Community Health II Paper

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The Health Problem Identification

The aggregate for which our group was assigned consisted of older adults who currently reside at Village Pointe (VP) and Village Gardens (VG). Resident participation during student encounters consisted of 13 African American women and two African American men, for which ages ranged from 63 to 86 years old. Further characteristics of the aggregate included low socioeconomic status, transportation deficits, sedentary behavioral trends, and social isolation. From subjective, objective, and systematic review of system assessments analyzed from the previous semester, health problems were identified, which consisted of chronic hypertension, type II diabetes, and obesity.

Health Planning Needs

From client interviews conducted during the summer semester, deficient knowledge had been determined to be a commonality. VP and VG residents verbally confirmed that there was little interference when making it to their health appointments and claimed they were compliant with taking their prescribed medications. In addition, all residents were aware of the need to make diet modifications and incorporate physical activity (PA) into their daily routines, for which changes had been made. However, when asked about the frequency, duration, and level of intensity regarding PA engagement, all participants were found to fall significantly short when compared to the PA recommendations set by the Office of Disease Prevention and Health Promotion. Thus, the goal of increasing PA awareness amongst the residents was the focus for which interventions were structured towards.

To meet the goal of increasing PA awareness, physically engaging activities were scheduled to be incorporated upon student encounters throughout the fall semester. By providing

a consistent and repetitious schedule of routine activities, the expectation was for residents to become familiar with what constitutes as adequate PA in hopes for them to implement PA behaviors into their daily routines independent of facilitation. Due to time constraints, meetings were limited to once per week, which were scheduled for every Wednesday from September 5th through December 5th, excluding days for which school was not in session. Each encounter was scheduled to be held for at least two hours, for which vital signs would be taken to compare to prior interpretations, and moderate intensive exercise would be implemented for approximately 60 minutes.

To measure the effectiveness of implementing a PA schedule, each resident would be assessed for adherence in meeting recommendations provided during student encounters. During vital sign assessments, residents would be asked to list PA they had participated in throughout the week. In addition, frequency and duration times would be inquired upon. The level of intensity would be analyzed after the conclusion of the semester, for which vital signs would be compared with individual baselines, to determine if conditioning had improved. Vital signs to be measured would include blood pressure, heart rate, respirations, and body weight. Results that were equivalent or of greater value to baseline vitals would be considered as not meeting intensity needs, while lower values would be considered having met them.

Alternative Interventions

Interventions were dependent on resources available. Firstly, a designated area to implement interventions had to be reserved and the appropriate personnel had to be acquired. Some of the activities we had planned needed a larger area to be implemented, so we had to adjust. For example, we were lacking space to implement the walking, so we had to adjust to

walk outside in the neighborhood surrounding it. In addition, group engagement was dependent on facilitation by group home staff, so the original plan on one of the days was to lead Tai Chi, but the staff member preferred we walked, so we did.

Interventions

Implementation

Both primary and secondary level interventions were implemented based on our assessment and plan. This included education and health screenings of residents of the Village, as well as other community members from CSCCC food pantry. Education was offered regarding proper nutrition to include healthy choices and options to overcome barriers such as accessibility or financial stressors. Individuals that have easier access to good produce on a regular basis are more likely to maintain a healthy diet than those who do not (Savage, Kub, & Groves, 2016).

There were many individuals with diabetes that were not managing their condition well and were having significant adverse effects. These were contributing to comorbidities or creating new health issues. We reviewed basic diabetes management and discussed details specific for some, such as the importance of foot care. Due to deteriorating circulation and neuropathy, the diabetic patient must be diligent in caring for their feet to avoid pressure ulcers which could in turn lead to gangrene and amputation (Hinkle, & Cheever, 2014).

The only opportunity we had to work with the residents at the Village allowed us to focus on physical activity. We provided a secondary intervention in the form of blood pressure screenings and we discussed the values and their benefits or consequences. A few residents then went for a long walk in the neighborhood with us; most residents kept a determined pace and

increased their heart rates, thus getting adequate exercise. Simple physical activity gain through a walk or other purposeful movement at home has many benefits for the older adult including: decreasing the risk or severity of diabetes, stroke, hypertension, and depression, as well as improving or maintaining safe independent ambulation and decreasing the risk of falls by 40% (Hale & Marshall, 2017). One resident was unable to keep that pace and followed slowly with her walker. One group leader maintained a much slower pace with her and was able to continue discussing health benefits of good nutrition and physical activity.

Literature Review and Support for Intervention

Research surrounding the quality of health-related services and programs provided for older adults in community housing has focused on the availability and type of services offered, and the effects of those services on the health and well-being of the older adult community. Services can include providing for basic needs, such as help with housekeeping, providing healthy meals, and transportation to and from grocery stores and medical facilities for appointments. Other services are more direct, such as having health care providers on-site who can monitor the residents' health issues and having social workers and counselors who can connect older adults to needed and readily available community resources. Additionally, some housing communities also offer health-related programs that support the social and physical health of older adults, such as educational programs (nutrition, diabetes, hypertension etc.), social groups, and physical activity programs.

Numerous extant researches have shown that there are abundant benefits to offering health-related services for older adults within community housing. These include physical health benefits, which leads to fewer hospitalizations, emergency room (ER) visits, and nursing home

transfers and admissions (Gusmano, Rodwin, & Weisz, 2018; Thurmond & Geno, 2018). Additionally, offering services such as support groups and providing counselors improves the mental health of older adult residents (Castle & Resnick, 2016; Ewen, Washington, Emerson, Carswell, & Smith, 2017). Further, the more health-related services community housing provides for older adults increases their overall quality of life as well as providing cost savings for the larger community (Castle & Resnick, 2016; Gusmano et al., 2018).

Thurmond & Geno (2018) studied various instances of partnerships between community health service organizations and older adult community housing and found that there were numerous benefits to such partnerships. Among the cases they looked at was a senior housing complex in Tennessee that partnered with a university nursing program to allow students to provide medical care and education for the residents. This program resulted in a 10% reduction in ER visits among the residents, a 99% rate of residents who obtained a primary care provider and a 95% rate of residents keeping their medical appointments (Thurmond & Geno, 2018). The same study also highlighted another program, the Volunteers of America National Services (VOANS) program, which provides services coordinators to 158 housing sites in 42 states and Puerto Rico. Thurmond & Geno (2018) underscored that the VOANS service coordinators help bring services such as meals, social enrichment programs, and health and wellness related programs which allows 86% of program participants to successfully age in place. Additionally, another study by Castle and Resnick (2016) found that older adults who lived in service-enriched housing had significantly lower rates of ER admissions, hospital stays, and nursing home transfers than did older adults in housing without such services provided. They estimated that

for every 100 residents in service-enriched housing, 21 ER admissions and 20 hospital visits were prevented.

Older adults also reap mental health benefits from living in community housing that is responsive and provides services. Agarwal & Brydges (2018) looked at the effects of offering health-based programs within older adult housing on the mental health of the residents. Castle & Resnick (2016) found that residents who had access to a health-based program were more likely to feel socially connected and had lower levels of isolation. Another study by Ewen et al. (2017) found that older adults who lived in housing that provided them with services such as transportation, senior centers, and meals, had higher perceived purpose in life and lower rates of mental health problems than those without access to such services.

These physical and mental health benefits not only lead to greater quality of life for the residents but they also provide cost savings for the community. Castle & Resnick (2016) estimated that there is an annual benefit of over $200,000 for every 100 residents who live in service-enriched housing, just taking into account the cost of ER and hospital stays. After looking at the significant differences in length of hospital stays and ambulatory care in seniors living in housing that provides supportive social services compared to those who do not, Gusmano et al. (2018) concluded that investments in social services within older adult housing would significantly reduce Medicare spending.

Barriers

Although it is clear that community housing programs and services provide a great benefit for older adults, there are a number of barriers to providing such services. Specific to the implementation of our community health program at the senior housing center, we experienced

difficulty coordinating a successful event, due to: 1) lack of communication and willingness on the part of the staff; 2) lack of outreach to the community of older adults; and 3) a potential lack of addressing existing physical and mental health barriers that may have kept some seniors from participating in the program.

The staff member who was our point of contact became unresponsive to our emails despite our numerous attempts to initiate communication. We planned various activities for the residents, but the staff member failed to provide us with a location and time to carry out our program. If we had the opportunity to work with a more responsive staff member, the organization and implementation of our program would have been more successful.

Additionally, there was a lack of outreach to the community of older adults about our program. This led to a reduced participation rate, because many residents may have been unaware that the program was taking place, and/or not educated about the potential benefits they could receive from attending. Again, this could have been prevented with better coordination and communication between us and our point of contact at the community housing center.

Lastly, in order to increase participation at events like these, the community housing center should ensure that the residents' basic needs are being met. Depending on the needs of each particular resident, these may include providing physical and mental health-related services, access to meals, housekeeping help, and transportation. When individuals' basic needs are being met and their mental and physical health is addressed, they are more open to participating in programs such as the one we provided.

Evaluation

Evaluation Plan

The objective is to understand the impact of activity on older adults and the effects on their health status. The impact of routine exercise on the aggregate would be a subjective report, and the health status is a combination of subjective and objective.

The effect of activity on the older adults' should have been measured with a baseline test, and a questionnaire at the end of the process. The baseline would include questions regarding their socioeconomic status, and subjective questions such as how they perceive their current health status and their satisfaction with their level of activity. In order to make the data more quantitative, we would ask the questions using the Likert scale, which is a five point scale ranging from not satisfied to fully satisfied (Sowle, Francis, Margrett, Shelley, & Franke, 2017). This makes it easier to document, and narrows the possible responses. We also had been taking vital signs during the meetings with the aggregate, so any decrease in blood pressure and heart rate was observed. They were also asked about their level of activity before the intervention, and their knowledge of recommendations regarding physical activity were recorded.

At the end of the time with this community partner, we would have hoped to provide another questionnaire. This would have consisted of similar questions regarding their socioeconomic status and perceived health, as well as their opinion of the activity program. It would have listed the various activities we performed, such as Tai Chi and walking with the residents, and have them rate their satisfaction with the intervention, and the likelihood of continuing the activity in the future. We would also reassess the level of activity they currently performed, and the recommended level for healthy living.

The expected outcomes were to have a difference in reported health status, with an increase in level of satisfaction of health. It is suggested an increased level of physical activity

can lead to a higher perceived level of physical function and health status (Halaweh, Willén, & Svantesson, 2017). Based on the level of interest, it can be assumed Tai Chi was the most popular intervention among this group, with walking and chair exercises following. In order to see a change in blood pressures, the interventions would need to be more consistent and common, instead of once a week, but slight decreases may have been seen, as well as decreases in resting heart rate. They would also give accurate reportings of the recommended amount of physical activity per week, and their reported level of activity per week would more closely align with the recommendation.

Limits of Evaluation

The evaluation was unable to occur because of miscommunication and an inability to interact with the aggregate. We experienced a gatekeeper to our community, and had difficulty communicating with our point of contact. They were unable to commit to dates when the residents would be available, which made it difficult to interact. This was the largest barrier to our evaluation, but we were able to adjust and find a larger aggregate to work with. This larger aggregate was a great experience, but we did not have a chance to assess their needs, so we did not begin an intervention. In the future, with more time with the larger organization, we would be able to implement and evaluate.

Recommendations

Expansion of the aggregate to include multiple organizations within the community would allow us to reach more individuals. The limited access to our site in addition to the sparse attendance at the planned activities left little interaction and actual implementation of interventions. Further development of the relationship with Senior Services of Southeastern

Virginia (SSSEVA) is an ideal opportunity. This is a large organization with considerable resources and connection to countless older adults in the Hampton Roads area. In addition to SSSEVA, other organizations within the community such as local recreation centers would be ideal to contact. They already serve this population and have established relationships with the older adults in their community that would enable us to reach many people with theoretically little difficulty. The City of Norfolk has 18 recreation centers, two of which are within walking distance of the ODU Norfolk campus.

In addition to expanding the aggregate, the availability of printed educational materials to distribute to individuals would reinforce the subjects discussed and encourage further study. A 2015 article from Focus on Education entitled *Health education for older adults*, states "Printed materials should be created to benefit the patient and allow for him or her to take them home and have time for review and self-paced learning" (Reinhardt, 2015). The development of these materials could be an assignment for students in N430 Nursing Care of the Older Adult, which would ensure they are reviewed thoroughly for accuracy.

Implications

With an expanded audience, more older adults could be positively impacted by our outreach and benefit from the implemented interventions. There would be an opportunity to identify additional problems and concerns within this population that their "gatekeepers" are unaware of or unable to assist them with at this time. As students, we are in a unique position to have individualized contact with this population. By having printed materials to leave with people, we would be offering them additional support at a later time. They may go back to

review the information for a reminder or clarification that they did not want to ask for in person, and the printed materials are an additional interaction.

Conclusion

This clinical experience has shown the importance of communication and the necessity of adaptability in community nursing. The communication between the gatekeeper at the Village and Old Dominion was stopped abruptly. It meant following up with communication and responding quickly to ensure ample time to adjust for changes. We made sure to allow time for responses when planning. The adaptability occurred later in the semester, when we still needed time with the aggregate, but were unable to go into the original community, so we expanded our population to SSSEVA. This also helped us understand the services available to the older adults, so we became better informed for helping patients and community members in the future.

References

Agarwal, G., & Brydges, M. (2018). Effects of a community health promotion program on social factors in a vulnerable older adult population residing in social housing. *BMC Geriatrics*, *18*(1), 95. https://doi.org/10.1186/s12877-018-0764-9

Castle, N., & Resnick, N. (2016). Service-enriched housing: The staying at home program. *Journal of Applied Gerontology*, *35*(8), 857–877. https://doi.org/10.1177/0733464814540049

Ewen, H. H., Washington, T. R., Emerson, K. G., Carswell, A. T., & Smith, M. L. (2017). Variation in older adult characteristics by residence type and use of home- and community-based services. *International Journal of Environmental Research and Public Health; Basel*, *14*(3), 330. http://dx.doi.org.proxy.lib.odu.edu/10.3390/ijerph14030330

Gusmano, M. K., Rodwin, V. G., & Weisz, D. (2018). Medicare beneficiaries living in housing with supportive services experienced lower hospital use than others. *Health Affairs*, *37*(10), 1562–1569. https://doi.org/10.1377/hlthaff.2018.0070

Halaweh, H., Willén, C., & Svantesson, U. (2017). Association between physical activity and physical functioning in community-dwelling older adults. *European Journal of Physiotherapy*, *19*(1), 40–47. https://doi-org.proxy.lib.odu.edu/10.1080/21679169.2016.1240831

Hale, D. & Marshall, K. (2017). Physical activity for older adults. *Home Healthcare Now*, 35(3), 172–173. doi:10.1097/NHH.0000000000000496.

Hinkle, J. L. & Cheever, K. H. (2014). *Brunner & Suddarth's textbook of medical-surgical nursing* (13th ed.). Philadelphia, PA: Wolters Kluwer.

Reinhardt, L. (2015, May 26). *Health education for older adults*. Retrieved from http://nursing.advanceweb.com/health-education-for-older-adults-42115/

Savage, C. L., Kub, J. E., & Groves, S. L. (2016). *Public health science and nursing practice caring for populations*. Philadelphia, PA: F. A. Davis Company.

Sowle, A. J., Francis, S. L., Margrett, J. A., Shelley, M. C., & Franke, W. D. (2017). A Community-Based Exergaming Physical Activity Program Improves Readiness-to-Change and Self-Effficacy Among Rural-Residing Older Adults. *Journal of Aging & Physical Activity*, *25*(3), 432–437. https://doi-org.proxy.lib.odu.edu/10.1123/japa.2015-0278

Thurmond, D., & Geno, S. W. (2018). Integrating health and supportive services in affordable senior housing: New Models for Service Coordination, *27*(2), 12.