What is The Public Health Nurse's Role in the Oregon Healthy Start Program?: Opinion of an Expert Panel

By

Dianna L. Pickett

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Approved:

[redacted]

Catherine Salveson, RN, Ph.D. Assistant Professor Research Advisor
OHSU School of Nursing

[redacted]

Shelley Jones, RN, Ph. D., COHN-B Assistant Professor Committee Member
OHSU School of Nursing

[redacted]

Lila Wickham, RN, MS Public Health Nursing Consultant Committee Member
Oregon Health Division

[redacted]

Beverly Hoelter, RN, DNSc, FAAN Associate Dean of Academic Affairs

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Abstract

WHAT IS THE PUBLIC HEALTH NURSE'S ROLE IN THE OREGON HEALTHY START PROGRAM?: OPINION OF AN EXPERT PANEL

The Oregon Healthy Start Program (OHS) uses a collaborative, multi-disciplinary approach to helping families where young children are at high risk of poor emotional, intellectual and physical development, and child abuse. Public health nurses (PHN) participate in the OHS Program in a variety of ways throughout the state. The purpose of this project was to better define the most unique and effective role for the PHN in the program.

A Delphi qualitative research model was used to assemble a panel of experts in public health nursing and the OHS Program with the purpose of coming to a consensus on the most appropriate role for the PHN. McKenna (1994) defines the Delphi method as a series of interviews conducted to elicit opinions, predictions or judgments from a panel of experts about a topic of interest. Several rounds of questions are typically used. Between interview sets, the data are summarized and feedback is given to the participants regarding the developing opinions of the group. Each set of answers is then used to construct the next round of questions in an effort to come to a consensus on an issue. Information was elicited three times from this panel; twice through interviews with each panel member. The third time feedback was returned to the researcher through the mail. Analysis was done by summarizing each set of data from the first interviews, grouping salient points, and then coding and categorizing the points into themes or aspects as they

emerged. A draft document was written and returned to the panel for comment during the next interviews. The process was repeated after the second set of interviews. The third draft document was then sent by mail. Feedback returned by mail was used to produce the final document.

Twenty-one people were invited, and all agreed to participate in a Delphi panel. Invitation was based on their Healthy Start position category: This included paraprofessionals, public health nurses, supervisors, program managers, and collaborators working in local programs in all regions of the state; and state collaborators. Participants had at least two years working experience with the Healthy Start Program; were known as experts in public health nursing, the Healthy Start program; or both; and were interested in the topic of discussion. Because of the small number, all state level collaborators were invited to participate. All were asked not to represent their role in the program, but to speak from their own experience and knowledge base.

The result is a document that defines a recommended role of the PHN, identifies barriers to the PHN's participation in the program, and recommends program elements that can better integrate the PHN role into the OHS Program in an effective and meaningful way. It is endorsed by the entire panel. This document may be useful to local community partners who are designing new OHS collaborations, and to inform modification of the current OHS Program. The project results are specific to the OHS Program; however, sections may be generalizable to other multi-disciplinary collaborations where PHNs are involved.

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Chapter I: Introduction

The Oregon Healthy Start (OHS) Program uses a collaborative, multi-disciplinary approach to helping families where young children are at high risk of poor emotional, intellectual and physical development, and child abuse. There are twelve counties in Oregon that have fully operational programs, and seven more in various stages of early development. The goal of the Oregon Commission on Children and Families (OCCF), the parent organization for Oregon Healthy Start, is to develop OHS programs in all thirty-six counties.

Through my work for the Deschutes County Health Department, and then the Oregon Health Division (OHD), I have been involved with the OHS program since the first programs began in 1994. I am interested in better defining the most effective role that the public health nurse can play in OHS programs for two reasons. First, public health nursing has been seriously challenged by outcome-based program models, like OHS, to prove that its contributions to the health of the community are worth their cost. It is difficult to measure outcomes for nursing activities that are preventive in nature because it is easier to measure the bad things that happen than the bad things that are prevented. It is also difficult to measure how the nurse's body of skill, knowledge and level of connection with the community influences program outcomes in a way that is unique compared to that of a paraprofessional working in the program. To program designers and policy makers the less expensive paraprofessional is attractive. However, if the public health

nursing role was defined by what nurses uniquely do best, it would better inform decisions about staffing, program design and budgeting, and strengthen the nurse's contribution to the program. Second, using a clear definition of the unique role of public health nursing, nurses and paraprofessionals may more easily learn to fit their roles together for the benefit of the families they serve.

History of the Program

The political birth of the OHS program resulted in a strained relationship between the OCCF and the OHD. In 1993 Oregon authorized legislation for the Healthy Start initiative in Oregon. Oregon's Healthy Start Program is based on the Hawaii Healthy Start model, and the Healthy Families of America initiative that was adopted by the National Committee to Prevent Child Abuse in 1992. The Oregon initiative integrates public health as a key partner in building on existing community resources to meet the Oregon Healthy Start Program goals. Oregon's legislative mandate includes public health as a collaborator, but the relationship between the OCCF and the OHD was not clearly defined.

The model of the OHS Program was the Hawaii Healthy Start Program, which includes social workers in its design, and contracts with public health nurses to perform a health monitoring function rather than as an integral part of the program. All funding formulas are based on specific contracted services from local public health nurses. The Oregon Health Division envisioned public health as playing a more integral role when it was designated as a collaborator in OHS. Oregon included public health as a more involved partner but the PHN's role was left to local communities to define. OCCF,

intending to allow counties to develop their OHS programs in ways that meet their community's individual needs, did not give clear directions to counties as to how public health nurses were to be involved. This created confusion and conflict at the local level as community collaborators attempted to design their own programs. Public health nurses expected to contribute expertise gleaned from more than one hundred years of home visiting experience but were inexperienced at working together with paraprofessionals. Generally, they were unsure what their relationship should be. The five original program designs varied a great deal in their levels of PHN involvement. Animosity began to build between OCCF and OHD and their interchange began to resemble strained cooperation rather than collaboration.

This was truly an unfortunate situation. This rocky beginning, in many instances, has hindered the public health nurse's acceptance into local programs across the state. Currently, PHN involvement in local programs varies, from simply directing and monitoring targeted case management (TCM) services carried out by home visitors, to periodic screening for child health problems and supervision of teams of home visitors.

Two well-defined relationships with public health emerged and influenced the role of public health nurses in OHS programs, but these have weakened. The first centers on reimbursement for services. In order for OHS Programs to bill the Oregon Medical Assistance Program (OMAP) for the cost of targeted case management (TCM) services, the administrative rules require that a PHN direct the paraprofessionals providing those services. In most cases this has been a paper review of all the billing dates and TCM plans generated by the programs. Nurses perceive this to be tedious and unsatisfying work, and

it has further frayed the relationship between the nurses and the OHS Program. The need for PHN oversight has recently ended with a new system of reimbursement, Medicaid Administration Reimbursement, which has been instituted by OMAP for Healthy Start programs. The program does not require a nurse for this function. In some counties it was the only function the nurse was asked to perform.

The second relationship public health has with OHS is the use of the Oregon Health Division database for collecting part of the data for the OHS Program. There is work being done to create a database that will eliminate the need for duplicate data entry and streamline the system. This will make it unnecessary for the OHS Program to use the Health Division database. A disadvantage of doing this is that by removing the OHS data from the OHD database system that population's characteristics and needs are also removed and not included in the big picture depicting Oregon's people. They could essentially become invisible. There is concern regarding whether the new database system will compare favorably to the well established OHD system, with its interconnections to other state databases depicting the health of Oregonians, and its sophisticated quality assurance features and security measures. Separating from the OHD system may solve some of the practical problems with data entry, but may compromise more important data about OHS families and minimize the program's visibility and impact on policy makers.

The role of the PHN in the OHS Program is endangered because it is not well understood by OHS collaborators and PHNs themselves. The Definition and Role of Public Health Nursing: A Statement of the American Public Health Association (APHA) Public Health Nursing Section (1996) defined public health nursing in this way: "Public

health nursing is the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences." The public health nurse uses nursing assessment skills to diagnose the health and health care needs of the population, plans and implements interventions to address those needs in an effective, efficient and equitable way, and then evaluates the impact of the interventions on the health of both individuals and the population. The definition describes it in this way:

> Public health nurses integrate community involvement and knowledge about the entire population with personal, clinical understandings of the health and illness experiences of individuals and families within the population. They translate and articulate the health and illness experiences of diverse, often vulnerable individuals and families in the population to health planners and policy makers, and assist members of the community to voice their problems and aspiration. Public health nurses are knowledgeable about multiple strategies for intervention, from those applicable to the entire population, to those for the family, and the individual. Public health nurses translate knowledge from the health and social sciences to individuals and population groups through targeted intervention, programs, and advocacy (APHA, 1996).

When a public health nurse sets to work with a family, program, or project the nurse acts as a lynch pin connecting to the bigger wheel of public health knowledge, and can access the expertise that is needed in all areas to assist in problem solving. It is obvious that public health nurses can, and do, contribute much more than TCM oversight and the use of a database to the OHS collaboration. It is necessary to more clearly define

the role of the public health nurse within collaborative programs that assist high risk families. A clearer picture of what nurses have to offer OHS Programs would be useful in policy making and in the process of developing and modifying program design. To protect and promote the meaningful contribution that PHNs offer to the OHS Program is to assure a high quality of care for the families the programs serve.

Challenges in Defining the Oregon Healthy Start Role

Defining the role and the PHN's impact on such programs is imperative. However, a serious threat to reliability inherent in conducting a study of the outcomes of OHS Program designs related to the intensity of PHN involvement is that quantitative data concerning nursing outcomes is too spare. Usually outcomes are reported as multi-disciplinary group outcomes that are too general to show a strong correlation with nursing interventions. A qualitative exploration of the role is more likely to highlight the importance of complex and sometimes subtle connections PHNs weave in the web of the program design that enhances the overall outcomes.

The purpose of this study was to convene a panel of experts who support the program and ask them to state concisely what the role of the PHN is in the OHS Program. The question posed was: What is the unique role of the public health nurse that is vital to meeting the goals of the Oregon Healthy Start program? The panel will ultimately create a statement that defines the role of the PHN in the Oregon Healthy Start program that is supported by experts in that program and in public health nursing. Such a document will support and articulate the role of the PHN in the OHS Program and help assure the ongoing participation in, and the valuable contribution of PHNs to the quality of the

program. Without consensus regarding their role, the nurses' participation in the OHS Program may be in jeopardy.

Chapter II: Review of literature

What makes PHN involvement in programs for high risk families important? The literature holds a varied body of information on home visiting. David Olds, Ph.D. and Harriet Kitzman, Ph.D. have compared the results of randomized trials concerning home visit programs across the country and in other countries as well (Olds & Kitzman, 1993). Other research has compared outcomes of nurse directed programs to programs employing other professionals and paraprofessionals (Barnes-Boyd, C., Norr, K., Nacion, K., 1996; Deal, 1994; Barnes-Boyd, C., Norr, K., Nacion, K., 1996; Olds, D, 1992; Olds, D., Henderson, Jr., R., Chamberlin, R., Tatelbaum, R., 1986, 1986; Olds, D., Kitzman, H., 1990). Generally, the programs that are collaborations between nurses and others are reported as group outcomes. Unfortunately, nursing roles are not defined well enough to show up as unique in such studies. Olds and Kitzman (1993, pg. 82) state, "There are few consistencies in the pattern of program features that might explain which program characteristics contribute to enhanced effectiveness in preventing health and behavioral problems. For both behavioral and child health outcomes, the measures used are not well standardized." In regard to the risk characteristics of the families that are most likely to be helped, "There was no discernible pattern of program effect regarding program influence on health and behavior that might identify the types of at-risk families that are most likely to benefit from home visiting programs" (Olds and Kitzman, 1993, pg. 82). The differences in the quality of implementation and training and background of home visitors is likely to contribute to the difficulty in finding a pattern.

Olds and Kitzman (1993) have identified characteristics of programs that improve family outcomes. The most effective programs are those that are comprehensive, target high risk families, are staffed by well-trained professionals, and offer frequent visits. The majority of the programs that fit this description employ nurses. Those using paraprofessionals tend to be more narrowly focused. There is a need for further research to determine the mix of public health nurse and paraprofessional skills that most effectively impact the needs of low income and high risk families.

Deal (1994) searched the literature for articles that describe services and interventions provided by public health nurses and documented their effectiveness. The nurses' contributions were divided into two broad categories: home-based and community-level. The home-based category refers to nursing activities that are focused on the individual or the family. Community-level refers to activities which focus on high-risk populations with the aim to promote changes that improve the health of the community. She found that often studies have not shown benefits of home visiting because the study design used small sample group size, unclear or absent operational definition of the interventions evaluated, lack of proof of reliable measures, did not target high risk families, and interventions were limited in number and intensity of service. Intensity of service refers to the number of visits offered per month and the variety and comprehensiveness of the assistance available to the individual or family. More recently studies have been conducted in a more rigorous fashion, evaluating programs that target socio-demographically high risk groups and programs that provide comprehensive and intensive services. Deal (1994) states that, "More recent studies of higher methodological quality indicate that home-based interventions by nurses are indeed effective at promoting

maternal-child health when interventions begin prenatally, target women in high socio-demographic risk groups, and provide intensive services to meet comprehensive client needs." The result is evidenced in a more positive maternal self-perception, less maternal depression, greater social support and better maternal-infant interaction. Measures were used to evaluate child abuse and neglect, health behaviors, child health, growth, and development, and drug and alcohol use. The programs that demonstrated the best outcomes were initiated during pregnancy, allowed intervention to continue over a longer length of time. They were based on an ecological model of intervention, and targeted high risk families with multiple risk factors. An element of the programs is active case finding. Families often do not access services because they are suspicious of the "system", or they don't know how to access the system at all. Deal (1994) recommended collaboration between nurses and other professionals and paraprofessionals on home-based program designs.

PHNs were the key instigators of collaborations that spearheaded the original local Healthy Start programs because of their knowledge of the community need and commitment to assuring that issues of vulnerable populations are heard and addressed. Deal (1994) states that community-level activities and nursing interventions rely on the nurse's unique understanding of the needs faced by individuals, as well as the social, environmental, and economic conditions of the community. The PHN establishes community networks and provides leadership in program development. Also, PHNs assist in program evaluation and modification of programs to meet the needs of the community and foster community collaboration.

Families that are most successful in a program are those who believe they have a concrete need for the service. Families often drop out of programs when they feel that the program no longer addresses their needs. Olds and Kitzman (1990, 1993) suggest that low-income parents often do not perceive a need for special effort to help their children grow and develop, but they are concerned about physical health issues during pregnancy and their children's early childhood. Because nurses are trained in the management of family health and the prevention of health problems, there is a perception that they have the experience to answer to common questions parents ask about the health of their children. They are able to assist parents to problem-solve and find solutions, and are valued as home visitors. Having a nurse in the program to care directly for families, or to work together with the paraprofessional as a consultant and resource on health issues may keep families in the program longer.

Barnes-Boyd, et al (June, 1996) described the REACH program, which addressed the preventable causes of postneonatal mortality and morbidity. These included weight loss, respiratory problems, and diarrhea. They found that among the REACH program infants there were no neonatal deaths, and fewer postnatal deaths than found in the comparison group. "REACH and comparison infants had the same number and types of problems, but the monitoring and education provided by home visits may have helped the REACH mothers to manage their infants' problems and prevent them from becoming life threatening" (Barnes-Boyd, et al., June. 1996). REACH mothers were also more likely to breast-feed their infants. Targeting the health information to the actual health problems the infants may experience made the health teaching more relevant to the mothers. Public

health nurses can work directly with families to address these health concerns, but are also extremely valuable to collaborative programs when they teach paraprofessionals and others regarding health needs of families and evaluate the health component of programs.

Outcome measures employed in the studies of the effectiveness of nursing interventions include maternal depression, effective life skills, less smoking, continued education, decreased reliance on public assistance, unplanned and closely spaced pregnancies, adequate diet, breastfeeding, decreased drug and alcohol use, and greater social support. Measures of child outcomes include better maternal-child interaction, intellectual development, adequate birth weight and growth, less child abuse and neglect, and fewer emergency room visits.

Evolving Public Health Nursing Functions

The National Association of County Health Officials (NACHO) (July, 1993) published a report entitled "Core Public Health Functions". It was used as a basis for discussion regarding how public health fits into health care reform. It was meant to define the essential functions of public health, and create a common understanding of population-based health services and their role in health care reform. It also attempted to categorize those services that should be purchased through public funding mechanisms. The core functions, as described, consist of, "Assessment of community health status and available resources. Policy Development resulting in proposals to support and encourage better health. Assurance that needed services are available" (NACHO, July, 1993, pg. 4). In recent years public health has had to rely heavily on programmatic funding and Medicaid reimbursement, focusing nursing activities toward the individual client and away from

population-based services. The pendulum is now beginning to swing back. It is becoming clear that all three levels of activities must be maintained to assure individual, family and community health. "Public Health Nursing Within Core Public Health Functions: A Progress Report" (Public Health Nursing Directors of Washington, July, 1993) presents a model which demonstrates how public health nurses perform core public health functions on three levels: individual, family, and community.

Analyzing information about the community, family and individual is an essential skill that public health nurses use. In the course of their work with vulnerable populations, agencies, and private providers public health nurses develop trust and have access to valuable information on all three levels. Because of their intimate work with populations that are difficult to engage, they are often the first to identify emerging issues. The analysis of nursing assessments adds insight to the process of policy development that will affect the individual, family, and the broader community.

When defining the role of the PHN in collaborative programs like OHS, the core public health functions are key to identifying how the nurse can participate effectively with a multi-disciplinary team to make a difference for individuals, families and the community. The following example of how one nurse working within an OHS Program performed core public health functions may clarify this concept. A nurse supervisor of a team of home visitors in a local Healthy Start Program was told that a teen, who was parenting a premature baby, dropped out of the program shortly after enrolling because she didn't have time to meet with the home visitor. The nurse began to hear in case conferences with other HSHV that some of their families were leaving the program citing the same

reason. With the advent of Welfare Reform new mothers were being required to go back to school soon after the birth of their infants or enroll in the Jobs Program, which kept them away from home most of the day. The HSHVs offered to schedule their meetings in the evenings, but parents still refused because they had so little time for necessary activities such as grocery shopping, laundry, meals and bedtime routines.

The nurse knew that the early newborn period is especially stressful for new parents. It is a critical time when parents and infants develop lasting interaction patterns, breastfeeding is established, fertility resumes, and the parent learns important infant care practices that prevent illness and injury, among other adjustments to parenting. High risk families need support during this early phase of parenting, but their refusal of services was reasonable under the circumstances. The nurse made arrangements for the director of the regional Jobs Program to visit with the staff to create a solution. The Jobs Program subsequently made it clear to the regional Jobs Program staff and Welfare Case Managers that parents are allowed to count the weekly home visit from OHS Programs as a Jobs Program activity without putting their grants in jeopardy. Teens in school-based teen parent programs were allowed to count their group visits and individual school visits with the home visitor as well. In this way the nurse assessed the needs of one family headed by a high risk teen parent, as well as the needs of other vulnerable families. By bringing the problem to the attention of the Jobs Program and problem solving together a policy was instituted that assured the opportunity for program support for the community as well as for the one teen and her infant. This is an example of an individual assessment having policy development and assurance impacts for the community.

Identification of the most valued core public health nursing functions in the OHS collaboration will make measurement and comparison of the outcomes of different program designs possible in the future. Each one of the twelve local OHS Programs across the state is different. Variations among the Oregon programs make it exceedingly difficult to compare them. As expected in collaborative programs, outcomes are reported in a way that "shares the glory" among the collaborating partners. There are no measured outcomes that tie directly to nursing interventions. The literature gives few clues to what unique gifts nursing brings to a collaboration or how nursing influence can be teased out of the overall impact of such programs. In fact, the literature calls for more research on this subject.

If nursing is to become fully aware of its own place in multi-disciplinary program efforts, it must have research focused on the fruits of nursing skill and expertise that is brought to bear on the complex issues that families face. The research must be sensitive enough to register how these attributes of nursing affect outcomes in a preventative way in order to see what does not happen, or is prevented, when nurses are involved. In order to begin to evaluate the outcomes of public health nursing interventions it is first imperative to identify the functions that are most valued and needed by the OHS Program collaboration. Then the outcomes of programs that are designed to employ these functions can be compared to the outcomes of programs that use them less.

Chapter III: Methods

The subject of this study is a large and complex state program. It was important to find a workable way in which to proceed which recognized both the practical and political facets of the investigation.

Study Design

The intended result of this project was a statement defining the role of public health nurses in the Oregon Healthy Start program that is endorsed by the expert panel. It is hoped that the statement will assist providers in the OHS Program in developing the PHN's role to its full potential. The study design is qualitative in nature. The Delphi research method was used to facilitate a panel of experts in coming to a consensus regarding the unique role of public health nurses in the Healthy Start Program.

The Delphi method employs a series of interviews to elicit opinions, predictions or judgments from a panel of experts about a topic of interest. Several rounds of questions are used. Between interview sets the data are summarized and feedback is given to the participants regarding the developing opinions of the group. Each set of answers is used to construct the next round of questions in an effort to come to a consensus on an issue (McKenna, 1994). McKenna (1994) states,

> The Delphi process lends itself to areas of research where the aim is to identify opinions and ideological positions, and to reach agreement regarding these issues (Turoff, 1970). Lindeman (1975) maintains that it is especially effective in difficult areas which can benefit from subjective judgements on a collective basis, but for which there may be no definitive answer. (p. 1223)

The Delphi method was chosen as the most appropriate study design for this project, with the potential to produce consensus about the role of the PHN. The OHS Program is complex and the public health nurse's functions within it are diverse and varied in scope depending on the local program design. The design of the study was sensitive to the complex and subtle nuances of the current and potential role of the PHN, and competently

elicited opinions that were well considered and rich in detail. A qualitative study design can best accomplished this result. This Delphi process sets the stage for potential future support of the PHN role. The experts, who have authority and influence and who have agreed on the role of the PHN, may have an investment in the protection and promotion of the role in collaboration within the OHS Program. This may also smooth the political discord surrounding PHN involvement in the program.

Quantitative questionnaires do not allow for the depth of response needed, and focus groups, due to the distances between sites in the state, would be difficult and expensive to convene and repeat until consensus is reached.

Validity

The Delphi method enhanced the validity of the resulting consensus of opinion by allowing for comprehensive data triangulation and member checks among the expert panel members as a feature of the design process. This feature also reduced the effect of the inadvertent interjection of the researcher's own ideas into the consensus. This panel was not informed of the identity of the other panel members in order to reduce social desirability response bias. A potential threat to validity is inherent in the fact that the researcher/interviewer is known by the panel members to be involved with the OHS Program at the state level. This may have biased their comments to some degree, however, their responses and comments seemed quite candid.

Study Participants.

There are twelve Healthy Start programs which are more than two years old. They are located in the northwestern, southern, the combined Columbia basin and central regions, and eastern regions of Oregon. An invitation was sent to potential participants

(Appendix A). Twenty-one people were invited. Invitation was based on Healthy Start position category. These include:

1. HSHVs (4) - Paraprofessionals with special training through the OHS Program who work with families in the home,
2. PHNs (3) - Registered nurses with a public health background who work with program families,
3. local program managers (4) who may also be responsible for staff supervision, and who have backgrounds in public health nursing, education, and social work,
4. Local program supervisors (2) who supervise HSHV staff, and have backgrounds in early childhood education and mental health counseling,
5. local program collaborators (3) - partners representing health departments or local Commissions on Children and Families who responsible for the local Healthy Start Program, as well as others,
6. State collaborators (5) representing state public health nursing, the Oregon Healthy Start Program, the Oregon Commission on Children and Families, and the Oregon Healthy Start Evaluation team.

Participants had at least two years working experience with the Healthy Start Program, were known as experts in public health nursing, the Healthy Start program or both, and were interested in the topic of discussion. Because of the small number, all state level collaborators were invited to participate. Those participating were asked not to represent their role in the program, but to speak from their own personal experience and knowledge base.

Each of the four regions in Oregon where direct services have been provided for two years or more were represented (Appendix B). The reason for this is that currently PHNs function in different ways in programs that are different from each other due to the size of the program, density of population, and community need and characteristics. Having participants with experience in varied programs will assist panel members to distill the role of the nurse to one that is appropriate in any setting.

The invited experts expressed interest and eagerness to participate in the project. No one refused the opportunity. They were engaged and candid throughout the process, often mailing or faxing written information and articles that seemed to apply to the project. The intention of many of the panel members was to use the document in their own work in communities and in state level planning efforts. This supports the importance and timeliness of definition and clarity regarding the PHN's role in the OHS Program.

Procedures

All participants, after returning the signed form agreeing to participate (Appendix C), were sent a packet of background information about the role of public health nursing. This included a copy of the Oregon Healthy Start Goals, and a copy of two documents (Appendix D). These two documents are "The Definition and Role of Public Health Nursing: A Statement of APHA Public Health Nursing Section", March, 1996, and "Public Health Nursing and Maternal and Child Health Home Visiting Programs", Oregon Health Division, April 4, 1995.

Initial appointments were made at the convenience of the participants for telephone or personal interviews. The interviews were audio tape recorded, with permission from

the participants, in order to facilitate the summary and analysis of the data, and will be destroyed at the end of the project. Care was taken by the interviewer to phrase questions and responses to answers in an inquisitive, non-judgmental manner, and to clarify answers when unclear or incomplete. The Delphi interview process was repeated twice by phone and once by mail. It was intended that by the end of the Delphi process all participants were able to support the document defining the PHN role.

All interviews by phone were about an hour in length. The first interview was semi-structured. The interview schedule was composed of open-ended questions regarding aspects of the public health nurse's role in the OHS Program (Appendix E). The second interview was unstructured, using the draft document to stimulate specific feedback. The third revisions were made using the feedback of panel members who reviewed the second draft statement and returned their comments by mail.

Protection of Human Subjects

Before the first interviews were conducted each participant was given a detailed explanation of the purpose of the study, the research method, and the participant's responsibilities to the study. The written agreement to participate was signed by all panel members. Participants were assured in writing that the results of the interviews would be reported in a way that would not connect them personally with their own answers to promote honest consideration of the questions and decrease bias in answering. Transcribed and taped interviews will be destroyed at the end of the project. It is intended that the finished document will be the result of consensus of the group, and that panel members will support and endorse it enthusiastically. Panel members have the option to

sign the final document, but will not be required to do so. Those not in agreement with the final document will be given the opportunity to submit an alternative position in lieu of signing the document.

Chapter IV: Results

The result of the work of the Delphi panel is a document entitled, "The Public Health Nurse's Role in the Oregon Healthy Start Program: Opinion of an Expert Panel" (Dec. 1998), which includes its recommendations for the role of the nurse, citing the public health nurses' knowledge, skills, strengths and expertise, as well as examples of contributions the nurse can offer to the OHS Program. The statement also describes the challenges presented by systems, and common perceptions and concerns that act as barriers to the PHN's full and effective participation. Finally, the panel recommended design elements that facilitate integration of the expertise and skill of public health nurses in an effective and meaningful way (Appendix F).

Data Analysis

The Delphi method requires analysis of each interview to pick out the salient points, issues, and questions that need further clarification. The process requires a summary of each contact. The points are grouped into themes. A list of codes is used to categorize the themes or aspects which are revealed through the interviews. As more interviews are conducted theme codes are added as they appear.

The tapes and notes from the first interviews were used to itemize and code points made by the panel. They were then summarized, analyzed, and grouped into themes. This

data was used to write the draft document. The over-arching themes developed into the four aspects of the section, "The recommended role of the public health nurse in the Oregon Healthy Start Program." Supporting themes comprised the rationale for those aspects grouped as, "Knowledge, skills strengths, and expertise", and "Examples of contributions that Public Health Nurses can offer."

Themes identifying areas of tension that have resulted in barriers to effective integration of the nurse comprise the sections "Systems", and "Common perceptions and concerns." The section, "Recommended elements of program design that integrate the expertise and skill of public health nurses into the Healthy Start Program in an effective and meaningful way" was created from themes describing the ideal program design.

All points were used to develop the themes included in the draft document. Single contradictory points were clarified with the panel members submitting them (Appendix G). This usually resulted in further explanation that refined a theme, incorporation of the point into another theme, or withdrawal of the point in favor of another. The first draft document, when completed, was returned to the panel members for review.

The second set of interviews were unstructured, and used the first draft document as a reference, and refinement of it as a catalyst for discussion with panel members. The information from these interviews was summarized and analyzed. Themes were identified and appropriate changes were made to the first draft document (Appendix H). The second draft was then sent to the panel for written feedback. Comments were returned by mail. Summary and analysis of the third set of data were done in the same way, producing the final draft of the document (Appendix I).

Chapter V: Discussion

The panel of experts identified the most unique contributions that the PHN can make to the OHS Program. Those most valued are related to the PHN's knowledge, skills, strength, and expertise regarding health issues of young children and their families who are at significant health, medical and social risk. The PHN's approach is holistic and ecological, with the aim of health risk reduction, prevention of disease, and promotion of wellness. The PHN is able to performs core public health functions within the OHS Program for individual children and families, as well as the entire program population. The American public Health Association Public Health Nursing Section (1996) explains the PHN's role in this way:

> Public health nursing may be practiced by one public health nurse or by a group of public health nurses working collaboratively. In both instances, public health nurses are directly engaged in the inter-disciplinary activities of the core public health functions of assessment, assurance and policy development. Interventions or strategies may be targeted to multiple levels depending on where the most effective outcomes are possible. They include strategies aimed at entire population groups, families, or individuals. In any setting, the role of public health nurses focuses on the prevention of illness, injury or disability, the promotion of health, and maintenance of the health of populations (p. 2).

This broad skill and perspective can provide the program with population-based state and community health assessments, strategies developed to meet state and national public health goals, and access to expertise from related public health programs, such as communicable disease control and immunizations; reproductive and perinatal health; childhood injury prevention; nutrition; dental health; and others. When PHNs fully

participate in the OHS Program service quality is enhanced and more comprehensive. The panel articulated recognition and appreciation of the PHN as a unique partner and powerful resource to the program.

The Recommended Role of the Public Health Nurse in the Oregon Healthy Start Program

The panel's recommendation for the role for the public health nurse in the Oregon Healthy Start Program as follows:

1. Working Partner: To act as the key collaborative partner with a public health focus in meeting all program goals.
2. Health Expert: To integrate public health nursing knowledge and expertise to support the healthy growth and development of the Healthy Start population of young children and their families.
3. Communicator and Health Expert: To facilitate communication with, and access to, community resources and providers of health care when family health issues arise.
4. Health Consultant and Mentor: To work closely with the Healthy Start Home Visitors (HSHV) and offer consultation, support, mentoring and training.

The Public Health Nurse's Role in Collaboration

PHNs were seen by the panel as key collaborative partners. Inherent in the collaborative approach to the OHS Program is a challenge to partnering organizations and professionals. Ideally, collaboration is a durable and pervasive relationship. To attain

mutual goals it may be necessary to share resources unequally, and to share authority and power. Blending perspectives, resources and services in a new way can be both risky and mutually beneficial. For the most part, public health programs, PHNs, and their partners are attempting to leave behind old patterns, and are stretching to learn to function in a truly collaborative way. As one local collaborator put it,

> If you are working collaboratively you don't get to say, 'Well, do it anyway because I'm in charge'.

It has forced partners to blend aspects of their organizational structures, divide responsibilities, and dovetail their activities with families to avoid duplicating efforts and to maximize resources. It is a profound and sometimes painful system change.

Find common ground. The effort to collaborate has thrown differences among the partners into bold relief, but has also highlighted their similarities. For instance, collaborating disciplines employ different intervention models. The OHS Program employs a social work model to meet the goals the following goals:

1. Enhancing family stability
2. Supporting positive parenting practices
3. Promoting school readiness
4. Improving health outcomes for children and families
5. Reducing the incidence of child abuse and neglect (Oregon Commission on Children and Families Healthy Start, 11/12/97).

These goals are accomplished by addressing the social issues families faces. The health risks that accompany social issues are monitored by facilitating access to, and compliance

with, routine health care, such as well child care and immunizations. Whenever social issues cause health issues that cannot be addresses with routine case management the help of health professionals is recruited.

In contrast, the public health nursing model begins with the family 's health issue or risk. The expert panel identified the importance of the PHN's health expertise. The APHA (1996) defines the PHNs role in this way:

> Public health nursing is the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences (p. 1).

When a nursing assessment reveals that the health issue or risk is caused or influenced by a social issue which cannot be resolved by routine case management, the nurse involves a social work professional. It is difficult for PHNs to separate social issues from health issues when dealing with families. The OHS Program challenges PHNs to learn to rely on the their partners to take responsibility for assisting enrolled families in this area. This different models, however, are built upon a shared understanding of how social issues affect families. It provides philosophical common ground on which to base the OHS Program collaboration, to inform policy decisions, and to motivate commitment to quality.

Avoid duplication of services. There is concern among many, that PHNs and HSHVs may duplicate services to families in the program. Panel members described how they visualize PHNs working in collaboration without duplicating services. One program manager used the analogy of services received in a bank:

> The teller at the bank meets the 'bankee' and provides direct service on the front line. If there is a need for anything more complicated than cashing checks and

> moving money from one account to the other, another layer of expertise is brought in. The back layer of health expertise is the PHNs' area...The (HSHV) works with them by having keen observation skills so she can call in consultation when needed.

Another expert likened the collaboration to baseball:

> It's kind of like bringing in a pinch hitter in baseball. You bring a specific set of skills to a specific situation and you hope the outcome is good.

One expert said,

> They (HSHV) are a bridge to the expertise of the nurse...They value their role as generalists.

In the community a symbiotic association between the PHN and the HSHV can result in comprehensive and effective services. An example given by one panel member illustrates how the PHN and the HSHV can work together without duplicating services:

> The (HSHV) became concerned about the infant's development. He wasn't sitting up when he should have. She called the PHN to discuss the concern and get consultation. The (HSHV) did not have the expertise to recommend a course of action to the parent, as the PHN could, but the nurse didn't have to visit frequently because the (HSHV) was monitoring for anything out of the ordinary and would consult with the nurse, if needed. They continue to check in with each other and re-evaluate as they go along with the family.

In this example the PHN acted as a working partner by collaborating with the HSHV around the health needs of the infant. The family received the benefited of the PHN's

health expertise, and the HSHV had on-going PHN consultation while visiting the family. When PHNs contribute their knowledge, skills, strength and expertise to the OHS Program, systems can be developed that support this kind of consistent teamwork without duplication of service. These systems are indicative of collaborations that;

1. effectively integrates a health component into the program,
2. can have a positive impact on the health of enrolled families, and
3. is likely to move the program toward meeting it's goals.

The Public Health Nurse's Role with Enrolled Families

The expert panel agreed that the PHN's perspective has value at the community program level in direct work with enrolled families. Panel members gave numerous accounts of the PHN's value as a health expert, and consultant. One program manager remarked,

> ...promoting healthy growth and development, that's where without question the (HSHV) see the expertise of the nurse and always refer back to them there .

Consultant. The panel members listed unique contributions PHN can make that enhance the quality of home visiting services for program families. They identified the PHN as a working partner and consultant when health related interventions and case management services are needed. This is especially true when a family's need for support and care are above and beyond routine health maintenance. When a family's health needs can be met with simple health education and resource referral by the HSHV, PHN consultation and assessment on an "as needed" basis was deemed essential in order to prevent health problems, and to avoid missing important changes in health status. This is especially important when the family is at high health and social risk.

Home visitor and case manager. When health needs are complex the PHN can take the lead, working closely with the family, making home visits, consulting and flexibly coordinating activities the with the HSHV. A story shared by a PHN exemplified the importance of the PHN's expertise in the program. The HSHV in the local program had been visiting a family with a child who seemed to be having difficulty hearing. The HSHV consulted with the PHN, and they decided that the PHN would make a home visit to assess the child. She performed hearing and developmental screens, which both scored in the abnormal range. During the PHN's thorough nursing assessment of the child's health history, current health, behavior, environment, and the parent's observations and concerns, she realized that this was not a hearing problem. The PHN recognized the need for further assessment. She communicated with specialists and made referrals for the child, who subsequently was diagnosed with autism. She continued to advocate for the family to access services for their child. She was able to offered the parents information about autism, along with supportive resources to help them parent and care for this special child. This kind of comprehensive health assessment skill, and ability to design specific health interventions is unique to public health nursing. It is essential to home visiting programs that provide comprehensive home visiting services to families with young children, such as the OHS Program.

Communicator and resource linker. In this story the PHN functioned not only as a health expert and consultant, but also was an important link to needed health resources. The panel agreed that the PHN is important as a communicator and health resource linker. Families experience difficulty accessing health resources for a variety of reasons. The

PHN is able to effectively advocate for needed care due to a sophisticated understanding of the health care system, and credibility and relationships within it. One PHN gave an example of consulting with a pediatrician regarding a child with a developmental delay:

> I think he (the pediatrician) realized that this kid wasn't looking exactly right, but our ability to have something concrete on paper that says we went through this standardized test and this is what we saw...I think that gives credibility to the program. And it backs the (HSHV). It makes them feel like they're not left holding the bag as far as making sure this kid gets what he needs.

The PHN is the natural first choice to communicate with health care providers about possible or actual health problems of children and their parents.

The Public Health Nurse's Program Role

The PHN's unique perspective was also valued by the expert panel when it is applied to the OHS Program itself. PHN contributions identified as most important relate to the development of the health component of the program at both the state and local community level. They agreed that the integration of the health perspective can move the program toward meeting not only the health goals, but all OHS Program goals. A state collaborator commented:

> They (PHNs) have a more well rounded cross-trained approach to things. And basically, I think, with very young babies the health issues are paramount, and that is how you establish rapport with families...centered around health. And if you don't have that kind of substance, and you don't have that aspect to the curriculum, you're not going to reach these other goals, which are more indirect kinds of things.

The PHN is the working partner with a public health focus essential to the development and refinement of the health component of the program, as well as an essential contributor to the overall successes of enrolled families. The PHN can contribute as a working partner in the organization of the program, offering health expertise by;

1. providing skills in the development of health promotion materials for families,
2. developing and facilitating liaisons between the program and health providers and agencies at community and state levels,
3. using health data to assist in community assessment , and monitor health outcomes,
4. developing strategies to assure that program health outcomes are met,
5. participating as an advocate at community, state, and national levels for programs that target children at risk, and by
6. acting as a point of entry into the program through triage and assessment functions.

The PHN's experience and professional history using the home visit strategy to reach high risk families was considered by the panel to be an asset to the program. A knowledgeable and experienced PHN was seen as a valuable mentor. One HSHV stated:

> ...the health nurse, with her expertise, is critical in helping us as (HSHV) when we haven't had that nursing background. They can be a teacher to us. That's a strong point.

The PHN can share this strength by offering training and support, especially for home visitors who are new to the program.

Barriers to the Effective Integration of the Public Health Nurse Role

The panel members identified two types of barriers to the effective integration of the PHN's role:

1. Barriers that exist in the organizational system and design of the program.
2. Stumbling blocks caused by common perceptions and unresolved concerns of people working in the program.

The system barriers in some respects have acted as catalysts for the misconceptions and fears that have negatively influence human interactions.

Systems issues

Unclear roles and boundaries. The system barrier that experts mentioned most often is the lack of clearly defined roles and boundaries for PHNs and HSHVs. There is very little scholarly research on which to base a program design that will effectively blend PHN and paraprofessional home visit services, therefore local collaborators have integrated PHNs into community programs in diverse ways. There is uncertainty which of these designs utilize the PHN's knowledge, skills, strengths, and expertise in the most effective or appropriate way. It has fueled discussion regarding the quality of the program, and the most effective and efficient use of resources for home visit services. It has caused confusion that is evident at both the state and community level and sparked concern over possible duplication of services to families. One PHN gave an example:

> ...we went to the county commissioners to talk about the budget and they said 'but you have all the staff doing the same things as PHNs. Why do we need PHNs?' It's like... no! HSHV don't do the same things that PHNs do. They don't

always serve the same population that PHNs can, or do the same things.

This confusion may stem from a pervasive misunderstanding of the differences between home visit services provided by PHNs and those provided by HSHVs. Both use the home visit modality to provide service to families, however, the services differ in focus, approach, intensity, and type of intervention. Often the boundaries between the PHN's role and the HSHV's role are blurred. Few programs have clearly defined the boundaries between the two roles, nor written job descriptions that reflect the relationship between them. PHNs often do not understand their responsibilities to the program. HSHVs are somewhat uncertain about when to call in PHNs, or what they can expect from them. A HSHV explained:

> ...we don't understand that the relationship needs to be close... working together. It causes confusion because there is no job description: 'This is exactly what you need to do.' With Healthy Start programs coming in as fast as they are... it's hard for people to catch up to the fact that it's all going to be teamwork thing.

Decisions regarding the way in which PHNs will work within the program have an impact on the quality of the program, and will be felt by the families served.

The relationship of the PHN role in the program is confounded further by the use of the common use of the term "paraprofessional" for the HSHV. Some programs have hired HSHV from the communities they serve, and do not require an advanced educational background beyond high school. Most programs, however, have hired HSHV with associate, baccalaureate, and graduate degrees. A program manager put it succinctly:

> Their label (PHN) defines their job. The 'paraprofessional' label just defines their status, and it is only defined as 'not professional'.

Nurses are uncertain of the level of assessment and problem-solving skills to expect of the HSHVs. One program manager asserted that there is a belief that,

> ...the (HSHV) with a higher degree is better equipped to do home visits. This isn't necessarily so. The PHN should be relating in the same way, and not make an assumption that the (HSHV) will understand the health issues. As long as they are not PHNs they are 'paraprofessionals'.

Because of this confusion PHNs are unsure of their professional and legal responsibility for services provided together with HSHV. In some cases this limits their involvement in the program.

On the other hand, the expert panel agreed that PHNs working in the OHS Programs also have varying levels of preparation for the role. One local collaborator admitted,

> Unfortunately, PHNs don't all have background, preparation and experience that is diverse so they can function in a comprehensive way in Healthy Start.

However, a HSHV countered,

> We have nurses here with an average of about twenty years of home visitation experience individually. In Other words, most of them have been doing this kind of service to the public since the beginning of their working careers.

In many areas of the state programs have difficulty finding nurse applicants from which to choose who come with public health education and training. Experience working in

community settings also varies among them. This may be due in part to the reduction in PHN home visit programs in Oregon previous to the OHS Program.

Different approaches to work with families. Another system barrier to integration of the PHN results from the inherently different approaches PHNs and HSHV employ when working with families. This is due to their different focuses of intervention, and individual organizational characteristics and program requirements. The HSHV's focus is on building family's strengths, and supporting positive parenting. They provide long term support to encourage the family to learn new skills; act independently; and become self sufficient over time. The PHN's interventions are usually shorter term, focusing on health related issues that are of a more urgent nature. The PHN often assists the parents to resolve health issues by teaching them specific skills; accessing other resources; and by taking the lead with interventions within the health system on the family's behalf. Confusion results for the PHN, HSHV, and family when roles are unclear, however, clearly defined roles can result in a balanced team approach.

Organizational differences. Variation among collaborating organizations was also named as a significant barrier to the integration of the PHN role. The delivery of high quality services together despite different organizational cultures, perspectives, and approaches is a significant challenge for Healthy Start collaboration at the state and community level. Health department program eligibility criteria sometimes differs from that of the OHS Program. Varying organizational rules and systems which include salaries and benefits, paperwork requirements, and even office locations complicate the effort to work together.

Inadequate communication systems. The panel members agreed that many individual community program system designs may not build in regular time for communication between the PHN and the HSHV. In most programs, the PHN does not have an existing structure for communication and consultation with the HSHV, as the program supervisor has. Time may not be factored into the week for meetings to consult on cases, to make mutual plans regarding coordination of services, or to debrief with each other. Both PHNs and HSHV spend much of their time in the field away from their offices. Some programs do not have technical communication systems, such as voice mail or e-mail for their staff. It is difficult to leave detailed messages about mutual families with an office assistant. Communication patterns tend to be less frequent and adequate when the PHN is not located near or in the office with the HSHV.

Lack of funding. Finally, lack of funding for public health nursing services was identified as a barrier to full integration of the PHN role. Even though the OHS Program is a collaboration with public health, the competitive state legislative process has pitted the Oregon Commission on Children and Families and the Oregon Health Division against each other to secure funding for these collaborative services. When public health looses funding the OHS Program collaboration looses a portion of the PHNs contribution. One PHN summed it up:

> It's always hard to see people fall through the cracks, but people do. Public health continues to lose so much as far as what they're supported financially to do. There's still this expectation that they should take care of things and take care of people, but they don't have the support they need to do it.

A program manager admitted:

> Availability! That makes a good working relationship because the (HSHV) see families so frequently they need feedback more frequently. It's tough when the nurse is busy out there and unavailable.

Panel members saw the lack of available funding for public health nursing programs as having a negative effecting on the time PHNs have to devote to the program. This limits the scope of their contribution.

Common Perceptions and Concerns

Several common negative perceptions and concerns were mentioned by the panel members as frequent barriers to the full integration of the PHN's role into the program. They acknowledged that they did not necessarily share these attitudes, but experience has made them aware that they exist. The panel also agreed that though these perception and concerns are common, they are not pervasive. They are more likely to cause problems where they are most strongly felt. Misconceptions and hard feelings have often resulted from system designs that inadvertently discourage teamwork and communication. Positive working relationships develop slowly, if at all, under these circumstances. Panel members expressed guarded optimism, however. They observed that trust developing over time among collaborators has begun to improve working relationships. Perhaps bringing these problems to light will motivate changes to the system that improve perceptions and ease the concerns.

History. Panel members cited the contentious political birth of the OHS Program as the beginning of a thread of resentment that ran through collaborations from the state

to community levels. Though tensions have eased over the four years of the program's existence, stress on the system, such as budget cuts, can exacerbate it. This resentment may play a role in the common perception of unequal power between the PHN and the HSHV. One HSHV remarked:

> You felt like the nurse just told you what to do, and you didn't have any input in that situation. You didn't agree with it, but didn't have any recourse.

It may also be a factor in the disagreement between PHNs and the OHS Program about the interpreted value of research and supporting data for each other's program models.

Unclear understanding of PHN and HSHV Contributions. Panel members believe there are misconceptions by both PHNs and HSHV regarding how what they do day-to-day in the program contributes to reaching the goals of the OHS Program. They do not see the differences in what they contribute. Some PHNs and HSHV believe that they actually duplicate each other's services when working with mutual families through home visiting. In some cases, PHNs fear that the less expensive HSHV will replace them in home-based care for families with young children in Oregon. This has led to competition between them for the community's population of young families.

Unclear PHN responsibility. PHNs are unsure of their own level of legal and professional responsibility for the independent actions of HSHVs related to the health of program families. They are not sure of the level of supervision for HSHVs regarding health issues, and are concerned that HSHVs may over step their scope of practice, or overlook family health issues without regular PHN consultation.

Use of Funds. Panel members mentioned the frequent belief among PHNs that the unique value of their role was linked to generating TCM reimbursement for the program by overseeing the TCM plans and follow-up activities of the HSHVs. When Medicaid Administrative Match funding was instituted instead, and this function was no longer necessary, PHNs could no longer identify their unique role.

Cultural differences between HSHVs and PHNs. Panel members also agreed that in programs where there are cultural difference between the PHNs and the HSHVs there may be organizational and personal challenges to relationships among team members.

Recommended Elements of Program Design

Each community is different and is charged with the task of designing a program that best suits the unique needs of families who live there. What PHNs do in each program may be different, but if these elements are in place, the PHN will be able to participate in a meaningful way for the benefit of the OHS population, and to meet the goals of the program. The panel suggested that OHS Program local collaborators use the elements to guide their efforts to design the PHN role in a way that best fits their individual resource availability, program, and community needs. These are the elements of program design, recommended by the panel of experts, that integrate the expertise and skill of public health nurses into the OHS Program in an effective and meaningful way.

Role and Boundaries

It is important that roles and boundaries for both PHNs and HSHVs be clearly written as job descriptions and policies, and should supported at both the state and

community levels. They should be expressed as expectations to all staff working in the program. If this is true, differences in roles and boundaries are more likely to be understood and accepted by all staff members.

Roles. All staff members should understand how their unique roles blend together in a multi-disciplinary approach to reaching program goals. Differing approaches to working with families should be both tolerated and integrated into the program, as long as they support the OHS philosophy and goals. The panel expressed the need to find a replacement for the term "paraprofessional" that more accurately describes the role of the HSHV. When the PHN and HSHV roles are clear, families who have contact with them will have more accurate expectations of them.

The panel recommended that the PHN role include early involvement with families with infants birth to age two. This contact with the family should be used for nursing assessment and planning for collaborative care and support, especially for those with health risks or challenges. They also supported on-going research based exploration of best practices regarding PHN and HSHV program models to assist with the integration of the PHN role into the OHS Program model.

Boundaries. There should be clear guidelines describing the circumstances that initiate a PHN consultation or family referral.

Adequate Time Is Available for PHNs to Participate in the Program

PHNs need adequate time to participate and consult with the OHS Program staff. This may require exploration of funding sources to pay for the PHN's time in the program.

Valued elements of PHN participation and consultation include:

1. collaboration on plans and coordination of care for families,
2. joint home visiting with the HSHV when needed,
3. home visiting for families , especially when the infant is young (birth to age two years) and has a health or medical issue
4. participation in joint staff meetings, trainings, and opportunities for debriefing, socializing and developing collegial relationships,
5. regular PHN offerings of training regarding a variety of pertinent topics, and
6. participation in program development and problem-solving.

Communication Is Encouraged Between PHNS and HSHV

The panel members agreed that when OHS Program and health department staff are housed in the same office communication opportunities and quality are enhanced. Program philosophy and design should encourage:

1. regular and frequent, open and reciprocal communication between the PHN and the HSHV to plan their activities with mutual families,
2. to avoid duplication of services,
3. to engage in organizational problem-solving, and
4. to address training needs.

Spontaneous up-dating of information about families can be facilitated by paper and technical communication systems, such as voice mail, e-mail, and shared files and care plans. Time allotted for regular meetings between PHNs and HSHV is essential.

Collaborators Support Skillful PHN and HSHV Practice

Collaborators should consult on the development of hiring practices, orientation, training, and supervision that support PHNs and HSHVs in carrying out their roles in a skillful way. Collaborators should also have a consultation role in hiring decisions.

Qualifications for the PHN and HSHV roles. Nurses hired to work with the OHS Program ideally should have an educational background and experience that includes:

1. public health theory and practice (bachelors degree in nursing),
2. skills in parent-child interaction assessment, and
3. at least two years supervised experience working with families in a community setting.

This may not be possible in communities where there is a shortage of nurses with this background.

Applicants hired for the HSHV role should have the qualifications that meet the role responsibilities. It may be necessary for community programs to decide upon the minimum level of education and experience that best fits their program needs.

Supervision and training. Supervision of the PHN and HSHV should be regular, comprehensive, and of high quality. Also, high quality training that is regular and on-going should be provided for all PHNs, HSHVs, and supervisors through the program. Cultural sensitivity and competence should be a theme that is developed through training, experience and facilitation.

Staff Members Are Able to Forge Relationships Based on Good Will

Staff members are most able to work in teams when they are can forge effective, collaborative, and smooth working relationships based on skills and abilities that foster good will. These include, but are not limited to:

1. interpersonal communication skills that depersonalize problems, accomplishes confrontation in a support way, and are culturally competent,
2. patience, flexibility, and a sense of humor, and
3. a willingness to develop rapport with co-workers and learn from each other.

Efforts to hire people with these abilities, and assist staff members to refine them, will enhance teamwork and collaboration in the program.

State Collaborators Work Together

State collaborators should demonstrate understanding and appreciation of each other's respective contributions to the OHS Program, and work together to support and improve the quality of the program. There must also be a commitment to the assurance of adequate funding for all aspects of the integrated OHS Program model for the program to survive and be effective. At the state level among collaborators and legislators there should be a clear understanding of, and support for, the role of public health in the OHS Program. Exploration of effective models that incorporate the expertise and skill of home visitors and PHNs is essential. Flexibility in community and state OHS Program designs will allow for creative organizational problem-solving among collaborators without diluting the quality of the program. This judicious flexibility can be instrumental in finding

ways to fit the OHS Program model into a continuum of programs that assists Oregon's young children and their families.

Summary

The political birth of the Oregon Healthy Start (OHS) Program resulted in a strained relationship between the Oregon Commission on Children and Families (OCCF) and the Oregon Health Division (OHD). In 1993 Oregon authorized legislation for the Healthy Start initiative. It was based on the Hawaii Healthy Start model and the Healthy Families of America initiative (adopted by the National Committee to Prevent Child Abuse in 1992). The Oregon initiative integrates public health as a key partner in building on existing community resources to meet the goals of the Oregon Healthy Start Program goals. There has, however, been no clear direction regarding the design of the partnership with public health. The role of the public health nurse (PHN) varies in the organizational design and structure of local collaborations through out the state. Currently, there is still no standard definition of the most effective role for the nurse in the Oregon Healthy Start Program.

Purpose of the Project

The Oregon Healthy Start Program (OHS) uses a collaborative, multi-disciplinary approach to helping families where young children are at high risk of poor emotional, intellectual and physical development, and child abuse. The model employs Healthy Start Home Visitors (HSHV), paraprofessionals trained in home visiting skills, to deliver home based services. Public health nurses (PHNs) participate in the OHS Program in a variety

of ways throughout the state. The purpose of this project was to better define the most unique and effective role for the PHN in the program.

Literature Review

A review of the literature revealed that programs employing nurses to deliver service are effective at promoting maternal child health. They are most effective when services are:

1. initiated prenatally,
2. provided to women who are socially at risk, and
3. address complex needs with intensive services.

Nurses have skills that can assist families to problem-solve and to make positive life changes. In fact, most of the programs that fit this description employ nurses. PHNs are described as uniquely aware of the strengths and needs of the community, as well as those of individuals within it, and that they have credibility with both. PHNs have valuable information about the community because of their work with vulnerable populations, agencies and private providers. Using core public health functions to guide their practice, they focus interventions on the individual, family, and the community through performance of assessment, policy development, and assurance activities. The literature supports their ability to provide leadership in program development and evaluation.

Collaborative home visit programs usually report program outcomes that "share the glory" for triumphs among all collaborators. The PHN's role is not defined well enough in collaborative models to be connected with unique outcomes. There is little in the literature regarding the unique gifts that PHNs bring to these kinds of programs.

Before PHNs can learn how to offer their knowledge, skills, strengths, and expertise in an effective way to collaborative programs, like the OHS Program, it is imperative that further research be done to determine the PHN functions that are considered most valuable, and then connect them to the outcomes that they produce.

Method

This project set out to facilitate a group of experts, in public health nursing and the OHS Program, in coming to a consensus of opinion regarding the most unique, valuable, and effective role for the PHN in the Oregon Healthy Start Program. Through a qualitative research design, a Delphi panel of experts was convened. The expert panel was chosen for their varying perspectives. They held positions as:

1. HSHVs,
2. PHNs,
3. local program collaborators,
4. managers and supervisors, and
5. state collaborators.

They had different educational and professional backgrounds, and lived and worked in different parts of the state. Data from three sets of interviews with each panel member was analyzed, grouped into themes, and summarized.

Results

The process resulted in a document supported by the expert panel that makes a recommendation for the role of the public health in the OHS Program:

1. Working Partner: To act as the key collaborative partner with a public health focus in meeting all program goals.

2. Health Expert: To integrate public health nursing knowledge and expertise to support the healthy growth and development of the Healthy Start population of young children and their families.

3. Communicator and Health Expert: To facilitate communication with, and access to, community resources and providers of health care when family health issues arise.

4. Health Consultant and Mentor: To work closely with the Healthy Start Home Visitors (HSHV) and offer consultation, support, mentoring and training.

The document explored barriers to full integration of the PHN role into the program. These barriers were traced to systems issues and common perceptions and concerns within the program. The document also makes recommends elements of program design that integrate the PHN role in a meaningful way.

Though based on the Hawaii Healthy Start model and the Healthy Families of America initiative, the subject of this project is a program that has developed into an original Oregon model. The discussion and work that the panel has done has been based on the historical, organizational, professional, and political variables that exist in Oregon. However, some of the findings may be generalizable to other similar programs. This may be especially true for those findings that relate to universal public health nursing

knowledge, skills, strengths and expertise. Systems identified as barriers to integration of the PHN role into the OHS Program may also ring true for programs with similar systems.

Conclusions

Collaborations can be complicated and require new ways of thinking to succeed. Though the social work model that OHS Program is based upon is different from the PHN model, both disciplines have a history of experience dealing with the social problems that affect families. This shared understanding can create common ground from which to approach programmatic issues. The exploration of the role of the PHN in the OHS program has exposed public health nursing as a powerful resource to Oregon's population of young children and their families. Its strengths emanate from unique skills, expertise, and knowledge base. The challenge to the OHS Program collaboration is to integrate these strengths by surmounting barriers which can limit the PHN's involvement in the program, and thwart smooth working relationships. The public health nursing perspective can add an invaluable depth to the program, and help to move it toward meeting all of its goals. The full integration of the PHN role into the OHS Program can have a significant impact on young enrolled families, and improve life for children across the state. The effort is well worth the reward.

Reference List

American Public Health Association Public Health Nursing Section (Mar., 1996) The Definition and Role of Public Health Nursing. Washington, D.C.: Author.

Association of Oregon Public Health Nursing Supervisors (April 4, 1995) Public Health Nursing and Maternal and Child Health home Visiting Programs.

Barnes-Boyd, C., Norr, K., Nacion, K. (June, 1996). Evaluation of an interagency home visiting program to reduce postneonatal mortality in disadvantaged communities. Public Health Nursing, 13 (3), 201-208.

Deal, L. W. (Oct., 1994). The effectiveness of community health nursing interventions: a literature review. Public Health Nursing, 11 (5), 315-323.

Helvie, C. O. (1990). Advanced Practice in the Community. In D. Ruth (Ed.), Community Analysis and Community Diagnosis (pp. 208-233). Thousand Oaks, Ca.: Sage.

May, K. M., McLaughlin, F., Penner, M., (June, 1991). Preventing low birth weight: marketing and volunteer outreach. Public Health Nursing, 8 (2), 97-104.

Mc Kenna, H. (1994). The Delphi Technique: a Worthwhile Research approach for nursing? Journal of Advanced Nursing, 19, 1221-1225.

National Association of County Health Officials (July, 1993). Core public health functions. Washington, D.C.: Author.

Olds, D. L. (June, 1992). Home visitation for pregnant women and parents of young children. American Journal of Diseases of Children, 146, 704-708.

Olds, D., Henderson, C. R., Chamberlin, R., Tatelbaum, R. (1986), Improving the delivery of prenatal care and outcomes of pregnancy: A randomized trial of nurse home visitation. Pediatrics, 77, 16-28.

Olds, D., Henderson, C. R., Chamberlin, R., Tatelbaum, R. (1986), Preventing child abuse and neglect: a randomized trial of nurse home visitation. Pediatrics, 78, 65-78.

Olds, D., Kitzman, H. (1990). Can home visitation improve the health of women and children at environmental risk? Pediatrics, 86, 108-116.

Olds, D. L., Kitzman, H. (1993). Review of research on home visiting for pregnant women and parents of young children. The Future of Children: Home Visiting, 3 (3), 53-92.

Oregon Commission on Children and Families. (July 1, 1996-JUNE 30, 1997). Oregon's Healthy Start Effort 1996-97 Status Report: Part 1, 6. Salem, Oregon: Author.

Pratt, C., Katzev, A., Henderson, T. (March, 1996) . Oregon's Healthy Start effort interim report. Oregon State University, Corvallis, Or.

Public Health Nursing Directors of Washington (July, 1993). Public health nursing within core public health functions. Olympia, WA.: Author.

Saunders, E. J., Goodall, K. (Nov.-Dec., 1985). A social services-public health partnership in child protection: a rural model. Public Health Reports, 100 (6), 663-666.

Suppiah, C. (Feb., 1994). Working in partnership with community mothers. Health Visitor, 67 (2), 51-3.

Appendix A

Invitation letter

June 9, 1998

Dear ,

I am a graduate nursing student at the Oregon Health Sciences University School of Nursing (OHSU). In my work as the Babies First! Co-coordinator for the Oregon Health Division, and earlier as manager of MCH programs at Deschutes County Health Department, I have had an opportunity to be involved with the Oregon Healthy Start program from its inception. I have observed that the role of the public health nurse in the Healthy Start program design varies from one site to the next, and that it is usually not well defined or understood. I have chosen to better clarify this role through the masters research project that is required for graduation from OHSU. I would like to invite you to participate in the expert panel that will be defining the unique role of the public health nurse that is vital to meeting the goals of the Oregon Healthy Start program.

The panel will consist of expert public health nurses, home visitors, managers, and directors within the Oregon Healthy Start program, and Oregon Healthy Start collaborators and expert public health nurses at both state and national levels. All panel members will be interviewed regarding their opinions about the role of public health nurses in the Oregon Healthy Start program. The interview replies of panel members' will be held in confidence. Subsequent rounds of interviews will be conducted until the panel members reach a consensus. The information from the interviews will be analyzed and a document will be developed and modified that better defines the role. Panel members will have the opportunity to show their endorsement and support of the definition by signing the final document. It will then be shared with the Oregon Healthy Start Program and its collaborators at all levels for use in future program design and policy making.

I would be pleased to include you in the expert panel. Sharing your opinions and thoughts regarding the public health nurses' role will clear the muddy waters and may result in better use of the public health nurse's gifts in the program. This could improve efficiency, communication and program quality, and ultimately will positively affect the families that this collaboration serves. If you would like to participate in the panel, please read and sign the attached explanation of the project and return it to me in the stamped envelope provided.

Thank you for considering participation in this project. I will be looking forward to your reply.

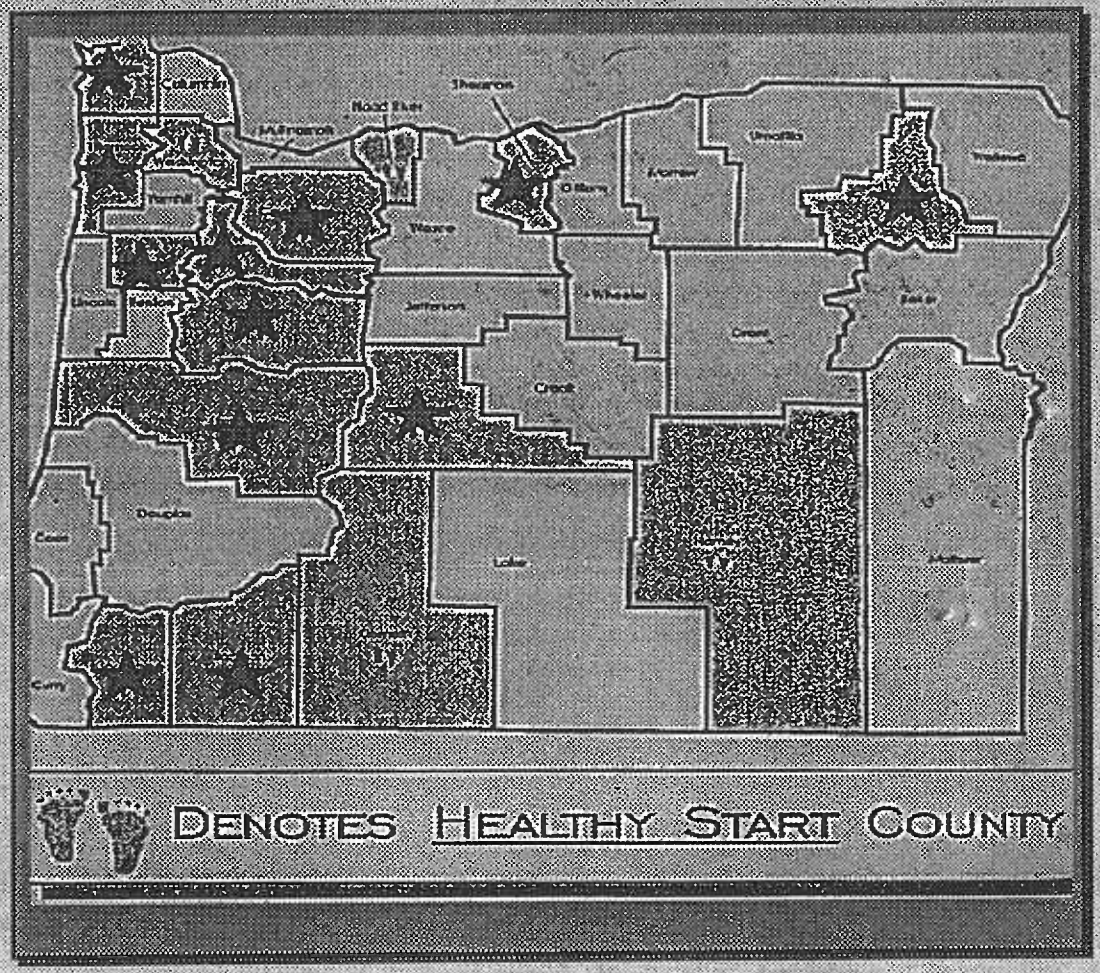
Sincerely,

Dianna L. Pickett
Graduate Nursing Student
Oregon Health Sciences University
School of Nursing

Appendix B

Map

★Healthy Start Programs with two or more years in operation



Appendix C

Invitation to participate

INVITATION TO PARTICIPATE IN AN EXPERT PANEL
TO DEFINE:
WHAT IS THE UNIQUE ROLE OF THE PUBLIC HEALTH NURSE THAT IS VITAL TO MEETING THE GOALS OF THE OREGON HEALTHY START PROGRAM?

PURPOSE:
You have been invited to participate because you are a recognized expert working within the Healthy Start program, working as a public health nurse, or both, and you have had at least two years working experience. The purpose of the project is to define the role of the public health nurse that is essential to meeting Healthy Start program goals. I am conducting the project as part of the requirements for a masters degree in nursing.

PROCEDURES:
I will send you two documents that will provide background information about the role of public health nursing, and then will be interviewed about the role of the public health nurse in the Healthy Start program. Reading the materials will take about an hour. The first round of panel interviews will be analyzed for common themes and then a second round of interviews will be conducted to clarify the opinions of the panel. These interviews will last no more than one hour, will be done in person or by phone, and will be scheduled at your convenience. No individual response will be identifiable in the finished document, nor to others outside the interview. Questions will be presented in subsequent rounds of interviews until the panel has reached consensus regarding the public health nurses' role in Healthy Start programs. At the end of the project a document will be developed that reflects this consensus. It will be presented to Healthy Start programs, collaborators and policy makers for their use. Panel members will have the opportunity to sign the document to show their support of the public health nurse role as defined.

BENEFITS:
The primary beneficiaries of this project will be the families who receive services through Oregon Healthy Start programs. By sharing opinions, experience and expertise the participants may provide information that will further develop the public health nurse's role in the Healthy Start program to the benefit of the families it serves. However, those working in the program and collaborating at all levels will have a clearer understanding of the public health nurse's abilities and purpose. This could improve efficiency, communication, and program quality, indirectly benefiting all panel participants, too.

CONFIDENTIALITY:
All collected information will be available only to Dianna Pickett and the members of her project committee. Diverse opinions are appreciated and will not affect your relationship with the Oregon Health Division or Oregon Healthy Start program staff. It is the intention of the investigator that the resulting definition of the public health nurse's role in Oregon Healthy Start programs will be consensual. All participants will have the option to show support by signing the final document it at the end of the project.

COSTS:
The investigator will cover all costs incurred by this project.

LIABILITY:
The Oregon Health Sciences University, as a public institution, is subject to the Oregon Tort Claims Act, and is self-insured for liability claims. If you suffer any injury from this research project, compensation would be available to you only if you establish that the injury occurred through the fault of the University, its officers, or employees. If you have further questions, please call the Medical Services Director at (503) 494-8014.

PARTICIPATION:
Dianna L. Pickett, (541) 385-8496, has offered to answer any other questions you may have about this project. If you have any questions regarding participation, you may contact the Oregon Health Sciences University Institutional Review Board at (503) 494-7887. Your participation is voluntary. You may refuse to participate, or you may withdraw from this project anytime without affecting your relationship with or treatment at the Oregon Health Sciences University.

Your signature below shows that you have read the foregoing and agree to participate in this project.

_____ _____

Participant Signature Date

_____ _____

Investigator Date

Appendix D

Background materials:

American Public Health Association Public Health Nursing Section (Mar., 1996) The Definition and Role of Public Health Nursing. Washington, D.C.: Author.

Association of Oregon Public Health Nursing Supervisors (April 4, 1995) Public Health Nursing and Maternal and Child Health home Visiting Programs.

Oregon Healthy Start Goals

THE DEFINITION and ROLE of PUBLIC HEALTH NURSING

A Statement of APHA Public Health Nursing Section

March 1996

THE DEFINITION AND ROLE OF PUBLIC HEALTH NURSING

A Statement of APHA Public Health Nursing Section

1996

This definition of public health nursing practice is an update of the 1980 statement. It has been developed to describe the roles of public health nursing and to provide a guide for public health nursing practice in the evolving health care system.

Background

Public health nursing practice is affected by biological, cultural, environmental, economic, social, and political factors. As part of the health care system public health nursing practice is responsive to these factors through working with the community to promote health and prevent disease, injury and disability (Appendix A).

The health needs of people in the U.S. and the role of public health have been addressed in public policy documents including the 1988 Institute of Medicine's The Future of Public Health, the 1990 Department of Health and Human Services's Healthy People 2000: National Health Promotion and Disease Prevention, the 1993 Public Health Service's The Core Functions Project: Health Care Reform and Public Health and the 1995 Institute of Medicine's Nursing, Health and the Environment: Strengthening the Relationship to Improve the Public's Health (Appendix B). The efforts to plan an effective health care delivery system in these documents include a recognition of the unique contribution public health nurses make to the health care system. This definition of public health nursing is designed to provide an understanding of the practice of public health nursing in the health care system.

Definition

Public health nursing is the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences.

Public health nursing practice is a systematic process by which:

1. the health and health care needs of a population are assessed in order to identify sub-populations, families, and individuals who would benefit from health promotion or who are at risk of illness, injury, disability, or premature death;
2. a plan for intervention is developed with the community to meet identified needs that takes into account available resources, the range of activities that contribute to health and the prevention of illness, injury, disability, and premature death;
3. the plan is implemented effectively, efficiently, and equitably;
4. evaluations are conducted to determine the extent to which the interventions have an impact on the health status of individuals and the population;
5. the results of the process are used to influence and direct the current delivery of care,

Examples of Activities of Public Health Nurses

The activities of public health nurses include the following:

1. they provide essential input to interdisciplinary programs that monitor, anticipate, and respond to public health problems in population groups, regardless of which disease or public health threat is identified;

2. they evaluate health trends and risk factors of population groups and help determine priorities for targeted interventions;

3. they work with communities or specific population groups within the community to develop public policy and targeted health promotion and disease prevention activities;

4. they participate in assessing and evaluating health care services to ensure that people are informed of programs and services available and are assisted in the utilization of available services.

5. they provide health education, care management and primary care to individuals and families who are members of vulnerable populations and high risk groups.

Public health nurses provide a critical linkage between epidemiological data and clinical understanding of health and illness as it is experienced in peoples' lives. This understanding is translated into action for the public good. An illustration of this role is the surveillance and monitoring of disease trends within the community. Emerging patterns that potentially threaten the public's health are identified and appropriate interventions planned, coordinated and implemented. This is a role that public health nurses can do in any setting; however it occurs mainly in the public sector. Public health nurses contribute to systems for monitoring crucial health status indicators such as environmentally caused illnesses, immunization levels, infant mortality rates, and communicable disease occurrence in order to identify problems that threaten the public's health and develop effective interventions.

Factors Influencing a Strong Public Health Nursing Role

Factors influencing the extent to which a strong public health nursing role is realized are the expectations and involvement of the populations served, agency objectives and resources, and the influence and leadership of public health nurses. Historically, public health agencies had a legislative mandate to protect and advocate for the health of the entire population in a designated jurisdiction. They coordinated their activities with private and voluntary health agencies, sharing common goals and concerns to meet the needs of the community.

The current health care system includes a range of public, private and managed health care providers with varying missions and levels of involvement with the community as a whole. The populations served by these provider agencies may be more narrowly focused and the care they deliver determined by funding source (e.g., managed care provider), setting (e.g., school or workplace), specific population characteristics (e.g., age or sex), or health concern (e.g., mental illness or obstetrics).

Realistic adaptations need to be made in the role of public health nurses practice according to the type of community-based health agency in which public health nurses are

Appendix A

Current Context of Public Health Nursing Practice - 1995

Key issues in the current context of health care delivery that affect public health nursing practice include health care reform, the delivery of care in a variety of community settings, increasingly interdisciplinary health care, an emphasis on health promotion and risk reduction, and changing demographics. Health care reform in the 1990's is influenced by concerns about cost containment and the growing number of uninsured and underinsured people who are unable to access health care in the private sector. The trend in health care reform is to manage care with the goal of controlling costs while maintaining quality and continuity of care.

Lack of access to affordable care created a need for primary care that public health departments stepped in to fill.. The need for primary care emerged when health care programs initiated during the 1960's and 1970's were reduced or eliminated during the 1980's and 1990's. Other factors affecting the need for primary care included changing social forces, employment patterns and insurance rates. Many public health nurses currently provide primary care to individuals in this vulnerable population. The provision of primary care by public health agencies has its benefits, including improved prenatal care, childhood immunizations and infectious disease care. However, a cost to public health has been that public health nurses have had to focus on individual care rather than developing interventions based on population need. The impact of changes in access to care and in federal funding through state block grants is unknown. One possibility is that the changing health care environment will provide public health nurses with the opportunity to refocus their work and strengthen their capabilities to provide more population focused services withsubsequent improvements in the health of entire communities.

There is an increasing emphasis on care delivered in the community. Advances in science have led to new treatments that enable health care providers to effectively treat conditions that were once terminal and manage complex illnesses outside the hospital setting. People are discharged early from hospitals after procedures that once involved lengthy stays. Outpatient surgery has replaced much inpatient care. Home care for recovery from an illness and terminal hospice style nursing care are available in most communities. Nurses who once worked exclusively in hospital settings are now providing patient care in the community.

The provision of a wider range of care by nurses in homes, schools and worksettings has increased the importance of interdisciplinary efforts. Public health nurses work with a variety of providers, including counselors, health educators, nutritionists, outreach workers, pharmacists, physical therapists, physicians, social workers, and volunteers. They work with other providers of services; such as those in schools, the judicial system and social services to maximize the effective, efficient delivery of health services to individuals, populations, and communities.

The past ten years have brought increased emphasis on risk reduction, health promotion,

Appendix B

Public Policy Documents

1. The Institute of Medicine. 1988. The Future of PublicHealth.

2. Public Health Service. 1993. The Core Functions Project: Health Care Reform and Public Health.

3. U.S. Department of Health and Human Services. 1990. Healthy People 2000: National Health Promotion and Disease Prevention.

4. The Institute of Medicine. 1995. Nursing, Health and the Environment: Strengthening the Relationship to Improve the Public's Health.

The Future of Public Health defines the mission of public health as fulfilling society's interest in assuring conditions in which people can be healthy. Its aim is to generate organized community effort to address the public interest in health by applying scientific and technical knowledge to prevent disease and promote health. The report defined the core functions of public health as assessment, policy development and assurance.

The Core Functions Project identified ten activities performed in meeting the core functions. These include: 1) health status monitoring and surveillance; 2) investigation and control of disease and injuries; 3) protection of environment, work-place, housing, food, and water; 4) laboratory services to support disease control and environmental protection; 5) health education and information; 6) community mobilization for health related issues; 7) targeted outreach and linkage to personal services; 8) health services quality assurance and accountability; 9) training and education of public health professionals; and 10) leadership, policy, planning and administration. These identified activities have been used to describe the role of public health in health care reform. Public health nurses provide many of these services throughout the country.

Healthy People 2000 revealed the broad spectrum of health problems affecting people in the U.S. Specific objectives and recommendations were made to address these problems. It stressed that many diseases and problems are the result of interactions among the environment, genetics and lifestyle and can be affected by health promotion and disease prevention activities.

Nursing, Health, and the Environment: Strengthening the Relationship to Improve the Public's Health is a document prepared by the Committee on Enhancing Environmental Health Content in Nursing Practice. It highlights the growing need for public health nurses to be informed and involved advocates concerning environmental issues.

Appendix D
Public Health Nursing in Private, Voluntary, or Non-Official Agencies

Most community-based health care agencies serve a specific segment of the community. The approach may be comprehensive and concerned with prevention of illness as well as treatment of disease or disability. However, comprehensive care may be offered to the individual but not to the entire family. In other instances, the agency intervenes only in relation to a specific health problem (e.g., hypertension, cancer, pregnancy) or a specific phase of a health problem (e.g., emergency, hospice, halfway house). Regardless of the point at which nurses intervene in the health-illness continuum or the developmental phase of the client receiving community based care, public health nursing practice is based on consistent principles. Because of the extraordinary diversity of programs and services and the current trend toward care in the community, the following guidelines are offered. They can be adapted to the particular characteristics of an agency.

The single factor that most distinguishes these programs from those with a public health mandate is the population definition used for planning and services. All too frequently, the target population or case load consists of those individuals who meet program criteria and present themselves for services. Program planning usually is based on the needs of these individuals rather than on the needs of eligible individuals, including those who fail to come for care. While it is true that comprehensive, holistic care with an appropriate emphasis on risk assessment and anticipatory guidance may be given to individuals who come in for care; often the focus of nursing service, planning, and programming does not go farther to include reaching the population at risk which the presenting individual personifies.

The first step in analysis of the population base requires the nurse to become familiar with the people enrolled in the program. If resources necessitate priority setting, it is important to identify those individuals/families at highest risk of illness or poor recovery for whom nursing intervention and resources can make a difference. In the second step of the analysis, the public health nurse must extend the scope of service to those individuals/families within the community who meet the criteria for service but who have not availed themselves of the care offered or have dropped out of the program. This "targeted outreach" becomes critical when a program wishes to measure its success by the improved health status of the entire community. The needs of and changes achieved in the group seeking care may not accurately reflect the health needs or health levels of the larger community. It is the responsibility of public health nurses and those working with the public health nurse to assure that services are available and accessible and that populations at risk are informed of them.

In summary, for those agencies in which program planning and evaluation for assessment, assurance and policy development based on the total population are not feasible, an intermediate approach is recommended. The nurse moves away from solely meeting the needs of consumers as individually presented and toward practicing public health nursing for all individuals or families within the population group or program focus.

Appendix B

Public Health Nursing and Maternal and Child Health Home Visiting Programs

PUBLIC HEALTH NURSING AND MATERNAL AND CHILD HEALTH HOME VISITING PROGRAMS
APRIL 4, 1995

PURPOSE:

1. To provide a guide for future short and long term planning efforts
2. To assure public health nursing approaches planning efforts as a unified body speaking with a common voice
3. To use as a reference or a basis for dialogue when discussing home visiting with other partners.

ANTICIPATED PLANNING EFFORTS:

1. Statewide Family Support/Family Preservation Planning
2. Healthy Start/Oregon Commission on Children and Families Planning
3. Oregon Options
4. Other
   a. Carnegie Foundation report opportunities
   b. Systems development initiatives
   c. Local health department planning

WHAT ARE HOME VISIT PROGRAMS?

Home visit programs are service delivery models. Recent years have seen renewed interest in home visits as a strategy for effectively reaching families.

The following have been identified as key components of effective early intervention/prevention focussed home visit programs:

- ♥ Universal and voluntary
- ♥ Multiple goals and objectives
- ♥ Method of evaluation
- ♥ Defined target population
- ♥ Providing a continuum of services based on the unique needs of the target population
- ♥ Flexible in intensity and duration
- ♥ Well trained dedicated staff with skills that match the services they deliver
- ♥ Family is included in planning, policy and decision making
- ♥ Culturally sensitive

2. A foundation of practice that emphasizes primary prevention and health promotion.

3. An ability to both assess and understand the conditions that affect an individual or family's health, such as economics, housing, & social conditions and to develop both individual and community strategies that address health issues.

4. A range of public health nursing competencies which include:

a. Ability to perform standardized health screening

b. Ability to perform comprehensive nursing assessments of the individual's or family's physical, emotional, developmental and environmental status.

c. Ability to use screening and assessment to determine nursing diagnosis

d. Skills interpreting health related information to families enabling them to integrate this information into their daily lives

e. Development and implementation of a comprehensive plan of care which includes the following intervention strategies:

1. Teaching strategies focused on health promotion and disease prevention.
2. Counseling, coaching and supporting the individual or family to reach mutually identified goals.
3. Case management activities which assist the family to access and utilize additional services.
4. Family advocacy which includes a family centered, holistic approach to the management of complex care.

f. An evaluation of the nursing plan which determines the extent to which these intervention strategies impacted the identified health outcomes.

ROLE OF PUBLIC HEALTH NURSING IN MCH HOME VISITING

Public health nurses have many roles in the delivery of home visit services to families:

1. ***Direct service provider of home visits.***
Screening and assessment, developing a plan with the family, providing health education, counseling, clinical procedures, case management, and advocacy.

STANDARDS FOR REGISTERED NURSE SCOPE OF PRACTICE
851-45-010

From Oregon State Board of Nursing, Nurse Practice Act, Oregon Revised Statutes (As Amended 1993) and Administrative Rules Regulating the Practice of Nursing, December, 1994.

1. The Board recognizes that the scope of practice for the registered nurse encompasses a variety of roles, including, but not limited to:
   a. Provision of client care;
   b. Supervision of others in the provision of care;
   c. Development and implementation of health care policy;
   d. Consultation in the practice of nursing;
   e. Nursing administration
   f. Nursing Education;
   g. Case Management
   h. Nursing Research
   i. Teaching health care providers and prospective health care providers;
   j. Specialization in advanced practice.

2. Standards related to the registered nurse's responsibility to apply the nursing process. The registered nurse shall:

   a. Conduct and document nursing assessments of the health status of individuals and groups by:

      1. Collecting objective and subjective data from observations, examinations, interviews, and written records in an accurate and timely manner as appropriate to the client's health care needs. The data include, but are not limited to:

      - Physical and emotional status
      - Growth and development
      - Cultural, religious, and socioeconomic background
      - Client and family health history
      - Information collected by other health team members
      - Information gathered from family or significant others;
      - Client knowledge and perception about health status and potential for maintaining health status
      - Ability to perform activities of daily living
      - Patterns of coping and interacting
      - Consideration of client's health goals
      - Environmental factors, eg, physical, social, emotional, and ecological
      - Available and accessible human and material resources

3. Standards related to the registered nurse's responsibilities as a member of the nursing profession. The registered nurse shall:

a. Have knowledge of the statutes and regulations governing nursing and function within the legal boundaries of registered nurse practice.

b. Accept responsibility for individual nursing actions and maintain competency in one's area of practice.

c. Obtain instruction and supervision as necessary when implementing nursing techniques or practices.

d. Function as a member of the health team.

g. Collaborate with other members of the health team to provide optimum client care.

f. Consult with nurses and other health team members and make referrals if necessary.

g. Contribute to the formulation, interpretation, implementation, and evaluation of the objectives and policies related to nursing practice within the employment setting.

h. Report unsafe nursing practices either directly to the Board or through appropriate channels and unsafe practice conditions to the appropriate regulatory agency(s).

i. Accept only client care assignments for which one is educationally prepared and when competency has been maintained.

j. Act as an advocate for the client.

k. Assign or delegate to others only those nursing measures which that person is prepared to perform and qualified to perform and are within that person's scope of practice/scope of duties.

l. Delegate, in settings where a registered nurse is not regularly scheduled, specific tasks of nursing care to an unlicensed person only as described in the Board's delegation rules (Division 47).

m. Supervise others to whom nursing interventions have been assigned or delegated.

n. Retain professional accountability for nursing care when assigning or delegating nursing interventions.

o. Teach health care practices to other health care providers.

p. Contribute to policy development and implement policies in a manner which meets the needs of the clients served by the agency/facility in which the nurse practices.

4. Standards related to the registered nurse's authority to accept and implement orders for client care/treatment.

a. The registered nurse may accept and implement orders for client care from licensed health care professionals who are authorized to independently diagnose and treat. These health care professionals are:

AOPHNS RECOMMENDATIONS

AOPHNs recognizes that families have unique needs that can best be met by a system that provides a continuum of services. Home visiting programs have been identified as an effective strategy for working with families. In order to meet their maximum potential for effectiveness, home visit programs must be part of a broader system of comprehensive, family support services.

The public health nurse plays an important role as both a direct provider of home visit services as well as in the design, planning, implementation, and evaluation of service delivery systems.

AOPHNS recognizes that communities have differing strengths and resources that may require different approaches to service delivery. AOPHNS is committed to working within local and state committees to assist with planning efforts related to the development of comprehensive service systems including home visits.

AOPHNS recommends that all future planning efforts work to:

1. Insure that home visits begin prenatally and continue until the child is at least two years of age but preferably until school age.

2. Incorporate the key components of home visit programs:
   - ♥ Universal and voluntary
   - ♥ Multiple goals and objectives
   - ♥ Method of evaluation
   - ♥ Defined target population
   - ♥ Providing a continuum of services based on the unique needs of the target population
   - ♥ Flexible in intensity and duration
   - ♥ Well trained dedicated staff with skills that match the services they deliver
   - ♥ Family is included in planning, policy and decision making
   - ♥ Culturally sensitive

3. Structure a continuum or tier level of services based on the unique needs of the family

4. Utilize public health nurses as part of a blended delivery system

5. Assure that home visit programs are a component of a broader system of family support services.

6. Assure that the other needed family support services are available and accessible as part of the comprehensive service delivery system.

STUDIES DOCUMENTING THE EFFICACY OF PUBLIC HEALTH NURSING HOME VISIT PROGRAMS

1. Olds, D., Henderson, C., and Kitzman, H. Does prenatal and infancy nurse home visitation have enduring effects on qualities of parental caregiving and child health at 25-50 months of life? *Pediatrics* In press.

   The infants of young, unmarried, low income adolescent mothers receiving public health nursing home visits had fewer emergency room visits, fewer emergency room visits for unintentional injuries, and fewer injuries recorded in their medical records.

2. Olds, D.L., Henderson, C.R., Tatelbaum, R. and Chamberlin, R. Improving the life-course development of socially disadvantaged mothers: A randomized trial of nurse home visitation. *American Journal of Public Health* (1988) 78:1436-45.

   Public health nurses visited socially disadvantaged first time mothers. During four years of home visiting, mothers returned to school more quickly, increased the number of months they were employed, had fewer subsequent pregnancies, and postponed the birth of their second child.

3. Olds, D.L., and Kitzman, H. Can home visitation improve the health of women and children at environmental risk? *Pediatrics* (1990) 86.1:108-16.

   A literature review of home visiting programs revealed that the "more effective programs employed nurses who began visiting during pregnancy, who visited frequently and long enough to establish a therapeutic alliance with families, and who addressed the systems of behavioral and psychosocial factors that influence maternal and child outcomes."

4. Olds, D.L. Home visitation for pregnant women and parents of young children. *American Journal of the Diseases of Children* (1992) 146:704-708.

   Successful home visit programs contain the following: a focus on families at greater need for service, the use of nurses who begin during pregnancy and follow the family at least through the second year of the child's life, the promotion of positive health related behaviors and qualities of infant care giving, and provisions to reduce family stress by improving the social and physical environments in which families live.

5. Olds, D.L., Henderson, C.R., Tatelbaum, R., and Chamberlin, R. Improving the delivery of prenatal care and outcomes of pregnancy: A randomized trial of nurse home visitation. *Pediatrics* (1986) 77:16-28.

   Young, unmarried low income women receiving public health nursing home visit services decreased the number of cigarettes smoked daily, exhibited a better diet at the end of the pregnancy, utilized support systems, WIC and

AMERICAN NURSES ASSOCIATION. STANDARDS OF COMMUNITY HEALTH NURSING PRACTICE. 1986.

1. The nurse applies theoretical concepts as a basis for decisions in practice.

2. The nurse systematically collects data that are comprehensive and accurate.

3. The nurse analyzes data collected about the community, family, and individual to determine diagnoses.

4. At each level of prevention the nurse develops plans that specify nursing actions unique to client needs.

5. The nurse, guided by the plan, intervenes to promote, maintain, or restore health, to prevent illness, and to effect rehabilitation.

6. The nurse evaluates responses of the community, family, and individual to interventions in order to determine progress toward goal achievement and to revise the data base, diagnoses, and plan.

7. The nurse participates in peer review and other means of evaluation to assure quality of nursing practice. The nurse assumes responsibility for professional development and contributes to the professional growth of others.

8. The nurse collaborates with other health care providers, professionals, and community representatives in assessing, planning, implementing, and evaluating programs for community health.

9. The nurse contributes to theory and practice in community health nursing through research.

Oregon Healthy Start Goals

By enhancing family stability and supporting positive parenting practices, Oregon Healthy Start seeks to promote school readiness, improve health outcomes for children and families and reduce the incidence of child abuse and neglect. Healthy Start has the following goals:

1. Provide information and short-term support services to all first-birth families
2. Systematically identify higher risk families and offer long-term support services
3. Enhance family functioning in higher risk families by:
    a. Building trusting relationships,
    b. Teaching problem solving skills, and
    c. Improving the family's support system
4. Encourage positive parent-child interaction in higher risk families
5. Promote healthy growth and development for children in higher risk families.

Appendix E

First interview schedule

Interview Questions

1. What do you believe to be the Unique role of the nurse in contributing to Healthy Start Goals?

   Please give an example.

2. What are the characteristics of a good working relationship between public health nurses and paraprofessionals?

   Describe the beliefs and system issues that hinder ideal working relationships between the PHN and paraprofessionals within this program.

The Public Health Nurse's Role in the Oregon Healthy Start Program: Opinion of an Expert Panel

December 1998

Edited By: Dianna L. Pickett R.N. B.S.N.

LIST OF EXPERT PANEL PARTICIPANTS

The following experts participated in the development of this document, and endorse the content and recommendations within it.

Public Health Nurses

Healthy Start Home Visitors

Local Program Collaborators

Local program managers

State Program Collaborators

RESEARCH COMMITTEE

Research Advisor

Catherine Salveson, RN, Ph. D.
Assistant Professor
OHSU School of Nursing

Committee Members

Shelley Jones, RN, Ph. D., COHN-B
Assistant Professor
OHSU School of Nursing

Lydia Metje, RN, Ph. D.
Assistant Professor
OHSU School of Nursing

Lila Wickham, RN, MS
Public Health Nursing Consultant
Oregon Health Division

The Unique Role That the Public Health Nurse Can Play in Meeting the Goals of the Oregon Healthy Start Program

Executive Summary

The purpose of this document is to define the unique, most effective role of the public health nurse (PHN) in the Oregon Healthy Start Program based on the knowledge, skills, strengths, and expertise of the nursing profession. It is a product of the knowledge and wisdom of experts who are working with the Healthy Start Program in Oregon. These experts include PHNs, Healthy Start Home Visitors (HSHV), local program managers, and local community and state collaborators. The document also identifies barriers to smooth collaboration, and lists elements of program design that integrate the PHN role in an effective and meaningful way.

Why Define the Role of the Public Health Nurse?

In 1993 Oregon authorized legislation for the Healthy Start Initiative. The initiative integrates public health as a key partner in meeting the program goals, however, the design of the partnership was not clear. Currently, there is no standard definition of the role of the PHN, and it varies throughout local programs in the state. As a result, it is difficult to evaluate the effectiveness of the PHN's contribution to the program. These gaps have caused confusion regarding the importance of the PHN's role in meeting the Oregon Healthy Start goals.

What is the Recommended Role of the Public Health Nurse?

The four aspects of the recommended role are based on professional strengths and skills of the PHN. They are complimentary to those of other disciplines within the collaboration. Local Healthy Start collaborators are advised to incorporate the PHN role as it best fits the available resources, and the needs of their individual program and community.

Working Partner

To act as the key collaborative partner with a public health focus in meeting all program goals.

Health Expert

To integrate public health nursing knowledge and expertise to support the healthy growth and development of the Healthy Start population of young children and their families.

Communicator and Health Resource Linker

To facilitate communication with, and access to, community resources and providers of health care when family health issues arise.

Health Consultant and Mentor

To work closely with the Healthy Start Home Visitors (HSHV) and offer consultation, support, mentoring and training.

What Systems Issues or Common Perceptions and Concerns Limit PHN Contributions and Hinder Smooth Collaboration?

Systems Issues

- Unclear roles and boundaries
- Different approaches to work with families
- Organizational differences
- Lack of funding
- Inadequate communication systems

Common Perceptions and Concerns

- History
- Unclear understanding of PHN and HSHV contributions
- Unspoken inequality of power between the PHN and HSHV
- Unclear PHN responsibility
- Use of funds
- Different interpretation of research
- Cultural difference between HSHVs and PHNs

Elements of Program Design that Integrate the Recommended Role of the Public Health Nurse into the Healthy Start Program

- Clear roles, boundaries, and job descriptions
- Adequate time for PHN participation
- Effective communication
- Systems that support skillful practice
- Good will
- State level support for effective collaboration

Table of Contents

The Unique Role That the Public Health Nurse Can Play in Meeting the Goals of the Oregon Healthy Start Program

Introduction

The purpose of this statement is to define the unique, most effective role of the public health nurse (PHN) in the Oregon Healthy Start Program, based on the knowledge, skills, strengths, and expertise of the nursing profession. The creation of the statement and the recommendations within it are the product of the collective knowledge and wisdom of experts who are working in the Healthy Start Program in Oregon. These experts include public health nurses, Healthy Start home visitors, program managers, local community and state collaborators.

Why Define the Role of the Public Health Nurse?

Public health nursing has begun to define its role in response to the atmosphere of change in health care and public health in America. PHNs are now, more than ever, called to collaborate with others to meet the needs of American citizens. Definitions of public health nursing's role have been written to clarify the PHN's responsibilities and contributions. The role of the public health nurse has been defined in its relationship to the American health care system by the American Public Health Association (APHA) Public Health Nursing Section's in March, 1996 with The Definition of the Role of Public Health Nursing (Appendix A). A document by the Oregon Association of Public Health Nurse Supervisors' (AOPHNS), written April 4, 1995, Public Health Nursing and Maternal and Child Health Home Visiting Programs (Appendix B) defines the role of the PHN in programs that employ MCH home visiting strategies. These works have been used as reference for this statement.

In 1993 Oregon authorized legislation for the Healthy Start initiative in Oregon. Oregon's Healthy Start Program is based on the Hawaii Healthy Start model, and the Healthy Families of America initiative that was adopted by the National Committee to Prevent Child Abuse in 1992. The Oregon initiative integrates public health as a key partner in meeting the Oregon Healthy Start Program goals (Appendix C). There is, however, no clear direction regarding the design of the partnership with public health. As a result, the role of the PHN varies in the organizational design and structure of local collaborations through out the state. Currently, there is no standard definition of the most effective role for the nurse in the Oregon Healthy Start Program, therefore, it is difficult to evaluate the effectiveness of the PHN's contributions to the program. Together, these gaps have caused confusion regarding the importance of the PHNs' role in meeting the Oregon Healthy Start Program goals.

What Is the Unique Role of the Public Health Nurse?

This statement defines a unique role for the public health nurse based on professional strengths and the needs of the program, identifies barriers to smooth collaboration, and lists elements of program design that integrate the PHN role in an effective and meaningful way. A glossary has been provided.

There are four aspects of the recommended role of the PHN. Each is based on the professional strengths and skills of the PHN who has an educational background in public health nursing and experience working in the community. The contributions that PHNs can make are related to these strengths and skills. They are complimentary to those of other disciplines within the Oregon Healthy Start collaboration. Some of them are similar skills or shared strengths. It is recommended that local Healthy Start collaborators consider their own available resources, and incorporate the PHN role to best fit the individual program and community needs.

The Recommended Role of the Public Health Nurse in The Oregon Healthy Start Program:

Working Partner
To act as the key collaborative partner with a public health focus in meeting all program goals.

Health Expert
To integrate public health nursing knowledge and expertise to support the healthy growth and development of the Healthy Start population of young children and their families.

Communicator and Health Resource Linker
To facilitate communication with, and access to, community resources and providers of health care when family health issues arise.

Health Consultant and Mentor
To work closely with the Healthy Start Home Visitors (HSHV) and offer consultation, support, mentoring and training.

Working Partner:

To act as the key collaborative partner with a public health focus in meeting all program goals.

PHN Knowledge, Skills, Strengths, and Expertise	*Some Examples of Contributions That PHNs Can Offer*
♦ Experience addressing health and wellness issues with populations at significant health, medical and social risk.	♦ Participate in the development and refinement of the health component of the program at the community and state level.
♦ Public health focus on prevention of disease, health risk reduction, and promotion of health and wellness.	

♦ Skill communicating with families, groups and community leaders.	♦ Facilitate and participate in communication with other agencies and providers of care to develop services at the community and state level.
♦ Holistic and ecological approach to the child, beginning with the maintenance of good health and expanding to all issues affecting health, development, and well- being.	♦ Act as a consultant in the development of health promotion materials for Healthy Start families.
♦ Skill in the gathering and use of data.	♦ Use data in community assessment.
♦ Experience working in collaboration with other agencies and groups, and credibility within the system.	♦ Advocate at the community, state, and national levels for programs that target families and children at risk.

Health Expert:

To integrate public health nursing knowledge and expertise to support the healthy growth and development of the Healthy Start population of young children and their families.

PHN Knowledge, Skills, Strengths, and Expertise	*Some Examples of Contributions That PHNs Can Offer*
♦ Broad MCH knowledge of the of conception, pregnancy, child health, growth and development, from healthy and functional to poor health, chronic, and acute illness.	♦ Monitor data regarding the health of Healthy Start families and develop strategies to assure that program health outcomes are met.
♦ Experience working with multi issue families with health, medical, and social risks. ♦ Understanding of medical treatments and care.	♦ Be available to consult with home visitors and collaborate on the care for all Healthy Start families.
♦ Professional history and experience using the home visit strategy with families at risk.	♦ Provide PHN services to families in the home, especially when health or medical issues exist.
♦ Ability to establish rapport with new parents around health issues when they most want and need advice.	♦ Act as the primary case manager for a family, and as a child's liaison to multi disciplinary case conferencing.

♦ Use of the nursing process (Assessment, nursing diagnosis, plan for intervention, evaluation) ♦ Experience performing in-depth health assessments which lead to a nursing diagnosis. ♦ Educational background to counsel and assist families to problem-solve and make life changes that affect the health and well-being of the child. ♦ Experience with public health case management. ♦ Communication skills.	
♦ Known point of entry into the community support network. ♦ In-depth knowledge of the entire community, and it's resources.	♦ Assist in the triage of family referrals by individual risk and need, and program capacity into the Healthy Start program.
♦ Skills and training to accurately screen and perform physical, emotional, and developmental health nursing assessments of infants, and then plan appropriate interventions .	♦ Provide consultation to HSHV regarding the public health and medical issues of complex, high risk families.

Communicator and Health Resources Linker: To facilitate communication with, and access to, community resources and providers of health care when family health issues arise.

PHN Knowledge, Skills, Strengths, and Expertise	*Some Examples of Contributions that PHNs Can Offer*
♦ Understanding of complex health and social systems in the community. ♦ Intrinsic credibility within the broad based system of community providers of care and services.	♦ Advocate for families within health and social service systems when necessary. ♦ Assist families to access health resources when family needs are beyond routine health maintenance.

Health Consultant and Mentor:

To work closely with Healthy Start Home Visitors (HSHV), and offer consultation, support, mentoring and training.

PHN Knowledge, Skills, Strengths, and Expertise	*Some Examples of Contributions That PHNs Can Offer*
♦ Experience using the home visit strategy of working with families.	♦ Offer mentoring and support to the HSHV regarding the experience of home visiting. ♦ Offer training for the HSHV regarding health issues of young children and families, and other topics related to their health and well being.
♦ Experience coordinating care with other home visitors	♦ Participate in case conferencing with the HSHV to be responsive to the needs of families. ♦ Blend public health nursing care with HSHV activities by setting mutual objectives, and coordinating home visits with flexibility and sensitivity to the families needs.

What Systems Issues or Common Perceptions and Concerns Limit PHN Contributions and Hinder Smooth Collaboration?

Systems Issues

Unclear Roles and Boundaries

♦ Unclear roles and boundaries between the PHN and the HSHV exist at both the state and community level.

* The title of "Paraprofessional" for the HSHV was inherited from wording in the Oregon initiative. It is not descriptive of their role in the program, nor usually of their qualifications.

* Job descriptions usually do not reflect clear relationship between roles.

* There is a lack of research on which to base the blending of the PHN and HSHV roles in an effective way.

* Misunderstanding of the difference between the services provided by PHNs and HSHVs through the home visit strategy.

Different Approaches to Work with Families

♦ PHN's and HSHV's approach their work with families differently. They have different focuses of intervention, individual organizational characteristics, and program requirements. These differences affect the duration, dosage and intensity of their contact with the family. Confusion results when roles are not clear. When roles are clear, the differences can result in a balanced team approach.

* The HSHVs' focus is on building on the family's own strengths in parenting. They provide long term support to encourage the family to learn new skills, act independently, and become self sufficient over time.

* The PHNs' interventions focus on health related issues that are of a more urgent nature. The PHN often assists the family to resolve health issues by teaching them specific skills, by accessing other resources, or by taking the lead intervening within the health system on the family's behalf.

Organizational Differences

♦ Providing a service together despite different organizational cultures, perspectives and approaches, program eligibility criteria, organizational rules and systems, salaries and benefits, office locations and paperwork is a significant challenge for Healthy Start collaboration at both the state and community level.

Lack of Funding

♦ There is a lack of available funding for nursing time in the program in many communities.

* Large PHNs caseloads reduce time for participation in the program.

* The competitive state legislative process has pitted the Oregon Commission on Children and Families and the Oregon Health Division against each other to secure funding for their collaborative effort.

* Funding for Targeted Case Management (TCM) through the Office of Medical Assistance Programs (OMAP) was a mixed blessing. In some counties the TCM funds limited the PHN's role to chart review and oversight; in others it was used as an opportunity for communication and case conferencing between the PHN and the HSHV about infants receiving Medicaid. TCM has now been replaced by the Medicaid Administrative Match funding which does not require a PHN's participation.

Inadequate Communication systems

♦ The individual community program's communication system design may not build in time for close communication between the PHN and the HSHV.

* Systems do not always allow for time for the PHN and HSHV to consult on cases, make mutual plans, and debrief with each other.

* When the PHN is not the supervisor for the HSHV, communication regarding mutual families is more difficult.

* HSHVs and PHNs spend much of their time in the field. When one or both do not have voice mail it is difficult for them to leave detailed information for each other about mutual families.

* When PHN and the HSHV do not share offices, communication and smooth working relationships are more difficult to maintain.

Common Perceptions and Concerns

History

♦ The contentious early history of the Healthy Start Program has left resentment within the organizations attempting to collaborate.

Unclear Understanding of PHN and HSHV Contributions

♦ PHNs and HSHVs often do not clearly understand how they contribute to reaching the program goals.

* Both PHNs and HSHV often believe that they duplicate each others services.

* Often they do not see the differences in what they contribute, nor the need for the other in the broader community. This leads to the belief that they are competing with each other to care for the same population of families.

* PHNs have concerns that the less expensive HSHV will replace the PHN in home-based models in Oregon.

Unspoken Inequality of Power Between the PHN and the HSHV

♦ There may be an unspoken inequality of power between the PHN and the HSHV, making their working relationship less smooth and collaborative.

Unclear PHN Responsibility

♦ PHNs are unsure of their own level of legal and professional responsibility for the independent actions of HSHVs related to the health of program families.

* PHNs are concerned that HSHVs will over step their scope of practice.

* PHNs are concerned that health issues will be over looked without regular PHN consultation on family progress.

* PHNs are often unsure of the level of supervision in the Healthy Start program, especially regarding health issues.

Use of Funds

♦ Medicaid Administrative Match Funding has replaced TCM in Healthy Start programs. It does not require PHN participation, as TCM does. PHNs are concerned that programs will not replace PHN time unless enabled to do so by other funding.

Different Interpretation of Research

♦ There is disagreement between PHNs and the Healthy Start Program about the interpretation of the research and supporting data for each other's program models.

Cultural Difference Between HSHVs and PHNs

♦ In some programs there is a cultural difference between the HSHV and PHN staff. These differences present an organizational and personal challenge to relationships among team members.

Elements of Program Design That Integrate the Recommended Role of the Public Health Nurse into the Healthy Start Program

Each community is different and is charged with the task of designing a program that best suits the unique needs of families who live there. What PHNs do in each program may be different, but if these elements are in place, the PHN will be able to participate in a meaningful way for the benefit of the Healthy Start population, and to meet the goals of the program.

Clear Roles and Boundaries and Job Descriptions

- Roles, boundaries, and job descriptions are clearly written for both the PHNs and HSHVs. They are supported at both the state and community levels, and are expressed as expectations to all staff.

  * The PHN role includes early involvement with families with infants birth to age two for nursing assessment and planning for collaborative care and support, especially for those with health risks or challenges.

  * Roles are blended in a multi disciplinary approach to families.

  * There are clear guidelines describing when to initiate a PHN consultation or referral.

  * A replacement has been found for the term "paraprofessional" that more accurately describes the role and educational preparation of the HSHV.

  * All staff members understand the differences between the roles of the PHN and the HSHV, and accept the boundaries between them.

  * The families have accurate expectations of both PHNs and HSHV.

  * All staff members understand how these roles work together to move families toward reaching their goals, and move the program toward the Healthy Start goals for the population.

  * There is tolerance and integration of different approaches to working with families, as long as they support the Healthy Start philosophy and goals.

Adequate Time for PHN Participation

- Adequate nursing time is available for participation and consultation with the Healthy Start Program staff. This may require exploration of funding sources to pay for nursing time. Elements of participation and consultation valued in the program include:

* Collaboration on planning and coordination of care for families is encouraged and planned for in program design.

* PHN/HSHV joint home visiting is possible when needed.

* PHN services are available to families in the home, especially when the infant is young (birth to age two years) and has a health or medical issue.

* Joint staff meetings and trainings are routine, as well as time for PHNs and HSHV to debrief, socialize, and develop collegial relationships.

* PHNs offer regular training regarding a variety of pertinent topics.

* PHNs participate in program development and problem-solving.

Effective Communication

♦ Program philosophy and design encourages regular and frequent, open and reciprocal communication between the PHN and the HSHV. Time is used to plan their activities with mutual families to avoid duplication of services, to engage in organizational problem solving, and to address training needs.

* Paper and technical communication systems, such as voice mail, e-mail, shared files and care plans, etc., allow for the spontaneous up-dating of information about families.

* Time is allotted for regular meetings between PHNs and HSHV.

* When Healthy Start and health department staff are housed in the same office communication opportunities and quality are enhanced.

Systems That Support Skillful Practice

♦ Collaborators consult on hiring practices, orientation, training and supervision needs that support the PHN and HSHV in carrying out their roles in a skillful way.

* Nurses hired to work with the Healthy Start program are well qualified to work with high risk families in a collaborative community-based program. Ideally, nurses working with the Healthy Start Program should have;

  - educational background and experience that includes public health theory and practice (bachelors degree in nursing),
  - skills in parent child interaction assessment,

- and at least two years supervised experience working with families in the community.

This may not be possible in communities where there is a shortage of nurses with this background.

* The person hired for the HSHV role has the qualifications that fit the responsibilities that the role requires. Currently the educational background of HSHVs varies widely across community programs.

* Collaborators have a consultation role regarding hiring decisions.

* High quality, regular, and on-going training is provided through the program.

* Cultural sensitivity and competence is developed through training, experience and facilitation.

* Supervision of the PHN and HSHV is regular, comprehensive, and of high quality.

* Support and training is available for program supervisors.

Good Will

♦ All staff members are able to forge effective, collaborative and smooth working relationships based on good will when they have the following skills and abilities:

* Patience	Able to depersonalize problems
Flexibility	Skilled in supportive confrontation
Sense of humor	Able to build rapport with co- workers
Compassion	Skilled in interpersonal communication
Cultural competence	Willing to learn from others

State Level Support for Effective Collaboration

♦ State collaborators demonstrate understanding and appreciation of each other's respective contributions to the Healthy Start Program, and work together to support and improve the quality of the program.

* There is a commitment to the assurance of adequate funding for all aspects of the integrated Oregon Healthy Start Program model.
* Collaborators and legislators at the state level clearly understand and support the role of public health in the program.

* There is on-going research-based exploration of best practices and models that effectively integrate the PHN and paraprofessional roles.

* There is enough flexibility in community and state Healthy Start Program designs to allow for creative organizational problem-solving among collaborators without diluting the quality of the program.

* There is exploration of ways the Oregon Healthy Start model can best fit into a continuum of programs that assists young children and their families.

GLOSSARY

Collaboration: A mutually beneficial and well defined relationship of two or more individuals or organizations which enlarges the effectiveness of a service or product.

Consult: To provide information or advice

Ecological: The concept that people are affected by, and affect their environment. This includes their relationship as an individual with their families, and communities, and their physical environment.

Healthy Start Home Visitor (HSHV): Community Healthy Start Program position title designating a staff member who provides intensive home visiting services to enrolled families focusing on building on the family's own strengths to improve parenting and family functioning. The title for this position varies among community programs. It is referred to in Oregon legislation as "paraprofessional".

Holistic: The concept that human beings are more than the sum of their parts. Holism includes the mind, body, spirit, and community.

Multi disciplinary approach: A strategy using the knowledge and expertise of varied professional disciplines to analyze issues, make action plans, and resolve problems.

Nursing assessment: A systematic and comprehensive approach to gathering information about a client's health and factors that affect it. This information is then interpreted with the client, and used in the development of a nursing diagnosis.

Nursing Diagnosis: A clinical judgement about an individual, family, or community response to actual or potential health problems/life processes, as defined by the North American Nursing Diagnosis Association in 1990 (Helvie, 1998)

Public Health Nurse (PHN): A registered nurse who's practice focuses on promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences.

REFERENCE LIST

American Public Health Association Public Health Nursing Section (Mar., 1996) The Definition and Role of Public Health Nursing. Washington, D.C.: Author.

Association of Oregon Public Health Nursing Supervisors (April 4, 1995) Public Health Nursing and Maternal and Child Health home Visiting Programs.

Barnes-Boyd, C., Norr, K., Nacion, K. (June, 1996). Evaluation of an interagency home visiting program to reduce postneonatal mortality in disadvantaged communities. Public Health Nursing, 13 (3), 201-208.

Deal, L. W. (Oct., 1994). The effectiveness of community health nursing interventions: a literature review. Public Health Nursing, 11 (5), 315-323.

Helvie, C. O. (1990). Advanced Practice in the Community. In D. Ruth (Ed.), Community Analysis and Community Diagnosis (pp. 208-233). Thousand Oaks, Ca.: Sage.

May, K. M., McLaughlin, F., Penner, M., (June, 1991). Preventing low birth weight: marketing and volunteer outreach. Public Health Nursing, 8 (2), 97-104.

Mc Kenna, H. (1994). The Delphi Technique: a Worthwhile Research approach for nursing? Journal of Advanced Nursing, 19, 1221-1225.

National Association of County Health Officials (July, 1993). Core public health functions. Washington, D. C.: Author.

Olds, D. L. (June, 1992). Home visitation for pregnant women and parents of young children. American Journal of Diseases of Children, 146, 704-708.

Olds, D., Henderson, C. R., Chamberlin, R., Tatelbaum, R. (1986), Improving the delivery of prenatal care and outcomes of pregnancy: A randomized trial of nurse home visitation. Pediatrics, 77, 16-28.

Olds, D., Henderson, C. R., Chamberlin, R., Tatelbaum, R. (1986), Preventing child abuse and neglect: a randomized trial of nurse home visitation. Pediatrics, 78, 65-78.

Olds, D., Kitzman, H. (1990). Can home visitation improve the health of women and children at environmental risk? Pediatrics, 86, 108-116.

Olds, D. L., Kitzman, H. (1993). Review of research on home visiting for pregnant women and parents of young children. The Future of Children: Home Visiting, 3 (3), 53-92.

Oregon Commission on Children and Families. (July 1,1996-June 30, 1997). Oregon's Healthy Start Effort 1996-97 Status Report: Part 1. Salem, Oregon: Author.

Pratt, C., Katzev, A., Henderson, T. (March, 1996) . Oregon's Healthy Start effort interim report. Oregon State University, Corvallis, Or.

Public Health Nursing Directors of Washington (July, 1993). Public health nursing within core public health functions.

Saunders, E. J., Goodall, K. (Nov.-Dec., 1985). A social services-public health partnership in child protection: a rural model. Public Health Reports, 100 (6), 663-666.

Suppiah, C. (Feb., 1994). Working in partnership with community mothers. Health Visitor, 67 (2), 51-3.

Appendix A

The Definition of the Role of Public Health Nursing

THE DEFINITION and ROLE of PUBLIC HEALTH NURSING

A Statement of APHA Public Health Nursing Section

March 1996

THE DEFINITION AND ROLE OF PUBLIC HEALTH NURSING

A Statement of APHA Public Health Nursing Section

1996

This definition of public health nursing practice is an update of the 1980 statement. It has been developed to describe the roles of public health nursing and to provide a guide for public health nursing practice in the evolving health care system.

Background

Public health nursing practice is affected by biological, cultural, environmental, economic, social, and political factors. As part of the health care system public health nursing practice is responsive to these factors through working with the community to promote health and prevent disease, injury and disability (Appendix A).

The health needs of people in the U.S. and the role of public health have been addressed in public policy documents including the 1988 Institute of Medicine's The Future of Public Health, the 1990 Department of Health and Human Services's Healthy People 2000: National Health Promotion and Disease Prevention, the 1993 Public Health Service's The Core Functions Project: Health Care Reform and Public Health and the 1995 Institute of Medicine's Nursing, Health and the Environment: Strengthening the Relationship to Improve the Public's Health (Appendix B). The efforts to plan an effective health care delivery system in these documents include a recognition of the unique contribution public health nurses make to the health care system. This definition of public health nursing is designed to provide an understanding of the practice of public health nursing in the health care system.

Definition

Public health nursing is the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences.

Public health nursing practice is a systematic process by which:

1. the health and health care needs of a population are assessed in order to identify sub-populations, families, and individuals who would benefit from health promotion or who are at risk of illness, injury, disability, or premature death;
2. a plan for intervention is developed with the community to meet identified needs that takes into account available resources, the range of activities that contribute to health and the prevention of illness, injury, disability, and premature death;
3. the plan is implemented effectively, efficiently, and equitably;
4. evaluations are conducted to determine the extent to which the interventions have an impact on the health status of individuals and the population;
5. the results of the process are used to influence and direct the current delivery of care,

Examples of Activities of Public Health Nurses

The activities of public health nurses include the following:

1. they provide essential input to interdisciplinary programs that monitor, anticipate, and respond to public health problems in population groups, regardless of which disease or public health threat is identified;

2. they evaluate health trends and risk factors of population groups and help determine priorities for targeted interventions;

3. they work with communities or specific population groups within the community to develop public policy and targeted health promotion and disease prevention activities;

4. they participate in assessing and evaluating health care services to ensure that people are informed of programs and services available and are assisted in the utilization of available services.

5. they provide health education, care management and primary care to individuals and families who are members of vulnerable populations and high risk groups.

Public health nurses provide a critical linkage between epidemiological data and clinical understanding of health and illness as it is experienced in peoples' lives. This understanding is translated into action for the public good. An illustration of this role is the surveillance and monitoring of disease trends within the community. Emerging patterns that potentially threaten the public's health are identified and appropriate interventions planned, coordinated and implemented. This is a role that public health nurses can do in any setting; however it occurs mainly in the public sector. Public health nurses contribute to systems for monitoring crucial health status indicators such as environmentally caused illnesses, immunization levels, infant mortality rates, and communicable disease occurrence in order to identify problems that threaten the public's health and develop effective interventions.

Factors Influencing a Strong Public Health Nursing Role

Factors influencing the extent to which a strong public health nursing role is realized are the expectations and involvement of the populations served, agency objectives and resources, and the influence and leadership of public health nurses. Historically, public health agencies had a legislative mandate to protect and advocate for the health of the entire population in a designated jurisdiction. They coordinated their activities with private and voluntary health agencies, sharing common goals and concerns to meet the needs of the community.

The current health care system includes a range of public, private and managed health care providers with varying missions and levels of involvement with the community as a whole. The populations served by these provider agencies may be more narrowly focused and the care they deliver determined by funding source (e.g., managed care provider), setting (e.g., school or workplace), specific population characteristics (e.g., age or sex), or health concern (e.g., mental illness or obstetrics).

Realistic adaptations need to be made in the role of public health nurses practice according to the type of community-based health agency in which public health nurses are

Appendix A

Current Context of Public Health Nursing Practice - 1995

Key issues in the current context of health care delivery that affect public health nursing practice include health care reform, the delivery of care in a variety of community settings, increasingly interdisciplinary health care, an emphasis on health promotion and risk reduction, and changing demographics. Health care reform in the 1990's is influenced by concerns about cost containment and the growing number of uninsured and underinsured people who are unable to access health care in the private sector. The trend in health care reform is to manage care with the goal of controlling costs while maintaining quality and continuity of care.

Lack of access to affordable care created a need for primary care that public health departments stepped in to fill.. The need for primary care emerged when health care programs initiated during the 1960's and 1970's were reduced or eliminated during the 1980's and 1990's. Other factors affecting the need for primary care included changing social forces, employment patterns and insurance rates. Many public health nurses currently provide primary care to individuals in this vulnerable population. The provision of primary care by public health agencies has its benefits, including improved prenatal care, childhood immunizations and infectious disease care. However, a cost to public health has been that public health nurses have had to focus on individual care rather than developing interventions based on population need. The impact of changes in access to care and in federal funding through state block grants is unknown. One possibility is that the changing health care environment will provide public health nurses with the opportunity to refocus their work and strengthen their capabilities to provide more population focused services withsubsequent improvements in the health of entire communities.

There is an increasing emphasis on care delivered in the community. Advances in science have led to new treatments that enable health care providers to effectively treat conditions that were once terminal and manage complex illnesses outside the hospital setting. People are discharged early from hospitals after procedures that once involved lengthy stays. Outpatient surgery has replaced much inpatient care. Home care for recovery from an illness and terminal hospice style nursing care are available in most communities. Nurses who once worked exclusively in hospital settings are now providing patient care in the community.

The provision of a wider range of care by nurses in homes, schools and worksettings has increased the importance of interdisciplinary efforts. Public health nurses work with a variety of providers, including counselors, health educators, nutritionists, outreach workers, pharmacists, physical therapists, physicians, social workers, and volunteers. They work with other providers of services; such as those in schools, the judicial system and social services to maximize the effective, efficient delivery of health services to individuals, populations, and communities.

The past ten years have brought increased emphasis on risk reduction, health promotion,

Appendix B

Public Policy Documents

1. The Institute of Medicine. 1988. The Future of PublicHealth.

2. Public Health Service. 1993. The Core Functions Project: Health Care Reform and Public Health.

3. U.S. Department of Health and Human Services. 1990. Healthy People 2000: National Health Promotion and Disease Prevention.

4. The Institute of Medicine. 1995. Nursing, Health and the Environment: Strengthening the Relationship to Improve the Public's Health.

The Future of Public Health defines the mission of public health as fulfilling society's interest in assuring conditions in which people can be healthy. Its aim is to generate organized community effort to address the public interest in health by applying scientific and technical knowledge to prevent disease and promote health. The report defined the core functions of public health as assessment, policy development and assurance.

The Core Functions Project identified ten activities performed in meeting the core functions. These include: 1) health status monitoring and surveillance; 2) investigation and control of disease and injuries; 3) protection of environment, work-place, housing, food, and water; 4) laboratory services to support disease control and environmental protection; 5) health education and information; 6) community mobilization for health related issues; 7) targeted outreach and linkage to personal services; 8) health services quality assurance and accountability; 9) training and education of public health professionals; and 10) leadership, policy, planning and administration. These identified activities have been used to describe the role of public health in health care reform. Public health nurses provide many of these services throughout the country.

Healthy People 2000 revealed the broad spectrum of health problems affecting people in the U.S. Specific objectives and recommendations were made to address these problems. It stressed that many diseases and problems are the result of interactions among the environment, genetics and lifestyle and can be affected by health promotion and disease prevention activities.

Nursing, Health, and the Environment: Strengthening the Relationship to Improve the Public's Health is a document prepared by the Committee on Enhancing Environmental Health Content in Nursing Practice. It highlights the growing need for public health nurses to be informed and involved advocates concerning environmental issues.

Appendix D
Public Health Nursing in Private, Voluntary, or Non-Official Agencies

Most community-based health care agencies serve a specific segment of the community. The approach may be comprehensive and concerned with prevention of illness as well as treatment of disease or disability. However, comprehensive care may be offered to the individual but not to the entire family. In other instances, the agency intervenes only in relation to a specific health problem (e.g., hypertension, cancer, pregnancy) or a specific phase of a health problem (e.g., emergency, hospice, halfway house). Regardless of the point at which nurses intervene in the health-illness continuum or the developmental phase of the client receiving community based care, public health nursing practice is based on consistent principles. Because of the extraordinary diversity of programs and services and the current trend toward care in the community, the following guidelines are offered. They can be adapted to the particular characteristics of an agency.

The single factor that most distinguishes these programs from those with a public health mandate is the population definition used for planning and services. All too frequently, the target population or case load consists of those individuals who meet program criteria and present themselves for services. Program planning usually is based on the needs of these individuals rather than on the needs of eligible individuals, including those who fail to come for care. While it is true that comprehensive, holistic care with an appropriate emphasis on risk assessment and anticipatory guidance may be given to individuals who come in for care; often the focus of nursing service, planning, and programming does not go farther to include reaching the population at risk which the presenting individual personifies.

The first step in analysis of the population base requires the nurse to become familiar with the people enrolled in the program. If resources necessitate priority setting, it is important to identify those individuals/families at highest risk of illness or poor recovery for whom nursing intervention and resources can make a difference. In the second step of the analysis, the public health nurse must extend the scope of service to those individuals/families within the community who meet the criteria for service but who have not availed themselves of the care offered or have dropped out of the program. This "targeted outreach" becomes critical when a program wishes to measure its success by the improved health status of the entire community. The needs of and changes achieved in the group seeking care may not accurately reflect the health needs or health levels of the larger community. It is the responsibility of public health nurses and those working with the public health nurse to assure that services are available and accessible and that populations at risk are informed of them.

In summary, for those agencies in which program planning and evaluation for assessment, assurance and policy development based on the total population are not feasible, an intermediate approach is recommended. The nurse moves away from solely meeting the needs of consumers as individually presented and toward practicing public health nursing for all individuals or families within the population group or program focus.

Appendix B

Public Health Nursing and Maternal and Child Health Home Visiting Programs

PUBLIC HEALTH NURSING AND MATERNAL AND CHILD HEALTH HOME VISITING PROGRAMS
APRIL 4, 1995

PURPOSE:

1. To provide a guide for future short and long term planning efforts
2. To assure public health nursing approaches planning efforts as a unified body speaking with a common voice
3. To use as a reference or a basis for dialogue when discussing home visiting with other partners.

ANTICIPATED PLANNING EFFORTS:

1. Statewide Family Support/Family Preservation Planning
2. Healthy Start/Oregon Commission on Children and Families Planning
3. Oregon Options
4. Other
   a. Carnegie Foundation report opportunities
   b. Systems development initiatives
   c. Local health department planning

WHAT ARE HOME VISIT PROGRAMS?

Home visit programs are service delivery models. Recent years have seen renewed interest in home visits as a strategy for effectively reaching families.

The following have been identified as key components of effective early intervention/prevention focussed home visit programs:

- ♥ Universal and voluntary
- ♥ Multiple goals and objectives
- ♥ Method of evaluation
- ♥ Defined target population
- ♥ Providing a continuum of services based on the unique needs of the target population
- ♥ Flexible in intensity and duration
- ♥ Well trained dedicated staff with skills that match the services they deliver
- ♥ Family is included in planning, policy and decision making
- ♥ Culturally sensitive

2. A foundation of practice that emphasizes primary prevention and health promotion.

3. An ability to both assess and understand the conditions that affect an individual or family's health, such as economics, housing, & social conditions and to develop both individual and community strategies that address health issues.

4. A range of public health nursing competencies which include:

a. Ability to perform standardized health screening

b. Ability to perform comprehensive nursing assessments of the individual's or family's physical, emotional, developmental and environmental status.

c. Ability to use screening and assessment to determine nursing diagnosis

d. Skills interpreting health related information to families enabling them to integrate this information into their daily lives

e. Development and implementation of a comprehensive plan of care which includes the following intervention strategies:

1. Teaching strategies focused on health promotion and disease prevention.
2. Counseling, coaching and supporting the individual or family to reach mutually identified goals.
3. Case management activities which assist the family to access and utilize additional services.
4. Family advocacy which includes a family centered, holistic approach to the management of complex care.

f. An evaluation of the nursing plan which determines the extent to which these intervention strategies impacted the identified health outcomes.

ROLE OF PUBLIC HEALTH NURSING IN MCH HOME VISITING

Public health nurses have many roles in the delivery of home visit services to families:

1. ***Direct service provider of home visits.***
Screening and assessment, developing a plan with the family, providing health education, counseling, clinical procedures, case management, and advocacy.

STANDARDS FOR REGISTERED NURSE SCOPE OF PRACTICE
851-45-010

From Oregon State Board of Nursing, Nurse Practice Act, Oregon Revised Statutes (As Amended 1993) and Administrative Rules Regulating the Practice of Nursing, December, 1994.

1. The Board recognizes that the scope of practice for the registered nurse encompasses a variety of roles, including, but not limited to:
   a. Provision of client care;
   b. Supervision of others in the provision of care;
   c. Development and implementation of health care policy;
   d. Consultation in the practice of nursing;
   e. Nursing administration
   f. Nursing Education;
   g. Case Management
   h. Nursing Research
   i. Teaching health care providers and prospective health care providers;
   j. Specialization in advanced practice.

2. Standards related to the registered nurse's responsibility to apply the nursing process. The registered nurse shall:

   a. Conduct and document nursing assessments of the health status of individuals and groups by:

      1. Collecting objective and subjective data from observations, examinations, interviews, and written records in an accurate and timely manner as appropriate to the client's health care needs. The data include, but are not limited to:

      - Physical and emotional status
      - Growth and development
      - Cultural, religious, and socioeconomic background
      - Client and family health history
      - Information collected by other health team members
      - Information gathered from family or significant others;
      - Client knowledge and perception about health status and potential for maintaining health status
      - Ability to perform activities of daily living
      - Patterns of coping and interacting
      - Consideration of client's health goals
      - Environmental factors, eg, physical, social, emotional, and ecological
      - Available and accessible human and material resources

3. Standards related to the registered nurse's responsibilities as a member of the nursing profession. The registered nurse shall:

a. Have knowledge of the statutes and regulations governing nursing and function within the legal boundaries of registered nurse practice.

b. Accept responsibility for individual nursing actions and maintain competency in one's area of practice.

c. Obtain instruction and supervision as necessary when implementing nursing techniques or practices.

d. Function as a member of the health team.

g. Collaborate with other members of the health team to provide optimum client care.

f. Consult with nurses and other health team members and make referrals if necessary.

g. Contribute to the formulation, interpretation, implementation, and evaluation of the objectives and policies related to nursing practice within the employment setting.

h. Report unsafe nursing practices either directly to the Board or through appropriate channels and unsafe practice conditions to the appropriate regulatory agency(s).

i. Accept only client care assignments for which one is educationally prepared and when competency has been maintained.

j. Act as an advocate for the client.

k. Assign or delegate to others only those nursing measures which that person is prepared to perform and qualified to perform and are within that person's scope of practice/scope of duties.

l. Delegate, in settings where a registered nurse is not regularly scheduled, specific tasks of nursing care to an unlicensed person only as described in the Board's delegation rules (Division 47).

m. Supervise others to whom nursing interventions have been assigned or delegated.

n. Retain professional accountability for nursing care when assigning or delegating nursing interventions.

o. Teach health care practices to other health care providers.

p. Contribute to policy development and implement policies in a manner which meets the needs of the clients served by the agency/facility in which the nurse practices.

4. Standards related to the registered nurse's authority to accept and implement orders for client care/treatment.

a. The registered nurse may accept and implement orders for client care from licensed health care professionals who are authorized to independently diagnose and treat. These health care professionals are:

AOPHNS RECOMMENDATIONS

AOPHNs recognizes that families have unique needs that can best be met by a system that provides a continuum of services. Home visiting programs have been identified as an effective strategy for working with families. In order to meet their maximum potential for effectiveness, home visit programs must be part of a broader system of comprehensive, family support services.

The public health nurse plays an important role as both a direct provider of home visit services as well as in the design, planning, implementation, and evaluation of service delivery systems.

AOPHNS recognizes that communities have differing strengths and resources that may require different approaches to service delivery. AOPHNS is committed to working within local and state committees to assist with planning efforts related to the development of comprehensive service systems including home visits.

AOPHNS recommends that all future planning efforts work to:

1. Insure that home visits begin prenatally and continue until the child is at least two years of age but preferably until school age.

2. Incorporate the key components of home visit programs:
   - ♥ Universal and voluntary
   - ♥ Multiple goals and objectives
   - ♥ Method of evaluation
   - ♥ Defined target population
   - ♥ Providing a continuum of services based on the unique needs of the target population
   - ♥ Flexible in intensity and duration
   - ♥ Well trained dedicated staff with skills that match the services they deliver
   - ♥ Family is included in planning, policy and decision making
   - ♥ Culturally sensitive

3. Structure a continuum or tier level of services based on the unique needs of the family

4. Utilize public health nurses as part of a blended delivery system

5. Assure that home visit programs are a component of a broader system of family support services.

6. Assure that the other needed family support services are available and accessible as part of the comprehensive service delivery system.

STUDIES DOCUMENTING THE EFFICACY OF PUBLIC HEALTH NURSING HOME VISIT PROGRAMS

1. Olds, D., Henderson, C., and Kitzman, H. Does prenatal and infancy nurse home visitation have enduring effects on qualities of parental caregiving and child health at 25-50 months of life? *Pediatrics* In press.

   The infants of young, unmarried, low income adolescent mothers receiving public health nursing home visits had fewer emergency room visits, fewer emergency room visits for unintentional injuries, and fewer injuries recorded in their medical records.

2. Olds, D.L., Henderson, C.R., Tatelbaum, R. and Chamberlin, R. Improving the life-course development of socially disadvantaged mothers: A randomized trial of nurse home visitation. *American Journal of Public Health* (1988) 78:1436-45.

   Public health nurses visited socially disadvantaged first time mothers. During four years of home visiting, mothers returned to school more quickly, increased the number of months they were employed, had fewer subsequent pregnancies, and postponed the birth of their second child.

3. Olds, D.L., and Kitzman, H. Can home visitation improve the health of women and children at environmental risk? *Pediatrics* (1990) 86,1:108-16.

   A literature review of home visiting programs revealed that the "more effective programs employed nurses who began visiting during pregnancy, who visited frequently and long enough to establish a therapeutic alliance with families, and who addressed the systems of behavioral and psychosocial factors that influence maternal and child outcomes."

4. Olds, D.L. Home visitation for pregnant women and parents of young children. *American Journal of the Diseases of Children* (1992) 146:704-708.

   Successful home visit programs contain the following: a focus on families at greater need for service, the use of nurses who begin during pregnancy and follow the family at least through the second year of the child's life, the promotion of positive health related behaviors and qualities of infant care giving, and provisions to reduce family stress by improving the social and physical environments in which families live.

5. Olds, D.L., Henderson, C.R., Tatelbaum, R., and Chamberlin, R. Improving the delivery of prenatal care and outcomes of pregnancy: A randomized trial of nurse home visitation. *Pediatrics* (1986) 77:16-28.

   Young, unmarried low income women receiving public health nursing home visit services decreased the number of cigarettes smoked daily, exhibited a better diet at the end of the pregnancy, utilized support systems, WIC and

AMERICAN NURSES ASSOCIATION, STANDARDS OF COMMUNITY HEALTH NURSING PRACTICE, 1986.

1. The nurse applies theoretical concepts as a basis for decisions in practice.

2. The nurse systematically collects data that are comprehensive and accurate.

3. The nurse analyzes data collected about the community, family, and individual to determine diagnoses.

4. At each level of prevention the nurse develops plans that specify nursing actions unique to client needs.

5. The nurse, guided by the plan, intervenes to promote, maintain, or restore health, to prevent illness, and to effect rehabilitation.

6. The nurse evaluates responses of the community, family, and individual to interventions in order to determine progress toward goal achievement and to revise the data base, diagnoses, and plan.

7. The nurse participates in peer review and other means of evaluation to assure quality of nursing practice. The nurse assumes responsibility for professional development and contributes to the professional growth of others.

8. The nurse collaborates with other health care providers, professionals, and community representatives in assessing, planning, implementing, and evaluating programs for community health.

9. The nurse contributes to theory and practice in community health nursing through research.

Appendix C

Oregon Healthy Start Goals

Oregon Healthy Start Goals

By enhancing family stability and supporting positive parenting practices, Oregon Healthy Start seeks to promote school readiness, improve health outcomes for children and families and reduce the incidence of child abuse and neglect. Healthy Start has the following goals:

1. Provide information and short-term support services to all first-birth families
2. systematically identify higher risk families and offer long-term support services
3. Enhance family functioning in higher risk families by:
    a. Building trusting relationships,
    b. Teaching problem solving skills, and
    c. Improving the family's support system
4. Encourage positive parent-child interaction in higher risk families
5. Promote healthy growth and development for children in higher risk families.