



**County of Los Angeles
Department of Public Health**

Public Health Nursing Practice Manual



LOS ANGELES COUNTY
Department of Public Health
Public Health Nursing
Practice Manual

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Foreword

September 2007

The *Public Health Nursing Practice Manual* has been revised and is an up-to-date reference to define, direct and guide the practice of public health nursing in Los Angeles County. The Manual's availability and use throughout the Departments of Public Health and Children and Family Services ensures that public health professional nursing practice is consistent and in keeping with national trends and standards.

This second edition has been updated to reflect changes in the national standards for public health nursing practice and program requirements, as well as changes in documentation and evaluation of practice methodologies.

The contents of this manual were developed with the district public health nurse (DPHN) in mind. However, Section A pertains to PHNs practicing in both districts and programs. Sections B-F were designed so that program-specific PHN practice standards/guidelines could be inserted into those sections.

Major changes and updates in this edition include:

- **Section A:** Updated to reflect changes in the 2007 *Public Health Nursing: Scope and Standards of Practice*
- **Section C:** Revised to reflect changes in DPHN practice standards due to new regulations or program requirements, and revisions to the Standards of Practice outlined in the above document
- **Section E:** Guidance documents developed for PHN Assessment and Consumer/Community Service with reference to the Nursing Practice Management System Manual for detailed instructions on completing the computer modules
- **Section F:** Evaluation of Practice section– completely revised for ease of use and tested for interrater reliability
- **Section G:** Appendix: New section–Includes “Quad Council PHN Competencies”
- **Section H:** Best Practices: New section for manual user to add best practice references

Use and refer to this manual often, as it will help facilitate your practice. Whether you are new to this specialty or an experienced PHN, the Manual will help increase the depth of your practice and is one of the many tools to help you achieve your goal of promoting and protecting the health of all Los Angeles County residents.

Sincerely,



Nancie S. Bendaña, RN, MS
Director of Public Health Nursing
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Acknowledgements

Many nurses have researched and shaped the concepts and insights provided in this manual. A multilevel Public Health Nursing (PHN) committee chaired by Myrna Aguila developed the 2003 version of this manual. Additional contributions and final editing was completed by Noël Bazini-Barakat, Cherie Forshā, and Kathleen Smith under the direction of Margaret Avila, former Director of Public Health Nursing.

This 2007 revision of the *Public Health Nursing Practice Manual* was edited by two multilevel PHN subcommittees of the PHN Practice Committee, and Nursing Administration. These individuals are named in the title page and represent PHNs from district field nursing, Acute Communicable Disease Control, Childhood Lead Poisoning Prevention, Newborn Screening, Sexually Transmitted Disease, Sudden Infant Death Syndrome, and Tuberculosis Control programs. Cindy Young, a registered dietician, represented the Nutrition Program. Without their commitment, expertise and insight, the manual revision would not have taken place.

A deep appreciation to Debra Dorst-Porada, Kathleen Smith, and Norina Cadena who spent countless hours reviewing and editing the revisions, and to the Evaluation of Practice Subcommittee. The Evaluation of Practice Subcommittee met twice a month for more than a year to develop the Evaluation of Practice forms and instructions, calculation spreadsheets, training module, and also conducted interrater reliability testing. Much gratitude is extended to Dr. Jeffrey Gunzenhauser who served as advisor for the interrater reliability testing procedure and as results reviewer.

Finally, much gratitude is extended to Loretta Abkar for her word processing and formatting expertise and for her patience and skill in tracking the numerous revisions requested by the editors.

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Los Angeles County Public Health Nursing Vision and Mission

Vision: Public Health Nursing—Working Together to Assure Healthy People in Healthy Communities

Mission: Public Health Nursing improves the well being of communities by promoting health and preventing disease, disability and premature death among all residents of Los Angeles County. Public Health Nursing improves the quality of neighborhood life by working in partnership with community residents to create the conditions that ensure healthy lives.

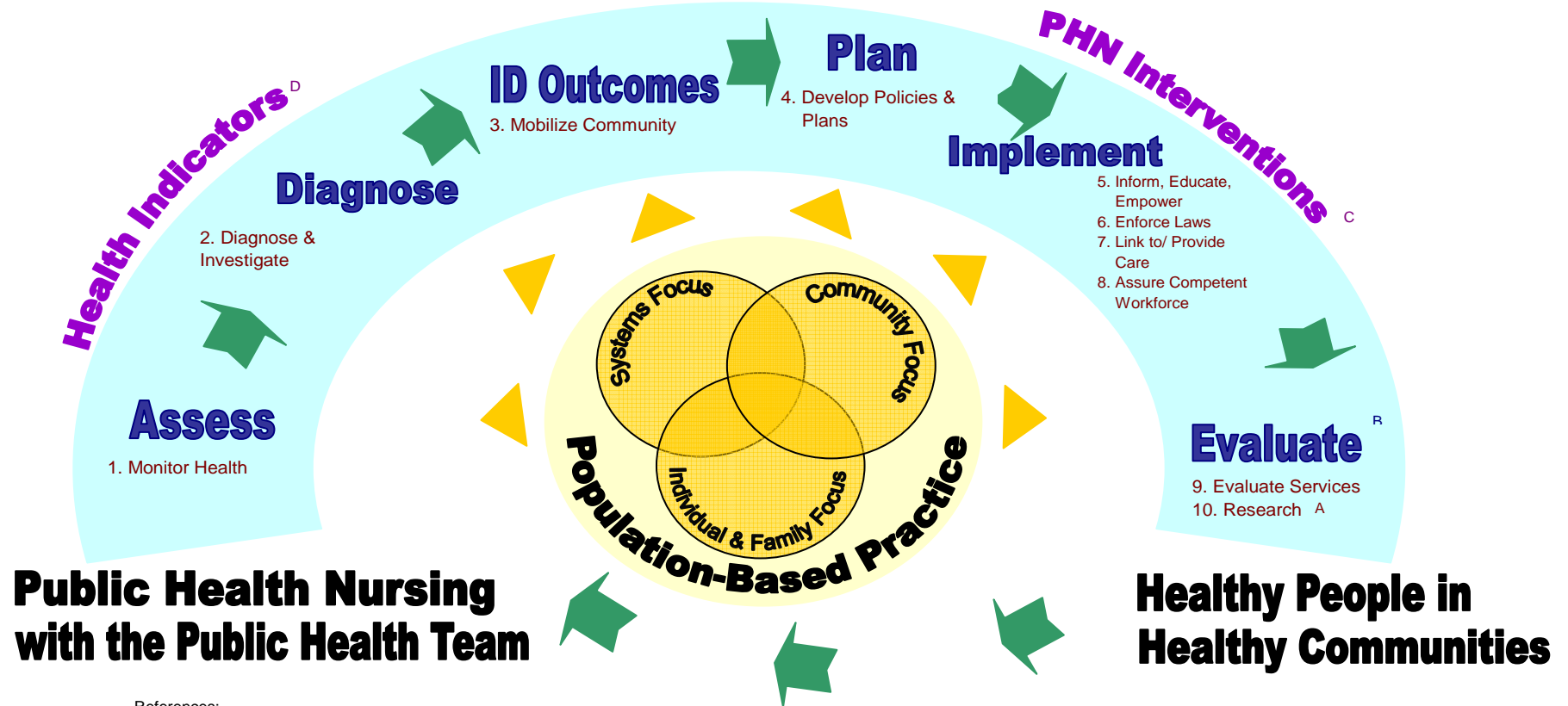
Public Health Nursing

- Assesses and monitors the health status of the population using the health indicators from Healthy People 2010 and local indicators.
- Defines goals and objectives using the core public health functions and the ten essential public health services.
- Responds to the health needs of the population from either an individual/family-focused, community-focused, and/or systems-focused population-based practice.
- Utilizes the nursing process to promote and encourage healthy behaviors.
- Emphasizes primary prevention.
- Implements action in a collaborative and transdisciplinary approach with colleagues in the public and private sector so as to maximize the efficient and effective use of resources.
- Maximizes every contact with the residents of Los Angeles County so as to prevent missed opportunities for health promotion.
- Conducts/participates in research for new insights and innovative solutions to clinical practice and quality of services.
- Applies ethical principles to guide public health nursing practice.

Public Health Nursing Services/Activities include, but are not limited to, the following:

- Sharing the analysis of the practice data in a transdisciplinary health team environment.
- Engaging in collaborative relationships with community based agencies and/or specific populations to develop public policy and target disease prevention activities.
- Analyzing data collected from practice and evaluating health trends, services and risk factors to determine priorities for planning outcomes and determining intervention or action.
- Serving as public health team leader in emergency preparedness and response situations.
- Coordinating programs, services, and other activities to achieve established objectives.
- Providing consultation to community groups, health professionals and agencies to facilitate the implementation of programs and services.

Public Health Nursing Practice Model*



References:

- (A) Public Health Functions Steering Committee. (1994, Fall). *Public Health in America*. Retrieved May 7, 2001, from the World Wide Web: <http://health.gov/phfunctions/public.htm>
- (B) American Nurses Association. (2007). *Public Health Nursing: Scope and Standards of Practice*. Silver Spring, MD: American Nurses Association.
- (C) Minnesota Department of Health, Public Health Nursing Section. (2000). *Public Health Nursing Practice for the 21st Century: National Satellite Learning Conference; Competency Development in Population-based Practice October 5, November 2, December 7, 2000*. St. Paul, MN: Minnesota Department of Health, Public Health Nursing Section. Retrieved May 7, 2001, from the World Wide Web: <http://www.health.state.mn.us/divs/chs/phn/material.htm>
- (D) U.S. Department of Health and Human Services. (2000). *Healthy People 2010*. (Vol. 1). McLean, VA: International Medical Publishing, Inc.

*Created by Los Angeles County DPH, Public Health Nursing with input from CCLHDND-Southern Region. This model serves as the basis for the CCLHDND California PHN Practice Model (04-2007).
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Public Health Nursing Practice Model

Introduction

A PHN model was developed to describe the building blocks of PHN practice and to delineate their relationship to each other. The model communicates the foundation of the practice to those within the discipline and also to public health colleagues from other disciplines. This narrative serves as an accompanying text to the diagram, elaborating on the components of the model.

Assumptions of Population-Based Practice and the Tenets of Public Health

The Public Health Nursing Practice Model is built upon the assumption that public health nursing practice is population-based. Practice is population-based if it meets the following criteria, which are a blend of tenets developed by the Quad Council of Public Health Nursing Organizations¹ and Minnesota Department of Health, PHN Section²:

- Focuses on entire populations possessing similar health concerns or characteristics.
- Relies upon an assessment of population health status.
- Considers the broad determinants of health.
- Considers all levels of prevention, with a preference for primary prevention.
 - i. Primary Prevention: promoting health, protecting against health threats to the community, and keeping problems from occurring in the first place.
 - ii. Secondary Prevention: detecting and treating problems in their early stages. It keeps problems from causing serious or long-term effects or from affecting others.
 - iii. Tertiary Prevention: preventing existing problems from getting worse.
- Considers all levels of practice.
 - i. Individual/Family Focused Practice: changes knowledge, attitude, beliefs, values, practices, and behaviors of individuals, alone or as part of a family or group.
 - ii. Community-Focused Practice: changes community norms, attitudes, awareness, practices, and behaviors of the population.
 - iii. Systems-Focused Practice: changes organizations, policies, laws, and power structures of the systems that affect health.
- Reaches out to all who might benefit, not focusing on just those who present themselves.
- Demonstrates a dominant concern for the greater good of all the people. The interest of the whole take priority over the best interest of the individual or group.
- Creates healthy environmental, social, and economic conditions in which people can thrive.
- Supports resource allocation to achieve maximum population health gain. Resources are allocated so that they will do the most good to the greatest number of people.
- Collaborates with members of other professions/organizations.

These tenets permeate all aspects of the Public Health Nursing Practice Model to assure that nursing practice is grounded in a population-based perspective.

Interplay of the Key Components

The PHN Practice Model is a melding of nationally recognized components: The Standards of

PHN Practice¹, the ten Essential Services³, Healthy People 2010⁴ ten leading health indicators, and Minnesota's Framework of seventeen PHN Interventions². The model is grounded in the precepts that PHN practice uses a team approach, is population-based and has as its goal the creation of the conditions in which healthy people can live in healthy communities.

The diagram of this PHN Practice Model is a simplified representation of the concept and components of the practice process. It is intended to present the key elements and the relationship among these elements. It is a tool for understanding and applying the model to the reality of the practice process.⁵

Public Health Nursing with the Public Health Team

The model begins with the depiction of Public Health Nursing as an integral part of an interdisciplinary team approach to public health practice. Natural partners on the team with Public Health Nursing include nutritionists, physicians, social workers, public health investigators, environmental health specialists, health educators and representatives from the community, among others. The cause of most public health concerns can be traced to many factors and likewise the solutions require a multifaceted approach. Thus the team approach is crucial to success in any public health nursing endeavor.

Scope and Standards of PHN Practice

In 1999, the leaders of the Quad Council of PHN Organizations recognized that PHN practice was changing with a renewed emphasis on the improvement of the health of the entire population. This recognition prompted the Council to articulate a framework for PHN practice that was population-based. Such a framework would help prepare public health nursing to shift its practice focus and to develop the capacity to articulate the aspects of the practice that were unique to public health nursing. This framework has been described by the Council in the *Scope and Standards of Public Health Nursing Practice*¹.

The Quad Council is comprised of:

1. American Nurses Association (ANA) Council for Community, Primary, and Long-Term Care Nursing Practice,
2. American Public Health Association PHN Section,
3. Association of Community Health Nursing Educators, and
4. Association of State and Territorial Directors of Nursing.

In 2004, a volunteer work group of public health and community health nursing stakeholders convened to review and revised the 1999 Scope and Standards to reflect contemporary public health nursing practice and to set a framework for future practice.

The revised PHN Standards of Practice, as outlined in the *Public Health Nursing: Scope and Standards of Practice*, (2007 revision)⁶ includes the following components:

1. Assessment
2. Population diagnosis and priorities
3. Outcome Identification
4. Planning
5. Implementation
6. Evaluation

The six Standards of Practice describe a competent level of public health nursing care as demonstrated by the critical thinking model known as the nursing process.

Population-based Practice

The model depicts three interwoven circles that show the three levels of population-based practice: individual and family, community and systems. The circles are nested within the overall label of population-based practice, which applies at all points of the nursing process described in the PHN Standards. Consideration must be given to all three levels of practice at each step in the nursing process.

The Ten Essential Public Health Services

The American Public Health Association³, in partnership with other public health associations, has described the fundamental public health services in language the general public can understand. Using the three Public Health Core Functions of assessment, assurance, and policy development as a starting point, the ten Essential Public Health Services were defined (see page A8). These essential services are easily incorporated into the nursing process as described by the PHN Standards, demonstrating that the PHN Practice Model is consistent with nationally accepted practice for all public health workers. This is an important consideration for a model that has to be viable within an interdisciplinary public health team environment.

Health Indicators

PHN resources are often scarce and need to be directed thoughtfully in order to achieve public health improvement objectives. The consideration of health indicators assists in this process at the assessment and diagnosis steps of the nursing process. In deciding what indicators to choose, the public health team can be guided by work that has been done at the national level to identify the most important indicators for health improvement of the population.

Healthy People 2010⁴ is the national agenda on health promotion and prevention of disease, disability, and premature death. The health objectives described in this agenda are designed to identify the most significant threats to health and to establish national goals to reduce these threats. Work continues to build on goals set forth in 1979 through national health objectives established by the Surgeon General's report, Healthy People. These objectives, and those set forth in Healthy People 2000, can serve as a guide for the development of health plans for states and for local communities.

The two overarching goals of Healthy People 2010 are to increase quality and years of healthy life, and to eliminate health disparities. The ten leading health indicators represent the major public health concerns in the United States. They were chosen,

“Based on their ability to motivate action, the availability of data to measure progress, and their

relevance as broad public health issues.” The indicators are: physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care. Consideration of the ten leading Healthy People 2010 indicators during the initial steps of the nursing process helps to ensure that practice will be consistent with national priorities.

Local Indicators are an important additional consideration during assessment and diagnosis and can be addressed depending on local priorities and resources. Some communities may have pressing public health concerns not included in the Healthy People 2010 leading indicators and so must direct their energies accordingly.

PHN Interventions

The State of Minnesota Department of Health Services, Public Health Nursing Section², spent several years identifying actions, or “interventions”, that public health nursing utilizes on behalf of individuals, families and communities to improve and promote the health status of populations. As a result of the study, seventeen PHN interventions were identified: surveillance, disease and health event investigation, case finding, outreach, screening, referral and follow-up, case management, delegated function, health teaching, counseling, consultation, collaboration, coalition building, community organizing, advocacy, social marketing, policy development and enforcement.

Minnesota recognized that there are three underlying assumptions to the seventeen interventions:

1. Selecting interventions is part of the planning step in the nursing process. This means that assessment, diagnosis and problem identification have already occurred.
2. The interventions are grounded in an assessment of the community’s health.
3. Interventions may be implemented alone or in conjunction with other interventions.

Summary

The development of this practice model is a dynamic and cyclical process. It is responsive to the current application of the concepts to the reality of local practice. Attempts to adjust the articulation of the practice model are continually made in reply to feedback, request for clarification, and recommendations for modifications for enhancing adaptation to the various practice settings and populations served at the local level.

References:

- ¹Quad Council of Public Health Nursing Organizations. (1999). *Scope and Standards of Public Health Nursing Practice*. Washington D.C.: American Nurses Association.
- ²Minnesota Department of Health, Public Health Nursing Section. (2000). *Public Health Nursing Practice for the 21st Century: National Satellite Learning Conference; Competency Development in Population-based Practice October 5, November 2, December 7, 2000*. St. Paul, MN: Minnesota Department of Health, Public Health Nursing Section. Retrieved May 7, 2001, from the World Wide Web: <http://www.health.state.mn.us/divs/chs/phn/material.htm>
- ³Public Health Functions Steering Committee. (1994, Fall). *Public Health in America*. Retrieved May 7, 2001, from the World Wide Web: <http://health.gov/phfunctions/public.htm>

⁴U.S. Department of Health and Human Services. (2000). *Healthy People 2010. (Vol. 1)*. McLean, VA: International Medical Publishing, Inc.

⁵Nicoll, Leslie H. (1997, Third Edition). *Perspectives on Nursing Theory*. Philadelphia, NY: Lippincott-Raven Publishers.

⁶American Nurses Association (2007). *Public Health Nursing: Scope and Standards of Practice*. Silver Spring, Maryland: American Nurses Association.

Standards of Public Health Nursing Practice

Assessment

The public health nurse collects comprehensive data pertinent to the health status of populations.

Population Diagnosis and Priorities

The public health nurse analyzes the assessment data to determine the population diagnoses and priorities.

Outcomes Identification

The public health nurse identifies expected outcomes for a plan that is based on population diagnoses and priorities.

Planning

The public health nurse develops a plan that reflects best practices by identifying strategies, action plans, and alternatives to attain expected outcomes.

Implementation

The Public Health Nurse implements the identified plan by partnering with others.

- **Coordination:** the public health nurse coordinates programs, services and other activities to implement the identified plan.
- **Health Education and Health Promotion:** the public health nurse employs multiple strategies to promote health, prevent disease, and ensure a safe environment for populations.
- **Consultation:** the public health nurse provides consultation to various community groups, and officials to facilitate the implementation of programs and services.
- **Regulatory Activities:** the public health nurse identifies, interprets, and implements public health laws, regulations, and policies.

Evaluation

The public health nurse evaluates the health status of the population.

Source

American Nurses Association (2007). *Public Health Nursing: Scope and Standards of Practice*. Silver Spring, Maryland: American Nurses Association.



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 & assure 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



Adopted: Fall 1994, Source: Public Health Functions Steering Committee, Members (July 1995): American Public Health Association-Association of Schools of Public Health-Association of State and Territorial Health Officials-Environmental Council of the States-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.



HEALTHY PEOPLE



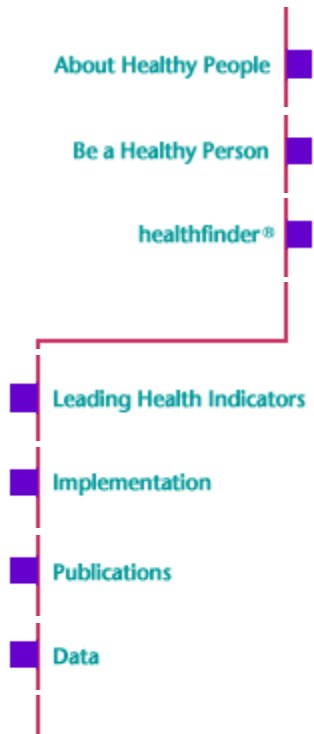
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What Are the Leading Health Indicators?

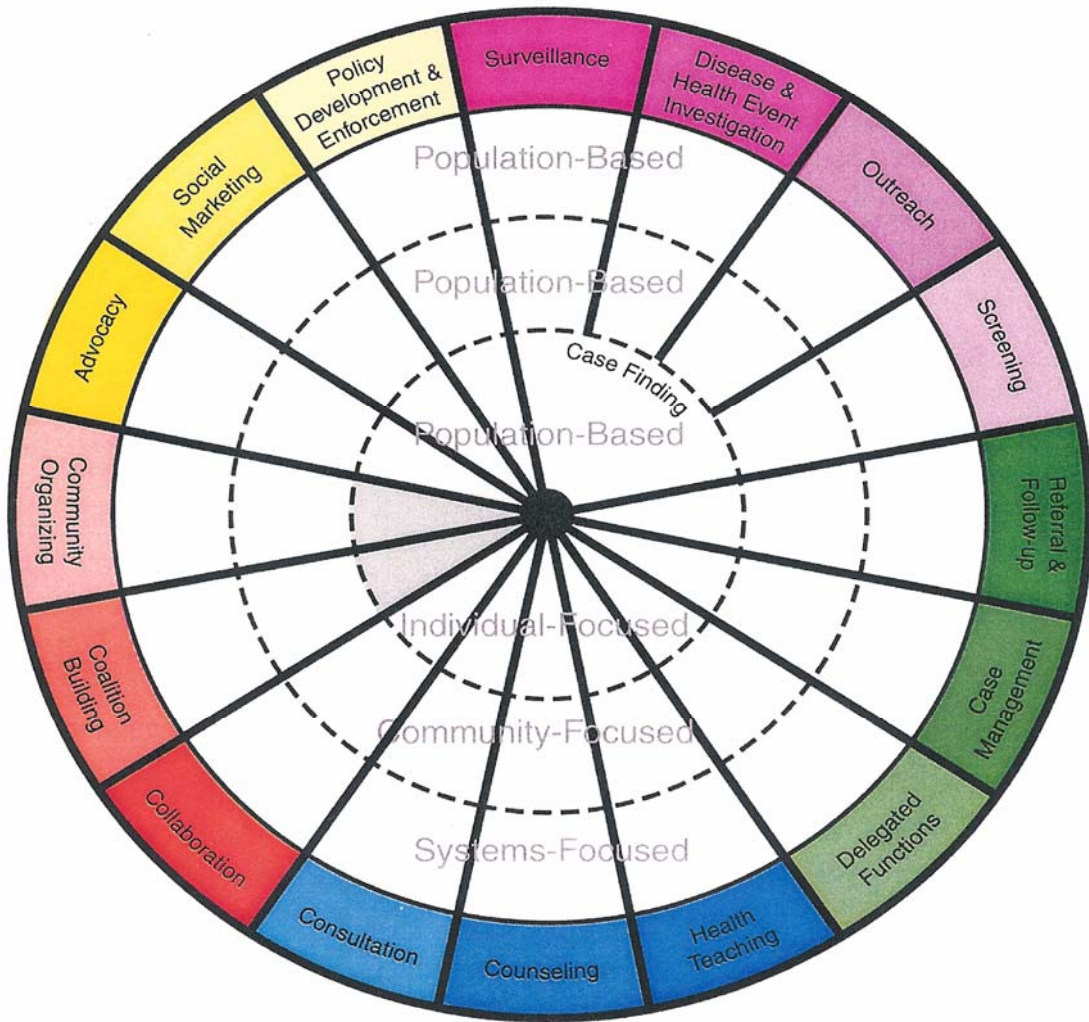
The Leading Health Indicators will be used to measure the health of the Nation over the next 10 years. Each of the 10 Leading Health Indicators has one or more objectives from Healthy People 2010 associated with it. As a group, the Leading Health Indicators reflect the major health concerns in the United States at the beginning of the 21st century. The Leading Health Indicators were selected on the basis of their ability to motivate action, the availability of data to measure progress, and their importance as public health issues.

The Leading Health Indicators are—

1. Physical Activity
2. Overweight and Obesity
3. Tobacco Use
4. Substance Abuse
5. Responsible Sexual Behavior
6. Mental Health
7. Injury and Violence
8. Environmental Quality
9. Immunization
10. Access to Health Care

Public Health Interventions

Applications for Public Health Nursing Practice



March 2001

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

Population-Based Public Health Nursing Practice

Population-based public health nursing:

- Has a focus based on entire populations possessing similar health concerns or characteristics.
- Is based on an assessment of community needs.
- Addresses the broad determinants of health.
- Considers multiple levels of practice.
- Considers multiple levels of prevention with preference for primary prevention.

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 the individuals and families within those populations known to be at risk. Interventions at each of these levels of practice contribute to the overall goal of improving population health.

Population-based individual-focused or family-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.

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.

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.

Levels of Prevention

“Prevention is anticipatory action taken to prevent the occurrence of an event or to minimize its effect after it has occurred.”¹ 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.

Source

Minnesota Department of Health, Public Health Nursing Section. (2000). *Public Health Nursing Practice for the 21st Century: National Satellite Learning Conference; Competency Development in Population-based Practice October 5, November 2, December 7, 2000*. St. Paul, MN: Minnesota Department of Health, Public Health Nursing Section. Retrieved May 7, 2001, from the World Wide Web:
<http://www.health.state.mn.us/divs/chs/phn/material.htm>

¹Turnock, B. (1997). *Public Health: What it is and how it works*. Gaithersburg, MD: Aspen Publishers, Inc.

Designing Meaningful, Measurable Objectives

The next step in the program planning process after selecting indicators is writing objectives. Objectives may be written at both the health status and intermediate levels. Health status objectives tend to have a longer time frame; intermediate objectives measure changes that ultimately lead to changes in health status.

Each goal usually has several objectives. Objectives are statements that indicate in what specific ways you intend to reach your stated goal. Objectives are concrete and measurable statements of how the goal will be reached. There are different levels of objectives; all of them are important. The objectives that you choose are the basis of both program planning AND program evaluation.

Objectives generally follow the format: “By [time frame], [percent of change] of [who or what] will [indicator].”

Examples:

By when?	% Change	of	Who	will	Indicator
By when?	Who	of	% Change	will	Indicator

The components of an objective include:

- Who will change (Target population)
- What will change (Indicator)
- Time frame of change
- The amount of change (Either the proportion of the target population expected to show change or the amount of change expected on the indicator)

All objectives measure change. Measuring change requires a baseline. If a baseline does not exist it must be established before a measure of change can take place.

Types of Objectives: Outcome, Intermediate, Process

1. Outcome Objectives

Outcome objectives measure the end result of the intervention or strategy. They may measure the impact on the overall problem, ultimate goal, side effects, or social and economics consequences. Outcome objectives tend to be long-term and often measure changes in health status of a population (frequently described in terms of morbidity or mortality).

2. Intermediate Objectives

Intermediate objectives link the outcome objectives to the process objectives. They describe the changes that will occur that ultimately result in or produce the desired outcome. They are precursors to attaining the outcome. Intermediate objectives have shorter time frames and clearly reflect what can be accomplished and measured within the time period of the program plan. Intermediate objectives assess measures which have a high probability of reducing a health problem or increasing resiliency/capacity. These objectives measure the impact of specific interventions designed to achieve the outcome. Intermediate objectives measure changes in organizations, laws, policies, and power structures at the systems level, changes in community norms, attitudes, awareness, beliefs, practices, and behavior at the community level, and knowledge, attitude, beliefs, values, skills, circumstances, behaviors, and practices at the individual/family level.

3. Process Objectives

Process objectives are the methods of the intervention. They detail the specific tasks that will be carried out within a specified time frame. Process objectives describes the input; the means by which the intervention or strategy will be implemented. They include inputs, participation, and reactions.

The most convincing, useful program planning and program evaluation have measurable, meaningful objectives at all levels, and should reflect the theory of action underlying the strategies.

Source:

Minnesota Department of Health, Public Health Nursing Section. (2000). Public Health Nursing Practice for the 21st Century: National Satellite Learning Conference; Competency Development in Population-based Practice October 5, November 2, December 7, 2000. St. Paul, MN: Minnesota Department of Health, Public Health Nursing Section. Retrieved May 7, 2001, <http://www.health.state.mn.us/divs/chs/phn/material.htm>

PHN Assessment of Populations-of-Interest

Each client and family encountered by the public health nurse at the individual and family level of practice should be offered a complete PHN Assessment using the PHN Assessment module in the Nursing Practice Management System (NPMS). Refer to the NPMS Manual and to pages E1-E5: Guidance for the Public Health Nursing Assessment for instructions on completing the assessment. By using data gathered in the assessment, the public health nurse will set health improvement goals with the client/family, direct the client/family to needed community resources, and evaluate the effectiveness of proposed health improvement interventions.

The public health nurse is likely to encounter certain populations-of-interest within the broader population including infants, children, adolescents, seniors and pregnant women among others. The PHN is encouraged to expand the assessment process to include areas of focus or concern for these populations.

This section includes topics for each population with suggestions to the public health nurse for expanded assessment. These suggestions are in addition to the guidance already given in instructions in the NPMS Manual and the section on Guidance for the Public Health Nursing Assessment (pp. E1–E5).

Infants 0-11 months

Mental Health

- Caregiver/infant bonding is essential for optimum growth.

Primary Care Provider

- An assigned health care provider for the infant ensures continuity of care.
- Infant should be scheduled for well baby checkups and health assessment according to periodicity schedule.
- Routine use of the emergency room leads to episodic and disjointed care.

Health Care Coverage

- Almost all children in California qualify for some type of health care coverage.
- Caregiver understands how to access care including after hours and emergency care.

Dental Care

- Propping the bottle and putting the infant to sleep with liquids high in sugar, such as milk, and sodas, can lead to dental caries.
- Juices should be served in sippy cups only.
- Hold the infant when feeding and only put breast milk, formula, or water in the bottle in quantities as advised by the primary care provider.
- Wipe the gums of the infant with a soft wet cloth after feeding even if no teeth have yet erupted.
- Begin tooth brushing with a soft brush and pea size amount of fluoridated toothpaste as soon as teeth erupt.
- Encourage caregiver to introduce sippy cup by 9 months and wean off bottle by 12 months.

Family Violence

- The stress of a new baby in a household may precipitate the use of dysfunctional coping mechanisms.
- Domestic Violence 800-978-3600 or local resource.
- L.A. County Domestic Violence Council Resources and Information: 888-994-7575.

Safety and Injury Prevention

- Child proofing a baby's home to prevent injury is essential.
- Proper car seat use is vital for preventing injury and death.
- Strongly advise the caregiver to position the baby on back when putting to sleep to prevent SIDS.
- Child Abuse Hotline: 800-540-4000.
- Poison Control: 800-222-1222.

Immunization

- Delayed or absent immunizations may adversely affect the health of the infant.

Diet

- WIC is a valuable resource if eligible.
- Breastfeeding is recommended at a minimum for the first six months.

Exercise/Physical Activity

- Vary the infant's position and provide safe opportunities for exploration.

Smoking/Chemical Dependency

- Drug/alcohol/tobacco exposure in utero can affect infant.
- Second hand smoke exposure can affect infant.

Safer Sex Practices/Education

- Use of contraceptives postpartum can delay subsequent pregnancies.

Environmental Health

- Lead-based paint and lead-contaminated dust are the top sources of lead poisoning
- Take-home exposure from family members working in lead-related industries (recycling or manufacturing of automobile batteries) are common sources of lead poisoning.

Growth and Development

- Discuss with the caregiver whether the child's growth and development are appropriate for age.

Cultural Practices

- Discourage use of home remedies such as Greta, Pay-loo-ah and Azarcon because of possible exposure to lead.
- Discourage use of imported ceramic ware for cooking and storing food because of possible exposure to lead.
- Discourage use of spices and seasonings imported from other countries because of possible exposure to lead.

Children 1-12 years

Mental Health

- Caregiver bonding is essential for optimum growth.
- Body image concerns, low self esteem, and peer pressure may result in mental health issues.

Primary Care Provider

- An assigned health care provider for the child ensures continuity of care.
- Child should be scheduled for well child checkups and health assessment according to periodicity schedule.
- Routine use of the emergency room leads to episodic and disjointed care.

Health Care Coverage

- Almost all children in California qualify for some type of health care coverage.
- Caregiver understands how to access care including after hours and emergency care.

Dental Care

- Begin tooth brushing with a soft brush and floss as soon as teeth erupt.
- Brush at least once before bedtime, and do not allow eating or drinking after teeth have been brushed except for water.
- Promote brushing after every meal and avoid sugary, sticky foods such as caramels and similar foods.
- Preventive dental appointments every six months.

Family Violence

- The stress of a toddler in a household may precipitate the use of dysfunctional coping mechanisms.
- Domestic Violence 800-978-3600 or local resource.
- L.A. County Domestic Violence Council Resources and Information: 888-994-7575.

Safety and Injury Prevention

- Motor vehicle accidents are the leading cause of death in the United States.
- California Law requires children be properly secured in a child seat or booster seat until they are at least 6-years old or weighing at least 60 pounds.
- Children need to be able to pass the “Five Point Test” before being able to ride in a motor vehicle without a booster seat and just using the seat belt.
 1. Does the child sit all the way back against the auto seat?
 2. Do the child's knees bend comfortably at the edge of the auto seat?
 3. Does the belt cross the shoulder between the neck and arm?
 4. Is the lap belt as low as possible, touching the thighs?
 5. Can the child stay seated like this for the whole trip?
- Drowning is the second leading cause of injury in the United States.
- Child proofing a child’s home to prevent injury is essential.
- Children must wear a helmet when biking or using skates/scooter/skate board according to State law.

- Child Abuse Hotline: 800-540-4000.
- Poison Control: 800-222-1222.

Immunization

- Delayed or absent immunizations may adversely affect the health of the child.

Diet

- WIC is a valuable resource if eligible.
- Eating the recommended 5-9 servings of fruits and vegetables a day helps to prevent chronic diseases and maintain a healthy weight.
- Encourage caregivers to contact their child's school to inquire about the school breakfast and lunch program.

Exercise/Physical Activity

- Promoting exercise and physical activity during early development decreases adverse effects as children mature.
- The recommendation for physical activity is 60 minutes of moderate to vigorous physical activity every day as appropriate for the age of the child.

Smoking/Chemical Dependency

- Ineffective coping and peer pressure may result in drug exploration.
- Second hand smoke exposure can affect toddler/child.

Safer Sex Practices/Education

- Encourage the caregiver to be prepared to discuss and answer questions about reproduction/sex.

Environmental Health

- Lead-based paint and lead-contaminated dust are the top sources of lead poisoning.
- Take-home exposure from family members working in lead-related industries (recycling or manufacturing of automobile batteries) are common sources of lead poisoning.

Growth and Development

- Discuss with the caregiver whether the child's height and weight are appropriate for age.
- Discuss age appropriate discipline techniques with the caregiver.

Cultural Practices

- Discourage use of home remedies such as Greta, Pay-loo-ah and Azarcon because of possible exposure to lead.
- Discourage use of imported ceramic ware for cooking and storing food because of possible exposure to lead.
- Discourage use of spices and seasonings imported from other countries because of possible exposure to lead.

Adolescent 13-18 years

Mental Health

- Emotional changes are common at this stage, which may be attributed to hormonal changes.
- Body image concerns, low self-esteem and peer pressure may result in mental health issues.

Primary Care Provider

- An assigned health care provider for the adolescent ensures continuity of care.
- Adolescent should be scheduled for well child checkups and health assessment according to the periodicity schedule.
- Routine use of the emergency room leads to episodic and disjointed care.
- Adolescent girls should receive an annual pap smear and pelvic exam once sexually active or at age 18, whichever comes first.

Health Care Coverage

- Almost all children in California qualify for some type of health care coverage.
- Caregiver understands how to access health care including after hours and emergency care.

Dental Care

- Braces may necessitate increased attention to dental hygiene.
- Extra care should be taken when brushing because hormonal changes cause a change in the mouth bacterial flora making the teen more prone to decay.
- New mouth bacteria may be introduced through shared straws, drinks, and kissing which may increase the risk of dental decay.
- Poor food choices can lead to increased tooth decay.
- Encourage use of fluoridated toothpaste and daily flossing.
- Encourage preventive dental appointments every six months.

Family Violence

- Children in homes with violence may exhibit violent behavior or increased isolation.
- Domestic Violence 800-978-3600 or local resource.
- L.A. County Domestic Violence Council Resources and Information: 888-994-7575.

Safety and Injury Prevention

- Homicide and suicide are major causes of death in the United States.
- Violence, including gang related violence, is a major source of adolescent injury and trauma in the United States.
- The risk of motor vehicle crashes is higher among teen drivers than any other age group.
- Adolescents must wear a seat belt when riding in vehicles according to State law.
- Child Abuse Hotline: 800-540-4000.
- Poison Control: 800-222-1222.
- Encourage the caregiver to discuss tattooing, piercing, and the possibility of infection, scarring, and lifelong adverse health consequences.
- Adolescents must wear a helmet when biking and when using skates/scooters/skateboards according to State law.

Immunization

- Delayed or absent immunizations may adversely effect the health of the adolescent.
- Adolescent may be due for Tdap booster or meningococcal vaccine for college bound students.

Diet

- Encourage the caregiver to ensure that food intake is sufficient for adequate growth.
- Eating the recommended 5-9 servings of fruits and vegetables a day helps to prevent chronic diseases and maintain a healthy weight.
- Encourage caregivers to contact their child's school to inquire about the school breakfast and lunch program.
- Poor food choices can lead to weight gain.
- Body image concerns may lead to eating disorders.

Exercise/Physical Activity

- Reduce TV watching, video game viewing, and recreational computer use to increase time for exercise.
- The recommendation for physical activity is 60 minutes of moderate to vigorous physical activity every day.

Smoking/Chemical Dependency

- First exposure to cigarettes, alcohol and many illicit or over the counter drugs may occur.

Safer Sex Practices/Education

- Encourage the caregiver to openly discuss reproduction/sex education.
- Encourage the caregiver to discuss the of use abstinence, condom use if indicated, and review other family planning methods.
- Encourage the caregiver to discuss sexually transmitted diseases and the possible health consequences.
- Encourage the caregiver to review the availability of the local STD clinic.

Cultural Practices

- Discourage use of home remedies such as Greta, Pay-loo-ah and Azarcon because of possible exposure to lead.
- Discourage use of imported ceramic ware for cooking and storing food because of possible exposure to lead.
- Discourage use of spices and seasonings imported from other countries because of possible exposure to lead.

Seniors

Mental Health

- Inability to function independently may adversely affect behavior.
- May have feelings of depression related to losses.
- This age group has had the highest suicide rate since 1933 in the United States.

Primary Care Provider

- An assigned health care provider for the senior ensures continuity of care.

Health Care Coverage

- Almost all seniors age 65 and older qualify for Medi-Care coverage.

Dental Care

- Poor dentition may adversely affect nutritional status.
- Client should be encouraged to schedule preventive dental appointments every six months.

Family Violence

- Elder Abuse Hotline: 877-477-3646.
- Domestic Violence 800 978-3600 or local resource.
- L.A. County Domestic Violence Council Resources and Information: 888-994-7575.

Safety and Injury Prevention

- Prevention of falls is a top priority.
- Client should assess home environment for hazards.
- Poison Control: 800-222-1222.
- Encourage client to schedule a routine eye examination.
- Encourage family members to periodically assess client's driving ability.
- Seniors must wear a seat belt when riding in a vehicle according to State law.

Immunization

- Delayed or absent immunizations may adversely affect the health of the senior.
- Senior may be due for Td booster, influenza and pneumococcal vaccines.

Diet

- Food intake may be affected by loneliness, social isolation, lack of desire or skill to cook, financial hardship, physical problems, and special diet.
- Eating the recommended 5-9 servings of fruits and vegetables a day helps to prevent chronic diseases and maintain a healthy weight.
- Low-income seniors may qualify for food stamps.
- Contact the local area agency on aging for more information about senior meal sites: 800- 510-2020 or local resource.

Exercise/Physical Activity

- Strength training in addition to cardiovascular conditioning exercise can benefit seniors.
- Perform any moderate to vigorous intensity aerobic activity for at least 30 minutes on most days of the week as recommended by the client's provider.

Smoking/Chemical Dependency

- Exposure to cigarettes, alcohol and illicit drugs may occur.

Safer Sex Practices/Education

- Encourage use of condoms.
- Discuss sexually transmitted diseases and the possible health consequences.

Cultural Practices

- Discourage use of home remedies such as Greta, Pay-loo-ah and Azarcon because of possible exposure to lead.
- Discourage use of imported ceramic ware for cooking and storing food because of possible exposure to lead.
- Discourage use of spices and seasonings imported from other countries because of possible exposure to lead.

Pregnant Women

Mental Health

- Partum and postpartum depression may be a concern.

Primary Care Provider

- Early and consistent prenatal care is associated with good pregnancy outcomes.

Health Care Coverage

- Almost all low-income pregnant women qualify for Medi-Cal coverage.

Dental Care

- Lack of dental care and poor dental hygiene has been associated with poor pregnancy outcomes.
- Good dental health is important in the pregnant woman because mouth bacteria can be transmitted to the baby as soon as the baby is born.
- Hormonal changes in pregnancy can cause gums to be more sensitive and cause bleeding which may discourage women from brushing and flossing.

Family Violence

- Existing family violence may escalate during pregnancy.
 - Domestic Violence: 800-978-3600 or local resource.
- L.A. County Domestic Violence Council Resources and Information: 888-994-7575.

Safety and Injury Prevention

- Seat belt use may require some adjustments for pregnancy girth.
- Poison Control: 800-222-1222.

Immunization

- Encourage client to discuss tetanus and influenza vaccination with prenatal care provider.

Diet

- Low income, pregnant women can qualify for WIC: 1-888-942-9675.
- Food Stamps: 877-597-4777.
- Pica behavior may be present.
- Eating the recommended 5-9 servings of fruits and vegetables a day helps to prevent chronic diseases and maintain a healthy weight.

Exercise/Physical Activity

- Encourage client to discuss the proper amount of exercise/activity with the prenatal care provider.

Smoking/Chemical Dependency

- Strongly discourage tobacco, alcohol, and drug use not prescribed by the prenatal care provider during pregnancy.

Safer Sex Practices/Education

- While there is no need for birth control, condom use may still be indicated to prevent sexually transmitted diseases.

Cultural Practices

- Discourage use of home remedies, such as use of Greta, Pay-loo-ah and Azarcon because of possible lead exposure.
- Discourage use of imported ceramic ware for cooking and storing food because of possible exposure to lead.
- Discourage use of spices and seasonings imported from other countries because of possible exposure to lead.

Acute Communicable Disease: Individual

Standard of Practice	Description	Practice
<p>Assessment</p>	<p>The public health nurse collects comprehensive data pertinent to the health status of populations.</p> <p>The most pertinent Healthy People 2010 Leading Health Indicators are:</p> <ul style="list-style-type: none"> • Environmental Quality • Immunization • Responsible Sexual Behavior • Access to Health Care • Mental Health 	<ol style="list-style-type: none"> 1. Review the Communicable Disease form or referral when received from Public Health Nursing Supervisor (PHNS) and on the Nursing Practice Management System (NPMS). Document Date/Time/Signature on referral when received from PHNS. 2. Analyze report for: <ul style="list-style-type: none"> • Lab data • Information regarding sensitive occupation or situation • Disease • Symptoms • Date of onset • Incubation period • Source • Mode of transmission • Period of communicability • Specific treatment • Control measures 3. Assess case/contacts(s) per PHN Assessment criteria.

Acute Communicable Disease: Individual

Standard of Practice	Description	Practice
<p>Population Diagnosis and Priorities</p>	<p>The public health nurse analyzes the assessment data to determine the population diagnoses and priorities.</p> <p>Analyze the collected assessment data to determine if there is an identified, actual or potential problem.</p>	<ol style="list-style-type: none"> 1. Verify the medical diagnosis and determine the priority of action: <ul style="list-style-type: none"> • Review Section/page D1-D2 of the Public Health Nursing Practice Manual for priority per Acute Communicable Disease Control (ACDC) or determine the priority of action in consultation with the PHNS as needed. Document priority selected. 2. Consider the client's/contacts' need for nursing interventions based on the medical diagnosis. 3. Consider the client's/contacts' need for nursing intervention to promote health, facilitate well being, foster healing, alleviate suffering, and improve quality of life.
<p>Outcomes Identification</p>	<p>The public health nurse identifies expected outcomes for a plan that is based on population diagnoses and priorities.</p> <p>Outcome objective:</p> <ul style="list-style-type: none"> • Prevent the spread of communicable diseases within families, communities, health facilities, or other sites. 	<ol style="list-style-type: none"> 1. Determine and document specific health needs/goals for client/contact situation.

Acute Communicable Disease: Individual

Standard of Practice	Description	Practice
<p>Planning</p>	<p>The public health nurse develops a plan that reflects best practices by identifying strategies, action plans, and alternatives to attain expected outcomes.</p> <p>Minnesota DHS PHN Section’s Public Health Interventions (PHN Interventions) are used to determine the plan (See list of interventions in Section/page A10).</p> <ul style="list-style-type: none"> • Consult and collaborate as needed with: <ul style="list-style-type: none"> o Public Health Nursing Supervisor (PHNS) o Nurse Manager (as directed by PHNS) o Area Medical Director (as directed by PHNS) o ACDC (as directed by PHNS) o Public Health Investigator (as directed by PHNS) o Private/Public Health Laboratory o Health Care Provider o Environmental Health o Other Regulatory Agencies o Public Health Registrar o Case/Contact Employer or School/Child Care o Family of the Client 	<p>1. PHN Intervention – Disease and Health Event Investigation:</p> <ul style="list-style-type: none"> • Review Acute Communicable Disease Control Manual (B-73) for: <ul style="list-style-type: none"> o Symptoms o Incubation period o Source o Mode of transmission o Period of communicability o Specific treatment o Control measures • Obtain educational and resource materials. • Obtain specimen containers if applicable. • Obtain referral information. • Elicit epidemiological data. • Relate case to time, place, person (when? where? who?). • Analyze probable causative factor (how? why?). • Analyze actual/potential for spread of disease. • Take appropriate action in the event of sensitive occupation or situation (see B-73). • Provide instruction on appropriate specimen collection. • Institute appropriate control measures. • Document on epidemiological form. • Maintain desk card until closure on Hansen’s cases/contacts and Typhoid carriers.

Acute Communicable Disease: Individual

Standard of Practice	Description	Practice
<p>Planning (Cont.)</p>		<p>2. PHN Intervention – Health Teaching/Counseling:</p> <ul style="list-style-type: none"> • Educate the client and family regarding the symptoms, source, incubation period, mode of transmission, period of communicability and precautions needed to prevent the spread of infection per the B-73. • Educate client on proper specimen collection. • Discuss the need for case/contact(s) to have evaluation/clearance and explain procedures. • Assure client that confidentiality will be maintained. <p>3. PHN Intervention – Referral and Follow-up:</p> <ul style="list-style-type: none"> • Refer for treatment/prophylaxis if indicated: <ul style="list-style-type: none"> ○ Follow up with client(s) to determine if treatment/prophylaxis is taken as indicated. • Make referrals as needed. • File Foodborne Illness Report (H-26) with district registrar if illness relates to a commercial establishment or product. <p>4. PHN Intervention – Surveillance:</p> <ul style="list-style-type: none"> • Monitor case/contact(s) until cleared/closed. • Submit specimens as indicated. <p>5. PHN Intervention – Other:</p> <ul style="list-style-type: none"> • Plan interventions needed to assist case/contact(s) with concerns identified in the PHN Assessment.

Acute Communicable Disease: Individual

Standard of Practice	Description	Practice
<p>Implementation</p>	<p>The public health nurse implements the identified plan by partnering with others.</p> <ul style="list-style-type: none"> • Coordination – The public health nurse coordinates programs, services, and other activities to implement the identified plan. • Health Education and Health Promotion – The public health nurse employs multiple strategies to promote health, prevent disease, and ensure a safe environment for populations. • Consultation – The public health nurse provides consultation to various community groups and officials to facilitate the implementation of programs and services. • Regulatory Activities – The public health nurse identifies, interprets, and implements public health laws, regulations, and policies. 	<ol style="list-style-type: none"> 1. PHN interventions are implemented as stated in the plan: <ul style="list-style-type: none"> • Disease and Health Event Investigation • Health Teaching/Counseling • Referral and Follow-up • Surveillance • Other interventions as needed 2. Document all consultations, collaborations, interventions and client/caretaker encounters on the epidemiological form(s), and/or progress notes/NPMS.
<p>Evaluation</p>	<p>The public health nurse evaluates the health status of the population.</p> <p>The PHN examines the effectiveness of the interventions, including the need for modification of the interventions in relation to outcomes.</p>	<ol style="list-style-type: none"> 1. Evaluate the effectiveness of the interventions on the health of the client/contact(s); e.g. document client understands disease process and prevention of transmission: 2. Determine and document action for non-adherent client/contact(s). <ul style="list-style-type: none"> • Consult with PHNS.

Acute Communicable Disease: Individual

Standard of Practice	Description	Practice
<p>Evaluation (Cont.)</p>		<p>3. Complete investigation forms:</p> <ul style="list-style-type: none"> • Submit report within 5 working days of closure or timeframe agreed upon in consultation with the PHNS. • Submit interim reports as needed until case is closed. <p>4. Document in the NPMS:</p> <ul style="list-style-type: none"> • File a copy of the PHN Assessment per PHN Assessment Form instructions. <p>5. Evaluate client satisfaction:</p> <ul style="list-style-type: none"> • Give client satisfaction form to the client/caregiver for completion and submission in a pre-addressed, stamped envelope.

Acute Communicable Disease: Outbreak in a Healthcare Facility

Standard of Practice	Description	Practice
<p>Assessment</p>	<p>The public health nurse collects comprehensive data pertinent to the health status of populations.</p> <p>The most pertinent Healthy People 2010 Leading Health Indicators are:</p> <ul style="list-style-type: none"> • Environmental Quality • Mental Health • Immunization • Responsible Sexual Behavior • Access to Health Care 	<ol style="list-style-type: none"> 1. Review outbreak form or referral when received from Public Health Nursing Supervisor (PHNS) and on the Nursing Practice Management System (NPMS). Document Date/Time/Signature on referral when received from PHNS. 2. Analyze report for: <ul style="list-style-type: none"> • Lab data • Disease • Symptoms (duration) • Date of onset • Incubation period • Source • Mode of transmission • Period of communicability • Specific treatment • Control measures • Number of staff/patients affected • Size/type of facility • Name of facility liaison 3. Assess for other facility needs or concerns unrelated to the outbreak.
<p>Population Diagnosis and Priorities</p>	<p>The public health nurse analyzes the assessment data to determine the population diagnoses and priorities.</p> <p>Analyze the collected assessment data to determine if there is an identified, actual or potential problem.</p>	<ol style="list-style-type: none"> 1. Verify the medical diagnosis and determine the priority of action: <ul style="list-style-type: none"> • Review Section/page D1-D2 of the Public Health Nursing Practice Manual for priority per Acute Communicable

Acute Communicable Disease: Outbreak in a Healthcare Facility

Standard of Practice	Description	Practice
Population Diagnosis and Priorities (Cont.)		<p>Disease Control (ACDC) or determine the priority of action in consultation with the PHNS as needed. Document priority selected.</p> <ol style="list-style-type: none"> 2. Consider the facility’s need for nursing interventions based on the medical diagnosis. 3. Consider the facility’s need for nursing intervention to promote health, facilitate well being foster healing alleviate suffering and improve quality of life.
Outcomes Identification	<p>The public health nurse identifies expected outcomes for a plan that is based on population diagnoses and priorities.</p> <p>Outcome objective:</p> <ul style="list-style-type: none"> • Prevent the spread of communicable diseases within families, communities, health facilities, or other site. 	<ol style="list-style-type: none"> 1. Determine and document specific health needs/goals for the facility.

Acute Communicable Disease: Outbreak in a Healthcare Facility

Standard of Practice	Description	Practice
<p>Planning</p>	<p>The public health nurse develops a plan that reflects best practices by identifying strategies, action plans, and alternatives to attain expected outcomes.</p> <p>Minnesota DHS PHN Section’s Public Health Interventions (PHN Interventions) are used to determine the plan (See list of interventions in Section/page A10).</p> <ul style="list-style-type: none"> • Consult and collaborate as needed with: <ul style="list-style-type: none"> ○ Public Health Nursing Supervisor (PHNS) ○ Nurse Manager (as directed by PHNS) ○ Area Medical Director (as directed by PHNS) ○ Public Health Investigation (as directed by PHNS) ○ ACDC (as directed by PHNS) ○ Private/Public Health Laboratory ○ Health Care Provider ○ Environmental Health ○ Public Health Registrar ○ Health Care Facility Administrator/Nursing Director or Designee ○ Health Facilities Division ○ Other Regulatory Agencies ○ Case/Contact, Employer or School/Child Care ○ Family/Household 	<p>1. PHN Intervention – Disease and Health Event Investigation:</p> <ul style="list-style-type: none"> • Review Acute Communicable Disease Control Manual (B-73): <ul style="list-style-type: none"> ○ Symptoms ○ Incubation period ○ Source ○ Mode of transmission ○ Period of communicability ○ Specific treatment ○ Control measures • Obtain educational and resource materials. • Obtain referral information. • Obtain specimen containers if applicable. • Elicit epidemiological data. • Determine if outbreak exists at initial visit. • Request outbreak number from registrar if needed and if there is no outbreak, refer back to PHNS. • Establish liaison for facility if not already done. • Relate outbreak to time, place, person (when? where? who?). • Analyze probable causative factor (how? why?). • Analyze actual/potential for spread of disease. • Take appropriate action in the event of sensitive occupation or situation (see B-73). • Develop a case definition. • Evaluate extent of illness in patients/staff/community. • Review staffing at the facility. <ul style="list-style-type: none"> ○ Staff assignment/case relationship ○ Staff/patient ratio

Acute Communicable Disease: Outbreak in a Healthcare Facility

Standard of Practice	Description	Practice
<p>Planning (Cont.)</p>		<ul style="list-style-type: none"> ○ Number of employees and patients ○ Total capacity ● Conduct environmental assessment (bathrooms, laundry, trash, kitchen, etc.). Note deficiencies and report to Los Angeles County Department of Public Health, Health Facilities Licensing and Certification Division (800-228-1019). ● Review and institute appropriate control measures. ● Document on epidemiological form. ● Complete line listing of cases involved. ● Complete a facility floor plan, noting locations of cases and contacts. ● Maintain a desk card on outbreaks that require more than one-month follow-up for resolution. ● Initiate a medical record. <p>2. PHN Intervention – Case Management:</p> <ul style="list-style-type: none"> ● Implement a facility management plan based on interpretation of findings. ● Notify public health laboratory about the outbreak after obtaining outbreak number from the registrar, name of the facility, and number of anticipated specimens. <p>3. PHN Intervention – Surveillance:</p> <ul style="list-style-type: none"> ● Monitor case/contact(s) until cleared/closed. <ul style="list-style-type: none"> ○ Submit specimens as indicated. ● Monitor facility for further outbreaks. <p>4. PHN Intervention – Health Teaching/Counseling:</p> <ul style="list-style-type: none"> ● Educate the staff, patients, and/or families regarding the symptoms, source, incubation period, mode of

Acute Communicable Disease: Outbreak in a Healthcare Facility

Standard of Practice	Description	Practice
<p>Planning (Cont.)</p>		<p>transmission, period of communicability, and precautions needed to prevent the spread of infection.</p> <ul style="list-style-type: none"> • Discuss the need for case/contact(s) to have evaluation/clearance and explain procedures. • Provide instruction on appropriate specimen collection (if applicable). <p>5. PHN Intervention – Collaboration:</p> <ul style="list-style-type: none"> • Collaborate with the AMD in writing the recommendations to the facility for outbreak control. <p>6. PHN Intervention – Referral and Follow-up:</p> <ul style="list-style-type: none"> • Review control measures, treatment, and/or prophylaxis recommendations of the AMD with the facility administrator or designee. Provide these recommendations to the facility administrator or designee in the form of a written letter from the AMD. • File Foodborne Illness report (H-26) with district registrar if illness relates to a commercial establishment or product outside of the facility. • Contact the Los Angeles County Environmental Health Food and Milk Program (626-430-5400) if applicable. <p>7. PHN Intervention – Other:</p> <ul style="list-style-type: none"> • Plan interventions needed to assist the facility with needs and concerns unrelated to the outbreak.

Acute Communicable Disease: Outbreak in a Healthcare Facility

Standard of Practice	Description	Practice
Implementation	<p>The public health nurse implements the identified plan by partnering with others.</p> <ul style="list-style-type: none"> • Coordination – The public health nurse coordinates programs, services, and other activities to implement the identified plan. • Health Education and Health Promotion – The public health nurse employs multiple strategies to promote health, prevent disease, and ensure a safe environment for populations. • Consultation – The public health nurse provides consultation to various community groups and officials to facilitate the implementation of programs and services. • Regulatory Activities – The public health nurse identifies, interprets, and implements public health laws, regulations, and policies. 	<ol style="list-style-type: none"> 1. PHN interventions are implemented as stated in the plan: <ul style="list-style-type: none"> • Disease and Health Event Investigation • Case Management • Surveillance • Health Teaching/Counseling • Collaboration • Referral and Follow-up • Other interventions as needed 2. Document all consultations, collaborations, interventions and facility encounters on the epidemiological form(s), and/or progress notes/NPMS.
Evaluation	<p>The public health nurse evaluates the health status of the population (all affected by disease).</p> <p>The PHN examines the effectiveness of the interventions, including the need for modification of the interventions in relation to outcomes.</p>	<ol style="list-style-type: none"> 1. Evaluate the effectiveness of the interventions on the health of the contacts: <ul style="list-style-type: none"> • Verify and document facility compliance with the recommendations. 2. Evaluate adherence by the facility to the recommendations for control: 3. Determine action for non-adherent facility: <ul style="list-style-type: none"> • Consult with PHNS.

Acute Communicable Disease: Outbreak in a Healthcare Facility

Standard of Practice	Description	Practice
<p>Evaluation (Cont.)</p>		<p>4. Complete investigation forms:</p> <ul style="list-style-type: none"> • Submit interim reports as needed until case is closed. • Submit final report within 10 days of closure or timeframe agreed upon in consultation with PHNS. <p>5. Document in the NPMS:</p> <ul style="list-style-type: none"> • Complete the Consumer/Community Service module and file hard copy of form in the medical record. <p>6. Evaluate client satisfaction:</p> <ul style="list-style-type: none"> • Give client satisfaction form to the facility/agency representative for completion and submission in a pre-addressed, stamped envelope.

Acute Communicable Disease: Outbreak in a Non-Healthcare Facility

Standard of Practice	Description	Practice
<p>Assessment</p>	<p>The public health nurse collects comprehensive data pertinent to the health status of populations.</p> <p>The most pertinent Healthy People 2010 Leading Health Indicators are:</p> <ul style="list-style-type: none"> • Environmental Quality • Mental Health • Immunization • Responsible Sexual Behavior • Access to Health Care 	<ol style="list-style-type: none"> 1. Review outbreak form or referral when received from Public Health Nursing Supervisor (PHNS), and on the Nursing Practice Management System (NPMS). Document Date/Time/Signature on referral when received from PHNS. 2. Analyze report for: <ul style="list-style-type: none"> • Lab data • Disease • Symptoms (duration) • Date of onset • Incubation period • Source • Mode of transmission • Period of communicability • Specific treatment • Control measures • Number of staff/clients affected • Size/type of facility • Name of facility liaison 3. Assess for other facility needs or concerns unrelated to the outbreak.

Acute Communicable Disease: Outbreak in a Non-Healthcare Facility

Standard of Practice	Description	Practice
<p>Population Diagnosis and Priorities</p>	<p>The public health nurse analyzes the assessment data to determine the population diagnoses and priorities.</p> <p>Analyze the collected assessment data to determine if there is an identified, actual or potential problem.</p>	<ol style="list-style-type: none"> 1. Verify the medical diagnosis and determine the priority of action. <ul style="list-style-type: none"> • Review Section/page D1-D2 of the Public Health Nursing Practice Manual for priority per Acute Communicable Disease Control (ACDC) or determine priority in consultation with the PHNS as needed. Document priority selected. 2. Consider the facility’s need for nursing interventions based on the medical diagnosis. 3. Consider the facility’s need for nursing intervention to promote health, facilitate well being, foster healing, alleviate suffering, and improve quality of life.
<p>Outcomes Identification</p>	<p>The public health nurse identifies expected outcomes for a plan that is based on population diagnoses and priorities.</p> <p>Outcome objective:</p> <ul style="list-style-type: none"> • Prevent the spread of communicable diseases within families, communities, health facilities, or other sites. 	<ol style="list-style-type: none"> 1. Determine and document specific health needs/goals for the facility.

Acute Communicable Disease: Outbreak in a Non-Healthcare Facility

Standard of Practice	Description	Practice
<p>Planning</p>	<p>The public health nurse develops a plan that reflects best practices by identifying strategies, action plans, and alternatives to attain expected outcomes.</p> <p>Minnesota DHS PHN Section’s Public Health Interventions (PHN Interventions) are used to determine the plan (See list of interventions in Section/page A10).</p> <ul style="list-style-type: none"> • Consult and collaborate as needed with: <ul style="list-style-type: none"> ○ Public Health Nursing Supervisor (PHNS) ○ Nurse Manager (as directed by PHNS) ○ Area Medical Director (as directed by PHNS) ○ Public Health Investigation (as directed by PHNS) ○ ACDC (as directed by PHNS) ○ Private/Public Health Laboratory ○ Health Care Provider ○ Environmental Health ○ Other Regulatory Agencies ○ Public Health Registrar ○ Facility Administrator or Designee ○ Case/Contact Employer or School/Child Care ○ Family/Household 	<p>1. PHN Intervention – Disease and Health Event Investigation:</p> <ul style="list-style-type: none"> • Review Acute Communicable Disease Control Manual (B-73) for: <ul style="list-style-type: none"> ○ Symptoms ○ Incubation period ○ Source ○ Mode of transmission ○ Period of communicability ○ Specific treatment ○ Control measures • Obtain educational and resource materials. • Obtain specimen containers if applicable. • Elicit epidemiological data. • Determine if outbreak exists at initial visit. • Request outbreak number from registrar if needed and if there is no outbreak, refer back to PHNS. • Establish liaison for facility if not already done. • Relate outbreak to time, place, person (when? where? who?). • Analyze probable causative factor (how? why?). • Analyze actual/potential for spread of disease. • Take appropriate action in the event of sensitive occupation or situation (see B-73). • Evaluate extent of illness in clients/staff/community. • Develop case definition. • Conduct environmental assessment (hand washing facilities, bathrooms, laundry, trash, kitchen, etc.). • Review staffing: <ul style="list-style-type: none"> ○ Staff assignment/case relationship

Acute Communicable Disease: Outbreak in a Non-Healthcare Facility

Standard of Practice	Description	Practice
<p>Planning (Cont.)</p>		<ul style="list-style-type: none"> ○ Staff/client ratio ○ Number of employees and clients ○ Total capacity ● Review and institute appropriate control measures. ● Document on epidemiological form. ● Complete line listing of cases involved. ● Maintain a desk card on outbreaks that require more than one month for resolution. ● Initiate medical record. <p>2. PHN Intervention – Case Management:</p> <ul style="list-style-type: none"> ● Implement a facility management plan based on interpretation of findings. ● Notify public health laboratory about the outbreak after obtaining outbreak number from the registrar, name of the facility, and number of anticipated specimens. <p>3. PHN Intervention – Surveillance:</p> <ul style="list-style-type: none"> ● Monitor case/contacts until cleared/closed. ● Submit specimens as indicated. ● Monitor facility for further outbreaks. <p>4. PHN Intervention – Health Teaching/Counseling:</p> <ul style="list-style-type: none"> ● Educate the staff, clients, and/or families regarding the symptoms, source, incubation period, mode of transmission, period of communicability, and precautions needed to prevent the spread of infection per the B-73. ● Discuss the need for case/contacts to have evaluation/clearance and explain procedures. ● Provide instruction on appropriate specimen collection (if applicable).

Acute Communicable Disease: Outbreak in a Non-Healthcare Facility

Standard of Practice	Description	Practice
<p>Planning (Cont.)</p>		<p>5. PHN Intervention – Collaboration:</p> <ul style="list-style-type: none"> • Collaborate with the AMD in writing the recommendations to the facility for outbreak control. <p>6. PHN Intervention – Referral and Follow-up:</p> <ul style="list-style-type: none"> • Review control measures, treatment, and/or prophylaxis recommendations of the AMD with the facility administrator or designee. Provide these recommendations to the facility administrator or designee in the form of a written letter from the AMD. • File Foodborne Illness report (H-26) with district registrar if illness relates to a commercial establishment or product outside of the facility. • Contact the Los Angeles County Environmental Health Food and Milk Program (626-430-5400) if applicable. <p>7. PHN Intervention – Other:</p> <ul style="list-style-type: none"> • Plan interventions needed to assist the facility with needs and concerns unrelated to the outbreak.
<p>Implementation</p>	<p>The public health nurse implements the identified plan by partnering with others.</p> <ul style="list-style-type: none"> • Coordination – The public health nurse coordinates programs, services, and other activities to implement the identified plan. • Health Education and Health Promotion – The public health nurse employs multiple strategies to promote health, prevent disease, and ensure a safe environment for populations. 	<p>1. PHN interventions are implemented as stated in the plan:</p> <ul style="list-style-type: none"> • Disease and Health Event Investigation • Case Management • Surveillance • Health Teaching/Counseling • Collaboration • Referral and Follow-up • Other interventions as needed

Acute Communicable Disease: Outbreak in a Non-Healthcare Facility

Standard of Practice	Description	Practice
<p>Implementation (Cont.)</p>	<ul style="list-style-type: none"> • Consultation – The public health nurse provides consultation to various community groups and officials to facilitate the implementation of programs and services. • Regulatory Activities – The public health nurse identifies, interprets, and implements public health laws, regulations, and policies. 	<p>2. Document all consultations, collaborations, interventions and facility encounters on the epidemiological form(s), and/or in the medical record/NPMS.</p>
<p>Evaluation</p>	<p>The public health nurse evaluates the health status of the population (all affected by disease).</p> <p>The PHN examines the effectiveness of the interventions, including the need for modification of the interventions in relation to outcomes.</p>	<ol style="list-style-type: none"> 1. Evaluate the effectiveness of the interventions on the health of the contacts: <ul style="list-style-type: none"> • Verify and document facility compliance with the recommendations. 2. Evaluate adherence by the facility to the recommendations for control: 3. Determine action for non-adherent facility: <ul style="list-style-type: none"> • Consult with PHNS. 4. Complete investigation forms: <ul style="list-style-type: none"> • Submit interim reports as needed until case is closed. • Submit final report within 10 days of closure or timeframe agreed upon in consultation with PHNS. 5. Document in the NPMS: <ul style="list-style-type: none"> • Complete Consumer/Community Service module and file hard copy in the medical record. 6. Evaluate client satisfaction: <ul style="list-style-type: none"> • Give client satisfaction form to the facility/agency representative for completion and submission in a pre-addressed, stamped envelope.

Lead Poisoning

Standard of Practice	Description	Practice
<p>Assessment</p>	<p>The public health nurse collects comprehensive data, pertinent to the health status of populations.</p> <p>The most pertinent Healthy People 2010 Leading Health Indicators are:</p> <ul style="list-style-type: none"> • Environmental Quality • Access to Health Care 	<ol style="list-style-type: none"> 1. Review referral documents when received from Public Health Nursing Supervisor (PHNS), and on the Nursing Practice Management System (NPMS). Document Date/Time/Signature on referral when received from PHNS. 2. Analyze report for: <ul style="list-style-type: none"> • Laboratory results • Lead Poisoning Case Management Reporting (CMR) form • CLPPP Progress Notes 3. Assess case/family/caregiver and complete the forms related to: <ul style="list-style-type: none"> • Lead exposure and management per guidelines in the: <ul style="list-style-type: none"> ○ Lead Poisoning Follow up form/ instructions/Appendix C (LPFF) ○ Management Guidelines for Childhood Lead Exposure by Blood Lead Levels (BLL Matrix) ○ MOU between Maternal Child and Adolescent Health Program, the Childhood Lead Poisoning Prevention Program, Environmental Health Services and Community Health Services ○ Medi-Cal Outreach Questionnaire ○ CLPPP Progress Notes ○ “Reminder” cover letter • Educational and resource needs related to lead exposure. 4. Assess case/household per PHN Assessment criteria.

Lead Poisoning

Standard of Practice	Description	Practice
Assessment (Cont.)		<ol style="list-style-type: none"> 5. Assess nutrition status of client with the client’s caregiver using the CLPPP nutritional screening form “What Does Your Child Eat?” 6. Assess client and household members for lead exposure per the CLPPP Progress Notes and the LPPF.
Population Diagnosis and Priorities	<p>The public health nurse analyzes the assessment data to determine the population diagnoses and priorities.</p> <p>Analyze the collected assessment data to determine if there is an identified, actual or potential problem.</p>	<ol style="list-style-type: none"> 1. Verify the medical diagnosis and determine the priority of action. <ul style="list-style-type: none"> • Review Section/page D3 of the Public Health Nursing Practice Manual for priority per Childhood Lead Poisoning Prevention Program (CLPPP) Matrix or determine the priority of action in consultation with the PHNS as needed. Document priority selected. 2. Consider the client’s/household members’ need for nursing interventions based on possible or potential lead exposure and/or lead hazards. 3. Consider the client’s/household members’ need for nursing intervention to promote health, facilitate well being, foster healing, alleviate suffering, and improve quality of life.
Outcomes Identification	<p>The public health nurse identifies expected outcomes for plan that is based on population diagnoses and priorities.</p> <p>Outcome Objective:</p> <ul style="list-style-type: none"> • Prevent and/or minimize the risk factors associated with exposure to lead by: <ul style="list-style-type: none"> ○ Identifying the lead exposure source ○ Interrupting the pathway of the lead exposure ○ Ensuring a reduction in the elevated blood lead levels ○ Reducing or eliminating the consequences 	<ol style="list-style-type: none"> 1. Determine and document specific health needs/goals for client’s/household members’ situation. <ul style="list-style-type: none"> • Determine appropriate timelines for attainment of lead related outcomes according to the assessment and diagnoses (see Matrix and MOU).

Lead Poisoning

Standard of Practice	Description	Practice
<p>Planning</p>	<p>The public health nurse develops a plan that reflects best practices by identifying strategies, action plans, and alternatives to attain expected outcomes.</p> <p>Minnesota DHS PHN Section’s Public Health Interventions (PHN Interventions) are used to determine the plan (See list of interventions in Section/page A10).</p> <ul style="list-style-type: none"> • Consult and collaborate as needed with: <ul style="list-style-type: none"> ○ Public Health Nursing Supervisor (PHNS) ○ Nurse Manager (as directed by PHNS) ○ Area Medical Director (as directed by PHNS) ○ Analyzing Laboratories ○ Health Care Provider ○ Environmental Health ○ Housing Authority ○ Other Regulatory Agencies ○ Childhood Lead Poisoning Prevention Program ○ Client/household members/employer/school/childcare provider ○ CHDP ○ Maternal Child and Adolescent Health ○ California Children Services ○ Department of Children and Family Services ○ California Regional Center ○ Foster Care 	<ol style="list-style-type: none"> 1. PHN Intervention – Health Teaching/Counseling: <ul style="list-style-type: none"> • Educate the client/household members/caregiver using the lead awareness and health education materials included in the DPHN packet received with the referral. • Provide nutrition counseling based on the nutritional assessment using the nutritional screening form “What Does Your Child Eat?” and “My Pyramid Steps to a Healthier You” at www.mypyramid.gov. 2. PHN Intervention – Case Management: <ul style="list-style-type: none"> • Provide nursing care per the guidelines in: <ul style="list-style-type: none"> ○ Matrix and the MOU • Maintain a desk card until closure. • Coordinate retesting of client every 4-6 weeks with the primary care provider (PCP). • Select the growth chart by age and gender and plot height and weight. • Obtain caregiver/client signatures for the DHS General Consent form (H521) and the DHS Release of Confidential Information Consent form (H196). • Follow at-risk household members with elevated BLL per the same guidelines in the Matrix as for the client. • Open a medical record. • Document all interventions and client encounters. 3. PHN Intervention – Surveillance: <ul style="list-style-type: none"> • Monitor adherence to recommended medical treatment.

Lead Poisoning

Standard of Practice	Description	Practice
<p>Planning (Cont.)</p>		<ul style="list-style-type: none"> • Monitor client and at-risk household members until client and at-risk household members meet closure definition (Matrix). • Review BLL results of client and at-risk household members every 4-6 weeks. • Review with Registered Environmental Health Services Specialist (REHS) the progress of remediation, abatement, or removal of lead source in reducing or eliminating the consequences of lead exposure. <p>4. PHN Intervention – Case Finding:</p> <ul style="list-style-type: none"> • Ensure that at-risk household members receive a BLL per guidelines in the Matrix. <p>5. PHN Intervention – Consultation:</p> <ul style="list-style-type: none"> • Provide advice to the PCP based on the guidelines in the Matrix under PCP actions. • Review Appendix A-1 and A-2, Appendices B and C with the REHS in the identification and reduction of environmental lead sources. <p>6. PHN Intervention – Collaboration:</p> <ul style="list-style-type: none"> • Collaborate with the REHS per the MOU (Appendix C). • Provide an update (including BLLs) to the CLPPP-PHN every 3 months by phone or fax and document in the medical record. <p>7. PHN Intervention – Referral and Follow-up:</p> <ul style="list-style-type: none"> • Make referrals as needed based on assessment.

Lead Poisoning

Standard of Practice	Description	Practice
Planning (Cont.)		<ul style="list-style-type: none"> • Follow up with the PCP on the PHN and REHS recommendations in Appendix C. • Follow up with the PCP every 4-6 weeks to ensure that client and at-risk household members are retested for BLL. • Refer at-risk household members in the categories listed on the CLPPP Progress Notes to their PCP for evaluation of possible lead exposure and BLL. • Refer affected household members with elevated BLLs to their PCP for follow up. • Consult with the CLPPP-PHN for those household members who have no PCP and no health care coverage. • Refer the client and household members for health care coverage based on results on Medi-Cal Outreach Questionnaire. <p>8. PHN Intervention – Disease and Health Event Investigation:</p> <ul style="list-style-type: none"> • Provide disease and health event investigation per the guidelines in the: <ul style="list-style-type: none"> ○ LPFF and Appendix C ○ Matrix ○ MOU ○ CLPPP Progress Notes <p>9. PHN Intervention – Other:</p> <ul style="list-style-type: none"> • Plan interventions needed to assist client/household members with concerns identified in the PHN Assessment.

Lead Poisoning

Standard of Practice	Description	Practice
Implementation	<p>The public health nurse implements the identified plan by partnering with others.</p> <ul style="list-style-type: none"> • Coordination – The public health nurse coordinates programs, services, and other activities to implement the identified plan. • Health Education and Health Promotion – The public health nurse employs multiple strategies to promote health, prevent disease, and ensure a safe environment for populations. • Consultation – The public health nurse provides consultation to various community groups and officials to facilitate the implementation of programs and services. • Regulatory Activities – The public health nurse identifies, interprets, and implements public health laws, regulations, and policies. 	<ol style="list-style-type: none"> 1. PHN interventions are implemented as stated in the plan: <ul style="list-style-type: none"> • Health Teaching/Counseling • Case Management • Surveillance • Consultation • Collaboration • Referral and Follow-up • Disease and Health Event Investigation • Case Finding • Other interventions as needed 2. Document all consultations, collaborations, interventions, and encounters with caretaker on the investigation forms, and/or in the medical record/NPMS.
Evaluation	<p>The public health nurse evaluates the health status of the population.</p> <p>The PHN examines the effectiveness of the interventions, including the need for modification of the interventions in relation to outcomes.</p>	<ol style="list-style-type: none"> 1. Evaluate the effectiveness of the interventions on the health of the client/household members; e.g. document client understands lead poisoning: 2. Determine action on non-adherent client/household member: <ul style="list-style-type: none"> • Consult with PHNS and the CLPPP-PHN. 3. Complete and submit investigation forms: <ul style="list-style-type: none"> • Submit the initial documentation on the LPFF (p. 1-10), Appendix C, nutritional assessment “What Does Your Child Eat”, growth chart and Medi-Cal Outreach Questionnaire to the PHNS for review within 14 days

Lead Poisoning

Standard of Practice	Description	Practice
<p>Evaluation (Cont.)</p>		<p>of the initial home visit or within the timeframe agreed upon with the PHNS.</p> <ul style="list-style-type: none"> • Fax the initial documentation on the LPFF (p. 1-10), Appendix C (p. 1) to the assigned REHS within 30 calendar days of the initial DPHN home visit. • Submit the original LPFF and Appendix C, nutritional assessment “What Does Your Child Eat”, growth chart, client consent form, client release of information form, Medi-Cal Outreach Questionnaire, and the PHN Assessment to the assigned CLPPP-PHN within 30 days of case closure. • Retain a copy of all forms for the district medical record. <p>4. Document in the NPMS:</p> <ul style="list-style-type: none"> • File a copy of the PHN Assessment per the PHN Assessment Form instructions. <p>5. Evaluate caregiver satisfaction:</p> <ul style="list-style-type: none"> • Give client satisfaction form to the caregiver for completion and submission in a pre-addressed, stamped envelope.

Newborn Screening

Standard of Practice	Description	Practice
<p>Assessment</p>	<p>The public health nurse collects comprehensive data pertinent to the health status of populations.</p> <p>The most pertinent Healthy People 2010 Leading Health Indicators are:</p> <ul style="list-style-type: none"> • Access to Health Care 	<ol style="list-style-type: none"> 1. Review referral documents when received from Public Health Nursing Supervisor (PHNS) and on the Nursing Practice Management System (NPMS). Document Date/Time/Signature on referral when received from PHNS. 2. Analyze report for: <ul style="list-style-type: none"> • Disease • Referral source • Reason for referral: <ul style="list-style-type: none"> o Specimen was obtained too early o Specimen is inadequate o Specimen is missing o Home birth o Reported as presumptive positive for referred condition • Infant’s name, date of birth and place of birth • Mother’s name 3. Assess family/caregiver needs for further educational and resource information related to Newborn Screening. 4. Assess infant and household per PHN Assessment criteria.
<p>Population Diagnosis and Priorities</p>	<p>The public health nurse analyzes the assessment data to determine the population diagnoses and priorities.</p> <p>Analyze the collected assessment data to determine if there is an identified, actual or potential problem.</p>	<ol style="list-style-type: none"> 1. Verify the medical diagnosis/concern and determine the priority of action. <ul style="list-style-type: none"> • Review Section/page D4 of the Public Health Nursing Practice Manual for priority per Maternal Child and Adolescent Health or determine priority in consultation with the PHNS as needed. Document priority selected.

Newborn Screening

Standard of Practice	Description	Practice
Population Diagnosis and Priorities (Cont.)		<ol style="list-style-type: none"> 2. Consider the infant’s/caregiver’s need for nursing intervention based on the medical diagnosis/concern. 3. Consider the infant’s/caregiver’s need for nursing intervention to promote health, facilitate well being, foster healing, alleviate suffering, and improve quality of life.
Outcomes Identification	<p>The public health nurse identifies expected outcomes for a plan that is based on population diagnoses and priorities.</p> <p>Outcome Objective:</p> <ul style="list-style-type: none"> • Prevent and/or minimize the risk factors associated with genetic, endocrine, and hemoglobin diseases for which screening is performed. 	<ol style="list-style-type: none"> 1. Determine and document specific health needs/goals for infant’s situation.
Planning	<p>The public health nurse develops a plan that reflects best practices by identifying strategies, action plans, and alternatives to attain expected outcomes.</p> <p>Minnesota DHS PHN Section’s Public Health Interventions (PH Interventions) are used to determine the plan (See list of interventions in Section/page A10).</p> <ul style="list-style-type: none"> • Consult and collaborate as needed with: <ul style="list-style-type: none"> o Public Health Nursing Supervisor (PHNS) o Nurse Manager (as directed by PHNS) o Area Medical Director (as directed by PHNS) o Private Laboratory o Health Care Provider o Newborn Screening Program Coordinator 	<ol style="list-style-type: none"> 1. PHN Intervention – Disease and Health Event Investigation: <ul style="list-style-type: none"> • Obtain education and resource materials. • Obtain referral resource information to share with caregiver. 2. PHN Intervention – Health Teaching/Counseling: <ul style="list-style-type: none"> • Educate family regarding genetic, endocrine, and hemoglobin diseases for which screening was performed and the importance of early detection and proper treatment. • Provide family with educational/resource materials.

Newborn Screening

Standard of Practice	Description	Practice
Planning (Cont.)	<ul style="list-style-type: none"> o Primary caretaker/family/household 	<p>3. PHN Intervention – Referral and Follow-up:</p> <ul style="list-style-type: none"> • Refer client for testing and treatment as requested in the referral. <p>4. PHN Intervention – Other:</p> <ul style="list-style-type: none"> • Plan interventions needed to assist infant/caregiver/household with concerns identified in the PHN Assessment.
Implementation	<p>The public health nurse implements the identified plan by partnering with others.</p> <ul style="list-style-type: none"> • Coordination – The public health nurse coordinates programs, services, and other activities to implement the identified plan. • Health Education And Health Promotion – The public health nurse employs multiple strategies to promote health, prevent disease, and ensure a safe environment for populations. • Consultation – The public health nurse provides consultation to various community groups and officials to facilitate the implementation of programs and services. • Regulatory Activities – The public health nurse identifies, interprets, and implements public health laws, regulations, and policies. 	<p>1. PHN interventions are implemented as stated in the plan:</p> <ul style="list-style-type: none"> • Disease and Health Event Investigation • Health Teaching/Counseling • Referral and Follow-up • Other interventions as needed <p>2. Document all consultations, collaborations, interventions, and encounters with caretaker on the investigation forms, and/or progress notes/NPMS.</p>

Newborn Screening

Standard of Practice	Description	Practice
Evaluation	<p>The public health nurse evaluates the health status of the population (all affected by the case).</p> <ul style="list-style-type: none"> • The PHN examines the effectiveness of the interventions, including the need for modification of the interventions in relation to outcomes. 	<ol style="list-style-type: none"> 1. Evaluate the effectiveness of the interventions on the health of the infant/caregiver/household members; e.g. document caretaker’s understanding of the newborn screening process: <ul style="list-style-type: none"> • Determine if the infant kept the appointment for testing and treatment (if indicated). 2. Determine and document action for non-adherent caregiver or if caregiver cannot be located: <ul style="list-style-type: none"> • Consult with PHNS and contact Newborn Screening Program Coordinator (213-639-6457) after two unsuccessful attempts to locate the client or to obtain compliance from the caretaker. 3. Complete investigation forms: <ul style="list-style-type: none"> • Submit the final report to PHNS for review and submit dispositioned report/referral to the Newborn Screening Area Service Center and the Newborn Screening Coordinator by fax and postal mail within 30 days of receipt of referral or within timeframe agreed upon in consultation with the PHNS. 4. Document in the NPMS: <ul style="list-style-type: none"> • File a copy of the PHN Assessment per the PHN Assessment Form instructions. 5. Evaluate client satisfaction: <ul style="list-style-type: none"> • Give client satisfaction form to the caregiver for completion and submission in a pre-addressed, stamped envelope.

Sexually Transmitted Disease

Standard of Practice	Description	Practice
Assessment	<p>The public health nurse collects comprehensive data pertinent to the health status of populations.</p> <p>The most pertinent Healthy People 2010 Leading Health Indicators:</p> <ul style="list-style-type: none"> • Responsible Sexual Behavior • Mental Health • Injury and Violence • Access to Health Care 	<ol style="list-style-type: none"> 1. Review referral when received from Public Health Nursing Supervisor (PHNS) in Casewatch® and in the Nursing Practice Management System (NPMS). Document Date/Time/Signature on referral when received from PHNS. 2. Analyze report for: <ul style="list-style-type: none"> • Type of disease • Site of infection • Laboratory data • Age of client (If case is under 14 years of age a child abuse report should be completed in accordance with the Child Sexual Assault Reporting requirements) • Specific treatment 3. Conduct record search with STD program, if necessary. 4. Assess case/contacts(s) per PHN assessment criteria.
Population Diagnosis and Priorities	<p>The public health nurse analyzes the assessment data to determine the population diagnoses and priorities.</p> <p>Analyze the collected assessment data to determine if there is an identified, actual or potential problem.</p>	<ol style="list-style-type: none"> 1. Verify the medical diagnosis and determine priority of action: <ul style="list-style-type: none"> • Review Section/page D5 of the Public Health Nursing Practice Manual for the priority per the STD program or determine priority of action in collaboration with the PHNS as needed. Document priority selected. 2. Consider the client's/contacts' need for nursing interventions based on the medical diagnosis. 3. Consider the client's/contacts' need for nursing intervention to promote health, facilitate well being, foster healing, alleviate suffering, and improve quality of life.

Sexually Transmitted Disease

Standard of Practice	Description	Practice
Outcomes Identification	<p>The public health nurse identifies expected outcomes for a plan that is based on population diagnoses and priorities.</p> <p>Outcome Objectives:</p> <ul style="list-style-type: none"> • Prevent the spread of sexually transmitted diseases in Los Angeles County. • Case and contacts are free of STD. 	<p>1. Determine and document specific health needs/goals for client/contact situation.</p> <ul style="list-style-type: none"> • Determine appropriate timeline for attainment of the outcomes according to the assessment and diagnoses. • Ensure that client’s treatment is completed and partner(s) is referred for follow up as indicated.
Planning	<p>The public health nurse develops a plan that reflects best practices by identifying strategies, action plans, and alternatives to obtain expected outcomes.</p> <p>Minnesota DHS PHN Section’s Public Health Interventions (PH Interventions) are used to determine the plan (See list of interventions in Section/page A10).</p> <ul style="list-style-type: none"> • Consult and collaborate as needed with: <ul style="list-style-type: none"> ○ Public Health Nursing Supervisor (PHNS) ○ Nurse Manager (as directed by PHNS) ○ Area Medical Director (as directed by PHNS) ○ Public Health Investigator (as directed by PHNS) ○ STD Clinician and Clinic Staff ○ Sexually Transmitted Disease Program (as directed by PHNS) ○ DCFS ○ SCAN Team ○ Law Enforcement ○ Family/household ○ Private/Public Health Laboratory ○ Health Care Provider 	<p>1. PHN Intervention – Disease and Health Event Investigation:</p> <ul style="list-style-type: none"> • Review: <ul style="list-style-type: none"> ○ Symptoms ○ Incubation period ○ Source ○ Period of communicability ○ Specific treatment ○ Control measures ○ Sexually Transmitted Disease Procedure Manual • Obtain STD educational and resource materials. • Analyze actual/potential for spread of disease. • Determine psychosocial, socioeconomic and cultural influences and attitudes. • Determine risk factors for infection/re-infection. • Client visit: <ul style="list-style-type: none"> ○ Provide identification and explain the purpose of the visit to the client ○ Secure private setting for interview ○ Ensure client confidentiality ○ Elicit epidemiological data

Sexually Transmitted Disease

Standard of Practice	Description	Practice
<p>Planning (Cont.)</p>		<p>2. PHN Intervention – Health Teaching/Counseling:</p> <ul style="list-style-type: none"> • Determine the client’s understanding of the disease, transmission, treatment, and prevention. • Educate client regarding the STD using culturally sensitive and age appropriate information (verbal and written). • Provide risk reduction education and impact on fetus, if applicable. <p><u>Suspected Child Abuse Cases:</u></p> <ul style="list-style-type: none"> • Explain the importance of medical evaluation of household members to the parent(s)/guardian(s), as indicated. • Explain the involvement of law enforcement and the Department of Children and Family Services (DCFS) in cases of suspected child abuse, if appropriate, using professional judgment. <p>3. PHN Intervention – Case Finding:</p> <ul style="list-style-type: none"> • Interview client for contact(s). • Initiate appropriate form(s). Document on contact form: <ul style="list-style-type: none"> ○ Date of initial contact ○ Epidemiological data ○ Potential for spread of disease and re-infection ○ Education/counseling provided ○ Plan of action for case and susceptible contacts • Maintain a desk card on child abuse cases and those cases requiring more than one month of follow-up.

Sexually Transmitted Disease

Standard of Practice	Description	Practice
Planning (Cont.)		<p>4. PHN Intervention – Referral and Follow-up:</p> <ul style="list-style-type: none"> • Complete PHN Assessment and make referrals as needed. • Refer client/contact(s) for testing and treatment, if applicable. <p>5. PHN Intervention – Other:</p> <ul style="list-style-type: none"> • Plan interventions needed to assist case/contact(s) with concerns identified in the PHN Assessment.
Implementation	<p>The public health nurse implements the identified plan by partnering with others.</p> <ul style="list-style-type: none"> • Coordination – The public health nurse coordinates programs, services, and other activities to implement the identified plan. • Health Education and Health Promotion – The public health nurse employs multiple strategies to promote health, prevent disease, and ensure a safe environment for populations. • Consultation – The public health nurse provides consultation to various community groups and officials to facilitate the implementation of programs and services. • Regulatory Activities – The public health nurse identifies, interprets, and implements public health laws, regulations, and policies. 	<p>1. PHN interventions are implemented as stated in the plan:</p> <ul style="list-style-type: none"> • Disease and Health Event Investigation • Health Teaching/Counseling • Case Finding • Referral and Follow-up • Surveillance • Other interventions as needed <p>2. Document all consultations, collaborations, interventions and client encounters in Casewatch® field notes or progress notes, and in the NPMS.</p>

Sexually Transmitted Disease

Standard of Practice	Description	Practice
<p>Evaluation</p>	<p>The public health nurse evaluates the health status of the population (all affected by the case).</p> <p>The PHN examines the effectiveness of the interventions, including the need for modification of the interventions in relation to outcomes.</p>	<ol style="list-style-type: none"> 1. Evaluate the effectiveness of the interventions on the health of the client/contact(s); e.g. document client understands the disease process and prevention of transmission: 2. Determine and document client/contact(s) adherence: <ul style="list-style-type: none"> • Medical evaluation is obtained. • Treatment is completed. 3. Determine action for non-adherent client/contact(s): <ul style="list-style-type: none"> • Consult with PHNS. 4. Document in Casewatch®: <ul style="list-style-type: none"> • Disposition and close case within 14 days of receipt of referral or within timeframe agreed upon in consultation with PHNS. 5. Document in the NPMS: <ul style="list-style-type: none"> • File a copy of the PHN Assessment per the PHN Assessment Form instructions. 6. Evaluate client satisfaction: <ul style="list-style-type: none"> • Give client satisfaction form to the client for completion and submission in a pre-addressed, stamped envelope.

Sudden Infant Death Syndrome

Standard of Practice	Description	Practice
Assessment	<p>The public health nurse collects comprehensive data pertinent to the health status of populations.</p> <p>The most pertinent Healthy People 2010 Leading Health Indicators:</p> <ul style="list-style-type: none"> • Environmental Quality • Mental Health • Injury and Violence • Access to Health Care • Tobacco Use • Substance Abuse 	<ol style="list-style-type: none"> 1. Review referral documents when received from Public Health Nursing Supervisor (PHNS) and on the Nursing Practice Management System (NPMS). Document Date/Time/Signature on referral when received from PHNS. 2. Analyze the referral packet received from the MCAH SIDS Coordinator. 3. Call the MCAH SIDS Coordinator for further information. 4. Assess family needs for grief counseling: <ul style="list-style-type: none"> • Consider the extended family, siblings and childcare provider. 5. Assess the caregiver/household/provider per PHN Assessment criteria.
Population Diagnosis and Priorities	<p>The public health nurse analyzes the assessment data to determine the population diagnoses and priorities.</p> <p>Analyze the collected assessment data to determine if there is an identified, actual or potential problem.</p>	<ol style="list-style-type: none"> 1. Verify the provisional medical diagnosis and determine the priority of action: <ul style="list-style-type: none"> • Review Section/page D6 of the Public Health Nursing Practice Manual for priority per Maternal, Child and Adolescent Health (MCAH) or determine the priority of action in consultation with the PHNS as needed. Document priority selected. 2. Consider the caregiver/household/provider’s need for nursing interventions based on the provisional medical diagnosis. 3. Consider the caregiver/household/provider’s need for nursing intervention to promote health, facilitate well being, foster healing, alleviate suffering, and improve quality of life.

Sudden Infant Death Syndrome

Standard of Practice	Description	Practice
Outcomes Identification	<p>The public health nurse identifies expected outcomes for a plan that is based on population diagnoses and priorities.</p> <p>Outcome objective:</p> <ul style="list-style-type: none"> • Prevent ineffective grieving. 	<p>1. Determine and document specific health needs/goals for the caregiver/household/provider situation.</p>
Planning	<p>The public health nurse develops a plan that reflects best practices by identifying strategies, action plans, and alternatives to obtain expected outcomes.</p> <p>Minnesota DHS PHN Section’s Public Health Interventions (PHN Interventions) are used to determine the plan (See list of interventions in Section/page A10).</p> <ul style="list-style-type: none"> • Consult and collaborate as needed with: <ul style="list-style-type: none"> ○ Public Health Nursing Supervisor (PHNS) ○ Nurse Manager (as directed by PHNS) ○ Coroner’s Office ○ Area Medical Director (as directed by PHNS) ○ MCAH SIDS Coordinator ○ Health care provider ○ Environmental Health ○ Department of Children and Family Services ○ Child care provider ○ Primary caretaker/family/household ○ Grief support services 	<p>1. PHN Intervention – Disease and Health Event Investigation:</p> <ul style="list-style-type: none"> • Interview caregiver using the materials provided in the packet received from the MCAH SIDS Coordinator including the: <ul style="list-style-type: none"> ○ Presumptive SIDS referral from the LA County SIDS Program ○ Progress note from the MCAH SIDS Coordinator ○ SIDS Reporting form from the LA County Officer of the Coroner ○ Public Health Service Report including instructions and definitions <p>2. PHN Intervention – Health Teaching/Counseling:</p> <ul style="list-style-type: none"> • Educate caregiver/household/provider on current SIDS data and research using the SIDS education and information materials provided in the packet from the MCAH SIDS Coordinator. <p>3. PHN Intervention – Referral and Follow-up:</p> <ul style="list-style-type: none"> • Refer caregiver/household/provider to support services and other agencies as needed using referral materials in the packet from the MCAH SIDS Coordinator.

Sudden Infant Death Syndrome

Standard of Practice	Description	Practice
Planning (Cont.)		<p>4. PHN Intervention – Surveillance:</p> <ul style="list-style-type: none"> • Once initial investigation is completed, determine the need for on-going PHN involvement based on professional judgment and consultation with the PHNS and the MCAH SIDS Coordinator. <p>5. PHN Intervention – Other:</p> <ul style="list-style-type: none"> • Plan interventions needed to assist caregiver/household/provider with concerns identified in the PHN Assessment.
Implementation	<p>The public health nurse implements the identified plan by partnering with others.</p> <ul style="list-style-type: none"> • Coordination – The public health nurse coordinates programs, services, and other activities to implement the identified plan. • Health Education and Health Promotion – The public health nurse employs multiple strategies to promote health, prevent disease, and ensure a safe environment for populations. • Consultation – The public health nurse provides consultation to various community groups and officials to facilitate the implementation of programs and services. • Regulatory Activities – The public health nurse identifies, interprets, and implements public health laws, regulations, and policies. 	<p>1. PHN interventions are implemented as stated in the plan:</p> <ul style="list-style-type: none"> • Disease and Health Event Investigation • Health Teaching/Counseling • Referral and Follow-up • Surveillance • Other interventions as needed <p>2. Document all consultations, collaborations, interventions, and caretaker encounters on the investigation forms and/or progress notes/NPMS.</p>

Sudden Infant Death Syndrome

Standard of Practice	Description	Practice
<p>Evaluation</p>	<p>The public health nurse evaluates the health status of the population (all affected by the death of the child).</p> <p>The PHN examines the effectiveness of the interventions, including the need for modification of the interventions in relation to outcomes.</p>	<ol style="list-style-type: none"> 1. Evaluate the effectiveness of the interventions on the health of the caregiver/household/provider; e.g. document caregiver understands SIDS diagnosis process: 2. Determine and document action for the non-adherent caregiver: <ul style="list-style-type: none"> • Document when contact is not established or service is refused on the PHN Progress Note included in the packet from the MCAH SIDS Coordinator. • Consult with PHNS and MCAH SIDS Coordinator as needed. 3. Complete investigation forms: <ul style="list-style-type: none"> • Complete the PH Services Report, Report of Contact, PHN Progress Note, and the SB 90 PHN Case Tracking Form and submit to the MCAH SIDS Coordinator via the PHNS within 2 weeks of the initial referral. 4. Document in the NPMS: <ul style="list-style-type: none"> • File a copy of the PHN Assessment per PHN Assessment Form instructions. 5. Evaluate client satisfaction: <ul style="list-style-type: none"> • Give client satisfaction form to the caregiver for completion and submission in a pre-addressed, stamped envelope.

Tuberculosis (TB) Cases and Suspects

Standard of Practice	Description	Practice
<p>Assessment</p>	<p>The public health nurse collects comprehensive data pertinent to the health status of populations.</p> <p>The most pertinent Healthy People 2010 Leading Health Indicators:</p> <ul style="list-style-type: none"> • Substance Abuse • Responsible Sexual Behavior • Mental Health • Environmental Quality • Access to Health Care • Tobacco Use 	<ol style="list-style-type: none"> 1. Review referral documents when received from the Public Health Nursing Supervisor (PHNS) and on the Nursing Practice Management System (NPMS). Document Date/Time/Signature on referral when received from PHNS. 2. Analyze report for: <ul style="list-style-type: none"> • Site of disease • Date of onset • Diagnosis • Source of referral (if under private provider care, contact provider prior to home visit if contact was not already made by TB Control) • Tuberculin skin test (TST) results and BCG status • Chest X-Ray results • Bacteriology/laboratory results (i.e., pathology report, CSF chemistry, etc.) • Any medical and/or previous TB history • Symptoms and probable communicability status • Medications for TB/Other medications • Living situation/psychosocial factors • Contact referral source if insufficient/incomplete information given and client is not currently hospitalized 3. Assess case/household per PHN Assessment criteria.
<p>Population Diagnosis and Priorities</p>	<p>The public health nurse analyzes the assessment data to determine the population diagnoses and priorities.</p> <p>Analyze the collected assessment data to determine if there is an identified, actual or potential problem.</p>	<ol style="list-style-type: none"> 1. Verify the medical diagnosis and determine the priority of action: <ul style="list-style-type: none"> • Review Section/page D7 of the Public Health Nursing Practice Manual for priority or determine the priority of action in consultation with the PHNS as needed. Document priority selected.

Tuberculosis (TB) Cases and Suspects

Standard of Practice	Description	Practice
Population Diagnosis and Priorities (Cont.)		<ol style="list-style-type: none"> 2. Consider the client’s/household’s need for nursing interventions based on the medical diagnosis. 3. Consider the client’s/household’s need for nursing intervention to promote health, facilitate well being, foster healing, alleviate suffering, and improve quality of life.
Outcomes Identification	<p>The public health nurse identifies expected outcomes for a plan that is based on population diagnoses and priorities.</p> <p>Outcome objectives:</p> <ul style="list-style-type: none"> • Prevent the spread of TB within families, communities, health facilities, or other populations. • Cure the client of TB disease. 	<ol style="list-style-type: none"> 1. Determine and document specific health needs/goals for client/contact situation. <ul style="list-style-type: none"> • Determine appropriate timeline for attainment of the outcomes according to the assessment and diagnoses and per the TB Control Program Manual 2003 (pages 5-4 and 5-14).
Planning	<p>The public health nurse develops a plan that reflects best practices by identifying strategies, action plans, and alternatives to attain expected outcomes.</p> <p>Minnesota DHS PHN Section’s Public Health Interventions (PH Interventions) are used to determine the plan (See list of interventions in Section/page A10).</p> <ul style="list-style-type: none"> • Consult and collaborate as needed with: <ul style="list-style-type: none"> ○ Public Health Nursing Supervisor (PHNS) ○ Nurse Manager (as directed by PHNS) ○ Area Medical Director (as directed by PHNS) ○ TB Control (as directed by PHNS) ○ Private/Public Health Laboratory ○ TB Clinician and clinic staff ○ Health Care Provider ○ Public Health Investigation 	<ol style="list-style-type: none"> 1. PHN Intervention – Disease and Health Event Investigation: <ul style="list-style-type: none"> • Review: <ul style="list-style-type: none"> ○ Symptoms ○ Incubation period ○ Source ○ Mode of transmission ○ Period of communicability ○ Specific treatment ○ Control measures ○ TB Control Program Manual 2003 Chapters 3 and 4 • Obtain TB education and resource materials. • Obtain specimen containers, if applicable. • Obtain TST supplies, as needed.

Tuberculosis (TB) Cases and Suspects

Standard of Practice	Description	Practice
<p>Planning (Cont.)</p>	<ul style="list-style-type: none"> ○ Agency where possible exposure occurred ○ Client/contact’s employer/school/child care/agency ○ Family/household 	<ul style="list-style-type: none"> ● Elicit epidemiological data. ● Determine the onset of symptoms and current status of symptoms. ● Analyze actual/potential for spread of disease. ● Determine the probability of adherence. ● Determine the impact of the diagnosis on cultural beliefs and psycho/social impact. ● Provide instruction on appropriate specimen collection, if applicable. ● Institute appropriate control measures, if applicable. ● Document all consultations, collaborations, interventions and client encounters in the medical record. <p>2. PHN Intervention – Case Finding:</p> <ul style="list-style-type: none"> ● Initiate contact investigation per Contact Investigation Standards in the TB Control Program Manual 2003 (Appendix L). ● Explain to the client that confidentiality will be safeguarded. ● Administer TST, if applicable. ● Refer contacts for evaluation/treatment (PHN TB Contact Investigation Standard C49-C55), if applicable. ● Initiate appropriate forms: H-289 and H-304, if applicable. ● Initiate source case finding for children who are Class 3/5 (Source Case/Associate Investigation Standards in the TB Control Program Manual 2003 Appendix L).

Tuberculosis (TB) Cases and Suspects

Standard of Practice	Description	Practice
<p>Planning (Cont.)</p>		<p>3. PHN Intervention – Health Teaching/Counseling:</p> <ul style="list-style-type: none"> • Educate client/contacts using culturally sensitive and age appropriate information (verbal and written). • Educate client/contacts regarding the disease process, necessary follow-up and medication prescribed. • Provide instruction on appropriate specimen collection, if applicable. • Educate about TB and precautions needed to prevent the spread of disease, if client is communicable. <p>4. PHN Intervention – Referral and Follow-up:</p> <ul style="list-style-type: none"> • Refer all contacts for evaluation and follow-up, if applicable (PHN TB Contact Follow-up Individual Standard C49-C55). • Refer client to provider for ongoing follow-up. • Refer client/contacts to community resources as needed according to identified needs. • If the client was born in Mexico, has family in Mexico or may be visiting there, provide the client the “Cure TB” Binational Referral Program wallet card to facilitate continuity of care in the event of an unplanned trip or move. <p>5. PHN Intervention – Case Management:</p> <ul style="list-style-type: none"> • Maintain desk card on the client. • Document all interventions in the medical record. • Notify public health center TB clinician/PMD of changes in status of client, if applicable. • Initiate: <ul style="list-style-type: none"> ○ PHN TB Class 3/5 Assessment Form

Tuberculosis (TB) Cases and Suspects

Standard of Practice	Description	Practice
Planning (Cont.)		<ul style="list-style-type: none"> ○ H-304 if indicated ○ H-290 Registration ● Ensure the client is reclassified as indicated within 3 months from the date the referral was received. ● Ensure that the client who is a TB 3 completes the required treatment (TB Control Manual 2003 Chapter 5). ● Contact the client by monthly home visit to ensure that the client is following recommended management program unless otherwise approved by the PHNS. <ul style="list-style-type: none"> ○ Assess the following: <ul style="list-style-type: none"> ❖ Adherence with treatment <ul style="list-style-type: none"> ◆ Count the TB medication, if the client is not on DOT ○ Date of last health provider/clinic visit ○ Current medications ○ Date of last refill, if private provider ○ Date of next healthcare provider or clinic appointment ○ Educational, psychosocial, and medical needs related to TB ○ Other non-TB related concerns ○ Document visit on monthly PHN TB Follow-up Form within 2 working days ● Document all other client encounters on progress notes, and update the desk card as needed within 2 working days of the client encounter or within timeframe agreed upon with the PHNS.

Tuberculosis (TB) Cases and Suspects

Standard of Practice	Description	Practice
Planning (Cont.)		<ul style="list-style-type: none"> • Review chart within 2 working days after each clinic visit or within timeframe agreed upon with the PHNS for: <ul style="list-style-type: none"> ○ Problems elicited ○ Medication changes ○ Clinical orders ○ Sputum results ○ Drug susceptibility ○ DOT adherence ○ Diagnosis ○ Closure • Contact client for broken chest clinic appointments (TB Control Program Manual 2003 page 5-12 and 5-13 and PHN Practice Manual D7). • Contact client for broken DOT appointments (TB Control Program Manual 2003 page 5-13 and PHN Practice Manual D7). • Request for PMD medical update initially and every month as long as TB case/suspect continues with treatment or until closure. <ul style="list-style-type: none"> ○ Initiate PMD Cover Letter and the “Request for Tuberculosis Update” form via fax to the PMD and document in progress notes that the medical update has been requested. ○ Review the information provided on the update form received from PMD and route to TB clinician for review. ○ Contact the PMD if the “Request for Tuberculosis Medical Update” form is not returned within one week to determine if the client remains under their care and if the form was received.

Tuberculosis (TB) Cases and Suspects

Standard of Practice	Description	Practice
Planning (Cont.)		<ul style="list-style-type: none"> ○ Fax another request to the PMD if the form has not been received and documented in that progress note that this is the second request. ○ Review the case with the PHNS and then the TB clinician if the PMD does not complete the “Request for Tuberculosis Medical Update” form or provide information within one week after the second request. <p>6. PHN Intervention – Surveillance:</p> <ul style="list-style-type: none"> ● Monitor adherence to home isolation and “Patient Education Instructions for Home Isolation for Contagious Tuberculosis” H-3070, if applicable. ● Monitor adherence to recommended medical treatment, if applicable. ● Monitor client for complications and additional concerns until closure at least monthly and as needed. <p>7. PHN Intervention – Other: Plan interventions needed to assist case/contact(s) with concerns identified in the PHN Assessment.</p>
Implementation	<p>The public health nurse implements the identified plan by partnering with others.</p> <ul style="list-style-type: none"> ● Coordination – The public health nurse coordinates programs, services, and other activities to implement the identified plan. ● Health Education and Health Promotion – The public health nurse employs multiple strategies to promote health, prevent disease, and ensure a safe environment for populations. 	<p>1. PHN interventions are implemented as stated in the plan:</p> <ul style="list-style-type: none"> ● Disease and Health Event Investigation ● Case Finding ● Health Teaching/Counseling ● Referral and Follow-up ● Case Management ● Surveillance ● Other interventions as needed

Tuberculosis (TB) Cases and Suspects

Standard of Practice	Description	Practice
Implementation (Cont.)	<ul style="list-style-type: none"> • Consultation – The public health nurse provides consultation to various community groups and officials to facilitate the implementation of programs and services. • Regulatory Activities – The public health nurse identifies, interprets, and implements public health laws, regulations, and policies. 	<ol style="list-style-type: none"> 2. Document all consultations, collaborations, interventions, and client/caretaker encounters on the investigation forms, and/or in the medical record/NPMS
Evaluation	<p>The public health nurse evaluates the health status of the population (all affected by the case).</p> <p>The PHN examines the effectiveness of the interventions, including the need for modification of the interventions in relation to outcomes.</p>	<ol style="list-style-type: none"> 1. Evaluate the effectiveness of the interventions on the health of the client/contact(s); e.g. document client understands the disease process and prevention of transmission: 2. Determine and document action for the non-adherent client and/or if client cannot be located: <ul style="list-style-type: none"> • Consult with the TB clinician for non-adherent clients. • Make 2 home visit attempts to verify the client’s residence. If client cannot be found, consult with the PHNS for review and recommendations. • Attempt to locate the client via postal clearance and calling emergency numbers or other contact numbers listed in the client record. • If the client is referred for district PHI follow up, contact the assigned PHI every 2 weeks until final disposition and document the client’s status in the medical record. • If the client is referred for TBC PHI follow up and a Legal Order was initiated, contact the assigned TBC PHI monthly until final disposition and document the client’s status in the medical record.

Tuberculosis (TB) Cases and Suspects

Standard of Practice	Description	Practice
<p>Evaluation (Cont.)</p>		<p>3. Complete reporting forms:</p> <ul style="list-style-type: none"> • Submit (H-290) registration within 14 days of receipt of the suspect referral or within timeframe agreed upon in consultation with the PHNS. • Ensure that the H-304 is dispositioned and submitted, if indicated. • Submit TB Patient Clinical Summary (H-513) for closure within 7 days of closure or within time frame agreed upon during consultation with the PHNS. • Ensure that the H-290 confirmation is submitted within 7 days of the final culture report from all sites, within 7 days of clinical diagnosis or within timeframe agreed upon in consultation with PHNS. • Ensure that the H-289 is submitted to TB Control after the completion of the initial screening process. The initial screening process is completed once the H-304s are dispositioned. <p>4. Assessment::</p> <ul style="list-style-type: none"> • Complete the PHN TB Class 3/5 Assessment Form and file in client’s chart. • File a copy of the PHN Assessment Form per the PHN Assessment Form instructions. <p>5. Evaluate client satisfaction:</p> <ul style="list-style-type: none"> • Give client satisfaction form to the client for completion and submission in a pre-addressed, stamped envelope.

Tuberculosis (TB) Contact Follow-up: Individual

Standard of Practice	Description	Practice
<p>Assessment</p>	<p>The public health nurse collects comprehensive data pertinent to the health status of populations.</p> <p>The most pertinent Healthy People 2010 Leading Health Indicators:</p> <ul style="list-style-type: none"> • Substance Abuse • Responsible Sexual Behavior • Mental Health • Environmental Quality • Access to Health Care • Tobacco Use 	<ol style="list-style-type: none"> 1. Review referral documents when received from the Public Health Nursing Supervisor (PHNS) and on the Nursing Practice Management System (NPMS). Document Date/Time/Signature on referral when received from PHNS. 2. Analyze referral for: <ul style="list-style-type: none"> • Contact information <ul style="list-style-type: none"> ○ TST status ○ CXR results ○ Date of last contact to index case ○ Any medical and/or previous TB history • Status of source case and the risk to transmit (high or low) • Site of disease • Date of onset • Diagnosis • Source of referral – (if under private provider care, contact provider prior to home visit if contact was not already made by TB Control) • Tuberculin skin test (TST) results and BCG status • Chest X-Ray results • Bacteriology/laboratory results (i.e., pathology report, CSF chemistry, etc.) of index case • Any medical and/or previous TB history • Symptoms and probable communicability status • Medications for TB start date • Other medications • Number of persons potentially exposed • Description of site where exposure occurred, e.g. high school, skilled nursing facility, etc.

Tuberculosis (TB) Contact Follow-up: Individual

Standard of Practice	Description	Practice
Assessment (Cont.)		<ul style="list-style-type: none"> • Living situation/social factors • Contact referral source if insufficient/incomplete information given and client is not currently hospitalized <p>3. Assess contact/household per the PHN Assessment criteria.</p>
Population Diagnosis and Priorities	<p>The public health nurse analyzes the assessment data to determine the population diagnoses and priorities.</p> <ul style="list-style-type: none"> • Analyze the collected assessment data to determine if there is an identified, actual or potential problem. 	<p>1. Verify the medical diagnosis and determine the priority of action:</p> <ul style="list-style-type: none"> • Review Section/page D7 of the Public Health Nursing Practice Manual and the Contact Investigation Standards in the TB Control Program Manual 2003 (Appendix L) or determine priority in consultation with the PHNS as needed. Document priority selected. <p>2. Consider the contact’s/household’s need for nursing interventions based on the medical diagnosis.</p> <p>3. Consider the contact’s/household’s need for nursing intervention to promote health, facilitate well being, foster healing, alleviate suffering, and improve quality of life.</p>
Outcomes Identification	<p>The public health nurse identifies expected outcomes for a plan that is based on population diagnoses and priorities.</p> <p>Outcome Objectives:</p> <ul style="list-style-type: none"> • Prevent the spread of TB within families, communities, health facilities, or other sites. • Contacts are free of TB disease and/or infection. 	<p>1. Determine and document specific health needs/goals for contact’s/household’s situation:</p> <ul style="list-style-type: none"> • Determine appropriate timelines for attainment of the outcomes according to the assessment and diagnoses (TB Control Program Manual 2003 Contact Investigation Standards Appendix L).

Tuberculosis (TB) Contact Follow-up: Individual

Standard of Practice	Description	Practice
<p>Planning</p>	<p>The public health nurse develops a plan that reflects best practices by identifying strategies, action plans, and alternatives to attain expected outcomes.</p> <p>Minnesota DHS PHN Section’s Public Health Interventions (PH Interventions) are used to determine the plan (See list of interventions in Section A10).</p> <ul style="list-style-type: none"> • Consult and collaborate as needed with: <ul style="list-style-type: none"> ○ Public Health Nursing Supervisor (PHNS) ○ Nurse Manager (as directed by PHNS) ○ Area Medical Director (as directed by PHNS) ○ TB Control (as directed by PHNS) ○ TB Clinician and Clinic Staff ○ Private/Public Health Laboratory ○ Health Care Provider ○ Public Health Investigation ○ Agency where possible exposure occurred ○ Client/Contact’s Employer/School/Child Care/ Agency ○ Family/Household 	<p>1. PHN Intervention - Disease and Health Event Investigation:</p> <ul style="list-style-type: none"> • Review: <ul style="list-style-type: none"> ○ Symptoms ○ Incubation period ○ Source ○ Mode of transmission ○ Period of communicability ○ Specific treatment ○ Control measures (TB Control Program Manual 2003 Chapters 3 and 4) • Obtain TB educational and resource materials. • Obtain TST supplies, as needed. • Review CHS Policy #201 regarding Area Medical Director’s authority over control of communicable disease in the health districts. • Consult with PMD/TB Clinician, contact the facility/agency, determine the contact person, if indicated. • Elicit epidemiological data from facility/agency or school district representative if applicable. • Determine the onset of symptoms and current status of symptoms of the index case. • Analyze actual/potential for spread of disease. • Assess environmental factors (e.g. indoor, poor ventilation, specific duties, size and location of worksite/classroom). • Determine the impact of the diagnosis on cultural beliefs and psychosocial impact on contacts. • Assess barriers to adherence and medical history.

Tuberculosis (TB) Contact Follow-up: Individual

Standard of Practice	Description	Practice
<p>Planning (Cont.)</p>		<ul style="list-style-type: none"> • Assess the susceptibilities of individual contacts (e.g. high risk factors, age, HIV status, immunocompromising conditions, etc.). • Refer to the Memo: School Contact Investigation (11-9-99), the Los Angeles Unified School District and Tuberculosis Control Procedure for Contact Investigation and Reporting Suspects and Confirmed Cases of TB (Students, Employees and Volunteers Grade K-12 Only) (8-4-99), and General Protocols for Follow up (8-4-99) for follow up of high or low risk contacts in schools. • Classify contact(s) as high or low risk to becoming infected and give follow-up priority to high risk. • Initiate a medical record for high-risk contacts. <p>2. PHN Intervention – Case Finding:</p> <ul style="list-style-type: none"> • Initiate contact follow-up as per TB Contact Investigation Standards in the TB Control Program Manual 2003 (Appendix L). • Explain to the contact that the identity of the index case is confidential. • Administer TST as indicated. • Offer TST and chest x-ray as indicated for worksite and/or Industrial Contact Investigation. • Initiate appropriate forms: H-289 and H-304. <p>3. PHN Intervention – Health Teaching/Counseling:</p> <ul style="list-style-type: none"> • Educate contact regarding the disease process, precautions to prevent spread of disease, necessary follow-up and medication prescribed. • Educate regarding TB infection vs. TB disease.

Tuberculosis (TB) Contact Follow-up: Individual

Standard of Practice	Description	Practice
Planning (Cont.)		<p>4. PHN Intervention - Referral and Follow-up:</p> <ul style="list-style-type: none"> • Refer contact to provider for evaluation and follow-up. • Refer contact to community resources according to identified needs. • If the client was born in Mexico, has family in Mexico or may be visiting there, provide the client the “Cure TB” Binational Referral Program wallet card to facilitate continuity of care in the event of an unplanned trip or move. <p>5. PHN Intervention – Case Management:</p> <ul style="list-style-type: none"> • Maintain desk card on each high-risk contact as determined by Area Nurse Manager. • Document all interventions in the medical record. <p>6. PHN Intervention – Surveillance:</p> <ul style="list-style-type: none"> • Monitor contact adherence to recommended medical treatment and appointments per the TB Control Program Manual page 6-10. <p>7. PHN Intervention – Other:</p> <ul style="list-style-type: none"> • Plan interventions needed to assist case/contact(s) with concerns identified in the PHN Assessment.
Implementation	<p>The public health nurse implements the identified plan by partnering with others.</p> <ul style="list-style-type: none"> • Coordination – The public health nurse coordinates programs, services, and other activities to implement the identified plan. 	<p>1. PHN interventions are implemented as stated in the plan:</p> <ul style="list-style-type: none"> • Disease and Health Event Investigation • Case Finding • Health Teaching/Counseling • Referral and Follow-up • Case Management

Tuberculosis (TB) Contact Follow-up: Individual

Standard of Practice	Description	Practice
Implementation (Cont.)	<ul style="list-style-type: none"> • Health Education and Health Promotion – The public health nurse employs multiple strategies to promote health, prevent disease, and ensure a safe environment for populations. • Consultation – The public health nurse provides consultation to various community groups and officials to facilitate the implementation of programs and services. • Regulatory Activities – The public health nurse identifies, interprets, and implements public health laws, regulations, and policies. 	<ul style="list-style-type: none"> • Surveillance • Other interventions as needed <p>2. Document all consultations, collaborations, interventions, and client/caretaker encounters on the investigation forms, and/or in the medical record/NPMS.</p>
Evaluation	<p>The public health nurse evaluates the health status of the population (all affected by the case).</p> <p>The PHN examines the effectiveness of the interventions, including the need for modification of the interventions in relation to outcomes.</p>	<p>1. Evaluate the effectiveness of the interventions on the health of the contact(s); e.g. document client/caretaker understands the disease process and prevention of transmission:</p> <p>2. Determine and document action for the non-adherent contact:</p> <ul style="list-style-type: none"> • Consult with PHNS and the TB Clinician. <p>3. Complete investigation forms:</p> <ul style="list-style-type: none"> • Submit as follows or within timeframe agreed upon in consultation with PHNS: <ul style="list-style-type: none"> ○ Higher risk contact within public health nurse’s district: submit within 30 days. ○ Lower risk contact within public health nurse’s district: submit within 45 days. ○ Higher risk contact outside of public health nurse’s district: send a copy of the H-289 and the original H-304 to district of residence within 7 days.

Tuberculosis (TB) Contact Follow-up: Individual

Standard of Practice	Description	Practice
<p>Evaluation (Cont.)</p>		<ul style="list-style-type: none"> ○ Lower risk contact outside of public health nurse’s district: send a copy of the H-289 and the original H-304 to district of residence within 14 days. ○ Higher risk contact outside of the jurisdiction of Los Angeles County Public Health: send a copy of the H-289 or Interjurisdictional TB Notification (ITBN) to TB Control Program within 7 days. ○ Lower risk contact outside of the jurisdiction of Los Angeles County Public Health: send a copy of the H-289 or Interjurisdictional TB Notification (ITBN) to the TB Control Program within 14 days. ○ Ensure that H-304 Preventative Treatment Closure is dispositioned and submitted if indicated. <p>4. Document in the NPMS:</p> <ul style="list-style-type: none"> ● File a copy of the PHN Assessment per the PHN Assessment Form instructions. <p>5. Evaluate client satisfaction:</p> <ul style="list-style-type: none"> ● Give client satisfaction form to the contact for completion and submission in a pre-addressed, stamped envelope.

Tuberculosis (TB) Source Case Finding in a Documented Converter

Standard of Practice	Description	Practice
Assessment	<p>The public health nurse collects comprehensive data pertinent to the health status of populations.</p> <p>The most pertinent Healthy People 2010 Leading Health Indicators:</p> <ul style="list-style-type: none"> • Substance Abuse • Responsible Sexual Behavior • Mental Health • Injury and Violence • Immunizations • Environmental Quality • Access to Health Care • Tobacco Use 	<ol style="list-style-type: none"> 1. Review referral documents when received from Public Health Nursing Supervisor (PHNS) and on the Nursing Practice Management system (NPMS). Document Date/Time/Signature on referral when received from PHNS. 2. Analyze report for: <ul style="list-style-type: none"> • Source of referral (if under private provider care, contact provider prior to home visit if contact was not already made by TB Control) • Tuberculin skin test (TST) results and BCG status • Chest X-Ray results • Travel History (i.e. time in the United States) • Medications for latent TB infection • Other medications 3. Assess client/household per PHN Assessment criteria.
Population Diagnosis and Priorities	<p>The public health nurse analyzes the assessment data to determine the population diagnoses and priorities.</p> <p>Analyze the collected assessment data to determine if there is an identified, actual or potential problem.</p>	<ol style="list-style-type: none"> 1. Verify the medical diagnosis and determine priority of action: <ul style="list-style-type: none"> • Review Section/page D7 of the Public Health Nursing Practice Manual and the Source Case/Associate Investigation Standards in the TB Control Program Manual 2003 (Appendix L) for the priority of action or determine priority in consultation with the PHNS as needed. Document priority selected.

Tuberculosis (TB) Source Case Finding in a Documented Converter

Standard of Practice	Description	Practice
Population Diagnosis and Priorities (Cont.)		<ol style="list-style-type: none"> 2. Consider the client’s/household’s/associate’s need for nursing interventions based on the medical diagnosis. 3. Consider the client’s/household’s/associate’s need for nursing intervention to promote health, facilitate well being, foster healing, alleviate suffering and improve quality of life.
Outcomes Identification	<p>The public health nurse identifies expected outcomes for a plan based on population diagnoses and priorities.</p> <p>Outcome Objectives:</p> <ul style="list-style-type: none"> • Prevent the spread of TB within families, communities, health facilities, or other sites. • Client is free of TB disease. • Identify source case(s). 	<ol style="list-style-type: none"> 1. Determine and document specific health needs/goals for client/household/associate situation. <ul style="list-style-type: none"> • Determine appropriate timeline for attainment of the outcomes according to the assessment and diagnoses (TB Control Program Manual 2003 Appendix L).
Planning	<p>The public health nurse develops a plan that reflects best practice by identifying strategies, action plans, and alternatives to attain expected outcomes.</p> <p>Minnesota DHS PHN Section’s Public Health Interventions (PH Interventions) are used to determine the plan (See list of interventions in Section/page A10).</p> <ul style="list-style-type: none"> • Consult and collaborate as needed with: <ul style="list-style-type: none"> ○ Public Health Nurse Supervisor (PHNS) ○ Nurse Manager (as directed by PHNS) ○ Area Medical Director (as directed by PHNS) ○ TB Control (as directed by PHNS) ○ Private/Public Health Laboratory ○ TB Clinician and Clinic Staff ○ Health Care Provider ○ Public Health Investigation (as directed by PHNS) 	<ol style="list-style-type: none"> 1. PHN Intervention – Disease and Health Event Investigation: <ul style="list-style-type: none"> • Review the index case’s history for: <ul style="list-style-type: none"> ○ Symptoms ○ Source ○ Mode of transmission ○ Specific treatment ○ Control measures • Obtain TB educational and resource materials. • Obtain TST supplies, as needed. • Elicit epidemiological data. • Determine probability of adherence. • Determine the impact of the diagnosis on cultural beliefs and psychosocial impact.

Tuberculosis (TB) Source Case Finding in a Documented Converter

Standard of Practice	Description	Practice
Planning (Cont.)	<ul style="list-style-type: none"> ○ Agency where possible exposure occurred. ○ Client/family/household 	<p>2. PHN Intervention – Case Finding:</p> <ul style="list-style-type: none"> • Initiate source case finding per Source Case/Associate Investigation Standards in the TB Control Program Manual 2003 (Appendix L). • Initiate evaluation of client and associates per LTBI guidelines (TB Control Program Manual 2003 page 2-6). • Explain to the associate that the identity of the client is confidential. • Administer TST as indicated. • Refer suspected source case(s) for evaluation/treatment. • Initiate forms: H-289 and H-304. <p>3. PHN Intervention – Health Teaching/Counseling:</p> <ul style="list-style-type: none"> • Educate client/caretaker and associates regarding the disease process, necessary follow-up and medication prescribed. • Provide educational information as needed regarding TB infection vs. disease. <p>4. PHN Intervention – Referral and Follow-up:</p> <ul style="list-style-type: none"> • Refer associates to provider for evaluation and follow-up as needed. • If client was born in Mexico, has a family in Mexico or may be visiting there, provide the client with the “Cure TB” Binational Referral Program Wallet Card to facilitate continuity of care in the event of an unplanned trip or move.

Tuberculosis (TB) Source Case Finding in a Documented Converter

Standard of Practice	Description	Practice
Planning (Cont.)		<p>5. PHN Intervention – Case Management:</p> <ul style="list-style-type: none"> • At discretion of the Area Nurse Manager, the PHN may maintain desk card. • Document all interventions in the medical record. <p>6. PHN Intervention – Surveillance:</p> <ul style="list-style-type: none"> • For clients under county health center supervision, monitor client adherence to recommended medical treatment and appointments per TB Control Program Manual 2003 page 2-12). • For clients under PMD supervision, close to further follow up. <p>7. PHN Intervention – Other: Refer client/household/associates to community resources as needed according to needs identified in the PHN Assessment.</p>
Implementation	<p>The public health nurse implements the identified plan by partnering with others.</p> <ul style="list-style-type: none"> • Coordination – The public health nurse coordinates programs, services, and other activities to implement the identified plan. • Health Education And Health Promotion – The public health nurse employs multiple strategies to promote health, prevent disease, and ensure a safe environment for populations. • Consultation – The public health nurse provides consultation to various community groups and officials to facilitate the implementation of programs and services. 	<p>1. PHN interventions are implemented as stated in the plan:</p> <ul style="list-style-type: none"> • Disease and Health Event Investigation • Case Finding • Health Teaching/Counseling • Referral and Follow-up • Case Management • Surveillance • Other interventions as needed <p>2. Document all consultations, collaborations, interventions, and client/caretaker encounters on the investigation forms and/or in the medical record/NPMS.</p>

Tuberculosis (TB) Source Case Finding in a Documented Converter

Standard of Practice	Description	Practice
Implementation (Cont.)	<ul style="list-style-type: none"> • Regulatory Activities – The public health nurse identifies, interprets, and implements public health laws, regulations, and policies. 	
Evaluation	<p>The public health nurse evaluates the health status of the population (all affected by the case).</p> <ul style="list-style-type: none"> • This is done by examining the effectiveness of the interventions, including the need for modification of the interventions, in relation to outcomes. 	<ol style="list-style-type: none"> 1. Evaluate the effectiveness of the interventions on the health of the client(s); e.g. document client/caretaker understands the difference between TB infection and disease: 2. Determine and document action for the non-adherent client/caretaker: <ul style="list-style-type: none"> • Consult with PHNS. 3. Complete investigation forms: <ul style="list-style-type: none"> • Disposition the H-304 as “closed to PMD”, for clients who will continue with their PMD for medical supervision. • Disposition and submit the H-304 per instructions for clients under county health center supervision. • Complete and submit the H-289 with the dispositioned statistical copies of the H-304s of the associates within 45 days of receipt of the original report or within timeframe agreed upon with the PHNS. • Ensure that H-304 Preventative Treatment Closure copies are dispositioned and submitted, if indicated. • Complete and submit Interjurisdictional TB Notification Form (ITBN), if indicated. 4. Document in the NPMS: <ul style="list-style-type: none"> • File a copy of the PHN Assessment per the PHN Assessment Form instructions.

Tuberculosis (TB) Source Case Finding in a Documented Converter

Standard of Practice	Description	Practice
Evaluation (Cont.)		<p>5. Evaluate client satisfaction:</p> <ul style="list-style-type: none"> • Give client satisfaction form to client or client’s caregiver for completion and submission in a pre-addressed, stamped envelope.

**Acute Communicable Disease:
Per Acute Communicable Disease Control Manual (B-73) 4-04**

Priority I – Immediate (upon receipt of report):

- | | |
|---------------------------|---|
| 1. Anthrax | 7. Q Fever (Query Fever) (with clustering occurs) |
| 2. Botulism | 8. Relapsing Fever (louse-borne, tick-borne) |
| 3. Cholera | 9. Smallpox |
| 4. Diphtheria | 10. Tularemia |
| 5. Hepatitis B, Perinatal | 11. Yellow Fever |
| 6. Plague | 12. Others as indicated by Chief, ACDC |

Day of the Report (before end of business day):

- | | |
|---|---------------------------------------|
| 1. Haemophilus influenzae, invasive disease | 3. Poliomyelitis |
| 2. Meningococcal Infections | 4. Others as indicated by Chief, ACDC |

Priority II – Within 24 Hours of Report:

- | | |
|---|--|
| 1. Amebiasis* | 12. Paratyphoid Fever* |
| 2. Campylobacteriosis* | 13. Salmonellosis* |
| 3. Cryptosporidiosis* | 14. Shigellosis* |
| 4. Foodborne Disease (priority IV if reported late) | 15. Typhoid Case/Carrier* |
| 5. Hepatitis A* | 16. Yersiniosis (to determine if SOS otherwise no routine investigation) |
| 6. Dengue | 17. Ringworm of Scalp-outbreaks |
| 7. Diarrhea of the Newborn (outbreaks only) | 18. Scabies-outbreaks |
| 8. Escherichia-Coli O157:H7 and Hemolytic Uremic Syndrome | 19. Staphylococcal Infections-outbreaks (institutions only) |
| 9. Gastroenteritis, Viral-outbreaks | 20. Streptococcal Infections, group A and Streptococcal Toxic Shock Syndrome (food handlers, dairy workers, outbreaks) |
| 10. Measles (Rubeola) | 21. Trichinosis |
| 11. Pertussis | 22. Others as indicated by Chief, ACDC |

**Contact to ascertain if Sensitive Occupation/Situation (SOS); if not follow up as Priority IV.*

**Acute Communicable Disease:
Per Acute Communicable Disease Control Manual (B-73) (4-04)**

Priority III – None

Priority IV – Within 3 Days of Report:

1. Cysticercosis
2. Encephalitis, Arboviral
3. Enteric infections (no sensitive occupation/situation)
 - A. Amebiasis
 - B. Campylobacteriosis
 - C. Cryptosporidiosis
 - D. Hepatitis A
 - E. Paratyphoid Fever
 - F. Salmonellosis
 - G. Shigellosis
 - H. Typhoid Case/Carrier
4. Foodborne Disease (if reported late)
5. Giardiasis (SOS and outbreaks only)
6. Hepatitis B (acute cases only)
7. Hepatitis C
8. Listeriosis
9. Meningitis, Viral-outbreaks
10. Typhus, Flea-borne (murine typhus, endemic typhus)
11. Others as indicated by Chief, ACDC

Priority V – Within 4 Days of Report:

1. Mumps-outbreaks

Priority VI – Within 7 Days of Report:

1. Brucellosis
2. Coccidiomycosis
3. Leptospirosis
4. Q Fever (Query Fever)
5. Rocky Mountain Spotted Fever
6. Rubella, Acute or Postnatal
7. Rubella, Congenital
8. Tetanus
9. Toxoplasmosis (Congenital only)
10. Others as indicated by Chief, ACDC

Priority VII – Within 14 Days of Report:

1. Leprosy (Hansen's Disease)

Always consult the Acute Communicable Disease Control Manual (B-73) prior to action. Determine the priority for follow up of any disease or condition not listed here in consultation with PHN supervision with advice from the Area Medical Director and the ACDC Program Staff.

Lead Poisoning:

Per Matrix: Management Guidelines for Childhood Lead Exposure by Blood Lead Level Protocol (6-1-05)

Priority I, II, III, IV, V, VI - None

Priority VII - Within 14 Days of Report:

1. Two blood lead levels from 14.5 mcg/dl to 19.4 mcg/dl drawn at least 30 days and no more than 600 days apart in a child.

Newborn Screening: per Maternal Child and Adolescent Health Program Newborn Screening Coordinator

Priority I, II – None

Priority III – Within 2 Days of Report:

1. Newborns whose initial newborn screening blood test is presumed positive, missed or inadequate and the Newborn Screening Area Service Center was unable to contact the mother.

Sexually Transmitted Diseases: Per Sexually Transmitted Disease Program Nursing Unit

Priority I – On Day of Report:

1. Child under 14 years with syphilis, gonorrhea, Chlamydia, and PID (suspect child sexual abuse).
2. Newborn with gonorrhea/Chlamydia conjunctivitis.

Priority II – Within 24 Hours of Report: none

Priority III – Within 2 Days of Report: none

Priority IV – Within 3 Days of Report:

1. Pregnant/postpartum (up to six weeks) women with syphilis, Chlamydia, or gonorrhea.
2. Pregnant women with pelvic inflammatory disease or HIV.
3. Infants whose mothers were diagnosed with Chlamydia or gonorrhea at delivery.
4. Mothers whose infants were diagnosed with Chlamydia or gonorrhea.
5. Infants with suspected congenital syphilis in need of evaluation and treatment

Priority V – Within 7 Days of Report:

1. Interview record for investigation/referral of partners for syphilis, gonorrhea or Chlamydia.

Consult with Sexually Transmitted Disease Procedure Manual, Centers for Disease Control and Prevention STD Treatment Guidelines for additional information prior to action. Determine the priority for follow up of any disease or condition not listed here in consultation with PHN supervision with advice from the STD Clinician, Area Medical Director, and the STD Program Nursing Unit.

Sudden Infant Death Syndrome: Per Health and Safety Code California State Law (Statute 1991; Chapter 268)

Priority I, II, III – None

Priority IV – Within 3 Days (72 Hours) of Report:

1. The family or primary caregiver of all presumptive Sudden Infant Death Syndrome cases will be contacted by a PHN in person, by telephone, or by mail.

Tuberculosis: Per Tuberculosis Control Program April 2003

Priority I - None

Priority II - Within 24 Hours of Report:

1. Client who has a positive sputum smear for AFB, abnormal chest x-ray and/or signs and symptoms of communicable tuberculosis Class 5 receiving or not receiving anti-tuberculosis medications.
2. Newly diagnosed Class 3 (positive culture MTBC) not receiving anti-tuberculosis medication.
3. Client who has communicable tuberculosis (Class 3) or communicable tuberculosis suspect (Class 5) and has left the hospital against medical advice from a health care institution, i.e., hospital (follow up to be coordinated with PHI).
4. Client who misses a DOT dose.

Priority III - Within 2 Days of Report:

1. Client who has an urgent suspect radiograph (Class 5) and no clinical assessment has been done.
2. Client who has a smear positive for AFB (Class 5) and/or culture positive for MTBC (Class 3) who has broken a clinic appointment.
3. All TB Class 3 & 5 patients who break their MD/ERN appointments.

Priority IV - Within 3 Days of Report:

1. Newly diagnosed Class 3 or Class 5 who is HIV positive.
2. Newly diagnosed Class 3 or Class 5 who is less than 6 years of age.
3. Newly diagnosed Class 3 who is multidrug resistant (INH and Rifampin).
4. Client who is hospitalized and has a positive sputum smear for AFB requiring a report of home situation.
5. Contact investigation for a newly diagnosed Class 3 or Class 5 who is assessed as higher risk to transmit.

Priority V - Within 7 Days of Report:

1. Newly diagnosed Class 3 or Class 5 who is not included in the above priorities including Alien Referral Class B1).
2. Contact investigation for a newly diagnosed Class 3 or Class 5 who is assessed as lower risk to transmit.
3. Client who is receiving treatment for latent tuberculosis infection (LTBI) for a high-risk medical condition and breaks a clinic appointment.
4. High-risk contact who breaks an appointment for the initial examination.
5. Documented converter who breaks an appointment.

Priority VI - Within 14 Days of Report:

1. Class 5 – Alien Referral Class B2.
2. Source Case Finding for documented converters under the age of 4.
3. Source Case Finding for the age 4 and above, if resources allow and a reasonable probability of finding the source.

Always consult the Tuberculosis Control Program Manual prior to action. Consult with PHN supervision with advice from the Area Medical Director, TB Clinic clinician and the TB Program Staff if there are questions about the priority of action.

Guidance for the Public Health Nursing Assessment*

Topic	Guidance
Family Unit	<ul style="list-style-type: none"> • Complete a separate PHN Assessment for each “family”. A “family is an individual or group of individuals who live under the same roof or on the same property and who consider themselves a “family” or who act as a “family”. In determining who is a family member, the PHN should consider the extent to which the members share physical facilities and the extent to which they are psychosocially and financially interdependent. • The PHN uses professional judgment in making the determination of “family”. If a visitor to the household is not considered part of the family unit, do not include the visitor on the assessment form. Document services provided to a visitor on a progress note and file in the “one visit” file.
Who is Assessed?	<ul style="list-style-type: none"> • The PHN should attempt to do an assessment for each member even if the member is absent using nursing judgment. History may be obtained from another household member and documented for a household member. The PHN should document who is providing the history for a given client. If a specific item can not be assessed because the assessment is being conducted outside of the home (office/clinic, telephone, or other), leave section blank and write an explanation in the comments section at the bottom of the page. If client does not want to answer a specific question, mark delined. • Every attempt should be made to do a home visit on every referral in order to do a complete assessment. Completing the assessment entirely on the phone is not acceptable if the client is willing to have a home visit. Every referral should generate a PHN Assessment except if the case is closed, transferred, inaccessible to the nurse (such as in jail), or returned to referral source before the PHN makes contact with the client. • If the nurse makes contact with the client but is unable to do an assessment, she/he will go to the encounter/disposition tab in the NPMS and mark “closed” under the disposition section indicating the reason that is applicable.
FV (Family Violence)	<ul style="list-style-type: none"> • Ask any member who is age 12 or over if there are any concerns about family violence. Check “no” or “yes” as appropriate. If you suspect there may be a problem based on your observation and assessment, check “susp”. The nurse can assess children age 11 or under according to her/his judgment. The nurse can ask the child separately, apart from other household members according to her/his judgment. The nurse can use the following questions at her/his discretion to assess an individual based on professional judgment at the time of assessment. • Start with these statements “Family violence is a common problem. Statistics show that every 3 minutes a woman is battered. Preventing injury and violence is one of the ten high priority public health issues in the United States”, then ask: <ul style="list-style-type: none"> ◦ Has this problem touched your life in any way? How so? ◦ Have you ever called 911 for help? Have you had to ask for help from the police or neighbors? ◦ Have you been hit, kicked, punched, or otherwise hurt by someone in the past year?

*See NPMS manual for detailed instructions on completing the PHN Assessment module.

Guidance for the Public Health Nursing Assessment*

Topic	Guidance
<p>FV (Family Violence) (Cont'd)</p>	<ul style="list-style-type: none"> ◦ Have you experienced physical violence in the past year? ◦ Do you feel safe in your current relationship? ◦ Is there a partner from a previous relationship who is making you feel unsafe now? • A “yes” answer to any one of these questions indicates a high risk for future abuse and indicates that the individual should be counseled and referred for family violence assistance. Public health nurses do not provide “medical services for a physical condition coming within the definition of a suspicious injury.” PHNs are required to make a mandated written suspicious injury report to local police if they observe an act of violence or if the client discloses that the STD for which she/he is being treated is the result of a sexual assault.
<p>Healthy Habits</p>	<ul style="list-style-type: none"> • Ask the member or parent questions about whether he/she has a healthy diet (for adults, 3 cups of milk per day, 6 ounces of protein per day, 2 ½ cups of vegetables per day, 2 cups of fruit per day, at least 3 ounces of whole grains, minimal use of unhealthy fats, oils, and sweets). The nurse can assess children age 11 or under according to her/his judgment. The nurse can ask the child separately, apart from other household members according to her/his judgment. • Ask the member or parent if he/she engages in physical activity/exercises at least 30 minutes a day, most days of the week. The nurse can assess children age 11 or under according to her/his judgment. The nurse can ask the child separately, apart from other household members according to her/his judgment. • Ask the member or parent if he/she smokes, uses drugs and/or alcohol. The nurse can assess children ages 11 or under according to her/his judgment. The nurse can ask the child separately, apart from other household members according to her/his judgment. • Ask the member about safer sexual practices (uses barrier protection if in a non monogamous relationship, limits number of partners, no sharing of personal sex items). The nurse can assess children age 11 or under according to her/his judgment. The nurse can ask the child separately, apart from other household members according to her/his judgment. • Add additional comments in the text box provided if desired.

*See NPMS manual for detailed instructions on completing the PHN Assessment module

Guidance for the Public Health Nursing Assessment*

Topic	Guidance
Industry or Outbreak	For those individuals who are screened in an industry/group and not transferred to the district of residence (DOR) for follow-up, there is no requirement that they automatically receive a PHN Assessment by the DOR. The PHN in charge of the industry follow-up makes a case-by-case referral to the DOR of any contact who, in her/his judgment, is in need of and could benefit from a complete PHN Assessment of contact and household. In such a case, the PHN in charge of the industry writes a progress note to refer to the DOR explaining the reason for the referral and why a PHN Assessment is warranted. The PHN of the DOR of the contact will initiate a PHN Assessment and note in the comments section on the intake page in NPMS the PF # and location of the medical record of the index client, if there is one.
Plan	List the Health Need/Goals that the PHN assessed. These may be those that the PHN identifies, those that the member identifies or those that the PHN identifies jointly with the member. Each problem identified in the assessment should have a health need/goal listed.
Action/Intervention	For each health need/goal identified, check off the action/intervention given to the family and check off where the member(s) was referred as appropriate. Document follow-up of an action/intervention (referral) in the Plan (health need/goal) section on subsequent encounters. Check “other” and write in any other referrals made that are not on the list.
Anticipatory Guidance	Check off any anticipatory guidance that the PHN gave to the family. Use this section to document advice that the PHN gave not related to a health need/goal identified in the assessment . For example, if the members all have a healthy diet but the PHN still reinforces the importance of folic acid or healthy diet choices with the family, the PHN would check it off here. Or if a member is pregnant and the PHN wants to advise about bottle caries, the PHN would check it off here. Write in the comments section any additional comments about the plan for this family.
Disposition	See NPMS Manual Section Encounter/Disposition Part 2 # 3 for additional information. If a client/family requires more than four (4) encounters to assist with the identified health goals/needs (not related to the original referral), close Level 2 in NPMS and enter the date and purpose of the next encounter in the text box. Open a medical record, print a copy of the PHN Assessment and place the Assessment in the Miscellaneous section of the chart. Continue to document in the medical record progress notes utilizing the SOAP format.
Printing and Filing	Print and file a copy of the PHN Assessment in a local health center/program file per the health center/program procedure. If the index case or any household members have a chart, put one copy in the miscellaneous section of each chart.

*See NPMS manual for detailed instructions on completing the PHN Assessment module

PHN ASSESSMENT FORM

Date Form Initiated _____ SPA _____ District _____ Program _____ CT _____
 Client's Last/First Name _____ AKA Last/First Name _____
 Telephone _____ Home Work Other _____
 Address _____ City _____ Zip _____
 Ethnicity/Race _____ Language _____
 Source of Referral: Disease Control Health Line Other _____
 Referral Type ACD TB STD OB-HCF OB-GENL _____
 LEAD SIDS ABUSE OTHER _____

PHN ASSESSMENT

Family Member	Primary Care Health Coverage	Family Violence	Safety	Immunization	Healthy Habits
# _____ <input type="checkbox"/> Declined _____ DOB _____ <input type="checkbox"/> self <input type="checkbox"/> other _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Pregnant EDD _____ <input type="checkbox"/> Diabetic <input type="checkbox"/> Asthma <input type="checkbox"/> Mental Health Concern Date _____	Primary Provider <input type="checkbox"/> No <input type="checkbox"/> Yes Health Coverage <input type="checkbox"/> No <input type="checkbox"/> Yes Type _____ Needs Dental Care? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Susp <input type="checkbox"/> Declined	Hazard <input type="checkbox"/> None <input type="checkbox"/> Yes _____ _____ <input type="checkbox"/> Declined	Up-to-date <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure _____ <input type="checkbox"/> verified <input type="checkbox"/> by history <input type="checkbox"/> Declined	Healthy diet? <input type="checkbox"/> No <input type="checkbox"/> Yes Exercises? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NA Smokes/Chem. <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NA Dependency? Safer Sex <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NA Practices? <input type="checkbox"/> Declined
# _____ <input type="checkbox"/> Declined _____ DOB _____ <input type="checkbox"/> self <input type="checkbox"/> other _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Pregnant EDD _____ <input type="checkbox"/> Diabetic <input type="checkbox"/> Asthma <input type="checkbox"/> Mental Health Concern Date _____	Primary Provider <input type="checkbox"/> No <input type="checkbox"/> Yes Health Coverage <input type="checkbox"/> No <input type="checkbox"/> Yes Type _____ Needs Dental Care? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Susp <input type="checkbox"/> Declined	Hazard <input type="checkbox"/> None <input type="checkbox"/> Yes _____ _____ <input type="checkbox"/> Declined	Up-to-date <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure _____ <input type="checkbox"/> verified <input type="checkbox"/> by history <input type="checkbox"/> Declined	Healthy diet? <input type="checkbox"/> No <input type="checkbox"/> Yes Exercises? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NA Smokes/Chem. <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NA Dependency? Safer Sex <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NA Practices? <input type="checkbox"/> Declined
# _____ <input type="checkbox"/> Declined _____ DOB _____ <input type="checkbox"/> self <input type="checkbox"/> other _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Pregnant EDD _____ <input type="checkbox"/> Diabetic <input type="checkbox"/> Asthma <input type="checkbox"/> Mental Health Concern Date _____	Primary Provider <input type="checkbox"/> No <input type="checkbox"/> Yes Health Coverage <input type="checkbox"/> No <input type="checkbox"/> Yes Type _____ Needs Dental Care? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Susp <input type="checkbox"/> Declined	Hazard <input type="checkbox"/> None <input type="checkbox"/> Yes _____ _____ <input type="checkbox"/> Declined	Up-to-date <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure _____ <input type="checkbox"/> verified <input type="checkbox"/> by history <input type="checkbox"/> Declined	Healthy diet? <input type="checkbox"/> No <input type="checkbox"/> Yes Exercises? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NA Smokes/Chem. <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NA Dependency? Safer Sex <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NA Practices? <input type="checkbox"/> Declined
# _____ <input type="checkbox"/> Declined _____ DOB _____ <input type="checkbox"/> self <input type="checkbox"/> other _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Pregnant EDD _____ <input type="checkbox"/> Diabetic <input type="checkbox"/> Asthma <input type="checkbox"/> Mental Health Concern Date _____	Primary Provider <input type="checkbox"/> No <input type="checkbox"/> Yes Health Coverage <input type="checkbox"/> No <input type="checkbox"/> Yes Type _____ Needs Dental Care? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Susp <input type="checkbox"/> Declined	Hazard <input type="checkbox"/> None <input type="checkbox"/> Yes _____ _____ <input type="checkbox"/> Declined	Up-to-date <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure _____ <input type="checkbox"/> verified <input type="checkbox"/> by history <input type="checkbox"/> Declined	Healthy diet? <input type="checkbox"/> No <input type="checkbox"/> Yes Exercises? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NA Smokes/Chem. <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NA Dependency? Safer Sex <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NA Practices? <input type="checkbox"/> Declined

Comments _____

Encounter (circle) 1 2 3 4 date ____ Home Office Telephone Other

PLAN

Health Need/Goal: _____
 Health Need/Goal: _____
 Health Need/Goal: _____
 Health Need/Goal: _____

ACTION/INTERVENTION given:

<input type="checkbox"/> Breastfeeding	<input type="checkbox"/> Day Care	<input type="checkbox"/> Family Planning	<input type="checkbox"/> Parenting Class	<input type="checkbox"/> Safer Sex Practice
<input type="checkbox"/> Building & Safety	<input type="checkbox"/> DCFS	<input type="checkbox"/> Food	<input type="checkbox"/> PCG	<input type="checkbox"/> Shelter/Housing
<input type="checkbox"/> CCS	<input type="checkbox"/> Dental Care	<input type="checkbox"/> Immunization	<input type="checkbox"/> Ped. Primary Care	<input type="checkbox"/> Smoking Cessation
<input type="checkbox"/> CHDP	<input type="checkbox"/> DPSS	<input type="checkbox"/> Legal Aid	<input type="checkbox"/> Physical Activity	<input type="checkbox"/> Transportation
<input type="checkbox"/> Clothing	<input type="checkbox"/> Drug/ETOH Tx	<input type="checkbox"/> NFP	<input type="checkbox"/> Prenatal Care	<input type="checkbox"/> Vision Care
<input type="checkbox"/> Comm. Disease	<input type="checkbox"/> Environ. Health	<input type="checkbox"/> Nutrition Counseling	<input type="checkbox"/> Regional Center	<input type="checkbox"/> WIC

Counseling/Mental Health referral: _____
 Family Violence referral: _____
 Healthy Families worker at _____ Medi-Cal worker at _____
 Medical Care at _____ Public Health Clinic at _____
 Other _____

Anticipatory Guidance Given About:

<input type="checkbox"/> Back to Sleep	<input type="checkbox"/> Bottle Caries	<input type="checkbox"/> Physical Activity	<input type="checkbox"/> Folic Acid	<input type="checkbox"/> Nutrition Counseling
<input type="checkbox"/> Immunization	<input type="checkbox"/> Pre-Conception Counseling	<input type="checkbox"/> Safer Sex Practices	<input type="checkbox"/> Safety/Injury Prevention	<input type="checkbox"/> Smoking/Chem. Dep.
<input type="checkbox"/> Other _____				

Nutrition/ Physical Activity Counseling/Referral:

Time: _____
 Comments _____

Comments _____

DISPOSITION

On-going Level 1 intervention; next contact (date/purpose) _____

Close--Level 1
 Level 2 intervention needed; next contact (date/purpose) _____

Close Individual/Family declines further service UTL other reason _____

Close moved within LA County jurisdiction (complete transfer section below) moved outside LA County jurisdiction
 Transfer to _____

Client Satisfaction form given: yes no

PHN (print) _____

PHN (sign) _____ Date _____

(For Closure Only)

PHNS (print) _____

PHNS (sign) _____ Date _____

Guidance for Consumer/Community Service*

Topic	Guidance
<p>Purpose</p>	<p>Consumer/community service in the NPMS documents the service provided by the PHN at the community and systems levels of practice. The following are examples of interventions/activities that are documented:</p> <ul style="list-style-type: none"> • Telephone calls and office visits • Field services to consumers and community agencies such as consultation, group education, community settings, advising consumers over the phone • Outreach • Acute Communicable Disease Outbreaks and follow-up with Tuberculosis worksite/industries • Activities related to fulfilling the requirements of grants such as nutrition-related and emergency preparedness • Collaboration with other public health disciplines and between districts and programs are documented. <p><u>Definition of collaboration:</u> Collaboration commits two or more persons or organizations to achieving a common goal through enhancing the capacity of one or more of them to promote and protect health (from Public health interventions: Applications for public health nursing practice, Minnesota Department of Health, Division of Community Health Services, Public Health Nursing Section, 2001).</p>
<p>Time Spent</p>	<p>If more than one PHN participates in providing a service, use the following example to record the time spent:</p> <p>Example: Three PHNs provide a group education class to a group of high school students. The service requires each PHN to spend one (1) hour in preparation. Travel time was 30 minutes round trip to the schools, and the PHNs spent two (2) hours giving the class. The coordinator or lead PHN would combine the preparation hours from all three PHNs and document in NPMS as follows:</p> <p style="text-align: center;">Preparation: 3 hours Participation: 2 hours Travel: 30 minutes</p>
<p>Printing</p>	<p>Print the Consumer/Community Service Form per the health center/program procedure.</p>

*See NPMS manual for detailed instructions on completing the Consumer/Community Service module.

PHN Consumer/Community Service Form

PHN(s) _____

Date _____

District _____

Individual/Agency _____

Telephone _____

Address _____

Apt.# _____

Zip _____

Census Tract _____

Fax _____

City _____

Name of Person who called (if agency) _____

Source of request

- Board of Supervisor
- Business
- County Agency
- Drug/Alcohol Treatment Program
- Individual
- Mental Health Provider
- PH Mandate
- Place of worship
- Police
- Private Health Care Provider/Clinic
- Regional Center
- School
- Senior Program
- Shelter provider
- WIC
- Youth program
- Other

Role of PHN

- Chair of Meeting
- Chair of Organization
- Member of Group
- Provided Consultation
- Public Speaking/Health Education to a group (# of staff/employees + # of others = (total))
- CD outbreak investigation(# of persons investigated[# on line listing])

Site of service

- At Community Event
- PHN Office
- On site at Agency
- Telephone
- Other

Number of PHNs who participated

- myself alone
- myself and other PHNs

Collaboration with other PH disciplines

- Environmental Health
- Health education
- Nutrition
- PHI
- Epi Analyst
- Medicine
- None

Collaboration with other PH programs

- ACD
- Immunization
- TB control
- None
- Health Facilities
- Other

Referral/Information/Education/Consultation Provided about

- Access to Primary care
- Dental Care
- Health Care Coverage
- Public Health Goals
- Transportation
- Agency Policies/Procedures
- Diabetes
- Immunization
- Safer Sex Practice
- Welfare Program
- Alcohol/Chem.Dependency
- Legal Aid
- Safety and Injury Prevention
- WIC
- Asthma
- Environmental Health
- Mental Health Concern
- Senior Care
- Other
- Chronic Disease (not asthma or diabetes)
- PH Policies/Procedures
- Shelter/Housing
- Communicable Disease
- Family Planning
- Pregnancy
- Smoking

Time Spent

Preparation: _____ hour(s) _____ min(s) Participation: _____ hour(s) _____ min(s) Travel: _____ hour(s) _____ min(s)

Nutrition Counseling Physical Activity

Type of Activity

Nutrition Promotion/Marketing Nutrition Education at Special Events Staff Training/Professional Development

Nutrition Education in a Classroom Setting

Time Spent on Nutrition/Physical Activity Counseling/Referral _____ hour(s) _____ min(s)

Comments: _____

Instructions for PHN TB Class 3/5 Assessment Form

Topic	Guidance
General Instructions	<ol style="list-style-type: none"> 1. The assessment is to be completed for all TB 3 and TB 5 clients placed on 2 or more TB drugs. <ol style="list-style-type: none"> a. If the TB 5 client is not placed on TB medications (i.e. Alien Referral), use the PHN TB 3 or TB 5 Assessment form page 1 and the PHN Assessment form. b. If the client becomes a TB 3, complete the remaining pages of the PHN TB 3 or TB 5 Assessment form. Applicable information may be transferred from the PHN Assessment form. 2. The assessment may be completed during several client contacts according to priority of information needed. The form should be completed within 1-2 months of initial referral depending on client variables (i.e., accessibility, cooperation). If more time is needed, PHN should confer with PHNS. 3. Date and initial each entry as completed. Initial, print and sign name at the bottom of each page. More than one PHN may initial and sign. 4. The comment section at the bottom of each page is to be used as needed. 5. Imprint each page (bottom right) with the client’s addressograph. 6. The assessment is attached to the chart under the miscellaneous section and is to replace the progress notes in documenting the initial client assessment.
Subjective	<ol style="list-style-type: none"> 1. Presenting symptoms: Indicate onset/date and duration/frequency and characteristics on symptoms checked “yes”. 2. Medical History and Past TB History: If history of hepatitis/liver disease, specify type, i.e., Hepatitis A, B, C or type of liver disease. Review of Systems – Define the problem in the remarks, i.e., diabetes – IDDM or NIDDM well or poorly controlled; GI disease, i.e., gastric ulcers, Crohn’s Disease, ileostomy; respiratory, i.e., COPD, asthma, etc. 3. Dental: Define the problem requiring care, i.e., due for exam, poor dental hygiene/caries, denture problems, mouth odor, etc. 4. Nutritional Status: Weight changes – Complete information. (May refer back to symptom/ onset info) Appetite – Complete information. (May refer back to symptom/ onset info) Review basic food groups with the client. Comments on problems found.

Instructions for PHN TB Class 3/5 Assessment Form

Topic	Guidance
<p>Subjective (Cont.)</p>	<p>5. Sexual History:</p> <ul style="list-style-type: none"> a. Contraception used – Condom, vasectomy, tubal ligation, BC pills, etc. b. Use “N/A” if client is post-menopausal, has had hysterectomy, had permanent BC method such as tubal ligation or partner with vasectomy. Indicate in the blank space the applicable reason. c. Use “None” if client is of child bearing age but not using birth control method. d. Use “Interested” if the client is not using a BC method but wishes info. e. Comments: Male – Does self-breast and testicular exam? Female – Does self-breast exam? Other issues – i.e., Transgender, transvestite, etc. f. May go to “Preventive Health Measures” if appropriate (i.e. Discussion re: preventive measures have evolved during information gathering), to address sexual activities and safer sex practices. <p>6. Psychosocial:</p> <ul style="list-style-type: none"> g. It is important to assess language proficiency to determine the need for an interpreter and to choose appropriate literature. h. Use the comments section to elaborate on any problems elicited. i. For primary care provider, list name, address and phone of provider in comments section. j. Specify living situation / arrangement by checking the appropriate box. k. Length of time at current residence: If less than 6 months, list previous living arrangement, # living in home now, and in the past 6 months including frequent daytime, evening or overnight visitors in the past 2 to 4 months. <p>7. Preventive Health Measures:</p> <ul style="list-style-type: none"> l. This section is designed per the PHN Assessment Form. When completing the PHN Assessment Form, information about the index client can be obtained for inclusion on the PHN Assessment form. m. The PHN may wish to address sexual activity and safer sex practices at this time from a preventive health approach. Use the comments section to elaborate on problems. <p>8. Adherence/Compliance:</p> <ul style="list-style-type: none"> n. It is important to get feedback from the client regarding her/his understanding and acceptance of the diagnosis. It may take 2 or more visits before the client truly understands and accepts her/his TB diagnosis and is willing to adhere to the medical and nursing regimen.

Instructions for PHN TB Class 3/5 Assessment Form

Topic	Guidance
Subjective (Cont.)	<p>9. Work exposure:</p> <ul style="list-style-type: none"> a. Discussion about contacts may lead to other questions depending on the individual client. b. In the subjective section the information is given by the client. In the objective section, the information is obtained by site visit and evaluation which may be done by a PHN in another district. <p>10. School Exposure: (See #9 above)</p> <p>11. Family/Non-Family Contacts: Obtain as much information as possible re: the index client contacts using sections 9-10 as a guide.</p>
Objective	<p>1. Lab and X Ray – Studies:</p> <ul style="list-style-type: none"> a. If information is already listed on other forms/documents in the client’s medical record such as CMR, H290, H1365, H1397, hospital discharge summary, list the forms/documents on the line “see _____”. b. If the information cannot be found elsewhere in the record, check all appropriated boxes. Write in date and test results for TST, CXR, laboratory results and drug resistance / sensitivities. <p>2. Medication:</p> <ul style="list-style-type: none"> a. Check appropriate box for DOT. b. Initial Regimen: List names of medications the client was initially started on and the start date, dosage, route and frequency. Start date is the first date the client was prescribed TB medication from any source. c. Current TB Regimen: List names of TB medications that the client is currently on including their start date, dosage, route, and frequency. d. Number of Pills/Capsules On Hand: Count pills/capsules in each individual container and write number of pills/capsules in the # pills/caps on hand section. Use the comment section under “correct pill count” to assess and elaborate on any problem/incorrect count. List all other current medications and dosages (prescribed, street drugs, over-the-counter, herbal). <p>3. Physical:</p> <p>Physical Appearance: Is client thin, obese, pale, ambulatory, amputee, etc?</p> <p>Cough: Is client coughing during visit? Characteristics of cough?</p> <p>Affect: Is client cooperative, friendly, hostile, confused, responds appropriately, receptive of visit, evasive?</p>

Instructions for PHN TB Class 3/5 Assessment Form

Topic	Guidance
Objective (Cont.)	<p>4. Home situation:</p> <p>a. Describe:</p> <ul style="list-style-type: none"> ◦ Sleeping arrangement: Such as shared bed/room, open/small, closed space. ◦ Ventilation (type of ventilation): Such as open windows, forced air ventilation. ◦ Neighborhood: Such as dense/multi-unit apartment, single-family dwelling, boarded-up building/homes. <p>b. Comments: Add any information that may be pertinent to this case.</p> <p>5. Work/ School site:</p> <p>a. The objective information may differ from the subjective information obtained from the client’s history. If the work/school sites will not receive contact investigation enter “N/A”. If the work/school investigation is to be done in another district, check referred to district and fill in “Name and CT”. It is not necessary for the referred district to report back to the DPHN of the district re: the industry follow-up. If the industry is in the DOR of the index case district, work/school site objective information should be entered on the form by the PHN(s) of the DOR.</p> <p>b. Describe:</p> <ul style="list-style-type: none"> ◦ Work / School e.g., elementary school, continuing education school, office, factory, etc. and # of students/employees at site. ◦ School/work space: describe work space/classrooms – indoor/outdoors, opened/closed, small/spacious, proximity to others, etc. ◦ Ventilation: open windows, forced air ventilation, available sunlight indoors. ◦ Lunch/break area: indoor/outdoors, opened/closed, small/spacious, open window, air conditioning, etc. ◦ Personal class space or workstation: indoor/outdoor, opened/closed, small/spacious, open window, proximity to others. ◦ Comments: Add any information that may be pertinent to this case.

Instructions for PHN TB Class 3/5 Assessment Form

Topic	Guidance
Assessment	<ol style="list-style-type: none"> 1. Check a proper box as indicated. Refer back to initial referral. <u>Note:</u> Please list site(s) of disease. 2. Review PHN Practice Manual for priority. 3. Check box to indicate risk of transmission by the client. 4. Check whether or not home isolation is indicated. 5.-15. Self explanatory. 16. Indicate health needs as they arise: i.e. need for food vouchers, transportation, or any needs related to the client’s health.
Plan	<ol style="list-style-type: none"> 1. Date H290 registration is submitted/initial of person submitting H290 registration. 2. If applicable, date that H304 of client is submitted/initial of person submitting H304. 3. Date H289/ interview of index re: contact(s) initiated/initial of person initiating H289. 4. If H289 initiated, date H304(s) for contact(s) initiated/initial of person initiating H304(s). 5. If applicable, date H289 and H304(s) of out-of-district contact(s) referred to district of resident/initial of person referring out-of-district contact(s). 6. Date H289 and dispositioned H304(s) submitted/initial of person submitting H289 and dispositioned H304(s). 7. Date H290 confirmation or H513 closure submitted/initial of person submitting H290 confirmation or H513 closure. Indicate reason for closure in space provided. 8. If applicable, date work/school contact follow-up initiated/initial of person initiating work/school contact follow-up. If work/school out-of-district, name of district referred to. 9. Date education provided/initial of person providing education. Education is to be provided verbally and in writing per TB Program guidelines. 10. Date education re: communicability and transmission prevention techniques provided/initial of person providing the education. 11. If applicable, date education re: home isolation provided/initial of person providing home isolation education. Explain to client reason for home isolation, specific precautions he/she needs to take, consequences to self and public if not followed, and who will inform client when he/she no longer requires home isolation.

Instructions for PHN TB Class 3/5 Assessment Form

Topic	Guidance
Plan (Cont.)	<ol style="list-style-type: none"> 12. Date TB medications reviewed with client and family (if any)/initial of person providing TB meds review. 13. Date side effects of TB meds reviewed with client and family (if any)/initial of person reviewing TB meds side effects. Instructions about whom to call if client experiences problems to be provided verbally and in writing- write name/phone number provided. 14. Date importance of adherence to TB regimen and consequences of non-adherence explained to client and family/ initial of person providing adherence education. Clarify consequences, for example, PHI may be involved or MDR may develop. 15. Date instructions regarding where to call if unable to keep appointment provided/initial of person providing instructions. 16. Check referrals provided, date referrals provided, and initial of person providing referrals. 17. After initial contact, provide information regarding next TB follow-up appointment- date/initial of person writing-in information. 18. Write-in any other plan and date and initial.
End of each page	<ol style="list-style-type: none"> 1. At bottom of each page, initial/print name/signature of PHNs who completed the form. If more than one PHN was involved, all must sign. 2. Place client's addressograph in bottom right corner.

PHN TB CLASS 3/5 ASSESSMENT FORM

Date received in District: _____

Type of Referral: _____

<i>SUBJECTIVE</i>	Date/ Initial																
<p>¹Presenting symptoms: _____ <input type="checkbox"/> symptomatic for TB <input type="checkbox"/> asymptomatic for TB</p> <p>INDICATE ONSET/ DATE AND DURATION/ FREQUENCY AND CHARACTERISTICS:</p> <p>Cough <input type="checkbox"/> no <input type="checkbox"/> yes _____</p> <p>Productive cough <input type="checkbox"/> no <input type="checkbox"/> yes _____</p> <p>Hemoptysis <input type="checkbox"/> no <input type="checkbox"/> yes _____</p> <p>Loss of appetite <input type="checkbox"/> no <input type="checkbox"/> yes _____</p> <p>Weight loss <input type="checkbox"/> no <input type="checkbox"/> yes _____</p> <p>Fever <input type="checkbox"/> no <input type="checkbox"/> yes _____</p> <p>Night sweats <input type="checkbox"/> no <input type="checkbox"/> yes _____</p> <p>Fatigue <input type="checkbox"/> no <input type="checkbox"/> yes _____</p> <p>Dyspnea <input type="checkbox"/> no <input type="checkbox"/> yes _____</p> <p>Wheezing <input type="checkbox"/> no <input type="checkbox"/> yes _____</p> <p>Chest pain <input type="checkbox"/> no <input type="checkbox"/> yes _____</p>																	
<p>²Medical History and Past TB History</p> <p>Client currently taking TB medications: <input type="checkbox"/> no <input type="checkbox"/> yes</p> <p>All other current medications and dosages: _____</p> <p>Previous tuberculin skin test (TST): <input type="checkbox"/> no <input type="checkbox"/> yes (dates and result: _____)</p> <p>Previous history of TB: <input type="checkbox"/> no <input type="checkbox"/> yes (year _____) <input type="checkbox"/> pulmonary <input type="checkbox"/> extrapulmonary site: _____</p> <p>Previous treatment for TB: <input type="checkbox"/> no <input type="checkbox"/> yes</p> <p>Specify previous TB therapy dates, drugs, and location: <input type="checkbox"/> INH <input type="checkbox"/> Rifampin <input type="checkbox"/> Rifamate <input type="checkbox"/> EMB <input type="checkbox"/> PZA <input type="checkbox"/> other _____</p> <p>Previous Hospitalization for TB: <input type="checkbox"/> no <input type="checkbox"/> yes (dates and location): _____</p> <p>History of TB drug reactions: <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unknown</p> <p>Source of TB: family history: <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unknown <input type="checkbox"/> other exposure (relationship/ date): _____</p> <p>Contact/ exposure to someone with or suspected with TB: <input type="checkbox"/> no <input type="checkbox"/> yes, name/ when: _____</p> <p>Current illnesses/ medical conditions and diagnoses (dates) : _____</p> <p>Past history of illnesses and diagnoses (dates): _____</p> <p>Inhalation exposure: <input type="checkbox"/> no <input type="checkbox"/> yes (specify): _____</p> <p>Hospitalization and surgery (dates and places): _____</p> <p>Blood transfusions <input type="checkbox"/> no <input type="checkbox"/> yes (date): _____</p> <p>Injuries: _____</p> <p>Liver disease: <input type="checkbox"/> hx resolved hepatitis _____ <input type="checkbox"/> chronic/carrier hepatitis _____ <input type="checkbox"/> no hx of hepatitis <input type="checkbox"/> not sure <input type="checkbox"/> hx of other type of liver disease _____</p> <p>HIV screening: test done <input type="checkbox"/> no <input type="checkbox"/> yes (date): _____ Result: <input type="checkbox"/> positive <input type="checkbox"/> negative <input type="checkbox"/> unknown</p> <p>REVIEW OF SYSTEMS (Check only if problems present):</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Head and Neck</td> <td><input type="checkbox"/> Eye Disorder</td> <td><input type="checkbox"/> Ear Disorder</td> <td rowspan="5" style="vertical-align: top;">Remarks: _____ _____ _____</td> </tr> <tr> <td><input type="checkbox"/> Respiratory</td> <td><input type="checkbox"/> Muscular/ Skeletal</td> <td><input type="checkbox"/> Heart Disease</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Gastro-intestinal</td> <td><input type="checkbox"/> Liver Disease</td> </tr> <tr> <td><input type="checkbox"/> Kidney Disease</td> <td><input type="checkbox"/> G.U./ Gyn</td> <td><input type="checkbox"/> CNS</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> ALLERGIES AND DRUG REACTIONS: <input type="checkbox"/> none <input type="checkbox"/> yes (list) _____</td> </tr> </table>	<input type="checkbox"/> Head and Neck	<input type="checkbox"/> Eye Disorder	<input type="checkbox"/> Ear Disorder	Remarks: _____ _____ _____	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Muscular/ Skeletal	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gastro-intestinal	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> G.U./ Gyn	<input type="checkbox"/> CNS	<input type="checkbox"/> ALLERGIES AND DRUG REACTIONS: <input type="checkbox"/> none <input type="checkbox"/> yes (list) _____			
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<p>³Dental: last checkup: _____ <input type="checkbox"/> uses dentures <input type="checkbox"/> no dental provider <input type="checkbox"/> no dental needs</p> <p>dental provider _____</p> <p><input type="checkbox"/> needs care (Type: _____)</p>																	

<p>⁸Adherence/Compliance</p> <p>Client accepts dx: <input type="checkbox"/> no <input type="checkbox"/> yes family accepts dx: <input type="checkbox"/> no <input type="checkbox"/> yes</p> <p>Client understands TB disease process and treatment: <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> limited</p> <p>Family understands TB disease process and treatment: <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> limited</p> <p>Client is alert and able to care for self: <input type="checkbox"/> no <input type="checkbox"/> yes _____</p> <p>Client has disabilities: <input type="checkbox"/> no <input type="checkbox"/> yes (describe) _____</p> <p>Client needs assistance with ADL: <input type="checkbox"/> no <input type="checkbox"/> yes (describe) _____</p> <p>Agreeable to DOT: <input type="checkbox"/> no <input type="checkbox"/> yes. If no, why? _____</p> <p>Convenient time/place for DOT _____</p>	Date/ Initial
<p>⁹Work Exposure: <input type="checkbox"/> Employed (See also H289) <input type="checkbox"/> UNEMPLOYED (proceed to "School Exposure")</p> <p>Occupation/ type of work: _____</p> <p>Describe the worksite/ work space environment: _____</p> <p>_____</p> <p>Location of work: <input type="checkbox"/> outdoor <input type="checkbox"/> indoor <input type="checkbox"/> more than one area</p> <p>Length of time spent at work/ workspace per day: _____</p> <p>How many other people share the workspace _____</p> <p>Is there lunchtime or break spent in enclosed space with others <input type="checkbox"/> no <input type="checkbox"/> yes _____</p> <p>Client has been at present work x _____ year _____ months Last date at work _____</p> <p>Client has more than one job: <input type="checkbox"/> no <input type="checkbox"/> yes _____</p> <p>Address of employment(s): (REFER TO H289) _____</p> <p>Previous employment if less than 6 months in present job: _____</p> <p>Transportation to and from work: <input type="checkbox"/> bus <input type="checkbox"/> rail <input type="checkbox"/> private car alone <input type="checkbox"/> carpool <input type="checkbox"/> taxi <input type="checkbox"/> walk <input type="checkbox"/> bike <input type="checkbox"/> other</p>	
<p>¹⁰School Exposure: <input type="checkbox"/> goes to school <input type="checkbox"/> DOES NOT GO TO SCHOOL (Proceed to "Family/Non-Family")</p> <p>Has been enrolled at present school x _____ years and _____ months</p> <p>Concurrently attends another school: <input type="checkbox"/> no <input type="checkbox"/> yes (list): _____</p> <p>Address of school(s): (REFER TO H289) _____</p> <p>Describe the client's school schedule and activities/ classroom environment: _____</p> <p>_____</p> <p>Previous school if less than 6 months at present one: _____</p> <p>Location of classes: <input type="checkbox"/> outdoor <input type="checkbox"/> indoor <input type="checkbox"/> more than one area</p> <p>Number of classes and length of time spent in each class _____</p> <p>How many other people in class? _____</p> <p>Is there lunchtime or break spent in enclosed space with others? <input type="checkbox"/> no <input type="checkbox"/> yes _____</p> <p>Transportation to and from school: <input type="checkbox"/> school bus <input type="checkbox"/> public bus <input type="checkbox"/> rail <input type="checkbox"/> private car alone <input type="checkbox"/> carpool</p> <p><input type="checkbox"/> taxi <input type="checkbox"/> walk <input type="checkbox"/> bike <input type="checkbox"/> other _____</p>	
<p>¹¹Family/ Non-Family Contacts (See H289)</p> <p>How does client spend spare time? _____</p> <p>_____</p> <p>How much time does client spend with friends/other family and where? _____</p> <p>_____</p> <p>Place of worship attended/other extra curricular involvement/ frequency/ type of activities</p> <p>_____</p>	

Comments/ Date:

Initial	Print Name/Title	Signature/Title
Initial	Print Name/Title	Signature/Title

OBJECTIVE	Date/ Initial																																																																																
<p>¹ Lab and X Ray Studies see _____</p> <p>TST Date: _____ <input type="checkbox"/> negative ____ mm <input type="checkbox"/> positive ____ mm <input type="checkbox"/> not read <input type="checkbox"/> not done <input type="checkbox"/> previous TST</p> <p>Chest x-ray: date/location _____ <input type="checkbox"/> No CXR done</p> <p>CXR result: <input type="checkbox"/> normal <input type="checkbox"/> abnormal/TB: <input type="checkbox"/> cavitory <input type="checkbox"/> non-cavitory <input type="checkbox"/> abnormal/ Not TB/ Other Pathology</p> <p style="text-align: center;">MYCOBACTERIOLOGY</p> <table border="1" style="width:100%; border-collapse: collapse; margin: 10px 0;"> <thead> <tr> <th style="width: 15%;">Date</th> <th style="width: 15%;">Lab #</th> <th style="width: 25%;">Specimen Type</th> <th style="width: 15%;">Smear</th> <th style="width: 30%;">Culture</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>Susceptibility studies: <input type="checkbox"/> done <input type="checkbox"/> not done <input type="checkbox"/> pending Result: <input type="checkbox"/> susceptible to all first line TB drugs <input type="checkbox"/> resistant</p> <p>TB drug resistance to: _____ date/specimen site/drug resistance identified: _____</p> <p>HIV date: _____ <input type="checkbox"/> negative <input type="checkbox"/> positive <input type="checkbox"/> refused <input type="checkbox"/> not done</p> <p>Liver function tests: <input type="checkbox"/> done <input type="checkbox"/> not done <input type="checkbox"/> pending baseline results: <input type="checkbox"/> AST (sgot) _____ <input type="checkbox"/> ALT (sgpt) _____</p> <p>Other pertinent labs/diagnostic studies: _____ <input type="checkbox"/> None</p> <p>² Medications</p> <p>On TB DOT: <input type="checkbox"/> no <input type="checkbox"/> yes</p> <table border="1" style="width:100%; border-collapse: collapse; margin: 10px 0;"> <thead> <tr style="background-color: #e0e0e0;"> <th style="width: 15%;">TB DRUGS</th> <th style="width: 20%;">INITIAL REGIMEN/ DATE PRESCRIBED</th> <th style="width: 20%;">CURRENT TB REGIMEN/ DATE BEGUN</th> <th style="width: 15%;"># PILLS/CAPS ON HAND</th> <th style="width: 30%;">CORRECT PILL COUNT/COMMENTS</th> </tr> </thead> <tbody> <tr> <td>Isoniazid</td> <td> </td> <td> </td> <td> </td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> </tr> <tr> <td>Rifampin</td> <td> </td> <td> </td> <td> </td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> </tr> <tr> <td>Rifamate</td> <td> </td> <td> </td> <td> </td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> </tr> <tr> <td>Rifater</td> <td> </td> <td> </td> <td> </td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> </tr> <tr> <td>Ethambutol</td> <td> </td> <td> </td> <td> </td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> </tr> <tr> <td>Pyrazinamide</td> <td> </td> <td> </td> <td> </td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> </tr> <tr> <td>Vitamin B6</td> <td> </td> <td> </td> <td> </td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> </tr> </tbody> </table> <p>All other current medications and dosages: _____</p>	Date	Lab #	Specimen Type	Smear	Culture																																				TB DRUGS	INITIAL REGIMEN/ DATE PRESCRIBED	CURRENT TB REGIMEN/ DATE BEGUN	# PILLS/CAPS ON HAND	CORRECT PILL COUNT/COMMENTS	Isoniazid				<input type="checkbox"/> yes <input type="checkbox"/> no	Rifampin				<input type="checkbox"/> yes <input type="checkbox"/> no	Rifamate				<input type="checkbox"/> yes <input type="checkbox"/> no	Rifater				<input type="checkbox"/> yes <input type="checkbox"/> no	Ethambutol				<input type="checkbox"/> yes <input type="checkbox"/> no	Pyrazinamide				<input type="checkbox"/> yes <input type="checkbox"/> no	Vitamin B6				<input type="checkbox"/> yes <input type="checkbox"/> no	
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<p>³ Physical Appearance _____ Coughing: <input type="checkbox"/> no <input type="checkbox"/> yes _____ Affect _____</p>	<p>Date/ Initial</p>
<p>⁴ Home Situation <input type="checkbox"/> house <input type="checkbox"/> apt. <input type="checkbox"/> shelter <input type="checkbox"/> hotel or SRO <input type="checkbox"/> trailer <input type="checkbox"/> other _____ Describe living space _____ Describe sleeping space _____ Describe ventilation _____ Describe availability/amount of sunlight indoor _____ Describe neighborhood _____ Comments _____</p>	
<p>⁵ Work/school site #1 _____ <input type="checkbox"/> N/A <input type="checkbox"/> referred to district _____ Type of school/work _____ Describe school/workspace _____ Describe ventilation _____ Describe lunch/break room _____ Describe personal class space or work station _____</p>	
<p>Work/school site #2 _____ <input type="checkbox"/> N/A <input type="checkbox"/> referred to district _____ Type of school/work _____ Describe school/workspace _____ Describe ventilation _____ Describe lunch/break room _____ Describe personal class space or work station _____</p>	
<p>Work/school site #3 _____ <input type="checkbox"/> N/A <input type="checkbox"/> referred to district _____ Type of school/work _____ Describe school/workspace _____ Describe ventilation _____ Describe lunch/break room _____ Describe personal class space or work station _____</p>	

Comments/ Date:

Initial _____	Print Name/Title _____	Signature/Title _____
Initial _____	Print Name/Title _____	Signature/Title _____

ASSESSMENT	Date/ Initial
¹ TB <input type="checkbox"/> 3 <input type="checkbox"/> 5 (on TB Rx) Sites: _____ <input type="checkbox"/> Other TB 5 (deferred TB Rx, pending cultures) <input type="checkbox"/> symptomatic for TB <input type="checkbox"/> asymptomatic for TB	
² Priority in PHN practice manual: <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V <input type="checkbox"/> VI	
³ Risk of transmission: <input type="checkbox"/> none <input type="checkbox"/> low <input type="checkbox"/> high Due to: <input type="checkbox"/> AFB smear <input type="checkbox"/> CXR <input type="checkbox"/> clinical symptoms ⁴ Home isolation indicated: <input type="checkbox"/> no <input type="checkbox"/> yes if yes, instructions given <input type="checkbox"/>	
⁵ On TB medications currently: <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> On DOT <input type="checkbox"/> self-administered <input type="checkbox"/> deferred by clinician	
⁶ Liver function test results: <input type="checkbox"/> WNL <input type="checkbox"/> elevated	
⁷ Hx of latent TB infection (LTBI): <input type="checkbox"/> no <input type="checkbox"/> yes, date: _____ <input type="checkbox"/> unknown	
⁸ Hx of treatment for LTBI: <input type="checkbox"/> no <input type="checkbox"/> yes, date/location: _____	
⁹ Likelihood of adherence to TB regimen: <input type="checkbox"/> poor <input type="checkbox"/> questionable <input type="checkbox"/> good	
¹⁰ Barriers to adherence to TB regimen: <input type="checkbox"/> none <input type="checkbox"/> yes (list): _____	
¹¹ Language or cultural barriers to care: <input type="checkbox"/> none <input type="checkbox"/> yes (list) _____	
¹² Able to care for self: <input type="checkbox"/> no (explain below) _____ <input type="checkbox"/> yes	
¹³ Living space/environment safe for client: <input type="checkbox"/> no (explain) _____ <input type="checkbox"/> yes	
¹⁴ Living space/environment safe for staff: <input type="checkbox"/> no (explain) _____ <input type="checkbox"/> yes	
¹⁵ Psychosocial situation : <input type="checkbox"/> stable <input type="checkbox"/> unstable (explain) _____	
¹⁶ Health Need/Goal:	
Health Need/Goal:	
Health Need/Goal:	
Health Need/Goal:	
Health Need/Goal:	

Comments/ Date: _____

Initials Print Name/ Title Signature/ Title

Initials Print Name/ Title Signature/ Title

PLAN	Date/ Initial
¹ H290 registration submitted	
² H304 of client submitted (complete per protocol requirements).	
³ H289/ interview of index re: contacts initiated	
⁴ H304(s) for contact(s) initiated	
⁵ H289 and H304(s) of out of district contact(s) referred to district of residence	
⁶ H289 and dispositioned H304(s) submitted	
⁷ H290 confirmation submitted <input type="checkbox"/> or H513 closure submitted <input type="checkbox"/>	
⁸ Work/school contact follow up initiated Referred to: _____ (see H289)	
⁹ Information/education about TB, TB treatment regime, and contact follow up given verbally and in writing to client and family/household (if any). <input type="checkbox"/> TB literature provided in the appropriate language of the client.	
¹⁰ Client advised about communicability. Techniques to prevent transmission were explained to client and family/household (if any).	
¹¹ If home isolation indicated, home isolation explained to client/family/household (if any) and all agree to adhere to it until informed by the PHN/MD that it is no longer required. <input type="checkbox"/> Client verbalizes understanding and agreement.	
¹² TB medications reviewed with client and family (if any) and correct method for taking them was reviewed.	
¹³ TB meds side effects explained to client. Client to call _____ if problems. <input type="checkbox"/> Information given in writing.	
¹⁴ Importance of adherence to TB regime and consequences of non-adherence explained to client and family (if any).	
¹⁵ Explained to client that if unable to keep appointment(s), client to call: _____	
¹⁶ Action/Intervention: <input type="checkbox"/> Prenatal Care <input type="checkbox"/> Family Planning <input type="checkbox"/> WIC <input type="checkbox"/> Food <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Nutrition Counseling <input type="checkbox"/> Pediatric Primary Care <input type="checkbox"/> CHDP <input type="checkbox"/> Immunization <input type="checkbox"/> Regional Center <input type="checkbox"/> CCS <input type="checkbox"/> Parenting Class <input type="checkbox"/> Day Care <input type="checkbox"/> PCG <input type="checkbox"/> NFP <input type="checkbox"/> Dental Care <input type="checkbox"/> Vision Care <input type="checkbox"/> Exercise <input type="checkbox"/> Safer Sex Practices <input type="checkbox"/> Communicable Disease <input type="checkbox"/> Smoking Cessation <input type="checkbox"/> Drug/ETOH Treatment <input type="checkbox"/> Environmental Health <input type="checkbox"/> Building & Safety <input type="checkbox"/> Shelter/Housing <input type="checkbox"/> Clothing <input type="checkbox"/> Transportation <input type="checkbox"/> Legal Aid <input type="checkbox"/> DPSS <input type="checkbox"/> DCFS <input type="checkbox"/> Family Violence referral: _____ <input type="checkbox"/> Counseling/Mental Health referral: _____ <input type="checkbox"/> Healthy Families worker at _____ <input type="checkbox"/> Medi-Cal worker at _____ <input type="checkbox"/> Medical Care at _____ <input type="checkbox"/> Public Health Clinic at _____ <input type="checkbox"/> Other _____ Anticipatory Guidance given about: <input type="checkbox"/> Folic Acid <input type="checkbox"/> Healthy Diet <input type="checkbox"/> Bottle Caries <input type="checkbox"/> Smoking/Chem. Dep. <input type="checkbox"/> Exercise <input type="checkbox"/> Immunization <input type="checkbox"/> Pre-Conception Counseling <input type="checkbox"/> Safer Sex Practices <input type="checkbox"/> Back to Sleep <input type="checkbox"/> Safety/Injury Prevention Other: _____ Comments: _____	
¹⁷ Next TB Clinic Appointment: _____ Next PMD Appointment: _____	
¹⁸ Other Plan:	
Other Plan:	

Comments/ Date: _____

Initial Print Name/Title

Signature/Title

Initial Print Name/Title

Signature/Title

INSTRUCTIONS FOR PHN TB FOLLOW-UP

The progress note format follows the correct protocol for nursing documentation: subjective, objective, assessment and plan.

1. Enter the date of the home visit or telephone call. Indicate the type of contact.
2. Enter who you spoke with - client, family member, etc.; the last PMD visit; the next PMD visit.
3. Document any new medical concerns or questions.
4. Document any discussion regarding the TB regimen - meds, MD visits, necessary tests, etc.
5. Indicate any psychosocial problems or give updates on known difficulties.
6. Medication toxicity review is to be documented each visit: i.e., adverse s/s denied or list adverse s/s occurring.
7. Indicate if the pill count is not necessary: i.e., client is on DOT.
8. This information is necessary to determine if the client is compliant with medications. Total days refers to the number of days from the previous count to the current count.
9. Complete the information regarding the TB meds and indicate if the count is correct, “Y” or not “N”. May record any comments about the count. All the information requested is necessary to accurately complete the med. count: refill date, quantity, previous count and today’s count.
10. May enter other objective information.
11. Document your assessment based on information gathered at the home visit or other client contact (phone, workplace, etc.).
12. Indicate if TB education given and if med. toxicity reviewed.
13. Enter the person who should be called by the client. This is very important if the PHN is going on vacation, off for an extended time or has a change of assignment.
14. Document any referrals given or other comments. Indicate if the progress note/chart is sent for review- PHNS/Clinician. (Clinicians are to review PMD cases monthly following the home visit.)
15. PHN is to print his/her name.
16. PHN is to sign the progress note and imprint the client’s ID.
17. Document visit on monthly PHN TB Follow-up Form within 2 working days.

PUBLIC HEALTH NURSE (PHN) STANDARDS OF PRACTICE INSTRUCTIONS FOR USING THE EVALUATION FORMS AND WORKSHEETS

I. Who can be evaluated?

- A. A PHN must be working at least 3 months during the current evaluation period.
- B. A new PHN must be off probation and work 3 months during the evaluation period.
- C. A PHN who has transferred in from a program and is new to the district will be considered a new PHN for 6 months. Thereafter, the PHNS will evaluate her/his work once the PHN has worked at least 3 months of the evaluation period.
- D. A PHN who has transferred in from another health district must work in the new district at least 3 months of the evaluation period.
- E. A PHN who has transferred out, retired, resigned, or promoted will not be evaluated.

II. PHN Standards of Practice Evaluation Forms

- A. The Public Health Nursing Supervisor (PHNS) uses these forms to evaluate the records for each PHN.
 - 1. One form is used for a 6-month period per standard of practice.
- B. Complete all information as requested.
- C. The PHN must meet the standard elements in order to receive a “met” rating.
 - 1. The PHN either totally meets the standard elements or she/he does not (there is no partial credit).
 - 2. Explain the reason why the PHN did not meet a certain standard element in the comments section. Write small number e.g. (1) next to the comment.
- D. Check “not applicable” for a standard element which does not apply.
- E. Add the number of applicable standard elements (total possible elements minus the not applicable elements). Use this number as the denominator.
 - 1. Calculate the percentage of standard elements “met” using the formula provided.
 - 2. The resultant figure is the compliance percentage for that standard of practice.
 - 3. If more than one record is evaluated, add the compliance percentage for each record and divide by the number of records. Record this percentage under the appropriate category on Attachment B.
- F. The PHNS signs her/his name and date after each record is evaluated.
- G. Retain these forms:
 - 1. Use when reviewing and discussing the results with the individual PHN.
 - a. Keep on file for one year plus current year.

III. PHN Standards of Practice Evaluation, PHNS Tracking Worksheet (Attachment A)

- A. The PHNS uses this form to track the number of record evaluated.
 - 1. Keep at desk side.
 - 2. Update as records are evaluated.
 - 3. Review periodically to determine type of records needed to complete evaluation for the time period.

**PUBLIC HEALTH NURSE (PHN) STANDARDS OF PRACTICE
INSTRUCTIONS FOR USING THE EVALUATION FORMS AND WORKSHEETS**

- B. List each PHN that the PHNS supervises on one sheet.
- C. Using “hash” marks, indicate the number of records evaluated according to standard of practice.
- D. By the end of March and September:
 - 1. Each PHN should have the minimum number of records evaluated per the standard of practice.
 - a. Acute Communicable Diseases (ACD) Individual 2 cases
 - b. ACD Outbreak Health Care Facility (HCF) 1 case
 - c. ACD Outbreak Non-HCF 1 case
 - d. Sexually Transmitted Diseases (STD) 2 cases
 - e. Tuberculosis Suspect and/or Cases (TB 3/5) 2 cases
 - f. TB Contact Follow-up Individual 2 cases
 - g. TB Source Case Finding in a Documented Converter 1 case
 - h. Lead or Newborn Screening or Sudden Infant Death Syndrome (SIDS) 1 case
 - 2. Records are to be randomly selected according to the following parameters:
 - a. TB records that have been in the PHN’s caseload for at least 90 days or are closed.
 - b. ACD and STD records at completion or those that are closed.
 - c. Lead, SIDS, Newborn Screening that has been in the PHN’s caseload for at least 90 days or is closed.
 - d. Do not evaluate a previously evaluated record.
 - 3. If the PHN receives fewer cases for a standard of practice than the required minimum, the actual number evaluated will be entered in that section.
 - a. If no cases are available to evaluate, enter “N/A.”

IV. Individual PHN Evaluation of Practice Summary Worksheet (Attachment B)

- A. PHNS will use this worksheet to summarize outcomes of the evaluated records for individual PHN staff.
 - B. For each PHN, record on Attachment B the average % compliance for all evaluations completed under each Standard of Practice category. If no evaluations were completed for a given category, write in N/A.
 - C. If using Excel spreadsheet, the “total average percentage” will automatically be calculated.
 - D. If not using Excel spreadsheet:
 - 1. Total the percentages under each standard of practice category.
 - 2. Divide only by the number of standards evaluated.
 - 3. Record calculation result in the “total average percentage” column.
 - E. Write comments if applicable.
 - F. Both PHN and PHNS should sign and date the worksheet.
 - G. PHNS should sign and date that copy of worksheet was given to PHN.
- (See Review and Discussion Section VIII for additional instructions).

PUBLIC HEALTH NURSE (PHN) STANDARDS OF PRACTICE INSTRUCTIONS FOR USING THE EVALUATION FORMS AND WORKSHEETS

V. PHN Standards of Practice Evaluation

PHNS Summary of Staff Performance Report (Attachment C)

- A. PHNS uses this form to summarize the outcomes of the evaluated records for her/his assigned PHN staff.
- B. Copy or enter the percentages from the Individual PHN Evaluation of Practice Summary Worksheets (Attachment B) to Attachment C. You must enter N/A if no records were evaluated for a given category.
- C. If using Excel spreadsheet, calculations for “total average percentage” for each PHN, and the “overall PHN compliance %” are automatic. **Check that all category entries are correct. If one of the columns shows no records were evaluated under that category, enter N/A in the bottom shaded row.**
- D. If not using Excel spreadsheet, calculate and write the “total average percentage” for each PHN by adding all category percentages and then divide by the number of categories evaluated.
- E. If not using Excel spreadsheet, calculate “overall PHN compliance %” by adding “total average percentages” for all PHNs and then divide by the number of PHNs. Record result in lower right-hand shaded cell.
- F. Submit a copy of this form to the nurse manager by October 31 and April 30 of each year.

VI. PHN Standards of Practice Evaluation

Area Nurse Manager (ANM) Summary of Staff Performance Report (Attachment D)

- A. ANM uses this form to summarize the outcomes of the evaluated records for her/his assigned PHNS staff.
- B. Copy or enter the percentages from the PHNS Summary of Staff Performance Report (Attachment C) to Attachment D.
- C. If using Excel spreadsheet, calculations for “total average percentage” for each PHNS, and the “compliance % of all PHNs” are automatic. **Check that all category entries are correct. If one of the columns shows no records were evaluated under that category, enter N/A in the bottom shaded row.**
- D. If not using Excel spreadsheet, calculate and write the “total average percentage” for each PHNS by adding all category percentages and then divide by the number of categories evaluated.
- E. If not using Excel spreadsheet, calculate “compliance % for all PHNs” by adding “total average percentages” for all PHNSs and then divide by the number of PHNSs. Record result in lower right-hand shaded cell.
- F. Submit a copy of this form to the Nursing Director (ND) by November 15 and May 15 of each year.

PUBLIC HEALTH NURSE (PHN) STANDARDS OF PRACTICE INSTRUCTIONS FOR USING THE EVALUATION FORMS AND WORKSHEETS

VII. PHN Standards of Practice Evaluation

ND Summary of Staff Performance Worksheet (Attachment E)

- A. ND uses this form to summarize the outcomes of the evaluated records for the assigned ANM's staff.
- B. Copy the percentages from the ANM Summary of Staff Performance Report (Attachment D) to Attachment E.
- C. Calculations for "total average percentage" for each ANM, and the "Countywide compliance %" are automatic. **Check that all category entries are correct. If one of the columns shows no records were evaluated under that category, enter N/A in the bottom shaded row.**

VIII. Review and Discussion Session

- A. The PHNS is to meet with each individual PHN no later than October 31 and April 30 to review and discuss the results of the PHN Standards of Practice Evaluation. Using the Evaluation of Practice Forms and the Individual PHN Evaluation of Practice Summary Worksheet (Attachment B).
 1. Explain to the PHN why supervision determined that a standard was not met.
 2. Review with the PHN how to meet the expected standard and discuss methods or strategies the PHN can utilize to achieve the desired outcome.
 3. Acknowledge that a review and discussion session has taken place by both PHN and PHNS signing and dating Attachment B.
 4. Provide copy of form to PHN and date and sign that copy was received.
 5. File original Attachment B and related Evaluation Forms in the PHN's local personnel file.

IX. Using Information for Performance Evaluation (PE)

- A. The PHN who has completed one year of service should have a minimum of 6 months of evaluation information. Thereafter, evaluation results for two 6-month periods will be available for use in the PE.
- B. Evaluation information will be reflected in the PHN's PE in the areas of quantity and quality of work taking into consideration other factors which contribute to the section rating.

X. Interrater Reliability

- A. Nurse managers should assure that PHNS's conduct interrater reliability testing on a periodic basis and when a new PHNS is appointed.

PHN Standards of Practice Evaluation PHNS Tracking Worksheet

PHNS _____

Oct-March April-Sept Year _____

PHN Name	ACD			STD	TB			Other
	Individual ACD <small>(2)</small>	Outbreak HCF <small>(1)</small>	Outbreak Non-HCF <small>(1)</small>	STD <small>(2)</small>	Suspects (V) or Cases (III) <small>(2)</small>	Contacts <small>(2)</small>	SCF <small>(1)</small>	Lead or NB Screening or SIDS <small>(1)</small>
<i>Jane Doe</i>	<i>11</i>		<i>1</i>	<i>11</i>	<i>11</i>	<i>1</i>	<i>1</i>	

Individual PHN Evaluation of Practice Summary Worksheet (Attachment B)

PHN _____ (print)

PHNS _____ (print)

Oct-March

April-Sept

Year _____

ACD			STD	TB			Other	Total Average %
Individual ACD	Outbreak HCF	Outbreak Non-HCF	STD	Suspect (V) or Case (III)	Contacts	SCF	Lead or NB Screening or SID	

Supervisor's Comments:

PHN's Comments:

Goal/Strategies for Maintenance of Effort or Improvement:

PHN Signature _____

Date: _____

PHNS Signature _____

Date: _____

PHN Received copy of this form:

PHNS Signature _____

Date: _____

PHN Standards of Practice Evaluation PHNS Summary of Staff Performance Report

)

Oct-March (Due to ANM April 30)

Year _____

April-Sept (Due to ANM Oct 31)

PHNS _____

Health Center _____

PHN Name	ACD			STD	TB			Other	Total Average %
	Individual ACD	Outbreak HCF	Outbreak Non-HCF	STD	Suspect (V) or Case (III)	Contacts	SCF	Lead or NB Screening or SIDS	
<i>Jane Doe</i>	100%	95%	80%	100%	95%	100%	100%	90%	95%
Overall PHN Compliance %									

PHN Standards of Practice Evaluation Area Nurse Manager Summary of Staff Performance

ANM _____

Oct-March (Due to ND May 15)

Year _____

April-Sept (Due to ND Nov 15)

SPA _____ Health Center/s _____

PHNS Name	ACD			STD	TB			Other	Total Average %
	Individual ACD	Outbreak HCF	Outbreak Non-HCF	STD	Suspect (V) or Case (III)	Contacts	SCF	Lead or NB Screening or SIDS	
<i>Jane Doe</i>	100%	95%	80%	100%	95%	100%	100%	90%	95%
Compliance % for all PHNs									

PHN Standards of Practice Evaluation Nursing Director Summary

(Attachment E)

Oct-March

April-Sept

Year _____

ANM Name/SPA	ACD			STD	TB			Other	Total Average %
	Individual ACD	Outbreak HCF	Outbreak Non-HCF	STD	Suspect (V) or Case (III)	Contacts	SCF	Lead or NB Screening or SIDS	
<i>Jane Doe</i>	100%	95%	80%	100%	95%	100%	100%	90%	95%
Countywide compliance %									

Frequently Asked Questions District PHN Evaluation of Practice

- Question:** If the client is not found or is not able to be interviewed but the PHN gave health teaching or some other interventions to the family members, should elements such as “documents client’s understanding of disease and transmission process” be marked “met” or “not applicable”?

Answer: The element should be marked “not applicable” if the PHN did not interact with the client directly.
- Question:** How much detail is required for health teaching documentation? Is it enough if it is just stated “health teaching done”?

Answer: Yes
- Question:** Is any mention of health need/goal enough to mark “met”?

Answer: Yes
- Question:** If there is some indication that a form was completed, is that sufficient to mark “met” or must it be documented as completed in the progress notes or elsewhere (For instance, “H290 confirmation submitted”)?

Answer: Mark “met” if there is any indication that the form was completed such as the existence in the record of a copy of the form with submission date. There is no need to look for additional documentation in the progress notes or elsewhere in the record.
- Question:** When the standard/tool states “document”, can the documentation by the PHN be anywhere in the record?

Answer: Yes
- Question:** When supervisors are evaluating for PHN adherence to the standard, is it necessary to review all material (medical record, STD CaseWatch, NPMS, etc)?

Answer: Yes, otherwise variations may occur from rater to rater.
- Question:** If a tool element states “completes and submits”, do both need to be done to receive a “met”?

Answer: Yes
- Question:** If an intervention concerning a minor (client) is provided to a caregiver (for instance, health teaching), should the element be marked as “met”?

Answer: Yes
- Question:** How long does a lateral transfer DPHN have to work at her/his new location before she/he is evaluated?

Answer: 3 months

Frequently Asked Questions District PHN Evaluation of Practice

10. **Question:** What tools should the PHNS start with first when she/he starts the evaluation process?
Answer: Attachment “A” PHN Tracking Form and the appropriate evaluation tool.
11. **Question:** Is it necessary to have the priority # documented?
Answer: Yes
12. **Question:** Does the priority # have to be documented if the investigation/follow-up was initiated in the priority period?
Answer: Yes
13. **Question:** If the documentation seems incomplete in the record, does the PHNS rate every element or skip those that are missing?
Answer: Rate every element.
14. **Question:** Does date/time/signature have to be documented to be rated as “met”? **Answer:** Yes
15. **Question:** How does the PHNS randomly select records to evaluate?
Answer: Some suggested methods are:
- a. Evaluate the first medical records that cross the PHNS’ desk that meet the criteria.
 - b. Select medical records whose last name starts with the letters A-L for the first six months and then use the letters M-Z for the next six months.
 - c. Assign an odd or even number to closed cases or cases that meet the criteria for evaluation and then pick only odd or even records to evaluate.

Acute Communicable Disease Standard of Practice Evaluation Form: Individual

PHN _____

Circle appropriate period

Oct-March

April-Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
ASSESSMENT										
1. Documentation reflects that referral was reviewed as indicated by: <ul style="list-style-type: none"> Date/Time/Signature on referral when received from PHNS (p. C1). 										
2. Analyzes the report per PHN Practice Manual (p. C1) as demonstrated by the completeness or incompleteness of the data. <ul style="list-style-type: none"> Indicates that all data was complete or follows up on missing data, if needed. 										
3. PHN Assessment was completed or if not, why? (p .C1).										
COMMENTS:										

Acute Communicable Disease Standard of Practice Evaluation Form: Individual

PHN _____

Circle appropriate period

Oct-March

April-Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
POPULATION DIAGNOSIS AND PRIORITIES										
1. Documentation indicates medical diagnosis (p. C2).										
2. Priority of follow up documented (p. C2) as outlined in the PHN Practice Manual (p. D1) or as determined in consultation with the PHNS.										
COMMENTS:										
OUTCOMES IDENTIFICATION										
Documents health needs/goals for specific need(s) identified (p. C2).										
COMMENTS:										

Acute Communicable Disease Standard of Practice Evaluation Form: Individual

PHN _____

Circle appropriate period

Oct-March

April-Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
PLANNING										
Documents client specific plan that is selected from the PHN Practice Manual (pp. C3 – C4).										
COMMENTS:										
IMPLEMENTATION										
1. Completes and documents disease and health event investigation per PHN Practice Manual (p. C5).										
2. Documents health teaching/counseling (p. C5).										
3. Refers client as needed (p. C5).										
4. Conducts surveillance of client as indicated (p. C5). (Surveillance describes and monitors health events through ongoing & systematic collection, analysis, and interpretation of health data).										
COMMENTS:										

Acute Communicable Disease Standard of Practice Evaluation Form: Individual

PHN _____

Circle appropriate period

Oct-March

April-Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS	
	EVALUATION	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET		N/A
1. Documentation reflects consideration of client's needs in determining interventions and/or on-going revisions of the plan of care (p. C5).											
2. Documents client understands the disease process and prevention of transmission (p. C5).											
3. Initiates action for non-adherent client/contacts (p. C6).											
4. Follows up with non-adherent client/contacts (p. C6).											
5. Completes forms or report and submits investigation forms within 5 days of closure or timeframe agreed upon in consultation with PHNS (p. C6).											
6. Follows up on referrals as reported by client if more than one contact is needed (p. C5).											
TOTALS											
COMMENTS:											

Acute Communicable Disease Standard of Practice Evaluation Form: Individual

PHN _____

Circle appropriate period

Oct-March

April-Sept

Year

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Comments:

<p>Record #1 <u>Calculation of Percentage (%)</u> 17 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator $\frac{\# \text{ of MET Elements}}{\text{Total \# of Standard Elements (Denominator)}} = \text{ } \%$</p>
<p>Record #2 <u>Calculation of Percentage (%)</u> 17 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator $\frac{\# \text{ of MET Elements}}{\text{Total \# of Standard Elements (Denominator)}} = \text{ } \%$</p>
<p>Record #3 <u>Calculation of Percentage (%)</u> 17 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator $\frac{\# \text{ of MET Elements}}{\text{Total \# of Standard Elements (Denominator)}} = \text{ } \%$</p>

Compute average compliance for rating period:

Total of percentages = _____ % (Record percentage on Attachment B under ACD Individual)
of records

Acute Communicable Disease Standard of Practice Evaluation Form: Outbreak in a Healthcare Facility

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	
ASSESSMENT							
1. Documentation reflects that referral was reviewed (p. C7) as indicated by: <ul style="list-style-type: none"> • Date/Time/Signature on referral when received from PHNS. 							
2. Analyzes the report per PHN Practice Manual (p. C7) as demonstrated by the completeness or incompleteness of the data. <ul style="list-style-type: none"> • Indicates that all data was complete or follows up on missing data, if needed. 							
COMMENTS:							

Acute Communicable Disease Standard of Practice Evaluation Form: Outbreak in a Healthcare Facility

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	
POPULATION DIAGNOSIS AND PRIORITIES							
1. Documentation indicates medical diagnosis (p. C7).							
2. Priority of follow up is documented in the PHN Practice Manual (p. D1, D2) or as determined in consultation with the PHNS (p. C8).							
COMMENTS:							
OUTCOMES IDENTIFICATION							
Documents health needs/goals for specific need(s) identified (p. C8).							
COMMENTS:							

Acute Communicable Disease Standard of Practice Evaluation Form: Outbreak in a Healthcare Facility

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			COMMENTS
PLANNING	MET	NOT MET	N/A	MET	NOT MET	N/A	
Documents facility specific plan that is selected from the PHN Practice Manual (pp. C9-C11).							
COMMENTS:							
IMPLEMENTATION	MET	NOT MET	N/A	MET	NOT MET	N/A	
1. Completes and documents disease and health event investigation per PHN Practice Manual (p. C12).							
2. Interviews for source (p. C12).							
3. Documents health teaching/counseling (p. C12).							
4. Refers facility administrator or designee as needed (p. C12).							
5. Conducts surveillance of facility as indicated (p. C12). (Surveillance describes and monitors health events through ongoing and systematic collection, analysis, and interpretation of health data).							
COMMENTS:							

Acute Communicable Disease Standard of Practice Evaluation Form: Outbreak in a Healthcare Facility

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	
EVALUATION							
1. Documentation reflects consideration of facility needs in determining interventions and/or on-going revisions of plan of care (p. C12).							
2. Initiates action for non-adherent facility (p. C12).							
3. Follows up on non-adherent facility (p. C12).							
4. Completes and submits interim reports as needed until case is closed (p. C13).							
5. Completes and submits investigation forms within 10 days of closure or timeframe agreed upon in consultation with PHNS (p. C13).							
6. Completes Consumer/Community Services module in NPMS, and files hard copy in medical record (p. C13).							
7. Follows up on referrals as reported by facility administrator. (p. C12).							
TOTALS							
COMMENTS:							

Acute Communicable Disease Standard of Practice Evaluation Form: Outbreak in a Healthcare Facility

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Comments:

<p>Record #1</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;">18 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ % Total # of Standard Elements (Denominator)</p>
<p>Record #2</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;">18 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ % Total # of Standard Elements (Denominator)</p>

Compute average compliance for rating period:

Total of percentages = _____ % (Record percentage on Attachment B under ACD Outbreak HCF)
of records

Acute Communicable Diseases Standard of Practice Evaluation Form: Outbreak in a Non-Healthcare Facility/Agency

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	
ASSESSMENT							
1. Documentation reflects that referral was reviewed as indicated by: <ul style="list-style-type: none"> • Date/Time/Signature on referral when received from PHNS (p. C14). 							
2. Analyzes the report per PHN Practice Manual (p. C14) as demonstrated by the completeness or incompleteness of the data. <ul style="list-style-type: none"> • Indicates that all data was complete or follows up on missing data, if needed. 							
COMMENTS:							

Acute Communicable Diseases Standard of Practice Evaluation Form: Outbreak in a Non-Healthcare Facility/Agency

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	
POPULATION DIAGNOSIS AND PRIORITIES							
1. Documentation indicates medical diagnosis (p. C15).							
2. Priority of follow up is documented as outlined in the PHN Practice Manual (p. D1, D2) or as determined in consultation with the PHNS (p. C15).							
COMMENTS:							
OUTCOMES IDENTIFICATION							
Documents health needs/goals for specific need(s) identified (p. C15).							
COMMENTS:							

Acute Communicable Diseases Standard of Practice Evaluation Form: Outbreak in a Non-Healthcare Facility/Agency

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	
PLANNING	MET	NOT MET	N/A	MET	NOT MET	N/A	
Documents specific plan that is selected from the PHN Practice Manual (pp. C16-C18).							
COMMENTS:							
IMPLEMENTATION	MET	NOT MET	N/A	MET	NOT MET	N/A	
1. Completes and documents disease and health event investigation per PHN Practice Manual (p. C18).							
2. Interviews for source (p. C18).							
3. Documents health teaching/counseling (p. C18).							
4. Refers facility administrator or designee as needed (p. C18).							
5. Conducts surveillance of client as indicated (p. C18). (Surveillance describes & monitors health events through ongoing & systematic collection, analysis, and interpretation of health data).							
COMMENTS:							

Acute Communicable Diseases Standard of Practice Evaluation Form: Outbreak in a Non-Healthcare Facility/Agency

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	
EVALUATION							
1. Documentation reflects consideration of facility needs in determining interventions and/or on-going revisions of the plan of care (p. C19).							
2. Initiates action for non-adherent facility (p. C19).							
3. Follows up on non-adherent facility (p. C19).							
4. Completes and submits interim reports as needed until case is closed (p. C19).							
5. Completes and submits investigation forms within 10 days of closure or timeframe agreed upon in consultation with PHNS (p. C19).							
6. Completes Consumer/Community Services module in NPMS, and files hard copy in medical record (p. C19).							
7. Follows up on referrals as reported by facility administrator (p. C18).							
TOTALS							
COMMENTS:							

Acute Communicable Diseases Standard of Practice Evaluation Form: Outbreak in a Non-Healthcare Facility/Agency

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Comments:

Record #1

Calculation of Percentage (%)

18 possible Standard Elements **MINUS (-)**
not applicable (N/A) Elements = **Denominator**

of MET Elements _____ = _____ %
Total # of Standard Elements

Record #2

Calculation of Percentage (%)

18 possible Standard Elements **MINUS (-)**
not applicable (N/A) Elements = **Denominator**

of MET Elements _____ = _____ %
Total # of Standard Elements
(Denominator)

Compute average compliance for rating period:

Total of percentages = _____ % (Record percentage on Attachment B under ACD Outbreak Non-HCF)
of records

Lead Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
ASSESSMENT										
1. Documentation reflects that referral was reviewed as indicated by: <ul style="list-style-type: none"> • Date/Time/Signature on referral when received from PHNS (p. C20). 										
2. Analyzes the report per PHN Practice Manual (p. C20) as demonstrated by the completeness or incompleteness of the data. <ul style="list-style-type: none"> • Indicates that all data was complete or follows up on missing data, if needed. 										
3. PHN Assessment was completed or if not, why? (p. C20).										
COMMENTS:										

Lead Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
POPULATION DIAGNOSIS AND PRIORITIES										
1. Documentation indicates medical diagnosis (p. C21).										
2. Priority of follow up documented (p. C21) as outlined in the PHN Practice Manual (p. D3) or as determined in consultation with the PHNS.										
COMMENTS:										
OUTCOMES IDENTIFICATION										
Documents health needs/goals for specific need(s) identified (p. C21).										
COMMENTS:										
PLANNING										
Documents client specific plan that is selected from the PHN Practice Manual (pp. C22-C24).										
COMMENTS:										

Lead Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
IMPLEMENTATION										
1. Completes and documents disease and health event investigation per PHN Practice Manual (p. C25).										
2. Refers client/household as needed (p. C25).										
3. Documents health teaching/counseling regarding lead and nutrition were given to client and household members (p. C25).										
4. Monitors client's adherence to CLPPP recommended frequency for blood lead level (p. C25).										
5. Ensures that all at-risk household members receive a blood lead level (p. C25).										
COMMENTS:										

Lead Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
1. Documentation reflects consideration of client's needs in determining interventions and/or on-going revisions of the plan of care (p. C25).										
2. Documents client understands lead poisoning (p. C25).										
3. Initiates action for non-adherent client (p. C25).										
4. Follows up on non-adherent client (p. C25).										
5. Completes and submits lead investigation forms as per PHN Practice Manual (pp. C25-C26).										
6. Follows up on referrals as reported by client (p. C25).										
TOTALS										
COMMENTS:										

Lead Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Comments:

<p>Record #1</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;">18 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ % Total # of Standard Elements (Denominator)</p>
<p>Record #2</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;">18 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ % Total # of Standard Elements (Denominator)</p>
<p>Record #3</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;">18 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ % Total # of Standard Elements (Denominator)</p>

Compute average compliance for rating period:

Total of percentages = _____ % (Record percentage on Attachment B under Other Lead)
of records

Newborn Screening Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	
ASSESSMENT							
1. Documentation reflects that referral was reviewed as indicated by: <ul style="list-style-type: none"> • Date/Time/Signature on referral when received from PHNS (p. C27). 							
2. Analyzes the report per PHN Practice Manual (p. C27) as demonstrated by the completeness or incompleteness of the data. <ul style="list-style-type: none"> • Indicates that all data was complete or follow up on missing data, if needed. 							
3. Documents the assessment of family/caregiver needs for further education and resource information related to Newborn Screening (p. C27).							
4. PHN Assessment was completed or if not, why? (p. C27).							
COMMENTS:							

Newborn Screening Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			COMMENTS
POPULATION DIAGNOSIS AND PRIORITIES	MET	NOT MET	N/A	MET	NOT MET	N/A	
1. Documentation indicates medical diagnosis (p. C27).							
2. Priority of follow up documented as outlined in the PHN Practice Manual (p. D4) or as determined in consultation with the PHNS (p. C27).							
COMMENTS:							
OUTCOMES IDENTIFICATION	MET	NOT MET	N/A	MET	NOT MET	N/A	
Documents health needs/goals for specific need(s) identified (p. C28).							
COMMENTS:							

Newborn Screening Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			COMMENTS
PLANNING	MET	NOT MET	N/A	MET	NOT MET	N/A	
Documents client specific plan that is selected from the PHN Practice Manual (pp. C28-C29).							
COMMENTS:							
IMPLEMENTATION	MET	NOT MET	N/A	MET	NOT MET	N/A	
1. Completes and documents disease and health event investigation per PHN Practice Manual (p. C29).							
2. Documents health teaching/counseling (p. C29).							
3. Follows up on referrals as reported by caregiver if more than one contact is needed (p. C 29).							
COMMENTS:							

Newborn Screening Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	
EVALUATION							
1. Documentation reflects consideration of client's/family's needs in determining interventions and/or on-going revisions of the plan of care (p. C30).							
2. Documents understanding of the importance of newborn screening (p. C30).							
3. Documentation reflects action taken for non-adherent caregiver (p. C30).							
4. Completes investigation forms and submits per PHN Practice Manual (p. C30).							
5. Refers client as needed (p. C29).							
TOTALS							
COMMENTS:							

Newborn Screening Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

<p>Record #1</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;">16 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ % Total # of Standard Elements (Denominator)</p>
<p>Record #2</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;">16 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ % Total # of Standard Elements (Denominator)</p>

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Comments:

Compute average compliance for rating period:

Total of percentages = _____ % (Record percentage on Attachment B under Other NB)
of records

Sexually Transmitted Disease Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
ASSESSMENT										
1. Documentation reflects that referral was reviewed as indicated by: <ul style="list-style-type: none"> • Date/Time/Signature on referral when received from PHNS (p. C31). 										
2. Analyzes the report per PHN Practice Manual (p. C31) as demonstrated by the completeness or incompleteness of the data. <ul style="list-style-type: none"> • Indicates that all data was complete or follows up on missing data, if needed. 										
3. PHN Assessment was completed or if not, why? (p. C31).										
COMMENTS:										

Sexually Transmitted Disease Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
POPULATION DIAGNOSIS AND PRIORITIES										
1. Documentation indicates medical diagnosis (p. C31).										
2. Priority of follow up documented (p. C31) as outlined in the PHN Practice Manual (p. D5) or as determined in consultation with the PHNS.										
COMMENTS:										
OUTCOMES IDENTIFICATION										
Documents health needs/goals for specific need(s) identified (p. C32).										
COMMENTS:										
PLANNING										
Documents client's specific plan that is selected from the PHN Practice Manual (pp. C32-C34).										

Sexually Transmitted Disease Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
IMPLEMENTATION										
1. Completes and documents disease and health event investigation per PHN Practice Manual (p. C34).										
2. Documents health teaching/counseling (p. C34).										
3. Interviews for contacts (p. C34).										
4. Refers client/contacts as needed (p. C34).										
5. Conducts surveillance of client as indicated (p. C34). (Surveillance describes & monitors health events through ongoing & systematic collection, analysis, & interpretation of health data).										
COMMENTS:										

Sexually Transmitted Disease Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
EVALUATION										
1. Documentation reflects consideration of client's needs in determining interventions and/or on-going revisions of the plan of care (p. C35).										
2. Documents client understands the disease process and prevention of transmission (p. C35).										
3. Determines and documents the effectiveness of interventions (p. C35). <ul style="list-style-type: none"> • Verifies with appropriate medical provider or per client's self report that treatment was obtained and taken. 										
4. Initiates action for non-adherent client/contacts (p. C35).										
5. Follow up with non-adherent client/contacts (p. C35).										
6. Dispositions and closes case in Casewatch® within 14 days of receipt of referral or within timeframe agreed upon with PHNS (p. C35).										
7. Follows up on referrals as reported by client, if more than one client contact is needed (p. C34).										
TOTALS										

Sexually Transmitted Disease Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Reviewing Supervisor (name) _____ Date _____

(Signature) _____ Date _____

Comments:

<p>Record #1</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;">19 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ %</p> <p style="text-align: center;">Total # of Standard Elements (Denominator)</p>
<p>Record #2</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;">19 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ %</p> <p style="text-align: center;">Total # of Standard Elements (Denominator)</p>
<p>Record #3</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;">19 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ %</p> <p style="text-align: center;">Total # of Standard Elements (Denominator)</p>

Compute average compliance for rating period:

Total of percentages = _____ % (Record percentage on Attachment B under STD)
of records

Sudden Infant Death Syndrome Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	
ASSESSMENT							
1. Documentation reflects that referral was reviewed as indicated by: <ul style="list-style-type: none"> • Date/Time/Signature on referral when received from PHNS (p. C36). 							
2. Analyzes the report per PHN Practice Manual (p. C36) as demonstrated by the completeness or incompleteness of the data. <ul style="list-style-type: none"> • Indicates that all data was complete or follows up on missing data, if needed. 							
3. Documentation reflects an assessment of the family for the need of grief counseling (p. C36).							
4. PHN Assessment was completed or if not, why? (p. C36).							
COMMENTS:							

Sudden Infant Death Syndrome Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	
POPULATION DIAGNOSIS AND PRIORITIES							
1. Documentation indicates provisional medical diagnosis (p. C36).							
2. Priority of follow up documented as outlined in the PHN Practice Manual (p. D6) or as determined in consultation with the PHNS (p. C36).							
COMMENTS:							
OUTCOMES IDENTIFICATION							
Documents health needs/goals for specific need(s) identified (p. C37).							
COMMENTS:							

Sudden Infant Death Syndrome Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	
PLANNING							
Documents family/caregiver specific plan that is selected from the PHN Practice Manual (pp. C37-C38).							
COMMENTS:							
IMPLEMENTATION							
1. Completes and documents disease and health event investigation per PHN Practice Manual (p. C38).							
2. Documents health teaching/counseling (p. C38).							
3. Refers family/caregiver as needed (p. C38).							
COMMENTS:							

Sudden Infant Death Syndrome Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			COMMENTS
	EVALUATION	MET	NOT MET	N/A	MET	NOT MET	
1. Documentation reflects consideration of family/caregiver needs in determining interventions and/or on-going revisions of the plan of care (p. C39).							
2. Documents understanding of SIDS diagnosis process (p. C39).							
3. Completes forms and submits per PHN Practice Manual (p. C39).							
4. Follows-up on referrals as reported by family/caregiver if more than one contact is needed. (p. C38).							
TOTALS							
COMMENTS:							

Sudden Infant Death Syndrome Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Comments:

<p>Record #1</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;">15 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ %</p> <p style="text-align: center;">Total # of Standard Elements (Denominator)</p>
<p>Record #2</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;">15 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ %</p> <p style="text-align: center;">Total # of Standard Elements (Denominator)</p>

Compute average compliance for rating period:

Total of percentages = _____ % (Record percentage on Attachment B under Other SIDS)
of records

Tuberculosis (TB) Cases and Suspects Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
ASSESSMENT										
1. Documentation reflects that referral was reviewed as indicated by: <ul style="list-style-type: none"> • Date/Time/Signature on referral when received from PHNS (p. C40). 										
2. Analyzes the report per PHN Practice Manual (p. C40) as demonstrated by the completeness or incompleteness of the data. <ul style="list-style-type: none"> • Indicates that all data was complete or follows up on missing data, if needed. 										
3. PHN Assessment was completed or if not, why? (p. C40).										
COMMENTS:										

Tuberculosis (TB) Cases and Suspects Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
POPULATION DIAGNOSIS AND PRIORITIES										
1. Documentation indicates medical diagnosis (p. C41).										
2. Priority of follow up is documented (p. C41) as outlined in the PHN Practice Manual (p. D7) or as determined in consultation with the PHNS.										
COMMENTS:										
OUTCOMES IDENTIFICATION										
Documents health needs/goals for specific need(s) identified (p. C41).										
COMMENTS:										

Tuberculosis (TB) Cases and Suspects Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
PLANNING										
Documents client's specific plan that is selected from the PHN Practice Manual (pp. C41-C45).										
COMMENTS:										
IMPLEMENTATION										
1. Completes and documents disease and health event investigation per PHN Practice Manual (p. C46).										
2. Initiates contact investigation (p. C46).										
3. Documents health teaching/counseling (p. C46).										
4. Refers client as needed (p. C46).										
5. Conducts surveillance of client as indicated (p. C46). (Surveillance describes & monitors health events through ongoing & systematic collection, analysis, & interpretation of health data).										
6. Documents monthly home visit/contact (p. C46).										
COMMENTS:										

Tuberculosis (TB) Cases and Suspects Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
EVALUATION										
1. Documentation reflects consideration of client's needs in determining interventions and/or on-going revisions of the plan of care (p. 46).										
2. Documents client understands the disease process and prevention of transmission (p. C46).										
3. Initiates action for non-adherent client (p. C46).										
4. Follows up with non-adherent client (p. C46).										
5. Completes and submits H290 registration per PHN Practice Manual (p. C47).										
6. Completes and submits H290 confirmation per PHN Practice Manual (p. C47).										
7. Submits H513 closure per PHN Practice Manual (p. C47).										

Tuberculosis (TB) Cases and Suspects Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
8. Follows up on referrals as reported by client (p. C46).										
9. Initiates and submits H289 per PHN Practice Manual (p. C46)										
10. Completes TB class 3/5 Assessment Form (p. C48).										
TOTALS										
COMMENTS:										

Tuberculosis (TB) Cases and Suspects Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Comments:

Compute average compliance for rating period:

Total of percentages = _____ % (Record percentage on Attachment B under TB Suspect/Case)
of records

Record #1

Calculation of Percentage (%)

23 possible Standard Elements MINUS (-)
not applicable (N/A) Elements = **Denominator**

of MET Elements _____ = _____ %

Total # of Standard Elements

(Denominator)

Record #2

Calculation of Percentage (%)

23 possible Standard Elements MINUS (-)
not applicable (N/A) Elements = **Denominator**

of MET Elements _____ = _____ %

Total # of Standard Elements

(Denominator)

Record #3

Calculation of Percentage (%)

23 possible Standard Elements MINUS (-)
not applicable (N/A) Elements = **Denominator**

of MET Elements _____ = _____ %

Total # of Standard Elements

(Denominator)

Tuberculosis (TB) Contact Follow-up Standard of Practice Evaluation Form: Individual

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
ASSESSMENT										
1. Documentation reflects that referral was reviewed as indicated by: <ul style="list-style-type: none"> • Date/Time/Signature on referral when received from PHNS (p. C49). 										
2. Analyzes the report per PHN Practice Manual (p. C49) as demonstrated by the completeness or incompleteness of the data. <ul style="list-style-type: none"> • Indicates that all data was complete or follows up on missing data, if needed. 										
3. PHN Assessment was completed or if not, why? (p. C50).										
COMMENTS:										

Tuberculosis (TB) Contact Follow-up Standard of Practice Evaluation Form: Individual

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
POPULATION DIAGNOSIS AND PRIORITIES										
1. Documentation indicates medical diagnosis (p. C50).										
2. Priority of follow up documented (p. C50) as outlined in the PHN Practice Manual (p. D7) or as determined in consultation with the PHNS.										
COMMENTS:										
OUTCOMES IDENTIFICATION										
Documents health needs/goals for specific need(s) identified (p. C50).										
COMMENTS:										

Tuberculosis (TB) Contact Follow-up Standard of Practice Evaluation Form: Individual

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
PLANNING										
Documents client specific plan that is selected from the PHN Practice Manual (pp. C51-C53).										
COMMENTS:										
IMPLEMENTATION										
1. Completes and documents disease and health event investigation per PHN Practice Manual (p. C53).										
2. Initiates contact investigation (p. C53).										
3. Documents health teaching/counseling (p. C53).										
4. Refers client as needed (p. C53).										
5. Conducts surveillance of client as indicated (p. C54). (Surveillance describes & monitors health events through ongoing & systematic collection, analysis, & interpretation of health data).										
COMMENTS:										

Tuberculosis (TB) Contact Follow-up Standard of Practice Evaluation Form: Individual

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS	
	EVALUATION	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET		N/A
1. Documentation reflects consideration of client's needs in determining interventions and/or on-going revisions of the plan of care (p. C54).											
2. Documents client understands the disease and transmission process (p. C54).											
3. Initiates action for non-adherent client (p. C54).											
4. Follows up with non-adherent client (p. C54).											
5. Completes and submits H289 registration per PHN Practice Manual (pp. C54-C55).											
6. Ensure that H304 Preventative Treatment Closure is dispositioned and submitted if indicated (p. C55).											
7. Follows-up on referrals as reported by client (p. C53).											
TOTALS											
COMMENTS:											

Tuberculosis (TB) Contact Follow-up Standard of Practice Evaluation Form: Individual

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Comments:

<p>Record #1</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;">19 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ % Total # of Standard Elements (Denominator)</p>
<p>Record #2</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;">19 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ % Total # of Standard Elements (Denominator)</p>
<p>Record #3</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;">19 possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ % Total # of Standard Elements (Denominator)</p>

Compute average compliance for rating period:

Total of percentages = _____ % (Record percentage on Attachment B under TB Contacts)
of records

Tuberculosis (TB) Source Case Finding in a Documented Converter Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
ASSESSMENT										
1. Documentation reflects that referral was reviewed as indicated by: <ul style="list-style-type: none"> • Date/Time/Signature on referral when received from PHNS (p. C56). 										
2. Analyzes the report per PHN Practice Manual (p. C56) as demonstrated by the completeness or incompleteness of the data. <ul style="list-style-type: none"> • Indicates that all data was complete or follows up on missing data, if needed. 										
3. PHN Assessment was completed or if not, why? (p. C56).										
COMMENTS:										

Tuberculosis (TB) Source Case Finding in a Documented Converter Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
POPULATION DIAGNOSIS AND PRIORITIES										
1. Documentation indicates medical diagnosis (p. C56).										
2. Priority of follow up documented (p. C56) as outlined in the PHN Practice Manual (p. D7) or as determined in consultation with the PHNS.										
COMMENTS:										
OUTCOMES IDENTIFICATION										
Documents health needs/goals for specific need(s) identified (p. C57).										
COMMENTS:										

Tuberculosis (TB) Source Case Finding in a Documented Converter Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
PLANNING										
Documents client specific plan that is selected from the PHN Practice Manual (pp. C57-C59).										
COMMENTS:										
IMPLEMENTATION										
1. Completes and documents disease and health event investigation per PHN Practice Manual (p. C59).										
2. Initiates SCF (p. C59).										
3. Documents health teaching/ counseling (p. C59).										
4. Refers client as needed (p. C59).										
COMMENTS:										

Tuberculosis (TB) Source Case Finding in a Documented Converter Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

STANDARD ELEMENTS	RECORD # (1)			RECORD # (2)			RECORD # (3)			COMMENTS
	MET	NOT MET	N/A	MET	NOT MET	N/A	MET	NOT MET	N/A	
EVALUATION										
1. Documentation reflects consideration of client's needs in determining interventions and/or on-going revisions of the plan of care (p. C60).										
2. Documents client understands disease process (p. C60).										
3. Initiates action for non-adherent client (p. C60).										
4. Follows up with non-adherent client (p. C60).										
5. Completes and submits H289 and associated TB Statistical H304 copies per PHN Practice Manual (p. C60).										
6. Ensure that H304 Preventative Treatment Closure copies are dispositioned and submitted, if indicated (p. C60).										
7. Follows up on referrals as reported by client/caregiver (p. C59).										
TOTALS										
COMMENTS:										

Tuberculosis (TB) Source Case Finding in a Documented Converter Standard of Practice Evaluation Form

PHN _____

Circle appropriate period

Oct-March

April- Sept

Year

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Reviewing Supervisor (name) _____

(Signature) _____ Date _____

Comments:

Compute average compliance for rating period:

Total of percentages = _____ % (Record percentage on Attachment B under TB SCF)
of records

<p>Record #1</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;"><u>18</u> possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ %</p> <p>Total # of Standard Elements (Denominator)</p>
<p>Record #2</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;"><u>18</u> possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ %</p> <p>Total # of Standard Elements (Denominator)</p>
<p>Record #3</p> <p style="text-align: center;"><u>Calculation of Percentage (%)</u></p> <p style="text-align: center;"><u>18</u> possible Standard Elements MINUS (-) not applicable (N/A) Elements = Denominator</p> <p style="text-align: center;"># of MET Elements _____ = _____ %</p> <p>Total # of Standard Elements (Denominator)</p>

Quad Council PHN Competencies

Introduction

In 2000, the Quad Council began drafting a set of national competencies for public health nursing. This work was prompted, in part, by the Centers for Disease Control and Prevention's work on educating the public health workforce. The Council received feedback on a draft of these competencies from more than 220 nurses across the country who are members of one or more of its member organizations (see page A3). Public health core competencies are defined as a set of skills, knowledge, and attitudes necessary for the broad practice of public health.

Approach

The approach utilized by the Quad Council was to analyze the Council on Linkages between Academia and Public Health Practice (COL) "Core Competencies for Public Health Professionals" to determine their application to two levels of public health nursing practice: the staff nurse/generalist role and the manager/specialist/consultant role. The intent was to examine COL competencies' fit in relation to public health nursing practice, and to identify and refine unique competencies for public health nursing.

Application of Competencies to Public Health Nursing

The Quad Council's document focuses on how public health nurses apply the core competencies and defines the expected performance level for each competency statement. The document is designed for use with other documents such as the American Public Health Association's "Definition of Public Health Nursing", and the *Public Health Nursing: Scope and Standards of Practice* (American Nurses Association, 2007).

Population-Focused Practice

The Quad Council determined that, although COL competencies were developed with the understanding that public health practice is population-focused and public health nursing is also population-focused. However, one of the unique contributions of public health nurses is the ability to apply these principles at the individual and family level within the context of population-focused practice. Therefore, many of the competency statements indicate a level of awareness, knowledge or proficiency at the individual/family level.

Because of their population or system-focused language, the Quad Council determined that several specific competency statements and three entire domains would not include application at the individual/family level: "Domain 5 – community dimensions of practice," Domain 7 – financial planning and management skills," and Domain 8 – leadership and systems thinking skills.

Assumptions

- Public health nurses must first possess the competencies common to all baccalaureate-prepared nurses and then demonstrate additional competencies specific to their roles in public health.
- The progression from awareness to knowledge to proficiency is a continuum; there are no discrete boundaries between levels of competency.

- Both levels reflect competencies for a reasonably prudent PHN who has experience in the role (.e.g. not a “novice”), and not in a specialized or limited focus role.
- These competencies are intended to reflect the standard for public health nursing practice, not necessarily what is occurring in practice today.
- In any practice setting the job descriptions may reflect components from each level depending on the agency’s structure, size, leadership and services.

Source

Adapted from “Quad Council PHN Competencies (4/3/03)”.

PUBLIC HEALTH NURSING COMPETENCIES – Finalized 04/03

Source of competencies: Core Competencies for Public Health Professionals A Project of the Council on Linkages Between Academia and Public Health Practice Funded by the Health Resources and Services Administration

Domain #1: Analytic Assessment Skills		Generalist/Staff PHN		Manager/CNS/Consultant/ Program Specialist/Executive	
		Individuals & Families	Populations / Systems	Individuals & Families	Populations/ Systems
1.	Defines a problem	Proficiency	Knowledge	Proficiency	Proficiency
2.	Determines appropriate uses and limitations of both quantitative and qualitative data	Knowledge	Awareness	Proficiency	Proficiency
3.	Selects and defines variables relevant to defined public health problems	Knowledge	Knowledge	Proficiency	Proficiency
4.	Identifies relevant and appropriate data and information sources	Proficiency	Knowledge	Proficiency	Proficiency
5.	Evaluates the integrity and comparability of data and identifies gaps in data sources	Knowledge	Awareness	Proficiency	Proficiency
6.	Applies ethical principles to the collection, maintenance, use, and dissemination of data and information	Proficiency	Knowledge	Proficiency	Proficiency
7.	Partners with communities to attach meaning to collected quantitative and qualitative data	N/A (see Note 1)	Knowledge	N/A (see Note 1)	Proficiency
8.	Makes relevant inferences from quantitative and qualitative data	Knowledge	Awareness	Proficiency	Proficiency
9.	Obtains and interprets information regarding risks and benefits to the community	Knowledge	Knowledge	Proficiency	Proficiency
10.	Applies data collection processes, information technology applications, and computer systems storage/retrieval strategies	Knowledge	Awareness	Proficiency	Proficiency
11.	Recognizes how the data illuminates ethical, political, scientific, economic, and overall public health issues	Knowledge	Awareness	Proficiency	Proficiency

Definitions:

- **Awareness:** Basic level of mastery of the competency. Individuals may be able to identify the concept or skill but have limited ability to perform the skill.
- **Knowledge:** Intermediate level of mastery of the competency. Individuals are able to apply and describe the skill.
- **Proficiency:** Advanced level of mastery of the competency. Individuals are able to synthesize, critique or teach the skill.

PUBLIC HEALTH NURSING COMPETENCIES – Finalized 04/03

Source of competencies: Core Competencies for Public Health Professionals A Project of the Council on Linkages Between Academia and Public Health Practice Funded by the Health Resources and Services Administration

Domain #2: Policy Development/Program Planning Skills		Generalist/Staff PHN		Manager/CNS/Consultant/ Program Specialist/Executive	
		Individuals & Families	Populations / Systems	Individuals & Families	Populations/ Systems
1.	Collects, summarizes, and interprets information relevant to an issue	Knowledge	Awareness	Proficiency	Proficiency
2.	States policy options and writes clear and concise policy statements	Awareness	Awareness	Proficiency	Proficiency
3.	Identifies, interprets, and implements public health laws, regulations, and policies related to specific programs	Knowledge	Knowledge	Proficiency	Proficiency
4.	Articulates the health, fiscal, administrative, legal, social, and political implications of each policy option	Awareness	Awareness	Proficiency	Proficiency
5.	States the feasibility and expected outcomes of each policy option	Awareness	Awareness	Proficiency	Proficiency
6.	Utilizes current techniques in decision analysis and health planning	Knowledge	Awareness	Proficiency	Proficiency
7.	Decides on the appropriate course of action	Knowledge	Awareness	Proficiency	Proficiency
8.	Develops a plan to implement policy, including goals, outcome and process objectives, and implementation steps	Knowledge	Awareness	Proficiency	Proficiency
9.	Translates policy into organizational plans, structures, and programs	N/A (see Note 1)	Awareness	N/A (see Note 1)	Proficiency
10.	Prepares and implements emergency response plans	Knowledge	Knowledge	Proficiency	Proficiency
11.	Develops mechanisms to monitor and evaluate programs for their effectiveness and quality	Knowledge	Knowledge	Proficiency	Proficiency

Definitions:

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PUBLIC HEALTH NURSING COMPETENCIES – Finalized 04/03

Source of competencies: Core Competencies for Public Health Professionals A Project of the Council on Linkages Between Academia and Public Health Practice Funded by the Health Resources and Services Administration

Domain #3: Communication Skills		Generalist/Staff PHN		Manager/CNS/Consultant/ Program Specialist/Executive	
		Individuals & Families	Populations / Systems	Individuals & Families	Populations/ Systems
1.	Communicates effectively both in writing and orally, or in other ways	Proficiency	Knowledge	Proficiency	Proficiency
2.	Solicits input from individuals and organizations	Proficiency	Knowledge	Proficiency	Proficiency
3.	Advocates for public health programs and resources	Proficiency	Knowledge	Proficiency	Proficiency
4.	Leads and participates in groups to address specific issues	Proficiency	Knowledge	Proficiency	Proficiency
5.	Uses the media, advanced technologies, and community networks to communicate information	Knowledge	Awareness	Knowledge*	Knowledge*
				* reflects ability to determine need for and to utilize experts in these areas	
6.	Effectively presents accurate demographic, statistical, programmatic, and scientific information for professional and lay audiences	Knowledge	Knowledge	Proficiency	Proficiency
7.	Attitudes: Listens to others in an unbiased manner, respects points of view of others, and promotes the expression of diverse opinions and perspectives	Proficiency	Proficiency	Proficiency	Proficiency

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PUBLIC HEALTH NURSING COMPETENCIES – Finalized 04/03

Source of competencies: Core Competencies for Public Health Professionals A Project of the Council on Linkages Between Academia and Public Health Practice Funded by the Health Resources and Services Administration

Domain #4: Cultural Competency Skills		Generalist/Staff PHN		Manager/CNS/Consultant/ Program Specialist/Executive	
		Individuals & Families	Populations / Systems	Individuals & Families	Populations/ Systems
1.	Utilizes appropriate methods for interacting sensitively, effectively, and professionally with persons from diverse cultural, socioeconomic, educational, racial, ethnic and professional backgrounds, and persons of all ages and lifestyle preferences	Proficiency	Proficiency	Proficiency	Proficiency
2.	Identifies the role of cultural, social, and behavioral factors in determining the delivery of public health services	Knowledge	Knowledge	Proficiency	Proficiency
3.	Develops and adapts approaches to problems that take into account cultural differences	Proficiency	Knowledge	Proficiency	Proficiency
4.	Attitudes: Understands the dynamic forces contributing to cultural diversity	N/A (see Note 1)	Knowledge	N/A (see Note 1)	Proficiency
5.	Attitudes: Understands the importance of a diverse public health workforce	N/A (see Note 1)	Knowledge	N/A (see Note 1)	Proficiency

Definitions:

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- **Knowledge:** Intermediate level of mastery of the competency. Individuals are able to apply and describe the skill.
- **Proficiency:** Advanced level of mastery of the competency. Individuals are able to synthesize, critique or teach the skill.

PUBLIC HEALTH NURSING COMPETENCIES – Finalized 04/03

Source of competencies: Core Competencies for Public Health Professionals A Project of the Council on Linkages Between Academia and Public Health Practice Funded by the Health Resources and Services Administration

Domain #5: Community Dimensions of Practice Skills		Generalist/Staff PHN		Manager/CNS/Consultant/ Program Specialist/Executive	
		Individuals & Families	Populations / Systems	Individuals & Families	Populations/ Systems
1.	Establishes and maintains linkages with key stakeholders		Knowledge		Proficiency
2.	Utilizes leadership, team building, negotiation, and conflict resolution skills to build community partnerships		Knowledge		Proficiency
3.	Collaborates with community partners to promote the health of the population		Knowledge		Proficiency
4.	Identifies how public and private organizations operate within a community		Knowledge		Proficiency
5.	Accomplishes effective community engagements		Knowledge		Proficiency
6.	Identifies community assets and available resources		Knowledge		Proficiency
7.	Develops, implements, and evaluates a community public health assessment		Knowledge		Proficiency
8.	Describes the role of government in the delivery of community health services		Knowledge		Proficiency

Definitions:

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- **Proficiency:** Advanced level of mastery of the competency. Individuals are able to synthesize, critique or teach the skill.

PUBLIC HEALTH NURSING COMPETENCIES – Finalized 04/03

Source of competencies: Core Competencies for Public Health Professionals A Project of the Council on Linkages Between Academia and Public Health Practice Funded by the Health Resources and Services Administration

Domain #6: Basic Public Health Sciences Skills		Generalist/Staff PHN		Manager/CNS/Consultant/ Program Specialist/Executive	
		Individuals & Families	Populations / Systems	Individuals & Families	Populations/ Systems
1.	Identifies the individual's and organization's responsibilities within the context of the Essential Public Health Services and core functions	Knowledge	Knowledge	Proficiency	Proficiency
2.	Defines, assesses, and understands the health status of populations, determinants of health and illness, factors contributing to health promotion and disease prevention, and factors influencing the use of health services	Knowledge	Knowledge	Proficiency	Proficiency
3.	Understands the historical development, structure, and interaction of public health and health	Knowledge	Knowledge	Proficiency	Proficiency
4.	Identifies and applies basic research methods used in public health	Awareness	Awareness	Knowledge	Knowledge
5.	Applies the basic public health sciences including behavioral and social sciences, biostatistics, epidemiology, environmental public health, and prevention of chronic and infectious diseases and injuries	Awareness	Awareness	Knowledge	Knowledge
6.	Identifies and retrieves current relevant scientific evidence	Knowledge	Knowledge	Proficiency	Proficiency
7.	Identifies the limitations of research and the importance of observations and interrelationships	Awareness	Awareness	Knowledge	Knowledge
8.	Attitudes: Develops a lifelong commitment to rigorous critical thinking	Proficiency	Proficiency	Proficiency	Proficiency

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- **Proficiency:** Advanced level of mastery of the competency. Individuals are able to synthesize, critique or teach the skill.

PUBLIC HEALTH NURSING COMPETENCIES – Finalized 04/03

Source of competencies: Core Competencies for Public Health Professionals A Project of the Council on Linkages Between Academia and Public Health Practice Funded by the Health Resources and Services Administration

Domain #7: Financial Planning and Management Skills		Generalist/Staff PHN		Manager/CNS/Consultant/ Program Specialist/Executive	
		Individuals & Families	Populations / Systems	Individuals & Families	Populations/ Systems
1.	Develops and presents a budget		Awareness		Proficiency
2.	Manages programs within budget constraints		Knowledge		Proficiency
3.	Applies budget processes		Awareness		Proficiency
4.	Develops strategies for determining budget priorities		Awareness		Proficiency
5.	Monitors program performance		Knowledge		Proficiency
6.	Prepares proposals for funding from external sources		Awareness		Proficiency
7.	Applies basic human relations skills to the management of organizations, motivation of personnel, and resolution of conflicts		Knowledge		Proficiency
8.	Manages information systems for collection, retrieval, and use of data for decision-making		Awareness		Proficiency
9.	Negotiates and develops contracts and other documents for the provision of population-based services		Awareness		Proficiency
10.	Conducts cost-effectiveness, cost-benefit, and cost utility analyses		Awareness		Proficiency

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PUBLIC HEALTH NURSING COMPETENCIES – Finalized 04/03

Source of competencies: Core Competencies for Public Health Professionals A Project of the Council on Linkages Between Academia and Public Health Practice Funded by the Health Resources and Services Administration

Domain #8: Leadership and Systems Thinking Skills		Generalist/Staff PHN		Manager/CNS/Consultant/ Program Specialist/Executive	
		Individuals & Families	Populations / Systems	Individuals & Families	Populations/ Systems
1.	Creates a culture of ethical standards within organizations and communities		Knowledge		Proficiency
2.	Helps create key values and shared vision and uses these principles to guide action		Knowledge		Proficiency
3.	Identifies internal and external issues that may impact delivery of essential public health services (i.e. strategic planning)		Knowledge		Proficiency
4.	Facilitates collaboration with internal and external groups to ensure participation of key stakeholders		Knowledge		Proficiency
5.	Promotes team and organizational learning		Knowledge		Proficiency
6.	Contributes to development, implementation, and monitoring of organizational performance standards		Knowledge		Proficiency
7.	Uses the legal and political system to effect change		Knowledge		Proficiency
8.	Applies theory of organizational structures to professional practice		Awareness		Proficiency

Definitions:

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- **Proficiency:** Advanced level of mastery of the competency. Individuals are able to synthesize, critique or teach the skill.

Note 1: (applicable to Domains 1, 2 and 4) These competencies, because of their population or system-focused language, do not apply at the individual/family level, but are applicable to the broader context of population-focused public health services and systems.