Community Health Project Paper

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Chesapeake Care Clinic is a free clinic that provides care to individuals who have no health insurance and live within a certain financial bracket. I have had a passion for free clinics for a long time now. I chose this specific site for the variety of services they offer. I am acquainted with a prior employee of the clinic who helped me get in contact with the clinic. The staff at the clinic are very polite, open-minded, and helpful. The clinic has multiple specialties within it and has created many outreach programs to help the community being served. I gained access to the community by offering to chauffer patients to and from appointments. This gave me time to ask questions and get to know the aggregate being served. I understand the need for the community is still access to care. The goal of this paper is to create a plan, based off of nursing diagnoses, to address these concerns for access to care.

Aggregate Characteristics

The main community served by this clinic is South Norfolk. The average yearly income reported in 2012 by the residents was $30,112 (city-data.com). In 2017, 22.9% of the residents lived below the poverty line (city-data.com). During my community interviews, many residents felt they were not living in poverty. Since 2005 the percentage of children living in poverty has ranged from 24-33% (Virginia Department of Health (VDH), 2016). The majority of the community is suburban with little to no rural areas. Food stamps were used by 1,657 residents in 2017 (city-data.com). The majority of the population served by this clinic is 50 years and older. Chesapeake Regional Medical Center (CRMC) is the main hospital used by South Norfolk residents. CRMC developed a community needs assessment in 2018. This assessment revealed that 74% of a resident's yearly income was spent on housing or mortgage (CRMC, 2018). Interviewed residents agree that a mass amount of their income is spent on housing. High blood

pressure was reported by 60% of the residents (CRMC, 2018). Obesity within the community is at 33.8% (CRMC, 2018). Many residents do not have any health concerns about their weight. Of the residents that reported having high blood pressure or diabetes 30% reported and annual salary of $19,000 (CRMC, 2018). In Norfolk approximately 51% of households are single-parent households (VDH, 2016).

Health behaviors of the community were reported to be fair to poor. Many do not seek out care for illness until it needs emergent attention. This causes a bigger strain on the clinic and the local hospital. Interviewed residents expressed concerns about access to affordable care but they underestimated the need for continuous care for chronic health conditions. Genetically there are no factors that predispose this community to worsening health conditions. The community culture mindset of health issues has grown around a cost benefit ratio. Since there is a large issue with access to care many generations within this community will put off health concerns until it impedes their employment. External factors that affect the community health stem from economics and amenities within the community. Although this community is large and in need of multiple health clinics there are very few options for accessing care. Obesity is an issue among old and young for this community. The parks and recreational facilities within this community are minimal to absent. Public primary schools are overrun with the population of students. The community is in need of a massive intervention to improve their health.

Literature Review

There are many needs of the residents within South Norfolk. Access to care is a major issue. This stems from the problems associated with poverty. Many residents often have to decide between medicine, appointments, medical supplies and housing. Another issue faced by this community is the requirements placed by many health care facilities to receive free or discounted

services. Chesapeake Care Clinic has an income limit and a no insurance clause when you are provided services through them. Continued access to care is another issue among the patients at the clinic. Often, they cannot be present for all of the follow up appointments that are scheduled due to transportation issues and employment. This decreases compliance with care plans that the clinic has set up for them.

Kirby and Kaneda (2006) published an article to determine whether residential instability played a role in issues obtaining health care. This article revealed that poverty does play a role in access to healthcare (Kirby & Kaneda, 2006). Normally if there is major poverty population within a community, it will show in the amenities within the area. Shopping centers will be decreased, parks will be limited, schools are not as well ran as others, recreational centers are limited to none, and health care facilities are limited and not well regulated. All of these are concerns within the community of South Norfolk.

`Samuel (2017) published an article on a study performed to ascertain health disparities that contribute to access to healthcare. While assessing communities of different back grounds and socio-economics the results revealed that income and education played a major role in access to care (Samuel, 2017). Although the majority of adults in South Norfolk have a high school education many of them do not understand the disease process that they are ailed with. This has created a vicious cycle of hospital admissions and exacerbations of chronic diseases.

Namkee Choi, Bryan Choi, and Dianna DiNitto (2020) used the National Health Interview Study (NHIS) to inform their study on the unmet healthcare needs of uninsured U.S citizens. The NHIS revealed that 9.9% of participants age 50-64 had no form of health insurance (Choi et al., 2020). This age range tends to have multiple chronic health conditions and does not

yet qualify for Medicare. This puts them at an increased risk for morbidity and mortality without proper access to health care (Choi et al., 2020).

Felder-Heim and Mader (2020) published an article about a student ran free clinic. This article addressed the concerns about student ran free clinics versus clinics ran by the safety-net health-care system (Felder-Heim & Mader 2020). This article discussed the access to continuous care and its importance. Results revealed that compliance with appointments increased the positive health outcomes (Felder-Heim & Mader, 2020). Hypertension and diabetes were the diseases discussed within the article. These are two major issues within the population of South Norfolk. The issue of compliance with follow-up appointments is crucial when it comes to these two diseases.

Compare and Contrast

When comparing the community served by the clinic to the state, the Virginia department of health reports that 22.9% of South Norfolk residents have incomes below the poverty line versus the 10.6% of Virginia residents (VDH, 2017). South Norfolk resident's median income reported was $30,112 compared to the median income in Virginia of $70,192 (VDH, 2017). There is a larger premature age-adjusted mortality rate in South Norfolk than Virginia (VDH, 2017). Obesity rates are higher in South Norfolk at 33% compared to 28% in Virginia (VDH,2017). Mental Health provider patient ratios are practically doubled at a rate of 1,180:1 in South Norfolk compared to 680:1 in Virginia (VDH, 2017). The prevalence of diabetes is 15% in South Norfolk compared to the 10.3% in Virginia (VDH, 2017). South Norfolk when compared to Virginia overall seems to be in a worse state of health.

Nursing Diagnosis

The first priority nursing diagnosis is anxiety related to transportation to and from clinic appointments as evidenced by patients expressing concerns during interviews. Neuman's system model theory supports this diagnosis because it represents the patient as a whole rather than just the medical needs. Alligood (2018) describes Neuman's system model as a series of rings that form the defenses of a person. These lines are made up of our flexible lines of defense, normal lines of defense, and lines of resistance and stressors can manipulate these lines (Alligood, 2018).

The second priority nursing diagnosis is knowledge deficit relating to disease processes as evidenced by continuous exacerbations of disease, where the patients can not explain why they occurred. Pender's Health Promotion Model (HPM) supports the diagnosis because it encompasses the patient's perceptions of health along with health behaviors (Alligood, 2018). Many of the patients interviewed did not understand their health condition. Their perception of the disease was unrealistic, relating their condition to a cold.

The third priority nursing diagnosis is powerlessness related to inability to battle illness as evidenced by interviews where patients expressed sadness over their health situations. King's theory of goal attainment supports this diagnosis because it proposes the affect that environment, interpersonal interactions, and social systems can have on attainment of health goals (Alligood, 2018). Health goals are forever changing because illness and health are on a continuum the is always moving. Our interactions with providers, nurses, and anyone else changes our health care goals for the time being. Attainment of these goals is what drives us and when we cannot see any success, we become powerless to the feeling of failure.

The fourth priority nursing diagnosis is impaired physical mobility related to physical ailments related to main diagnoses as evidenced by patient's declining health status. Orem's self-care deficit theory supports this diagnosis because it describes the importance of self-care and the affects nursing care can have on it. During my interviews patients often admitted to neglecting their health due to lack of support. Whether it be family or staff related the neglect caused physical ailments like arthritic pain, severe shortness of breath with exertion, and limited mobility of joints.

The final priority nursing diagnosis is ineffective coping related to the disease process as evidenced by denial of symptoms. Pender's HPM supports this diagnosis because it relates the perception of health from the patients view that may need to be changed. Denial of symptoms is common among patients within this community. During interviews, many expressed that they have always had this problem and it was not related to their current health condition.

Planning

The priority nursing diagnosis for this community is anxiety related to transportation for health care. During interviews patients expressed concerns about transportation to appointments for continuous care. Forming a volunteer-based transportation team for the patient would be the main objective. Collaborations between the staff at the clinic and the transportation volunteers would be of extreme importance. Examining the need of transportation for each patient and scheduling appointments for dates and times there would be transportation services available could potentially alleviate some anxiety for these patients. Evaluating the results of the transportation services would be pre and post surveys of patients about their anxieties with transportation to appointments. The timeframe for evaluation would be 1 month. At the end of

this month surveys would be collected and if successful the volunteer service could be extended to include students form local schools or trained medical staff when needed for urgent patients.

Alternative Interventions

The clinic already uses medical transport for some of the patients. The only issue with this transport is that it costs the patient. If there could be no planning between the staff and the volunteers running the transportation services, then having one volunteer a shift transporting patients in most need would be beneficial. Also, contacting the city transportation services and obtaining bus-passes for the clinic to pass out to patients would be beneficial. To increase use of the city transportation services, contact could be made with city officials asking for a bus-stop to be laced directly in front of facility. This would give patients with limited mobility a more feasible option then the bus-stop a half a mile from the clinic.

Summary

The community of South Norfolk has a great help within Chesapeake Care Clinic. The patients of the clinic are extremely grateful of the services provided. The community has great health disparities related to poverty. The income and assistive programs are restrictive and often not sought after by the residents. Chesapeake Care Clinic is a great facility providing care to this community, issues of transportation and community growth have been of concern the past few years. I wish to address the concerns for transportation by implementing a program that will provide transportation to the patients of the clinic for appointments. This will decrease the stress throughout patients and staff at the clinic and will improve the health status of the patients.

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