PUBLIC HEALTH NURSING PRACTICE FOR THE 21ST CENTURY

National Satellite Learning Conference

Learning Guide

MINNESOTA MDH DEPARTMENT OF HEALTH

PUBLIC HEALTH NURSING PRACTICE FOR THE 21ST CENTURY:
COMPETENCY DEVELOPMENT IN POPULATION-BASED PRACTICE

Learning Guide

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Table of Contents

Introduction

The purpose of this kit is to provide you with the learning materials from Public Health Nursing Practice for the 21st Century: Competency Development in Population-based Practice. This National Satellite Learning Conference was produced by the Section of Public Health Nursing at the Minnesota Department of Health, in partnership with the Division of Nursing at the Health Resources and Services Administration, Department of Health and Human Services, the Centers for Disease Control and Prevention, and the Public Health Training Network. The three-part series was broadcast to a national audience of public health nurses in October, November, and December of 2000.

This kit can be used by anyone wanting to learn or teach about population-based public health nursing practice. Please feel free to copy the learner materials from the Guide and adapt the presentation for your learning situation. We request that in using the videos and materials you do not alter the content and give credit to the Minnesota Department of Health.

If you have comments or questions about the use of this kit, please contact us.

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Materials in this kit

3 Video Tapes

1 copy of each 3-hour satellite program

Session I	October 5, 2000
Session II	November 2, 2000
Session III	December 7, 2000

Learning Guide

The learning guide contains the goals and objectives for the course, an outline of the content for each session, learner materials, discussion questions, and pre/post test questions.

Public Health Interventions: Applications for Public Health Nursing Practice

This manual presents in detail each of the 17 public health interventions with examples and applications for public health nursing practice.

Purpose

This continuing education program is a series of three sessions broadcast nationally via satellite. The purpose is to enhance the knowledge, attitudes, and skills of public health nurses in population-based public health nursing practice.

Goals and Objectives

At the conclusion of this learning conference, learners will be able to:

- Describe the scope of population-based public health nursing process.
- Identify the principles or "cornerstones" underlying the practice of public health nursing.
- Describe the public health nursing interventions and identify the best practices associated with their successful implementation.

Faculty

Laurel Briske, MA, RN, CPNP

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The presenters are public health nurse consultants with the Section of Public Health Nursing at the Minnesota Department of Health. See the section on biographical sketches of the faculty.

Session 1

Session 1

This session instructs in the concept of population-based public health nursing practice and introduces the set of 17 related interventions used to operationalize it.

Learning Objectives

1. Define population-based public health nursing practice.
2. Recognize the levels of practice: community, individuals and families, and systems.
3. Identify the set of 17 interventions utilized by nurses in public health nursing practice.

Content

Population-based Public Health Nursing Practice

The main characteristics of this practice are introduced and described. Population-based public health nursing:

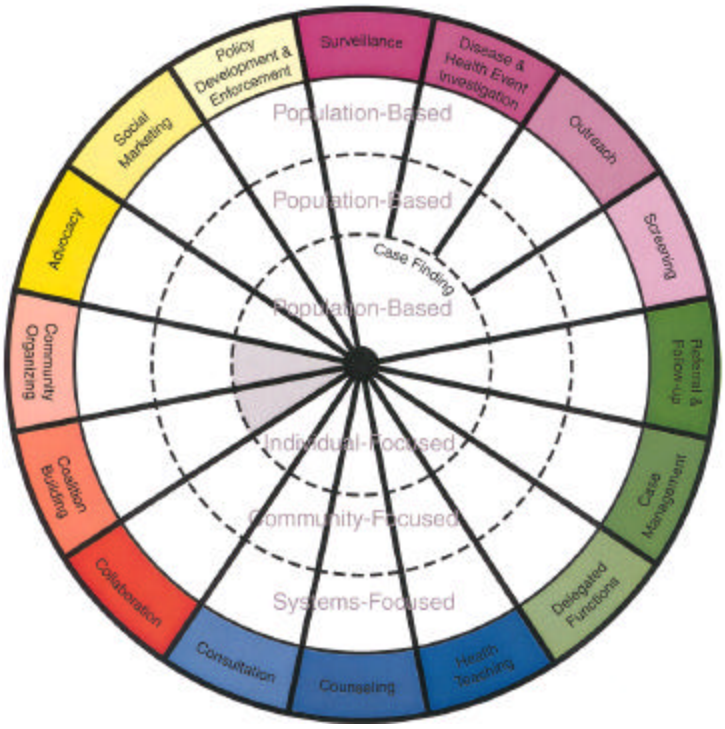
1. Focuses on entire populations possessing similar health concerns or characteristics
2. Is guided by an assessment of community need
3. Considers the broad determinants of health
4. Considers all levels of prevention with a preference for primary prevention
5. Considers all levels of practice.

The Levels of Public Health Nursing Practice Interventions

Each of the public health nursing interventions identified can be applied at some or all practice levels: with individuals or families, with the communities in which they live, and/or the systems within those communities that also impact on health. This is a defining difference of population-based public health nursing practice and is discussed in depth.

Public Health Nursing Interventions

The set of seventeen interventions nurses practicing in public health use to accomplish their population-based work are defined and described. The interventions, defined as *actions that public health nurses take on behalf of individuals, families, systems, and communities to improve or protect health status*, are presented graphically as a "wheel" of interventions.



Content Outline

Session 1 is three hours in length. This section outlines each segment with times and corresponding handouts. The time is approximate and will vary with VCR speed.

Video Tape

Session 1 – October 5, 2000

I. Introduction 6 minutes

II. History of Public Health Nursing 18 minutes

Includes a 9-minute clip of "Sentimental Women Need Not Apply: A History of the American Nurse."[1]

III. Population-based Practice

Handout 1 – Population-based Practice

A. Definition 2 minutes

B. Criteria for Population-based Practice

1. **Focuses on the entire population** 3 minutes
2. **Guided by an assessment of population health status** 2 minutes
3. **Considers the broad determinants of health** 1 minute
4. **Considers all levels of prevention** 3 minutes

[1] *Sentimental Women Need Not Apply: A History or the American Nurse*. 1993. VHS 60 minutes: color $350. To order call 1-800-523-0118 or mediaincorporated.com

Handout 2 – Levels of Prevention

5. **Considers all levels of intervention**

Handout 3 – Levels of Practice

a. **Community** 9 minutes

b. **Systems** 3 minutes

c. **Individual/Family** 9 minutes

d. **Examples** 12 minutes

BREAK 10 minutes

IV. Question and Answer Session 15 minutes

V. Public Health Interventions

Handout 4 – Definitions of Public Health Interventions

A. Definition 6 minutes

B. Descriptions and Examples by "Wedge" (Interventions that tend to be used together)

1. Red (pink) Wedge 13 minutes

Surveillance

Disease and other health event investigation

Outreach

Screening

Case-finding

2. Green Wedge 7 minutes

Referral and Follow-up

Case Management

Delegated Functions

3. Blue Wedge 7 minutes

Health Teaching

Counseling

Consultation

BREAK 10 minutes

4. Orange Wedge 7 minutes

Collaboration

Coalition Building

Community Organizing

5. Yellow Wedge 9 minutes

Advocacy

Social Marketing

Policy Development

VI. Summary of Session 9 minutes

VII. Example of practice using multiple interventions 10 minutes

VIII. Question and Answer Session 15 minutes

Handout 5 – Discussion Questions for Session 1

Test your knowledge – pre / post test questions

Total Session Time 180 minutes

160 minutes content

20 minutes of break

Session 1

Learner Materials

Handout 1 – Population-based Practice

Handout 2 – Levels of Prevention

Handout 3 – Levels of Practice

Handout 4 –Public Health Interventions

Handout 5 – Discussion Questions for Session 1

Test your knowledge – pre/post test questions

The learner materials may be copied without permission.

Public Health Nursing Practice for the 21st Century: Competency Development in Population-Based Practice Session 1 – Handout 1

Population-based Practice

A population is a collection of individuals who have one or more personal or environmental characteristics in common.[1]

A **population-of-interest** is a population that is essentially healthy but who could improve factors which promote or protect health.
A **population-at-risk** is a population with a common identified risk factor or risk-exposure that poses a threat to health.
Public health nursing practice is population-based if it meets all of the following criteria:

1. **Focuses on entire populations possessing similar health concerns or characteristics**
   This means focusing on everyone who is actually or potentially affected by a health concern or who share similar characteristics. Population-based interventions are not limited to only those who seek service or who are poor or otherwise vulnerable. Population-based planning always begins by identifying everyone who is in the population-of-interest or the population-at-risk. For example, it is a core public health function to assure that *all* children are immunized against vaccine-preventable disease. Even though limited resources may compel public health departments to target programs toward those children known to be at particular risk for being under or unimmunized, the public health system remains accountable for the immunization status of the total population of children.

2. **Guided by an assessment of population health status**
   This criteria cannot be emphasized enough. All public health programs are based on the needs of the community, which are determined through an assessment of the community's health status. As communities change, so do community needs. As community needs change, so should public health programs. This is one of the reasons that community assessment is so important. Public health departments need to assess the health status of populations on an ongoing basis, so that public health programs respond appropriately to new and emerging problems, concerns, and opportunities.

3. **Considers the broad determinants of health**
   A population-based approach examines all factors that promote or prevent health. It focuses on the entire range of factors, which determine health rather than just personal health risks or disease. Examples of health determinants include income and social status, housing, nutrition, employment and working conditions, social support networks, education, neighborhood safety and violence issues, physical environment, personal health practices and coping skills, cultural customs and values, and community capacity to support family and economic growth.

4. **Considers all levels of prevention, with a preference for primary prevention**
"Prevention is anticipatory action taken to prevent the occurrence of an event or to minimize its effect after it has occurred."[2] Not every event is preventable, but every event does have a preventable component. Thus, a population-based approach presumes that prevention may occur at any point - before a problem occurs, when a problem has begun but before signs and symptoms appear, or even after a problem has occurred. **Primary prevention** promotes health, such as building assets in youth, or keeps problems from occurring, for example, immunizing for vaccine-preventable diseases. **Secondary prevention** detects and treats problems early, such as screening for home safety, and correcting hazards before an injury occurs. **Tertiary prevention** keeps existing problems from getting worse, for instance, collaborating with health care providers to assure periodic examinations to prevent complications of diabetes such as blindness, renal disease failure, and limb amputation. **Whenever possible, public health programs emphasize primary prevention.**

5. **Considers all levels of practice**
A population-based approach considers intervening at all possible levels of practice. Interventions may be directed at the entire population within a community, the systems that affect the health of those populations, and/or the individuals and families within those populations known to be at risk.

- **Community-focused practice** changes community norms, attitudes, awareness, practices, and behaviors of the population-of-interest.
- **Systems-focused practice** changes organizations, policies, laws, and power structures of the systems that affect health.
- **Individual/family-focused practice** changes knowledge, attitudes, beliefs, values, practices, and behaviors of individuals, alone or as part of a family, class, or group.

Interventions at each of these levels of practice contribute to the overall goal of improving population health status. Public health professionals determine the most appropriate level(s) of practice based on community need and the availability of effective strategies and resources.

No one level of practice is more important than another; in fact, most public health problems are addressed at all three levels, often simultaneously. Consider, for example, smoking rates which continue to rise among the adolescent population. At the community level of practice, public health nurses coordinate "youth led, adult supported" social marketing campaigns intending to change the community norms regarding adolescents' tobacco use. At the systems level of practice, public health nurses facilitate community coalitions that advocate city councils to create stronger ordinances restricting over-the-counter youth access to tobacco. At the individual/family practice level, public health nurses teach middle school chemical health classes that increase knowledge about the risks of smoking, change attitudes toward tobacco use, and improve "refusal skills" among youth 12-14 years of age.

1. Williams, C. A., & Highriter, M. E. (1978). Community health nursing: population focus and evaluation. *Public Health Reviews*, *7*(3-4), 197-221.

2. Turnock, B. (1997). *Public Health: What it is and how it works*. Gaithersburg, MD: Aspen Publishers, Inc.

Public Health Nursing Practice for the 21st Century:
Competency Development in Population-Based Practice
Session 1 – Handout 2

Levels of Prevention

"Prevention is anticipatory action taken to prevent the occurrence of an event or to minimize its effect after it has occurred."[2] Not every event is preventable, but every event does have a preventable component.

Prevention occurs at primary, secondary, and tertiary levels:

Primary prevention both promotes health and protects against threats to health. It keeps problems from occurring in the first place. It promotes resiliency and protective factors, or reduces susceptibility and exposure to risk factors. Primary prevention is implemented before a problem develops. It targets essentially well populations.

Secondary prevention detects and treats problems in their early stages. It keeps problems from causing serious or long-term effects or from affecting others. It identifies risks or hazards and modifies, removes, or treats them before a problem becomes more serious. Secondary prevention is implemented after a problem has begun, but before signs and symptoms appear. It targets populations that have risk factors in common.

Tertiary prevention limits further negative effects from a problem. It keeps existing problems from getting worse. It alleviates the effects of disease and injury and restores individuals to their optimal level of functioning. Tertiary prevention is implemented after a disease or injury has occurred. It targets populations who have experienced disease or injury.

[2] Turnock, B. (1997). Public Health: What it is and how it works. Gaithersburg, MD: Aspen Publishers, Inc.

Public Health Nursing Practice for the 21st Century: Competency Development in Population-Based Practice
Session 1 – Handout 3

Levels of Practice

The ultimate goal of all levels of population-based practice is to improve population health. Public health interventions may be directed at entire populations within a community, the systems that affect the health of those populations, and/or individuals and families within those populations. Interventions at each of these levels of practice contribute to the overall goal of improving population health.

Population-based community-focused practice changes community norms, community attitudes, community awareness, community practices, and community behaviors. They are directed toward entire populations within the community or occasionally toward target groups within those populations. Community-focused practice is measured in terms of what proportion of the population actually changes.

Population-based systems-focused practice changes organizations, policies, laws, and power structures. The focus is not directly on individuals and communities but on the systems that impact health. Changing systems is often a more effective and long-lasting way to impact population health than requiring change from every single individual in a community.

Population-based individual-focused practice changes knowledge, attitudes, beliefs, practices, and behaviors of individuals. This practice level is directed at individuals, alone or as part of a family, class, or group. Individuals receive services because they are identified as belonging to a population-at-risk.

Public health professionals determine the most appropriate level(s) of practice based on community need and the availability of effective strategies and resources. No one level of practice is more important than another; in fact, most public health problems are addressed at all three levels, often simultaneously.

Public Health Nursing Practice for the 21st Century:
Competency Development in Population-Based Practice
Session 1 – Handout 4

Definitions of Public Health Interventions

Interventions are actions taken on behalf of communities, systems, individuals, and families to improve or protect health status. [3]

Surveillance describes and monitors health events through ongoing and systematic collection, analysis, and interpretation of health data for the purpose of planning, implementing, and evaluating public health interventions. [adapted from MMWR, 1988]

Disease and other health event investigation systematically gathers and analyzes data regarding threats to the health of populations, ascertains the source of the threat, identifies cases and others at risk, and determines control measures.

Outreach locates populations-of-interest or populations-at-risk and provides information about the nature of the concern, what can be done about it, and how services can be obtained.

Case finding locates individuals and families with identified risk factors and connects them with resources.

Screening identifies individuals with unrecognized health risk factors or asymptomatic disease conditions in populations.

Referral and follow-up assists individuals, families, groups, organizations, and/or communities to identify and access necessary resources in to prevent or resolve problems or concerns.

Case management optimizes self-care capabilities of individuals and families and the capacity of systems and communities to coordinate and provide services.

Delegated functions are direct care tasks a registered professional nurse carries out under the authority of a health care practitioner as allowed by law. Delegated functions also include any direct care tasks a registered professional nurse entrusts to other appropriate personnel to perform.

Health teaching communicates facts, ideas and skills that change knowledge, attitudes, values, beliefs, behaviors, and practices of individuals, families, systems, and/or communities.

[3] Adapted from Nursing's Social Policy Statement, p. 9. (1995). American Nurses Publishing.

Counseling establishes an interpersonal relationship with a community, a system, family or individual intended to increase or enhance their capacity for self-care and coping. Counseling engages the community, a system, family or individual at an emotional level.

Consultation seeks information and generates optional solutions to perceived problems or issues through interactive problem solving with a community, system, family or individual. The community, system, family or individual selects and acts on the option best meeting the circumstances.

Collaboration commits two or more persons or organizations to achieve a common goal through enhancing the capacity of one or more of the members to promote and protect health.
[adapted from Henneman, Lee, & Cohen. (1995). Collaboration: A concept analysis. *J. Advanced Nursing, 21,* 103-109.]

Coalition building promotes and develops alliances among organizations or constituencies for a common purpose. It builds linkages, solves problems, and/or enhances local leadership to address health concerns.

Community organizing helps community groups to identify common problems or goals, mobilize resources, and develop and implement strategies for reaching the goals they collectively have set.
[adapted from Minkler, M. (ed.). (1997). *Community Organizing and Community Building for Health*, p. 30. New Brunswick, NJ: Rutgers Univ. Press.]

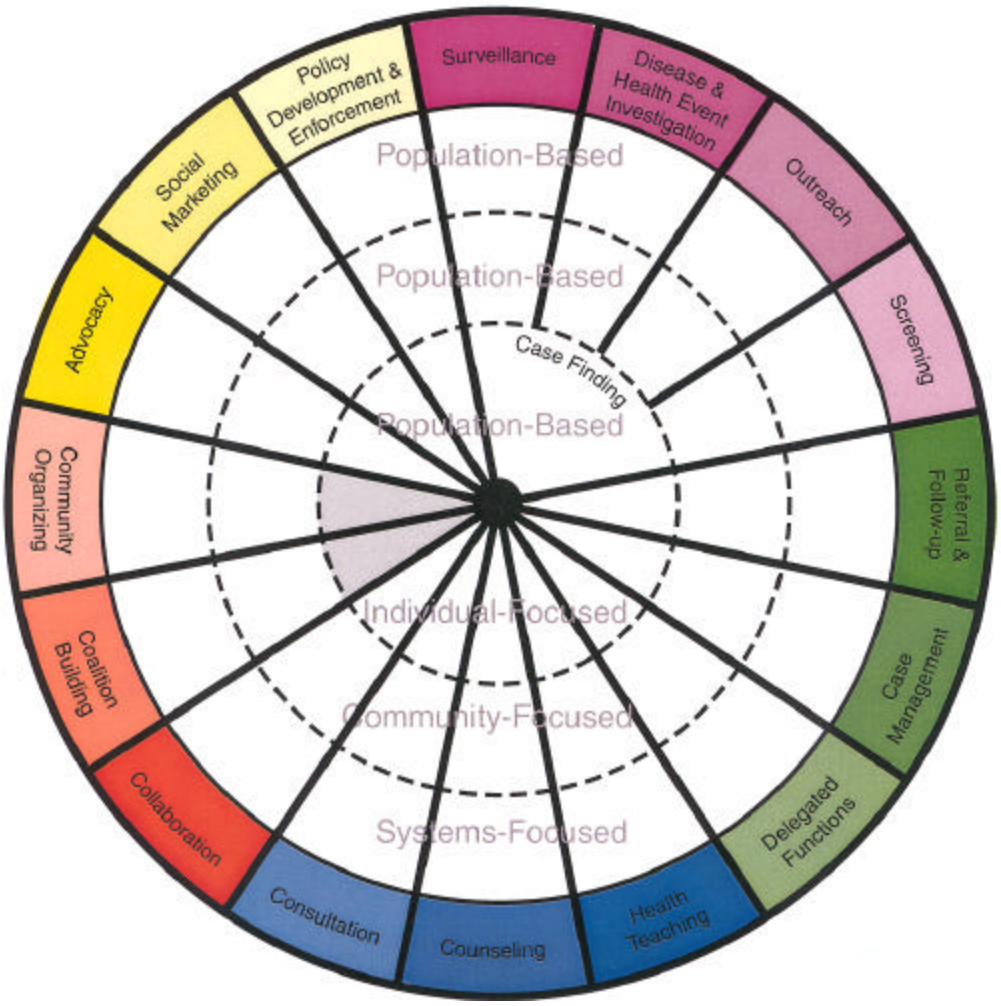
Advocacy pleads someone's cause or act on someone's behalf, with a focus on developing the community, system, individual or family's capacity to plead their own cause or act on their own behalf.

Social marketing utilizes commercial marketing principles and technologies for programs designed to influence the knowledge, attitudes, values, beliefs, behaviors, and practices of the population-of-interest.

Policy development places health issues on decision-makers' agendas, acquires a plan of resolution, and determines needed resources. Policy development results in laws, rules and regulations, ordinances, and policies. **Policy enforcement** compels others to comply with the laws, rules, regulations, ordinances and policies created in conjunction with policy development.

Section of Public Health Nursing
Minnesota Department of Health
September 2000

Public Health Interventions
Applications for Public Health Nursing



March 2001

Minnesota Department of Health
Division of Community Health Services
Public Health Nursing Section

Public Health Nursing Practice for the 21st Century: Competency Development in Population-Based Practice
Session 1 – Handout 5

Discussion Questions

Consider the following questions about today's session to help you incorporate what you have learned into your own practice.

1. What is your definition of population-based practice?

2. Is your current practice population-based? If not, how could it become more population-based?

3. List examples of the types of activities you have done in the last month. Determine their level of practice (community level, systems level, or individual/family level).

4. Using the list of activities from above, determine which of the interventions you used.

5. Using a copy of the "wheel" consider each intervention and practice level. Color in the interventions and practice levels you feel competent in implementing. Which interventions are not colored in?

Public Health Nursing Practice for the 21st Century: Competency Development in Population-Based Practice

Session 1

PRE TEST QUESTIONS

1. Which of the following could be an example of a **population-based** public health nursing intervention?
   a. Running a foot care clinic in a senior citizen center
   b. Designing and implementing a media campaign to increase community awareness of the dangers of alcohol consumption during pregnancy
   c. Collaborating on legislation to pass a smoking ban in restaurant
   d. b and c
   e. **All of the above**

2. The overall goal of public health nursing home visits to prevent child abuse is to improve the health of the population of children.
   a. True
   b. False

3. A main characteristic of population-based public health nursing practice is that:
   a. It gives preference to primary prevention
   b. It gives preference to secondary prevention
   c. It gives preference to tertiary prevention
   d. It considers multiple levels of prevention without preference to any particular level of prevention
   e. None of the above

4. Primary prevention refers to:
   a. Early diagnosis and prompt treatment
   b. Limitation of disability
   c. Rehabilitation
   d. **Prevention of exposure to risk factors**
   e. None of the above

5. An example of primary prevention of playground injuries is:
   a. **Changing the design of playground equipment**
   b. First aid training of school staff by school nurse
   c. Coordinating emergency response with local EMS service
   d. Establishing standing orders for school nurse to initiate treatment of injuries

6. Which of the following determinants of health should be considered in population based public health nursing practice?
   a. Diet, exercise, and smoking risk in populations
   b. Distribution of hypertension, diabetes, and asthma in populations
   c. Neighborhood safety
   d. Income disparity within populations
   e. a and b
   f. **All of the above**

7. The success of population-based interventions is measured by the number of people served.
   a. True
   b. **False**

8. Which of the following characteristics distinguish population-based public health practice from other forms of nursing practice?
   a. Preventive care located in the community
   b. Focus on an entire population possessing similar health concerns or characteristics
   c. Practice based on an assessment of community need
   d. a and b
   e. b and c
   f. All of the above

9. Population-based public health nursing interventions are:
   a. Individually and family-focused interventions
   b. Community-focused interventions
   c. Systems-focused interventions
   d. a and b
   e. b and c
   f. **All of the above**

10. Population-based public health nursing interventions are directed first at communities.
    a. True
    b. False

11. Community-focused interventions are directed at:
    a. Changing knowledge, attitudes and behaviors of individuals and families in the community
    b. Changing norms and attitudes in specific populations
    c. Changing behaviors in specific populations
    d. a and b
    e. b and c

Public Health Nursing Practice for the 21st Century: Competency Development in Population-Based Practice Session 1

Post Test Questions

1. Public health nursing practice is **population-based** if it:
   a. Focuses on care of homebound individuals
   b. Is based on political interest
   c. Places priorities on individual well being
   d. **Is grounded in a community needs assessment**
   d. Gives priority to tertiary prevention rather than primary or secondary prevention

2. An intervention is **population-based** if the need emerges from a systematic community assessment process.
   a. True
   b. False

3. The determinants of health include all of the following **but:**
   a. Access to health care services
   b. Housing
   c. Private health insurance
   d. Food, water, and air
   e. Personal coping skills
   f. Opportunities for outdoor recreation and solitude

4. Which of the following does **not** describe population-based public health nursing interventions as practiced in the year 2000?
   a. Interventions that are grounded in assessments of the community's health
   b. Interventions that consider the broad determinants of health
   c. Interventions that consider all levels of practice
   d. Interventions that are well-grounded in research

5. Each public health nursing intervention in the "Wheel" can be applied at the community level, the individual/family level, and the systems level.
   a. True
   b. False

6. Which of the following is defined as "an intervention through which the public health nurse assists individuals, families, groups, organizations, and/or communities to utilize necessary resources available to prevent or resolve problems or concerns?"
   a. Policy development
   b. Referral and follow-up
   c. Case management
   d. Collaboration
   e. Coalition building

7. Which of the following interventions involves "an interpersonal relationship between the public health nurse and a community, system, family, or individual intended to increase or enhance the capacity for self-care and coping?"

a. Collaboration
b. Outreach
c. Case finding
d. Counseling
e. Social marketing

8. Which of the following is an example of a public health nurse delegated function?

a. Developing a program for screening school aged children for lice
b. Administering asthma inhalants to a school aged child
c. Providing information to middle school children on the hazards of secondary smoke
d. Planning playground activities for children with special needs
e. a and d

9. Case Management is characterized by all of the following **except**:

a. **Reaching out to at-risk populations**
b. Developing self-care capabilities of systems, communities, and individuals/families
c. Promoting efficient use of resources
d. Decreasing fragmentation of care across settings
e. a and b

10. Investigating Disease and Other Health Events **does not** include:

a. Identifying the source of the threat
b. Identifying cases and their contacts
c. Identifying others at risk.
d. Determining control measures
e. Developing resources to control the event that are needed but unavailable to the population

11. A public health nurse recommends to the city council that they establish an ordinance prohibiting cigarette vending machines within the city limits. This is an example of a

a. Individual/family focused intervention
b. Community-focused intervention
c. Systems-focused intervention
d. a, b, and c

12. The public health nursing interventions are each distinct from one another and do not overlap.

a. True
b. False

13. Immunization is an example of:

a. Primary prevention
b. Secondary prevention
c. Tertiary prevention
d. None of the above
e. a and c

Session 2

Session 2

This session focuses on the fundamentals of population-based public health nursing practice, and the underlying values, principles, and processes that guide it.

Learning Objectives

1. Describe how public health nursing is both similar to, but different from, its two base disciplines of public health and nursing.

2. Identify the values and principles, the "cornerstones," underlying public health nursing.

3. Identify a process for assessing communities and prioritizing the needs revealed by community assessment.

4. Describe program planning and evaluation based on levels of intervention and levels of prevention.

5. Differentiate between health status and intermediate outcome indicators.

Content

The Cornerstones of Public Health Nursing Practice

The values and belief underlying public health and nursing are explored for their contributions to the practice of public health nursing. Topics such as sensitivity to the worth of all individuals, grounding in social justice, and the ethic of caring are highlighted.

Essential Public Health Services

Real examples from practice provide illustrations of the public health nursing application of the ten essential services.

Community Assessment and Problems Prioritization

A basic process for assessing a community's health status is described. This includes discussion of a process for selecting those community needs that may be most responsive to public health intervention.

Program Planning and Evaluation

The basic process for selecting programs or strategies to address community needs is described and discussed. This process considers levels of both interventions and prevention and includes an introduction to selecting outcome indicators.

Content Outline

Session 2 is three hours in length. This section outlines each segment with times and corresponding handouts. The time is approximate and will vary with VCR speed.

Video Tape

Session 2 – November 2, 2000

I. Introduction and Recap of Session I 10 minutes

II. Cornerstones of Public Health Nursing 40 minutes

Handout 1 -- Cornerstones of Public Health Nursing

III. Examples of the 10 essential services from public health nursing practice. 25 minutes

Handout 2 – Public Health in America

BREAK 10 minutes

IV. Question and Answer Session 10 minutes

V. Abby Knocking on the Door - Examples of public health nursing practice at the community, system, and individual levels of practice 20 minutes

VI. Assessment of the community 30 minutes

Handout 3 - Population-Based Public Health Practice

Handout 4 - Community Assessment

VII. Question and Answer Session 10 minutes

VIII. Prioritizing needs 9 minutes

Handout 5 - Prioritizing Process

Handout 6 - Categories of Public Health

IX. Selecting strategies and planning programs 6 minutes

Handout 7 - Examples of 3 Public Health Problems

X. Program evaluation. Health status and intermediate outcome measures. 10 minutes

Handout 8 - Discussion Questions for Session 2

Test your knowledge – pre/post test questions

Total Session Time 180 minutes

170 minutes content

10 minutes of break

Session 2

Learner Materials

- **Handout 1 – Cornerstones of Public Health Nursing**
- **Handout 2 – Public Health in America**
- **Handout 3 – Population-Based Public Health Practice**
- **Handout 4 – Community Assessment**
- **Handout 5 – Prioritizing Process**
- **Handout 6 – Categories of Public Health**
- **Handout 7 – Examples of 3 Public Health Problems**
- **Handout 8 – Discussion Questions**
- **Handout 9 – Selected Resources for Session 2**
- **Test your knowledge – pre / post test questions**

The learner materials may be copied without permission.

Public Health Nursing Practice for the 21st Century
Competency Development in Population-Based Practice
Session 2 – Handout 1

Public Health Nursing Practice is…

- Population-based
- Relationship-based
- Grounded in social justice, caring and compassion with a sensitivity to and respect for the worth of all people, especially the vulnerable
- Focused on prevention and health promotion
- Driven by epidemiological evidence
- Holistic
- Largely independent
- Committed long term to assuring the health of populations

CORNERSTONES OF PUBLIC HEALTH NURSING

PUBLIC HEALTH NURSING IS THE SYNTHESIS OF THE ART AND SCIENCE OF:

PUBLIC HEALTH	*AND*	NURSING
Population-Based		**Relationship-Based**
Grounded in Social Justice		**Grounded in an Ethic of Caring**
Relies on the Science of Epidemiology		**Holistic**
Focus on Health Promotion and Prevention		**Sensitivity to Diversity**
Long-term Commitment to the Community		**Independent Practice**

Public health nursing practice is *population based*, that is, based on a process that determines the health status of the community, identifies populations at risk, and determines the priority health problems of the community; and plans, implements, and evaluates public health strategies accordingly at community, systems, or family/individual levels. The selection of these strategies are *based in the science of epidemiology*.

Public health nurses' commitment to the communities, families, and individuals they serve emanates from a combination of the passion underlying their *social justice beliefs* that all persons, regardless of circumstances, are entitled equally to a basic quality of life, their *ethic of caring and compassion*, and *their sensitivity to and respect for the worth of all people, especially those persons who are vulnerable*.

Public health nursing practice is *relationship-based*, that is, all public health nursing interventions are provided in the context of a relationship. The relationships that public health nurses establish with the communities, families, individuals, and systems they serve are grounded in personal integrity, honesty, consistency, and trustworthiness.

Public health nursing is *committed long term to promoting and maintaining health and preventing illness, injury, and disability.* The interventions that public health nurses utilize for health promotion and prevention *encompass a holistic approach that includes the inter-relationship of mind, body, spirit as well as the dynamic relationships between people and their physical and social environments.*

Public health nurses use their extensive knowledge of the community to *organize community resources to collaboratively* meet the health needs of community, families, and individuals. As do all public health professionals, public health nurses can and will work alone if others are unable or choose not to work on an issue. Most public health nursing interventions are *independent nursing functions* as outlined in the Nurse Practice Act.

Minnesota Department of Health, Section of Public Health Nursing, June 1999

Public Health Nursing Practice for the 21st Century
Competency Development in Population-Based Practice
Session 2 – Handout 1

Cornerstones of Public Health Nursing

Definition of Public Health

Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy.

Adapted from The Future of Public Health. Institute of Medicine, National Academy Press. Washington, D.C.; 1988

Definition of Nursing

"The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to his health or recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible...[The nurse] is temporarily the consciousness of the unconscious, the love of life for the suicidal, the leg of the amputee, the eyes of the newly blind, a means of locomotion for the infant, knowledge and confidence for the young mother, the [voice] for those too weak or withdrawn to speak."

Henderson, VA (1961) Basic principles of nursing care. London: International Council of Nurses 5M 12/95, p.6

Definitions of Public Health Nursing

Public health nursing is the synthesis of the art and science of public health and nursing.

Cornerstones of Public Health Nursing, Minnesota Department of Health, 1999

Social Justice

"In the broadest sense, justice means that each person in society ought to receive his due and that the burdens and benefits of society should be fairly and equitably distributed."

Beauchamp, Dan. "Public Health as Social Justice" Inquiry Vol. XIII, March 1976. Pp 3-14

"Social justice is the foundation of public health… that invincible human spirit that led so many of us to enter the field of public health in the first place: a spirit of that has a compelling desire to make the world a better place, free of misery, inequity, and preventable suffering, a world in which we all can live, love, work, play, ail, and die with our dignity intact and our humanity cherished."

Krieger and Birn, Editorial, AJPH. November,1997

Caring

"Caring is not simply an emotional or attitudinal response. Caring is a total way of being or relating, of acting; a quality of investment and encouragement in the other- person, idea, thing, or self..."

Caring: The Mode of Being by S. Roach (Toronto: University of Toronto Press) 1984, p.2

Epidemiology Concepts

1. Epidemiology -" the study of the distribution of states of health and of the determinants of or deviations from health in populations". Epidemiology describes the health status of populations, explains the causes of diseases, predicts the occurrence of disease, and controls the distribution of disease. The conventional epidemiology model is the "epidemiology triangle", in which there is an agent, or whatever is thought to cause the disease or risk, a host, or whatever is affected by the agent, and an environment, or all the factors external to the host and agent which allow or promote the disease or risk.

2. Risk - the probability that an unfavorable event will occur

3. Relative risk - the ratio of risk among those exposed to a factor to those the risk of those not exposed. A high relative risk in the exposed population indicates a risk factor for the development of the human condition.

4. Rates of occurrence - statistical measures that indicate the extent of health problems in a population. Examples of rates include death rates, birth rates, cancer rates.

5. Incidence - the frequency of newly occurring cases of a disease or condition in a specified population during a given time period.

6. Prevalence - measure of the number of case of a given disease or condition in a specified population during a designated time; usually a rate measured at a point in time.

Adapted from Valanis, B., Epidemiology in Nursing and Health Care, 2nd Ed .Norwalk, CT: Appleton-Lang, 1992

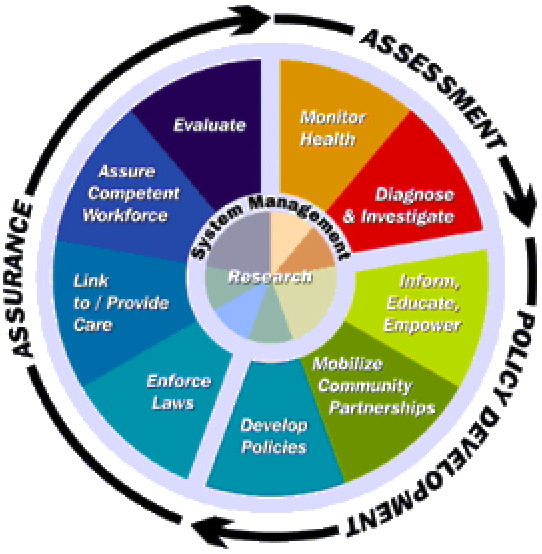
Definitions of Core Functions

1. **Assessment** - regularly and systematically collecting, assembling, analyzing, and making available information on the health of the community, including statistics on health status, community health needs, and epidemiologic and other studies of health problems.

2. **Policy Development** - to serve the public interest in the development of comprehensive public health policies by promoting use of the scientific knowledge base in decision making about public health and by leading in developing public health policy.

3. **Assurance** - to assure constituents that services necessary to achieve agreed upon goals are provided either by encouraging actions by other entities, by requiring such action through regulation, or by providing services directly.

The Future of Public Health. Institute of Medicine, National Academy Press. Washington, D.C.; 1988



PUBLIC HEALTH IN AMERICA

Vision:

Healthy People in Healthy Communities

Mission:

Promote Physical and Mental Health and Prevent Disease, Injury, and Disability

Public Health

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Assures the quality and accessibility of health services

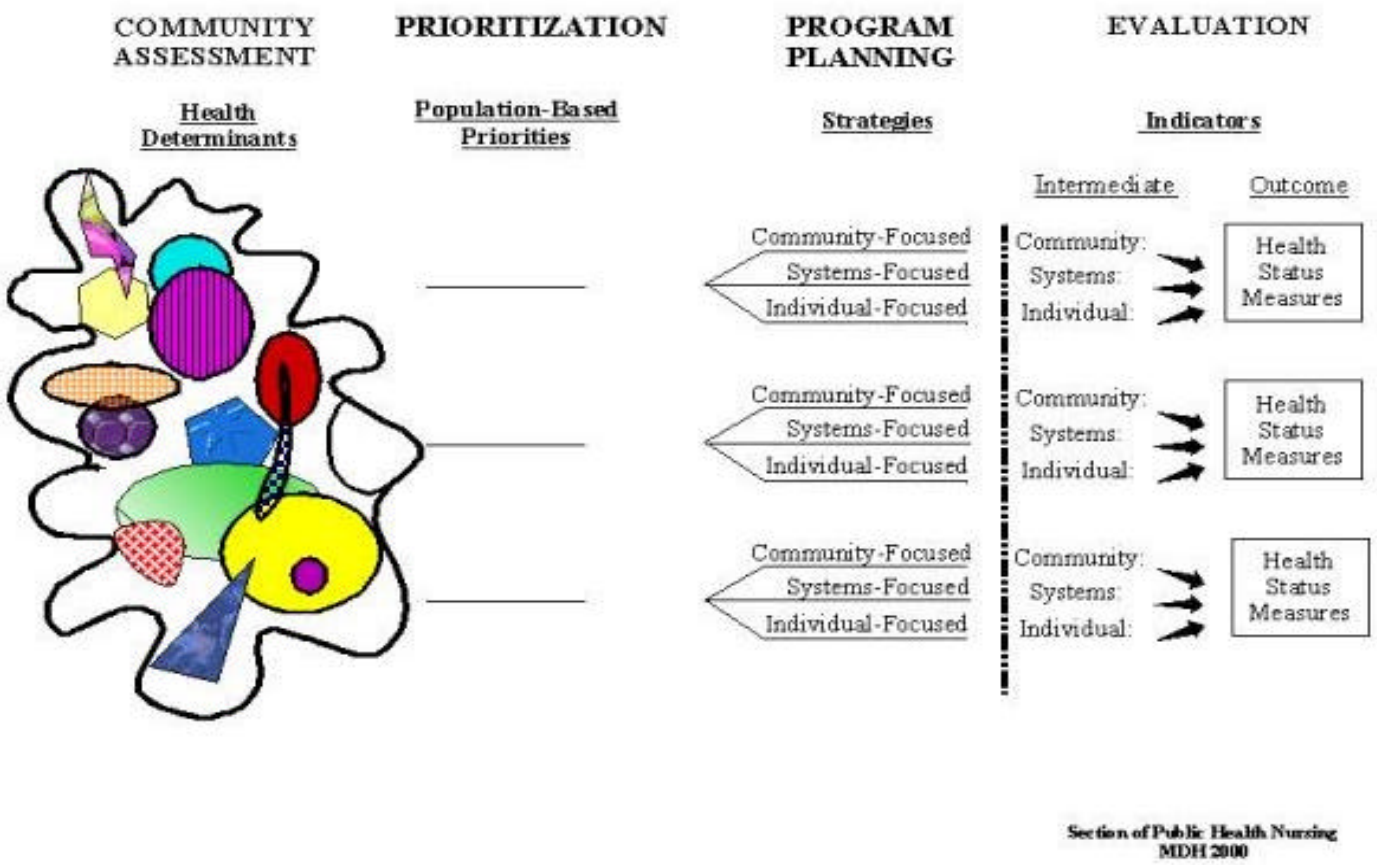
Essential Public Health Services

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

Source:Essential Public Health Services Work Group of the Public Health Functions Steering Committee
Membership: American Public Health Association, Association of Schools of Public Health; Association of State and Territorial Health Officials; Environmental Council of the States; Institute of Medicine, National Academy of Sciences; National Association of County and City Health Officials; National Association of State Alcohol and Drug Abuse Directors; National Association of State Mental Health Program Directors; Public Health Foundation; U.S. Public Health Service; Agency for Health Care Policy and Research; Centers for Disease Control and Prevention; Food and Drug Administration; Health Resources and Services Administration; Indian Health Service; National Institutes of Health; Office of the Assistant Secretary for Health; Substance Abuse and Mental Health Services Administration

Fall 1994
Source: http://www.health.gov/phfunctions/public.htm

POPULATION-BASED PUBLIC HEALTH PRACTICE



Section of Public Health Nursing
MDH 2000

Public Health Nursing Practice for the 21st Century
Competency Development in Population-Based Practice
Session 2 – Handout 4

COMMUNITY ASSESSMENT: TYPES OF DATA

The quality of the practice of public health is closely linked to the data on which it is based.

I. QUALITATIVE DATA

< **community opinion**

< key informant

< community survey

< community traditions, history, beliefs

< staff opinion / professional judgement

***Qualitative data** is obtained from sources such as focus groups, staff expertise, community testimony, key informant interviews, community reports, advisory committees, professional judgement (public health nurses, members of your health board, social workers, other professionals); story-telling, analysis of local newspaper topics / letters to the editor, community opinion surveys; and community studies that include qualitative analysis.*

II. QUANTITATIVE DATA

< **demographic data**
estimated population by age, gender, race and ethnicity, population per square mile; dependency ratios; number of female-headed single parent households , household income levels, educational level of head of household, and occupational level of household ; high school graduation rate; youth employment rate; adult employment rate; family poverty rate; child poverty rate; population gain or loss; immigration rates;

***Quantitative data** is obtained from such sources as state vital statistics; other state data systems such as the behavioral risk surveillance, hic census data; proprietary data; program evaluation; data sets from other state agencies such as Social Services or Corrections, community organizations such as Head Start, community opinion surveys; and local sources such as the sheriff's department, local battered women's shelter.*

< **vital statistics data** (data based on birth and death certificates)
natality data:
number of births; percent of premature births; percent of prenatal care first trimester; percent of births to unmarried mothers
mortality data:
neonatal and postneonatal infant mortality rates; leading causes of death by age group, suicide and homicide by ages

< **surveillance data**
selected notifiable diseases reported (sexually transmitted diseases and other selected diseases); number of substantiated reports of child maltreatment;

< **service utilization data**
number of women over 40 utilizing breast and cervical cancer screening; number of children under 1 year receiving public assistance, number of WIC participants;

< **survey data**
Student Survey data;

< **synthetic data estimates**
based on Behavioral Risk Survey;
behavioral risk factors for adults (e.g., percent at risk for: lack of seat belt use, hypertension, smoking, drinking and driving, etc.)
based on Alan Guttmacher Institute formula;
"number of women at risk of unintended pregnancy"

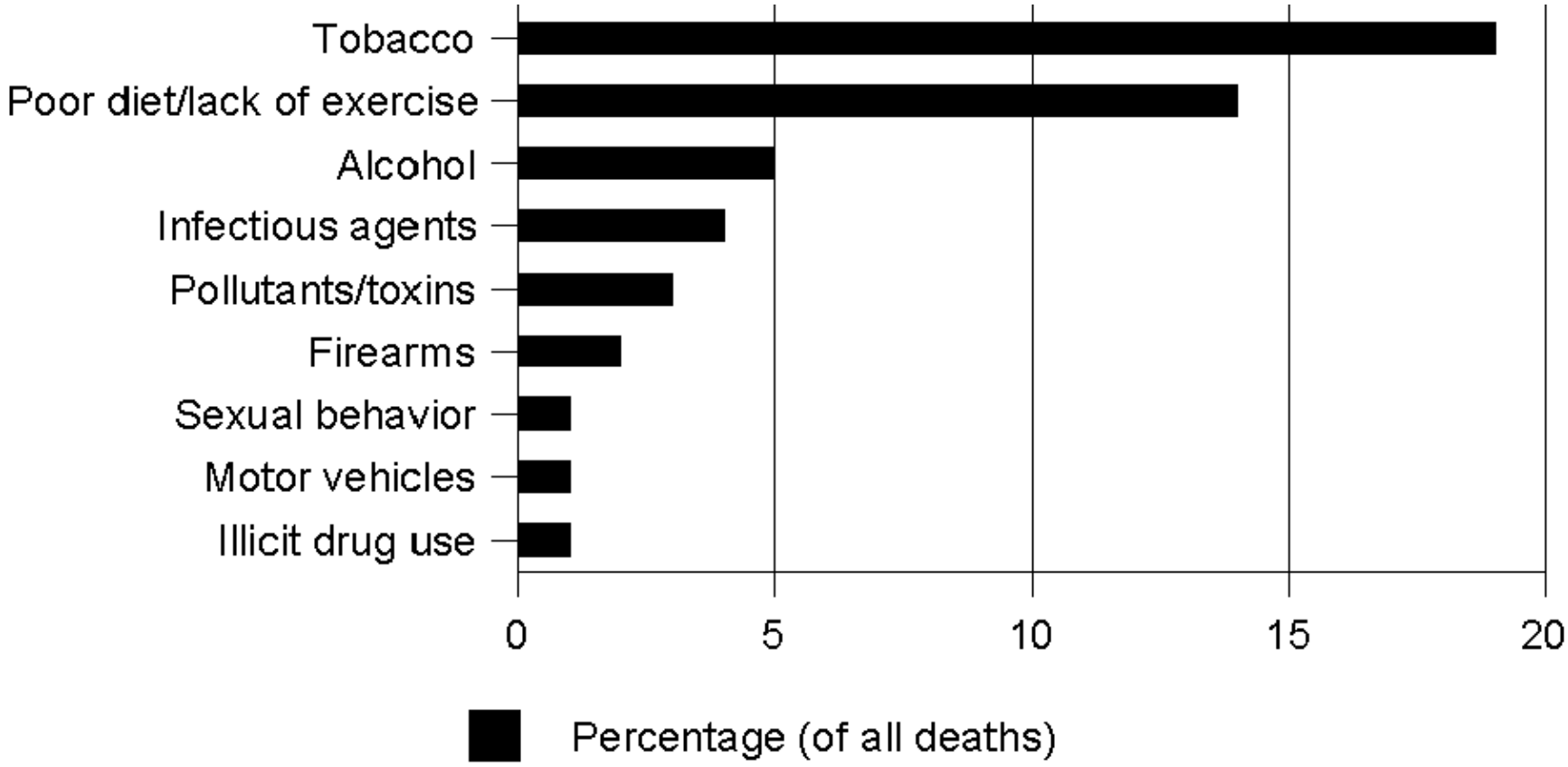
< program evaluation data
program specific data

< proprietary data
health plan utilization data
hospital emergency room admission data

While public health data is obtained from many existing sources, certain important data indicators may only exist within locales or must be gathered and generated within a specific site.

Other important data indicators are **not available from any source**, and must be approximated through proxy measures, preferably based on epidemiology and current research.

Actual Causes of Death, United States, 1990**



****McGinnis, J. M., Foege, W. H. (1992). Actual causes of death in the United States. *JAMA, 270*:2207-12.**

Public Health Nursing Practice for the 21st Century
Examples of Types of Data

DEMOGRAPHIC DATA

	Population	Population Density (per square mile)	Individuals # poverty	Persons #18 years	Persons 65-- 84 years	Persons 85+ years	Black	American Indian	Asian/ Pacific islander	Hispanic origin
Divide County, ND	2,416	2	11.2%	21.4%	23.3%	4.5%	0%	.5%	.2%	.3%
Chickasaw County, MS	18,274	36	18.6%	28.3%	11.8%	1.9%	40.6%	.1%	.1%	.5%
Yuba County, CA	61,561	98	22.8%	33.8%	10.3%	1.0%	4.3%	3.1%	11.3%	14.9%
Lubbock County, TX	230,672	256	19.7%	27.2%	8.9%	1.1%	8.3%	.4%	1.7%	27.7%
Worcester County, MA	725,540	480	9.8%	9.8%	12.4%	1.8%	2.8%	.2%	2.4%	5.9%

Data Source: U.S. Census Bureau, 1997 Document Source: Community Health Status Report <www.communityhealth.hrsa.gov>

HEALTH STATUS DATA

	Low birth weight (<2500 g)	Premature birth (< 37 weeks)	Teen mothers (<18)	Unmarried mothers	No care in first trimester	Infant mortality rate	White infant mortality rate	Black infant mortality rate
Divide County, ND	nrf**	nrf**	nrf**	nrf**	nrf**	nrf**	nrf**	nrf**
Chickasaw County, MS	9.4%	16.5%	12.1%	43.4%	23.9%	9.6	6.3	13.0
Yuba County, CA	6.5%	12.0%	7.0%	27.5%	39.1%	7.3	7.2	nrf**
Lubbock County, TX	8.8%	13.8%	8.5%	30.4%	24.2%	8.3	6.8	25.1
Worcester County, MA	6.6%	8.4%	3.3%	26.0%	12.3%	5.4	5.2	11.4
United States	7.5%	11.4%	12.7%	32.4%	17.0%	7.2	6.0	13.7

** nrf - no report, fewer than 500 births and 3 events (birth measures and infant mortality) or fewer than 10 events (death measures) occurred during the specified time period
Data Source: National Center for Health Statistics, Vital Reporting System, 1988-1997 Document Source: Community Health Status Report <www.communityhealth.hrsa.gov>

HEALTH STATUS DATA						RISK FACTOR DATA				
	Breast Cancer	Lung Cancer	Motor Vehicle Injuries	Suicide	Coronary Heart Disease *	Smoking *	Obesity *	Sedentary *	High Blood Pressure *	Diabetes *
Divide County, ND	nrf**	43.8	nrf**	nrf**	169.4	20.0%	33.5%	81.3%	25.5%	4.2%
Chickasaw County, MS	26.6	71.7	44.6	12.4	297.3	24.1%	37.5%	80.8%	34.4%	7.6%
Yuba County, CA	19.5	80.1	31.4	21.2	235.4	19.2%	31.0%	75.3%	21.2%	5.5%
Lubbock County, TX	26.0	62.4	18.3	11.8	241.7	21.9%	34.9%	79.2%	23.!%	5.5%
Worcester County, MA	32.5	57.1	8.8	7.5	182.1	20.9%	26.9%	78.0%	19.8%	3.9%

*** state data from the Behavioral Risk Factor Surveillance System, 1998**

*** * nrf - no report, fewer than 500 births and 3 events (birth measures and infant mortality) or fewer than 10 events (death measures) occurred during the specified time period**

Data Source: National Center for Health Statistics, Vital Reporting System, 1988-1997 Document Source: Community Health Status Report <www.communityhealth.hrsa.gov>

HEALTH STATUS DATA						
	Pertussis		Hepatitis B		Salmonella	
	cases	expected	cases	expected	cases	expected
Divide County, ND	0	(0)	1	(0)	2	(3)
Chickasaw County, MS	0	(3)	0	(2)	19	(14)
Yuba County, CA	5	(3)	53	(15)	21	(54)
Lubbock County, TX	24	(18)	47	(45)	219	(146)
Worcester County, MA	187	(66)	11	(55)	355	(387)

Data Source: Center for Disease Control and Prevention, 1989 - 1998
Document Source: Community Health Status Report <www.communityhealth.hrsa.gov>

Prioritizing Process

Worksheet A Problem Importance

"How important is this problem for our community?"

CATEGORY PROBLEM*	HIGH 3 points	MEDIUM 2 points	LOW 1 point
1. Estimate of the persons potentially affected by the problem (persons at risk). What percent is this of your total community population? # of persons: % of total population:			
2. Estimate of the persons at risk actually affected by the problem. # of persons:			
3. Premature death (years of potential life lost). YPLL =			
4. Severity (quality of life measure; i.e., extent to which the problem limits a person's ability to live the way they want to).			
5. Actual or potential economic burden to the community.			
6. Extent of public concern (perceived threat to the community).			
7. Ability of public health to prevent the problem from occurring (primary prevention).			
8. Size of the gap between existing community resources addressing the problem and need.			
9. Local criteria:			
10. Local criteria:			
SUBTOTALS		+	+

Community Health Services Division/Minnesota Department of Health. Community Health Services Planning Manual: Guidelines for Local Public Health Agencies (November, 1998). [For further information see http://www.health.state.mn.us or call 651/296-9676].

EXAMPLES OF PUBLIC HEALTH PROBLEMS

INFECTIOUS DISEASE	Increasing rate of sexually transmitted diseases, particularly chlamydia and gonorrhea, among adolescents and young adults due to unsafe sexual behavior.
CHRONIC/NONINFECTIOUS DISEASE	Premature morbidity and mortality from cardiovascular diseases related to lifestyle choices such as smoking, alcohol use, inadequate nutrition, and sedentary lifestyle.
ENVIRONMENTAL CONDITIONS	Prevalence of and potential risk of elevated blood lead levels among children due to environmental lead exposure.
ALCOHOL, TOBACCO, OTHER DRUGS	Accessibility of tobacco to minors due to the existence of cigarette vending machines in the community.
UNINTENTIONAL INJURY	Increasing morbidity and mortality related to falls in populations 75 years and older.
VIOLENCE	Increasing incidence of child abuse and neglect due to ineffective parenting and high levels of family stress.
UNINTENDED PREGNANCY	Increased incidence of adolescent pregnancy due to early onset of sexual activity and inadequate sexuality education.
PREGNANCY AND BIRTH	Prevalence of poor birth outcomes to women who experience inadequate weight gain, anemia, substance abuse, battering, and smoking during their pregnancies.
CHILD & ADOLESCENT GROWTH & DEVELOPMENT	Increase in the number of children who are experiencing developmental delays related to undetected vision, hearing, speech and language, lead exposure, and developmental problems.
DISABILITY/DECREASED INDEPENDENCE	Increasing numbers of seriously chronically mentally ill persons unable to maintain their independence within the community due to inability to manage their medications.
MENTAL HEALTH	High-risk behavior (e.g., suicide attempts, eating disorders, drug use, early sexual activity) among adolescents due to depression and low self-esteem.
SERVICE DELIVERY SYSTEMS	Fragmented children's mental health service system, which results in a lack of early intervention services to children with emotional behavior disorders.

Categories of Public Health

- Alcohol/Tobacco/Other Drug Use
- Child & Adolescent Growth and Development
- Chronic/Noninfectious Disease
- Disability/Decreased Independence
- Environmental Conditions
- Infectious Disease
- Mental Health
- Pregnancy and Birth
- Service Delivery Systems
- Unintended Pregnancy

ALCOHOL, TOBACCO AND OTHER DRUG USE[4]

Minnesota Public Health Improvement Goal:

Goal 1.Reduce the behavioral risks that are primary contributors to morbidity and mortality.

PREVENTION	PROMOTION
Public health seeks to prevent:	**Public health seeks to promote outcomes such as:**
Use of tobacco (except in religious ceremony)	Zero alcohol, tobacco and other drug use by youth
Use of illegal drugs	Responsible behavior regarding alcohol use by adults
Misuse and abuse of alcohol	Smoke-free environments
Misuses and abuse of over-the-counter and prescription drugs	Appropriate use of over-the-counter and prescription drugs
Chemical dependency	No use of illegal drugs

The category of ALCOHOL, TOBACCO AND OTHER DRUG USE does NOT include:

Chronic diseases associated with alcohol, tobacco and other drug use
(see Chronic Disease)

Fetal Alcohol Syndrome and Fetal Alcohol Effects
(see Pregnancy and Birth)

Alcohol use and vehicle operation
(See unintentional injury)

[4]The category of *Alcohol, Tobacco and Other Drug Use* was created to give special emphasis to public health activities that focus on preventing substance use and abuse, and thereby preventing the negative effects associated with alcohol, tobacco and other drug use (e.g., family dysfunction, violence, child neglect, chronic disease, unintended injury). Alcohol, tobacco and other drug use prevention comprises a significant public health effort.

CHILD AND ADOLESCENT GROWTH AND DEVELOPMENT

Minnesota Public Health Improvement Goal:

Goal 4. Promote health for all children, adolescents, and their families.

PREVENTION	PROMOTION
Public health seeks to prevent problems in child and adolescent growth and development[5], such as:	**Public health seeks to promote outcomes such as:**
Undetected health problems and developmental delays (e.g., exposure to lead or other environmental contaminants, dental problems, anemia, hearing loss)	Healthy for all children, adolescents, and families Optimal physical growth and development for all children and adolescents Positive parenting (parents of children and adolescents)
Undetected developmental issues	Nurturing and supportive family environments for all children and adolescents
Inadequate nutrition	Safe, health- focused learning environments (e.g. child care, schools) that support optimal academic achievement
Inadequate or ineffectual parenting	Children free of lead poisoning, dental diseases, etc.
Child neglect	Early detection of health problems, developmental delays and adolescent risk behaviors
Undetected emotional concerns	Early detection of emotional/behavioral problems
Adolescent risk behaviors	Medical home for all children
Out-of-Home Placement	Inclusion of children and adolescents with special needs/disabilities in all aspects of community life

The category of CHILD AND ADOLESCENT GROWTH AND DEVELOPMENT does NOT include:

Child abuse / family violence
(see Violence)

Immunizations
(see Infectious Disease)

Lead abatement
(see Environmental Conditions)

[5]This category focuses on ensuring that every child has what he or she needs to grow up healthy. This includes the role of the family as well as the importance of early identification of potential health and/or developmental problems.

CHRONIC/NONINFECTIOUS DISEASE

Minnesota Public Health Improvement Goals:

Goal 1. Reduce the behavioral risks that are primary contributors to morbidity and mortality.

Goal 12. Promote early detection and improved management of non-infectious disease and chronic conditions.

Goal 13. Promote optimal oral health for all Minnesotans.

PREVENTION	PROMOTION
Public health seeks to prevent chronic and non-infectious diseases[6] such as:	**Public health seeks to promote outcomes such as:**
Cancer Cardiovascular disease Stroke Hypertension High blood cholesterol Diabetes Asthma Dental diseases Lyme disease Obesity Anemia Other chronic/noninfectious diseases	Healthy behavior, lifestyle choices, and healthy communities, e.g.: healthy eating non-smoking physical activity sleep and rest responsible alcohol use by adults zero alcohol, tobacco and other drug use by youth Minimizing exposure to environmental risks (e.g., sun exposure, ticks, environmental tobacco smoke) Early detection of chronic/noninfectious disease

The category of CHRONIC/NON-INFECTIOUS DISEASE does NOT include:

Eating disorders -- bulimia, anorexia
(see Mental Health)

Anemia in pregnancy
(see Pregnancy and Birth)

Anemia in childhood
(see Child Growth and Development)

Lead poisoning
(see Environmental Conditions OR Child Growth and Development)

[6]Public health addresses those chronic diseases and conditions that are related to human behavior and that may be affected by public health strategies.

DISABILITY AND DECREASED INDEPENDENCE

Minnesota Public Health Improvement Goal:

Goal 10. Promote the well-being of the elderly and individuals with disability, disease and/or chronic illness.

PREVENTION	PROMOTION
Public health seeks to prevent complications of disability and decreased independence[7], such as:	**Public health seeks to promote outcomes such as:**
Self-neglect	Individuals with a disability and/or decreased independence attain/maintain their highest level of functioning
Unnecessary institutionalization	Mainstreaming of children with a disability or developmental delay
Elder neglect	All children with a disability or developmental delay reach their optimal level of development
Isolation	All adults retain independence in the least restrictive setting possible

The category of DISABILITY AND DECREASED INDEPENDENCE does NOT include:

Chemical dependency
(see Alcohol, Tobacco, and Other Drug Use)

Screening and/or detecting of health problems and developmental delays
(see Child Growth and Development)

Child neglect
(see Child Growth and Development)

Maltreatment
(see Violence)

Children with developmental delays or disabilities
(see Child Growth and Development)

Persons with a serious and persistent mental illness
(see Mental Health)

[7]This category is used once a disability or developmental delay is identified in an adult. The category also includes any person experiencing a sensory impairment (e.g., hearing or vision loss) or a person with a disability related to speech, neurological impairment, or cognitive functioning.

ENVIRONMENTAL CONDITIONS

Minnesota Public Health Improvement Goals:

Goal 11. Reduce exposure to environmental health hazards.

Goal 14. Reduce work-related injury and illness.

PREVENTION	PROMOTION
Public health seeks to prevent environmental conditions[8] such as:	**Public health seeks to promote environmental conditions such as:**
Asbestos exposure Lead exposure Radon exposure Mercury exposure Radioactivity and Radiation Ground and surface water contamination Contaminated and abandoned wells Food-borne and waterborne disease Air contamination (second-hand smoke (MN Clean Indoor Air Act - MCIAA), molds, carbon monoxide, etc.) Public health nuisances (e.g., animal control, noise pollution) Occupational disease (e.g., farmer's lung, hearing loss, carpal tunnel) Enclosed Sports Arenas Other environmental conditions	Clean air Clean water Safe food Environmentally sound management of solid waste, hazardous substances, sewage, and land Homes, workplaces, recreational areas, and playgrounds that are free of environmental risks

The category of ENVIRONMENTAL CONDITIONS does NOT include:

Lyme disease
(see Chronic/Noninfectious Disease)

Occupational injuries, including farm injury
(see Unintended Injury)

Lead screening
(see Child Growth and Development)

[8]"Environmental conditions" includes both environmental risks to human health and the management of environmental systems. Public health's primary concern is with the effect of the environment on human health, as opposed to other organizations' concerns with the effect of people on the environment. This category refers to activities that identify and mitigate environmental risks at the *source* (e.g., lead abatement), as opposed to identifying and treating *individuals* already exposed to the risk (e.g., lead screening programs).

INFECTIOUS DISEASE

Minnesota Public Health Improvement Goal:

Goal 9. Reduce infectious disease.

PREVENTION	PROMOTION
Public health seeks to prevent infectious diseases[9] such as:	**Public health seeks to promote outcomes such as:**
Sexually transmitted diseases (STDs) AIDS/HIV Tuberculosis Pediculosis (lice) Hepatitis Other infectious diseases Vaccine preventable diseases: measles rubella mumps polio diphtheria tetanus pertussis Hepatitis B hemophilus influenza B (HIB) influenza pneumococcal pneumonia	Minimal transmission of infectious disease Age-appropriately immunized populations Responsible sexual behavior Appropriate treatment of infectious disease in order to reduce morbidity, mortality, and further transmission Responsible substance use

The category of INFECTIOUS DISEASE does NOT include:

Food-borne or waterborne illnesses
(see Environmental Conditions)

Dental Diseases
(see Chronic/Noninfectious Disease)

[9]Infectious diseases are communicable and *usually* require a human interaction to be transmitted, as opposed to diseases that are transmitted through food or water.

MENTAL HEALTH

Minnesota Public Health Improvement Goal:

Goal 5. Promote, protect and improve mental health.

PREVENTION	PROMOTION
Public health seeks to prevent mental health problems [10] such as:	**Public health seeks to promote:**
Depression	Emotional health
Suicide	
Low self-esteem	Ability to cope with stressors
Development of mental illness	
Negative effects of stress	Positive attitude toward life
Eating disorders	
Sexual harassment	Healthy self-esteem
Negative emotional effects of abuse	
At risk behaviors	Life skills
Deterioration in the functioning of individuals with a chronic mental illness	Healthy school climates
	Community support for families
	Mental health care access in the community

The category of MENTAL HEALTH does NOT include:

Substance abuse
(see Alcohol, Tobacco, and Other Drug Use)

Abuse
(see Violence)

[10]This category includes the prevention of mental health problems through the reduction of risks to emotional health and the development of coping skills as well as serious and persistent mental illnesses that are considered a disability.

PREGNANCY AND BIRTH[11]

Minnesota Public Health Improvement Goal:

Goal 2. Improve birth outcomes and early childhood development.

PREVENTION	PROMOTION
Public health seeks to prevent birth outcomes such as:	**Public health seeks to promote outcomes such as:**
Infant mortality	Healthy pregnancies and healthy babies
Prematurity	
Low birth weight	Pregnancies free of alcohol, tobacco or other drug use
Congenital anomalies	
Fetal Alcohol Syndrome (FAS)	Positive birth outcomes for high-risk pregnancies (e.g., teen pregnancy, or mothers with gestational diabetes, pregnancy-induced hypertension, pre-term labor, or anemia)
Fetal Alcohol Effect (FAE)	
Pregnancy-related anemia	
Maternal mortality	

The category of PREGNANCY AND BIRTH does NOT include:

Pregnancy prevention
(see Unintended Pregnancy)

STDs
(see Infectious Disease)

[11]This category is used for all pregnancies, even those that were unintended.

SERVICE DELIVERY SYSTEMS

Minnesota Public Health Improvement Goals:

Goal 8. Improve the outcome of medical emergencies.

Goal 15. Assure access to and improve the quality of health services.

Goal 16. Ensure an effective state and local government public health system.

Goal 17. Eliminate the disparities in health outcomes and the health profile of people of color.

PREVENTION	PROMOTION
Public health seeks to prevent problems[12] such as:	**Public health seeks to promote outcomes such as:**
People not receiving services due to barriers such as -- finances lack of providers fragmented service delivery transportation communication culture/language child care	Citizens receive services to ensure optimal health
Deterioration of the public health infrastructure	Rapid and effective emergency medical treatment
Emergency services not available or not provided	Barriers to services are removed
Disparities in health status between minority and non-minority populations	Services are coordinated, timely, cost-effective, culturally sensitive, accessible, available, and comprehensive
	Clients are matched to appropriate services
	Collaboration takes place with other public systems and the private and non-profit sectors
	The public health role of advocacy with other systems is emphasized
	The public health infrastructure is stable and strong

[12]This category does not deal exclusively with health services, but looks at the whole continuum of services (e.g., social services, housing, medical providers, schools, economic assistance, etc.) that an individual might require -- including health services -- with particular concern as to how all those services interact.

UNINTENDED PREGNANCY[13]

Minnesota Public Health Improvement Goal:

Goal 3. Reduce unintended pregnancy.

PREVENTION	PROMOTION
Public health seeks to reduce:	**Public health seeks to promote outcomes such as:**
Mistimed and/or unwanted pregnancies	Responsible sexual behavior
Initiation of sexual intercourse at a young age	Use of contraception among sexually active individuals who do not want to become pregnant
	Pregnancies that are planned

The category of UNINTENDED PREGNANCY does NOT include:

Pregnancy and birth outcomes
(see Pregnancy and Birth)

STDs
(see Infectious Disease)

[13]This category focuses on the prevention of unintended pregnancy and thereby the prevention of the possible negative effects of an unintended pregnancy (especially unintended teen pregnancy), such as quitting school before graduation, poverty, low self-esteem, delayed/inadequate prenatal care, and poor birth outcomes.

UNINTENTIONAL INJURY

Minnesota Public Health Improvement Goals:

Goal 7. Reduce the behavioral and environmental health risks that are primary contributors to unintentional injury.

Goal 14. Reduce work-related injury and illness.

PREVENTION	PROMOTION
Public health seeks to prevent unintentional injuries [14] such as:	**Public health seeks to promote outcomes such as:**
Home and leisure injuries including: < Falls < Fire and fire-related injuries < Choking, Suffocation < Poisoning < Drowning < Sports and Playground Injuries (e.g., snowmobiles, all-terrain vehicles, rock climbing, horse-back riding, snow-skiing, in-line skating, boating, jet skis, water-skiing, diving) < Firearms < Motor vehicle-related injury < Motor vehicle < Bicycle < Pedestrian < Motorcycle	Reduced death and disability due to unintentional injuries Homes, workplaces, recreational areas and playgrounds free of injury hazards Population uses appropriate safety equipment Safe practices in handling of equipment (e.g., boats, motor vehicles, agricultural machinery, bicycles, recreational equipment, mouth guards for contact sports, etc.) Equipment and vehicles operators use no chemicals / alcohol
Alcohol-related injury (e.g., driving under the influence, alcohol-related falls, drowning, fire, boating, and snowmobiles crashes) Occupational injuries, including agricultural injuries Other unintentional injuries	

The category of UNINTENTIONAL INJURY does NOT include:

Intentional injury *(see Violence)*
Lead exposure *(see Environmental Conditions)*
Occupational disease *(see Environmental Conditions)*

[14]Unintended injuries are contrasted with intended (deliberate or violent) injuries such as murder, rape, assault, child abuse, or suicide.

VIOLENCE

Minnesota Public Health Improvement Goal:

Goal 6. Promote a violence-free society.

PREVENTION	PROMOTION
Public health seeks to prevent violence[15] such as:	**Public health seeks to promote outcomes such as:**
Homicides Maltreatment (physical, sexual, and/or emotional abuse) of children, seniors, or persons with a disability Domestic violence Workplace violence Violence in schools Gang violence Assault Sexual violence Other acts of violence	Reduced death, injury, disability and trauma due to violence Zero-tolerance of violence in the community (e.g., public demand for non-violent television programming) Violence-free families, workplaces, and schools Mutually respectful behavior Communities free of the fear of violence Community knowledge about healthy sexuality

The category of VIOLENCE does NOT include:

Accidental injuries *(see Unintended Injury)*

Child neglect *(see Growth and Development)*

Suicide *(see Mental Health)*

[15]Violence is defined as "the misuse of power and authority, and involves hurting people (children, adults, and the elderly) by hitting, punching, beating up, kicking, raping, biting, bullying, threatening, name-calling, shaking, choking, spitting, poking, swearing, withholding food, sleep, shelter, clothes, or medical care, or having any sexual contact with a child." *(The Initiative for Violence-Free Families and Communities in Ramsey County)*.

Public Health Nursing Practice for the 21st Century: Competency Development in Population-Based Practice
Session 2 – Handout 7

Program Planning and Evaluation

Childhood Lead Poisoning

Program Planning	Intermediate Indicators	Population Health Status Indicator
Seminars	Proportion of rental homes with lead hazards identified and mitigated.	Incidence of childhood lead poisoning
Screening protocol	Proportion of high risk children screened	
Home visits	• Hazards identified and mitigated • Compliance with medical treatment • Food intake	

Falls in populations >65 years old

Program planning	Intermediate Indicators	Population Health Status Indicator
Community education	Community awareness	Rate of injury and death related to falls in elderly
Provider training	Referral patterns	
Home safety screening	Hazards identified and corrected	

Unintended Adolescent Pregnancy

Program planning	Intermediate Indicators	Population Health Status Indicator
Coalition	Community standard	Rate of unintended adolescent pregnancy
Confidential services	Billing procedures	
Assertive building classes	Assertiveness skills	

Public Health Nursing Practice for the 21st Century: Competency Development in Population-Based Practice
Session 2 – Handout 8

Discussion Questions

Consider the following questions about today's session to help you incorporate what you have learned into your own practice.

1. What is your personal definition of public health nursing?

2. What is your agency's definition?

3. What are the values and principles they reflect?

4. Describe your department's approach to assessing communities. How are problems or strengths identified? Prioritized? How are resources assigned?

Public Health Nursing Practice for the 21st Century: Competency Development in Population-Based Practice
Session 2 – Handout 9

Selected Resources

Books and Other Print Materials

Association of State and territorial Directors of Nursing (2000). Public Health Nursing: A Partner for Healthy Populations. Washington, DC: American Nurses Publishing [9912 HP].

Community Health Services Division/Minnesota Department of Health. Community Health Services Planning Manual: Guidelines for Local Public Health Agencies (November, 1998). [For further information see http://www.health.state.mn.us or call 651/296-9676].

Durch, J. S., Bailey, L. A., & Stoto, M. A. (eds.). (1997). Improving health in the community: A role for performance monitoring. Washington, DC: National Academy Press.

National Association of County and City Health Officials (NACCHO). (1991, March). APEXPH: Assessment protocol for excellence in public health. [Note: Copies may be obtained from NACCHO at 202/783-5550 or http://www.naccho.org and go to "bookstore".]

Perrin, E. B., & Koshel, J. J. (eds.). (1997). Assessment of performance measures for public health, substance abuse, and mental health. Washington, DC: National Academy Press.

Quad Council of Public Health Nursing Organizations (1999). Scope and standards of public health nursing practice. Washington, DC: American Nurses Publishing [9910PH 3M 12/99].

Wald, Lillian (1915). The house on Henry Street.

Electronic Resources

John Snow website: http://www.ph.ucla.edu/epi/snow.html

Florence Nightingale website: http://www.florence-nightingale.co.uk

Community Health Status Indicators Project: http://www.communityhealth.hrsa.gov or http://www.phf.org

Core Functions/10 Essential Services: http://www.health.gov/phfunctions/public.htm; if you are interested in more information specific to the PHN stories used to illustrate the ten essential services, read on…

- For more information on the geographic information systems in public health described by Lila Taft, you can access an archived 2.5 hour cybercast, "GIS in Public Health: Using

Mapping and Spatial Analysis Technologies for Health Protections" originally broadcast 5/11/2000 by CDC/PHTN.

- For more information on surveillance methods referred to by Linda Opstad, see "Epi in a Suitcase," a web-based course based on the text, Principles and Practice of Public Health Surveillance edited by Steven M. Teutsch and R. Elliott Churchill. Oxford University Press, 1994; see http://www.cdc.gov/epo

- For more information on Carol Niewolny's story about handwashing, see http://www.co.ramsey.mn.us/PH/hdwsh.htm

- For more information on a community engagement process as described by Kathy Nowak, a CDC-produced document, Principles of Community Engagement, may be downloaded from CDC's website at http://www.phppo.cdc.gov/publications.asp. Further information on the Search Institute can be accessed at http://www.search-institute.org. Additional information on asset development can be found at the Asset-based Community Development Institute at Northwestern University's Institute for Policy Research; see http://www.nwu.edu/IPR/abcd.html

- For more information on Healthy Minnesotans described by Gayle Hallin, see http://www.health.state.mnus/divs/chs/hsd/mhip.htm; for more information on the tobacco endowments, see http://www.health.state.mn.us/divs/opa/tobacco.htm

- For more information on communicable disease control methods such as those described by Tim Ringhand, see CDC's self-study course available through http://www.cdc.gov/phtn/catalog/3012g.htm

- For more information on frontier status as described by Barbara Andrist, see Popper, F. J. (1986). The strange case of the contemporary American frontier. Yale Review, 76(1): 101-121. See also the "Data Sources, Definitions, and Notes" component of the Community Health Status Indicators Report at http://www.communityhealth.hrsa.gov

- For more information on assuring a competent workforce and an opportunity to comment on the proposed national core competencies for public health professionals drafted by the Council on Linkages Between Academia and Public Health Practice see: http://www.trainingfinder.org/index.htm

- For more information on health status disparities described by Ana Marie Miller, several websites address this national objective. See http://www.minority.unc.edu/resources for a list.

- For more information on Karen Monsen's evidence-based community attack on head lice, see http://www.co.washington.mn.us/pubhlth/pubcatn.html

Either the Centers for Disease Control's website (and especially the Public Health Training Network's catalogue) http://www.cdc.gov/phtn/catalog.htm or the Public Health Foundation's "training finder" link http://www.trainingfinder.org are probably the quickest ways to find out about other ways to quench your thirst for knowledge on population health. Although neither the Minnesota Department of Health nor the faculty for the "Public Health Nursing Practice for the 21st Century" series necessarily endorse these courses, please check them out to determine for yourself the extent to which they might meet your own learning needs, learning preferences, and budget. You might check with your state health department's distance learning coordinator for assistance to start. Here's a beginning list:

- "Setting Community Health Priorities" produced by the Rollins School of Public Health at Emory University
- "Practical Evaluation of Public Health Programs" produced by the School of Public Health at the University of Texas-Houston
- "Implementation/Evaluation of Health Promotion Programs" produced by Mississippi State University
- "Principles of Epidemiology" produced by CDC and the PHF
- "Epidemiology: Principles and Practice: produced by the London School of Hygiene and Tropical Medicine.

Public Health Nursing Practice for the 21st Century: Competency Development in Population-Based Practice Session 2

PRE TEST QUESTIONS

1. Which of the following concepts best reflects social justice?
   a. Greatest good for the greatest number
   b. Secondary over tertiary prevention
   c. Preferences of the community
   d. Community services available

2. Which of the following are recommended components of community assessment?
   a. Collection and analysis of information about the health of the community
   b. Dissemination of information about the health of the community
   c. Improvement of the health status of the community
   d. Systematic re-assessment of the health of the community
   e. a, c, and d
   f. **a, b, and d**

3. The following are recommended methods of data collection for community assessment:
   a. Examination of vital statistics data
   b. Key informant interviews
   c. Community opinion surveys
   d. Program evaluation data
   e. a and b
   f. **All of the above**

4. Good criteria for prioritizing problems identified through community assessment include all of the following **except:**
   a. Number of persons at risk
   b. Ability to achieve results within a short period of time
   c. Full utilization of existing staff and facilities within the community
   d. Years of potential life lost
   e. Potential economic burden of problem
   f. **b and c**

5. Which of the following would help you determine if you have a problem with premature births in your community?
   a. The number of infant deaths in the community
   b. The percent of births to women aged 11-16 in the community
   c. The difference in between the state infant mortality rate and the community's infant mortality rate
   d. The change in the infant mortality rate over the last ten years in the community
   e. a, c, and d
   f. b, c, and d

6. Selection of population-based public health nursing programs to address identified community needs must be based on:
   a. Research evidence supporting the effectiveness of the program
   b. Knowledge of other programs already serving the population
   c. Availability of resources to support the program
   d. Programs historically offered by the agency
   e. The acceptability of the program to the community
   f. a, b, c, and e

7. The core functions of public health are community assessment, planning, intervention, and evaluation.
   a. True
   b. False

8. Which of the following is an example of a health status outcome?
   a. Percentage of children properly restrained in seat belts
   b. Number of deaths due to motor vehicle crashes
   c. Number of people over the age of 65 who drive cars
   d. Reducing speed limits by legislative mandate
   e. Percentage of parents who have attended classes on correct use of infant seats
   f. All of the above

8. All of the following are examples of public health nursing's relationship with a community **except:**
   a. Involving the League of Women Voters in planning a community assessment.
   b. Sharing community health status information through a local newspaper article
   c. Considering the values and beliefs of a refugee population when planning programs
   d. Locating a W.I.C. clinic based on building availability and cost
   e. a and b

9. Which of the following are identified as Essential Public Health Services by the U.S. Public Health Service?
   a. Monitoring health status to identify community problems
   b. Ensuring an expert public health work force
   c. Providing direct care to vulnerable populations
   d. Mobilizing community partnerships and actions to solve health problems
   e. a, c, and d
   f. a, b, and d

Public Health Nursing Practice for the 21st Century: Competency Development in Population-Based Practice Session 2

POST TEST QUESTIONS

1. According to the IOM definition, the primary goal of public health is to:
   a. Protect the country from contagious disease outbreaks
   b. Demonstrate responsible stewardship of the public dollar
   c. **Assure the conditions in which people can be healthy**
   d. Assure minimum standard of living
   e. All of the above

2. Which of the following characterize vulnerable populations?
   a. Groups of persons at risk of poor physical health
   b. Groups of persons at risk of poor psychological health
   c. Groups of persons at risk of poor social health
   d. None of the above
   e. **All of the above**

3. Which of the following is an important concept describing social justice?
   a. Individual rights
   b. Personal responsibility
   c. Autonomy
   d. Profit motivated
   e. **Common good**

4. The principle(s) that public health nursing share(s) with nursing in general include:
   a. Relationship based care
   b. Holistic approach
   c. Epidemiology as the main research method
   d. Focus on tertiary prevention
   e. **a and b**
   f. a and d

5. An incidence rate reflects the number of new cases developing in a population at a specific time.
   a. True
   b. False

6. Epidemiology is defined as the study of infectious diseases in defined populations.
   a. True
   b. **False**

7. Which of these is the primary reason for government's involvement in promoting and protecting the health of the public?
   a. To stimulate the economy
   b. To provide preventive health services
   c. To provide high quality health care to vulnerable populations
   d. To carry out authority granted by the Constitution
   e. b and d

8. The first step in the community assessment process is to:
   a. Elicit the community's perception of their strengths, problems and health influences
   b. Gather and analyze existing/available information to identify health indicators
   c. Describe the population that comprises the community
   d. Identify all potential partners for assessment and planning

9. The sources of data used in the community assessment process include:
   a. Vital statistics
   b. Community input
   c. Quantitative data
   d. Public health staff expertise
   e. **All of the above**

10. Increasing the proportion of sexually active teens who report consistent condom use by 10% over two years is an indicator of which of type of evaluation:
   a. An intermediate status outcome
   b. A health status outcome
   c. A process outcome
   d. a and b
   e. b and c
   f. a and c

11. Which of the following is an example of a health status outcome?
   a. Routine distribution of copies of birth certificates to local health departments
   b. The proportion of women entering prenatal care in first trimester
   c. The proportion of women who reduce their alcohol consumption during pregnancy
   d. Home visits to pregnant teens
   e. Percentage of births weighing less than 2500 grams

Session 3

This session instructs in the concept of population-based public health nursing practice and expands on the set of 17 related interventions introduced in the first session.

Learning Objectives

1. Define the public health nursing process at the three practice levels.
2. Recognize best practices for implementing each intervention.
3. Identify relevant health status and intermediate outcome indicators used for evaluation.

Content

Public Health Nursing Process

At the systems, community, and individual/family levels of practice, the public health nursing process includes:

1. Identifying the population of interest
2. Establishing a relationship
3. Refining with further assessment
4. Eliciting perceptions
5. Setting goals
6. Selecting health status indicators

7. Selecting interventions
8. Selecting intermediate outcome indicators
9. Determining strategy for frequency and intensity
10. Determining evaluation methods
11. Implementing the intervention
12. Reassessing regularly
13. Adjusting interventions
14. Providing feedback
15. Collecting evaluation
16. Comparing results to plan
17. Identifying differences
18. Applying the results to practice.

Best Practices

The "best practices" evolved from theory, research, and expert opinion reviewed by a panel of public health nursing experts. The public health nurse's success in implementing any of the interventions is increased if the best practices are considered. Examples of best practices are given for Advocacy, Collaboration, Community Organizing, Counseling, Case management, Health Teaching, Referral and Follow-up, Screening, and Surveillance.

Evaluation measures

Intermediate and health status measures at the community, system, and individual levels are described for three public health nursing programs: Flood Response; Grief and loss program; and a Home Visiting program.

Content Outline

Session 3 is three hours in length. This section outlines each segment with times and corresponding handouts. The time is approximate and will vary with VCR speed.

Video Tape

Session 3 – December 7, 2000

I. Introduction and Recap of Session 2 10 minutes

II. The Public Health Nursing Process 18 minutes

Handout 1 – Public Health Nursing Process

III. Public Health Nursing Interventions: Application and Evaluation

Refer to the manual Public Health Interventions: Applications for Public Health Nursing Practice for details on the 9 interventions presented in this segment.

Handout 2 – Examples from practice

A. <u>Surveillance, Collaboration, Advocacy</u>

System Level Intervention

Flood Response Example 36 minutes

BREAK 10 minutes

Question and Answer Session 15 minutes

B. Counseling, Health Teaching, Community Organizing

Community Level Intervention

Grief and Loss Program Example 30 minutes

BREAK 10 minutes

C. Screening, Referral and Follow-up, Case Management

Individual and Family Level Intervention

Home Visiting Program Example 36 minutes

IV. Question and Answer Session 15 minutes

Handout 3 – Discussion Questions for Session 3

Test your knowledge – pre / post test questions

Total Session Time 180 minutes

160 minutes content

20 minutes of break

Session 3

Learner Materials

Handout 1 – Public Health Nursing Process

Handout 2 – Examples from Practice

Public Health Interventions: Applications for Public Health Nursing

Handout 3 – Discussion Questions for Session 3

Handout 4 – Selected Resources for Session 3

Test your knowledge – pre/post test questions

The learner materials may be copied without permission

Public Health Nursing Practice for the 21st Century: Public Health Nursing Process

Population-Based Community Assessment Process (precedes initiation of the public health nursing process)

- identify all potential partners
- engage as many community partners as possible
- describe the populations that comprise the community, their strengths, health risks, and health influences
- elicit the community's perception of their strengths, problems and health influences
- gather and analyze existing/available information to identify health indicators
- describe the systems that impact the community *(social, economic, educational, political, and judicial)*
- describe the population at risk based on the analyses
- identify the health influences/determinants that contribute to the identified risk
- collect additional information throughout the assessment process as needed
- based upon the community assessment, develop list of problems / issues / concerns
- prioritize the problems
- identify goals for each prioritized problem
- identify the measurable health status outcome indicators for each problem
- define the levels of intervention for each problem

	Public Health Nursing Process Systems Level	**Public Health Nursing Process Community Level**	**Public Health Nursing Process Individual/Family Level**
	In collaboration with all the organizations, services, citizens who are part of the systems intervention:	**In collaboration with all the organizations, services, citizens who are part of the community intervention:**	
Recruit additional partners	recruit additional partners (local, regional, state, national) from systems that are key to impacting and/or who have an interest in the health issue/problem	recruit additional community partners that may not have participated in the broader community assessment but have an interest in this particular problem	
Identify population of interest	identify those systems for which change is desired	identify the population of interest at risk for the problem	identify new and current clients in caseload who are at risk for the priority problem
Establish relationship	begin/continue establishing relationship with system partners	begin/continue establishing relationship with community partners and population of interest	begin/continue establishing relationship with the family
Refine and further assess	refine and further assess the impact and interrelationships of the various systems on the development and extent of the health issue/problem	refine and further assess the problem (demographics, health determinants, past and current efforts) identify the particular strengths, health risks, and health influences of the population of interest	identify the particular strengths, health risks, social supports and other factors influencing the health of the family and each family member
Elicit perceptions	develop a common consensus among system partners of the health issue/problem and the desired changes	elicit the population of interest's perception of their strengths, problems and health influences	elicit family's perception of their strengths, problems and other factors influencing their health
Set goals	in conjunction with system partners, develop system goals to be achieved	in conjunction with the population of interest, negotiate and come to agreement on community-focused goals	in conjunction with the family, negotiate and come to agreement on meaningful, achievable, measurable goals

Select health status indicators	based on systems goals, select meaningful, measurable health status indicators that will be used to measure success	based on the refined community goal/problem, select meaningful, measurable health status indicators that will be used to measure success	select meaningful, measurable health status indicators that will be used to measure success
Select interventions	select system-level interventions considering evidence of effectiveness, political support, acceptability to community, cost effectiveness, legality, ethics, greatest potential for successful outcome, non-duplicative, levels of prevention	select community-level interventions considering evidence of effectiveness, acceptability to community, cost effectiveness, legality, ethics, greatest potential for successful outcome, non-duplicative	select interventions considering evidence of effectiveness, acceptability to family, cost effectiveness, legality, ethics, greatest potential for successful outcome
Select intermediate outcome indicators	determine measurable, meaningful intermediate outcome indicators	determine measurable and meaningful intermediate outcome indicators	determine measurable, meaningful intermediate outcome indicators
Determine strategy frequency and intensity	utilizing best practices, determine intensity, sequencing, frequency of interventions considering urgency, political will, resources	utilizing best practices, determine intensity, sequencing, frequency of interventions	utilizing best practices, determine intensity, sequencing, frequency of interventions
Determine evaluation methods	determine evaluation methods for measuring process, intermediate, and outcome indicators	determine evaluation methods for measuring process, intermediate, and outcome indicators	determine evaluation methods for measuring process, intermediate, and outcome indicators
Implement interventions	implement the interventions	implement the interventions	implement the interventions
Regularly reassess	regularly reassess the system's response to the interventions and modify plan as indicated	reassess the population of interest's response to the interventions on an ongoing basis and modify plan as indicated	reassess and modify plan at each contact as necessary
Adjust interventions	adjust the frequency and intensity of the interventions according to the needs and resources of the community	adjust the frequency and intensity of the interventions accordingly	adjust the frequency and intensity of the interventions according to the needs and resources of the family
Provide feedback	provide feedback to system's representatives	provide feedback to the population of interest and informal and formal organizational representatives	provide regular feedback to family on progress (or lack thereof) on client goals
Collect evaluation	regularly and systematically collect evaluation information	regularly and systematically collect evaluation information	regularly and systematically collect evaluation information
Compare results to plan	compare actual results with planned indicators	compare actual results with planned indicators	compare actual results with planned indicators
Identify differences	identify and analyze differences in those in those systems that achieved outcomes compared to those who did not	identify and analyze differences in those in the population of interest who achieved outcomes compared to those who did not	identify and analyze differences in services received by families who achieved outcomes compared to those who did not
Apply results to practice	<apply results to identify needed systems changes <depending on readiness of the system to accept the results, present results to decision-makers and the general population	<apply results to modify community interventions <present results to community for policy considerations as appropriate	<report results to supervisor and other service providers as appropriate <apply results to personal practice and agency for policy considerations as appropriate

Examples from Practice

Flood Response

Intermediate Indicators	Population Health Status Indicators
Degree to which the disaster response plan was implemented as planned.	Number of injuries and deaths due to: – drowning – burns – electrocution – crushing
•Level of enforcement of policies and laws with regard to portable water. •Level of enforcement of policies and laws with regard to adequate sanitation. •Level of enforcement of policies and laws with regard to immunization status.	Number of infectious disease outbreaks due to: – contaminated water – contaminated food – temporary mass living conditions
Extent to which the health system managed medication administration and treatments.	Rate of hospital/shelter infirmary admissions due to exacerbation of chronic illness.

Grief and Loss Program

Intermediate Indicators	Population Health Status Indicators
Change in community norms regarding appropriate expressions of grief	Number/Rate of violent acts: -- homicide -- suicide -- incarcerations
•Change in community awareness of historical grief and its consequence •Change in community awareness of the relationship between historical grief and alcohol and other drug use •Change in alcohol and other drug use	Rates of: -- alcohol poisoning/drug overdose -- alcohol related injuries including injuries resulting from car crashes, fire, exposure, and pedestrian -- chronic diseases related to alcohol use, including cirrhosis and complications of diabetes

Home Visiting Program

Intermediate Indicators	Population Health Status Indicators
•Change in parental expectations •Change in parenting skills •Change in use of nonviolent discipline •Change in maternal depression •Change in utilization of community resources	Rate of child maltreatment
•Number of home hazards identified and corrected •Change in parental knowledge of growth and development •Change in parental expectation •Degree to which car seats are utilized correctly	Rates of childhood injuries and ingestion
•Change in knowledge about contraceptives and their use •Change in reported consistent use of contraceptives •Change in access to family planning services	Rate of unintended repeat pregnancies

Public Health Nursing Practice for the 21st Century: Competency Development in Population-Based Practice
Session 3 – Handout 3

Discussion Questions

Consider the following questions about today's session to help you incorporate what you have learned into your own practice.

1. Of the nine interventions presented, which two do you most commonly use in your PHN practice?

   A. Look up the basic steps for one of those interventions. How does your practice compare to the basic steps? Are there steps you do not use? Are there steps you do that are not identified?

   B. Now look up the best practices for the other interventions that you regularly use. Do you agree or disagree with the best practices? Do you see any that you might try to apply in your PHN practice?

2. What are some possible ways that you might use these interventions in your practice?

Public Health Nursing Practice for the 21st Century: Competency Development in Population-Based Practice
Session 3 – Handout 4

Selected Resources

Public Health and Disaster Response
Noji, E. (ed). (1997). *The Public Health Consequences of Disasters.* New York: Oxford.

Federal Emergency Management Administration Website includes a variety of resources for those interested, including their "Guide for All-Hazard Emergency Operations Planning" (1996, September), which can be downloaded. www.fema.gov

The Minnesota Department of Health/Community Health Services Division recently completed its Local Health Department Disaster Plan Template for the Health and Medical Annex to the Local Emergency Operations Plan. Call Douglas Benson at 651/215-0944 for further details. It may be downloaded at: http:www.health.state.mn.us/divs/chs/cds/wrkgrp/disastprep.html

Anderson, Julie W. (2000). *Health Conditions Associated with the Grand Forks' Flood Disaster: Pre-to Post-Flood Seasonal and Trend Analysis.* Unpublished doctoral dissertation, University of North Dakota, Grand Forks. [Note: For additional information contact Dr. Anderson at 701/780-1568 or email: janderso@altru.org]

Keene, Elizabeth (1998). "Phenomenological Study of the North Dakota Flood Experience and Its Impact on Survivors' Health." *International Journal of Trauma Nursing, 4*(3): 79-84.

Historical Grief
McPeek, George & Arthur H. (1988). *The Grieving Indian* (Winnipeg, Manitoba CA: Intertribal Christian Communications (Canada) Inc).

Brave Heart, M and DeBruyn, L. (1998). "The American Indian Holocaust: Healing Historical Unresolved Grief." *American Indian and Alaska Native Mental Health Research, 8*(2): 56-78.

The 3 C's: Community Organizing, Coalition Building, Collaboration
Fawcett, S. (1999). "Some Lessons on Community Organization and Change" in Rothman, J. (ed.). *Reflections on Community Organization: Enduring Themes and Critical Issues,* pp. 314-334. Itasca, IL: FE Peacock Publishers.

Home Visiting
Behrman, R. (ed.). (1993, Winter). "Home Visiting." *The Future of Children, 3*(3). Los Angeles, CA: The Center for the Future of Children, 300 Second Street, #102; 94022.

Behrman, R. (ed.). (1999, Spring/Summer). "Home Visiting: Recent Program Evaluations." *The Future of Children, 9*(1). Los Angeles, CA: The Center for the Future of Children, 300 Second Street, #102; 94022.

Brust, J., Heins, J., & Rheinberger, M. (1998). *A Review of The Research on Home Visiting: A Strategy for Preventing Child Maltreatment.* Anoka, MN: Health Care Coalition on Violence, 2829 Verndale Avenue, 55303.

Center for Child and Family Health. *The Public Health Nursing Home Visiting Report* (1999, September). Health Division, Oregon Department of Human Services.

Best Practices Development
For those interested in further information on the process used to develop the intervention best practices, please request a copy of the technical paper from Sue Strohschein by either calling 651/296-9581 (email: sue.strohschein@health.state.mn.us)

Health Status of American Indians in Minnesota
For those interested in further information presented in a recent seminar on tribal health status, please contact either David Stroud, MN Dept. Health/Center for Health Statistics at 651/296-9948 (email: david.stroud@health.state.mn.us) or MN Dept of Health/Office of Minority Health, at 651/296-3275.

Public Health Nursing Practice for the 21st Century: Competency Development in Population-Based Practice Session 3

PRE TEST QUESTIONS

1. In evaluating a program to reduce adolescent smoking, **intermediate** indicators would include:
   a. The number of program participants
   b. Age-adjusted mortality rates among program participants
   c. Change in knowledge, attitudes and smoking practices among program participants
   d. Change in knowledge, attitudes and smoking practices in adolescents in the community
   e. Change in enforcement of ordinances prohibiting tobacco sales to minors
   f. a, c, d, and e

2. A public health nurse teaching prenatal classes provides information on domestic abuse community resources. This is an example of an activity that is:
   a. Individual/family level of practice
   b. Community levelof practice
   c. Systems level of practice
   d. a, b, and c

3. A public health nurse attempting to reduce adolescent tobacco use writes a grant for funding to distribute anti-smoking T-shirts to teens in the county. This is an example of an activity that is:
   a. Individual/family level of practice
   b. Community level of practice
   c. Systems level of practice
   d. a, b, and c

4. Which of the following is defined as "the ongoing and systematic collection, analysis, and interpretation of health data in the process of describing and monitoring a health event?"
   a. Social marketing
   b. Case Finding
   c. Surveillance
   c. Screening
   d. Epidemiology

5. Which of the following interventions involve "commitment on the part of two or more persons or organizations to enhance the capacity of one or more of the members for mutual benefit and to achieve a common goal?"
   a. Collaboration
   b. Coalition building
   c. Consultation
   d. Community organizing
   e. Case finding

6. Which of the following is/are included in the public health nursing intervention of Policy Development?
   a. Achieving a place for the health issue on agenda of decision makers
   b. Developing a plan to resolve the issue
   c. Evaluating public health programmatic outcomes
   d. Assigning needed resources for resolving the issue
   e. a, b, and c.
   f. a, b, and d

7. Which of the following is **not** a source of best practices in population-based public health nursing?
   a. Research
   b. Theory
   c. Expert opinion
   d. Usual and customary practice
   e. None of the above

8. The **main** purpose of surveillance of infectious diseases is:
   a. To recognize when an outbreak is occurring so that control measures may be instituted
   b. To identify those responsible for the spread of the disease so that they may be restrained
   c. To prepare the medical system for handling people with the disease
   d. None of the above
   e. All of the above

9. Which of the following is **not** an assumption underlying each intervention?
   a. PHN interventions are focused on the entire population.
   b. The interventions are guided by an assessment of community health.
   c. Interventions can be done at the individual and family, community, and systems level.
   d. Interventions consider all levels of practice.
   e. **PHN interventions are nursing's contribution to core functions.**

10. My caseload is a population.
    a. True
    b. False

Public Health Nursing Practice for the 21st Century: Competency Development in Population-Based Practice Session 3

POST TEST QUESTIONS

1. All public health nursing interventions can be implemented at multiple practice levels.
   a. True
   b. False

2. Most public health nursing interventions are dependent nursing functions.
   a. True
   b. False

3. The PHN Interventions II Model demonstrates the use of advocacy when working with:
   a. The local county board to secure funds for developmental screening of refugee children
   b. A family seeking developmental services for their child
   c. A multi-county collaborative seeking legislative changes to the 0-3 childhood screening mandate
   d. All of the above

4. The purpose of outreach is to:
   a. Find previously unknown populations at risk for an identified problem
   b. Obtain information about the nature of the population's risk
   c. Identify what can be done about the identified problem
   d. Assist the at risk population utilize necessary resources
   e. a, b, and c.
   f. All of the above.

5. Establishment of a relationship is a critical component in the following public health nursing Intervention Levels:
   a. Community level
   b. Systems level
   c. Individual/family level
   d. a and b
   e. a and c
   f. a, b, and c

6. Population-based practice meets all of these criteria **except:**
   a. Interventions are based in community need
   b. Interventions focus on the entire population at risk or ultimately affected by the condition
   c. Interventions are selected based on current agency funding resources
   d. Interventions focus on the broad determinants of health
   e. Interventions are prevention focused

7. A variety of professionals cooperatively design a centralized intake process to simplify access to services for children with special needs. This is an example of:
   a. Individual/family intervention
   b. Community intervention
   c. Systems intervention
   d. All of the above

8. Surveillance is a PHN intervention directed toward either national or regional but not local events.
   a. True
   b. False

9. "Clients" refers to members of a "population of interest" identified by random self-identification.
   a. True
   b. False

10. The key to successful referral is:
    a. Collaboration
    b. Consultation
    c. Follow-up
    d. Counseling

11. Senior citizens self-refer themselves to a program in which public health nurses make home visits to older adults to identify home hazards. Together the public health nurse and the older adult make a plan to remove/reduce injury risks. This is an example of:
    a. Community intervention
    b. Individual/family intervention
    c. Systems intervention
    d. a and b
    e. b and c

12. PHN Interventions II, "The Wheel," are actions taken only on behalf of individuals and families.
    a. True
    b. False

Biographical Sketches

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BIOGRAPHICAL SKETCH

Name: Briske, Laurel, A.

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Education:

Institution and Location	Degree	Year Conferred	Field of Study
College of St. Catherine St. Paul, MN	Master of Arts in Nursing	1992	Pediatric Nurse Practitioner
College of St. Teresa Winona, MN	BSN	1973	Nursing

Professional Experience:

1998-Present	Public Health Nurse Advisor, Grant Coordinator Public Health Nursing Practice for the 21st Century, Section of Public Health Nursing, Minnesota Department of Health, St Paul, MN
1990-1998	Clinical Nurse Specialist, Injury and Violence Prevention Unit, Center for Health Promotion, Minnesota Department of Health, St Paul, MN
1989-1995	Pediatric Nurse Practitioner, Health Care for the Homeless Project, St Paul, MN
1989-1990	Public Health Nurse Advisor, Child Health Screening Unit, Family Health Division, Minnesota Department of Health, St Paul, MN
1987-1989	Health Consultant, U. S. Public Health Service, Region V, Chicago, IL
1984-1989	Public Health Nurse, Child Health Clinic, Dakota County Public Health, Apple Valley, MN
1980-1984	School Nurse, Independent School District #196, Rosemount, MN
1975-1976	Public Health Nurse, Scott County Human Services, Shakopee, MN
1974-1975	Clinic Nurse, Minneapolis Otolaryngology, Minneapolis, MN
1973-1974	Public Health Nurse, Des Moines-Polk County Health Department, Des Moines, IA

Licensure:

Certified Pediatric Nurse Practitioner	#89017	National Board of Pediatric Nurse Practitioners
Registered Nurse	#R072866	State of Minnesota
Certified Public Health Nurse	#3970	State of Minnesota
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Professional Organizations:

Minnesota Nurses Association
National Association of Pediatric Nurse Associates/Practitioners
Sigma Theta Tau

Publications:

Shultz, R., Sacks, J., Briske, L., Dickey, P., Kinde, M., Mallonee, S., & Douglas, M. (1998). Evaluation of three smoke detector promotion programs. *American Journal of Preventive Medicine, 15*(3), 165-171.

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Name: Olson Keller, Linda

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Education:

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School of Public Health University of Minnesota	MS	1980	Public Health Nursing
St. Olaf College Northfield, Minnesota	BSN	1974	Nursing

Professional Experience

1991- present	Public Health Nurse Consultant, Section of Public Health Nursing, Minnesota Department of Health
1993	Adjunct Faculty member, School of Nursing, University of Minnesota
1986-1991	Program Evaluation Specialist, Section of Public Health Nursing, Minnesota Department of Health
1984-1986	Associate Professor in Nursing, South Dakota State University, Brookings, South Dakota, Team Coordinator of Community Health Nursing Team.
1982-1983	Family Therapy Consultant, Family Consultation Center, Burnsville, Minnesota
1980-1984	Research Associate/Teaching Associate, Department of Family Social Science, University of Minnesota, St. Paul, Minnesota
1974-1977	Public Health Nurse, Rice County Public Health Service, Faribault, Minnesota

Grants /Research:

1990-1991	Principal Investigator, A Cooperative Agreement for Occupational and Safety Surveillance Through Health Departments and Nurses in Agriculture Communities: A State of Readiness. Grant award from NIOSH/CDC
1988-1989	Co-Principal Investigator, Winona Homecare Project Minnesota Nurses Association Foundation Grant

Licensure and Certifications:

- ANCC Certified Clinical Specialist in Community Health Nursing
  Certification number 185826-19 (Recertified for 12/1/97 - 11/30/02)
- Leadership in Public Policy Seminar (1992)
  Reflective Leadership Center, Hubert H. Humphrey Institute of Public Affairs
- Certified NCAST (Nursing Child Assessment Satellite Training) Instructor (1990)
- Minnesota Board of Public Health Certification, Number 3867
- Minnesota Registered Nurse License, Number 74787

Publications:

Olson Keller, L., Strohschein, S., Lia-Hoagberg, B., & Schaffer, M. (1998). Population-based public health nursing interventions: A model from practice. *Public Health Nursing, 15*(3), 207-215.

Dineen, K., Rossi, M., Lia-Hoagberg, B., & Olson Keller, L. (1992). Anteparturn home-care services for high-risk women. *JOGNN, 21,* 121-125.

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Education:

Institution and Location	Degree	Year Conferred	Field of Study
University of Minnesota/ School of Public Health (Minneapolis)	MS	1980	Public Health Nursing, Planning and Administration
University of Minnesota/ School of Nursing	BSN	1968	Nursing

Professional Experience:

1982-Present	Consultant in Public Health Nursing, Section of Public Health Nursing Minnesota Department of Health, St. Paul, MN
1979-1980	Research Fellow, Center for Health Services Research, School of Public Health, University of Minnesota
1978-1979	Graduate Assistant to Marla Salmon, ScD, RN, program chair, Programs in Nursing Administration, School of Public Health, University of Minnesota
1976-1978	Administrator and Planner, Chisago/Kanabec Community Health Services
1970-1976	Director, Wright County (Minnesota) Public Health Nursing Services

Licensure:

Registered Nurse	#61481	State of Minnesota
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Professional Memberships:

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Publications:

Lia-Hoagberg, B., Schaffer, M., & Strohschein, S. (1999). Public health nursing practice guidelines: An evaluation of dissemination and use. *Public Health Nursing, 16*(6), 397-404.

Strohschein, S., Schaffer, M., & Lia-Hoagberg, B. (1999). The Minnesota practice enhancement project: Development of research-based guidelines for public health nurses. *Nursing Outlook, 47*(2), 84-89.

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