the coalition as a whole should set a “launch date” for the planned program and have a celebration to develop energy and reflect the commitment of the wide variety of coalition partners. Coalition efforts to recruit and retain the dedication and interest of constituency members will also validate the leadership role of each constituency’s representative within the coalition. This results in strengthening the leader roles of coalition representatives in their community. APN activities in coalitions can often include leadership development of the coalition members.

Continued work toward achieving the planned outcomes will likely have both periods of accomplishment and periods with minimal progress. The APN can remind the coalition of the previously identified interim markers of progress toward the selected coalition outcomes. Achievement of each significant step should be recognized and celebrated. A good example of marking progress is the pictures that are posted in fund-raising campaigns that show increases in donations using an oversized thermometer posted in a visible location. Visible indicators or a giant “check-list” can convey to community members the status and growing impact of the coalition’s efforts. Small rewards or giveaways such as a celebratory balloon or a coalition-emblazoned key chain can also be used to signal progress toward outcomes.

The APN and the coalition members should plan periodic formative evaluations of the progress in attaining outcomes, as well as summative evaluations of those elements of the overall plan that have been completed. Marking success and progress is important for the coalition efforts as well, and offers possibilities for events that build the coalition team and the interpersonal relationships among coalition representatives. When the APN breaks down the program into do-able steps, the efficacy of community members and retention of coalition partners is enhanced.

**Sustaining Programs and Initiatives**

As programs and initiatives gain strength and the coalition sees their planning lead to better health outcomes in the community, the APN should consider ways to keep the work going and to establish it as a permanent element of that community. To do this, the APN and the coalition must take steps to institutionalize the initiative. These plans will ensure the continuity of the work and, with increased duration of the program, will increase the potential for achieving the
identified outcomes. The APN will introduce and guide the coalition first through a careful strategic plan for institutionalization. This will focus the coalition on what is needed. In fact, consideration of sustaining or institutionalizing an initiative should begin when it is first conceptualized, or at least when clear outcomes have been identified and are beginning to be implemented (Community Toolbox, 2011a). The importance of the institutionalization plan underscores the APN’s key role in guiding program development and in guiding the team to an understanding about what steps are necessary at which phase in the program planning and implementation.

**Planning for Institutionalization**

How should the APN guide the coalition in planning for institutionalization? A first step is to acknowledge that what it does is important and that the coalition’s program is worth continuing. In that light, it will make sense to ensure that the program’s mission, staffing, and resources are adequate. Given continued confidence in its planned outcomes, noting program accomplishments will provide the coalition with motivation to continue to build. Publicizing the coalition’s successes will solidify both the coalition and its constituencies and, more importantly, can draw the public into the coalition’s mission and work. Community members are key players in long-term sustainability and can assist in the institutionalization process. When programs involve more people, their staying power increases (Community Toolbox, 2011b). Perhaps a nearby community would like to develop a similar program? Perhaps outsiders would like to learn about how the program operates and how it achieves its goals? Enhancing the connections and respect for the program and spreading the coalition’s programs to new neighborhoods improve how others see the program, and this translates into more support for the program.

**Funding: A Major Barrier to Sustainability**

The major barrier to sustainability and to institutionalization is adequate financing, which for many organizations is an ongoing challenge to accomplishing the planned outcomes. As with other factors that support sustainability planning for future financial security, it is best addressed from the start of program inception. A place to begin is to market the organization by letting others know what the coalition’s program has accomplished. The APN and coalition members will build its image and community relations, develop members and friends, and actively deliver the coalition’s message for health and personal/community change.

Existing financial resources may go further if staff positions are shared with another compatible organization. Or the coalition’s program may become so successful that a larger organization would like to support it, or perhaps even assume responsibility for the coalition, its identified outcomes, and its programs in operation. Grants, fund-raising functions, third-party funding, public funding, a fee-schedule, and in-kind support may also assist with financing (Community Toolbox, 2011c). Community health programs can be particularly attractive to academic
partners such as nursing, public health or medical schools and universities, which the APN can assist in recruiting or relationship building. Personnel resources may be available in the form of educational programs in nursing, medicine, social work, public health, and other professions.

**Stabilization and Reassessment**

The role of the APN with the coalition and the change process is very active, but this role draws to an end during the step in Lewin’s Stages of Change known as refreezing. During this step, reassessment and stabilization are typical and expected, which focuses “the change agent’s and actor’s attention and energy on progress and continuity for the change” (Kettner, Dailey, & Nichols, 1985, p. 288). The APN may or may not continue with the community coalition. But even when the APN continues, the role of change agent is less necessary and begins to fade as the change is institutionalized or stabilized. But rather than immediately separating from a successful coalition program, the APN should emphasize the autonomous functioning and continued survival of the program (Kettner et al., 1985).

The APN should initiate a reassessment of the change process and the coalition’s work. Input is sought from all participants about whether the impact of the coalition’s changes is meeting their needs. Members of the community coalition itself give feedback, as do a sample of their constituents who are recruited to reflect on the practical consequences and the meaning of the change effort. To what extent has the change been accepted, approved, and adopted among coalition members, their constituents, stakeholders, and other community members? A careful review of whether the community coalition’s goals were met should be included. Though perhaps challenging to anticipate, this step will be easier if early in the project the APN guides the community coalition to accompany their specification of outcomes with clear descriptors for outcome achievement.

The APN will also assist and explore with the community coalition appropriate means to share their experiences with a wider audience through oral presentations, visual and audio media publicity, and articles for publication in magazines, journals, community newspapers, and online postings. The APN and coalition members may offer assistance to other community groups who are in the early stages of planning similar efforts. Coalition members may take the strengths of this coalition experience, with their new skills and abilities, and apply what they have gained to other issues in support of their own communities.

**SUMMARY**

The APN’s ability to employ the change process is an essential component of reaching beyond the clinical encounter to address the community context and conditions that lead to poor health in individuals and families. The community encounter engages the APN and community partners in an ongoing process of increased understanding and skill/ability development.
The APN who sets out to engage communities in change requires many skills. Foremost is the ability to strategically and successfully introduce the need for change to improve population health. At any one time, the APN may be called upon to moderate a focus group, diplomatically defuse a situation, collect data in order to identify targets for intervention and to measure change, and help in the identification and construction of achievable outcomes. Although the initial role of the APN is leader, he or she must also be prepared to step aside and allow members of the community to identify priorities for change. It is paramount that the APN understands that it is community members who make final decisions about health priorities. An important role of the APN is helping community members to acquire the necessary skills to make changes and to create a sustainable environment. It requires a true partnership between the APN and the community to create meaningful change and it is through helping communities to sustain those changes and become leaders themselves that those changes will become embedded in the community.

Extending APN practice into the community improves clinical outcomes directly because as community problems are identified and managed this complements the APN’s efforts to reduce individual and family health problems. Sustaining the coalitions and programs that develop as a result of the APN’s partnership with community members has the potential to achieve far reaching improvements in population health.

**EXERCISES AND DISCUSSION QUESTIONS**

**Exercise 10.1** What ethical principles apply when working with communities? Conduct a personal skills inventory. Of the ethical principles that you have identified, which ones do you have sufficient skills in to be able to work effectively with a community coalition? Are there areas where you would like to develop stronger abilities? How would you go about developing the skills and knowledge to do so?

**Exercise 10.2** Consider a community known to you. If you were working with a partnership group to set priorities for community collaboration, which priority-setting criteria would you recommend for use by your group?

**Exercise 10.3** What factors would you consider before you made an implicit/explicit commitment to engage with a community or neighborhood to improve residents’ health status? How would you specifically engage with the community to negotiate your role?

**Exercise 10.4** Consider a community known to you. You wish to take initial steps to build a partnership with the community. What data and
information will you have analyzed/considered before you contact community leaders/members/organizations? Which area leaders/members/organizations would you contact initially, to introduce the idea of a partnership?

**Exercise 10.5** Obtain a copy of the Tarimo (1991) *Priority Chart* (see the reference list). With others, select six or seven community issues or concerns and rank these using the tool. What did your group agree about? Disagree about? In what ways would your group consider modifying the tool?

**REFERENCES**


