THE PERCEPTION OF HEALTH ASSETS OF A RURAL IDAHO COMMUNITY BASED ON THE COMMUNITY-AS-PARTNER MODEL

By

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The following individuals read and discussed the thesis submitted by student Cherno Bah, and they evaluated his presentation and response to questions during the final oral examination. They found that the student passed the final oral examination.

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ABSTRACT

To improve the health status of rural communities, it is important to recognize and utilize all available health assets the community has to offer. When considering health assets, community members often fail to recognize resources such as economic status, communication, education, recreation, and politics, and instead focus only on obvious resources such as available physicians, Emergency Medical Technician (EMT) services and access to health clinics. The purpose of this study was to identify what community health assets are perceived among members of the rural community of Grangeville, Idaho and how these assets might be categorized according to the nine sub-systems from the Community-as-Partner model.

Forty Granville Idaho residents identified a total of 109 health assets, which were categorized into the nine Community-as-Partner subsystems by 4 nurses with rural health experience. The greatest majority (62%) of perceived assets were categorized as "health and services." The subsystems least identified with health assets included education, politics, communication, and economics. Findings from this study support the notion that when considering health assets, important assets may not be recognized as contributing to the health of a community.

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CHAPTER 1: THE RESEARCH PROBLEM

Introduction

Living in a rural community is seen by some as an escape from fast-paced city life. Nelson and Nelson (2011) reported that rural residents are thought to be less stressed and enjoy a better quality of life than urban residents. However, research indicates that rural residents, especially older people who account for a significant proportion of the rural population, have reported poorer health status when compared to their urban counterparts (Lau & Morse, 2008). Many parts of rural America experience a significant disadvantage especially in healthcare, and other sociodemographic barriers. Rural America is reported to have higher rates of unemployment, increased rural-urban migration, less educated members of society (Monnat and Beeler-Pickett, 2011), and inadequate or underdeveloped infrastructure. The National Organization of State Offices of Rural Health (2006) reported that similarities among rural communities include higher rates of poverty, chronic diseases, and limited access to transportation. Shi and Singh (2008) reported that these challenges are consistent dimensions of life in rural America and are often reflected in the health status of its people.

Due to differences in population distribution and characteristics of rural communities, exploring and interpreting the challenges and health issues affecting rural residents requires caution in order to avoid making inaccurate statements about rural America in general. In spite of their common characteristics, rural American

communities are very diverse (Bigbee, 2007). The experience and health status of one rural community is different from another rural community (Glasgow, Johnson, & Morton, 2004). In spite of these differences Bigbee (2007) pointed out that rural communities tend to share common problems such as shortages of healthcare providers and specialty care.

Statement of the Problem

In the state of Idaho, nearly 79.5% of counties (35 out of 44) are classified as rural and this consists of 90% of the total land area (Idaho Department of Commerce, & Housing and Finance Association, 2010). Nationally ranked 40th in population density and the fourth fastest growing state (U.S. Census Bureau, 2010), three in every ten Idaho residents live in a rural areas (Idaho Department of Commerce, & Housing and Finance Association, 2010). Like many rural communities across the country, rural Idahoans are faced with similar healthcare challenges and other socioeconomic barriers that are consistent with other rural communities across the nation. The challenges that many Idahoans face include limited healthcare insurance coverage, shortage of healthcare providers, and decreased access to basic healthcare services.

These challenges are complex and dynamic. One important factor that needs to be considered in order to address these challenges and to improve the health of rural communities is their definition of health. Understanding the health perceptions and behaviors of individuals or communities is an important component when considering the definition of health during assessment, program planning, and implementation (Bales, Winters, & Lee, 2010). Rural communities often fail to recognize resources within their communities such as political leaders, active community mobilizers, community's

economic strengths, and other important resources as health assets. Xu and Jacobs (2013) reported that to help address the challenges faced by rural communities, inter-community cooperation and a collaborative problems solving approach involving the government, stakeholders, and community members is fundamental.

Xu and Jacobs (2013) argued that in order to address these challenges in an effective way, existing resources and community problems must be acknowledged and incorporated into potential solutions. Doing so will require residents of rural communities to expand their definitions of health assets. In many instances, healthcare consumers tend to identify good doctors, hospitals, and emergency health services as resources or assets that determine one's health status. According to the World Health Organization (2013), determinants of health also include factors such as income level, educational opportunities, social support networks, and the physical environment. Unless communities learn to both recognize and implement resources that can impact these determinants of health, the overall health of the community may suffer.

The problem this study will address is how residents in a typical Idaho rural community, Grangeville, perceive health assets and whether or not, residents may recognize assets that are related to and may impact determinants of health.

Significance to Nursing

Because of their focus on holistic health care, nurses can help make a difference in how rural residents perceive health assets more than any other health care professional. Nurses can use their community assessment skills to help rural residents recognize a broader perspective of health determinants in their communities as potential health assets. By expanding the definition of health assets in rural communities, nurses can be

instrumental in mobilizing community networks to implement and apply resources that can have a positive impact on the overall health of the community.

Identifying and mobilizing community health assets gives the community the ability to respond to changes, and build on strengths available within the community to promote the health of their people. Nurses take a holistic and preventative approach to health issues and may be more likely than physicians to help residents of rural communities identify and define health assets more comprehensively. Nurses are reported to be better in health promotion and understanding of health problems than physicians because of the close interpersonal relationships they often develop with patients (Baldwin, Bazarko, Hancock, & Smith, 2010).

Therefore, the importance of nurses and their role in rural health promotion cannot be underestimated. In the following chapter, evidence retrieved from the literature about rural health, rural health policy trends, health disparities, and other related topics will be discussed.

CHAPTER 2: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Review of Relevant Literature

Health Determinants of Individuals and Communities

Health determinants are defined by the World Health Organization as the living condition of an individual in which socio-political factors significantly contribute to one's health status or that of the community in which he/she lives (Carmen, 2012). Less attention is focused on improving health by advancing educational, political, economic, and social determinants of health. Instead, people are more focused on improving individual behaviors such as smoking, or increasing access to healthcare services or having health insurance (Robert & Booske, 2011). The determinants of health such as recreational, economic, political, educational are often not recognized as factors that influences the health status of individuals or communities.

Identifying socio-economic and political resources that influence the health of disadvantaged populations such as rural and remote communities should not be taken lightly. Kelly et al. (2012) reported that geographic distribution of health determinants may greatly influence the health status of populations. Hence, identifying health determinants that are unique to rural communities such as environmental factors are important in developing programs to overcome health disparities associated with life in rural and remote communities (Kelly et al., 2012).

Characteristics of Rural Health in the United States

For many years, issues in rural health have focused on strengthening the existing healthcare delivery system, particularly, healthcare financing and the shortage of health care providers. This pattern has not only failed, but has contributed to an uncoordinated, fragmented and costly healthcare system (Mueller et al., 2011). In addition, too often, rural health research has focused on deficits of rural communities instead of the positive characteristics.

Studies in rural health care research indicate that rural deficits such as higher poverty rates, higher percentages of uninsured individuals, higher chronic illness, disability and poorer health status is uniformly common in most rural American communities (Agency for Health Research and Quality, 2010; American Public Health Association, 2012; Bigbee, 2007; Blakely, 2007; National Organization of State Offices of Rural Health, 2006). In addition, rural communities have also been reported to have higher proportions of children and elderly than their urban counterparts (Bigbee, 2007). Many of the older residents proportionately work less and tend to be in poorer health than the elderly residing in urban settings (Arcury et al., 2005).

A large number of aging rural residents suffer from multiple chronic conditions with nearly one in three reporting poor to fair health condition and nearly half reporting at least one chronic illness (Artnak, McGraw, & Stanley, 2011). Overall, the health status of rural residents is reflective of characteristics such as poverty, chronic illnesses, poor reported health status, and limited access to primary care (Bigbee, 1993; National Organization of State Offices of Rural Health, 2006). Priorities for rural healthcare must incorporate the provision of basic primary care, chronic illness management, health

promotion, and the recognition of community health resources or assets, all of which are central to the role of nurses in rural communities. In addition to recognition, greater emphasis also needs to be placed on the utilization of community resources to improve the general health status of rural communities.

Evolution of Rural Health Policy in the United States

Since the establishment of the Federal Office of Rural Health Policy in the 1980s, rural health research and policy intervention have dominated the agenda on healthcare issues in rural America. In 2000, the Minority Health and Health Disparities Research and Education Act was established to focus on the cultural dynamics affecting minority and underserved population groups and rural communities.

In a report from the Minority Health and Health Disparities Research and Education Act, Hartley (2004) discussed the importance of focusing on population-based practice models that can improve health outcomes. One such example is the Ed Wagner Chronic-Care Model. This model focuses fundamentally on improving quality care by integrating primary care into community medicine for chronically ill individuals (Kavanagh, 2010), such as those living in rural communities. Models like this can be very beneficial to rural populations since evidence shows that rural communities have higher rates of morbidity and mortality from chronic illness (Graves, 2009).

Rural health in the United States has been undergoing significant changes and has received greater attention in recent years than it has in the past. Of the many important health issues affecting rural and underserved communities, rural health disparities is one of the most widely discussed characteristics of rural populations by many healthcare

organizations. The Minority Health and Health Disparities Research and Education Act of 2000 defines health disparity as the significant difference in the rate of diseases incidence, prevalence, morbidity, mortality, or the health status of a given population compared to that of the general population.

Disparities between Rural and Urban Health

The determinants of health disparities among rural populations is reported to be the outcome of a complex interchange of factors ranging from age, income, culture, socio-dynamic, ethnicity, and the healthcare system (National Rural Health Association, 2006). Health outcome indicators such as access to healthcare, environmental quality, management of mental health/mental healthcare issues, immunization, and substance abuse outlined in the Healthy People Initiative of 2010 and 2020 are significant disparities affecting rural residents when compared to their urban counterparts. It has been reported that access, utilization, and cost of standardized and quality healthcare is not evenly distributed in the rural settings and rural residents are often faced with more barriers than in urban settings (Hartley, 2004).

Rural residents are thought to see their personal care providers less and are less likely to be engaged in proactive preventative healthcare services when compared to urban residents according to findings from the national Healthcare Disparities Report of 2004 published by Agency for Healthcare Research and Quality (2010). Over the years, it has also been noted that across the country, minority children continue to experience more medical and oral health disparities especially among Latino and Asian ethnic groups (Flores & Hua, 2013). Children constitute one of the highest proportions of

residents of rural communities in America. This is significant because ethnic and racial minority populations are increasing nationally (Flores & Hua, 2013).

Health planners must incorporate population-based conceptual frameworks to guide health promotion that address health disparities in rural communities. Bhattacharya (2013) reported that conceptual frameworks that focus on community-based strengths can generate transformational ideas that are partnership and population-based with the goal of improving health outcomes.

Morbidity and Mortality between Rural and Urban

Across the nation, studies have shown that morbidity and mortality rates are uniformly higher among rural populations than those who live in urban areas (Wallace, Grindeanu, & Cirillo, 2004). Studies have also shown that people who live in rural areas face higher mortality rates related to chronic diseases when compared to urban residents (Eberhardt, Ingram, & Makus, 2001). In a report from the National Health Interview Survey data collected in 2001, rural residents were reported to have higher rates of chronic diseases such as cardiovascular, cancer, and pulmonary illnesses (Wallace et al., 2004).

Rural Community Health Assets

For many years, deficits such as socio-economic issues, lower educational levels, higher unemployment, and inadequate recreational opportunities have dominated discussions about the conditions of rural communities. These disparities are extensive and can impact the health of the nation in general. Strasser (2003) reported that healthcare deficits that impact rural American residents are very similar to deficits that impact rural

communities in countries other than the United States. Hence, challenges of rural communities are a global issue. While rural and remote communities may experience more health disparities than in urban settings, health-related resources may exist in rural communities that are not recognized as determinants of health and therefore get overlooked when planning and implementing health care programs.

Resources such as personal, social, economic, and environmental factors can be used to create a positive impact and improve the health of communities in meaningful and positive ways (Buxton et al., 2007). It is fundamental that members of rural communities be able to identify and know how to utilize all available resources. If health assets are available within the community and consumers do not know how to access or use them, the consequence can affect the entire community. Therefore, as important as identifying health assets, it is also important to know how to access and use them to improve health (Sriram, 2008).

Building on health assets can also provide a framework for transformation and provide clues on how to improve healthcare disparities (Averill, 2003). Identifying community health assets can serve as a tool community members can utilize to tackle problems affecting the community. For example, according to Anderson and McFarlane (2008), a community asset such as an after-school recreational program can help keep young people active after school instead of engaging in detrimental activities that may land them in trouble later on. Another reason to focus on community health assets is because it is an opportunity to gather and reorganize resources in order to generate new ideas, and enhance and protect existing resources (Allen, 2003).

It is assumed that by identifying assets, rural communities will effectively utilize their own resources to improve their health outcomes. According to Mathie and Cunningham (2003), asset-focused community development is grounded on the idea that people in their own communities can re-organize and self-direct health-improvements using existing but often unrecognized assets. While the current literature attributes utilization of community health assets with positive health outcomes, there is a need for more studies that focus on the impact that identification and utilization of health assets have on improving health outcomes of rural communities.

Consumer Perspectives

Perception is generally an individual's subjective viewpoint about how they interpret and understand an issue of concern (Anderson & McFarlane, 2008). Perception is the general view of community members about their community and it may also be the general view of personnel conducting a community assessment (Anderson & McFarlane, 2008). In this study, the health perspectives of community residents were assessed. Perception of health such as physical, psychological and social factors is important because according to the literature, perception of health of an individual has an important effect on to the individual's quality of life and overall health status (Cree, Hayduk, Soskolne, and Suarez-Almazor, 2001).

Conceptual Framework

The Community-as-Partner Model

For a very long time, the knowledge, expertise, and skills of healthcare providers who work in community health have been used in guiding community assessment, program planning, and implementation of health programs. However, many of these programs have not only failed but have also created mistrust between providers and community members (Goodkind et al., 2011). This is partly because many of these providers imposed their own ideas of health on the communities in which they work instead of listening to ideas of local residents they serve.

Consequently, these programs become ineffective and/or harmful to the community (Goodkind et al., 2011). In recognition of this gap, the World Health Organization (2007) has stressed the importance of partnership especially when working with communities to improve health outcomes. The WHO highlighted that there is an overwhelming consensus about the benefits of encouraging community health worker's partnership with local residents if improved and better health outcomes are to be achieved.

As a result, conceptual frameworks that promote partnership and participation were developed for use in community health practice. The Community-as-Partner model is one of many such models. Community assessment being one of the important roles of community health workers, Anderson and McFarlane (2008) developed the Community-as-Partner model as a tool to guide community assessment. Fashioned from Betty Neuman's systems theory (1972), and Selye's Stress Adaption theory (1973), the "Community-as-Client" model as it was originally called is based on a total person's

approach of viewing an individual's problem in a community setting (Anderson & McFarlane, 2008, p. 207). The authors (Anderson & McFarlane, 2008) changed the name of the model from "community-as-client" to "community-as-partner" to incorporate the principles of partnership in the model.

Stress adaptation in Selye's theory highlights how an individual or a community responds to an actual or potential stressor(s) as the community systems interacts with the environment (the people/core and the sub-systems). Anderson and McFarlane (2008) described stressors as any experiences or potential disequilibrium invading the individual or the community resulting in the inability to function in a normal way.

Betty Neumann's systems theory is reflected in the Community-as-Partner model through the incorporation of the nursing metaparadigms, nursing, environment, health, and person, using a systems approach. A systematic approach borrowed from Neuman's model can be used to show the interaction of the four metaparadigms with each other and can guide nursing assessment and intervention strategies to enhance community-wide health programs (Erci, 2008).

The goal of the Community-as-Partner model is to promote a healthy community while preserving and promoting existing community health programs through collaboration, partnership, and participation. The model integrates public health and applied nursing into community assessment while emphasizing how community assessment incorporates all community systems. The principles of primary health care, namely partnership and participation, are also incorporated into the model. These principles are outlined as one of the essential elements of primary health care in the World Health Organization's Alma Ata declaration of 1978.

The preposition of the partnership and active community participation is based on the idea that when communities are partnered with and empowered through participation, it becomes possible for community members to "make decisions and act on issues they believe are essential to their own health or well-being" (Anderson & McFarlane, 2008, p. 95). Conceptual models used in community health practice that emphasizes partnership and active community participation are reported to have the potential to improve health outcomes. For example, in an educational program, "Partners in Caring" used the Community-as-Partner model as a framework to guide its assessment of community partnership. The "Partners in Caring" program concluded that program sustainability and improved health outcomes are attainable if all partners are committed and work together (Bernal, Shellman, & Reid, 2004). In another study, Huttlinger, Schaller-Ayers, and Lawson (2004) concluded that the Community-as-Partner model is an exceptional interventional model that community health nurses can use in addressing healthcare disparities of rural and remote communities.

The Community-as-Partner model incorporates the four major concepts of nursing often referred to as the nursing metaparadigms (*Person, Environment, Health, and Nursing*) central to professional nursing practice. The metaparadigms reflected in the model provide the framework for the community assessment. According to the Community-as-Partner model, *Person* is described as everyone in a defined community and can include an individual, a group, or an aggregate population. Everyone in the community is a representation of *person* (Anderson & McFarlane, 2008). *Environment* is defined as the network of people in relation to their surroundings. *Environment* can also be thought of as the community in general (Anderson & McFarlane, 2008). *Health* is

defined as the resources for daily life (social and personal) and physical capacities (Anderson & McFarlane, 2008). *Nursing* in a broader view is defined by the Community-as-Partner model as the interventional and preventative component of the model.

There are two components to the Community-as-Partner model: *the Community Assessment Wheel* and *the Nursing Process.* The nursing process represents the interventional component while the community assessment wheel represents the assessment component of the model (Anderson & McFarlane, 2008).

The Community Assessment Wheel

The community assessment wheel is a diagram that is used as the guiding tool of the assessment process and it consists of the community core and eight sub-systems. The community assessment wheel focuses mainly on three parts: *the community core*, *the community sub-systems*, and *perception*, all of which are domains found within the community. The community core is defined by the model as the population to be assessed and is comprised of community members (Anderson & McFarlane, 2008). Assessment of the community core include: socio-demographic data such as age, sex, culture, education, employment, and socioeconomic status. In addition, it can also include an assessment of people's culture, values, and belief system to integrate cultural viewpoints.

The sub-systems of the assessment wheel consist of eight categories: Health & Social Services, Politics & Government, Safety & Transportation, Education, Physical Environment, Recreation, Economics, and Communication. Assessment of the eight sub-systems may include a range of factors such as air quality, parks, clinics, and community

organizations depending on the focus and objective of the assessment. The community assessment of the eight sub-systems is described as follows.

The *Physical environment sub-system* includes the assessment of air quality, housing, flora, zoning, space, green area, animals, people, man-made structure, natural beauty, and water. The *Health and social service subsystem* includes the assessment of disease prevalence, shelters, traditional healers, clinics, hospitals, healthcare providers, home health agencies, nursing homes, assisted living, mental health facilities, and social services, in the community and outside resources accessible to the community members. The *Transportation and safety sub-system* includes the assessment of how people get around the community (private or public transport), how many people use bicycles or cars, whether there are sidewalks, bike trails, disable accessible trails, what type of protective services are available (fire, police, and ambulance) in the community, as well as sanitation, and crime rate in the community. The *Economic sub-system* includes the assessment about where people shop, the employment and unemployment rate, whether the community is prospering, and the main source of employment for community members (Anderson & McFarlane, 2008).

The *Recreation sub-system* includes the assessment about where children play, the major forms of leisure activities community members engage in, and whether there are facilities available for these activities in the community. The *Communication sub-system* includes the assessment about the main medium of communication (radios, TV, newspapers) available in the community, where the most common gathering areas are, and what the formal/informal means of communication are in the community. The *Politics and government sub-system* includes the assessment about the community's

governmental jurisdiction, whether people are involved in politics and decision making, and the political party that is most dominant in the community. The *Education sub-system* includes the assessment about whether there are schools in the community (elementary, junior and high schools, or tertiary institution), the most pressing educational issues affecting the community, access to libraries, educational level of community members, and whether there are school health services and after-school programs in the community (Anderson & McFarlane, 2008). For the purpose of this study, the *community core* is defined as a sub-system, thus making it the ninth sub-system.

The final domain that the assessment wheel addresses is perception. Perception is generally defined as an individual's subjective view point about interpreting and understanding an issue of interest (Anderson & McFarlane, 2008). In community health assessment, Anderson and McFarlane (2008) define perception as the general view of the community members about their community. It may also include the general views of the personnel conducting the community assessment. These views can be subjective and/or objective. They can be as simple as a general statement of facts, belief systems, or an observation. Talmy (as cited in Huumo, 2010) said that perception is influenced by what our sensory system is able to interpret and understand from things we are able to select and that attract our attention.

The Community Assessment - Using the Assessment Wheel

Based on the Community-as-Partner model, a community has an ecological relationship with a variety of features within the community in which everything is connected and interrelated to everything else (Anderson & McFarlane, 2008). In the community assessment wheel diagram (Figure-1), the broken lines divide the eight sub-

systems and also surround the community core. The broken lines depicted in the diagram are a representation of how the eight sub-systems and the community core are interdependent with one another. The broken lines surrounding the community core and dividing the sub-systems is the community's strengths. This is otherwise known as the community's Lines of Resistance, which act to defend the community against stressors. An example of community strength can be a community's high rate of immunization against a particular disease. Broken lines surrounding the outer circle illustrated in the diagram are defined as the Flexible Lines of Defense, otherwise known as the community's buffer zone. Anderson and McFarlane (2008) reported that this represents the dynamics that impact the health of the community when affected by a stressor. An example of the community's buffer zone or flexible lines of defense is the community's act to mobilize and work together in times of crisis. This collaboration and active community participation in times of stress represents the community's flexible lines of defense meant to fight against community stressors.

The solid line surrounding the community and the sub-systems is a representation of the Normal Line of Defense. It is defined by Anderson and McFarland (2008) as the level of health or health status of the community at any given point. An example of a normal line of defense is the community's low crime rates, "high rates of immunization or low infant mortality or middle income level" (Anderson & McFarlane, 2008, p. 208). When the health status of the community is compromised or disrupted by stressors, the community responds in relation to the level of the imposed stress. This reaction is what presents to the community as the community's health problems. According to Anderson and McFarland (2008), an example is the outbreak of a vaccine preventable disease or the

closure of a free wellness clinic in the community. It may even be a natural disaster or high crime rate in a particular neighborhood. All these are community stressors that can impact the community's overall health status.

In order to be able to improve the health of communities, it is important to identify community health assets as defined by the Community-as-Partner Model. Hence, one aspect of this study is aimed at assessing community member's perceived health assets in the community of Grangeville, an agricultural farming community in north-western Idaho.

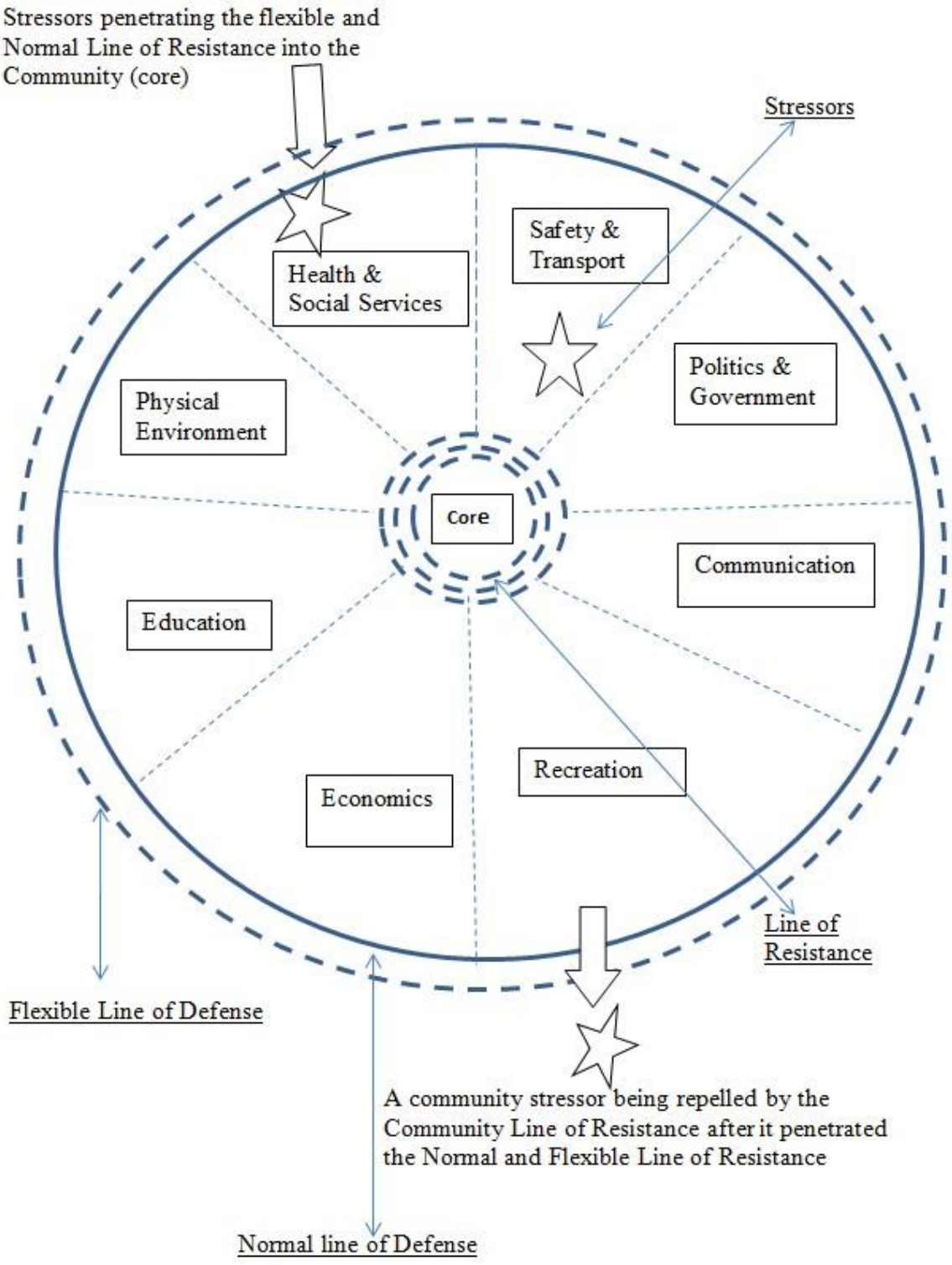

Figure 1 Community-as-Partner Model: the Assessment Wheel

The Nursing Process

The second component of the Community-as-Partner model is the nursing process. The aim of the nursing process in the Community-as-Partner model is to prevent or reduce possible encounters with stressors the community may come in contact with (Anderson & McFarlane, 2008). The Community-as-Partner model addresses the nursing process from the perspective of primary, secondary, and tertiary prevention. Primary prevention is aimed at preventing stressors defined by the model from coming in contact with the community. Secondary prevention occurs after a stressor is already in contact with the community and causes a reaction. The secondary prevention is aimed at early detection to prevent further damage. In the Community-as-Partner model, tertiary prevention is aimed at restoring and/or maintaining a healthy status of the community after a stressor has caused an impact (Anderson & McFarlane, 2008).

Statement of the Purpose

The purpose of this study is to identify community health assets perceived among members of the rural community of Grangeville, Idaho and what themes will best define the perceived health assets using the Community-as-Partner subsystems as the thematic definitions.

Research Questions

This study will address the following research questions:

1) How are community health assets perceived among individuals in Grangeville, a rural Idaho community?

2) Using the nine sub-systems from the Community-as-Partner model, how are perceived health assets identified by Grangeville, Idaho residents categorized into themes?

Conceptual Definitions

Health Assets: Morgan (2009) defines health assets as any factors or resources that can enhance the ability of an individual or community to maintain and sustain an optimal health status and to protect against stressors such as high crime rates. Health assets can play a positive role on impacting determinants of health such a**s** income level, educational opportunities, social support networks, and the physical environment (World Health Organization, 2013). In this study, healthcare assets are conceptually defined as environmental and community resources that can have a positive impact on affecting the health status of the community (Buxton et al., 2007).

Access to healthcare: Gulliford et al. (2002) stated that the meaning of 'access to healthcare' is a complex concept because availability and supply of healthcare services can depend on financial, organizational, social, and cultural barriers associated with the consumers of healthcare. In this study, access to healthcare will be defined as the ability to be able to reach or get in direct contact with resources for the purpose of improved health outcomes.

Rural: The definition of rural remains inconsistent in the current literature. The National Rural Health Association states that the definition of rural should depend on the purpose of a project that is being funded in a rural setting. For example, offices such as the Department of Agriculture, the Office for Healthcare Policy and Research, or the

Office for Budget Planning formulate their own definitions of rural to fit how they specifically interact with communities. The Office of Rural Health Policy (2010) defines rural as an area that is located in a non-metro county. In this study, rural will be conceptually defined according to the Office of Management and Budget (2010) using population size and proximity to a Metropolitan Statistical Area (MSA). A Metropolitan Statistical Area is defined as an area with a population of at least 50,000 inhabitants or an area that is part of a county that has a population of at least 100,000 people. Based on this definition, rural is any area with a population of less than 50,000 inhabitants or an area within a county of less than 100,000 people (OMB, 2010).

Operational Definitions

In this study, *perceived health assets* were operationally defined according to the nine sub-systems derived from the Community-as-Partner model (Anderson & McFarlane, 2008). The Community-as-Partner sub-systems include the Community Core, Health and Social Services, Politics & Government, Safety & Transportation, Education, Physical Environment, Recreation, Economics, and Communication. See the conceptual framework presented earlier in this chapter for definitions.

Rural is operationally defined in this study as Grangeville, Idaho. Grangeville fits the definition of a rural community based on the Office of Management and Budget (OMB, 2010) because it is within a county with less than 100,000 people and it has a population of less than 50,000 inhabitants. In the following chapter, the research methodology and design for this study will be discussed.

CHAPTER 3: METHODOLOGY

In 2009, nursing students from Boise State University (BSU) School of Nursing collected data from residents in three Idaho rural communities: Ketchum, McCall, and Grangeville, regarding perceptions of health assets and deficits in their community. The principal investigator was Dr. Jeri Bigbee, BSU School of Nursing Jody DeMeyer Endowed Chair. The study described in this thesis focuses on the data collected from one of these three rural communities, Grangeville, obtained during the 2009 study.

Research Design

This study used an exploratory descriptive design to conduct a secondary data analysis from the above described study. Quantitative and qualitative thematic analysis were used to show how participants perceived their health assets and how those assets were categorized into themes defined according to the subsystems from the Community-as-Partner model. This design is beneficial to this study because little is known about how residents of rural communities perceive health assets and how perceived health assets might be categorized into themes. The perceived commuity health assets from rural residents using the Community-as-Partner Model has not been previously explored. Therefore, by using an exploatory descriptive design, new insights and knowledge related to the topic can be identified and defined thereby increasing understanding of the topic. Furthermore, it has been argued that exploratory research furthers our understanding of the numerous determinants of health and health disparities in low-income or underserved

communities. This in turn can lead to the development of better conceptual frameworks to address these health problems (Maghboeba & Christian, 2010).

Setting

Grangeville, Idaho is a traditional rural community as defined by the Office of Management and Budget (2010) in which the primary industrial occupation is agriculture, namely lumber and grain farming. Grangeville has a population of 3141 (U.S. Bureau of Census, 2010). The median age of Grangeville residents is 44 years and the average household size is 2.23 people. Nearly 95% of Grangeville residents are of Caucasian ethnicity, .22% Black, .64% Asian, .43% Native American, and 2.87% from "other" ethnic groups. Less than one percent (.96%) of the people in Grangeville claimed to be of Hispanic origin while 99.04% are of non-Hispanic origin. The unemployment rate as of 2010 was 11.3%. The average income per person is $18,475, while the median household income is $33,906 (Idaho Department of Commerce & Housing and Finance Association, 2010).

Sample

A convenient sample of residents voluntarily participated in this study. Residents under 18 years of age were excluded from participating. The sample consisted of forty (n=40) participants of whom thirteen (n=13) were males and twenty-seven (n=27) were females. Seven (n=7) of the participants were employed as healthcare providers. The youngest participant was eighteen (18) years old and the oldest was eighty-six (86) years old. The number of years a participant lived in the community ranged from 8-months to eighty-five (85) years (see Table 4.1).

Protection of Human Subjects

This study involves minimal risks to the study participants. Both the 2009 study and this secondary data analysis were approved by the BSU Institutional Review Board. (See Appendix-A). The student researchers for both the 2009 study and this secondary data analysis completed CITI training. In the 2009 study, participants were free to stop the interview at any time or to refuse to respond to any or all interview questions. The primary data was maintained by the principle investigator. Only the principal investigator and research assistant(s) had authorization to access the data.

The graduate student researcher for the secondary data analysis was also a research team member for the 2009 study and was granted permission to use the data for the secondary analysis by the principle investigator. Data was stored in a locked cabinet in the graduate researcher's study room. The data is also protected electronically by a password security feature. Only the graduate student researcher and thesis chair from the BSU School of Nursing have access to the secondary data.

Data Collection Procedures

Student nurses from the BSU School of Nursing served as student researchers for the 2009 study. The student researchers conducted impromptu interviews with rural community residents based on scripted interview questions. Data was collected anonymously with no identifying information. All completed interviews were submitted to the principal investigator for safe storage. The data was de-identified using numerical codes to protect anonymity of participants. Interviews took place in late June through the end of July 2009. Interviews were conducted on days the student researchers were

available to collect data. Interviews took place during day-time hours and at public locations such as downtown street corners and in front of public retail stores.

No taping was involved in the data collection methods. Student researchers wrote down participant responses during the interview process and were provided with written scripts to refer to during the interview. Residents were approached by the student researchers at selected public community locations and were recruited to voluntarily participate in the study. The study was verbally explained to participants. Participants were not required to sign a consent form. Voluntary participation in the interview process indicated agreement to participate. Participants who verbally agreed to participate in the interviews responded to scripted questions from the researchers. At the end of the data collection exercise, the principal investigator collected and stored the data for further analysis

Data Collection Instrument

The interview questionnaire was developed by the research team for the 2009 study. A standardized interview tool was not used because there were no specific interview tools available in the literature asking the specific questions of interest to this study. Hence, the interview questions were developed based on specific questions the principle investigator and the research team were interested in gathering. As there was no content validity conducted for the interview questionnaire, findings from the secondary data analysis are limited and cannot be generalized beyond the rural population of Grangeville, Idaho. See Appendix B, for the interview questionnaire used to collect data for the 2009 study.

Data Analysis/Procedures

The study used quantitative and qualitative thematic analysis to describe the findings. Descriptive statistics using means, median, and percentages were calculated to describe the demographic profile of the sample and to show how the 109 assets identified by the sample were categorized into themes using the Community-as-Partner subsystems. The community health assets identified by the sample are listed verbatim in Table 4.4.

Credibility and dependability of the qualitative thematic analysis was established by having three experts plus the graduate student researcher assign each of the 109 perceived assets identified by Grangeville residents to one of the nine Community-as-Partner sub-systems. The combined number of assets assigned to each sub-system by each of the four reviewers were summed and converted to percentages (See Table 4.5). The average percentage of the four reviewers was calculated and depicts how assets were categorized into themes according to the Community-as-Partner model for this study (See Table 4.6).

According to Burns and Groves (2009), a minimum of three expert reviewers is acceptable to validate credibility and dependability of qualitative data interpretation. Rubio, Berg-Weger, Tebb, Lee, and Rauch (2003) also stated that while the literature is inconsistent in terms of the ideal number of reviewers, a minimum of three is recommended. The authors added that the reviewers should be professionals who have published or worked in the field in that particular area. In this study, all the three reviewers have expertise in rural health care. Chapter 4 reveals the findings from this study's data analysis.

CHAPTER 4: RESULTS

Subjects/Participants Demographic

As Table 4.1 indicates, the majority of the participants in the study have lived in the community between 10 and 20 years (n=13, 32.5%). In this study, there were a sample of forty participants (n=40), the majority being female (n = 27, 67.5%). The majority of the sample were between the ages of 25 and 49 years (n= 21, 52.5%) compared to the overall population of Grangeville in which only 28.4% of the population are between 25 and 49 years (n = 890). Also noteworthy is that those individuals who were 65 years and older made up only 7.5% of the sample (n = 3) compared to 20.3% (n = 638) of individuals over 65 years in Grangeville's general population. These findings suggest that the sample may not have been a true representation of Grangeville's age composition. Of the 40 individuals who participated in this study, 17.5% (n =7) were health care providers.

Table 4.1 Demographic profile of the sample

Sample Demographics		Total Numbers	Percentage
Gender	Male	13	32.5%
	Female	27	67.5%
Age	18 – 24	4	10.0%
	25 - 49	21	52.5%
	50-64	12	30.0%
Median Age = 46	65 +	3	7.5%
Employed as Health Care Providers	Yes	7	17.5%
	No	33	82.5%
Number of years participant lived in community			
Years	0.5-10	11	27.5%
	10-20	13	32.5%
	20-30	5	12.5%
	30-40	4	10.0%
	40-50	5	12.5%
	>50	2	5.0%

Table 4.2 Demographic breakdown of the Community's Age and Gender

Community Demographic (Grangeville)		**Total Numbers**	**Percentage**
Gender		Male=1530, Female=1611	Male=48.7, Female=51.3
Age	<18	725	24.8
	20-24	146	4.6
	25-34	349	11.1
	35-49	543	17.3
Median Age = 41.9	50-64	687	21.9
	65+	638	20.3

Grangeville is similar in demographic characteristics to other rural communities found in Idaho County but differs somewhat from rural communities in other counties in the state of Idaho. Noticeably, the demographic characteristics of Grangeville differ from other rural communities found in the United States. For example, the community of

Grangeville has a higher percentage of Caucasian residents (94.84%) than typical rural communities located in the United States (72.40%) and less minority representation as shown in Table 4.3. Income per capita and median household income levels of Grangeville residents tend to be lower than typical rural communities in other parts of the country (See Table 4.3).

Table 4.3 Demographic comparison: Grangeville, Idaho County, Idaho State & U.S.

Race	**Grangeville**	**County**	**State**	**U.S.**
White	94.84%	93.8%	89.10%	72.40%
Black	0.22%	0.3%	0.60%	12.60%
Asian	0.64%	0.5%	1.20%	4.80%
Native American	1.43%	2.9%	1.40%	0.90%
Other Race	2.87%	2.57%	7.70%	9.30%
Ethnicity	**Grangeville**	**County**	**State**	**U.S.**
Non-Hispanic origin	96.37%	97.41%	88.8%	83.70%
Hispanic origin	3.63%	2.59%	11.2%	16.30%
Income	**Grangeville**	**County**	**State**	**U.S.**
Income per capita	$18,475	$19,299	$22,788	$27,915
Median household	$33,906	$36,706	$46,788	$52,762

Research Question # 1: When forty participants from Grangeville, Idaho were asked how they perceive the health assets most important to them, they generated a total of 109 qualitative responses that were listed exactly as stated. While the majority of participants identified three of their top perceived health assets, some participants only identified one or two. See Table 4.4 for a listing of all perceived health assets identified by the sample.

Table 4.4 List of the 109 perceived health assets (Perceived community health assets)

1	Mobile MRI
2	Quick Ambulance EMT time
3	New clinic
4	Kids sports programs
5	Clean air
6	Outdoor activities
7	Outdoor activities
8	sharing of resources - doctors and patient travel to other communities
9	community has quite a few programs for weight loss and fitness
10	Hospital
11	Good hospital
12	Very good hospital
13	Clean Air
14	Quick ER response
15	Good nurses
16	Less stress
17	Recreation
18	Natural health food store (alternative/natural medicine)
19	One on one with doctors
20	Groaner's gym challenge
21	Clean air
22	Hospitals within 30 minutes
23	Hospital locations
24	Access to healthcare systems
25	Good basic local care
26	Women’s health center
27	Hospice
28	Accessible hospital with great technology
29	EMS services
30	Professionalism of staff at Syringa
31	Air Quality
32	Exercise
33	Two small hospitals close
34	Medicaid trying to start WIC
35	Access to doctors
36	Family supports
37	Less stress
38	Hospital doctors available
39	Good hospital
40	Quick services
41	Syringa hospital clinic
42	Good Hospital

43	Prompt service at clinic and hospital
44	gym "boot camp"
45	Being in country
46	Local gyms
47	Free press-Doctors note about tips for diet and exercise
48	Good nurses and staff
49	Plenty of recreation for people
50	EMT unit
51	Nice nursing home
52	Great ambulance crew
53	Safe street
54	Personalized care
55	Doctors know me –personalized care
56	Fresh clean air
57	Sparse population
58	Grocery stores promotes healthy eating
59	Availability of doctors
60	White bird annual bike ride
61	Safe streets
62	Good physical therapy
63	ER
64	Adequate HCP
65	Access to outreach clinic
66	Hospital in town
67	In home health
68	Good doctors/staff
69	Good nurses
70	Good doctors
71	Life style/stress is low
72	No pollution
73	Clinics
74	Sports activities for kids
75	Good hospital
76	Good doctors
77	Friendliness
78	Nursing home
79	Doctors will refer to other specialist if needed
80	Good doctor in cottonwood
81	CT Machine
82	Dispatcher
83	Teachers at school help student be healthy and stay off drugs
84	Hospital programs like smoking cessation
85	Less stress
86	HCP
87	Alternative medicine

88	Hospital public health classes
89	Hospital public classes
90	Good programs to help with diabetes, reconciliation
91	Good physicians
92	Great fire department to respond to disaster
93	Good nursing staff
94	Doctors spends more time with you
95	Hospital health classes
96	Safe
97	Nice people respectful
98	Good home health care
99	Program for diabetes and smoking groups
100	OB's in town
101	Walk-in clinic is good
102	Gym
103	Life-flight
104	Adequate government funding/grants
105	Health oriented people
106	Good weather
107	Lots of doctors
108	Good preventative healthcare and workshops
109	Good director of nurses

Research Question #2: The 109 identified health assets from the sample were categorized as themes using the nine subsystems from the Community-as-Partner model and were based on results from four reviewers who assigned each of the 109 assets to one of the nine subsystems (See Table 4.5). According to Table-4.6, the three subsystem that contained the highest percentage of health assets were; "*Health & Social Services"* (62.0%), "*Community Core"* (10.1%), and "*Recreation"* (9.9%). The sub-systems; "*Economic"* (1.6%), "*Education"* (1.4%), "*Politics & Government"* (0.9%), *and* "*Communication"* (0.9%), contained the lowest percentages of perceived health assets supporting the notion that people tend to identify health assets as those resources most directly associated with health and illness.

Table 4.5 Number of time a sub-system was identified by a reviewer

Sub-System	Reviewer #1	Reviewer #2	Reviewer #3	Reviewer #4
Community Core	11	5	9	19
Physical Environment	8	8	8	12
Education	2	2	1	1
Safety and Transportation	4	4	6	7
Politics and Government	1	1	1	1
Health and Social Services	72	71	72	54
Communication	1	1	0	2
Economics	0	5	1	1
Recreation	10	12	11	10

Table 4.6 The percentage of how each reviewer assigned assets to the nine subsystems and the average percentage for each sub-system (average percentage of all reviewers).

Sub-System	**Reviewer #1** percentage	**Reviewer #2** percentage	**Reviewer #3** percentage	**Reviewer #4** percentage	Average percent
Community Core	**10.10**	**4.59**	**8.26**	**17.76**	**10.1%**
Physical Environment	**7.34**	**7.34**	**7.34**	**11.21**	**8.3%**
Education	**1.83**	**1.83**	**0.92**	**0.93**	**1.4%**
Safety and Transportation	**3.67**	**3.67**	**5.50**	**6.54**	**4.9%**
Politics and Government	**0.92**	**0.92**	**0.92**	**0.93**	**0.9%**
Health and Social Services	**66.1**	**65.1**	**66.1**	**50.5**	**62.0%**
Communication	**0.92**	**0.92**	**0**	**1.87**	**0.9%**
Economics	**0**	**4.59**	**0.92**	**0.93**	**1.6%**
Recreation	**9.17**	**11.0**	**10.10**	**9.35**	**9.9%**

CHAPTER FIVE: DISCUSSION AND CONCLUSION

Demographics of Study Participants

In this study, there were more female participants than males. This is consistent with the census population data of Grangeville. This is noteworthy because in rural communities, women are believed to oversee their own health and that of the health of their families (Bales, Winters, & Lee, 2010). Therefore, their perception of health and health seeking behavior can have a fundamental influence on the perception and health seeking behavior of the entire family and consequently the community as a whole. In order to promote and implement ideal health programs that are consistent with how residents of rural and remote communities conceptualize health, the role and health perception of women must be recognized especially when they constitute a significant portion of the population.

The median age of the participants in this study was 46 years and that of Grangeville is 41.9 years. In a study by Zhang, Tao, and Anderson (2003), individuals within the age group 25-49 years are reported to have a characteristic behavior of delaying to seek formal medical care. While this is a usual pattern of health seeking behavior among this age group in general (Bales, Winters, & Lee, 2010), this can have a daunting effect on rural communities that are known to have higher incidents of chronic illness and other health related issues.

Contrary to the median age observed in the sample, existing literature states that rural communities tend to have a higher proportion of children and older adults (Bigbee, 2007). Middle age or young adults tend to migrate to urban areas where more opportunities exist, leaving the elderly, children (Johnson, 2006), and women of childbearing and childrearing age to make up a significant proportion of rural populations (Bales, Winters, & Lee, 2010). Since the majority of the study participants were between 25 and 64 years, the sample is not a typical representation of what the literature reflects about rural and remote community population characteristics. This may indicate that the sample was not a true representation of Grangeville and therefore needs to be considered a potential limitation of the study.

Research Questions # 1

Most of the 109 perceived health assets identified by the sample tend to identify obvious health aspects that are typically associated with primary health care or acute illness such as health services and access to medical providers. However, according to the World Health Organization, determinants of health include a much broader perspective such as income level, social status, educational opportunities, physical environment, and support networks that include job opportunities, access to mass media, and transportation systems (World Health Organization, 2008). In addition to the health determinants identified by the WHO, the final report of the Healthy People 2010 highlighted that policy making is another health determinant that plays an important role in the health of communities (Healthy People.gov, 2012). Examples of policies that have been shown to impact the health of communities include taxes on tobacco, which decreases the number of people who smoke cigarettes, and vehicle safety policies.

While recognized much less frequently than “health and social services” some of the study participants came closer to recognizing resources that were more aligned with indirect determinants of health such as those identified by the WHO. Example of assets identified by the sample that recognize health determinants other than those directly associated with an illness perspective include the “White Bird bike ride,” “outdoor activities,” “safe streets,” and “clean air.” Recognition of assets such as these are valuable examples that nurses and other health care providers can focus on when conducting health assessments and implementing strategies to improve the health of rural communities.

While most of the identified health assets in this study had to do with how individuals perceived health from an illnesses perspective, it is important for healthcare providers to focus on health assets that are preventative in nature to improve the overall health of communities. For example, in a study by Wolfenden et al. (2012), it was reported that by increasing the focus of preventative health services, healthy behaviors such as physical activity, healthy eating, and weight management were successful in promoting healthier behavior. The Center for Disease Control and Prevention (2012), has reported that there are several grants available to all communities across the nation for preventative health services. Community healthcare providers should take advantage of these financial opportunities and work with communities in creating and developing preventative health programs that address health determinants from a more comprehensive perspective.

Research Questions # 2

In this study, "health and social services" was the Community-as-Partner sub-system most frequently identified to describe perceived health assets. This is likely due to the tendency of individuals to perceive health from an illness perspective on the health-illness continuum. In addition to "health and social services," the next most frequently identified health category was "community core." Slightly over 10% of participants recognized community support networks as health-related resources. Examples of "community core" assets identified in this study included "family support," "friendliness," and "health-oriented people". While identified in the literature as a health determinant, support networks have been shown to have both positive and negative effects on the health of a community. Even though informal support systems are considered a strong health asset, Bales, Winters, and Lee (2010) found that reliance on informal support systems such as family, friends, and neighbors has its own downside because using informal support systems for medical care and health-related needs may cause a delay in seeking formal medical services.

On the contrary, other studies have reported that when people have a good social support system or cohesive family, the individual's mental health status and psychological well-being is more positive (Peek, 1996). Studies have suggested that having a positive outlook is thought to greatly influence and improve an individual's physical and mental health status (Pressman & Cohen, 2005). In this study, being "positive," "respectful," and "friendly" were among the identified health assets that were also categorized as "community core."

Not surprising, the subsystem "recreation" was the third most frequently identified health category in this study. Participants identified "kids' sports programs," "outdoor activities," "exercise," "gym boot camp," and the "annual bike ride" as perceived health assets that were categorized under the subsystem, "recreation." Recreational activities are believed to be an important part of addressing public health issues affecting the country, especially obesity. Studies have suggested that when addressing public health issues such as physical inactivity and obesity, parks and recreational services can have a significant role to play (Rosenberger, Bergerson, & Kline, 2009). Physical inactivity and obesity can be addressed by promoting and developing recreational infrastructure in high risk communities of which many rural communities apply (Rosenberger et al., 2009).

The sub-systems from the Community-as-Partner model in which the least number of health assets were assigned included "physical environment" "economics" "education" "safety & transport" "politics & government" and "communication". Even though these sub-systems were identified less frequently with perceived health assets in this study, they are as equally important as those that were the most frequently identified. These sub-systems that were least associated with health assets in this study represent health determinants identified in the literature that can have a significant impact on the health of individuals and on communities. For example, the World Health Organization reported that physical environment, transportation, economic status, educational level, and other social determinants of health, in one way or the other affects the health of individuals and communities at large (World Health Organization, 2008).

In another study, Robert and Booske (2011) reported that a wide range of social factors such as politics, education, environment, and the economy affect an individual's ability to make healthy decisions and choices. Robert and Booske (2011) further noted that some countries are already promoting social determinants of health such as social and economic factors as a way to improve the health outcomes of individuals and communities at large.

Conclusion

This is the first study that used the nine subsystems from the Community-as-Partner Model to categorize as themes perceived health assets as identified by members of rural communities. This study shows that individuals often perceive health assets as the obvious determinants of health, such as availability of medical facilities or medical providers at the exclusion of less obvious health determinants such as recreational opportunities, transportation, communication networks, and community leaders. This study suggests healthcare providers as well as lay-people may tend to perceive health assets from an illness perspective rather than from a more comprehensive perspective that includes the health determinants identified in the literature. Models such as the Community-as-Partner Model can help guide communities to effectively identify health assets more holistically in order to improve and promote the health of the community. Improving the health of communities goes beyond focusing on limited resources such as health care facilities and medical providers to include resources defined by the Community-as-Partner subsystems.

The National Rural Health Association (2006) has argued that by focusing on the health of communities in terms of assets such as economic, educational, recreational

issues, and other factors discussed in the Community-as-Partner model, we may improve not only the health status of our communities but also significantly reduce health disparities that exist as well. The process of attaining this goal will require a multi-institutional collaboration and partnership from all stakeholders.

Implications for Population Health Nursing

The effort to improve healthcare by shifting health promotion to a population health focus is gaining more attention in recent years (Thompson, 2008). Macdonald, Newburn-Cook, Allen, and Reutter (2013) argued that by embracing research models in population health nursing, it is possible to accurately understand what needs to be done to improve health outcomes of populations. Therefore, by using concepts of population health nursing in future nursing research and practice, health of populations may be improved.

Implications for Research, Education, and Future Nursing Practice

Findings obtained from this study may be used to guide future community health assessments for the purpose of program planning, policy development, and health program implementation. Since the Community-as-Partner model was developed as a framework to guide community assessment, these findings can serve as a stepping stone for future studies that explore how nurses working in population health might improve community outcomes by using assessment strategies that focus on identifying and utilizing health assets. Additionally, findings from this study can educate population health nurses about how to better define health assets for rural health populations based on a comprehensive perspective of health determinants.

Limitations

There were several limitations that impact this study and thus affect the ability to generalize the findings to explain how other rural residents might perceive health assets. One limitation was that there were limited studies in the literature that have looked at how members of rural and remote communities in America perceive health assets. Furthermore, there are no documented research studies that have applied the Community-as-Partner model to assess perceived community health assets. This lack of documentation in the literature makes it difficult to compare the findings from this study with other similar studies.

Another limitation of this study is that the sample was small and community residents under the age of 18 years were excluded from participation. As a result, this study may have missed important findings that this age group might have contributed. Ensuring a representative sample is important to consider especially when younger generations account for a significant portion of the population in rural communities.

The small sample size limits the generalizability of the findings beyond the community of Grangeville. In spite of these limitations, this study has generated further research questions and highlighted suggestions about how best to educate residents in rural communities regarding the recognition and implementation of health assets that can impact health outcomes in rural settings.

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APPENDIX A

IRB Approval

Office of Research Compliance
1910 University Drive
Boise, Idaho 83725-1138
HumanSubjects@boisestate.edu | 208.426.5401

DATE: October 11, 2012

TO: Cherno Bah (PI)
Shoni Davis (co-PI)

FROM: Institutional Review Board (IRB)
Office of Research Compliance

SUBJECT: IRB Notification of Exemption
Project Title: *Rural Community Health Assets Study*

The Boise State University IRB has reviewed your protocol application and has determined that your research is exempt from further IRB review and supervision under 45 CFR 46.101(b).

Review Type: Exempt, Category #2	Date of Approval: October 10, 2012
Exemption Approval Number: EX 187-SB12-121	

This exemption covers any research and data collected under your protocol as of the date of approval indicated above, unless terminated in writing by the principal investigator or the Boise State University IRB. All amendments or changes (including personnel changes) to your approved protocol **must** be brought to the attention of the IRB for review and approval before they occur, as these modifications may change your exempt status. Complete and submit a MODIFICATION/AMENDMENT FORM indicating any changes to your project.

Annual renewals are not required for exempt protocols. When the research project is completed, please notify our office by submitting a FINAL REPORT FORM. The exempt status expires when the research project is completed (closed) or when the review category changes as described above.

All relevant forms are available online. If you have any questions or concerns, please contact the Office of Research Compliance, 208-426-5401 or HumanSubjects@boisestate.edu.

Thank you and good luck with your research.

Mary E. Pritchard

Dr. Mary E. Pritchard
Chairperson
Boise State University Institutional Review Board

APPENDIX B

Interview Questions

Rural Community Health Assets/Deficits Study Interview

Hello, my name is _____. I am a Boise State University nursing and I am working in _____ (community) this summer as part of a class in rural nursing. As part of this class, we are conducting a study focusing on the health of rural communities. I would like to ask you a few questions about your views related to your community. This is an anonymous survey. For this project, we are requesting some demographic information. Due to the makeup of Idaho's population, the combined answers to these questions may make an individual person identifiable. We will make every effort possible to protect participants' confidentiality. However, If you are uncomfortable answering any of these questions, you may decline to answer.

Would you like to participate? (If no, thank them for their time)
Yes_____ No_____

What is your age? _____ Years ____ decline to answer

Are you currently employed as a healthcare provider? Yes_____ No_____

How long have you lived in this community? _____Years____ decline to answer

What do you see as the three most important strengths (assets) in this community in terms of health?

1.

2.

3.

What do you see as the three most important weaknesses, challenges, or problems in this community in terms of health?

1.

2.

3.

Thank you for your participation.

Participant's gender: Male_____ Female_____

Community: ____Ketchum ___McCall ____ Gooding____ Grangeville _____

Interviewer: _____