**Community Program Planning Paper**

Student's Name

Institution

Course Name and Number

Instructor's Name

Date

**Mobilize**

 To bring about change in the 33165 zip code, the community nurse first needs to mobilize those interested in bringing change. To do this, the nurse could hold community meetings to discuss the health concerns that are common in the area and brainstorm ways to address these concerns. The nurse could also work with local organizations to promote health and wellness initiatives in the community. Additionally, the nurse could use social media to spread awareness of the health concerns in the community and to engage community members in conversations about how to improve the community's health. Some common health concerns in the 33165 zip code include obesity, diabetes, hypertension, and stress. To address these concerns, the community nurse could work with community members to promote healthy eating habits and physical activity. The nurse could also work to increase access to healthcare services in the community and provide education on preventing and managing chronic health conditions. Additionally, the nurse could work to reduce stress in the community by providing resources and support for those struggling to make ends meet. The nurse can help improve the community's overall health by addressing the community's shared health concerns.

**Assess**

 In the Assess stage, the community nurse would collect data on the community's health needs. This data could come from various sources, including health surveys, interviews with community members, and data from local hospitals and clinics (Stevens, 2019). The data would be used to identify the most common health concerns in the community. In this community, common health concerns include obesity, diabetes, hypertension, and stress. The data would also be used to identify health care access or outcomes disparities. For example, if the data showed that Cubans in the community have higher rates of obesity and diabetes, the community nurse would work to address this disparity. The nurse would then look at the community's available resources. Several community health centers and clinics in the area provide primary and preventive care services. There are also several hospitals in the area. However, there are limited mental health resources available. Finally, the nurse would identify any barriers preventing residents from accessing care. Some common barriers include lack of insurance, transportation, and language barriers. In addition, many residents in this community live below the poverty line and may be unable to afford care.

**Plan**

 In the Plan section of the MAP-IT model, the community nurse would first assess the needs of the community and identify the health concerns that are most common in the 33165 zip code. Next, the nurse would develop goals and objectives to address these health concerns. Some goals and objectives might include reducing the obesity rate by 5% over the next year, the diabetes rate by 3% over the next year, and the hypertension rate by 2% over the next year. To achieve these goals, the nurse would then develop strategies and interventions that would be implemented in the community. Some examples of strategies and interventions that could be used to achieve the goals include promoting healthy eating and physical activity, providing education on managing diabetes and hypertension, and offering stress-reduction classes.

**Implement**

 In the implementing section of the MAP-IT model, the community nurse would first work with local health care providers to develop educational materials on these health concerns. These educational materials would then be distributed to residents through local community organizations. The nurse would also work with these organizations to develop programs and events promoting healthy lifestyle choices. For example, the nurse could work with a local gym to offer discounted memberships to residents or work with a local grocery store to offer cooking classes. By taking these steps, the community nurse can help improve the community's health and make lasting changes.

 **Track**

 When tracking the effectiveness of an implementation plan, the community nurse would want to consider a few different factors. To start, they would want to consider what kind of data they need to track to see if the plan is working. This could include things like changes in health outcomes, changes in risk factors, or changes in health care utilization (Francke et al., 2018). They would also want to consider how they would collect this data. This could involve surveys, interviews, or data from medical records. Once the data is collected, the nurse would then want to analyze it to see if there are any patterns or trends. Finally, the nurse would want to share the results of their analysis with the community and other stakeholders. This could help ensure that the plan is on track and that necessary adjustments are made.

**References**

Francke, A. L., Smit, M. C., de Veer, A. J., & Mistiaen, P. (2018). A systematic meta-review influences the implementation of clinical guidelines for health care professionals. *BMC medical informatics and decision making*, *8*(1), 1-11.

Stevens, P. E. (2019). Focus groups: Collecting aggregate‐level data to understand community health phenomena. *Public health nursing*, *13*(3), 170-176.