Implementation of a Pilot Nurse Residency Program for Army Public Health Nurses

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Abstract

Graduates of the Principles of Military Preventive Medicine course do not have access to a formal residency/orientation program upon graduation and transition into the role of an Army Public Health Nurse (APHN). There is consensus in the literature that additional competencies and knowledge beyond those attained in an entry level educational program are needed to transition effectively into a new professional role. Based on formative assessment data, current APHN residency/orientation programs are informal, sporadically located, vary in length, and training opportunities. The large degree of program variance and lack of standardization negatively impacts the development of competent and confident APHNs prepared for independent practice. The purpose of this scholarly project is to determine if a formal one-year nurse residency program (NRP) for APHNs improves competence and confidence in practice. A convenience sample of June 2015 nurse graduates of the Principles of Military Preventive Medicine Course (N=2) was recruited to participate in the pilot NRP. Outcomes of perceived confidence and competence in professional practice are measured at four points in the program using the APHN Readiness Assessment Tool. Phase One results are reported in this paper. Overall program satisfaction will be evaluated at program completion. At completion of Phase One, four month re-assessment mean scores improved in six of the ten essential public health services assessed. Improvement in mean scores was also seen in two of the fourteen confidence specific questions. Differences between baseline and four month re-assessment mean scores were not statistically significant. This project is the first attempt to formalize and standardize processes related to the professional transition of new nurse graduates of the Principles of Military Preventive Medicine course into public health nursing practice. It also provides an
opportunity to evaluate tools designed to track competency assessment/validation and evaluate evidence-based NRP processes with a public health nurse population.
Implementation of a Nurse Residency Program for Army Public Health Nurses

**Background/Statement of the Problem**

Army Medicine is in the midst of a reorganization to improve healthcare service delivery across the Army. A critical component to the organizational restructure is the assurance of a competent nurse workforce (Army Medicine, 2013). As the health care environment becomes more resource constrained and complex, demands upon nurses are increased. This shift in the current operating environment makes assimilation into a new practice area very difficult. This is evidenced by growing issues with professional performance among Army Public Health Nurses (APHN). The APHN specialty includes 140 active duty Army officers currently serving in military communities throughout the world. With so much dispersion among personnel, it is difficult to assure a competent workforce. Standard training guidance and business practices are essential to ensure appropriate oversight and high quality healthcare. APHN key leader feedback revealed the specialty lacked clear identification of the critical skills and competencies necessary for entry-level public health nursing practice. There is no standard process to assess and validate APHN competency, nor a formal method to transition new APHNs into autonomous practice (H. Warrington, Personal Communication, October 14, 2014).

The complex nature of public health in the 21st century requires innovation beyond ordinary learning methods to prepare public health professionals for future population level health challenges. Health care organizations are charged with identifying the education and training needs of personnel and implementing appropriate policies and programs to address those needs (IOM, 2003). In support of organizational strategic priorities, Army leadership is interested in exploring educational/training strategies that will improve competence in its public health nurses. Formal nurse residency programs (NRP) are one strategy with documented
positive outcomes. Benefits of an effective NRP include improvements in self-confidence, competency, leadership behaviors, recruitment and retention (Blanzola, Lindeman & King, 2004; Lindsey & Kleiner, 2005; Ulrich et al., 2010). Evidence supporting NRPs also influenced the Institute of Medicine (IOM, 2010) in its *Future of Nursing* report recommendation of implementing NRPs to facilitate transition into a new practice area. A similar recommendation was reached during an assessment of public health nurse experts conducted by the Robert Wood Johnson Foundation (RWJF, 2012). Consensus among focus group participants and key informant interviews identified the use of NRPs as a key strategy in preparing the future practitioners in the field. An effective formal residency program has the potential to develop more competent and confident nurses prepared for independent practice.

New nurse graduates of the Army’s Principles of Military Preventive Medicine course (11 week Army specialty course to become a public health nurse) do not have access to a formal residency/orientation program upon graduation and transition into the role of an APHN. There is consensus in the literature that additional competencies and knowledge beyond those attained in an entry-level educational program are needed to transition into a new professional role (Goode, Lynn, Krsek & Bednash, 2009; IOM, 2010). Current APHN residency/orientation programs are informal and are not available at all Army hospitals where new APHNs are assigned after graduation. A public health nursing gap analysis revealed that current APHN programs vary in length, training opportunities, accessibility to professional development, and quality of preceptorship/coaching (H. Warrington, personal communication, March 16, 2012).

The purpose of this project is to develop and implement a formal one-year residency/orientation program for APHNs. Implementation takes place in three phases – Phase One (Sept–Dec 2015); Phase Two (Jan-April 2016); and Phase Three (May-Aug 2016). NRP
activities were facilitated by an assigned preceptor and aligned with approved competencies and skills established for entry-level public health nursing practice. Professional development sessions were tailored to the needs of the residents based on an assessment of identified knowledge gaps and underdeveloped skills. Outcomes of interest are perceived confidence, competence and skill proficiency in professional practice. Phase One results reported a slight decline in overall mean scores between baseline and 4 month reassessment, but mean score improvements in six assessment categories.

**Theoretical Framework**

The Nursing Intellectual Capital (NIC) theory will guide program planning, implementation and evaluation of the NRP. The theory explains the interrelationships between the practice environment, combined nurses’ skills and experience, along with patient and organizational outcomes. The basic premise is that nursing intellectual capital is derived from two central concepts: nurse human capital and nurse structural capital. The NIC theory also proposes that two environmental factors affect nursing human capital: nurse staffing and employee support for continued professional development (CPD) (Covell, 2008).

Nurse human capital is defined as the knowledge and skills obtained from academic preparation and participation in CPD activities (e.g. formalized NRP for APHNs) (Covell, 2008; Covell & Sidani, 2013). APHNs that complete a formalized NRP will contribute to the organization’s nurse human capital by expanding the collective nurses’ skills and experiences that impact patient and organizational outcomes. Employer support for CPD plays a significant role in influencing nurse human capital. It is defined as an organization’s investment in nursing human capital; this can include financial support to develop or participate in CPD and paid and unpaid time off to learn (Covell, 2008; Covell & Sidani, 2013). This organizational investment
can be translated as resource allocation and funding for the development and sustainment of the NRP. There also needs to be organizational support at the hospital level for APHNs attending the NRP to be in “resident” status for at least 12 months. There is an expectation that as a resident, nurses will not be practicing autonomously and should not be counted in staffing ratios. Organizations need to be prepared to augment staff accordingly for the length of the NRP. Once the resident completes the NRP, they become part of the regular staff and staffing ratios no longer need to be augmented.

The NIC theory describes how NRP success is directly influenced by Army Nurse Corps and hospital level financial, administrative and personnel support. Hospital level nurse staffing support (staff augmentation during NRP) also impacts the success of the NRP. This supportive practice environment leads to successful completion of the NRP and enhanced nurse human capital. The collective growth of nurse human capital results in improved patient outcomes from increased competence, along with confidence in nursing skills and decision making. Organizational outcomes are also improved due to the NRP’s utility in facilitating a smooth and comfortable transition into public health nursing practice. Utilization of the NIC theory to frame the intervention process ensures the appropriate mix of nurse human capital and structural capital support to create an environment of high quality patient care and high organizational achievement. Appendix A provides a depiction describing the NIC theory as it relates to project planning and implementation.

**Literature Review**

The evidence is compelling that by improving the transition experience of new graduate nurses and nurses entering a new specialty, negative role perceptions can be minimized as well as overall competency and confidence in professional practice may be improved (AAACN,
Formal NRPs are one strategy with documented positive outcomes in improving nurses’ transition experiences (Beecroft, Kunzman, & Krozek, 2001; Blanzola et al., 2004; Dilorio, Price, & Becker, 2001; Goode, Lynn, McElroy, Bednash, & Murray, 2013 Halfer & Graf, 2006; Kowalski & Cross, 2010; Williams, Goode, Krsek, Bednash, & Lynn, 2007). The literature describes NRPs as having a wide range of program goals, various program components and processes (Anderson, Hair, & Todero, 2012). This review of the evidence examines the effectiveness of NRPs in improving nurses’ perceived competence and confidence in professional practice. Evidence is also introduced identifying common program components essential in successful NRPs.

A practice environment supportive of continuous professional development is necessary to improve nurse competence and ensure delivery of high quality patient care (Kramer & Schmalenberg, 2004). Kowalski and Cross (2010) facilitated a supportive educational environment by developing and implementing a one-year NRP to improve clinical competency in new graduate registered nurses (RN). In this descriptive study, nurse residents (n=55) completed a two-phased residency program which included an education component, preceptor/preceptee interaction, and peer support. Clinical competency was measured using a Preceptor Evaluation for Resident form developed by the study hospital. Data were collected by preceptors at six different measurement periods throughout the program (3, 6, 8 weeks and 3, 6, 8 months). Investigator results showed significant improvement from week three mean scores (78.1) to month eight mean scores (111.1) (\(p<0.001\)) (Kowalski & Cross, 2010). The evidence suggests enhanced knowledge and improved competence in nurse residents.

Confidence is a consequence of increased competency and is a critical component in a nurse’s ability to remain agile and effectively manage various complex professional situations.
Blanzola et al. (2004) reported outcomes from a 16-week nursing internship program developed by the United States Navy. This was the only study found describing the implementation of an NRP in a military nursing population. The program’s objective was to increase new graduate nurses’ competency and facilitate a smooth transition into Navy Medicine culture (Blanzola et al., 2004). In a quasi-experimental design, the control (no NRP participation) and intervention (NRP participation) groups were assigned based on their arrival to the Navy hospital for duty. Organizational attributes and clinical competencies were measured using a survey instrument developed by the Navy hospital. The intervention and control groups were evaluated 4 times during the course of the internship program by staff and peers. Intervention and control groups also completed self-assessments before the program start, after the program, and six months post assignment to their respective units. Significant differences were noted in the intervention group’s self-evaluation at program start and at program completion, suggesting increased clinical confidence with their role. The intervention group also had significantly higher mean evaluators’ competency scores at the end of the internship ($p=0.013$) and at six months post unit assignment ($p=0.005$) than the control group. Results supported the hypothesis that intervention participants would score higher on organizational core competencies, as measured by self and peer evaluations, than nurses who did not attend the program.

Through appropriate organizational support, resources and leader commitment, long-term confidence and competence improvements can be achieved through sustained employee participation in a NRP. A ten-year review of the American Association of Colleges of Nursing (AACN) and the University Health System Consortium (UHC) graduate residency program provided longitudinal evidence supporting the use of NRPs as an effective strategy in improving competence and confidence (Goode et al., 2013). The AACN/UHC NRP was a one-year
program delivered using a standardized, evidence-based curriculum focused on leadership, patient safety, outcomes and the professional role (Goode et al., 2013). Data presented included survey results from new graduate residents that participated in the NRP from 2002 through 2012. The Casey-Fink Graduate Nurse Experience Survey (CFNES) was the instrument used to measure overall confidence and competence. Total mean scores of the CFNES between program start and completion show significant increases over time (p<0.001). These results remained consistent across the years of evaluation suggesting improved overall confidence and competency in residents at program’s end.

Studies describe NRPs with a variety of programmatic designs and processes. Through extensive evidence reviews, common elements to successful NRPs have been identified and include use of preceptors, reflective journaling and program length of at least one year. In several studies where preceptors were assigned to nurse residents, the selection of a preceptor was found to be essential to the success of the NRP (Beecroft et al., 2001; Blanzola et al., 2004; Dilorio et al., 2001; Goode et al., 2013; Halfer & Graf, 2006; Kowalski & Cross, 2010; Williams et al., 2007). Messmer, Jones, and Taylor (2004) recommended that preceptors be competent or proficient nurses, but do not have to be experts. Other programs selected preceptors based on expert knowledge and commitment to the program, its staff, and supporting the growth and development of nurses in the organization (Cavanaugh & Huse 2004; Beecroft, Hernandez & Reid, 2008).

The use of journaling to develop self-regulation skills has become a common component of NRPs (Kuiper, 2004; Anderson, Linden, Allen & Gibbs, 2009). Reflective journaling is a technique to promote critical thinking in practice. Journaling provides a platform for nurses to
reflect on recently learned concepts and apply learned principles to practice situations and critically evaluate their performance and decision-making throughout the NRP.

Residency programs in the literature vary in length from eight weeks (Owens et. al., 2001) to 18 months (Keller et al., 2006). A recent study by Kramer et al. (2013) provided a current synthesis of NRPs and reported that NRPs one year in length provided the best transition experience for participants.

Participation in a NRP appears to be associated with increased confidence in professional performance (see Appendix B) (Beecroft et al., 2001; Blanzola et al., 2004; Dilorio et al., 2001; Goode et al., 2013; Halfer & Graf, 2006). Regarding improved competence, Blanzola et al. (2004) demonstrated improved perceived and evaluator validated competence with participation in a NRP. Kowalski and Cross (2010) reported a significant increase in preceptor assessed competence after completion of a one year residency program. Several other studies showed improved perceived competence after completion of a NRP (Dilorio et al., 2001; Beecroft et al., 2001; Halfer & Graf, 2006; Williams et al., 2007; Goode et al, 2013).

Overall, the findings from the literature review support the implementation of a NRP to improve confidence and competence in professional practice. Army Nurse Corps leader observations and feedback further validate the need to implement a NRP for public health nurses to effectively transition into practice. The project and purpose are aligned with Army Nurse Corps strategic priorities and anticipated outcomes are expected to facilitate the improvement of early professional development and training for APHNs across the Army.
Methods

Study Design, Setting and Project Population

The implementation of a formal nurse residency program for Army public health nurses is a quality improvement project. An uncontrolled single group, pre-posttest design was used to evaluate the primary program outcomes and overall satisfaction. Nurse residents will complete perceived confidence and competence questionnaires at month zero, month four, month eight, and at program completion (month 12). In addition, an overall program evaluation will be administered at program completion. Results presented in this paper only report Phase One data. The projected project timeline is located in Appendix C.

The project sample was attained through a convenience sample including all July 2015 nurse graduates of the Principles of Military Preventive Medicine course. This produced a sample size of two nurses. Program implementation occurred at the graduates’ respective follow-on locations. As a result, Phase One implementation occurred in two locations: An APHN section located at an Army Community Hospital in the Western part of the US and an APHN section at an Army Medical Center in the Southeastern part of the US.

Procedures

The program includes a didactic component and a clinical/public health experience component. The didactic component consists of monthly professional development sessions, a quarterly journal club meeting, and reflective journaling. The clinical/public health experience consists of regularly scheduled opportunities to learn and practice APHN specific tasks and skills under the guidance of a more experienced APHN. Each was assigned a preceptor at the beginning of the program. Assigned preceptors provide daily oversight of the resident assuring guidance, instruction, insight on professional nursing resources and feedback. The chief of the
APHN section at the pilot site was responsible for selecting the preceptor for each resident. Selection criteria for preceptors included: nurses that are technically proficient, have solid oral and written communication skills, possess an innate coaching/teaching ability and have a genuine interest in developing future APHNs. Expectations of preceptors included: identifying a variety of population-based learning opportunities for the resident’s clinical experience (hospital sections, installation and community agencies); facilitating ongoing communication with various public health agencies, APHN leadership and the resident to ensure appropriate progression in program; assisting resident in developing knowledge and skills for population-based practice; and modeling professional practice.

**Monthly professional development sessions.** The project lead was responsible for the creation of all program materials including professional development sessions. Sessions were informed and designed based on APHN key leader feedback identifying new graduate knowledge gaps and underdeveloped skills. The Principles of Military Preventive Medicine curriculum was also reviewed to identify public health nursing topic areas with limited coverage, which also informed session topic selection. Sessions are one hour in length and delivered in a web-based format (PowerPoint slides with presenter audio embedded). They are accessible via the US Government Information System milBook. This is a Department of Defense professional networking and collaboration site that allows for the sharing of content on a secure platform. A webpage on this platform was created for preceptors and titled *APHN NRP Preceptor Resource Page.* All program materials and professional development sessions are stored on this page. A second webpage for residents was also created, titled *APHN NRP Resident Resource Page.* Monthly professional development sessions and resident specific materials are stored on this page.
The pilot site APHN chief or preceptor accessed the training via the milBook APHN NRP Preceptor Resource Page and initiated training with the residents. Monthly training sessions consisted of a web based lecture and the pilot site APHN chief or preceptor facilitating a post lecture discussion or exercise using accompanying lesson notes. The professional development sessions topics include: 1) Operating “In the Big Picture” – Understanding Civilian/Army/DoD Strategic Frameworks that Guide Public Health Practice, 2) Building and Sustaining Collaborations and Partnerships, 3) DoD Efforts to Improve the Lifespace, 4) Locating, Interpreting, and Translating the Evidence, 5) Take Charge of Your Professional Development; 6) Optimizing the Use of Population-based Data Sets in Practice, 7) Presenting Public Health to Senior Leaders, 8) “We’re Here to Support You” – Understanding the Capabilities of the Army Public Health Center, 9) Marketing the Value of APHN, and 10) Optimizing the APHN role in Public Health Preparedness. Professional development sessions are scheduled once a month from Oct 2015-July 2016. Lesson notes and presentations completed during Phase One of implementation are provided in Appendix D. All professional development sessions went through a formal review process beginning with an expert panel of eight APHNs to ensure content validity and relevance to APHN practice. Once the initial expert review is completed, sessions were then be reviewed by and approved through the Army Public Health Center Command Review and Clearance to further validate content and ensure content adhered to Army communication policies and was appropriate for unlimited distribution.

**Journal club.** The pilot site APHN staff facilitated quarterly journal club meetings with residents. Facilitation of a journal club provides a platform for residents to practice critical thinking skills keeping current with public health research and translation science, learn to evaluate the strength of evidence and promote implementation of new knowledge into practice.
Articles were pre-selected and accessible from the *milBook* APHN NRP Preceptor Resource page. It is the responsibility of the preceptor to schedule journal club dates and included them on the resident’s rotation schedule. All APHN section staff were invited to attend. Residents attended as a requirement of program participation.

**Resident journal.** Residents kept weekly journal logs describing their program experiences. The use of journaling to develop self-regulation skills has become a common component to NRPs (Kuiper, 2004; Anderson, Linden, Allen & Gibbs, 2009). Training residents to use self-regulation has the potential to improve clinical reasoning, support the development of competencies, and enhance professional decision making (Kuiper, 2004). Journal entries were reviewed by the project lead in an effort to gain greater insight on program processes, resident satisfaction, and enhance the meaning of program evaluation quantitative data. Journal entries were also reviewed by the preceptor. Entries were used by the preceptor to facilitate discussion during the monthly scheduled resident/preceptor meetings. This meeting serves as a forum for the preceptor and resident to discuss recent learning experiences, resident progress, issues, concerns and any needed modifications to the clinical/public health rotation schedule to improve the overall residency experience.

**Rotation schedule and clinical/public health experiences.** Within the first 30 days of the resident being assigned a preceptor, the pair completed a tentative rotation schedule outlining public health experiences planned for the duration of the program. Experiences focused on core APHN program areas and overarching preventive medicine roles. Residency experiences will include dedicated time practicing skills and gaining information in the following areas:

- Human Immunodeficiency Virus (HIV) Program Management
- Sexual Transmitted Infection (STI) Program Management
- Latent Tuberculosis Infection (LTBI) Program Management
- Communicable Disease Reporting and Investigation
The preceptor guided residency experience provided nurses the opportunity for practical application of skills/tasks in the community setting with an experienced APHN within reach for additional guidance. The ability for routine practice of skills facilitates an increased sense of confidence and development of competence in new APHNs.

Preceptors monitor progress in and validate competences using the *Entry Level APHN Competency Assessment and Validation Checklist* (Appendix E). This tool was developed specifically for this program and documents the required tasks/skills needed for a competent newly practicing APHN. The APHN expert panel reviewed the tool and came to a consensus that the tasks/skills included reflect the required task/skills of a newly practicing APHN. Tasks/skills are aligned with the Quad Council Core Competencies for Public Health Nurses (Quad Council, 2011) and the Essential Public Health Services (CDC, 2014). Residency experiences are planned to expose residents to opportunities that will allow them to engage in the skills/tasks outlined on the tool which demonstrates proficiency in the aligned competency. The tool is used throughout the course of the program as a tracking mechanism to assess and validate skills and competencies acquired.

**Progress meetings.** The project lead provides implementation oversight by conducting monthly progress meetings with preceptors. Residents also meet with the project lead quarterly. Residents and preceptors meet separately with the project lead via the Army’s web conferencing
electronic platform. Meetings focus on program satisfaction. There are also discussions on issues, concerns, and recommendations to refine program elements.

**Human Subjects Protection**

The intent of this project is to implement a program pilot and evaluate its effectiveness. There will be no research conducted during any part of the pilot. Data collection is for the purpose of quality improvement and refinement of program processes with the anticipation of future program expansion. Data collection tools do not collect any personal identifiable information nor protected health information. The benefits of participation include additional education and training beyond the traditional entry level APHN preparation, opportunity for practical application in population-based practices and increased access to APHN experts facilitating a smoother transition into practice. This project has been reviewed by the University of Maryland, Baltimore Institutional Review Board (IRB) and given a determination of Non-Human Subjects Research. The Army Medical Department Center and School IRB also reviewed this project proposal and concurred with University of Maryland, Baltimore’s determination.

**Data Collection**

The primary outcomes of perceived confidence and competence in professional practice are being evaluated using the *APHN Readiness Assessment Tool*. This tool was developed specifically for this project and adapted from the Survey of Public Health Nurses in Local Health Departments (Issel, Baldwin, Lyons, & Madamala, 2006) and Casey/Fink Readiness for Practice Tool (Fink, Krugman, Casey, & Goode, 2008). Selected items were revised to reflect the unique practice and requirements of Army Public Health nursing. Approval was obtained to use both instruments in the evaluation of this project. The original tools both have established reliability
and validity. The overall internal consistency of the original tools is 0.90-0.97 and 0.89, respectively.

The APHN Readiness Assessment Tool (Appendix F) is a 75 item instrument divided into two sections. In the first section, 61 five-point Likert competency specific questions are aligned with the 10 essential public health services. The second section evaluates confidence in practice with fourteen 4-point Likert confidence specific questions. The paired t-test was performed to evaluate any differences between month zero and month four (Phase One) scores on the APHN Readiness Assessment tool.

Program processes will be evaluated using the APHN NRP Program Evaluation Tool (Appendix G). This tool will be used to assess the residents’ satisfaction with the program as a whole and will be administered at program completion. This tool was developed specifically for this pilot and consists of 39 items (33 five-point Likert questions and six multiple choice questions), divided into four areas: preceptor satisfaction, learning environment satisfaction, work environment satisfaction and recommendations for program improvement. The Likert categories on the APHN NRP Program Evaluation Tool will be assigned a numerical value 1= Very Dissatisfied to 5=Very Satisfied, then mean satisfaction scores will be calculated. Satisfaction score between the two pilot sites will be evaluated using an independent samples t-test. The significance level for t-test results will be p<0.05.

Data Analysis and Results

In Phase One (Sept – Dec 2015), both pilot sites reported easy integration and adherence of program processes resulting in: three professional development sessions completed, 16 weeks of documented resident journaling, one journal club meeting conducted, four face to face preceptor/resident update meetings and continued use of the newly developed APHN
competency assessment and validation checklist. Outcome metrics of perceived competence and confidence were assessed using the APHN Readiness Assessment tool.

Responses from the residents’ month zero and month four APHN Readiness Assessments were entered into Microsoft Excel version for statistical analysis at the completion of Phase One. The mean age residents was 37.5 years. Neither resident had public health nursing experience prior to completing the Principles of Military Preventive Medicine course. The highest level of education for both residents was a Bachelor of Science in Nursing degree. The mean number of years of experience as a registered nurse was 5.75 years (Table 1).

At baseline, the overall mean score for part one (competency specific questions) of the APHN Readiness Assessment was 2.43 out of a possible mean score of five. The four month re-assessment mean score was 2.42. There was no significant difference between overall baseline and four month mean scores (t=0.1, p=.94). Mean score improvement was noted in six of the ten essential public health services categories. Those categories include: Essential #2 (Diagnose and Investigate Health Problems), Essential #3: (Informing, Educating and Empowering Populations at Risk), Essential #5 (Develop Policies that Support Community Efforts), Essential #6 (Enforcement of Laws and Regulations), Essential #7 (Linking People to Services), Essential #10 (Researching Innovative Solutions). There was no statistical significance measured in public health services category mean score improvements (Table 2).

The Part two (confidence specific questions) overall mean score at baseline was 3.35. The four month re-assessment score was 3.28. There was no significant difference between overall baseline and four month mean scores (t=1, p=0.5). Mean score improvement was noted in two of fourteen confidence specific questions. That was question one, “I feel comfortable communicating with line commanders/other installation stakeholders about public health related
issues” (Baseline $M=2.5$ vs. Four Month $M=3.0$) and question six, “I am comfortable communicating and coordinating care with interdisciplinary MTF members” (Baseline $M=2.5$ vs. Four Month $M=3.0$). No significant differences were noted between baseline and four month re-assessment mean scores in any questions.

**Discussion**

After four months of pilot NRP implementation, there was no significant difference in mean assessment scores. This pattern was in overall scores from both sections of the APHN Readiness Assessment tool (competence and confidence questions). During these four months, residents were still adjusting from moving to a new duty assignment in addition to becoming acclimated to a new work environment. As an Army nurse, when one is re-assigned to a new duty location every two to three years, the first four to six months of arrival are critical in that there is a sense of urgency to become familiar with hospital protocol, policies and to begin forming relationships with superiors, colleagues, and other staff in an effort to ensure smooth integration with the team. This is further complicated by transitioning into a new practice role, such as public health nursing.

Residents described this phase of the program as a very exciting but overwhelming time. At the start of the pilot, residents were very excited for the opportunity to be actively engage in the field practicing the knowledge and applying the skills attained during the Principles of Military Medicine course. It is during the first four months that residents participated in professional developments session exposing them to the current state of Army Public Health Nursing and its alignment with larger Army and Department of Defense (DoD) public health initiatives. They also were introduced to concepts of collaboration and partnership building which are essential in facilitating leader/community support and relationships needed to
implement and sustain public health programs. These principles can also be leveraged when
developing and influencing public health policy. There was a great deal of content introduced
and can be seen as very overwhelming. This was coupled with the overall fast pace work
environment of the APHN.

The clinical/public health experience component of the program was another eye opener
for residents. Residents hit the ground running with their preceptor completely engaged in the
full range of tasks and skills required by APHNs. In the first four months of the program,
residents had opportunities to practice tasks and skills in several APHN program areas. Based on
their didactic training in the Principles of Military Preventive Medicine course, residents felt
adequately prepared to execute many tasks (e.g., Child Youth and School Services activities).
Residents also reported at times feeling frustrated because they felt inadequately prepared for
other APHN specific tasks (e.g., Community Health Needs Assessment methodology
development and disseminating public health information to leaders). Regarding some aspects
of their training, residents perceived differences between what was taught in the course as
opposed to the realities of practice once in the field. They often spoke about having to re-learn
some processes because executing what was taught in the course was not feasible in the field.
This further exacerbated the feeling of being overwhelmed, frustrated and unsure about their
practice as a public health nurse.

Phase One results and qualitative feedback are consistent with a phenomena described in
the literature called “Transition Shock.” This concept was introduced as part of the Stages of
Transition Theory. In her work, Duchscher (2008) attempts to explain the initial role transition
experience in new nurse graduates. There are three stages of transition. The first stage is
“Doing”. This period is the most turbulent time in the transition experience and describes the
first three to four months of practice after completing professional schooling. This is when “Transition Shock” occurs. This stage includes a large amount of professional and personal anxiety as nurses work through the processes of discovery, learning, performing, reflecting, modifying and re-evaluation (Duchscher, 2009). A nurse’s lack of experience is exposed and that brings on a sense of insecurity and lack of confidence in practice. As nurses experience the stages of transition and then transition to the “Being” and “Knowing” stages, a consistent advancement in thinking, skill proficiency and knowledge level is noted. Nurses are re-energized through their improved professional growth and are motivated to continue seeking challenging practice opportunities preparing for long-term career progression (Duchscher, 2008).

The decline in mean Readiness Assessment scores and qualitative feedback suggests that residents experienced some degree of Transition Shock during Phase One of the program. It can be argued that participation in the pilot program lessen the effects. If resident experiences continue to model the Stages of Transition theory, it is anticipated that mean assessment scores from Phase Two and Three will improve suggesting residents are becoming more confidence and competent in practice.

Limitations

The most significant project limitation is the small sample size. The extremely small sample size inhibits the ability to ensure adequate power to detect differences. This limitation impacts the validity and reliability of Phase One quantitative data. However, the sample is representative of the average number of new graduate nurses that complete the Principle of Military Medicine course and begin the practice transition process each cycle.

External validity is weakened due to the limited generalizability of results. This NRP was specifically designed for APHNs. This is a very specialized group of nurses that function in
an expanded capacity beyond that of the civilian public health nurse. Although they share many similarities in practice, APHNs also provide support to military communities that includes providing essential public health services in wartime or humanitarian environments. Therefore, results from this project are not generalizable beyond the Army Public Health nursing population.

**Implications for Practice**

The current state of initial education and training for APHNs isn’t aligned with Army Medicine strategic priorities. Based on March 2015 formative assessment data, current APHN residency/orientation programs are informal, sporadically offered, vary in length, and in training opportunities. The large degree of program variance and lack of standardization is not aligned with Army Medicine's efforts of organizational transition from a healthcare system to a “System for Health”. The establishment of a formalized residency program will reduce the variance in delivery of entry-level APHN education and training along with improve overall satisfaction in the new APHN’s transitional experience – supporting the Army Medicine 2020 Campaign Plan (Line of Effort #4 – Leader Development).

This project is the first attempt to formalize and standardize processes related to the professional transition of new nurse graduates of the Principles of Military Preventive Medicine course into public health nursing practice. It also provides an opportunity to evaluate tools designed to track competency assessment/validation and evaluate evidence-based NRP processes with a public health nurse population.

**Conclusion**

The APHN specialty is made up of 140 active duty Army officers currently serving in military communities throughout the world. With so much dispersion among personnel, it is
difficult to assure a competence workforce. The current APHN practice environment is unable to support the transition of new APHNs into their new practice role. In an effort to address this gap in the practice infrastructure, an NRP tailored to the needs to the APHN population was implemented. A formal residency/orientation program provides a supportive environment for APHNs to practice and hone required entry level skills while gaining confidence and competence in public health nursing practice. Although Phase One results report a slight decline in overall mean scores between baseline and 4 month reassessment, mean score improvements were reported in many assessment categories. As the pilot program progresses and residents continue to grow professionally and technically, it is anticipated that overall mean assessment scores will improve. A follow-up to this report will be written at program completion in August 2016. Based on final program results, Army Nurse leadership will move to formally adopt this program as standard practice for newly transitioning APHNs.
References


Lindsey, G. & Kleiner, B. (2005). Nurse residency program: an effective tool for recruitment and


Table 1
Resident Demographic Data (N=2)

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<td>30-45</td>
<td>37.5 (7.5)</td>
<td>1 (50%)</td>
</tr>
<tr>
<td>40-46</td>
<td></td>
<td></td>
<td>1 (50%)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td>1 (50%)</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td>1 (50%)</td>
</tr>
<tr>
<td>Years Active Duty Service at start of Principles of Military Preventive Medicine Course</td>
<td>8-23</td>
<td>15.5 (7.5)</td>
<td></td>
</tr>
<tr>
<td>8-10</td>
<td></td>
<td></td>
<td>1 (50%)</td>
</tr>
<tr>
<td>11-20</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>21-23</td>
<td></td>
<td></td>
<td>1 (50%)</td>
</tr>
<tr>
<td>Years of Nursing Experience</td>
<td>2.5-9</td>
<td>5.75 (3.25)</td>
<td></td>
</tr>
<tr>
<td>2-4</td>
<td></td>
<td></td>
<td>1 (50%)</td>
</tr>
<tr>
<td>5-9</td>
<td></td>
<td></td>
<td>1 (50%)</td>
</tr>
<tr>
<td>Years public health experience at start of Principles of Military Preventive Medicine Course</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No prior experience (Zero Years)</td>
<td></td>
<td></td>
<td>2 (100%)</td>
</tr>
<tr>
<td>Highest Level of Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BSN</td>
<td></td>
<td></td>
<td>2 (100%)</td>
</tr>
</tbody>
</table>
Table 2
Comparison of Phase One mean scores on the APHN Readiness Assessment Tool (N=2)

<table>
<thead>
<tr>
<th>APHN Readiness Assessment Tool Score</th>
<th>Month 0 Mean (SD)</th>
<th>Month 4 Mean (SD)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part One Total Score</td>
<td>2.43 (0.91)</td>
<td>2.42 (0.88)</td>
<td>0.94</td>
</tr>
<tr>
<td>Essential #1: Monitoring Community Health Status</td>
<td>1.77 (0.67)</td>
<td>1.60 (0.72)</td>
<td>0.5</td>
</tr>
<tr>
<td>Essential #2: Diagnose and Investigate Health Problems</td>
<td>1.5 (0.5)</td>
<td>2.0 (0)</td>
<td>0.5</td>
</tr>
<tr>
<td>Essential #3: Informing, Educating and Empowering Populations at Risk</td>
<td>2.1 (0.54)</td>
<td>2.2 (0.75)</td>
<td>0.87</td>
</tr>
<tr>
<td>Essential #4: Mobilizing Community Partnerships</td>
<td>3.55 (0.74)</td>
<td>3.25 (0.77)</td>
<td>0.5</td>
</tr>
<tr>
<td>Essential #5: Develop Policies that Support Community Efforts</td>
<td>2.5 (0.65)</td>
<td>2.6 (0.76)</td>
<td>0.5</td>
</tr>
<tr>
<td>Essential #6: Enforcement of Laws and Regulations</td>
<td>2.5 (0.5)</td>
<td>2.6 (0.48)</td>
<td>0.5</td>
</tr>
<tr>
<td>Essential #7: Linking People to Services</td>
<td>2.4 (0.49)</td>
<td>2.6 (0.49)</td>
<td>0.70</td>
</tr>
<tr>
<td>Essential #8: Assuring a Competent Workforce</td>
<td>2.9 (1.17)</td>
<td>2.9 (1.17)</td>
<td>No change</td>
</tr>
<tr>
<td>Essential #9: Evaluating Health Services</td>
<td>2.25 (0.43)</td>
<td>2.1 (0.43)</td>
<td>0.5</td>
</tr>
<tr>
<td>Essential #10: Researching Innovative Solutions</td>
<td>2.75 (0.83)</td>
<td>3.0 (0.71)</td>
<td>0.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>APHN Readiness Assessment Tool Score</th>
<th>Month 0 Mean (SD)</th>
<th>Month 4 Mean (SD)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part Two Total Score</td>
<td>3.35 (0.65)</td>
<td>3.28 (0.51)</td>
<td>0.5</td>
</tr>
<tr>
<td>Q1: I feel comfortable communicating with line commanders/other installation stakeholders about public health related issues.</td>
<td>2.5 (0.5)</td>
<td>3 (0)</td>
<td>0.5</td>
</tr>
<tr>
<td>Q2: I feel comfortable teaching health related topics to Soldiers.</td>
<td>4 (0)</td>
<td>3.5 (0.5)</td>
<td>0.5</td>
</tr>
<tr>
<td>Q3: I feel confident in my ability to problem solve.</td>
<td>3.5 (0.5)</td>
<td>3.5 (0.5)</td>
<td>No Change</td>
</tr>
<tr>
<td>Q4: I am comfortable asking for help.</td>
<td>4 (0)</td>
<td>4 (0)</td>
<td>No Change</td>
</tr>
<tr>
<td>Q5: I use current evidence to make public health nursing decisions.</td>
<td>3 (0)</td>
<td>3 (0)</td>
<td>No Change</td>
</tr>
<tr>
<td>Q6: I am comfortable communicating and coordinating care with interdisciplinary MTF team members.</td>
<td>2.5 (0.5)</td>
<td>3 (0)</td>
<td>0.5</td>
</tr>
<tr>
<td>Q7: I feel comfortable teaching health related topics to family members, retirees, and DA Civilians.</td>
<td>4 (0)</td>
<td>4 (0)</td>
<td>No Change</td>
</tr>
<tr>
<td>Q8: I am comfortable taking action to solve problems.</td>
<td>3.5 (0.5)</td>
<td>3.5 (0.5)</td>
<td>No Change</td>
</tr>
<tr>
<td>Q 9: I feel confident identifying actual or potential safety risks to my patients.</td>
<td>4 (0)</td>
<td>3.5 (0.5)</td>
<td>0.5</td>
</tr>
<tr>
<td>Q 10: I feel comfortable communicating with patients in the clinical setting.</td>
<td>4 (0)</td>
<td>3.5 (0.5)</td>
<td>0.5</td>
</tr>
<tr>
<td>Q 11: I feel confident in my ability to link beneficiaries to resources on or off the installation.</td>
<td>2.5 (0.5)</td>
<td>2.5 (0.5)</td>
<td>No Change</td>
</tr>
<tr>
<td>Q 12: I am confident in my ability to articulate APHN’s role and value added to military communities.</td>
<td>3 (0)</td>
<td>3 (0)</td>
<td>No Change</td>
</tr>
<tr>
<td>Q 13: I feel comfortable collaborating with installation stakeholders on public health related issues.</td>
<td>3 (0)</td>
<td>3 (0)</td>
<td>No Change</td>
</tr>
<tr>
<td>Q 14: I feel am confident in my ability to practice as a competent public health nurse.</td>
<td>3.5 (0.5)</td>
<td>3 (0)</td>
<td>0.5</td>
</tr>
</tbody>
</table>
Appendix A

Modified Structure of the Nursing Intellectual Capital Theory

## Appendix B

**Evidence Strength and Quality Analysis Using the Melnyk – Fineout-Overholt Evidence Grading Criteria**

<table>
<thead>
<tr>
<th>Source (Authors, year)</th>
<th>Objective/Study intervention or exposures compared</th>
<th>Design</th>
<th>Sample</th>
<th>Outcomes Studies (how measured)</th>
<th>Results</th>
<th>Evid. Rating (1-7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beecroft, P., Kunzman, L., &amp; Krozek, C. (2001)</td>
<td>1) Facilitate transition of new graduates nurse into practice. 2) Prepare a beginning level staff nurse who is confident and provides competent and safe patient care. 3) Increase the commitment and retention of new graduate nurses within the organization</td>
<td>Quasi-experimental with a control and experimental group</td>
<td>Control n=45  Intervention n=50</td>
<td>1) Transition of the Graduate Nurse to Professional RN Instrument(s) used: Professional Subscale of Corwin’s Nursing Role Conception Scale &amp; Schutzenhofer Professional Nursing Autonomy Scale 2) Confidence in Providing Competent and Safe Patient Care Instrument used: Skills Competency Self-Confidence Survey &amp; Slater Nursing Competencies Rating Scale 3) Commitment and Retention of Graduate Nurses within the Organization Instruments used: Organizational Commitment Questionnaire &amp; Anticipated Turnover Scale</td>
<td>Confidence in Providing Competence Care: Intervention group demonstrated continuous increases in perceived confidence regarding competence (Baseline = 87, Program Completion = 123, Six months Post Program = 132). Retention: Control group more likely to voluntarily terminate employment at 6 months compared to the nurse interns (p=0.01).</td>
<td>4</td>
</tr>
<tr>
<td>Study</td>
<td>Objective</td>
<td>Design</td>
<td>Sample</td>
<td>Instruments</td>
<td>Findings</td>
<td></td>
</tr>
<tr>
<td>-------</td>
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<td>-------------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>Blanzola, C., Lindeman R., &amp; King, M. (2004)</td>
<td>To increase new graduate nurses’ competency and facilitate their smooth transition to the Navy culture.</td>
<td>Quasi-experimental design with a control and experimental group</td>
<td>Control n=10, Intervention n=8</td>
<td>1) Organizational Attributes&lt;br&gt;Instrument: Organization developed survey&lt;br&gt;2) Clinical Competence&lt;br&gt;Instrument: Organization developed survey</td>
<td>Clinical Competence: Intervention group with higher mean evaluator competency scores at end of program (p=0.013) and at six months post unit assignment (p=0.005) than control group. Confidence: Improvement in Neuroscience Nursing Self-Efficacy Scale mean scores (Baseline = 5.82; Program Completion = 8.38), suggesting interns’ confidence in caring for persons with neurological disorders was increased.</td>
<td></td>
</tr>
<tr>
<td>Halfer, D. &amp; Graf, E. (2006)</td>
<td>To examine what are the sources of new graduate nurse job satisfaction and dissatisfaction; their perceptions of the work environment; and do these perceptions change with length of time in their positions?</td>
<td>Descriptive Cohort Design</td>
<td>n=84 graduate nurses hired over a one year period</td>
<td>1) Graduate confidence in delivery of competent nursing care&lt;br&gt;Instrument: Halfer-Graf Job/Work Environment Nursing Satisfaction Survey (Data collected over 3, 6, 12, 18 months)&lt;br&gt;2) Perceptions of the work environment&lt;br&gt;Instrument: Halfer-Graf Job/Work Environment Nursing Satisfaction Survey (Data collected over 3, 6, 12, 18 months)</td>
<td>Graduate confidence in delivery of competent nursing care: Significant improvement in mean scores addressing knowledge and skills to perform job (p=0.01). Perceptions of the work environment: Although not statistically significant, mean score improvements were seen in the following variables: Ability to participate in professional development sessions (Baseline 3.21; 18 month 3.71).</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Objective</td>
<td>Methodology</td>
<td>Sample Size</td>
<td>Measures</td>
<td>Results</td>
<td>References</td>
</tr>
<tr>
<td>-------</td>
<td>-----------</td>
<td>-------------</td>
<td>-------------</td>
<td>----------</td>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>Kowalski, S. &amp; Cross, C. (2010)</td>
<td>To examine if the level of clinical competency and critical thinking ability improve in</td>
<td>Descriptive cohort study</td>
<td>n=55</td>
<td>1) Clinical competency and critical thinking ability Instrument: Preceptor Evaluation of Resident Form Developed by the hospital’s</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### SCHOLARLY PROJECT

<table>
<thead>
<tr>
<th>Goode, C., Lynn, M., McElroy,</th>
<th>The study aim was to examine outcomes of 10</th>
<th>Descriptive Cohort study</th>
<th>n=1,016</th>
<th>1) <strong>Overall confidence and competence over the 10 year period</strong></th>
<th>Overall confidence and competence over the 10 year period: Significant increase in</th>
</tr>
</thead>
</table>

**new graduate nurses during a residency program; does the level of stress and anxiety of new RNs decrease during the course of the residency program; do new graduate RNs experience positive professional transition during the residency program; what percent of new graduate RNs remain employed during a one year residency program.**

**education staff**

2) **Perceived Resident Stress**  
   Instrument: Pagana’s Clinical Stress Questionnaire

3) **Perceived Resident Anxiety**  
   Instrument: Spielberger’s State-Trait Anxiety Inventory

4) **Resident’s Perceived Professional Transition**  
   Instrument: Casey-Fink Graduate Nurse Experience Survey

5) **Nurse Retention**  
   Measurement: Hospital’s Administration Records

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**improvement in all items, however, only five of the nine items showed statistically significant improvement.**

**Perceived Resident Stress:**  
   Pagana “Threat” mean scores significantly decreased (p=0.004). Pagana “Challenge” mean scores decreased also, but were not statistically significant (p=0.195).

**Perceived Resident Anxiety:**  
   Overall anxiety mean scores decreased (34 vs. 14), but they were not significant.

**Resident’s Perceived Professional Transition:**  
   Increases in mean scores were noted in three of the four Casey-Fink sub scales (Support, Patient Safety, and Communication/Leadership). Only one was found to be statistically significant increase (Communication/Leadership). (p=0.022).

**Nurse Retention:**  
   At the time of article publication, the retention rate was 96%.
| D., Bednash, G., & Murray, B. (2013) | years of research on the University Health System Consortium/ American Association of Colleges of Nursing post-baccalaureate new graduate nurse residency program and to report lessons learned | Instrument: Casey-Fink Graduate Nurses Experiences Survey  
2) Nurse Retention over the 10 year period  
Measurement: Hospital Administration Data | overall mean scores over the course of the 10 year period (p<0.001).  
Nurse Retention over the 10 year period: Retention rates increased from 88% (first year of program) to a current rate of 94.6%. |
<table>
<thead>
<tr>
<th>Source (Authors, year)</th>
<th>Strengths</th>
<th>Weakness</th>
<th>Level of Quality</th>
</tr>
</thead>
</table>
2) Use of previously validated data collection tools  
3) Use of various instruments to evaluate outcomes | 1) No power calculation  
2) Limited generalizability (Pediatric nurses) | B |
2) Use of various instruments to evaluate outcomes | 1) No power calculation  
2) No analysis using inferential statistics  
3) Limited generalizability (Neuroscience nurses) | C |
2) Small sample size  
3) Limited generalizability (Navy nurses) | C |
| Halfer, D & Graf, E. (2006) | 1) Newly developed survey instrument was evidenced-based  
2) Validity and reliability testing was conducted on the survey instrument | 1) No power calculation  
2) Survey attrition impacted the significance of several variables that changed over time | B |
2) Use of various instruments to evaluate outcomes  
3) Standardized residency program format | 1) No power calculation | B |
2) Use of various instruments to evaluate outcomes | 1) No power calculation  
2) Small sample size | B |
2) Standardized residency program format | 1) No power calculation | B |
Evidence Synthesis

<table>
<thead>
<tr>
<th>Level of Evidence</th>
<th>Number of Studies</th>
<th>Summary of Findings</th>
<th>Overall Quality</th>
</tr>
</thead>
</table>
| Level 4           | 2                 | 1) Increased perceived confidence in professional performance after participation in a nurse residency program.  
                        2) Improved perceived and evaluator validated competence with participation of a nurse residency program. | B |
| Level 6           | 5                 | 1) Increased confidence in professional performance after participation in a nurse residency program.  
                        2) Improved perceived competence after completion of a nurse residency program.  
                        3) Improved preceptor assessed competence after completion of a nurse residency program. | C |
### Appendix C

Projected NRP Pilot Project Timeline

<table>
<thead>
<tr>
<th>Goal</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finalize Project Proposal</td>
<td>5/1</td>
<td>-</td>
</tr>
<tr>
<td>Present proposal and secure committee approval</td>
<td>5/14 @ 0900</td>
<td>-</td>
</tr>
<tr>
<td>Submit to IRB Committee</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Conduct Phase One of Project</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Analyze, Synthesize and Evaluate Findings</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prepare Final Scholarly Project Manuscript</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Appendix D

Army Public Health Nursing
Pilot Nurse Residency Program Lesson Notes
Professional Development Session #1: Operating in the Big Picture - Understanding Civilian/Army/DoD Strategic Frameworks that Guide Practice

Objectives: Army Public Health Nurses (APHN) will understand how APHN’s mission aligns with and supports Department of the Army (DA) and Army Medical Department (AMEDD) and Army Nurse Corps’ (ANC) missions and priorities. APHNs will develop a written statement that articulates the links between installation-level APHN practice and installation-level nursing, military treatment facility, and senior Army commander missions.

A. Strategic Mission Overviews
   1. Department of the Army (DA) Mission: The Army’s mission is to fight and win our Nation’s wars by providing prompt, sustained land dominance across the full range of military operations and spectrum of conflict in support of combatant commanders.
   2. Army Medical Department (AMEDD) Mission: Army Medicine provides responsive and reliable health services and influences Health to improve readiness, save lives, and advance wellness in support of the Force, Military Families, and all those entrusted to our care.
   3. Army Nurse Corps (ANC) Mission: Providing responsive, innovative, and evidenced based nursing care integrated on the Army Medicine Team to enhance readiness, preserve life and function, and promote health and wellness for all those entrusted to our care.
   4. Army Public Health Nursing (APHN) Mission: Preserves the strength of our Nation by ensuring the delivery of Essential Public Health Services to America’s Sons and Daughters and supports the creation of healthy environments for military communities.

B. Strategic Environment (Army Strategic Planning Guidance):
   1. Budget constraints: The Army must reshape to meet the security challenges of the future within a constrained DoD budget.
   2. Regional instabilities: The political instability and violence increases in the Middle East and China present territorial issues in the Pacific. In Europe, allied nations struggle with the balance of domestic and military spending due to financial crisis while Russia’s diplomatic positions have hardened and military posture threatens. Iran, Pakistan and North Korea provide international security concerns. State and non-state actors’ access to affordable technologies complicate the challenges that instability brings.
   3. Continued need for a credible force in readiness: A credible force in readiness has strategic utility far beyond deterrence, providing the Nation a broad set of capabilities for shaping the environment.
   4. Diversity of Army operational commitments: The most fundamental role for Army forces is to deter or defeat enemy threats on land. Complementing the deterrence or defeat of threats on land is the control of those land areas, and when necessary, securing their populations. Those Army forces are the initial step to enabling a population to establish the rule of law and peaceful transition of political authority from military to civilian government. The Army’s enabling roles inclu
SCHOLARLY PROJECT

- Support to Security Cooperation:
- Support Domestic Civil Authorities
- Entry Operations, and
- Army Support to Other Services, the Joint Force, and the Department of Defense

5. The next unanticipated crisis, in an unforeseen place, unfolding in an unforeseen manner requiring the rapid commitment of Army Forces is inevitable.

C. Army Strategic Priorities

1. Adaptive Army Leaders for a Complex World: Soldiers and Civilians across the Total Army with the morals, ethics, individual toughness, fighting spirit, intellectual capacity, tactical competence, technical proficiency, and strategic perspective to understand the complex contemporary security environment and Unified Action partner capabilities to better lead Army, Joint, Interagency, Intergovernmental, and Multinational task forces and teams to prevail in peace and war.

2. A Globally Responsive and Regionally Engaged Army: A ready and capable Total Army that provides joint and multinational forces with expeditionary, strategically adaptive, and campaign-quality land power that assures partners, while it deters, coerces, and when necessary, compels adversaries across the range of military operations.

3. A Ready and Modern Army: An operationally ready and responsive Total Army manned, trained, and equipped to rapidly deploy, fight, sustain itself, and win against complex state and non-state threats in austere environments and rugged terrain. The American Soldier remains the most discriminately lethal force on the battlefield. The Army can successfully execute all of its missions across the range of military operations.

4. Soldiers Committed to Our Army Profession: Soldiers and Civilians who exemplify the morals, ethics, military expertise, honorable service, esprit de corps, and professional stewardship inherent to the Army Values, committed to the defense of our nation and way of life, continuing to earn the trust of the American people and their confidence in our Army.

5. The Premier All Volunteer Army: A professional force composed of the highest quality Soldiers and Civilians dedicated to the Army for the long term for a career in uniform and a lifetime of service through retirement. Supporting the force is a level of regular military compensation, retirement, and health care, while honoring the service and sacrifice of our Veterans, Retirees, Wounded Warriors and Families. “Once a Soldier, Always a Soldier.”

D. DA Mission with AMEDD Mission

1. Priority #4 - Soldiers Committed to Our Army Profession:
   a. Soldiers and Civilians who exemplify the morals, ethics, military expertise, honorable service, spirit de corps, and professional stewardship inherent to the Army Values, committed to the defense of our nation and way of life, continuing to earn the trust of the American people and their confidence in our Army.
   b. Objective #3: Enhance Army Professionalism through Army Values: Build the comprehensive physical, mental, emotional, and spiritual resiliency of our Soldiers, civilians, and their families to enable them to thrive personally and professionally.

2. Priority #5 - The Premier All Volunteer Army
   a. A professional force composed of the highest quality Soldiers and Civilians dedicated to the Army for the long term for a career in uniform and a lifetime of service through retirement.
Supporting the force is a level of regular military compensation, retirement, and health care, while honoring the service and sacrifice of our Veterans, Retirees, Wounded Warriors and Families. “Once a Soldier, Always a Soldier.”

b. Objective #1: Remain an Army Committed to Quality of Life (QOL) for its Soldiers and Families as a critical factor in maintaining the all-volunteer force. Through the Ready and Resilient Campaign, Soldier for Life, and Wounded Warrior Care programs, improve the safety, health, readiness, and resilience of our people in order to preserve and keep good faith with our most valuable resource – Soldiers and their families.

E: AMEDD Frameworks to Support DA Mission

1. Commander’s Intent: Transform from a healthcare system to a System for Health. The System for Health will maintain, restore and improve the health, readiness and resilience of Soldiers, Families and Communities in order to enable the Army to Prevent, Shape and Win the nation’s wars.

2. AMEDD 2020 Campaign Plan: Establishes the framework through which the (AMEDD) will ensure its forces remain ready to meet current and emerging Medical Support requirements to Combatant Commanders and CONUS Sustaining Bases

3. Key Tasks
a. Create a System of Health: The Army Surgeon General’s strategy to move towards a healthier population and healthier living by encouraging and incentivizing personal behavior improvements that maintain, restore and improve physical and mental well-being.

b. Influence the Life Space: Within the environment where Soldiers and Families live and work is the Lifespace and influences on health, including finances, commissary, fitness center, work environment, Family, friends and community.

c. Promote Healthy Lifestyles and Behaviors: Encouraging Healthy Behavior improves individual, Family and organizational stamina. This can be done through, but is not limited to, educating individuals and promoting accountability for responsible behaviors; prevention of drug abuse, excessive alcohol use; and promotion of tobacco-free living. Engaging leaders and holding them accountable for setting conditions that promote healthy choices and reduce domestic, sexual and workplace violence, hazing, bullying, and suicide will be a key component of this task. Reducing preventable injuries (e.g., sports injuries) which directly impact the readiness of the Force are also components to be emphasized.

d. Provide a Consistent Patient Experience: This includes Service Lines for health promotion, maintenance, restoration and improvement. The Service Line model identifies evidence based practice and tools to set standardized clinical practices throughout that domain of practice.

f. Strengthen Partnerships and Relationships: Developing and strengthening relationships and mutually beneficial partnerships result in improved collaboration, communications, coordination and understanding of Army Medicine in the context of mutual internal and external interests.
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g. Establish Operating Company Methodology: The Operating Company Model (OCM) is an organizational methodology that will enable Army Medicine to move toward a System For Health. The OCM framework is designed around integrated, standard processes across the organization; performance metrics and decision-making that are clearly defined for these processes, thereby driving accountability; and a high focus and priority given to process quality, repeatability, and standards to drive a better, more consistent patient experience while also containing costs.
h. Establish Metrics for Health: Performance Metrics and Accountability falls under OCM and entails implementation of a performance management system inclusive of metrics, benefits realization for resource and budget consumption, and a continuous improvement mechanism.
i. Model Healthy Lifestyles
j. Transform Reimbursement System
k. Change the Conversation from healthcare to health
l. Enable Active Communities: The entails initiatives outside of traditional AMEDD missions, such as community planning for a “built environment” that supports and promotes healthy living.

F: APHN Frameworks Aligned to Nested Missions

1. Army Regulation (AR) 40-5, Department of the Army Pamphlet 40-11, AR 600-63, AR 600-110
   a. Epidemiology and Disease Control
   b. Health Promotion
   c. Child Care Health Consultant
2. AR 608-10 and AR 600-75.
3. AR 600-20
   a. Ready and Resilient Campaign
   b. Community Health Promotion Council
4. Healthy People 2020
5. National Prevention Strategy
6. Ready & Resilient Campaign
7. Soldier Medical Readiness Campaign Plan
8. Army Medicine 2020 Campaign Plan
9. System for Health
10. Patient Centered Medical Home
11. Performance Triad
12. Tobacco-Free Living

G: Conclusion

H: Practical Exercise

1. Practical Exercise: Consider Army Public Health Nursing’s core functions and essential services and reflect on Army Public Health Nursing’s roles in epidemiology and disease control; child youth, and school services, and health promotion at the installation level. Write a statement that links installation-level Army Public Health Nursing practice with ANC, AMEDD, and Army missions.
2. Instruction: (20 minutes) Instruct the students to reflect Army Public Health Nursing’s core functions, essential services and roles in epidemiology and disease control; child youth, and school services, and health promotion and how they link to ANC, AMEDD, and Army missions. Instruct the students to develop a written statement that concisely articulates the links between installation-level APHN practice and installation-level nursing, military treatment facility, and senior Army commander missions. Have some of the students read their statements to the class to facilitate discussion, clarification, and feedback.

Possible Statement Response:

Army Public Health Nursing has distinct responsibilities at the installation level, through its core functions of assessment, assurance, and policy development, to locally set conditions for healthy and sanitary provision of child care; prevention and control of communicable diseases; and promotion of healthy lifestyles as part of Army Nurse Corps' and Army Medical Command's broader efforts to improve readiness, save lives, and promote health and wellness in order to protect and improve the Army's ability to fight and win our Nation's wars.
REFERENCES


Operating in the Big Picture
Understanding Civilian/Army/DoD Strategic Frameworks that Guide Practice

APHN Professional Development Session

Training Objectives

1. Amy Public Health Nurses (APHN) will understand how APHN’s mission aligns with and supports Department of the Army (DA), Army Medical Department (AMEDD) and Army Nurse Corps (ANC) missions and priorities.

2. APHNs will develop a written statement that articulates the links between installation-level APHN practice and installation-level nursing, military treatment facility, and senior Army commander missions.
Briefing Outline

PURPOSE: To present overarching strategic DA, AMEDD, and ANC missions and priorities and how APHN’s mission aligns with and supports DA, AMEDD, and ANC missions.

1. Strategic environment
2. Strategic priorities
3. Strategic mission overviews
4. DA and AMEDD mission synchronization
5. AMEDD mission
6. APHN framework
7. Practical exercise

The Strength of our Nation is our Army,
The Strength of our Army is our Soldiers,
The Strength of our Soldiers is our Families,
This is what makes us Army Strong!

GEN Raymon T. Odierno
39th Chief of Staff of the Army
Adaptive Army Leaders for a Complex World
A Globally Responsive and Regionally Engaged Army
A Ready and Modern Army
Soldiers Committed to Our Army Profession
The Premier All Volunteer Army

"The All-Volunteer Army will remain the most highly trained and professional land force in the world. It is uniquely organized with the capability and capacity to provide expeditionary, decisive land power to the Joint Force and ready to perform across the range of military operations to Prevent, Shape, and Win in support of Combatant Commanders to defend the Nation and its interests at home and abroad, both today and against emerging threats."

Army Chief of Staff
General Raymond T. Odierno
The Army's Strategic Vision
Strategic Mission Overviews

1. Fight and win our Nation's wars...
2. Improve readiness
   - Save lives
   - Advance wellness
3. Enhance readiness
   - Preserve life & function
   - Promote health & wellness
4. Preserves the strength through essential public health services

Mission Synchronization

Soldiers Committed to Our Army Profession
- Enhance Army Professionalism through Army Values
- PHYSICAL, MENTAL, AND EMOTIONAL RESILIENCY

The Premier All Volunteer Army
- Remain an Army Committed to Quality of Life
- Improve SAFETY, HEALTH, READINESS, AND RESILIENCY
**APHC Framework**

**SAFETY, HEALTH, READINESS, AND PHYSICAL, MENTAL, EMOTIONAL, AND SPIRITUAL RESILIENCY**

- **Policy**
  - AR 40-5
  - DA Pam 40-11
  - AR 500-20
  - AR 500-63
  - AR 500-110
  - AR 508-10
  - AR 508-75

**Core Functions and Essential Public Health Services**

**Strategic Initiatives**
- Healthy People 2020
- National Prevention Strategy
- Ready & Resilient Campaign
- Soldier Medical Readiness Campaign Plan
- Army Medicine 2020
- Campaign Plan
- System for Health
- Performance Triad
- Patient Centered Medical Home
- Tobacco-Free Living

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**Army Medicine 2020**

**Army Medicine 2020 Campaign Plan**

**Vision**

**Lines of Effort**

**Outcomes Endstate**

**System For Health**

**LOE 1: Create Capacity**
- OBU 1.1 Maintain Ready, Healthy, and Effective Health Services
- OBU 1.2 Support Patient Experience

**LOE 2: Enhance Diplomacy**
- OBU 2.1 Develop and Strengthen Relationships

**LOE 3: Improve Stamina**
- OBU 3.1 Improve Performance and Resilience
- OBU 3.2 Develop Healthy Communities and Environments
- OBU 3.3 Increase Healthy Behaviors

**LOE 4: Develop Leaders and Organizations**
- OBU 4.1 Lead and Empower the Best Talent
- OBU 4.2 Develop Leaders and Organizations

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**Army Medicine in order to prevent, shape, and win**

- System for Health: Healthy, Resilient, and Ready soldiers, Families, and Communities
System for Health (SFH) is a partnership among Soldiers, Families, Civilians, Leaders, Health Teams and Communities to promote Readiness, Resilience and Responsibility

- **MAINTAINS** health through fitness and illness/injury prevention
- **RESTORES** health through patient centered care
- **IMPROVES** health through informed choices in the Lifespace

---

**TODAY: Health Care**
- Impersonal
- Volume Driven Incentives
- Poor Coordination
- Stymied by Silos
- Inconsistent Practice Patterns
- Data with No Built Meaning

**TOMORROW: Health Care**
- Personalized
- Value-based Incentives
- Population Management
- Rich & Interactive Teams
- Application of Leading Practices
- Exploits data to empower better Healthcare

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As part of the System for Health, Army Medicine has initiated programs to enhance **sleep, activity, and nutrition**, in our beneficiary populations

- The Performance Triad positively influences the human dimension and domain
- The goal of the Performance Triad is to improve stamina, readiness and health through enhanced activity and improved nutrition and sleep
- This program directly supports the Army’s Ready and Resilient Campaign and the Comprehensive Soldier and Family Fitness (CSF2) Program

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UNCLASSIFIED
Tobacco Free Living

- VA/DoD revision of Clinical Practice Guideline for Tobacco Use Cessation
- Expansion of tobacco free areas
- Increase access to tobacco use cessation services
- Working towards tobacco free workforce during duty day
- Tobacco Sales/Price Parity

Strategic Initiative Resources

- Healthy People 2020: http://www.healthypeople.gov/
- Ready & Resilient Campaign: http://www.army.mil/readyandreilient
- Soldier Medical Readiness Campaign Plan: http://phc.amc.army.mil/topics/campaigns/smrc/Pages/default.aspx
- Performance Triad: http://phc.amc.army.mil/topics/campaigns/perftriad/Pages/default.aspx
- Tobacco-Free Living: http://phc.amc.army.mil/topics/healthyliving/tfl/Pages/default.aspx
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Disclaimers

"The views expressed in this presentation are those of the author(s) and do not necessarily reflect the official policy of the Department of Defense, Department of the Army, U.S. Army Medical Department or the U.S."

"Use of trademarked name does not imply endorsement by the U.S. Army, but is intended only to assist in identification of a specific product."
Consider Army Public Health Nursing’s core functions and essential services and reflect on Army Public Health Nursing’s roles in epidemiology and disease control; child youth, and school services, and health promotion at the installation level.

Write a statement that links installation-level Army Public Health Nursing practice with ANC, AMEDD, and Army missions.

References

References

A. Training Objectives - (Slide 2)
   1. Demonstrate the significance of public health collaboration and partnership between military and civilian community organization.
   2. Identify the benefits to community collaboration and partnerships.
   3. List actionable steps APHN sections can take to establish and sustain effective collaborations and partnerships.

B. Briefing Outline - (Slide 3)
PURPOSE: To provide strategies to improve a new APHN’s ability to establish and sustain collaborations and partnerships with outside agencies and installation organizations.
   1. Introduction
   2. Military and Civilian Partnership (Objectives 1 and 2)
   3. Plan of Action (Objective 3 with examples)
   4. Conclusion
   5. References
   6. Questions
   7. Practical Exercise

C. Introduction - (Slide 4)
   1. The health and welfare of a community relies on the actions and contributions of outside agencies and installation organizations. Strong relationships between units can be mutually beneficial in building the inherent strength of each sector and the community.
   2. Definitions:
      a. Collaboration: mutually beneficial and well-defined relationship committed by two or more persons or organizations to achieving common goals (ASRPHND Collaboration Primer)
         (1) Allows for the blending of perspectives, expertise, resources and shared accountability and responsibility
      b. Partnership: a collaborative relationship between entities to work toward shared objectives through a mutually agreed division of labor (Partnership for Development: Proposed Actions for the World Bank)

D. Military and Civilian Partnership - (Slides 5)
   1. USAPHC mission: “Promote health and prevent disease, injury and disability of Soldiers and military retirees, their families and DOD civilians”
   2. Military and DOD civilian families highly rely not only on the military organization but also on the outside community
NOTE: Soldiers, their families and Army civilians usually live off post, our collaborations with local health departments, academia and others will help us to reach out to our populations where they live, as well as where they work

3. Public organizations that military builds relationship with includes:
   a. Academic communities
   b. Sister public health organizations
   c. Local health department
   d. Other organizations that will benefit both the military and DOD civilians (i.e. CDC, WHO and etc.)

E. Military and Civilian Partnerships - (Slide 6)
1. Significance of Collaboration and Partnership (NACCHO)
   a. Improved disease and surveillance and communication
   b. Enhanced reach into communities
   c. Coordinated public health response to emergencies
   d. Use of existing systems for emergency response
      e. Incorporates a broad array of locally available infrastructure
      f. Public communication plan
      g. Joint community engagement

F. Military and Civilian Partnership - (Slide 7)
1. Benefits of Collaboration
   a. The ability to share ideas and information
   b. The ability to have diverse talents and capabilities of individuals between agencies and installation organizations
   c. Being able to gain access to different skill sets of individuals and/or groups
   d. Accelerates learning and distributing skills and knowledge
   e. Add depth and breadth to the community
   f. The ability to gain better understanding of other agencies and installation organizations
   g. Expands the community’s ability to respond comprehensively to community needs

G. Plan of Action - (Slide 8)
1. Discussion points in this section will include: 1) Levels of partnership (Hogue’s Level of Community Linkage Model); 2) Factors Influencing Positive Community Collaboration; 3) Structuring a Collaborative Partnership (Six Collaboration Success Factors); and 4) Problems and Conflicts

H. Levels of Partnerships - (Slide 9)
1. This slide is a depiction of the various levels and models of partnership that are discussed in the literature.

NOTE: The plan of action depends on the type of partnerships you and/or the organization want to have. Explain to group that you will be explaining and utilizing the Hogue’s Level of Community Linkage Model. Based on Hogue’s Level of Community Linkage Model the
different levels of partnerships include, networking, cooperation, coordination, coalition and collaboration.

I. Hogue’s Level of Community Linkage Model - (Slides 10)

1. Networking (units raise their awareness of each other through informal contact to explore interests and development)

(a) Relationship Characteristics
   (i) Aware of organization
   (ii) Loosely defined roles
   (iii) Little communication
   (iv) All decisions are made independently
   (v) Reflects an initial level of trust and commitment

(b) Structure
   (i) Most informal and easiest to form
   (ii) Roles loosely defined
   (iii) Loose/flexible links

(c) Process
   (i) Low key leadership
   (ii) Minimal decision making
   (iii) Informal communication

Examples: Identify, and meet local civilian counterpart county state department; Ask to be on distribution for schedule civilian County public health related conferences, meetings. Attended local training events

J. Hogue’s Level of Community Linkage Model – (Slide 11)

1. Cooperation (units engaged in negotiation and compromise to ensure appropriate tasks are executed)

(a) Relationship Characteristics
   (i) Provide information to each other
   (ii) Somewhat defined roles
   (iii) Formal communication
   (iv) All decisions are made independently

(b) Structure
   (i) Semi-formal
   (ii) Roles somewhat defined
   (iii) Links are advisory

(c) Process
   (i) Facilitative leaders
   (ii) Complex decision making
   (iii) Formal communication within the central group

Examples: Levels; Community level. During Annual Flu campaign, if there is a shortage of vaccines for military beneficiaries, APHN’s may play a key role in facilitating coordination /
information about vaccine availability within the community and authorization for use IAW military guidelines. Level (County/State) APHN’s are often members of the Installation Emergency Preparedness Team and may need to coordinate functions during Emergency Prep exercises with local Healthcare/Public Health Nurses.

**K. Houge’s Level of Community Linkage Model - (Slide 12)**

1. Coordination (units pursue a common goal that is executed independently)
   (a) Relationship Characteristics
      (i) Share information and resources
      (ii) Defined roles
      (iii) Frequent communication
      (iv) Some shared decision making
   (b) Structure
      (i) Roles defined
      (ii) Links formalized
      (iii) Group develops new resources and joint budget
   (c) Process
      (i) Autonomous leadership but focus in on issue
      (ii) Group decision making in central and subgroup
      (iii) Communication is frequent and clear

   **Examples:** During events involving civilian partnerships, APHN’s may facilitate in establishing frequent communication through scheduled meetings with partner agency such as local public health clinics, schools and public county health departments such as participating in local health fairs affiliated with local county events.

**L. Houge’s Level of Community Linkage Model - (Slide 13)**

1. Coalition (units group their resources to pursue their common goal)
   (a) Relationship Characteristics
      (i) Share ideas and resources
      (ii) Frequent and prioritized communication
      (iii) All members have a vote in decision making
   (b) Structure
      (i) Roles and time defined
      (ii) Links formal with written agreement
      (iii) Group develops new resources and joint budget
   (c) Process
      (i) Shared leadership
      (ii) Decision making formal with all members
      (iii) Communication is common and prioritized

   **Examples:** Agreements between local public health agencies who receive regular STD and other communicable reported disease may have regularly scheduled meetings between APHN and counterpart to ensure reporting measures remain accurate and timely. Written agreements
between sister services (Army/Air Force) may have established different or additional roles for the APHN.

**M. Houge’s Level of Community Linkage Model - (Slide 14)**

1. **Collaboration** (units are all committed, supportive, and executing jointly to achieve the common goal and purpose)

   (a) Relationship Characteristics
      (i) Members belong to one system
      (ii) Frequent communication characterized by mutual trust
      (iii) Consensus is reached in all decisions

   (b) Structure
      (i) Roles, time and evaluation formalized
      (ii) Links are formal and written in work assignments

   (c) Process
      (i) High level of leadership, trust, and productivity
      (ii) Ideas and decisions equally shared
      (iii) Highly developed communication

**Examples:** The APHN may be a key player in maintaining strong relationships at a lower level bridging the gaps and fixing the glitches in support of maintaining a major Collaborative Agreement.

**N. Houge’s Level of Community Linkage Model Diagram - (Slide 15)**

**O. Factors Influencing Positive Community Collaboration - (Slide 16)**

1. Successful Collaboration is achieved when: (Source: Collaboration: what makes it work 2nd edition, Mattessich, Paul)
   (a) Supportive community **Environment**
   (b) Favorable collaborative **Membership Characteristics**
   (c) Clearly organized **Process and Structure**
   (d) Effective and operational **Communication**
   (e) **Purpose** is focused and empowering
   (f) Adequate and sufficient **Resources**

**NOTE:** Paying attention to these different factors of collaboration will greatly increase the likelihood of a successful effort.

**P. Collaboration Success Factors - (Slides 17)**

1. Environment
   (a) Is there a favorable political and social climate?
   (b) Is there a history of cooperation or collaboration in the community?
2. Membership Characteristics
   (a) Are there mutual respect, trust and understanding among members?
   (b) Are the right people involved?
   (c) Does the purpose serve all?
   (d) Is there flexibility among members?
3. Process and Structure
   (a) Do participants have clear roles?
   (b) Have the group developed clear policies and procedures?
   (c) Do all members have a stake in the outcomes?
   (d) Is the collaboration able to adapt?

Q. Collaboration Success Factors - (Slide 18)
1. Communication
   (a) Is there an established communication plan?
   (b) Are communications clear?
2. Purpose
   (a) Is there a shared vision?
   (b) Are the goals and objectives concrete and obtainable?
3. Resources
   (a) Are there sufficient funds, staff, material and time
   (b) Are there skilled leaderships

R. Collaboration Success Factors Diagram - (Slide 19)

S. Structuring a Collaborative Partnership - (Slides 20)
1. Three Stages of Collaborative Partnership Development (Partnerships: frameworks for Working Together)
   (a) Formation
      (i) Defining the need for partnership
      (ii) Starting the process
      (iii) Setting up and maintaining the partnership
   (b) Management
      (i) Create partnership norms
      (ii) Develop collaborative work plans
      (iii) Utilize technology
      (iv) Implement evaluation and monitoring
   (c) Transition, Ending, and Renewal

NOTE: The goal of partnerships is to achieve more than individual organizations can achieve on their own. The whole of the partnership adds more than the sum the individual parts

T. Structuring a Collaborative Partnership - (Slide 21)
1. Step One: Defining the need for partnership - Is establishing partnerships the most appropriate decision?
• Short term vs long term?
  (i) Short term interest – what does your organization need to get in the next twelve months to stay engaged in the partnership?
  (ii) Long term interest – What does your organization need to get in the next eighteen to thirty six months to stay engaged in the partnership?
• Questions to discuss with one another
  (i) Is there a need for a partnership?
    1. Determine the basis of setting up the partnership
    2. Group of like-minded people with shared vision who decided partnership is the best route to achieve goals
    3. Potential partners willing to support partnership
  (ii) What organizational benefits will be gained from this partnership?
    1. Clearly identified goals that only a partnership arrangement could help achieve
    2. Provide added value for the organization
    3. Self interest
  (iii) Is someone else already have or doing something similar?
    1. Do other organization already have similar established goals or plan
    2. Consider approaching them to develop partnership and avoid duplication
    3. If not appropriate or feasible, incorporate lesson they have learned to the new partnership arrangement
  (iv) Is there commitment involved from each organization to support the partnership?
    1. Approach partner organization, is partnership positive or negative?
    2. Important both organization are committed, agreed, and supportive of the developing the partnership
  (v) What strategies and priorities will this partnership support?
    1. Identify the strategies and priorities of the partnership support

U. Structuring a Collaborative Partnership - (Slide 22)
1. Step Two: Starting the process
   (a) Process starts with building and developing relationship as a whole and not individually
   (b) Four stages of team building (Tuckman)
      (i) Forming – the initial stage of the partnership process is to form the group and bringing people together.
      (ii) Storming – group starts questioning the purpose of the partnership. This stage is critical as it is where individuals have their open and honest perception and understanding of the overall goal and vision. Disagreement often happen during this stage, but disagreements can lead to stronger and more versatile work dynamic
      (iii) Norming – process in which the partnership is reaching shared agreement. Have the ambition to work together to achieve the partnership goals.
      (iv) Performing – group are motivated and knowledgeable of the partnership goals and visions.
(c) Questions to discuss: Documentation is important when establishing the process of partnership

(i) Who are potential members? - Identify and document the members. Determine how many members should be part in the partnership and in what proportion.

(ii) What are the responsibilities, arrangements, and objectives of leadership? - Determine the leader of the group. Identify individual leadership roles and responsibilities. Develop a clear written statement of the partnership leader’s objective and responsibilities

(iii) What is the shared vision and goals? - Document and understand the shared vision, objectives, and goals. Member needs to be clear about the purpose and goal of the partnership

(iv) Is there a plan and what are the priorities? - The partnership needs to have a strategy and action plan that sets out a clear structure. Strategy needs to reflect how it will manage change and how well it is doing

(v) What is the function and nature of the partnership? - It is important that members are clear at what level and function the partnership is operating

(vi) What are the benefits? - Identify the outcomes and benefits for the group. Benefits need to be clearly established and agreed upon by all members of the group

V. Structuring a Collaborative Partnership - (Slide 23)
1. Step Three: Setting up and maintain the partnership
(a) Clear and concise agreement, documentation!

NOTE: Documenting clear and concise agreement is needed to understand how agreements on action will be taken and to help create a sense of shared responsibility. Documentation of agreement to include but not limited: Key aims, objectives, and outcomes; Job roles and duties; Plan or strategy that forms the basis of the work relationship. These documentations could take the form of a legal constitution or contract.

(b) Questions to discuss:

(i) Do all members know their roles and responsibilities?
   1. Members need to agree and understand what their role and responsibilities are within the context of the purpose and outcomes of the partnership
   2. Each member will need to understand their role in collective decision-making, delivering activities, and representation of the partnership
   3. Understand what skills and competencies needed to achieve the vision and goals

(ii) Is there an accepted commitment to joint investment and resources?
   1. Resources mean more than just money, include time, knowledge, energy, and personnel.

(iii) Is there an effective robust communication?
   1. Being open and honest, constant communication and exchanging information at all level within the partnership will help build trust and strengthen the partnership
   2. All parties need to be open and willing to communicate honestly with one another
W. Structuring a Collaborative Partnership - (Slide 24)
1. Create Partnership Norms and Memorandum
   (a) Partnership norms “ground rules” vs MOU/MA (Memorandum of Understanding/Agreement)
   (b) Partnership norms – informal guidelines on how members will behave and interact with one another
   (c) MOU/MA – formal guidelines that establish the partners’ roles, expectations, authority, accountability, and contribution in a partnership relationship

NOTE: The biggest difference between the two is that the MOU addresses the formal agreements between the organizations but do not establish the “how” of the relationship. Partnership norms address how the each member will work together. Partnership norms must be agreed upon by all members of the group.

- Partnership norms = healthy working relationship

NOTE: Relationships are the foundation of all partnerships. Creating and following partnership norms will maintain a healthy working relationship. Understand each member past experience, work style, cultural values, expectations, and self-interest

- Four steps to implementing partnership norms:
  (i) Identifying
    1. Identify the shared value of the group
    2. Discuss and identify areas in which norms will necessary
       a. Example: communication, knowledge and resource management, decision making, conflict resolution and/or meetings
    3. Ensure to listen to each person’s perspective and as a group decide and agree on what the norms will be
  (ii) Documenting
    1. Document the partnership norms and make them easily accessible to everyone in the group
  (iii) Communicating
    1. Communicate the partnership norms regularly. Example. Laminate cards or fact sheets
  (iv) Updating
    1. Update partnership norms as necessary
    2. Revisit norms and assess for change based on current situation and development

X. Structuring a Collaborative Partnership - (Slide 25)
1. Develop Collaborative Work Plans
   (a) Collaborative work plans – document that outlines the structure of work or initiative within the partnership
(i) Establish buy-in
1. Openly communicate goals and objectives
2. Understand each member’s stake or interest
3. Provide opportunities for members to give input and feedback
4. Continually to emphasize and remind members about the goals and objectives

(ii) Being realistic
1. Focus on specific areas that are linked to the partnership. Do not focus on too many broad issues
2. Distribute work equitably
3. Include members to review work plan and provide feedback as necessary

(iii) Having measurable results
1. Identify at least one indicator of success for each task assigned
2. Identify short, intermediate, and long term outcomes

(iv) Being accountable
1. Have specific due dates for each tasks and goals
2. Clearly identify each member’s task
3. Regularly review and communicate progress

Y. Sample Collaborative Work Plan Worksheet Graph - (Slide 26)

Z. Structuring a Collaborative Partnership - (Slide 27)
1. Utilize Technology
(a) Technology is the way to go!

NOTE: Partnership norms, communication, and collaborative work plans can all be supported by the use of technology.

- Depth of collaboration allowed by technology systems
  (i) Methods for distributing information examples: electronic newsletters, websites, electronic clearinghouse
  (ii) Systems for collaborating examples: electronic mailing lists, shared documents, web-based databases
  (iii) Real time interactions examples: online chatting and internet forums, online meetings and trainings, virtual workspaces
  (iv) Managing projects examples: project management software

AA. Structuring a Collaborative Partnership - (Slide 28)
1. Implement evaluation and monitoring
(a) How is the partnership working?
  (i) Determined by an ongoing program of monitoring, evaluation and revising
    1. Relates to “performing stage” of Team Building (Tuckman’s)
  (ii) Evaluations can be conducted in many ways:
    2. Appreciative inquiry Model, Collaboration Self-assessment Tool, etc.
(b) Key questions to ask:
  1. Does the partnership still meet vision and goals?
2. Are the overall visions, purpose and goals still recognized by the group?
3. Is the partnership performing well?
   a. Is there still clear understanding of members and organization roles and responsibilities?
4. Are there any changes that need to be made?
   a. Revise any deficiencies, issues and/or concerns
5. What can we learn from the past lessons?
   a. Learn what has been successful and what has not

**BB. Structuring a Collaborative Partnership - (Slide 29)**
1. Appreciative Inquiry model – considers what is working well and what you’d most like to do more of to strengthen the collaboration

**CC. Structuring a Collaborative Partnership - (Slide 30)**
1. Collaboration Self-Assessment Tool
   (a) Collaborative group scores from 0-30 - collaborations has many components that comprise a successful collaboration. There are goals, working members, and strong leadership.
   (b) Collaborative group scores between 31-48 - the group has some of the factors; however, there is some need to develop the inter-workings of the group. The group may need to determine new ways of working together.
   (c) Collaborative group scores between 49-65 - the group may wish to refocus their goals and leadership. Establishing a group's strengths and challenges can serve as a springboard to building a more effective collaborative group.

**DD. Structuring a Collaborative Partnership - (Slide 31)**
1. Transition, Ending, and Renewal Stage
   (a) Every collaborative partnership will eventually consider issues of transition, ending, and renewal.
      (i) Time renew goals, vision and commitment
      (ii) Time to let organizational partners go
      (iii) Time to end the partnership altogether
   (b) All partnership need closure
      (i) Often time closure is missed due to
      (ii) Partnership ends immediately with no substantive communication
      (iii) End without an end – dwindling down without closing out
   (c) Consolidate learning

**NOTE:** Determine what worked, what didn’t, who they learned from, and who they want to continue to learn from. Determine lessons learned, accomplishments, and what needs to be left behind, or what is new and needs to be accomplished

**EE. Problems and Conflicts Involving Collaboration and Partnership - (Slide 32)**
1. Decisions
   (a) Failure to communicate
(b) Limited vision and failure to inspire
(c) Lack of evaluation or monitoring systems
(d) Lack and/or unclear roles and responsibilities

2. Money
   (a) Financial and time commitments outweigh potential benefits

3. Time
   (a) Progress is not being made
   (b) Too little time for effective consultation

4. Identity
   (a) Imbalance of power
   (b) Individuals and/or organization dominates, manipulates and/or competed for the lead
   (c) Lack of commitment; unwilling participants

**FF. Conclusion - (Slide 33)**

Conclusion Statement: Overall, collaborative partnerships are effective when all members of the participating groups understand the value and purpose of working collectively. Population health cannot be addressed effectively without the participation of many organizations synchronizing efforts on public health issues of mutual interest. As APHNs, we need to be proactive and seek opportunities to share knowledge and work together tackling the complex public health challenges of the 21st century.

**GG. Questions Slide (Slide 34) - “Coming together is a beginning, keeping together is progress, and working together is success.” Henry Ford**

NOTE: At this point the presentation will no longer advance on its own. The preceptor will need to be engaged with the participants and advance the slides from (Slide 35 – end).

**HH. Presentation Credit Slide – (Slide 35)**

**II. APHC Branding Slide – (Slide 36)**

**JJ. Practical Exercise #1 – (Slide 37) – As a group have the participants answer the question on the slide.**

**QUESTION:** According to Hogue, what are the levels of the community linkage model?

**ANSWER:** networking, cooperation, coordination, coalition, collaboration (click the enter button for each answer to appear on the screen before it will advance to the next slide)

**KK. Practical Exercise #2 – (Slide 38) - As a group have the participants answer the question on the slide.**

**QUESTION:** What are the six categories of factors influencing successful collaboration?
ANSWER: environment, membership characteristics, process and structure, communication, purpose, and resources (You will need to click the enter again for all of the answers to appear on the slide before you can advance the presentation)

LL. Practical Exercise #3 – (Slide 39) – As a group please discuss the following questions with the group.

QUESTIONS: Based on the identified goal, discuss the following questions:
(1) List organizations that you could develop a partnership with
(2) What could be the contributions for each partner organization?
(3) What opportunities and challenges exist in forming the collaborative partnership?

• Once the discussion is complete, then move to practical exercise #4

MM. Practical Exercise #4: Memorandum of Agreement between 673D MDG and MEDDAC-AK (Army and Air Force Agreement) – (Slide 40)

1. Explain to the group that you will be reviewing and analyzing the next 3 slides

NN. Practical Exercise #4 – (Slide 41) Preceptor Facilitation Instructions
1. Ask group if they can identify any issues with the information on the slide.
2. Ask group if there is an established communication plan?
   A. If not identified, (click enter once on the slide and it will highlight “frequently to address issues”)
      (i) Explain to the group that when establishing group communication ensure to include fixed schedule dates (i.e. annually, monthly, weekly and etc.)
3. Click enter again and it will highlight “resources”, ask group if roles and responsibilities are clear?
   (i) Group members should be able to explain that the identified jobs are not clear and concise.
   (ii) If not identified, explain to group that the roles and responsibilities need to be clear specifying in-depth what each resources are (job title and credentials (MD, PA, type of nurses and etc).
   (iii) Example: line d) EFMP – not sure what type of personnel and duty are needed to fulfill the position.

OO. Practical Exercise #4 – (Slide 42) Preceptor Facilitation Instructions
1. Ask group to identify any issues with the information on the slide.
2. Ask group if there is a Transition, Ending and Renewal phase in the MOA?
   (i). If not identified, (click enter once on the slide and it will highlight “indefinitely” and “review at any time”)
   (ii). Address group that all MOA/MOU should implement a fixed date for transitioning, ending and or renewal.

PP. Practical Exercise #4 – (Slide 43) Updated MOA (Preceptor Facilitation Instructions)
1. Explain to the group that the updated MOA now includes a fixed scheduled date (biannual)
   (i) If the group asked whether or not the role and responsibilities are updated. Notify the group that it is still an ongoing process in determining skills and qualification for the duties

QQ. Practical Exercise #4 – (Slide 44) Updated MOA (Preceptor Facilitation Instructions)
1. Explain to the group that the updated MOA now includes a date for transitioning, ending and renewal
2. It also stated that the MOA shall be reviewed annually

PP. References – (Slides 45-47)


Establishing and Sustaining Collaborations and Partnerships

APHN Professional Development Session

Training Objectives

- Discuss the significance of public health collaboration and partnership between military and civilian community organization
- Identify the benefits to community collaboration and partnerships
- List actionable steps APHN sections can take to establish and sustain effective collaborations and partnerships
**INTRODUCTION**

- The health and welfare of a community relies on the actions and contributions of outside agencies and installation organizations. Strong relationships between units can be mutually beneficial in building the inherent strength of each sector and the community.
- Definition:
  - Collaboration: mutually beneficial and well-defined relationship committed by two or more persons or organizations to achieving common goals (ASRPHND Collaboration Primer)
    - Allows for the blending of perspectives, expertise, resources and shared accountability and responsibility
  - Partnership: a collaborative relationship between entities to work toward shared objectives through a mutually agreed division of labor (Partnership for Development: Proposed Actions for the World Bank)
Military and Civilian Partnership

- APHC mission: “Promote health and prevent disease, injury and disability of Soldiers and military retirees, their families and DOD civilians”
- Military and DOD civilian families highly rely not only on the military organization but also on the outside community
- Public organizations that military builds relationship with includes:
  - Academic communities
  - Sister public health organizations
  - Local health department
  - Other organizations that will benefit both the military and DOD civilians (i.e. CDC, WHO and etc)

Military and Civilian Partnership

- Significance of Collaboration and Partnership (NACCHO)
  - Improved disease and surveillance and communication
  - Enhanced reach into communities
  - Coordinated public health response to emergencies
  - Use of existing systems for emergency response
  - Incorporates a broad array of locally available infrastructure
  - Joint community engagement
Military and Civilian Partnership

- Benefits of Collaboration
  - The ability to share ideas and information
  - The ability to have diverse talents and capabilities of individuals between agencies and installation organizations
  - Being able to gain access to different skill sets of individuals and/or groups
  - Accelerates learning and distributing skills and knowledge
  - Add depth and breadth to the community
  - The ability to gain better understanding of other agencies and installation organizations
  - Expands the community's ability to respond comprehensively to community needs

Plan of Action

- Levels of Partnership
- Factors of Successful Collaboration
- Structuring a Collaborative Partnership
- Problems and Conflicts
Levels of Partnerships

- Hogue Model
  - Networking
  - Cooperation
  - Coordination
  - Coalition
  - Collaboration

Frey et al. / Measuring Collaboration

Hogue’s Level of Community Linkage Model

- Networking (units raise their awareness of each other through informal contact to explore interests and development)
  - Relationship Characteristics
    - Aware of organization
    - Loosely defined roles
    - Little communication
    - All decisions are made independently
    - Reflects an initial level of trust and commitment
  - Structure
    - Most informal and easiest to form
    - Roles loosely defined
    - Loose/flexible links
  - Process
    - Low key leadership
    - Minimal decision making
    - Informal communication
Hogue's Level of Community Linkage Model

- Cooperation (units engaged in negotiation and compromise to ensure appropriate tasks are executed)
  - Relationship Characteristics
    - Provide information to each other
    - Somewhat defined roles
    - Formal communication
    - All decisions are made independently
  - Structure
    - Semi-formal
    - Roles somewhat defined
    - Links are advisory
  - Process
    - Facilitative leaders
    - Complex decision making
    - Formal communication within the central group

- Coordination (units pursue a common goal that is executed independently)
  - Relationship Characteristics
    - Share information and resources
    - Defined roles
    - Frequent communication
    - Some shared decision making
  - Structure
    - Roles defined
    - Links formalized
    - Group develops new resources and joint budget
  - Process
    - Autonomous leadership but focus on issue
    - Group decision making in central and subgroup
    - Communication is frequent and clear
Hogue's Level of Community Linkage Model

- **Coalition** (units group their resources to pursue their common goal)
  - Relationship Characteristics
    - Share ideas and resources
    - Frequent and prioritized communication
    - All members have a vote in decision making
  - Structure
    - Roles and time defined
    - Links formal with written agreement
    - Group develops new resources and joint budget
  - Process
    - Shared leadership
    - Decision making formal with all members
    - Communication is common and prioritized

- **Collaboration** (units are all committed, supportive, and executing jointly to achieve the common goal and purpose)
  - Relationship Characteristics
    - Members belong to one system
    - Frequent communication characterized by mutual trust
    - Consensus is reached in all decisions
  - Structure
    - Roles, time and evaluation formalized
    - Links are formal and written in work assignments
  - Process
    - High level of leadership, trust, and productivity
    - Ideas and decisions equally shared
    - Highly developed communication
Factors Influencing Positive Collaboration

- Successful Collaborations is achieved when:
  - Supportive community Environment
  - Favorable collaborative Member Characteristics
  - Clearly organized Process and Structure
  - Effective and operational Communication
  - Purpose is focused and empowering
  - Adequate and sufficient Resources

Mattessich, Murray-Close, Monsey, 2001
Collaboration Success Factors

- **Environment**
  - Is there a history of cooperation or collaboration in the community?
  - Is the collaborative group seen as a legitimate issue leader in the community?
  - Is there a favorable political and social climate?

- **Membership Characteristics**
  - Are there mutual respect, trust, and understanding among members?
  - Are the right people involved?
  - Does the purpose serve all?
  - Is there flexibility among members?

- **Process and Structure**
  - Do participants have clear roles?
  - Have the group developed clear policies and procedures?
  - Do all members have a stake in the outcomes?
  - Is the collaboration able to adapt and be flexible?

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Collaboration Success Factors

- **Communication**
  - Is there an established communication plan?
  - Are communications clear and concise?
  - Are there open and frequent communication?

- **Purpose**
  - Is there a shared vision?
  - Are the goals and objectives concrete and obtainable?

- **Resources**
  - Are there sufficient funds, staff, material, and time?
  - Skilled leadership?
Three Stages of Collaborative Partnership Development:

- **Formation**
  - Defining the need for partnership
  - Starting the process
  - Setting up and maintain the partnership

- **Management**
  - Creates partnership norms
  - Develop collaborative work plans
  - Implement evaluation and monitoring

- **Transition, Ending, and Renewal**
Structuring a Collaborative Partnership

- **Formation Stage – Step One: Defining the Need for Partnership**
  - Is establishing partnerships the most appropriate decision?
    - Identifying Self-Interest
      - Short term vs long term interest?
    - Questions to discuss:
      - Is there a need for a partnership?
      - What organizational benefits will be gained from this partnership?
      - Is someone else already have or doing something similar?
      - Is there commitment involved from each organization to support the partnership?
      - What strategies and priorities will this partnership support?

- **Formation Stage – Step Two: Starting the Process**
  - Process starts with building and developing relationship as a whole and not individually
  - Four stages of team building (Tuckman)
    - Forming, Storming, Norming, Performing
  - Questions to discuss:
    - Who are potential members?
    - What are the responsibilities, arrangements, and objectives of leadership?
    - What is the shared vision and goals?
    - Is there a plan and what are the priorities?
    - What is the function and nature of the partnership
    - What are the benefits?
Structuring a Collaborative Partnership

- Formation Stage – Step Three: Setting up/maintaining the Partnership
  - Clear and concise agreement, documentation!
  - Questions to discuss:
    - Do all members know their roles and responsibilities?
    - Is there an accepted commitment to joint investment and resources?
    - Is there an effective robust communication?

- Management Stage: Create Partnership Norms and Memorandums
  - Partnership Norms "ground rules" vs MOU/MOA (Memorandum of Understanding/Agreement)
    - Partnership norms – informal guidelines on how members will behave and interact with one another
    - MOU/MOA – formal guidelines that establish the partners’ roles, expectations, authority, accountability, and contribution in a partnership relationship
  - Partnership norms = Healthy working relationship!
  - Four steps to implementing partnership norms:
    - Identifying
    - Documenting
    - Communicating
    - Updating
**Structuring a Collaborative Partnership**

- Management Stage: Develop Collaborative Work Plans
  - Collaborative work plans – document that outlines the structure of work or initiative within the partnership
    - Buy-in
    - Realistic
    - Measurable
    - Accountable

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**Collaborative Work Plan Worksheet**

![Collaborative Work Plan Worksheet](http://strengtheningnonprofits.org/resources/guidebooks/Partnerships.pdf)
Structuring a Collaborative Partnership

- Management Stage: Utilize Technology
  - Technology is the way to go!
  - Depth of collaboration allowed by technology systems
    - Methods for distributing information examples: electronic newsletters, websites, electronic clearinghouses
    - Systems for collaborating examples: electronic mailing lists, shared documents, web-based databases
    - Real time interactions examples: online chatting and internet forums, online meetings and trainings, virtual workspaces
    - Managing projects examples: project management software

- Management Stage: Implement Evaluation and Monitoring
  - How is the partnership working?
    - Determined by an ongoing program of monitoring, evaluation and revising
      - Relates to "performing stage" of Team Building (Tuckman’s)
    - Evaluations can be conducted in many ways:
      - Appreciative inquiry Model, Collaboration Self-assessment Tool, etc.
  - Key questions to ask:
    - Does the partnership still meet vision and goals?
    - Is the partnership performing well?
    - Are there any changes that need to be made?
    - What can we learn for present and future?
Structuring a Collaborative Partnership

- Define Affirmative Topic
- Discover: Ask about the best of what is
- Deliver: Create what will be
- Dream: Imagine what could be
- Design: Plan what will be

A COLLABORATION PROGRESS CHECKLIST

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<tr>
<th>Factors</th>
<th>Strongly Agree</th>
<th>Somewhat Agree</th>
<th>Neither Agree or Disagree</th>
<th>Somewhat Disagree</th>
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Borden & Perkin: Assessing Your Collaboration: Self-Evaluation Tool
Structuring a Collaborative Partnership

• Transition, Ending, and Renewal Stage
  – Every collaborative partnership will eventually consider issues of transition, ending, and renewal.
    • Time renew goals, vision and commitment
    • Time to let organizational partners go
    • Time to end the partnership altogether
  – All partnership need closure!
    • Often time closures are missed due to:
      – partnership ends immediately with no substantive communication
      – end without an end – dwindling down without closing out
    • Consolidate learning

Problems and Conflicts

Decisions:
  – Failure to communicate
  – Limited vision and failure to inspire
  – Lack of evaluation or monitoring systems
  – Lack and/or unclear roles and responsibilities

Money:
  – Financial and time commitments outweigh potential benefits

Time:
  – Progress is not being made
  – Too little time for effective consultation

Identity:
  – Imbalance of power
  – Individuals and/or organization dominates, manipulates and/or competed for the lead
  – Lack of commitment; unwilling participants
Collaborative partnerships are effective when all members of the participating groups understand the value and purpose of working collectively. Population health cannot be addressed effectively without the participation of many organizations synchronizing efforts on public health issues of mutual interest. As APHNs, we need to be proactive and seek opportunities to share knowledge and work together tackling the complex public health challenges of the 21st century.

"Coming together is a beginning, keeping together is progress, and working together is success." - Henry Ford
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The views expressed in this presentation are those of the author(s) and do not necessarily reflect the official policy of the Department of Defense, Department of the Army, U.S. Army Medical Department or the U.S."

"Use of trademarked name does not imply endorsement by the U.S. Army, but is intended only to assist in identification of a specific product."
According to Hogue, what are the levels of the community linkage model?

- Networking
- Cooperation
- Coordination
- Coalition
- Collaboration
Practical Exercise 2

What are the six categories of factors influencing successful collaboration?

Environment
Membership Characteristics
Process and Structure
Communication
Purpose
Resources

Practical Exercise 3

Identifying Strategic Partnership

Goal: Establish public health collaboration and partnership in regards to child obesity

1) List organizations that you could develop a partnership with
2) What could be the contributions for each partner organization?
3) What opportunities and challenges exist in forming the collaborative partnership?
Review and Analysis

Memorandum of Agreement between 673D MDG and MEDDAC-AK
(Army and Air Force Agreement)

6. Responsibilities.
   a. The Officers In Charge (OICs) of 3 MDG, TMC and MEDDAC-AK will interact frequently to address issues pertaining to the delivery of health care at JBER as referenced in 1.b.

   b. Commander, MEDDAC-AK will

      1) Transfer the following resources to 3 MDG IAV para. 5, TABLE 1:

         a) Industrial Hygiene: Three (3) Full Time Equivalents (FTE’s)
         b) Environmental Health: Two (2) FTE’s
         c) Occupational Health: One (1) FTE
         d) Exceptional Family Member Program (EFMP): One (1) FTE
         e) Health Promotions: One (1) FTE
         f) FAP: Three (3) GS FTE’s. Oversight and management of one (1) contract FTE will be transferred to 3MDG until termination of the contract. These FAP assets are supported by installation (Army Line/Service) Operations & Maintenance (O&M) funds currently transferred to MEDDAC-AK annually by Military Interdepartmental Purchase Request (MIPR). The OMA resource transfer will be coordinated via Army Installation Management Command (INCOM) with HC Army.
         g) O&M: Vehicle support, equipment/ supplies, and TDY cost in support of FTE transfers.
8. Implementation Instructions.
   a. This MOA is effective upon signature of all parties and shall remain in effect indefinitely.

   b. This agreement is subject to review at any time upon written request by either party. Under normal circumstances, prior notice of 180 days will be provided if the agreement is to be unilaterally modified, suspended, or terminated. Parties to this MOA will work and resolve issues at the lowest possible level.

9. Points of contact.

5. RESPONSIBILITIES.
   a. The Officers In Charge (OICs) of 673 MDG, TMC, and MEDDAC-AK will meet on a bi-annual scheduled date to review and evaluate the Preventive Medicine functions and services pertaining to the delivery of health care at JBER as referenced in 1.b.
6. IMPLEMENTATION, AMENDMENTS, AND TERMINATION.

a. This MOA is effective on the date signed by all parties and expires on 31 Jul 19.

b. The parties shall review the MOA annually, on the anniversary of its signing, and it may be modified, suspended, or cancelled at any time by mutual consent. This Agreement may also be unilaterally suspended or cancelled by either party upon giving at least 90 days written notice to the other party.

c. Parties to this MOA will work and resolve issues at the lowest possible level. Disputes which cannot be resolved at an organizational level will subject to any applicable law, executive order, directive or instruction, be elevated through the parties’ respective chains of command for resolution or will be resolved IAW DoDI 4000.19.

References


Purpose: To familiarize APHNs to the major Department of Defense (DoD) prevention initiatives aimed at improving military communities and the “Lifespace”

Training Objectives:
1. Define the “Lifespace” concept. Demonstrate how the Office of The Surgeon General (OTSG) intends for MEDCOM to affect the “Lifespace”, the 525,500 minutes a year (time not spent in front of a physician) IAW OPORD 14-20 Performance Triad Directive MEDCOM and Regional Medical Commands (RMCs), LTG Patricia Horoho.
2. Identify and define DoD initiatives that are aimed at improving military communities and their “Lifespace”:

   In affecting the “Lifespace”, information is key, but connecting with the appropriate resources is crucial, too. In effort to meet these objectives OTSG leverage the following DoD initiatives:
   A. Operation Live Well
   B. Healthy Base Initiative
   C. Performance Triad
   D. System for Health

A. Operation Live Well-The Department of Defense (DoD) seeks to improve the health and well-being of the entire DoD community. Operation Live Well is an umbrella or network to link the community with resources, which will serve beneficial in adopting a healthy lifestyle. There are a number of initiatives available to assist the DoD community; i.e. National Prevention Strategy, Health Base Initiative (HBI), Performance Triad (P3), and Let’s Move. The main focus area targeted by Operation Live Well are:
   1. Integrated wellness- concentrate on the visible and invisible portions of wellness highlighting the link between the physical and emotional/mental health. Mental health leads to physical health, and vice versa.
   2. Mental wellness- combined with emotional well-being is essential to being your best at any age. The more you are prepared for the effects of stress the better you can adapt and cope with stress.
   3. Nutrition- consuming a variety of nutritious foods and beverages keeps you performing and looking your best.
   4. Physical activity- staying in motion helps you to look and feel your best! Regular physical activity for the family will help improve overall health.
   5. Sleep- getting sufficient rest each night ensures optimal mental and physical performance. Sleep improve the immune system and can help alleviate stress.
   6. tobacco-free living- is avoiding use of all tobacco products and living free from secondhand smoke exposure.
B. Healthy Base Initiative (HBI) - This project was launch in 2013 at 14 different locations. The Office of Military Community and Family Policy, Office of the Secretary of Defense is encouraging military installations to heighten efforts focusing on good nutrition, active lifestyles, and tobacco-free living. Obesity and Tobacco is a severe problem for the military community; both active and veterans. The healthcare cost associated with military separation, days lost and are extremely expensive. To trend down these troubled area the initiative promotes a healthy and fit force, which is essential to national security by:

1. Increasing the awareness of the devastating impact of sedentary lifestyles and poor nutrition choices- helps to create an environment that:
   a. increases quality recruitment
   b. Increase retention.

2. Empowering the military community to make better nutritional choices- 
   a. increasing resilience will ensure optimal performance while defending our nation.

3. Increasing physical activity- staying in motion and regular activity 
   a. helps you to look and feel your best
   b. improve personal health
   c. Improve family health.

4. Decreasing tobacco use- benefits include: 
   a. increased cardiovascular capacity 
   b. more likely to engage in physical activity 
   c. increase circulation 
   d. decrease DoD cost associated with cancer 
   e. increased financial resources

5. Losing weight- Behavioral Risk Factor Surveillance System (BRFSS) has shown 67% of Americans are overweight or obese. Weight lose harvest the following benefits; 
   a. makes physical activity easier 
   b. leads to increase readiness 
   c. decrease the DoD cost associated obesity

6. Collaboration with local services- linking either services a community member to services. Some local services may include; 
   a. Tobacco cessation 
   b. MWR classes 
   c. Army Community Services (ACS) 
   d. Nutrition Care Division (NCD) 
   e. Garrison Wellness Program

C. Performance Triad (P3) - OPERATION ORDER 14-20 [PERFORMANCE TRIAD DIRECTIVES FOR MEDCOM AND REGIONAL MEDICAL COMMANDS (RMCs) / MAJOR SUBORDINATE COMMANDS (MSCs)]. This imitative is the Health component of resiliency with the effort to improve the lifestyle choices of our military community. Its primary focus is to educate the community, communicate
with the key stakeholders, and to partner with the MTFs IMCOM, FORCSOM, and TRADOC to synchronize and maximize awareness.

1. Literacy Campaign
   a. Messaging
   b. Outreach
   c. Education
   d. Collaborative partnership

Note: P3 is considered a health literacy program that links the customer to services to improve sleep, activity, and nutrition. Operation Live Well, HBI & P3 all encourage utilization of local programs that can assist the community improve. Examples of the programs are Health Promotion, the Army Wellness Center, Garrison Wellness Program, Civilian Fit Program, Strong Star, and Military Family Life Counselors (MFLC)

2. Professional Soldier Athlete
   a. Sleep- 7-8 hours recommended
   b. Activity- 10,000 steps daily and 150 minutes of aerobic type exercise
   c. Nutrition- 8 servings of fruits & vegetables and 8 glasses of water

3. Outcomes and end state
   a. Unit and Individual Readiness
   b. Resilience
   c. Human dimension and domain

4. Return on Readiness
   a. Increased lifespan
   b. Fewer sleep related automobile accidents
   c. Increased memory
   d. Increased mood
   e. Decreased DoD cost for retraining new recruits

D. The System for Health (SfH) is a critical enabler in the Ready and Resilient Campaign (R2C) and results in optimized human performance, health readiness, resilience, and overall personal health by adjusting the Human Domain (Person) and Human Dimension (Environment). In order to impact these two areas it hones in on three components:

1. Readiness, Resilience and Responsibility
   a. Improves-through Sleep, Activity, and Nutrition, (Performance Triad), SfH optimize performance through healthy behaviors.
   b. Restores-through providing evidence-based, person-centered, care that focuses on health and wellness (Delivery of Health).
   c. Maintains-healthy lifestyles through the promotion of safe, sustainable communities that support informed choices and Healthy Environments.
2. Enabling the land power
   a. P3- utilizing leader driven program to optimize the performance and health
   b. Delivery of health- requires a fundamental cultural change within Army Medicine
   c. Requires collaboration between installation/ community wide environmental, occupational, and public health programs
3. Person Centered verses Patient Centered
   a. Transforming the internal culture of the healthcare system from Healthcare to System for Health (SfH)
   b. Implementing Patient Center Medical Homes (PCMH)
   c. Seek help to prevent illness versus seeking help because of illness
4. Strategic Context
   a. Human dimension- the person; behaviors, mindset, etc...
   b. Human domain- environment; work, community, etc…

3. Discuss opportunities for potential APHN engagement within these various initiatives.
   The APHN has five organizational levels of opportunity; self, section/unit, MTF, garrison and installation to engage these initiatives using the 10 Essential Public Health Services and preserve the fighting strength of our DoD community. There are several common sections amongst all initiatives and all efforts support Operation Live Well and SFH.

10 Essential Public Health Services
1. Monitor health status to identify and solve community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure a competent public and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

NOTE: the above underlined Public Health Service are those the APHN can employ at numerous levels to affect the population of the installation. Below the numbers in bold reflect the number Public Health Services utilized.
   a. Personal: employs essential PH services #8
      1. Performance Triad (P3) - engage in services that can help you improve Sleep, Activity & Nutrition.
         a. Will help the APHN understand the services available
         b. Give creditability when sharing the programs with others
         c. Develops a personal testimony
2. HBI- Tobacco is one of the areas in Health Promotion so the APHN
   a. Indigenous to APHN
   b. Cross train in in Tobacco Cessation
   c. Volunteer for the Tobacco Free Campus Committee
b. Unit/ Section: #7 and 8
   1. Invite all initiative points of contact to the annual Retiree Health Fair planning meetings.
   2. P3- Have the P3 Action Officer (P3AO) present P3 to your section.
      a. Opens avenues for the section to engage in P3
      b. Improves the team’s readiness
      c. May lead to section competitions
      d. All APHNs will benefit from P3
      e. APHN becomes P3 advocate and improving readiness
3. HBI- APHN mission supports this initiative
   a. Tobacco Cessation is a great manner to support this initiative
   b. Health Promotion plan the Great American Smokeout awareness day
   c. Maintain proficient evidence based Tobacco Cessation support groups
c. MTF: #3, 4, 5, 7 & 8
   The APHN can impact the MTF in the following manners:
   1. P3-
      a. Ensure the MTF has a Community Health Promotion Council and the APHN is a participating member
         i. the APHN will be able to stay abreast on the momentum of P3
      b. Volunteer to assist the P3AO with future presentations
      c. Ask the P3AO questions about their duties
      d. Support the MTF efforts to improve P3; i.e. wellness challenges
      e. Share with APHN and MTF leadership about becoming the P3AO
2. HBI-
   a. Assist in the development of a Tobacco Free Campus Policy by being an active participant in the Workgroup
   b. Link with Occupational Health to ensure both the civilian and military population have access to the tobacco cessation program in support of the Tobacco Free Campus
3. SfH-
   a. Support all efforts created to improve patient care that lead to the return our military community back to their daily living
   b. Visit the staff at the PCMHs asking how you can assist making the APHN process easier for the staff
   c. Follow Environmental Health during their inspections
d. Garrison: #3, 4, 5, 7 & 8
   The APHN can impact Garrison in the following manner:
   1. P3-
      a. Identify the point of contact for the Garrison Wellness Program
      b. Link the P3AO with the Garrison Wellness Program POC
      c. Assist with merging the two initiatives.
Installation: #3, 4, 5, 7, 8
The APHN can impact Installation in the following manners:

1. P3-
   a. Participate in the Installation CHPC
      i. the APHN will be able to link with the installation HPO
      ii. the APHN will understand momentum of P3 at the installation level
   b. The APHN can volunteer to assist the P3AO with future presentations
   c. Can merge current APHN efforts with the P3AO future endeavors

2. HBI-
   a. Collaborate with and assist in the development tenant unit pilot programs
   b. Coordinate with the HPO on other CG directed programs

4. Synchronizing Health & Performance
   The military has implemented many new programs in efforts to improve the quality of life, decrease suicides, decrease divorces and improve retention of quality Soldiers. However, all of those initiatives have been working independent of one another. Synergistic efforts are crucial in ensuring all programs are successful, the military community maximizes its resiliency, and the DoD operates at optimal capacity.

A. Catalyst for change- Sub-optimal performance decreases unit readiness and or mission.

   1. Millions of unnecessary neuromuscular or musculoskeletal visits
   2. Decrease cognitive performance
   3. Thousands of non-deployable Soldiers
   4. Thousands of Soldiers discharged due to failing the height and weight standards
   5. Veteran’s transition to DoD civilian workforce
   6. Half of the retiree population is overweight or obese

B. Operationalizing R2C
   1. Community Health Promotion Council
      a. Senior Commander forum to address installation concerns
      b. Brigade (BDE) forum allow BDE attention and sharing with CG
   2. Commander R2C Challenges
      a. Suicides
      b. Sponsorship
      c. Substance abuse
      d. Financial difficulties
      e. GAT 2.0
      f. Mission verses resilience
   3. Health Tool Kit
      a. Embedded Behavioral Health (EBH)
         i. behavioral health readily available
         ii. decrease stigma for seeking assistance
      b. Army Wellness Centers (AWC)
i. health assessment
ii. body fat composition
iii. sleep hygiene
iv. basic nutrition
v. stress management
vi. well coaching
c. Health Promotion
   i. monthly observances
   ii. health fairs
d. Patient Center Medical Home (PCMH)
   i. decrease time seeking medical attention
   ii. one stop shop
   iii. close proximity to units

Note: Healthy people are essential for optimal DoD community function. Lifestyle and cultural changes are necessary for the defense of our nation. Continued efforts focused on prevention are vital for the support of the Army Medicine’s shift from a Healthcare System to the System for Health. With this cultural shift we will ensure our force remain at its best and safeguard the survival of the DoD Civilian Corps. Active Duty, Retirees, DoD Civilians and their children are all our responsibility as APHNs so we must ensure they’re most resilient by engaging, promoting, marketing and connecting them to as many initiatives or programs available to enhance maximum performance.
I. Read the scenario

A Hospital Commander wants to have a tobacco free campus within 6 months. The policy offers an employee fringe benefit program (offering benefits to civilian employees that are not eligible to obtain care). The Department of Preventive Medicine (DPM) is tasked with making this vision a reality.

1. Tobacco Cessation is run by the APHN Health Promotion Clinic
   a. Offers Tobacco Cessation Support Groups
   b. Serve as the tobacco subject matter expert for the installation
2. Occupational Health serves as the medical provider to prescribe medication

II. Ask the following questions

1. What DoD initiative/s supports a tobacco free campus?
2. How can APHN support this effort?
3. Which of the 10 essential Public Health serves will be employed?

III. List the 10 Public Health Essential Services

1. Monitor health status to identify and solve community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure a competent public and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

IV. Potential answers to scenario questions

1. What DoD initiative(s) supports a tobacco free campus?
   a. Operation Live Well
   b. Healthy Base Initiative
2. How can APHN support this effort?
   a. Volunteer to be on the Tobacco Free Campus Committee
   b. Ensure Health Promotion is part of the team
   c. Participate as a Tobacco Cessation Nurse
   d. Market the Tobacco Free Campus
      i. Hospital
      ii. Community Service Council (CSC)
      iii. Community Health Promotion Council (CHPC)
1. Hospital
2. BDEs
3. Installation
   e. Link with PCMH
3. Which of the 10 essential Public Health serves will be employed? – Discuss with the participants which essential services are applicable to this scenario and why.

V. Solicit discussion
   1. What other ways can the APHN engage the community with this initiative? (Allow about 5-10 minutes of discussion)

VI. End of Session

REFERENCES


Horoho, Patricia., LTG, U.S. Army Surgeon General. Operation Oder 14-20 "Performance Triad Directives for MEDCOM and Regional Medical Commands (RMCs)/ Major Subordinate Commands (MSC).” Fort Sam Houston, TX, U.S. Army Medical Command, March 17, 2010.

Olson, Keith E CIV USARMY HQDA DCS G-1 (US); May 10, 2013 e-mail concerning discharges due to failure to meet weight standards.


DoD Efforts to Improve the Lifespace

“Enabling the Health, Readiness, and Resilience of the World’s Premier Land Power”

APHN Professional Development Session

Training Objectives

➢ Define the term Lifespace
➢ Identify four DOD health initiatives
➢ Understand potential APHN engagement
➢ Understanding how synchronizing health affect performance

Image Credit: http://www.examiner.com/article/changing-family-dynamics
Outline:
- Operation Live Well
- Healthy Base Initiative (HBI)
- Performance Triad (P3)
- The System for Health (SFH)
- APHN Engagement
- Synchronizing Health & Performance

“What is the Lifespace?

YOUR LIFESPACE

- Time not spent in front of a provider
- Leaves 525,500 minutes for independent decisions
- Space where you make your daily decisions
- Average time in front of a provider is 100 min/yr

Image Credit: https://media-cashe-ec03.pinimg.com/736x/57/42/9d/57429d674d5d8f0d657bb19616c6745476.jpg
**Operation Live Well**

Operation Live Well is a DoD initiative aligned with the National Prevention Strategy. Its mission is to bring together the resources and capabilities of the entire local military community in creating an environment focused on the best ways to promote health, well-being, and readiness. The goal of this strategic approach is to create more ready, more resilient, and healthier armed forces and military communities.

- Integrated wellness
- Mental wellness
- Nutrition
- Physical activity
- Sleep
- Tobacco-free living

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**Healthy Base Initiative (HBI)**

Promotes a healthy and fit force by:

- Increasing the awareness of the devastating impact of sedentary lifestyles and poor nutrition choices
- Empowering the military community to make better nutritional choices
- Increasing physical activity
- Decreasing tobacco use
- Losing weight
- Collaboration with local services
Performance Triad (P3)

Focus on resiliency through:

➢ Messaging
➢ Outreach
➢ Education
➢ Collaborative partnerships

*Considered a health literacy program that links the customer to needed services

P3

YOU are a Professional Soldier Athlete!

- 8 is Great! 7-8 Hours of Sleep Per Night
  Go Caffeine Free 6 Hours before Bedtime

- 10,000 Steps a Day
  150 Minutes of Activity Per Week

- 8 is Great! Eat 8 Fruits & Vegetables a Day
  Re-Fuel 30-60 Minutes after Strenuous Activity

Source: www.armymedicine.mil
Performance Triad

The Performance Triad

Outcomes and End State

- As part of the System for Health, Army Medicine has initiated programs to enhance sleep, activity, and nutrition in our beneficiary populations
- The goal of the Performance Triad is to improve stamina, readiness and health through enhanced activity and improved nutrition and sleep
- This program directly supports the Army’s Ready and Resilient Campaign and the Comprehensive Soldier and Family Fitness (CSF2) Program
- The Performance Triad positively influences the human dimension and domain

Unit & Individual Readiness
Resilience
Human Dimension & Domain

Return on Readiness

- Just one sleepless night (<4 hours) can impair performance as much as a 0.16% blood-alcohol level
- 6K active duty (~12 BCTs) are non-deployable due to medical profiles
- 10% decrease in overweight soldiers enables FCRSCOM, 90% deployable goal
- $4.2B to train and replace all soldiers BMI > 30 (currently 78,734 active duty soldiers) who are 36% less likely to deploy
- 5+ fruit & vegetables is associated with a 5-fold increase in mental well-being compared to 1 portion
- Fatigue was a contributing factor in 628 Army accidents and 32 soldier deaths (FY 11-14)
- 10 million limited days of duty of CONFO 1 soldiers on duty limiting profiles
- Overweight recruits are 47% more likely to become injured and use 49% more healthcare resources in first 90 days
- $1.2M annually to replace soldiers discharged due to weight control ($75.9k per new recruit)
- Programs to improve health can result in a $3.27 return on investment for every $1.03 spent on prevention
- Performance Triad Pilot study baseline reports 99.6% of soldiers do not meet all target behaviors
System for Health

System for Health (SFH) is a partnership among Soldiers, Families, Civilians, Leaders, Health Teams and Communities to promote Readiness, Resilience and Responsibility.

- MAINTAINS health through fitness and illness/injury prevention
- RESTORES health through patient centered care
- IMPROVES health through informed choices in the Lifespace

TODAY health CARE
- Impersonal
- Volume Driven Incentives
- Poor Coordination
- Stymied by Silos
- Inconsistent Practice Patterns
- Data with No Built Meaning

TOMORROW HEALTHcare
- Personalized
- Value-based Incentives
- Population Management
- Rich & Interactive Teams
- Application of Leading Practices
- Exploits data to empower better Healthcare
System for Health: Enabling Land Power Through the Human Dimension

Performance Triad
Delivery of Health
Healthy Environments

Platform for Health Readiness
Sleep, Activity, & Nutrition Enables Physical, Emotional, & Cognitive Dominance
Physical | Emotional | Social | Spiritual | Family

Person-Centered vs. Patient Centered

“Predict and prevent disease”
- Self Care
  - Performance Triad
  - Emotional
  - Spiritual
- Social Networks
  - Friends
  - Spouses/family
  - Army Leaders/Unit
- MTF
  - Health & Wellness focused
  - Predictive, personalized preventive

“Find Disease and Fix it”
- Healthcare
  - Focused on disease, illness and injury
- Prevention
  - Focused on disease prevention
  - (immunizations, cancer screenings)
- MTF
  - Injury and illness treatment
  - Chronic care management

GOAL: Improve readiness, resilience, performance
GOAL: Maintain absence of disease and restore to previous state
**Strategic Context**

**Human Dimension:** encompasses the cognitive, physical, and social (CPS) components of our military community. (Draft Human Dimension Concept, version 0.898)

**Human Domain:** The totality of the physical, cultural, psychological, and social environments that influence human behavior.

*Human Dimension focuses inwardly on the Human Capital Lifecycle. Human Domain focuses externally on the human environment.*

---

**Potential APHN Engagement**

10 Essential Public Health Services Implemented

- **Personal Level**
  3. Assure a competent public and personal health care workforce

- **Unit/Section Level**
  7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
  8. Assure a competent public and personal health care workforce

- **MTF, Garrison and Installation Level**
  3. Inform, educate, and empower people about health issues
  4. Mobilize community partnerships to identify and solve health problems
  5. Develop policies and plans that support individual and community health efforts
  7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
  8. Assure a competent public and personal health care workforce
Synchronizing Health & Performance

Transform asynchronous efforts into

Army PRT
The "Common Engine"

Performance Tried

Maximize Unit-Level Performance Optimization & Injury Prevention

Soldier as a Weapons System

Endstate: Optimized Performance & Injury Prevention

Health Teams

Leaders

Army Medicine partners with local programs

Unit Leadership Accountability

Catalyst For Change

Sub-optimal human performance directly impacts unit readiness / mission

- There were 3.7 million AD military medical visits and hospitalizations for neuromuscular conditions in FY12

- Soldiers who get less than 7-6 hours of sleep per night lose 20% of their cognitive performance

- Over 20,000 Soldiers are medically non-deployable

- 1,815 Soldiers were discharged in FY12 due to failing to meet height/weight standards; with a recruiting and training cost loss of over $98 million

- 49% of Army Retirees' Body Mass Index is 30 or greater

Optimizing human performance through leader engagement and changes in attitudes and behaviors.
Operationalizing R2C

Community Health Promotion Council

PURPOSE: Senior Commander’s forum to organize and operationalize R2C
- Senior Commanders
- Health Promotion Officer
- Tenant Units / BDE Health Promotion Teams
- Community Representatives
- Director of Health Services
- Director of Psychological Health Services
- Garrison Commander
- HR Directorate
- Family Readiness Groups
- Suicide Prevention PM
- SHARP PM
- Alcohol Drug Control
- Chaplain, DPTMS, PAO

Command R2 Challenges

Health Service Toolkit
- SuicdiePrevention
- SHARP
- Family Advocacy
- Substance Abuse
- Medical Readiness
- Transition Teams
- Army Continuing Education
- Finance
- CDM Risk Reduction Dashboard
- CSF2 Comprehensive Soldier and Family Fitness
- GAT 2.0/ArmyFit

R2 Tactical Kit Bag

Improved Health = Improved Resilience = Improved Readiness

QUESTIONS?
Presentation Developed and Presented by:

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APHN, Department of Preventive Medicine
Carl R. Darnall Army Medical Center

Email: ronald.d.cole.mil@mail.mil

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"Use of trademarked name does not imply endorsement by the U.S. Army, but is intended only to assist in identification of a specific product."
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Which of the 10 Essential Public Health Services will be employed?


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• Olson, Keith E CIV USARMY HQDA DCS G-1 (US); May 10, 2013 e-mail concerning discharges due to failure to meet weight standards.


• Performance triad, operation order 14-20, OTSG, dated Mar 21, 2013


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<table>
<thead>
<tr>
<th>Required Task or Skill</th>
<th>Orientation (Preceptor initials &amp; date)</th>
<th>+ Eval Method</th>
<th>Competency Validated by Supervisor (Signature &amp; date)</th>
<th>Reference/Quad Council Core Competency (CC)/Essential PH Services (ES)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Stakeholder Introductions/Networking</td>
<td>CRITICAL THINKING: APHNs need to be aware of the resources in their areas of responsibility to more effectively link Soldiers and families to needed services. This interaction also facilitates identification of potential opportunities for collaboration. This requires proactive engagement with community stakeholders learning of their capabilities and articulating the APHNs value added to identify areas of mutual interest.</td>
<td></td>
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<tr>
<td>Installation Assets</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Community Health Promotion Council Chair (If Applicable)</td>
<td></td>
<td></td>
<td></td>
<td>CC - Domain 5: #3,4,5 / ES - #4</td>
</tr>
<tr>
<td>Army Wellness Center Director (If Applicable)</td>
<td></td>
<td></td>
<td></td>
<td>CC - Domain 5: #3,4,5 / ES - #4</td>
</tr>
<tr>
<td>Army Community Services POC</td>
<td></td>
<td></td>
<td></td>
<td>CC - Domain 5: #3,4,5 / ES - #4</td>
</tr>
<tr>
<td>Family Advocacy Program POC</td>
<td></td>
<td></td>
<td></td>
<td>CC - Domain 5: #3,4,5 / ES - #4</td>
</tr>
<tr>
<td>Child Youth and School Services Director</td>
<td></td>
<td></td>
<td></td>
<td>CC - Domain 5: #3,4,5 / ES - #4</td>
</tr>
<tr>
<td>Installation School Nurses (If Applicable)</td>
<td></td>
<td></td>
<td></td>
<td>CC - Domain 5: #3,4,5 / ES - #4</td>
</tr>
<tr>
<td>Army Substance Abuse POC</td>
<td></td>
<td></td>
<td></td>
<td>CC - Domain 5: #3,4,5 / ES - #4</td>
</tr>
<tr>
<td>Student Company CDRs and Drill Sergeants (If Applicable)</td>
<td></td>
<td></td>
<td></td>
<td>CC - Domain 5: #3,4,5 / ES - #4</td>
</tr>
<tr>
<td>Local Community Assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Health Department HIV POC</td>
<td></td>
<td></td>
<td></td>
<td>CC - Domain 5: #3,4,5 / ES - #4</td>
</tr>
<tr>
<td>Local Health Department STI POC</td>
<td></td>
<td></td>
<td></td>
<td>CC - Domain 5: #3,4,5 / ES - #4</td>
</tr>
<tr>
<td>Local Health Department LTBI POC</td>
<td></td>
<td></td>
<td></td>
<td>CC - Domain 5: #3,4,5 / ES - #4</td>
</tr>
<tr>
<td>Local Health Department Training/Education POC</td>
<td></td>
<td></td>
<td></td>
<td>CC - Domain 5: #3,4,5 / ES - #4</td>
</tr>
</tbody>
</table>
**Department of Preventive Medicine Overview**

**CRITICAL THINKING:** APHNs have several opportunities to be stationed in single assignment locations or serve as Chief, Preventive Medicine. Having a basic knowledge and understanding of the roles and responsibilities of Preventive Medicine (PM) personnel is essential in providing appropriate oversight and ensuring preventive medicine services for military communities. It also facilitates optimal use of PM assets when APHN leaders are knowledgeable in the capabilities and scope of practice of personnel.

| Shadow and observe daily operations with 68S Personnel (Preventive Medicine Specialist). Verbalize primary roles/responsibilities and scope of practice for 68Ss. | CC - Domain 5: #3; Domain 8: #5 ES - #8 |
| Shadow and observe daily operations with 72D Personnel (Environmental Science Officer). Verbalize primary roles/responsibilities and scope of practice for 72Ds. | CC - Domain 5: #3; Domain 8: #5 ES - #8 |
| Shadow and observe daily operations with Environmental Health (EH) Personnel. Verbalize mission and primary duties for the EH section. | CC - Domain 5: #3; Domain 8: #5 ES - #8 |
| Shadow and observe daily operations with Industrial Hygiene (IH) Section Personnel. Verbalize mission and primary duties for the IH section. | CC - Domain 5: #3; Domain 8: #5 ES - #8 |
| Shadow and observe daily operations with Occupational Health (OH) Section Personnel. Verbalize mission and primary duties for the OH section. | CC - Domain 5: #3; Domain 8: #5 ES - #8 |
| Shadow and observe daily operations with Hearing Conservation (HC) Section Personnel. Verbalize mission and primary duties for the HC section. | CC - Domain 5#3; Domain 8: #5 ES - #8 |
| Shadow and observe daily operations with Nuclear Medicine (Nuc Med) Section Personnel. Verbalize mission and primary duties for the Nuc Med section. (If Applicable) | CC - Domain 5#3; Domain 8: #5 ES - #8 |

**APHN TECHNICAL MISSION TASKS**

**Epidemiology Surveillance, Control and Prevention**

**CRITICAL THINKING:** Epidemiology surveillance is the ongoing systematic collection, analysis, interpretation of, and dissemination of data. APHNs proactively engaged in this process facilitate the preventing and controlling of disease and injury in military communities. APHNs recognize signs and symptoms of diseases of Public Health concern through assessing patient and community needs in contact interviews and outbreak investigations. Communicates and coordinates with other agencies (local, State, Federal).

**REQUIRED CLINICAL INFORMATION SYSTEM ACCESS**

- Disease Reporting System internet (DRSi) Contact your local MTF IM/IT
- Essence Contact your local MTF IM/IT
- ALTHA/CHCS Contact your local MTF IM/IT

**REQUIRED REGULATION/POLICY REVIEW**

### 3. CDC STI Treatment Guidelines (2010)
http://www.cdc.gov/std/treatment/default.htm

### 4. Tri-service Reportable Events Guidelines & Case Definitions (March 12)

### RECOMMENDED ONLINE TRAINING

1. CDC STI Self Study Modules
http://www2a.cdc.gov/STDTraining/Self-Study/default.htm
There are seven modules. You will need to register at "CDC Training and Education Online" to register for the module and complete the exam. You can access CDC Training and Education Online at http://www2a.cdc.gov/TCEOnline/

2. CDC Self Study Modules for TB
http://www.cdc.gov/tb/education/ssmodules/default.htm

3. USAPHC Epidemiology Surveillance DCO Training
http://phc.amedd.army.mil/topics/healthsurv/de/Pages/Epi-TechTraining.aspx. You will need a DCO user name and password to access the trainings.

### A. HIV Program Management

<table>
<thead>
<tr>
<th>Activity</th>
<th>CC - Domain 1: #5,6,7; Domain 6: #1,5,6, 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interprets community, installation and unit level HIV surveillance data to assess population health.</td>
<td></td>
</tr>
<tr>
<td>Aware of the centralized HIV management reporting process and point of contact at USAPHC.</td>
<td>CC – Domain 1: #4; Domain 5: #3,4,5,8; Domain 6: #1,8</td>
</tr>
<tr>
<td>Understands the process to manage local level HIV database (Excel file).</td>
<td>CC – Domain 1: #4, 11; Domain 6: #1,8; Domain 7: #13</td>
</tr>
<tr>
<td>Completes an initial HIV notification and initiates military and local health department reporting procedures.</td>
<td>CC – Domain 3: #2,6; Domain 6: #1,8</td>
</tr>
<tr>
<td>Completes case contact interview for an HIV positive patient.</td>
<td>CC – Domain 3: #2; Domain 6: #1,8</td>
</tr>
<tr>
<td>Completes second notification procedures for subsequent positive results.</td>
<td>CC – Domain 3: #2,6; Domain 6: #1,8</td>
</tr>
<tr>
<td>Provides HIV education to an at risk patient.</td>
<td>CC – Domain 3: #2,6; Domain 6: #1,8</td>
</tr>
<tr>
<td>Provides annual HIV education as requested by military units and community groups IAW AR 600-110.</td>
<td>CC – Domain 3: #2,4,5,6</td>
</tr>
</tbody>
</table>

### B. STI Surveillance and Education

<table>
<thead>
<tr>
<th>Activity</th>
<th>CC- Domain 1: #1, 2; Domain 6: #1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands the diagnosis and appropriate treatment procedures of infected persons and their sexual partners.</td>
<td></td>
</tr>
<tr>
<td>SCHOLARLY PROJECT</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Conduct STI personal interview and case contact investigation.</strong></td>
<td>CC – Domain 3: #2, 6; Domain 6: #1,8</td>
</tr>
<tr>
<td>Coordinates with STI POC at local health department for liaison/reporting purposes.</td>
<td>CC – Domain 5: #3, 4, 5; Domain 7: #2</td>
</tr>
<tr>
<td>Locates and interprets community, installation and unit level STI surveillance data to assess population health.</td>
<td>CC – Domain 1: #5</td>
</tr>
<tr>
<td>Complete DRSi reporting with 72 hours of positive lab result notification.</td>
<td>CC – Domain 1: #4, 11; Domain 6: #1,8; Domain 7: #13</td>
</tr>
<tr>
<td>Provide STI education as requested to all sectors of the community.</td>
<td>CC – Domain 3: #2, 4, 5, 6</td>
</tr>
<tr>
<td>Ensure Army STI Control program adheres to guidance published by the CDC regarding screening procedures, treatment, follow-up and prevention strategies.</td>
<td>CC – Domain 2: #12</td>
</tr>
<tr>
<td><strong>C. TB Surveillance Program Management</strong></td>
<td></td>
</tr>
<tr>
<td>Completes a N-95 mask fit test and is properly fitted.</td>
<td>CC – Domain 5: #1; Domain 6: #1, 5</td>
</tr>
<tr>
<td>Places TB Skin Test (TBST).</td>
<td>CC – Domain 5: #1; Domain 6: #1</td>
</tr>
<tr>
<td>Interprets TBST by measuring any observed induration on skin.</td>
<td>CC – Domain 5: #1; Domain 4: #1, 2, 3, 6; Domain 6: #1,8</td>
</tr>
<tr>
<td>Completes TB screening for patients with past positive TBST.</td>
<td>CC – Domain 5: #1; Domain 4: #1, 2, 3, 6; Domain 6: #1,8</td>
</tr>
<tr>
<td>Completes initial screening for signs and symptoms for Active TB and documents information in patient’s electronic medical record.</td>
<td>CC – Domain 5: #1; Domain 4: #1, 2, 3, 6; Domain 6: #1,8</td>
</tr>
<tr>
<td><strong>Medication Refill Clinic</strong></td>
<td></td>
</tr>
<tr>
<td>Completes assessment for medication side effects at each encounter.</td>
<td>CC – Domain 5: #1; Domain 4: #1, 2, 3, 6; Domain 6: #1,8</td>
</tr>
<tr>
<td>Documents assessment on INH clinic template in electronic medical record.</td>
<td>CC – Domain 5: #1; Domain 4: #1, 2, 3, 6</td>
</tr>
<tr>
<td>Provides medication education.</td>
<td>CC – Domain 3: #2, 4, 5, 6; Domain 4: #1, 2, 3, 6; Domain 5: #1;</td>
</tr>
<tr>
<td>Orders appropriate labwork (Liver Function Tests, etc.).</td>
<td>CC – Domain 5: #1; Domain 6: #1,8</td>
</tr>
<tr>
<td>Refers/consults with appropriate provider for abnormal findings per local SOP or clinical protocol.</td>
<td>CC – Domain 3: #2,6; Domain 5: #1; Domain 6: #1,8</td>
</tr>
</tbody>
</table>
### Active TB Management

<table>
<thead>
<tr>
<th>Task</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refers patient of suspected TB to appropriate provider for R/O active TB assessment.</td>
<td>CC – Domain 3: #2,6; Domain 5: #1, 4; Domain 6: #1,8</td>
</tr>
<tr>
<td>Identifies close contacts that require testing.</td>
<td>CC – Domain 5: #1; Domain 6: #1,8</td>
</tr>
<tr>
<td>Completes close contact testing or refers to appropriate MTF service or local health department for testing.</td>
<td>CC – Domain 5: #1; Domain 4: #1, 2, 3, 6; Domain 6: #1,8</td>
</tr>
<tr>
<td>Facilitates follow-up appointments for Active TB patients.</td>
<td>CC – Domain 5: #1; Domain 4: #1, 2, 3, 6; Domain 6: #1,8</td>
</tr>
<tr>
<td>Facilitates/perform Directly Observed Therapy (DOT) as ordered.</td>
<td>CC – Domain 5: #1; Domain 4: #1, 2, 3, 6; Domain 6: #1,8</td>
</tr>
<tr>
<td>Is familiar with DOT medication therapies.</td>
<td>CC – Domain 5: #1; Domain 6: #1</td>
</tr>
<tr>
<td>Monitors DOT patients for medication side effects/adverse effects and communicates with provider as needed.</td>
<td>CC – Domain 5: #1; Domain 4: #1, 2, 3, 6; Domain 6: #1,8</td>
</tr>
<tr>
<td>Monitors sputum smears and culture reports.</td>
<td>CC – Domain 5: #1; Domain 4: #1, 2, 3, 6; Domain 6: #1,8</td>
</tr>
</tbody>
</table>

### D. Disease and Health Event Investigation

<table>
<thead>
<tr>
<th>Task</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand the interrelationships between the elements of the Epidemiological Triad (Agent, Host, Environment).</td>
<td>CC – Domain 5: #1; Domain 6: #1</td>
</tr>
<tr>
<td>Utilize a systematic approach to conduct disease and health event investigation.</td>
<td>CC – Domain 5: #1; Domain 6: #1</td>
</tr>
<tr>
<td>• Prepare for the field work – Includes researching the potential disease(s); gather appropriate supplies and materials; make administrative arrangements; and coordinate with other personnel to execute the investigation.</td>
<td>CC – Domain 5: #1; Domain 6: #1</td>
</tr>
<tr>
<td>• Confirm the existence of a health event/outbreak – Establish usual or suspected levels of disease occurrence and then determine whether observed numbers exceed usual levels.</td>
<td>CC – Domain 5: #1; Domain 6: #1</td>
</tr>
<tr>
<td>• Verify the diagnosis – Establish a case criteria for deciding whether a person is classified as a case.</td>
<td>CC – Domain 5: #1; Domain 6: #1</td>
</tr>
<tr>
<td>• Define and identify case(s) – Utilize various methods to identify and count cases. Collect case information via interviews or initial questionnaire.</td>
<td>CC – Domain 5: #1; Domain 6: #1</td>
</tr>
<tr>
<td>• Describe and orient the data based on time, place and person</td>
<td>CC – Domain 5: #1; Domain 6: #1</td>
</tr>
<tr>
<td>• Develop hypotheses about the causal factors</td>
<td>CC – Domain 5: #1; Domain 6: #1</td>
</tr>
</tbody>
</table>
- Evaluate hypotheses by obtaining additional information to prove or disprove its validity
- Refine hypotheses and carry out additional studies (additional epidemiology, laboratory and environmental studies)
- Implement control and prevention measures (Chain of Infection focus)
- Communicate findings to appropriate leadership, community members, and installation stakeholders

**CRITICAL THINKING:** As the Health Consultant to CYSS, APHNs must gain the skills and knowledge, and understand the regulatory documents that guide CYSS operations. APHNs provides guidance and consultation in optimizing the health environment for enrolled CYSS children and staff resulting in the collaborative goal of a safe environment to prevent and reduce disease and injury.

**REQUIRED REGULATION/POLICY REVIEW**

1. AR 608-10 Child Development Services  
   http://cfoc.nrckids.org/
3. CYS Connections – Health Practices in CYS Settings  
   http://www.armycysconnections.com
4. AR 608-75 Exceptional Family Member Program  

**A. CYSS Staff Training Facilitation and Compliance**

- Reviews and updates medication administration, communicable disease, blood borne pathogens and SIDS presentation and training materials.  
  CC – Domain 6: #4,6 / ES - #3
- Conducts medication administration, communicable disease, blood borne pathogens and SIDS training classes to CYSS staff.  
  CC – Domain 3 / ES - #3
- Reviews and updates Epipen training materials.  
  CC – Domain 6: #4,6 / ES - #3
- Conducts Epipen training classes for CYSS staff.  
  CC – Domain 3 / ES - #3
- Reviews and updates asthma/inhaler training materials.  
  CC – Domain 6: #4,6 / ES - #3
- Conducts asthma/inhaler training class for CYSS staff.  
  CC – Domain 3 / ES - #3
- Conducts health related training on other topics as needed to CYSS staff.  
  CC – Domain 3 / ES - #3

**B. Health Consultation**

- Review applicable ARs and policies that govern health related exception to policy approval and documentation process.  
  CC – Domain 2: #1,4 / ES - #5,6
- Provide health consultation during IMCOM level and other inspections.  
  CC – Domain 1: #2, Domain: 3 #2,6,7 / ES - #3,4,7,9

**C. CYSS Inspections**

- Locates and utilizes current versions of CYS facility inspection forms.  
  CC – Domain 1: #6 / ES - #1
- Reviews past inspection documentation for trend in deficiencies; areas to review, follow-up and monitor progress.  
  CC – Domain 1: #6 / ES - #9
- Conduct facility inspection and administration review of Child Development Center(s) IAW AR 608-10 and document results.  
  CC – Domain 1: #1,2,5,6,10, Domain 6: #4,8 ES - #1,2,9
- Conduct facility inspection and administrative review of School Age Service(s) IAW AR 608-10 and document results.  
  CC – Domain 1: #1,2,5,6,10, Domain 6: #4,8 ES - #1,2,9
<table>
<thead>
<tr>
<th>Activity</th>
<th>CC – Domain</th>
<th>ES –</th>
</tr>
</thead>
</table>
| Conduct facility inspection and administrative review of Youth Service(s) IAW AR 608-10 and document results. | 1, 2, 5, 6, 10, 6 | #4, 8
| Conduct home inspection and administrative review of Family Child Care Home(s) IAW AR 608-10 and document results. | 1, 2, 5, 6, 10, 6 | #4, 8
| Conduct inspection follow-ups as needed to ensure deficiency corrections | 1, 2, 6 | ES - #9

**D. Special Needs Accommodation Process (SNAP)**

Describes the complete SNAP referral process beginning at Parent Central Registration.

Describe the APHN role in the SNAP review process and understand the roles of other members.

Locates and accesses current SNAP forms.

Participates in the SNAP meeting serving as the APHN representative.

Documents in ALTHA/CHCS – SNAP meeting summary.

**Health Promotion and Wellness**

**CRITICAL THINKING:** APHNs are charged with employing multiple strategies to promote health, prevent disease, and ensure a safe environment for populations. Interventions and strategies should be grounded in sound theory and be evidenced-based.

**REQUIRED REGULATION/POLICY REVIEW**

1. National Prevention Strategy
2. Healthy People 2020
3. Ready and Resilient Campaign
4. Army Medicine Campaign Plan (AMEDD 2020)
5. AR 600-63 Army Health Promotion
6. DA Pam 600-24 Health Promotion, Risk Reduction and Suicide Prevention
7. Generating Health & Discipline in the Force, Ahead of the Strategic Reset Report 2012 (Gold Book)
8. Treating Tobacco Use and Dependence Clinical Practice Guidelines (PHC, 2008 Update) (Adopted by DoD/VA)
9. Performance Triad Review
# A. Community Health Needs Assessment (CHNA)

<table>
<thead>
<tr>
<th>Activity</th>
<th>CC - Domain</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locate, interpret and collect data from various primary and secondary population based data sources (Military and Civilian) to inform CHNA metrics.</td>
<td>Domain 1: #2, 3, 4, 5, 6; Domain 2: #4;</td>
<td></td>
</tr>
<tr>
<td>Coordinate and collaborate with community stakeholders to conduct a comprehensive community health needs assessment to characterize the population’s health; identify available resources; assess needs for community health services; and identify community health priorities.</td>
<td>Domain 1: #9, 12, 13; Domain 2: # 8; Domain 8: #1, 2, 3, 4, 8</td>
<td></td>
</tr>
<tr>
<td>Disseminate CHNA findings to community stakeholders and installation leaders to influence and inform local health policies.</td>
<td>Domain 2: #10; Domain 3: #5</td>
<td></td>
</tr>
<tr>
<td>Prioritizes community health promotion activities based on health assessment resource constraints.</td>
<td>Domain 7: #10; Domain 8: #8</td>
<td></td>
</tr>
</tbody>
</table>

## B. Tobacco Prevention and Control

<table>
<thead>
<tr>
<th>Activity</th>
<th>CC - Domain</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review the tobacco-free living section of the National Prevention Strategy to ensure all programs are aligned with national efforts.</td>
<td>Domain 1: #1; Domain 2: #4</td>
<td></td>
</tr>
<tr>
<td>Identifies existing installation and local community resources to assist beneficiaries with tobacco prevention and cessation.</td>
<td>Domain 5: #8</td>
<td></td>
</tr>
<tr>
<td>Understands beneficiary referral processes for tobacco prevention and cessation programs within the local community.</td>
<td>Domain 6: #8</td>
<td></td>
</tr>
</tbody>
</table>

## C. Other Health Promotion Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>CC - Domain</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooperates with other organizations sponsoring complementary health initiatives in the community (e.g. health fairs, national health observances).</td>
<td>Domain 5: #3, 4, 5</td>
<td></td>
</tr>
<tr>
<td>Provides leadership in the development and implementation of health initiatives in the community (e.g. health fairs, national health observances).</td>
<td>Domain 8: #1,2, 3</td>
<td></td>
</tr>
<tr>
<td>Includes appropriate health education in the implementation of programs and services for populations.</td>
<td>Domain 3: #1-7</td>
<td></td>
</tr>
<tr>
<td>Selects teaching and learning methods appropriate to the health literacy of the population and their identified objectives.</td>
<td>Domain 3: #1-7</td>
<td></td>
</tr>
<tr>
<td>Presents culturally and age-appropriate health promotion, disease prevention and environmental safety information and education materials to populations.</td>
<td>Domain 4: #1, 6</td>
<td></td>
</tr>
<tr>
<td>Collects feedback from participants to determine program and service effectiveness and recommended changes.</td>
<td>Domain 8: #7</td>
<td></td>
</tr>
</tbody>
</table>

## Influenza Vaccination Oversight and Vaccine Management

**CRITICAL THINKING:** APHNs develop skills to recognize screening, educational requirements and recommendations of vaccinations for all age groups and make appropriate product selections based on responses. During vaccination administration, administers the right vaccine, right dose, and right route, to the right patient at the right time.

### REQUIRED REGULATION/POLICY REVIEW

1. AR 40-562 Immunization and Chemoprophylaxis  
2. Epidemiology and Prevention of Vaccine-Preventable Diseases (CDC Pink Book)  
3. ACIP Vaccine Recommendations  
   [http://www.cdc.gov/vaccines/hcp/acip-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/index.html)
Describe the process of obtaining Vaccine Information Sheets (VIS) and vaccine contraindication.  

| CC - Domain 1: #1,4,5,6,13; Domain 2: #4; Domain 6: #6  
| ES - #1 |

Understands the process of ordering vaccines and required supplies.  

| CC - Domain 1: #13 / ES - #1 |

Coordinate as needed with other MTF assets for personnel and IT support to conduct annual influenza vaccination clinic.  

| CC - Domain 2: #8; Domain 3: #2,6; Domain 5: #2,3,4,5,6  
| ES - #1 |

Coordinate with installation units without organic medical assets to facilitate influenza vaccination.  

| CC - Domain 2: #8; Domain 3: #2,3,4,5,6; Domain 4: #1,2,3,6; Domain 5: #2,3,4,5,6; Domain 6: #1; Domain 7: #9,10  
| ES - #1 |

Locates and interprets Armed Forces Health Surveillance Center (AFHSC) DoD Seasonal Influenza Surveillance Summary reports to monitor installation level influenza activity.  

| CC - Domain 2: #1,2,4,6,9,11,12; Domain 5: #8  
| ES - #1 |

### VACCINE ADMINISTRATION PROCEDURES

#### Intranasal Influenza Vaccine

Selects appropriate intranasal influenza product based on age and screening of patient.  

| CC - Domain 1: #1,2,3,6,13 / ES - #1 |

Verbalizes understanding of the standing order and package insert for the administration of intranasal influenza vaccine to adult and pediatric patients.  

| CC - Domain 1: #1,2,3,6,13 / ES - #1 |

Gathers required supplies for administering intranasal influenza vaccine (i.e., tissue, sharps container, etc.).  

| CC - Domain 1: #13 / ES - #1 & #4 |

Follows OSHA and Infection Control practices to administer vaccination.  

| CC - Domain 1: #1,2,3,6,12,13 / ES - #1 |

Prepares intranasal influenza vaccine for administration: Removes properly stored intranasal influenza vaccine from refrigerator at (2-8°C); Do Not Freeze; Prepares prefilled syringe sprayer; Maintains aseptic technique throughout vaccine preparation process.  

| CC - Domain 1: #1,2,3,6,12,13 / ES - #1 |

Administers intranasal influenza vaccine per ACIP/manufacturer guidelines ensuring proper route, dosage, timing, and indications/contraindications.  

| CC - Domain 1: #1,2,3,6,12,13 / ES - #1 |

Completes Immunization Recordkeeping as required.  

| CC - Domain 1: #4,5,8,9,10,11,13 / ES - #1 |

Provides post-vaccination instructions.  

| CC - Domain 3: #2,6 / ES - #1 |

Demonstrates ability to recognize signs and symptoms of a patient experiencing an anaphylactic reaction and responds appropriately.  

| CC - Domain 1: #1,2,3,6,12,13 / ES - #1 |

Properly documents adverse event in the Vaccine Adverse Event Reporting System (VAERS).  

| CC - Domain 1: #1,8,11,13 / ES - #1 |

#### Injectable Influenza Vaccine

Selects appropriate injectable influenza product based on age and screening of patient.  

| CC - Domain 1: #1,2,3,6,13 / ES - #1 |

Verbalizes understanding of the standing order and package insert for the administration of injectable influenza vaccine to adult and pediatric patients.  

| CC - Domain 1: #1,2,3,6,13 / ES - #1 |

Gathers required supplies for administering influenza vaccine (i.e., gauze, alcohol pads, bandages, sharps container, etc.).  

| CC - Domain 1: #13 / ES - #1 |

Follows OSHA and Infection Control practices.  

| CC - Domain 1: #1,2,3,6,12,13 / ES - #1 |

Prepares injectable influenza vaccine for administration: Removes properly stored influenza vaccine from refrigerator at (2-8°C); Do Not Freeze; Prepares prefilled syringe sprayer; Maintains aseptic technique throughout vaccine preparation process.  

| CC - Domain 1: #1,2,3,6,12,13 / ES - #1 |
stored influenza vaccine from refrigerator at (2-8°C); Do Not Freeze; Inspects vial/syringe for damage or contamination.

<table>
<thead>
<tr>
<th>Administrative Task</th>
<th>Critical Thinking</th>
<th>CC - Domain</th>
<th>ES -</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administers injectable influenza vaccine per ACIP/manufacturer guidelines ensuring proper route, dosage, timing, and indications/contraindications.</td>
<td></td>
<td>#1,2,3,6,12,13</td>
<td>#1</td>
</tr>
<tr>
<td>Completes Immunization Recordkeeping as required.</td>
<td></td>
<td>#4,5,8,9,10,11,13</td>
<td>#1</td>
</tr>
<tr>
<td>Provides post-vaccination instructions.</td>
<td></td>
<td>#2,6</td>
<td>#4</td>
</tr>
<tr>
<td>Demonstrates ability to recognize signs and symptoms of a patient experiencing an anaphylactic reaction and responds appropriately.</td>
<td></td>
<td>#1,8,11,13</td>
<td>#1</td>
</tr>
<tr>
<td>Properly documents adverse event in the Vaccine Adverse Event Reporting System (VAERS).</td>
<td></td>
<td>#1,8,11,13</td>
<td>#1</td>
</tr>
<tr>
<td><strong>Emergency Preparedness/Disaster Management</strong></td>
<td><strong>CRITICAL THINKING</strong>: Public health threats are always present. APHNs are an essential component to community preparedness. Acquired skills are vital in facilitating a community’s ability to prevent, respond to, and rapidly recover from public health threats. These tools are critical for protecting and securing our nation’s public health.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**REQUIRED REGULATION/POLICY REVIEW**

<table>
<thead>
<tr>
<th>Regulation/Policy</th>
<th>Link</th>
</tr>
</thead>
</table>

**RECOMMENDED TRAINING**

<table>
<thead>
<tr>
<th>Training</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDC Crisis and Emergency Risk Communication Course</td>
<td><a href="http://emergency.cdc.gov/cerc/cerconline/training/index.html">http://emergency.cdc.gov/cerc/cerconline/training/index.html</a></td>
</tr>
<tr>
<td>National Incident Management System (NIMS): IS-100.HCb Introduction to the Incident Command System for Healthcare/Hospitals</td>
<td><a href="http://training.fema.gov/is/courseoverview.aspx?code=IS-100.HCb">http://training.fema.gov/is/courseoverview.aspx?code=IS-100.HCb</a></td>
</tr>
</tbody>
</table>

**A. Community Preparedness**

<table>
<thead>
<tr>
<th>Activity</th>
<th>CC – Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support the development of public health, medical and mental/behavioral health systems that support recovery.</td>
<td># 6</td>
</tr>
<tr>
<td>Participate in awareness training with community partners on how to prevent, respond to, and recover from public health incidents.</td>
<td>#3, 4, 5</td>
</tr>
<tr>
<td>Promote awareness of and access to medical and mental/behavioral health resources that help protect the community’s health and address the population’s functional needs.</td>
<td>#6</td>
</tr>
<tr>
<td>Collaborate with local agencies (on and off post) to conduct preparedness activities.</td>
<td>#3, 4, 5</td>
</tr>
<tr>
<td>Identify populations within the community that may be at higher risk to adverse health outcomes.</td>
<td>#1</td>
</tr>
</tbody>
</table>

**B. Information Sharing**

<table>
<thead>
<tr>
<th>Activity</th>
<th>CC – Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify stakeholders to be incorporated into information flow.</td>
<td>#3, 4, 5</td>
</tr>
<tr>
<td>Collaborate with stakeholders to identify and develop rules and data elements for sharing.</td>
<td>#3, 4, 5</td>
</tr>
<tr>
<td>Coordinate and collaborate with stakeholders by exchanging information to</td>
<td>#3, 4, 5</td>
</tr>
<tr>
<td>C. Mass Care</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>Determine the public health role in mass care operations.</td>
<td>CC – Domain 5: #1</td>
</tr>
<tr>
<td>Determine the mass care needs of the impacted population.</td>
<td>CC – Domain 5: #1</td>
</tr>
<tr>
<td>Coordinate public health, medical and/or mental health mass care services.</td>
<td>CC – Domain 5: #1</td>
</tr>
<tr>
<td>Monitor mass care population health.</td>
<td>CC – Domain 5: #1</td>
</tr>
<tr>
<td>D. Non-Pharmaceutical Interventions</td>
<td></td>
</tr>
<tr>
<td>Identify factors that impact the ability to recommend or implement non-</td>
<td>CC – Domain 5: #1</td>
</tr>
<tr>
<td>pharmaceutical interventions.</td>
<td></td>
</tr>
<tr>
<td>Determine non-pharmaceutical interventions appropriate for emergency</td>
<td>CC – Domain 5: #1</td>
</tr>
<tr>
<td>event - strategies for disease, injury, and exposure control. (e.g. isolation</td>
<td></td>
</tr>
<tr>
<td>and quarantine, restrictions on movements and travel advisory/warning;</td>
<td></td>
</tr>
<tr>
<td>social distancing; external decontamination; hygiene, precautionary</td>
<td></td>
</tr>
<tr>
<td>protective measures).</td>
<td></td>
</tr>
<tr>
<td>Implement non-pharmaceutical interventions.</td>
<td>CC – Domain 5: #1</td>
</tr>
<tr>
<td>Monitor the implementation and effectiveness of interventions.</td>
<td>CC – Domain 5: #1</td>
</tr>
<tr>
<td>Coordinate with community partners to determine the point in which the</td>
<td>CC – Domain 5: #3, 4, 5</td>
</tr>
<tr>
<td>intervention is no longer needed.</td>
<td></td>
</tr>
<tr>
<td><strong>Health Risk Communication/Knowledge Facilitation</strong></td>
<td></td>
</tr>
<tr>
<td>CRITICAL THINKING: Effective health communication is a critical skill in</td>
<td></td>
</tr>
<tr>
<td>public health practice. In applying these skills, APHNs can expand</td>
<td></td>
</tr>
<tr>
<td>their influence and credibility in facilitating population behavior change,</td>
<td></td>
</tr>
<tr>
<td>policy change, and in organizing community stakeholders. These skills are</td>
<td></td>
</tr>
<tr>
<td>also extremely beneficial in professional and patient interactions</td>
<td></td>
</tr>
<tr>
<td>promoting effective information exchange.</td>
<td></td>
</tr>
</tbody>
</table>

### REQUIRED REGULATION/POLICY REVIEW

- **AR 25-50 Preparing and Managing Correspondence**

- **Making Health Communication Programs Work (National Cancer Institute)**

- **Gateway to Health Communication and Social Marketing Practice Website (CDC)**
  - [http://www.cdc.gov/healthcommunication/](http://www.cdc.gov/healthcommunication/)

- **Army Social Media Handbook 2013**

- Implements a variety of communication strategies appropriate to audience needs, desired audience outcomes, content and context.
  - CC – Domain 3: #1,2,4,5,6 / ES - #3
- Grounds communication strategies in theory and evidence-based teaching strategies.
  - CC – Domain 3: #2 / ES - #3
- Uses information technologies skillfully to support the knowledge facilitation process.
  - CC – Domain 3: #2 / ES - #3
<table>
<thead>
<tr>
<th>Models critical and reflective thinking.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Uses personal attributes (e.g. caring confidence, patience, integrity, and flexibility) that facilitate knowledge dissemination.</td>
<td>CC – Domain 3: #2 / ES - #3</td>
</tr>
<tr>
<td>Practices skilled oral, written, and electronic communication that reflects an awareness of self and others, along with an ability to convey ideas in a variety of contexts.</td>
<td>CC – Domain 3: #2 / ES - #3</td>
</tr>
<tr>
<td>Develops amicable professional relationships with fellow hospital staff, beneficiaries, installation and local community partners to promote effective information exchange.</td>
<td>CC – Domain 3: #6,7</td>
</tr>
</tbody>
</table>

**Continuing Professional Development**

| Participates in ongoing educational activities to maintain and enhance the knowledge and skills necessary to promote the health of the population. | CC - Domain 8: #5, 6 |
| Seeks experiences to develop and maintain competence in the skills needed to implement programs and services for populations. | CC - Domain 8: #5, 6 |
| Maintains professional records that provide evidence of competency and lifelong learning. | CC – Domain 8: #5 |
| Contributes to an environment that fosters ongoing educational experiences for self, colleagues, healthcare professionals and the population. | CC - Domain 8: #5,6 |

**CRITICAL THINKING: APHNs are charged to proactively attain knowledge and demonstrate competencies that reflect current nursing and public health practice. Nurses need to be skilled in using current nursing research and other evidence to expand nursing and public health knowledge, enhance role performance and increase knowledge of professional issues.**

<table>
<thead>
<tr>
<th>Local MTF APHN Task/Skills</th>
<th></th>
</tr>
</thead>
</table>
Preceptor’s Initials: ___________ Printed Name: __________________________________________ Signature:____________________________________________

Preceptor’s Initials: ___________ Printed Name: __________________________________________ Signature:____________________________________________

I understand that of all the topics listed, I will be allowed to perform only those for my skill level/scope of practice and only after I have successfully demonstrated competency.

Employee Signature: __________________________________________ Date: __________________
Appendix F

APHN Readiness Assessment

This is an evaluation tool to measure perceptions of your confidence and readiness to practice as an APHN competently and autonomously. There are no right or wrong answers. We encourage you to be honest, as no identifying information will be shared. Your answers will be kept completely confidential.

1. Essential #1: Monitoring Community Health Status
How competent do you feel with your knowledge or skills in each of the following area?

<table>
<thead>
<tr>
<th>Task or Skill</th>
<th>I need to be taught about this</th>
<th>I do or can do this with help</th>
<th>I do or can do this</th>
<th>I do this with ease</th>
<th>I do this as an expert, intuitively</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Process of Community Health Needs Assessment</td>
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<tr>
<td>Select appropriate sources of data for community assessment</td>
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<tr>
<td>Select appropriate methods for data gathering</td>
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<tr>
<td>CONDUCT PRIMARY DATA ANALYSIS</td>
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</tr>
<tr>
<td>a. Interviews</td>
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<tr>
<td>b. Surveys</td>
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<tr>
<td>c. Focus Groups</td>
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<tr>
<td>CONDUCT SECONDARY DATA ANALYSIS</td>
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<tr>
<td>a. National Vital Records (e.g., birthday, deaths)</td>
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<tr>
<td>b. Population based surveys</td>
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<tr>
<td>c. Census Data</td>
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<tr>
<td>d. Behavioral Risk Factor Surveillance Data</td>
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<tr>
<td>e. Centers for Disease Control and Prevention Data</td>
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</tbody>
</table>

2. Essential #2: Diagnose and Investigate Health Problems
How competent do you feel with your knowledge or skills in each of the following area?

<table>
<thead>
<tr>
<th>Task or Skill</th>
<th>I need to be taught about this</th>
<th>I do or can do this with help</th>
<th>I do or can do this</th>
<th>I do this with ease</th>
<th>I do this as an expert, intuitively</th>
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</thead>
<tbody>
<tr>
<td>Conduct infectious disease interviews and investigations</td>
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<tr>
<td>Conduct case finding</td>
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<tr>
<td>Conduct epidemiological investigations of disease outbreaks</td>
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<tr>
<td>Develop community diagnoses/health priorities</td>
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<tr>
<td>Interpret lab results regarding reportable infectious diseases</td>
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</tbody>
</table>
3. Essential #3: Informing, Educating and Empowering Populations at Risk
How competent do you feel with your knowledge or skills in each of the following areas?

<table>
<thead>
<tr>
<th>Task or Skill</th>
<th>I need to be taught about this</th>
<th>I do or can do this with help</th>
<th>I do or can do this</th>
<th>I do this with ease</th>
<th>I do this as an expert, intuitively</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select culturally competent interventions based on evidence</td>
<td></td>
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<tr>
<td>Solicits community based input from individuals and organizations</td>
<td></td>
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<tr>
<td>Develop and implement awareness campaigns</td>
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<tr>
<td>Develop and implement public education campaigns</td>
<td></td>
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<tr>
<td>Translate community health needs assessment findings into language understood by those at risk</td>
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</tbody>
</table>

4. Essential #4: Mobilizing Community Partnerships
How competent do you feel with your knowledge or skills in each of the following areas?

<table>
<thead>
<tr>
<th>Task or Skill</th>
<th>I need to be taught about this</th>
<th>I do or can do this with help</th>
<th>I do or can do this</th>
<th>I do this with ease</th>
<th>I do this as an expert, intuitively</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td></td>
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<tr>
<td>Utilizing the change process to manage</td>
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<tr>
<td>Develop culturally competent relationships with community partners</td>
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<tr>
<td>Coalition Building</td>
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<tr>
<td>Lead groups through problem solving or decision making process</td>
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<tr>
<td>Team Building</td>
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<tr>
<td>Negotiation</td>
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<tr>
<td>Motivate and Inspire others</td>
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<tr>
<td>Stress Management</td>
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<tr>
<td>Appropriate use of mass media and social media</td>
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</tbody>
</table>
5. Essential #5: Develop Policies and Plans that Support Individual and Community Health Efforts
How competent do you feel with your knowledge or skills in each of the following area?

<table>
<thead>
<tr>
<th>Task or Skill</th>
<th>I need to be taught about this</th>
<th>I do or can do this with help</th>
<th>I do or can do this</th>
<th>I do this with ease</th>
<th>I do this as an expert, intuitively</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying areas for policy development</td>
<td></td>
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<tr>
<td>Writing a clear and concise policy statement/position paper</td>
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<tr>
<td>Translating policy into practice</td>
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<tr>
<td>Identify key organizational leaders/installation decision makers</td>
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<tr>
<td>Influence key organizational leaders/decision makers through effective oral communication (Information and decision briefs)</td>
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<tr>
<td>Identifies mechanisms to monitor and evaluate programs for their effectiveness and quality</td>
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</tbody>
</table>

6. Essential #6: Enforcement of Laws and Regulations
How competent do you feel with your knowledge or skills in each of the following area?

<table>
<thead>
<tr>
<th>Task or Skill</th>
<th>I need to be taught about this</th>
<th>I do or can do this with help</th>
<th>I do or can do this</th>
<th>I do this with ease</th>
<th>I do this as an expert, intuitively</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to locate and access health related Army regulations</td>
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<tr>
<td>Ability to locate and access health related laws and regulations (civilian)</td>
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<tr>
<td>Translate health laws and regulations into standard operating procedures and protocols</td>
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<tr>
<td>Educate appropriate leaders and organizations on compliance with public health laws</td>
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</tbody>
</table>
7. **Essential #7: Linking People to Services**
How competent do you feel with your knowledge or skills in each of the following area?

<table>
<thead>
<tr>
<th>Task or Skill</th>
<th>I need to be taught about this</th>
<th>I do or can do this with help</th>
<th>I do or can do this</th>
<th>I do this with ease</th>
<th>I do this as an expert, intuitively</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify existing community resources within the installation</td>
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<tr>
<td>Identify existing community resources within the local community</td>
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<tr>
<td>Refer or link beneficiaries to available resources</td>
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<tr>
<td>Determine appropriate services to address a health need</td>
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<tr>
<td>Advocate for the development of needed services if a gap is identified</td>
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</table>

8. **Essential #8: Assuring a Competent Workforce**
How competent do you feel with your knowledge or skills in each of the following area?

<table>
<thead>
<tr>
<th>Task or Skill</th>
<th>I need to be taught about this</th>
<th>I do or can do this with help</th>
<th>I do or can do this</th>
<th>I do this with ease</th>
<th>I do this as an expert, intuitively</th>
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</thead>
<tbody>
<tr>
<td>Use of Individual Development Plan (IDP) to monitor professional development</td>
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<tr>
<td>Appropriate use of time management</td>
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<tr>
<td>Promotes staff development (recognizing strengths, empowerment, use of creativity)</td>
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<tr>
<td>Seeks out opportunities for continuing professional development (Web-based, Face to Face)</td>
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</tbody>
</table>
9. Essential #9: Evaluating Health Services
How competent do you feel with your knowledge or skills in each of the following areas?

<table>
<thead>
<tr>
<th>Task or Skill</th>
<th>I need to be taught about this</th>
<th>I do or can do this with help</th>
<th>I do or can do this</th>
<th>I do this with ease</th>
<th>I do this as an expert, intuitively</th>
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</thead>
<tbody>
<tr>
<td>Use appropriate methods to collect evaluation data</td>
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<tr>
<td>Analyze qualitative data</td>
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<tr>
<td>Identifying and evaluating process objectives</td>
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<tr>
<td>Identifying and evaluating impact and outcome objectives</td>
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<tr>
<td>Write recommendations for programmatic or services change based on evidence results</td>
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<tr>
<td>Engage in continuous quality improvement</td>
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<tr>
<td>Present program evaluation results to organizational leaders/decision makers</td>
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</tbody>
</table>

10. Essential #10: Researching Innovative Solutions
How competent do you feel with your knowledge or skills in each of the following areas?

<table>
<thead>
<tr>
<th>Task or Skill</th>
<th>I need to be taught about this</th>
<th>I do or can do this with help</th>
<th>I do or can do this</th>
<th>I do this with ease</th>
<th>I do this as an expert, intuitively</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifies researchable questions and problems</td>
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<tr>
<td>Identify evidence-based public health interventions</td>
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<tr>
<td>Conduct computer searches of professional literature</td>
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<tr>
<td>Conduct computer searches of government websites for innovative evidence-based programs</td>
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</tbody>
</table>
11. List three skills/tasks you are most uncomfortable performing independently at this time. Select from the list below.

1. ____________________________
2. ____________________________
3. ____________________________

4. I am independent in all skills/tasks listed below

List of skills/tasks:
- HIV Program Management
- STI Program Management
- LTBI Program Management
- Evidence-based practice implementation
- Outbreak Investigation/Epidemiology
- Mass Vaccination/Installation Influenza Campaign
- Communicable Disease Reporting (DRSi)
- Community Health Needs Assessment (Planning and Execution)
- Emergency Preparedness/PHEO activities

12. What is your current level of confidence in managing the following situations:

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel comfortable communicating with line commanders/other installation stakeholders about public health related issues.</td>
<td></td>
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<tr>
<td>I feel comfortable teaching health related topics to Soldiers.</td>
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<tr>
<td>I feel confident in my ability to problem solve.</td>
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<tr>
<td>I am comfortable asking for help.</td>
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<tr>
<td>I use current evidence to make public health nursing decisions.</td>
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<tr>
<td>I am comfortable communicating and coordinating care with interdisciplinary MTF team members.</td>
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<tr>
<td>I feel comfortable teaching health related topics to family members, retirees, and DA Civilians.</td>
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<tr>
<td>I am comfortable taking action to solve problems.</td>
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<tr>
<td>I feel confident identifying actual or potential safety risks to my patients.</td>
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<tr>
<td>I feel comfortable communicating with patients in the clinical setting.</td>
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<tr>
<td>I feel confident in my ability to link beneficiaries to resources on or off the installation.</td>
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<tr>
<td>I am confident in my ability to articulate APHN’s role and value added to military communities.</td>
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<tr>
<td>I feel comfortable collaborating with installation stakeholders on public health related issues.</td>
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<tr>
<td>I feel am confident in my ability to practice as a competent public health nurse.</td>
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</tbody>
</table>
Appendix G

APHN NRP Program Evaluation Tool

Thank you so much for completing this survey. The information you provide will help us improve the educational experience for you and your fellow 6AF5 new graduates. All questionnaire responses will be kept confidential and the individual identities of participants will not be used in any reports or publications that may result from this project. The survey completion time should be no more than 15 minutes.

1. How many months have you been participating in the APHN NRP?
   Number of Months: __________

2. Please rate your satisfaction with your preceptor in the following areas. Please check one box for each line below.

<table>
<thead>
<tr>
<th></th>
<th>Very Satisfied</th>
<th>Somewhat Satisfied</th>
<th>Neither Satisfied nor Dissatisfied</th>
<th>Somewhat Dissatisfied</th>
<th>Very Dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledgeable in APHN main program areas</td>
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<tr>
<td>Has a strong teaching ability</td>
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<tr>
<td>Has a genuine interest in teaching</td>
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<tr>
<td>Easily approachable for questions/professional discussion</td>
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<tr>
<td>Provides guidance that is based in evidence and aligned with Army doctrine</td>
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<tr>
<td>Is timely with feedback</td>
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<tr>
<td>Professional feedback is useful and will facilitate my growth as an APHN</td>
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<tr>
<td>Models professional behavior at all times</td>
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<tr>
<td>Makes a conscious effort to be accessible to resident</td>
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<tr>
<td>During monthly progress meeting, I am comfortable having an open conversation about both resident and preceptor strengths and weaknesses</td>
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<tr>
<td>Overall satisfaction with your preceptor</td>
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</tbody>
</table>

3. Please rate your satisfaction with the overall learning environment in the following areas. Please check one box for each line below.

<table>
<thead>
<tr>
<th></th>
<th>Very Satisfied</th>
<th>Somewhat Satisfied</th>
<th>Neither Satisfied nor Dissatisfied</th>
<th>Somewhat Dissatisfied</th>
<th>Very Dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of supervision is adequate</td>
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<tr>
<td>Degree of autonomy is appropriate</td>
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</tbody>
</table>
Designated staff are appropriately prepared to facilitate professional development sessions

Designated staff are appropriately prepared to facilitate journal club sessions

Classroom/training space provided for educational sessions are conducive to learning

Professional development sessions are relevant and will contribute to my growth as an APHN

Journal club sessions are relevant and will contribute to my growth as an APHN

Reflective journaling has provided an opportunity to reflect on myself, my decisions and experiences during public health rotations, and my progression as an APHN

I am experiencing a variety of population-based training opportunities with hospital sections, installation and local community agencies fostering my growth as an APHN

<table>
<thead>
<tr>
<th>Overall satisfaction with your Learning Environment</th>
<th>Very Satisfied</th>
<th>Somewhat Satisfied</th>
<th>Neither Satisfied nor Dissatisfied</th>
<th>Somewhat Dissatisfied</th>
<th>Very Dissatisfied</th>
</tr>
</thead>
</table>

4. Please rate your satisfaction with the overall work environment in the following areas. Please check one box for each line below.

I feel supported by the entire APHN section staff as I progress through the residency program

I am supported by the Preventive Medicine Department as I progress through the residency program

My work environment encourages continuing professional development

The APHN section engages in collaboration and partnerships within the area of responsibility. The APHN section works together on public health related issues with:
• Primary and specialty care practitioners
• Other hospital team members (e.g. social work, pharmacy, dietary)
• Installation resources/agencies
• Local community public health resources/agencies

I feel comfortable about bringing attention to tough problems and issues
I feel comfortable in asking questions about decisions/actions made by APHN leadership

Overall satisfaction with your work environment

5. Based on your experience to date, if you had a choice, how likely would you be to choose your preceptor?
   - Definitely would choose this preceptor again
   - Probably would choose this preceptor again
   - Probably would not choose this preceptor again
   - Definitely would not choose this preceptor again

6. Based on your experience to date, if you had a choice, how likely would you be to participate in the presented professional development sessions?
   - Definitely would choose to participate in the presented sessions again
   - Probably would choose to participate in the presented sessions again
   - Probably would not choose to participate in the presented sessions again
   - Definitely would not choose to participate in the presented session again

7. Based on your experience to date, if you had a choice, how likely would you be to participate in this NRP?
   - Definitely would choose to participate in this NRP again
   - Probably would choose to participate in this NRP again
   - Probably would not choose to participate in this NRP again
   - Definitely would not choose to participate in this NRP again

8. What are your recommendations/suggestions to improve the resident/preceptor experience?
9. What are your recommendations/suggestions to improve professional development sessions?
10. What are your recommendations/suggestions to improve the work environment supporting your NRP experience?