

KANSAS
PUBLIC HEALTH NURSING

and

Administrative Resources
Guidebook



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INTRODUCTION

Public Health in America

VISION:
Healthy People in Healthy Communities

MISSION:
Promote Health and Prevent Disease and Injury

Public Health: CORE Functions
(Institute of Medicine, 1988)

Public Health:

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

Core Functions:

In 1988, the Institute of Medicine's, *The Future of Public Health*, attempted to describe the things public health should be doing in three broad areas called core functions.

1. Assessment
2. Policy Development
3. Assurance

These functions correspond to the major phases of public problem-solving: identification of problems, mobilization of necessary effort and resources, and assurance that vital conditions are in place and that crucial services are received.

Though the three core functions of public health developed by the Institute of Medicine's report, *The Future of Public Health* (1988) were widely accepted among public health's policy and academic community, they did not explain to legislators or the general public what public health does.

Essential Public Health Services:

The **Essential Public Health Services** provide the fundamental framework, by describing the public health activities that should be undertaken in all communities.

The Core Public Health Functions Steering Committee developed the framework for the Essential Services in 1994. This steering committee included representatives from US Public Health Service agencies and other major public health organizations.

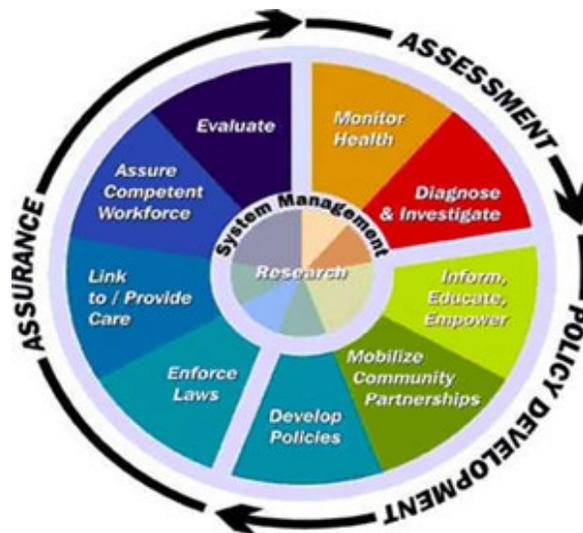
The Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems.

- [Monitor health](#) status to identify and solve community health problems
- [Diagnose and investigate](#) health problems and health hazards in the community

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

Further explanation and examples of Core Functions and Essential Services can be found by reading: ["What is Public Health"](#)

[Application Model \(read this document first\)](#)



New Essential Services Tool

<http://www.kdheks.gov/olrh/ImprovingPublicHealthInKansas.htm>

Public Health Accreditation

Kaye Bender, President and CEO of PHAB, The Seven Steps of Accreditation

www.phaboard.org/accreditation-process/seven-steps-of-public-healthaccreditation/

In order to improve the health of the public, the Public Health Accreditation Board (PHAB) www.phaboard.org/ is developing a national voluntary accreditation program for state, local, territorial and tribal public health departments. The goal of the accreditation program is to improve and protect the health of every community by advancing the quality and performance of public health departments.

Public health departments play a critical, but often unrecognized role in promoting and preserving the health of people in communities across the country. Despite the important role health departments play in our communities, there has not been a national system for ensuring their accountability and quality – until now.

Leading health practitioners and organizations recognized this, and helped develop a national voluntary public health accreditation program. Accreditation is a system of common standards used to measure performance. It is based on standards that health departments can put into practice to ensure they are providing the best services possible to keep their communities safe and healthy. Accreditation will drive public health departments to continuously improve their services and performance.

Other community services and organizations have seen the value of accreditation, such as schools, daycare centers, police departments and hospitals. Now, there is an opportunity for public health departments to measure their performance, get recognition for their accomplishments and demonstrate accountability within their communities.

The goal of public health accreditation is to improve and protect the health of the public by advancing the quality and performance of all health departments in the country. Having accredited public health departments means that no matter where you live – a West Coast suburb, a Midwestern city, or a rural community in the Southeast – you can feel confident that your public health department is providing the highest-quality services possible.

Everyone has the right to quality public health programs and services, and that means setting standards that encourage improvement of services.

Who is eligible?

The governmental entity that has the primary statutory or legal responsibility for public health in a state, a territory, a tribe or at the local level is eligible for accreditation. To be eligible, such entities must operate in a manner consistent with applicable federal, state, territorial, tribal and local statutes.

State and Territorial Health Department

The governmental body recognized in the state's or territory's constitution, statutes, or regulations or established by Executive Order, which has primary statutory authority to promote and protect the public's health and prevent disease in humans, is eligible to apply. Umbrella organizations and collaborations among state or territorial agencies may apply for accreditation if the primary entity is a part of the organization or collaboration. Where the state or territorial health department operates local and/or regional health departments, a single applicant or a number of individual applicants may choose to apply. Compliance with local-level standards must be demonstrated for each local and/or regional unit.

Local Health Department

The governmental body serving a jurisdiction or group of jurisdictions geographically smaller than a state, which is recognized in the state's constitution, statute, or regulations or established by local ordinance or through formal local cooperative agreement or mutual aid, and which has primary statutory authority to promote and protect the public's health and prevent disease in humans, is eligible to apply. The entity may

be a locally governed health department, a local entity of a centralized state health department, or a regional, county or district health department. An entity that meets this definition may apply jointly with other local-level eligible entities for accreditation status if some essential services are provided by sharing resources and the manner in which this occurs is clearly demonstrated.

Tribal Health Department

The health department serving a recognized tribe that has primary statutory authority to promote and protect the public's health and prevent disease in humans is eligible to apply.

Developing the Standards:

At their January 2009 Board meeting, the PHAB Board unanimously approved an initial draft set of standards and measures for vetting. The standards and measures were the products of months of development by a Standards Development Workgroup of state and local public health professionals, national and federal public health experts, public health researchers, and other technical experts. These initial standards and measures were subject to an "alpha" field test with a small group of local and state health agencies, resulting in multiple revisions.

PHAB also encouraged public feedback on the next draft of the documents, and a public comment period took place from February 7 to May 7, 2009. During that time, PHAB received over 4,000 individual comments, as well as other comments through online surveys and group feedback forms. The PHAB Standards Development Workgroup carefully reviewed each comment and, based on the feedback, proposed changes to the documents. The Workgroup's recommended changes were submitted to the PHAB Board of Directors, and in July 2009 they adopted the revised standards and measures for use in the beta test. The accreditation beta test is taking place from fall 2009 through the end of 2010, and will result in further refinement of the standards and processes. All of this feedback will help to shape the final national public health accreditation program, which will launch in 2011.

The development of draft standards and measures was guided by several principles. The standards and measures should:

- Advance the collective practice
- Be simple and reduce redundancy
- Minimize burden
- Reinforce local and state health departments' roles and demonstrate shared accountability
- Apply to all sizes and all forms of governance structure
- Be based on American National Standards Institute principles

About the Standards and Measures

There are two sets of standards and measures: one for Local Health Departments (also used by tribal health departments) and one for State and Territorial Health Agencies.

The two sets of standards and measures are very similar. Each is organized around eleven domains and has the same set of standards; however, in some cases the measures vary in order to properly reflect a local or state context. There are a total of 30 standards, and a total of 102 measures for local health departments and 111 for state and territorial health agencies. The standards and measures documents include a list of "conventions," which relate to certain assumptions employed in the development of the standards and measures.

Another important aspect of the draft standards and measures is the "guidance for documentation" feature. Associated with each measure is a description of the kinds of documentation a health department might include to attest to their ability to meet a measure. Some listed document is required; others are suggested. The examples listed in these draft standards and measures are not the only possible examples. There are likely to be many more options identified through the beta test and through implementation of the program.

PHAB Accreditation Overview

The standards and measures are the framework for evaluating a health department's processes and services, their outcomes, and progress toward specific goals and objectives.

The standards and measures were developed after a thorough process of study, vetting and testing. Building on years of work developed by state-based public health accreditation programs, the National Public Health Performance Standards Program, and the Operational Definition of a Local Health Department, a workgroup composed of public health professionals, experts, and researchers developed the standards and measures. The standards and measures can be used to advance the practice of public health, should reinforce the role of public health, demonstrate accountability and should apply to all sizes of health departments and all forms of governance.

In preparing for national accreditation, the standards and measures can be used by the applicant health department: to review and revise health department processes, procedures, and programs; as a source of information on developing capacity and performance excellence in providing the core functions of public health; to guide the internal development of quality; and to prepare for the documentation selection and submission and site visit steps of the accreditation process.

[Getting Started](#)

[Standards & Measures](#)

[Seven Steps of Public Health Department Accreditation](#)

[Accreditation Materials](#)

Historical Summary of Public Health and Public Health Nursing In Kansas

The earliest times of public health dealt with sanitation to prevent death and disease because there was no knowledge of germs, vaccines or antibiotics. In 1858, Florence Nightingale began education and training of nurses. She stressed nursing the room (environment) as well as the patient. Slowly there was a movement toward scientific and social development of public health.

In the United States generally, recorded public health problems came with the British and others coming to the new world. In the 1700's the colonies passed legislation for isolation of smallpox patients and quarantine for ships.

In 1885 the Kansas State Board of Health and local boards of health were established by the legislature. This was a first for states and territories located this far west. The board was appointed by the Governor and was composed of five physicians, one dentist, one veterinarian, one pharmacist, one hospital administrator, and one sanitary engineer. The first division of the State Health Department was Food, Drug, and Sanitation formed in 1904. Dr. Samuel J. Crumbine was appointed the same year as the first Executive Secretary. He was an innovative and tireless worker, and led in the development of some of the programs that remain today: venereal disease and tuberculosis control, stream pollution abatement, and insect and rodent control. His book Frontier Doctor is fascinating reading and a good source of history for early public health in Kansas. Another excellent reference is Lamps on the Prairie, a history of nursing in Kansas.

In 1912, the US Public Health Service and the US Children's Bureau were established. Kansas, a pioneer in advocating for children, created the Division of Child Hygiene in 1925. This was six years before the Shepard-Towner Act, which provided federal funds to stimulate establishment of state-level divisions and bureaus to protect mothers and children in every state. Dr. Lydia Allen DeVilbiss was appointed to direct the division in Kansas. She and two nurses staffed the "Warren Health Railway Car" that crossed Kansas with health promotion information and activities for mothers, children, and all citizens. Over a period of eight years, the health train visited 255 communities, staffed 95 conferences, and gave 94 lectures in addition to making routine examinations and explanations to visitors. Dr. Crumbine was so pleased with the success of the train that in his 1915 annual report he expressed the opinion that "the public health nurse is the cornerstone of all public health work."

The first school nurse was hired in Dodge City in 1916. By 1919, Kansas had 79 Public Health Nurses and Dr. Crumbine recommended and established a Department of Public Health Nursing under the State Board of Health, Division of Communicable Diseases and asked nurse Estelle Patrick to be its leader. Also in 1919, the first full-time county health officers were appointed in Geary, Marion, and Cherokee counties. From then on, at least one new county was added each year so that by 1981, there were 94 local health departments in Kansas.

Dr. C.E.A. Winslow, a professor at Yale University, was prominent leader in the American public health movement, and in 1920 gave the best known and most widely accepted definition of public health:

"the science and art of preventing disease, prolonging life and promoting health and efficiency through organized community effort for (a) the sanitation of the environment, (b) the control of communicable infections, (c) the education of the individual in personal hygiene, (d) the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and (e) the development of the social machinery to insure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity."

An early recognized standard definition of public health nursing was offered by nurse educator Ruth B. Freeman who was a member of the executive board of American Public Health Association offered an early-recognized standard definition of public health nursing:

"a special field of nursing in which technical nursing, interpersonal and organizational skills are applied in appropriate relationship to the skills of other members of health and social professions for the conservation of community health. It includes comprehensive nursing care of individuals, families, and groups and in addition, public health measures addressed to the community as a whole, such as epidemiologic investigations, law enforcement or organization of the community for health action."

In 1922 the State Division of Public Health Nursing in Kansas was formed to supplement, coordinate, and standardize the activities of public health nursing. Helda A. Cron, RN, of Cleveland was the division's first Public Health Nursing Director.

By 1929 there were 130 public health nurses serving agencies in Kansas. This number has increased over the years, due in part to outside financial support such as federal programs providing intermittent funding for expansion of nursing services. The number of counties served and the number of local nurses has increased over the years despite these fluctuations in funding. In 1990 there were local community health services available in 104 counties provided by more than 500 public health nurses. Additionally there were approximately 412 school nurses providing services in local school districts.

Since the Division of Public Health Nursing was formed in 1922, its status has changed several times. In 1953, the first three district nurses were hired to act as consultants to local nursing service (including stimulation of the development of local services) and to provide services in counties without local nurses. In 1997, the Director of Local Health Services and six Public Health Nurse Specialists located in the Office of Local and Rural Health provided primary liaison for local public health agencies and community organizations. In 2010 the Director of Local Health Services and two Public Health Nurse Specialists, located in the Bureau of Local and Rural Health provide primary liaison and accreditation preparation for the local public health agencies and community organizations.

Definition of Public Health
from the 1988 Institute of Medicine Report
<http://www.iom.edu/>

The Future of Public Health

“fulfilling society’s interest in assuring conditions in which people can be healthy”

This definition directs our attention to the many conditions that influence health and wellness, underscoring the broad scope of public health and legitimizing its interest in social, economic, political, and medical care factors that affect health and illness (Turnock).

Definition of Public Health Nursing
A Statement of APHA Public Health Nursing Section
1996
<http://www.apha.org/>

“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 subpopulations, 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. Appraisals 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, deployment of health resources, and the development of local, regional, state, and national health policy and research to promote health and prevent disease.

This definition of public health nursing practice is an update of a statement published in 1980. 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 (APHA, 1996). The complete (APHA) definition and role of public health nursing is addressed in this manual “Public Health Nursing Practice.”

Levels of Prevention

Primary prevention focuses on preventing disease before it occurs or is diagnosed; it prevents problem from affecting people in the first place.

Examples: immunizations, sanitation worksite safety practices, counseling for families with genetic conditions, community fluoridation of water, labeling of heart healthy foods in grocery stores and restaurants, child restraints in cars, provision of fitness trails, shields on tractor power take-offs, smoking cessation programs, positive parenting classes, and dental sealants.

Secondary prevention focuses on early detection and prompt treatment of an existing problem; it prevents a problem from causing serious or long-term effects to the individual or from affecting others.

Examples: cholesterol screening, STD clinics, water testing, early and periodic screening clinics, required reporting of measles, follow-up on a positive Mantoux, routine Pap smears and self-breast exams, treatment of intraocular pressure, dental fillings, and food, beverage, and lodging inspections.

Tertiary prevention focuses on limiting further negative effects from a problem; it prevents an existing problem and its existing consequences from getting worse.

Examples: home health visits for the chronically ill and disabled, speech therapy for an individual with CVA, reporting or vulnerable adults and maltreated children, referral to support groups, and services for children with handicaps.

Intervention Levels

Individual-based Interventions focus on creating changes such as health status, knowledge, or skills in either individuals or small groups. This is typically seen as direct service to clients or residents.

Examples: one-to-one counseling, home health aide supervisory visits, prenatal classes, home care visits, private will testing, emergency medical response to injury, pregnancy testing, case management, and respite services.

Community-based interventions focus on creating changes in populations. They are directed towards groups within the community or, occasionally, towards all people within the community.

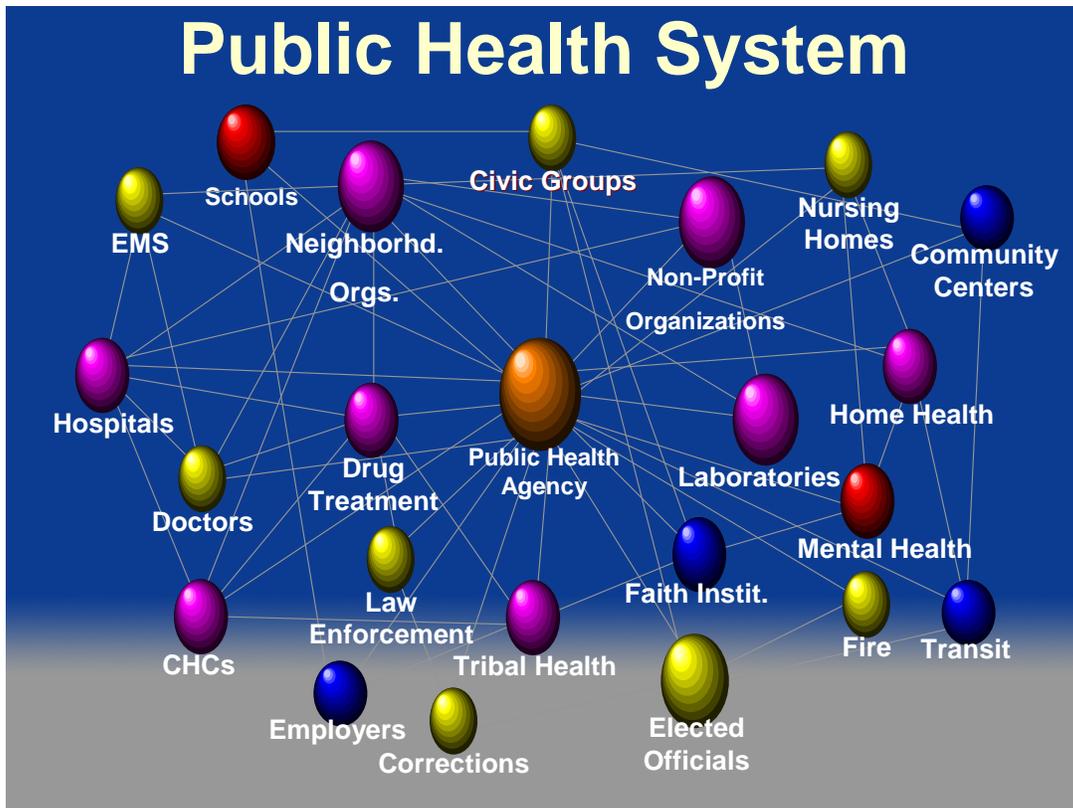
Examples: immunization clinics, media campaigns, lodging inspections, bike paths, worksite health promotion programs, health fairs, and scoliosis screenings in the schools.

System-based interventions focus on creating change in organizations, policies, laws, and structures. The focus is not directly on individuals or communities but on the system that serves them. Because these systems ultimately impact individuals, changing the system represents a cost-effective and long-lasting way to impact individuals.

Examples: reducing fat in a school lunch program, establishing a smoke-free workplace, reducing the number of grains of baby aspirin per bottle, improving access to health care, improving EMS response time, enforcement of hazardous waste ordinances, and playing an assurance role in home health care.

Systems Theory

Public health systems are commonly defined as “all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction.” These systems are a network of entities with differing roles, relationships, and interactions. (See figure below for a visual depiction of such a system.) All of the entities within a public health system contribute to the health and well-being of the community or state.



All systems are open in that there is a continuous exchange of information with the environment. A healthy system must achieve a balance internally and externally through regulation of the input and output. Through interactions with the environment, the system uses various mechanisms to maintain equilibrium. The systems theory assists the public health nurse and others to identify the community, assess and organize the collected data, set priorities, and plan programs to meet the needs of the assessed system.

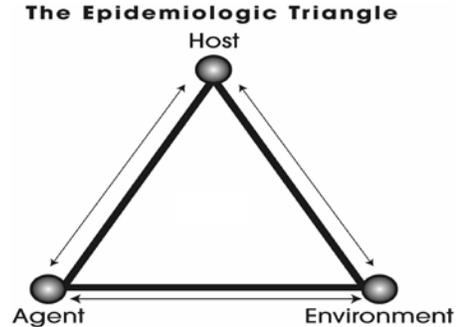
Public Health and Epidemiology Models

[The Epidemiologic Triangle](#)

The Epidemiologic Triangle is a model that scientists have developed for studying health problems. It can help your students understand infectious diseases and how they spread. It also gives students a chance to apply a scientific model to a variety of circumstances and facts.

The Triangle has three corners (called vertices):

- Agent, or microbe that causes the disease (the “what” of the Triangle)
- Host, or organism harboring the disease (the “who” of the Triangle)
- Environment, or those external factors that cause or allow disease transmission (the “where” of the Triangle)



An outbreak or an epidemic exists when there are more cases of a particular disease than expected in a given area, or among a specific group of people, over a particular period of time. Another other term you might come across is *endemic*, when a population has a high level of the disease all the time. For example, giardiasis and even malaria are endemic in parts of the world.

The mission of an epidemiologist is to break at least one of the sides of the Triangle, disrupting the connection between the environment, the host, and the agent, and stopping the continuation of disease.

Causes of Death and Disability

It is extremely important for those involved in a community health assessment process to understand basic information regarding causes of death and disability. There are four major factors contributing to premature death:

1. Unhealthy behaviors/Lifestyle
2. Unsafe environmental conditions
3. Inadequacies in the health care system
4. Biologic factors

Description of Public Health Capacities

Required to Efficiency Perform the CORE Functions Of Public Health

STRUCTURE AND POLICIES – The public health jurisdiction has clear lines of authority, the organizational structure and procedures in place to effectively carry out the core function. (Do we have the necessary authorizations and operational policies to improve performance?)

SKILLS AND RESOURCES – The public health jurisdiction has the workforce and the financing, facilities and equipment required to effectively carry out the core function. (Do we have the personnel, financing and other resources needed to improve performance?)

INFORMATION AND COMMUNICATION – The public health jurisdiction has the capability to receive process and communicate information, data and reports to effectively carry out the core function. (Do we have

access to relevant information and the ability to process and disseminate findings to improve performance?)

COMMUNITY INVOLVEMENT – The public health jurisdiction has processes in place to collaborate with the public it serves, with the officials it represents and with the health providers with which it practices to effectively carry out the core function. (Do we have the ability to influence and integrate performance in the community?)

QUALITY ASSURANCE – The public health jurisdiction has a system in place that incorporates principles of quality management and provides for the routine appraisal of the function to include its relationships with other core functions. (Do we continuously and systematically strive to improve performance?)

Quality Management & Quality Improvement

Quality Management in Public Health

A management process that focuses on meeting customer needs, continuous improvement, and employee involvement. The quality improvement process is a customer-focused process. Quality care means that the services provided match/meet of the populations(s), are technically correct, and achieve beneficial results. The escalating costs of health care have caused consumers and third party payors to demand quality care at reasonable costs. These demands are here to stay and more and more frequently, health care entities are being required to demonstrate beneficial outcomes in measurable terms. To say it simply, the public and payors want to know, "what am I getting for my money?"

An agency's Mission Statement should be the basis for its quality management program.

Continuous Quality Improvement Model

Continuous Quality Improvement (CQI) is a process that incorporates the PDCA cycle (plan, do, check, and act). It begins and ends with an assessment of performance. In public health practice, the community health needs assessment, which is an assessment of performance, is a dynamic and ongoing process reflecting a community system as opposed to a specific institution. CQI is a structured process that must involve agency employees in the planning and execution of improvements to provide quality health care that meets the needs of the public health customer. The process is focused on a problem or need instead of an indicator although indicators remain part of the measurement. The basic tenet of CQI is that improving processes will achieve far better results than finding people who cause the problems. Decisions for improving systems are based on facts, data, and statistical information. The process is ongoing and cyclic; it involves continuous appraisal and is always moving toward new levels with new standards. The prime difference between QA and CQI is that CQI emphasizes continuing improvement of performance and de-emphasizes whether or not a particular standard of performance was met. CQI has the goal of continuous improvement, reaching a level of performance never before achieved as opposed to the fixed goals of QA.

Performance measurement in the public health system must be able to measure inputs, processes, outputs, and outcomes in ways that allow for changes in one to be linked with the others. Without this, public health will not be able to make the changes necessary to improve the results it seeks. Public health has been extremely successful in measuring quantity (counting number served, procedures done, etc.), but has had limited success in assessing improvements in programs or organizational capacities attributable to public health departments.

The following course will help guide you through the process: [Basic Quality Improvement Tools for Public Health](#)

Other resources

[Public Health Quality Improvement Handbook](#)

[Performance Management & Quality Improvement: Resources & Tools](#)

[Accreditation and Quality Improvement](#)

[Public Health Quality Improvement Encyclopedia](#)

Performance Management & Quality Improvement (PM/QI)

Quality improvement (QI) in public health needs a deliberate and defined process, such as the Plan-Do-Check-Act (PDCA) cycle. Ongoing efforts like this need to achieve measurable improvements in the efficiency, effectiveness, quality, outcomes, or performance of services or processes. The ultimate goal is a positive impact on the community's health. These QI efforts can seek "incremental" improvement over time or "breakthrough" improvement all at once.

One major factor in implementing QI techniques in public health departments is the governmental nature of public health that has special considerations not typically found in organizations implementing a QI program.

By improving performance and quality, public health systems can save lives, cut costs, and get better results by managing performance. PHF collaborated with the Turning Point Performance Management National Excellence Collaborative since 2000 to study how organizations manage performance and to develop a series of publications and tools to help public health organizations better understand and apply these techniques. Visit the [Public Health Learning Resource Center](#) for additional information.

Definitions

Capacity – the capability to carry out the core functions of public health.

Customer – people who receive and use the work products or services of an organization. This can be a community, population, or families and individuals.

Inputs – capacities such as human resources, fiscal and physical resources, information resources, and system organizational resources necessary to carry out the core functions of public health.

Mission Statement – statement of the purpose of the organization; why the organization exists. For public health, it is assuring conditions in which people can be healthy.

Outcomes – the results of care for patients and populations based on long term objectives that define optimal, measurable future levels of health status.

Output – a product or service that is produced as part of the job and is passed on to the customer.

Process – a logical organization of people, materials, energy, equipment, and procedures into work activities designed to produce a specified end result, i.e. what is done to and for the patient.

Quality – meeting and exceeding the customers' needs and expectations, the first time and every time, keeping in mind that the customer's needs and expectations are not static.

Quality of care – the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Structure – characteristics of the providers or organizations delivering care, that is, the "inputs" to care.

Variability – the degree to which things are different from one another.

Quality Management – a management process that focuses on meeting customer needs, continuous improvement, and employee involvement.

ADMINISTRATION

Strategic Planning

What is Strategic Planning?

Strategic planning is a structural process designed to organize thoughts and plans in a logical manner that people can understand. There are many variations on the theme, many interpretations, but all focus on where an organization or project should progress along a future path. The process is a continuous one, but along the way specific and measurable actions should result.

Why do strategic planning?

It is difficult to move ahead without organizational consensus, and planning is a tool for developing that consensus. The process also encourages thoughtful decision-making about the allocation of scarce resources and helps individuals make decisions about how to structure individual departments, time and expenditure of funds. Strategic planning also sets up measurable parameters that can be evaluated, so that objective progress can be observed.

What are the components of a strategic plan?

Vision

Vision is a grand, global statement. It summarizes the ideal hope of the organization or project. It communicates organizational values. The vision statement is your dream, the way it "ought to be."

Vision example: Healthy Kansas

Mission

Mission is the statement of the special task or purpose of the organization/project. It answers two questions: "What is going to be done?" and "Why is it going to be done?" A mission statement should be outcome-oriented, broad-based, and concise.

Mission example: To increase the physical activity levels of Charles County, Kansas, high school students in an effort to develop a lifelong commitment to exercising on a regular basis, thereby preventing premature death and disability among this population.

Objectives

Objectives provide direction for action. They are statements of specific and measurable items that articulate how much will be accomplished and by when the results will be anticipated. They have baselines that use valid and reliable data derived from established data systems. The following should be true of all objectives:

- The results to be achieved should be important and understandable.
- Objectives should drive action and suggest a set of interim steps that will achieve the proposed targets within the specified time frame.
- Objectives should be useful and relevant.
- Objectives should be measurable and may include a range of measures, i.e. immediate, intermediate, and long-range.

All objectives have specific and necessary elements:

1. A target date, e.g. "by June 30, 1998...."
2. A focused issue, e.g. "immunization rates," or "personnel policies."
3. A measurable change, e.g. "achieved completion rates of 92%," or "reviewed and revised in accord with new county policies."
4. Baseline measures, e.g. "74% completion rate in 1996."
5. And in some cases a targeted population, e.g. .."children at 24 months of age.."

Health objectives are organized into three types:

Health Status/Outcome – Objectives that state the intended result of activities to reduce death, disease, and disability. Outcomes are long-term and define the optimal, measurable future levels of health. Example: Reduce deaths due to unintentional injuries.

Risk Outcome – Objectives to reduce the prevalence of risks to health or to increase behaviors known to reduce such risks. These are intermediate in nature, usually 2 to 5 years. Example: Increase the percent of persons wearing seat belts.

Process – Objectives that identify the activities, which are instituted to move a community toward a risk or outcome objective. Example: Institute community awareness program with the Highway Patrol.

Writing Behavioral Objectives

A behavioral objective is a statement of intended change in a learner's behavior as a result of the educational experience and these objectives are observable or measurable. Behavioral objectives are generally classified as occupying one of three domains: cognitive (intellectual), affective (attitudinal or emotional), and psychomotor (motor skills or doing). All learning outcomes are believed to fit within one of these domains.

Benefits of behavioral stated objectives are:

1. They provide direction for the instructor/health educator as well as indicating to students the instructional intent of the program.
2. They facilitate and guide selection of course content, teaching strategies, and supplemental materials by the instructor.
3. They facilitate the appraisal process at the end of the program.
4. They guide the student's selection of education to meet their learning needs and outline results expected to be accomplished by the program.

Key points for writing behavioral objectives are:

1. Begin each objective with an action verb, such as "describe," "identify," "analyze," "list," or "demonstrate." Verbs such as "knows," "understand," or "appreciates" are not appropriate because they are not observable or measurable.
2. Be sure the objective is stated as a learner performance outcome rather than as a teacher action or intent (What can the student do at the end of the program as a result of the program?)
3. Include only one desired behavior per objective.
4. Be sure the stated objectives are appropriate to the learner's needs, interests and knowledge base.

Suggested action verbs to use when writing behavioral objectives:

identity	state	discuss	list
classify	examine	differentiate	compare/contrast
outline	interpret	construct	assess/document
recall	order	relate	translate
describe	distinguish	apply	demonstrate
analyze	recognize	explain	define

Use the verb with a stem statement, such as, "Upon completion of the program, the participant will be able to..." at the beginning of the objectives.

Upon completion of this workshop, the nurse participant will be able to:

1. Discuss current research on senile dementia.
2. Identify clinical needs of elderly patients with mental disturbances.
3. Construct a nursing management plan for elderly patients with dementia.
4. Explain practical concerns and management techniques for elderly patients with mental impairment.

Strategies

Strategies are statements that describe how the objectives will be met. They identify approaches that are effective in making changes, such as public awareness campaigns, health education, social marketing, research and appraisal.

Strategy Examples:

Convince the Charles County School Board to enact a policy that requires all students to enroll in a physical education course each year of high school that meets at least three times a week and provides at least 20 minutes of aerobic exercise per session.

Develop a public awareness campaign that educates high school students, their parents, teachers and school board members about the importance of physical activity to health.

Action Plans

Action Plans are detailed working plans for the total strategy. They answer the questions: What? Who? When? Cost? Action plans break down the strategies into individual steps to be accomplished. They should create multiple opportunities for community involvement and leadership development.

Action Plan Examples:

<u>Person Responsible</u>	Cost	Action Step
Journalism Class	\$500	By January 1998, develop newsletter articles and posters that highlight the importance of physical education.
Principal	\$1,700	By May 1998, enroll all high school PE teachers in a summer college course that provides instruction in the implementation of the "Physical Dimensions" curriculum developed by the Kansas State Board of Education.
Coach Smith	\$2,400	By September 1998, initiate additional high school physical education courses that provide aerobic exercise for all students.

Resource:

Free Management Library: Basic description of Strategic planning
http://managementhelp.org/plan_dec/str_plan/basics.htm

Policies and Procedures

Policies and procedures need to be relevant to the specific goals or purposes of the agency. They should be definite and stable, but flexible enough to be adjusted to meet any fundamental change. They should be stated in a simple, succinct manner so that they can be understood and followed. These policies and procedures form the basis for quality assurance.

Strict adherence to policies and procedures in practice is very important and should include no exceptions. To accomplish this, employee participation in their development is essential. Policies and procedures encourage an agency to conserve its energies and resources by directing them toward established goals. In addition, they provide the necessary framework and organizational stability to confront and resolve problems. They provide the employees with established guidelines and thus support the effectiveness of their decision-making capabilities. They promote and encourage individual accountability and eliminate inconsistencies.

Policies are general statements about the overall program operation. They provide basic direction for maintenance of the program and are concerned with administrative as well as clinical circumstances. Policies are typically statements about the agency's assumptions and philosophy. (Example: All personnel involved in providing patient care in the clinic will be CPR-certified on an annual basis.)

Procedures provide detailed, step-by-step instructions for performing specific procedures in the Agency. Procedures are process-oriented and direct personnel in carrying out laboratory tests, counseling sessions, release of medical records, and any other task for which staff members are responsible. (Example: The blood pressure is measured by placing the cuff of the instrument around the patient's arm approximately two inches above the antecubital space....)

Standing orders are instructions, written and signed by physicians, to authorize or delegate medical actions in response to specific clinical care situations. They are explicit instructions about treatment which are communicated to a licensed person other than a physician (usually an ARNP or a RN). In the ambulatory setting, standing orders are generally related to prescription medications. They are extremely specific, deal with one single problem, and do not address assessment or diagnosis. Standing orders may be part of the clinical directives, but they must be reviewed, approved and signed annually by a physician, usually the Medical Consultant.

Protocols are written agreements between health care professionals, and generally apply to the judgment guidelines for the practice of advanced practice nursing. They are more precise than guidelines and allow for varying degrees of independent action. They attempt to standardize diagnostic and management strategies in an explicit and concise manner. (Example: Physicians and nurses who work together to establish or delineate areas of dependent, independent, and interdependent function; consistent, standardized data base; criteria for audit of care and performance; and assurance of thoroughness).

Types of Policies and Procedures

Organizational Policies and Procedures outline the implementation of management and administrative functions throughout the agency, including the establishment of clear lines of responsibility and accountability within each department and between departments.

Contractual Policies and Procedures outline the delineation of the credentialing and clinical privileges of physicians, nurse practitioners, and other health care providers. They can also outline effective management, safety, and quality controls for services from outside resources.

Rights and Responsibilities of Clients Policies and Procedures identify the basic rights of all human beings for independence of expression, decision, and action and concern for personal dignity and human relationships. It becomes the responsibility of the health professionals to assure that these rights are preserved for the clients.

Health Record Policies and Procedures ensure that an agency maintain confidential medical records that are documented accurately and in a timely manner. The records are readily accessible to appropriate personnel and permit prompt retrieval of information. Health records are maintained for each client receiving care and support the diagnosis and document the course and results of treatment accurately.

Financial Management and Accountability Policies and Procedures include all fiscal issues involved with the operations of a health agency, as well as an itemized and detailed explanation of fees for services rendered to a client.

Quality of Care Policies and Procedures demonstrate a consistent endeavor to deliver client care that is optimal within available resources and consistent with stated goals. They also demonstrate a planned and systematic process for monitoring and evaluating the quality and appropriateness of client care and for resolving identified problems. To assure quality of care, a mechanism for quarterly record review is established.

Emergency Policies and Procedures specify the scope and conduct of client care to be provided in an emergency.

Infection Control Policy and Procedures outline an effective program for the surveillance, prevention and control of infection.

Pharmaceutical Policies and Procedures specify the administration of medications by nurses and the prescriptive authorization for nurse practitioners.

Facilities Policies and Procedures specify that the areas in which clients receive treatment are designed, constructed, equipped and maintained in a manner that is designed to provide for the physical safety of clients, personnel and visitors.

Maintaining and Revising Policies and Procedures

The Policies and Procedures should be reviewed on an annual basis, or more frequently if indicated, by the administrative staff of the agency. All policies and procedures need to authenticate by date and signature and title of the director/administrator. In addition, periodic reviews should be done by the professional staff. Another phase can take place during the orientation process of new employees. They can be requested to note any questions or concerns for which there is no policy or procedure and for which they have to depend on word-of-mouth information.

A manual should be constructed so that policies and procedures can be added or removed when appropriate. A simple loose-leaf notebook can be used or Electronic policies and procedures are acceptable and may be easier to edit. The manual should be divided into sections and subsections with their own pagination for easier use and revisions. A Policy and Procedure Manual is only useful when it is accessible. All staff should know the location of the Manual. Participation of all staff in the formation and revisions of policies and procedures is essential. When employees are involved, there will be a stronger commitment for success.

Sample Policy and procedure: www.kdheks.gov/olrh/LHD_SamplePoliciesAndForms.htm

Fiscal Management Guidelines

Fiscal Management

Accounting records must adequately and accurately reflect the continual changes in assets, liabilities, income, expenses, and equity. It is imperative that the interrelationships among these accounts remain satisfactory.

Financial statements record past business activity and conditions. By careful study and analysis of past performance, the agency will better be able to determine projections for the future. Financial statements must conform to generally accepted accounting principles that are established by the accounting profession. Information contained in the statements is in large part directed to external parties for compliance purposes. Users of the information can determine whether or not the agency has adequately accounted for funds.

Definitions

Assets are the physical, financial, or other values that an agency has. Assets are divided into current and fixed.

Current assets are those that turn over – that is, they change from one form to another – within one year.

Cash includes the currency, the deposits in the checking account in the bank, and other non-interest bearing values that can be converted into cash immediately. It is the most liquid of any of the accounts. Accumulating too much cash means the agency reduces its income-producing capacity.

Accounts receivable form a current asset that results from giving credit to customers when they buy services or goods.

Inventory is an asset that provides a buffer between purchase and sales. Your money is tied up, space is used, products must be maintained and can become obsolete, etc.

Fixed assets are buildings, machinery, fixtures, vehicles, and land. The agency expects to own them for considerable time and writes off part of their cost each period as depreciation expense.

Liabilities are monies borrowed or owed.

Current liabilities are obligations to be paid within one year. They include accounts payable, notes payable, and accrued items (such as payroll).

Accounts payable are usually due within 30-60 days.

Notes payable are written obligations to pay, usually requiring payment of interest.

Long-term liabilities are usually bonds and mortgages.

Equity is the owners' share of an agency after the liabilities are subtracted from the assets.

Revenue is the return from goods and services sold.

Expenses are the costs of performing services. They include materials, wages, insurance, utilities, transportation, depreciation, taxes, supplies, and sales promotions.

Profit is the excess of revenue over expenses.

Loss is the excess of expenses over revenues.

Cost Studies

A COMMON PROBLEM IS THE LACK OF ACCURATE COST INFORMATION, WHICH USUALLY RESULTS IN PROFITS OF UNKNOWN QUANTITY, OR EVEN A LOSS.

Direct costs are costs incurred for a specific purpose that is uniquely traceable to that purpose.

Indirect costs are costs that are associated with more than one activity or product, but are costs that cannot be traced specifically to any one activity or product.

Cost accounting finds that actual costs of a program. The total costs of equipment, facilities (rent, mortgage), personnel (salaries and benefits), and supplies used over a period of time are calculated. The total program costs are divided by the number of clients participating in the program during that time. The total program cost per client is the end product.

Cost benefit studies are a way of assessing the desirability of a program by placing a specific dollar amount on all costs and benefits. If benefits outweigh the costs, then the program is said to have a "net positive impact." Sometimes it is difficult to place values on intangible benefits.

Cost effectiveness is a measure of the quality of a program as it relates to cost. It is a subset of cost benefit analysis and is designed to provide an estimate of costs incurred in achieving a given outcome. This type of study can answer the following questions:

Did the program meet its objectives?

Were clients and staff satisfied with the effects of the interventions?

Are things better as a result of the interventions?

Outcome measures might include increased client knowledge after health teaching, changes in the client's condition after treatment, etc. A cost effectiveness study requires collection of baseline data on clients before the program is implemented and appraisal after the program is completed.

Cost efficiency is the actual cost of performing a number of program services. To determine cost efficiency, productivity must be analyzed.

Productivity is the relationship between what the staff member does and how much it costs him/her to do it.

Cost studies are essential to show the worth of nursing in the marketplace and nurses should be familiar with the results of cost studies so that sound decisions may be made about future program management. Nurses must be ready to identify appropriate program outcomes, client outcomes, and total dimensions of nursing procedures so that appropriate decisions about program management will be made based on adequate information.

The Time Summary Program for Local Public Health is web-based training program on [KS-TRAIN](#) that is an easy way to calculate the indirect costs/maintenance of effort with in your health department.

[Time Summary Program for Local Public Health 2011](#) #1027729.

Fiscal Records

An agency minimally needs records of the following:

1. **Sales of goods and/or services** – both cash and charge accounts.
2. **Accounts receivable** – amounts of money that other people owe the agency.
3. **Purchases** – inventory purchased from vendors or wholesalers. The first step to keeping track of monies spent on supplies, equipment, etc., is to use number purchase order forms. By ordering everything through purchase order, more control over expenditures will be achieved. There will be increased knowledge regarding the date of ordering, the quantity ordered, the price, etc.
4. **Accounts payable** – money the agency owes to others.
5. **Owners' equity (county tax levy)** – funds invested into the agency by the owner, plus profit, and minus funds removed.
6. **Fixed assets** – to determine proper depreciation and replacement.
7. **Petty cash** – a check is written as needed to cover small itemized expenses and/or to maintain a certain level of cash within the agency.

One purpose of bookkeeping is to provide management and owners with data to be used in decision-making. The main purpose is to provide an accounting of assets, liabilities, expenses, and revenues.

Accounting Systems

The simplest accounting system is one that provides cash control.

Cash basis – can be provided by a good checking account procedure where all receipts are deposited into one account, all payments are made by check, and the bank statement is reconciled each month.

Accrual basis – records income and expenses as of the date they are obligated, whether actual money is transferred or not.

Modified accrual basis – income is recorded when it is received, and expenses are recorded when they are incurred.

ANY ONE OF THE ABOVE METHODS COULD BE USED FOR INCOME AND EXPENSES.

Double-entry accounting involves the process of entering the amount of a transaction twice – as a debit to one account, and as a credit to another.

THERE ARE SEVERAL COPYRIGHTED SYSTEMS PROVIDING SIMPLIFIED RECORDS, USUALLY IN SELF-CONTAINED RECORD BOOKS. A CERTIFIED PUBLIC ACCOUNTANT SHOULD BE CONSULTED BEFORE A SYSTEM IS PURCHASED, TO DETERMINE IF IT WILL MEET THE NEEDS OF THE AGENCY.

Budget

When properly used, budgets should focus attention on planning, improved communication and coordination within the agency. Budgets can provide direction, help to increase awareness of emerging problems, and assist in the development of timely solutions. Additionally, a properly used budget should provide a basis for performance measurement and appraisal.

A well-developed budget should provide a proper basis for control. The budget is a quantification of many subjective judgments and unfortunately is often allowed to become a rather inflexible tool.

Internal Control

The purpose of internal control procedures is to limit errors, promote efficient operations, and protect the agency's assets from fraud, waste, and theft.

The basic principles of good internal control are as follows:

1. Clearly establish each employee's responsibility. For example, if two people have access to the petty cash box and an error is found, it will be difficult to ascertain who is responsible for the error.
2. Maintain adequate records and follow the record keeping procedures in a timely manner.
3. Obtain adequate casualty insurance on assets.
4. Divide duties in the record keeping and maintenance of assets in a particular program or area. For example, one employee should not be placing orders, receiving merchandise, and paying vendors.
5. Rotate employees through job functions, if possible.
6. Obtain employee cooperation by explaining internal control procedures and why they are necessary.
7. Review internal control procedures periodically in order to see that they are being followed, or if necessary, that they are changed.

Fidelity Bond Protection

The system of internal control can make embezzlement difficult, but not impossible. Good control discourages most potential problems, and can often expose fraudulent practices quickly. However, there is still potential for loss of funds through collusion or theft.

Fidelity bond insurance can provide a secondary line of protection. This type of insurance serves as a guarantee, up to a designated amount, against financial loss caused by dishonest acts. The purpose of the bond is to indemnify the agency for loss of money or other property occasioned by dishonest acts of its bonded employees. The bond covers all fraudulent or dishonest acts including larceny, theft, embezzlement, forgery, misappropriation, wrongful abstraction or willful misapplication, committed by employees.

The amount of fidelity bond should be sufficient to protect the firm against disastrous losses, and all appropriate employees should be covered. Agencies frequently bond their personnel not solely because of the reimbursement feature, but because, through their surety companies' records and investigation services, losses frequently are prevented from occurring. The sureties save the employers time and money by uncovering the history of dishonesty of new employees.

Resource Links

[Basic Accounting Components of the Accounting System](#)

[Business Director](#)

Local Health Department Revenue and Expenditures

Each year revenue and expenditure information from local health departments is requested for the previous fiscal year. This annual compilation of information provides data reflective of changes in the funding sources and cost centers of local agencies. Data collected is categorized according to sources and must be consistent with findings of independent auditors who conduct annual examination of agency fiscal records.

Revenue

A. Local Tax

1. County Aid: Includes ad valorem tax, delinquent tax, motor vehicle tax, local sales tax, in-lieu-of tax, possibly other taxes, and any other financial aid from the county.
2. City Aid: Includes all financial assistance from cities.

B. Fees and Reimbursable

1. Title XVIII Fees (Medicare): Includes all Medicare receipts.
2. Title XIX Fees (Medicaid): Includes all Medicaid receipts.
3. Fees for Service: Includes receipts from every other source including patients and all third party payers.
4. Other: Includes revenue from sources not included in any other revenue categories.

C. Grants and Contracts

Includes income from all grants and contracts such as those from KDHE, Area Agencies on Aging, other local health departments, etc. Grants and contracts income is separated by origin of funds.

1. State Grants and Contracts
2. Federal Grants and Contracts
3. Other Grants and Contracts

Expenditures

A. Personnel: Includes personal services (salaries).

B. Other Operating Expenditures

C. Capital Outlay.

The following link, [Local Public Health Sample Policies and Forms](#), navigates to the policy and procedures examples on the Local Health Section web page of the KDHE website.

Fiscal

The following are samples of fiscal policies from which local health department administrators can draw for their agency, as appropriate. They are provided as examples of effective format, and as such, are not intended as an endorsement of policy content or requirement of KDHE.

Budget

The budget is prepared by the Administrator of the department and submitted annually to the County Commissioners for review. The County Commissioners have the responsibility of reviewing and approving the budget of the health department.

It is the policy of the Local Health Department to provide the most appropriate services at the lowest possible cost to meet the needs of its clients, the citizens of _____ County. To do this, the administrator of the department shall review the costs of services provided annually through cost studies including, but not limited to, cost efficiency, cost benefit, and cost effectiveness.

Fees

Fees for services will be reviewed annually by the Administrator and revised according to cost of service and supplies used. Fee schedules will receive final approval from the County Commission.

Some services are covered by various types of insurance, such as, Medicare, Medicaid, Blue Cross/Blue Shield, etc. The Health Department will bill Medicaid for covered services, if the client supplies information regarding the policy they have.

Contracts with Medicare and Medicaid will be kept on file in the agency and updated as indicated by those agencies, in order for the department to receive direct payments.

Other insurance agencies may be contracted with if it is in the best interest of the health department to do so.

If the service is not covered by insurance, the client is charged the fees at the time the service is rendered. However, clients are encouraged to pay what they can, when they can. Ledger is maintained to show each client's account and payments can be made at a later date. The accounts are carried until ____ and then turned over to Kansas Set off program <http://www.da.ks.gov/ar/setoff/default.htm> or written off the books.

For some services provided by the local health department, there is a sliding scale fee based on available household income. There are a few programs where the client must fill out the income verification as a requirement of the program. The full fee will be charged, unless household income forms have been filled out which indicate payment at a reduced rate.

All monies received from fees, donations, or grants are to be recorded in the cash ledger. A receipt must be made for each entry into the ledger. All clients will be offered a copy of their receipt. All checks are stamped immediately as payable to the _____ County Health Department. If checks are returned for insufficient funds, clients are contacted and requested to make payment in cash. The check is returned to the client upon payment of the fee. The health department will not charge a service fee. If clients are

unable to make restitution at that time, the amount owed will be entered on their ledger card and carried to the end of the fiscal year. If the fee has not been paid by the end of the fiscal year, the amount will be written off as uncollected.

At any clinic off site from the department where cash is taken from the cash drawer, a voucher must be made out and signed. When fees are collected at the field site, receipts are made out and the amount of cash returned to the department must be reconciled at the end of the day.

A daily cash deposit is made for the health department either to the department's checking account, or to the County Treasurer's office. A receipt is obtained at that time that must be reconciled monthly in the health department's records.

Three different people are responsible for handling cash processes, so that no one person is responsible for all aspects of handling money.

1. One person opens the mail and lists checks received.
2. One person takes cash fees and makes and enters payments in the appropriate ledgers.
3. One person makes the daily deposit slip for the department that must be reconciled with the cash drawer and the actual cash in hand.

A petty cash fund is maintained in the health department for making change, and for purchases of less than \$ _____, as approved by the Administrator. This fund will be reconciled daily.

Payment of Debts

Payment of debts will be done on the 1st working day of the month.

All bills will be reviewed for accuracy before payment.

All bills will be submitted to the Administrator for approval and signature, prior to payment.

Copies of all bills will be made and kept at the health department for verification and auditing purposes.

Payment of all bills will be issued from the County Clerk's office, unless otherwise requested by the Administrator.

Payroll

Hours worked will be submitted to the Administrator for approval on the ___th (date). Sick leave, vacation, or absences will be recorded. Time records will then be turned in to the County Clerk's office.

Payroll checks will be issued (at the time designated in the County Policies).

Gross and net amounts of each payroll check will be recorded and kept by (the County Clerk), and will be available to the Administrator for grant writing and budgeting purposes.

Record Keeping

There are several copyright systems providing simplified records, usually in self-contained record books or software. The policies of the health department should follow the system they utilize. If no system has been purchased or utilized, consult a certified public accountant.

Auditing

All financial records will be subject to an annual audit pursuant to KSA 75-1122, by a certified public accountant or a licensed municipal public accountant designated by the County.

Fee for Service/Sliding Fee Scale

Fee for service is established by local policy in compliance with state and federal guidelines (i.e. Title X guidelines). Public health principles, however, dictate that some services such as STD treatment, not be withheld because of inability of the individual to pay, when the protection of the health of a population is at risk. Additionally, local health departments may not charge for state or federally provided materials, but may in some instances charge an administration fee.

Use of a sliding fee scale is required for many federally funded programs, particularly maternal and child health programs and WIC. This scale is based on Poverty Guidelines updated annually by the U.S. Department of Health and Human Services and published each year in the Federal Register. These poverty guidelines are a simplified version of the Federal Government's statistical poverty thresholds used by the Bureau of the Census to prepare its statistical estimates of the number of persons and families in poverty. Definitions of "income," "family," "family unit," or "household" are not universal and usually are outlined by the program requiring use of the guidelines.

**AID TO LOCAL
Indirect Cost Reports**

If a local agency wishes to claim indirect costs as matching funds, it must submit an annual indirect cost proposal (Universal Contract, #17). Proposals are submitted to Internal Management, KDHE, for approval to use in budget allocations for state health agency grants.

Direct Costs are those that can be identified specifically with a particular program. Typical direct costs chargeable to grant programs are salaries, materials, supplies, equipment, and other items of expense incurred specifically to carry out program objectives.

Indirect Costs are those (a) incurred for a common or joint purpose benefiting more than one program or cost objective and (b) not readily assignable to the programs or cost objectives specifically benefited without effort disproportionate to the results achieved.

Some costs are not allowable such as bad debts, depreciation, and some capital expenditures. It is necessary to perform periodic time studies of professional staff and clerical staff to determine salary allocations per program. When preparing budgets, multiply the direct costs of each program by the percent of approved indirect costs and these dollars can then be shown as match.

For guidance in developing an indirect cost proposal, obtain a copy of OMB Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments, from the Document Distribution Center, Office of Administration, G-236 New Executive Office Building, Washington, D.C. 20402.

For further guidance, you may wish to consult with the CPA firm that conducts your county audit. If you have further questions. Please call Internal Management at 785-296-1524.

Computing Indirect Rate

$$\frac{\text{Indirect costs}}{\text{Total Direct Costs}} = \% \text{ of Indirect Costs}$$

Send you Agency's INDIRECT COST PROPOSAL for approval to:
Internal Management
Kansas Department of Health and Environment
Curtis Building
1000 SW Jackson, Suite 570
Topeka, KS 66612-1368

Aid to Local Grant Application and Award Process

http://www.kdheks.gov/doc_lib/index.html

Now on [KS-TRAIN](#), "BCHS: Public Health Aid to Local 2013 Grant Process," online course #1041097. This course will navigate you through the application process and how the grant application travels through the evaluation and reporting requirements.

Time Frames

The following schedule establishes time frames for the application and award process:

September 15 – Grant application guidelines and reporting requirement packets are reviewed and revised by program staff to assure accurate program objectives and funding criteria for current year.

December 15 – The Grant Application and Reporting Guidelines are approved. Final preparation of packet includes personnel allocation by program and budget forms required for submission.

January 15 – Grant applications are available on Website for local units and other interested applicants.

March 15 – Grant applications must be submitted by e-mail for consideration for funding.

During the period March 16 to April 15, KDHE staff work with local agency staff to clarify issues related to programs or the applications, review contract program attachments and recommend final awards.

April 20 – Meeting of KDHE Grant Review Committee, which includes the Director of the Health, OGS, Bureau Directors and Program staff to present funding plan. Recommendations are reviewed, substantive problems identified and resolutions determined prior to a final funding decision and approval by the Division Director.

May 1 – Final funding decisions and approved contract program attachments are provided to Internal Management for preparation of contracts.

May 15 – Contracts are mailed to Awardees from Internal Management.

Note: References to local health departments are intended to include all agencies applying for grant funding assistance. If specified dates fall on a weekend or holiday, then the first following workday is applicable.

Monthly/quarterly affidavits of expenditure and required progress reports are submitted as a single packet to Internal Management.

Grant Application Information

http://www.kdheks.gov/doc_lib/index.html

Each year, the Kansas Department of Health and Environment makes federal and state funds available to local units of government and other eligible agencies to support public health services in local communities. The goal is to support services, which maintain and improve the health of Kansas's citizens. There are two types of funding to local agencies:

1. State Formula Funds – General Health Services

These funds are available to county health departments on a formula basis to support general health services. To be eligible for these funds, the agency must be a county, city-county or multi-county health department supported by sufficient local tax revenues and expenditures to meet the maintenance of effort requirements.

2. Categorical Grant Funds

These funds support more specific or targeted health service needs. Continued funding is not automatic. Each year, a completed application for each type of funding must be submitted to KDHE by the established deadline. The applicant must meet local matching requirements for each type of categorical funds requested.

Information required for grant funding of local health services, including instructions and forms for completing application are available from at:

http://www.kdheks.gov/doc_lib/index.html

Local Maintenance of Effort

65-242. State financial assistance to local health departments; computation of assistance. For the purpose of insuring that adequate public health services are available to all inhabitants of the state of Kansas, the state shall assist in the financing of the operation of local health departments. Subject to appropriations therefor, state financial assistance shall be distributed to local health departments as follows:

- (a) First, each local health department shall, upon application therefor, receive \$7,000. If sufficient funds are not available to make this distribution, then the funds which are available shall be divided equally among those local health departments making application therefor.
- (b) Second, if any funds are available after the distribution required in subsection (a), the secretary shall distribute such funds as follows:
 - (1) A figure equal to the total amount of state financial assistance available for distribution, before deduction for the distribution in subsection (a), shall be determined.
 - (2) The figure determined in paragraph (1) of this subsection shall be allocated to local health departments making application for assistance based on the proportion that the population of the county or counties comprising the local health department applying for such assistance bears to the total population of all counties comprising local health departments which have applied for such financial assistance.
 - (3) If any local health department making application for assistance would receive an amount equal to or less than \$7,000 using the formula in paragraph (2) of this subsection, then such department shall be paid in accordance with subsection (a) only. If any local health department making application for assistance would receive more than \$7,000 using the formula in paragraph (2) of this subsection, then such department shall be paid based on the proportion that the population served by the county or counties comprising such local health department bears to the total population of all counties comprising local health departments which have made application for assistance, except for departments receiving funds under subsection (a), except that in no case shall the assistance distributed under this subsection (b) to a local health department exceed the amount that the local health department receives from local tax revenues for the county fiscal year in which the state financial assistance is paid.
- (c) If local tax revenues allotted to a local health department for a fiscal year fall below the level of local tax revenues allotted to the local health department for the preceding fiscal year, the amount of state financial assistance under this act for which such local health department is eligible for the fiscal year shall be reduced by a dollar amount equal to the dollar amount of reduction in local tax revenue for that fiscal year.

EMPLOYEE MANAGEMENT GUIDELINES

Before adopting any policies the local health department administrator must consult the County Clerk, Board of County Commissioners, County Counselor and/or other appropriate directive entities to determine if the governing body for the health department has already implemented these policies.

A Guide to Interviewing Recruitment/Selection Procedures

Filing a vacancy is a serious responsibility and can make the difference between getting the job done right and not getting it done at all. Those charged with this task need to understand the hiring process, develop their skills, and stick with a sound process. Arbitrary hiring decisions are very expensive. Relying too much on feelings is dangerous. Not knowing what you are really looking for can bankrupt your budget.

The Americans with Disabilities Act requires that the essential functions must be identified before proceeding with the staffing process. These are basic job duties the employee must be able to perform with or without reasonable accommodation. An analysis of the job to be done and a clearly written position description are also prerequisites. Consider technical, supervisory, and professional skills required.

Performance expectations should also be identified prior to candidate search and then reviewed with the candidate during the interview. These include job accomplishments and such things as attendance at meetings, belonging to organizations, continuing education requirements, etc. They are later incorporated into performance appraisals of the employee.

Interviewing

- Understanding that the interview best measures interpersonal skills and job knowledge, not skill level.
- Past behavior and job history are often good indicators of future success.
- Read cover letter, resume and/or application immediately before you meet with the candidate face-to-face for the first time.
- Allow 45 minutes to 1 hour for the initial interview.
- Follow an agenda and stick to your questions to avoid getting off track.
- Be on time for the interview, greet the candidate, make sure the site is comfortable and inviting, establish rapport, put candidates at ease, and never allow interruptions of any kind.
- Share your agenda and ask permission to take notes.
- Stay out of court by asking job related questions only and avoiding discriminatory statements.
- Listen for what the candidate is not saying, and don't hesitate to probe for more information if you need clarification.
- Gather information about the candidates before you invite them to question you.
- Be patient, avoid stress tactics and don't overload the candidate with more than one question at a time.
- Learn how the Americans with Disabilities Act (ADA) impacts interviewing and the correct way to interview candidates with disabilities.
- It is important to sell your organization to the candidate, but only at the end of the interviews.
- Every candidate, whether final or first interview, should be told what the next step will be.
- Leave a good impression on everyone by closing with a "thank you" in a friendly and positive manner even if you do not plan to hire the candidate.
- Document the interview but never write anything on the resume or application that could be taken as discriminatory.

References

- Have candidates sign a release from liability form so that references will feel more comfortable in giving information.
- Reference checks are usually conducted by phone using a similar list of questions for each of those being considered for the same position.
- You may not ask anything during the reference check that you could not legally ask of the candidate in person, including questions related to race, sex, religion, national origin, etc.
- Always check references yourself, and check on only those who are serious contenders for the job.
- Document findings as you go and use an appraisal form to help compare candidates.

The Final Decision

- Notify unselected candidates before announcing your selection. Let current employees who did not get the promotion know why and what they can do to have a better chance for other job openings in the future.
- Any candidate who appears too good to be true should be a sign that you should conduct an especially thorough interview and reference check before making the final decision.
- Potential is important, but don't hire someone solely on what he or she may someday be able to accomplish.
- Make a job offer as soon as possible in order to avoid losing a good candidate.

Interview Suggestions

Preparing Questions

When developing questions, always keep in mind that they must be job-related and appropriate for the complexity and level of the position. It is helpful to weigh the questions based on the importance of each selection criterion. Below are six main categories of questions that are commonly used by interviewers. Different types of questions may be combined to obtain a certain response.

1. Close-ended questions. These questions may sometimes be helpful when an interviewer(s) wants to know certain information at the outset or needs to determine specific kinds of knowledge. Example: "Could you name the five specific applications involved in...?"
2. Probing questions. These questions allow the interviewer(s) to delve deeper for needed information. Example: "Why?", "What caused that to happen?", or "Under what circumstances did that occur?"
3. Hypothetical questions. Hypothetical situations based on specific job-related facts are presented to the applicant for solutions. Example: "What would you do if..?"; "How would you handle..."
4. Loaded questions. These questions force an applicant to choose between two undesirable alternatives. The most effective way to employ a loaded question is to recall a real-life situation where two divergent approaches were both carefully considered, the frame the situation as a question starting with, "What would be your approach to a situation where..."
5. Leading questions. The interviewer(s) sets up the question so that the applicant provides the desired response. When leading questions are asked, the interviewer cannot hope to learn anything about the applicant.
6. Open-ended questions. These are the most effective questions, yield the greatest amount of information, and allow the applicant latitude in responding. Example: "What did you like about your last job?"

Evaluating Responses

As part of evaluating the responses, the interviewer(s) should review the job description to ensure thorough familiarity with the requirements, duties, and responsibilities of the position. Furthermore, the interviewer(s) should review the work history and relevant educational credentials of each candidate and consider the intangible requirements of the job. Finally the interviewer(s) should review the selection criteria, evaluate and rate the responses, and rate the applicants based on those criteria.

Interview Process

Pre-Interview

1. Schedule interviews to allow sufficient time for post-interview discussion, completion of notes, etc.
2. Secure an interview setting that is free from interruptions and distractions.
3. Review applications and resumes provided by the applicant.
4. Provide an accurate position description to each applicant and allow adequate time for reading before the interview begins.

Opening the Interview

1. Introduction of those present:
2. Provide a copy of the job description to the applicant for review
3. Interviewer should review County Policies/benefits

Examples:

- Holidays
- Sick leave
- Vacation/leave accrual
- Continuing Education
- KPHA dues
- Mileage rate for private vehicle (if appropriate)
- County vehicle usage
- Health insurance
- Retirement and/or KPERS
- Pay periods, i.e., monthly, biweekly, etc.
- Longevity pay

Questioning

1. Question the applicant following the method established in the developing stage.
2. Be consistent with all applicants.
3. Allow the applicant sufficient time to respond to each question.
4. Record any relevant information elicited from the questions.

Closing the Interview

1. Inform the applicant when the decision will be made and how notification will occur.
2. Confirm the date of the applicant's availability to begin work.
3. Confirm the applicant's correct address and telephone number.
4. Give the applicant a final opportunity to raise any questions.
5. Obtain all necessary information from the applicant about references.

Post Interview

1. Review the selection criteria.
2. Review and complete notes.
3. Avoid prejudice and discussion of applicants between interviews.
4. Use the selection criteria established in the developing stages.
5. Rank the applicants based on the selection criteria.

6. When possible, decide upon a second and third choice in the event the first choice should decline the offer.
7. Document the basis for the final recommendation.
8. Notify all applicants interviewed of the results prior to announcing the selection.

Sample Interview Questions

Administrative/Supervisory Positions

1. Describe your education and experience, which has prepared you for this position.
2. Describe your management style.
3. How would you conduct planning and goal setting for the agency?
4. How would you assure that goals and objectives are attained?
5. How would you manage conflict between staff members?
6. What do you see for the future of public health? For the agency?
7. This position requires some overnight travel. Is that workable for you?
8. What questions do you have regarding this positions?

Public Health Nurse Positions

1. Describe your education and experience, which has prepared you for public health nursing.
2. Why do you want to be a public health nurse?
3. Describe the skills in which you are strongest.
4. What skills would you need to learn or update for this position?
5. What type of work environment enables you to perform best?
6. In this position, you will deal with people from a variety of different cultures and lifestyles. What experiences have prepared you for this?
7. How do you manage conflict with co-workers?
8. This position requires some overnight travel. Is that workable for you?
9. What questions do you have regarding this position?

Ending The Interview

Discuss salary at this time, how much the applicant expects and if negotiation is possible.

1. What other questions do you have at this time?
2. If you are offered this position, will you accept it?
3. If you are offered this position, when would you be available to begin work?

Discuss when you expect to make your decision and when the applicant will be notified whether or not they are hired. BE SURE TO CHECK REFERENCES!

Model Orientation to Public Health

- A. Purpose: To provide a process of orientation about community health to new employees and to promote the competent performance of their duties.
- B. Objectives:
 1. Define the specific job to be performed and determine the information and skills needed.
 2. Establish the employee's baseline of knowledge and skills.
 3. Provide a mechanism for the employee to develop knowledge and skills necessary for job performance.
 4. Provide the new employee with the concepts and principles of community health nursing.
 5. Provide the new employee with an understanding of the department's total program.
- C. General guidelines: Orientation is an ongoing process that takes place over a period of time. A beneficial way to approach the orientation process is to divide it into two phases: the orientation phase and the training phase. The orientation phase primarily covers the items that deal with

personnel policies, workgroup, and general orientation to the agency. The training phase is longer and deals with assisting the employee to develop the knowledge and skills necessary to fulfill the position description. A suggested time framework is presented to assist the supervisor in developing a planned orientation.

The following are sample resources to aid in orientation of new staff:

1. [Core Public Health Program](#) - is a comprehensive one-year training program in public health for working public health professionals.
2. [Kansas Public Health Association](#) (KPHA) - is a professional association for Kansas's public health practitioners, professionals, and advocates. You will regular public health legislative updates and access to the updated public health statutes and laws book.
3. [Essential Services Tool](#) and the **KPHA Orientation Manual** to help in orientation.
4. Create a [KS-TRAIN](#) account:
For webbased courses
 - a. [KPHA: An Orientation to Public Health in Kansas](#) - #1017215
 - b. [Learning with Lilly - Introduction to Public Health Nursing](#) - #1016614
 - c. Preparedness independent study courses
 - (1) [IS-100.b - Introduction to Incident Command System, ICS-100 \(2011\)](#) - #1024627
 - (2) [IS-200.b - ICS for Single Resources and Initial Action Incidents](#) - #1024638
 - (3) [IS-700.a: Introduction to the National Incident Management System \(NIMS\)](#) - #1016070
 - (4) [IS-800.B National Response Framework, An Introduction](#) - #1011882
 - d. [KDHE: Blood borne Pathogen Training - Web-based \(1021712\)](#)
 - e. [KDHE: VFC Program and Immunization Administration Technique Basics](#) - #1018610
 - f. [Packaging & Shipping of Category A & Category B Infectious Substances: Inclusive of Evidence Control Measures, Web-Based](#) - #1025324
5. [PHF Quality Improvement \(QI\) Quick Guide](#) - The QI provides an introduction and a gateway to resources that public health professionals can use to pursue QI initiatives within their organizations.

Organizations

1. [Kansas Department of Health and Environment](#)
 - [Public Health Directory](#)
 - [Connections Monthly Newsletter](#)
 - [Regional Public Health Meetings](#)
2. [Kansas Association of Local Health Departments](#) (KALHD)
3. [Kansas Health Institute](#) (KHI) – sign up for their news at:
4. [National Association of Local Boards of Health](#) (NALBOH) - NALBOH represents the grassroots foundation of public health in America, and is the only organization in America dedicated to preparing and strengthening boards of health, empowering them to promote and protect the health of their communities through education, training, and technical assistance.
5. [NACCHO](#)
6. [American Public Health Association](#) (APHA)
7. [Public Health Foundation](#) (PHF)

Public Health Discussion and E-mail lists <http://phpartners.org/dlists.html>



<http://www.kdheks.gov/olrh/ImprovingPublicHealthInKansas.htm>

Essential Service Tool

Orientation of County Commissioners/Local Board of Health

Using your local health department web site to educate the entire community is an excellent way to increase the likelihood that your newly elected County Commissioner/Board of Health member will have an idea of what public health is and what their role is as a member of the Local Board of Health. It shouldn't be a secret that is saved until after election! You will also have better informed citizens that will be more likely to be advocates for public health. Offering data about your community and how it compares to other communities can also motivate citizens to participate in community improvement efforts. [The Community Health Status Indicators](#) is just one set of data that can be imported into your website for that purpose.

The [National Association of Local Boards of Health](#) (NALBOH) is a great resource for finding material that you can use. NALBOH offers many publications for board of health members and others in the public health community. For NALBOH members, many publications are available free of charge as a pdf download in the Members Only section.

Here is a sample of the publications from the [NALBOH Resource Catalog](#) that you might be able to use as resources:

1. **Assessment, Policy Development, and Assurance: The Role of the Local Board of Health** – details the role of the local board of health, the core functions, and the Ten Essential Services of Public Health. (VHS)
2. **Being an Effective Local Board of Health Member** – provides information to new and experienced local board of health members about their role in the local public health system. (Print)
3. **State Statutory Authority for Local Boards of Health** – examines the state statutes addressing local boards of health across the 50 states. The document analyzes key questions

including board composition, appointing authority, terms of office, powers and duties, and board governance. (Print)

4. **Guide for Local Boards of Health Considering the Feasibility of a Consolidation of Independent Local Public Health Jurisdictions** – This publication was developed to assist local boards of health that may be considering the feasibility and potential of a combination, consolidation, or regionalization of health departments or jurisdictions. It offers a compendium of experiences and involvement of both small and metropolitan health district consolidations. (Print)
5. **The Local Board of Health Environmental Health Primer** – provides information for local board of health members interested in environmental health issues facing their communities. This primer was designed to be placed in a three-ring binder. (Print)
6. **Emergency Preparedness Including Bioterrorism: An All Hazards Approach for Local Boards of Health** – specifically addresses the role of local board of health members in community preparedness and will enable board members to make more informed decisions regarding their public health agency's emergency preparedness efforts.

Fair Labor Standards Act

The Fair Labor Standards Act (FLSA) provides minimum wage, overtime pay, record keeping, and child labor standards. Some employees are specifically exempted for the requirement of the Act. Bona fide executive, administrative, and professional employees and outside sales people are exempt from the minimum wage and overtime requirements of the Act if they meet the tests set for each category. Whether employees are exempt depends on their duties and responsibilities and the salary paid.

The minimum weekly salary specified in each category is one of several tests applied in determining the exemption; it is not a minimum wage requirement. No employer is required to pay an employee the salary specified in the regulation, unless the exemption is claimed.

Any employee who is paid at least the minimum weekly salary specified and who also meets all of the duties and responsibilities specified is exempt from the minimum wage and overtime pay requirements of the law. A title does not make an employee exempt; nor is the employee exempt simply because payment on a salary rather than an hourly basis.

For specific questions about the statutory requirements, contact Wage and Hour Division's nearest office. Give detailed information regarding the question, since coverage and exemption depend on the facts in each case.

[Wage and Hour Division contact for Kansas web Link](#)

Kansas Department of Labor
Employment Standards
401 SW Topeka Boulevard
Topeka, KS 66603
(785) 296-4062

Americans with Disabilities Act

The Americans with Disabilities Act of 1990 (ADA) provides a national mandate for the elimination of discrimination against individuals with disabilities. The ADA includes five titles, which address the following areas:

- Title 1 – employment
- Title 2 – public services and transportation
- Title 3 – public accommodations

Title 4 – telecommunications

Title 5 – miscellaneous

Title 1 includes the following employment provisions:

- Employers may not discriminate against an individual with a disability in hiring or promotion if the person is otherwise qualified for the job.
- Employers can ask about one's ability to perform a job, but cannot inquire if someone has a disability or subject a person to tests that screen out people with disabilities.
- Employers will need to provide "reasonable accommodation" to individuals with disabilities. This includes steps such as job restructuring and modification of equipment.
- Employers do not need to provide accommodations that impose an "undue hardship" on business operations.

Title 2 addresses discrimination against the disabled by state and local governments, as well as the accessibility of transportation systems.

Title 3 mandates changes in the way public accommodations and commercial facilities must be adapted or constructed. Both existing buildings and new construction must meet requirements for accessibility.

Title 4 requires companies offering telephone service to the general public to offer telephone relay services to individuals who use telecommunications devices for the deaf (TDDs) or similar devices.

All employers with 15 or more employees were required to comply with ADA effective July 26, 1994.

For specific details regarding ADA requirements, contact the following resources:

Kansas Department of Human Resources

Phone: 785-266-1722

Toll free (800) 295-5232

FAX: (785) 296-6809

TTY: 711

<http://ks-commissionondisabilities.civicplus.com/index.aspx?NID=55>

[U.S. Dept. of Justice, Civil Rights Division 202-514-4609](http://www.dhs.gov/civilrights)

[Americans with Disabilities, US Dept. of Justice](http://www.dhs.gov/civilrights)

Family and Medical Leave Act of 1993

The purpose of the Family and Medical Leave Act of 1993 (FMLA) is to balance the demands of the workplace and the needs of families in a manner that accommodates the legitimate interests of employers. FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to “eligible” employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for a least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

For more information about this topic:

[Kansas Family and Medical Leave](#)

For additional Information Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor. [Wage & Division contacts for Kansas](#)

Contacting the Department of Labor
U.S. Department of Labor
200 Constitution Ave., NW
Washington, DC 20210

By Phone: [National Toll-Free Contact Center](#). Live assistance is available Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Time by calling, 1-866-4-USA-DOL, TTY: 1-877-889-5627.

Grievance Procedures

All agencies should have a written grievance procedure policy to provide a formal process for expressing dissatisfaction with any aspects of working conditions or actions which may jeopardize an employee's ability to perform their job in an efficient manner or within a reasonably acceptable working environment. Such procedures are provided to assure the opportunity for prompt and fair resolution of grievances in order to maintain a positive working environment. Public health or similar departments or agencies governed by boards will be subject to grievance procedure policies set out by the large agency, and if specific policies are listed by the LHD, it is important that they not conflict with those of the umbrella agency. Employees covered under a memorandum of agreement that includes a grievance procedure may usually choose the policy they wish to follow in filing their grievance. Once filed, their decision cannot be changed. Ideally, employees should resolve differences of opinions, situations of unfavorable working conditions and general employment related problems through normal communication channels and appropriate organizational structure routes of reporting. When the employee feels, however, that such problems have not and cannot be resolved in this manner, they should proceed with the specific grievance procedure.

The grievance policy should specify the appropriate method for filing a grievance (oral, written), the proper sequence of steps to be followed towards a resolution or final decision, subject matter limitations, time limitations, and general area of responsibility. The policy should also provide protection for employees filing the grievance, such that they are unimpeded and free from restraint, coercion, discrimination or reprisal. An alternate channel should be specified if the employee feels the issue is one that cannot be discussed with the supervisor, such as discrimination. How the policy will be made available to all employees should be addressed (bulletin boards, policy book, specific forms).

The grievance procedure is usually written in steps with specific instructions and time frames attached to each. The process goes through ascending levels of hierarchy if not reconciled at each lower level. A chart is a helpful attachment. If a grievance review committee is to be used, it should be stated as to how and of whom the committee will be formed, and the duties of the committee. The final decision-maker should be identified and right of appeal addressed.

Time limitations should be identified for filing a grievance and for response. This insures prompt action by all parties involved. If the time is in "working days," it should so state. Extensions, penalties and actions to be taken if time limitations are not met should be specified.

Grievance subject limitations should identify the reasons for which employees may and may not file grievances. One definition of grievance is "a statement of dissatisfaction over any condition of work which allegedly has an adverse effect on the employee." A grievance generally should not include matters for which another method of settlement or an appeal procedure is already established.

Time on duty/off duty should address whether time spent on grievances will be considered on duty for pay purposes.

General areas of responsibility should be outlined for employees, supervisors and agency administrators, and personnel offices involved in the grievance process.

[Americans with Disabilities Act of 1990: Title II.](#)

Sexual Harassment

A written policy regarding sexual harassment should be in place to comply with EEOC Guidelines on Discrimination Because of Sex. The policy should specifically prohibit sexual harassment of the agency's employees in any form in the workplace and in other employment-related activities. Such policy should outline the agency's proposed actions, up to and including dismissal, to insure that the work environment is free of sexually harassing behavior. It should also protect and forbid retaliation against any employee who exercises the right to report sexual harassment.

A statement may be included to address an individual's sexual orientation. One example of such statement is that "an individual's sexual orientation is not a criterion either for becoming an employee or remaining an employee of the agency. Performance appraisal and promotion status are based upon demonstrable job performance and behavior. An individual's sexual orientation is strictly personal and information about this matter should not be sought by agency personnel."

Sexual harassment as defined by law, is unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. Derogatory sexual remarks also constitute sexual harassment when:

- A. submission to such conduct is made, either explicitly or implicitly, a term or condition of an individual's employment;
- B. submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting the individual; or
- C. such conduct has the purpose or effect of interfering with an individual's work performance, or creating an intimidating, hostile, or offensive work environment.

Some behaviors, which could be construed as sexual harassment, include, but are not limited to:

- A. the continual or repeated verbal abuse of a sexual nature, including, but not limited to, graphic commentaries about an individual's body, sexually suggestive objects or pictures in the workplace, sexually degrading words used to describe the individual, or propositions of a sexual nature;
- B. the threat or insinuation that lack of sexual submission will adversely affect the individual's employment, wages, advancement, assigned duties or shifts, or other conditions that affect the individual's livelihood;
- C. jokes, graffiti, and/or display in the workplace of sexually suggestive calendars and posters which contribute to a hostile or offensive working environment; and
- D. sexual conduct, which indirectly affects the terms, conditions and opportunities of employment of another individual or creates a hostile work environment.

The procedure for filing a sexual harassment complaint should be outlined in the policy. The person with whom the report is to be filed, time frames for filing and investigation, documentation and confidentiality for both the person who files, and the alleged perpetrator must be addressed. A progressive discipline plan should be in place. Responsibilities of employers and employees to carry out the policy may be delineated.

Personnel/Health Files

Personnel files should be kept in the facility for all employees of that facility. A shell type file may also be kept at the county clerk's office in the case of local health departments if that is done for other county departments, but this file will not have detailed performance information.

A separate health file for each employee should also be maintained in the facility. This file is confidential.

Examples of items to be included in personnel files:

- Employee application
- Every appraisal
- Signed statement that employee has read policies and procedures. Update yearly or when policies and procedures change.
- Signed orientation checklist
- Continuing education and in-services attended
- Signed position description
- Copy of pertinent licenses or certificates (update)
- Merits, warnings, reprimands

Examples of items to be included in a health record:

- Initial and periodic TB skin test results
- Immunization record (updated)
- Disability statements

Staff Development System

Each local health department should be able to demonstrate that a staff development system is in place and that performance based training programs relative to the needs of the agency are available to the employees of the agency.

There are three components to a staff development system:

Orientation: activities designed to bring the newly hired employee to a basic level of safe and competent functioning within the agency. Normally, this process is begun with the first day of employment and will continue over several days to even months. Typical activities are: review of policies and procedures, review of personnel policies, discussion about mission and goals of agency, introduction to other personnel, orientation to physical layout of agency, review of safety policies, and assessment of skills according to a skills checklist developed within the agency. Orientation can include time spent with preceptors if such a system is in place.

In-service: ongoing educational activities designed to assist the employee to perform the job according to current standards. Typical activities are: in-services to present new drugs, procedures, or equipment; review of existing procedures; CPR recertification; and updates on forms or policies. Typically, these are required activities with documented participation. There is no continuing education credit for in-services.

Continuing education: professional education beyond the basic, designed to further knowledge and skills and to affect attitudes. Typically this will take the form of workshops, symposia, seminars, and professional group conferences. Normally, persons expect to earn continuing education credit for these activities. Other, less frequently mentioned activities are: further academic education, a planned program of journal reading, and presenting workshops. These latter may or may not earn continuing education credit.

In planning a staff development system, which includes all three components, a balance of needs and resources must be achieved. Needs must be prioritized according to the individual agency and resources expended to meet those priority needs first.

Employee Appraisal/Performance Appraisal

Employee appraisal or performance appraisal provides employees with feedback on their work, leading to greater clarity regarding organizational expectations and to a more effective channeling of employee ability. It may also lead to organizational or allocation decisions regarding promotion and pay. Unfortunately this appraisal is frequently a source of tension in the employee-employer relationship.

There are several purposes of employee appraisal/performance appraisal:

1. Communicate management goals and objectives to employees.
2. Document accomplishments and provide appropriate praise for good performance.
3. Motivate employees to improve their performance.
4. Distribute organizational rewards such as salary increases and promotions equitably.
5. Conduct personnel management research.

Criteria may be person-based, performance-based, or occasionally a mixture of the two. Person-based systems assess an employee's personality traits, characteristics, and aptitudes and often lead to very subjective assessments. Performance-based systems measure each employee's behaviors against previously established behaviors. For validity and legal reasons, the trend is toward performance related behaviors. Separate performance standards should be developed for each employee or class of similar positions and these standards must be altered periodically to meet changes in organizational objectives, resource allocation, or environmental constraints.

Several appraisal methods exist and examples shown will identify the method used. Graphic rating, ranking, and forced choice are most commonly used in person-based ratings. Of these, the forced choice technique is probably the most valid and least biased because the rater does not know the preference of the person who wrote the appraisal. Essay, objective, critical incident, and behaviorally anchored rating scales lend themselves toward performance-oriented criteria.

An employee's performance may be rated by a number of people. The immediate supervisor must commonly assess the performance of subordinates. Supervisory ratings reinforce authority relationships but are easily biased. Self-ratings have value in promoting honest discussion between supervisor and employee but studies have shown some self-ratings to be highly inflated while others were just the opposite. Peer ratings are occasionally used also.

In order for an appraisal system to be effective, several things should be considered. First, it may be wise to utilize separate systems for separate purposes. In reward allocation the rater becomes a judge, but when the purpose is to improve employee performance, the supervisor is more of a counselor or facilitator. Second, the rater should have the opportunity, ability, and desire to rate employees accurately. Third, occupation specific job descriptions should include performance standards as well as duties, responsibilities, and minimum qualifications, thus tying together job analysis and performance appraisal. Fourth, the appraisal should capture the employee's motivation for self-improvement with such objectives as promotion and career planning.

Job Descriptions

The job description should be a general outline of all the duties expected of the employee. One way to organize the job description is by categorizing the areas of responsibility for the position and then lists specific duties and tasks beneath each category. Job descriptions should be unique to the agency because each agency or organization is different and the job description should accurately reflect the job you expect the employee to do. It should be detailed to the extent that it will provide a clear picture of the job to someone not familiar with it, but general enough to provide a proper perspective by avoiding the extraneous.

The terms "position description" and "job description" are often used interchangeably. Technically, however, a **position** is a collection of duties constituting the total work assignment of a single worker. There are as many positions as there are workers in the country. A **job** is a group of positions, which are identical with respect to their major or significant tasks. There may be one or many persons employed in the same job. A job description is a brief description of major duties and responsibilities along with additional descriptions of key job behaviors, working conditions, minimum training, and required experience. Once written, the job description must be date and signed by the supervisor and employee. It must be reviewed and dated annually.

The job description should include:

1. A position summary or brief statement of the primary function(s) or purpose of the job.
2. A "work performed" section with a brief but complete description of duties and responsibilities prioritized for importance.
3. Organization relationships such as supervision, leadership, personal relations, contacts, problem solving, decision making, and accountability.
4. Working conditions or uncommon circumstances including environmental conditions, physical or special job demands.
5. Identifications of essential and primary functions.
6. Identification and documentation of minimum qualifications for the job, including knowledge, abilities, skills, experience, and education.
7. List standards of performance if those are in place.

Several examples of job descriptions have been provided for personnel commonly employees in a local public health agency. Remember that these are guides only and that the actual job description should be individualized for each agency.

Sample Job Descriptions

[Administrator](#)

[Family Planning Consultant](#)

[Health Officer](#)

[Medical Consultant](#)

[Office Manager](#)

[Pharmacy Consultant](#)

Performance Appraisal

The Performance appraisal is intended to be used as a communication tool between you and your employee. It is also used to measure whether the employee's performance and productivity have been sufficient to warrant a merit pay increase.

Remember that this appraisal covers a number of months. If you did not keep any written records of your employee's performance during this appraisal period, jot down any positive or negative circumstances you can recall before you complete this appraisal form. Do not base your opinion of the employee's performance on the past few days or weeks.

Check your employee's personnel file and make sure you are aware of its contents. If previous appraisals have been placed on file, review them.

If, in your opinion, your employee requires improvement in a given area, do not hesitate to check that area. This appraisal process does not necessarily penalize your employee for those answers that are checked unsatisfactory. Also remember there is nothing wrong with an employee being rated satisfactory.

After you have completed this appraisal, review it again to see if it has been filled out completely and whether it fairly represents your employee's performance and productivity during the appraisal period.

When you meet with your employee to discuss this appraisal keep the following in mind:

- Conduct the appraisal session in private
- Make sure the setting is reasonably comfortable
- Explain your reasons for any high or low marks
- Listen to your employee's comments and concerns
- Be sure to make suggestions for any improvements you feel are necessary
- Be sure the employee signs the appraisal form and acknowledges whether he or she would like a copy of the appraisal

Sample - [Performance Appraisal](#)

Information Management

What is a health record?

A systematic, logical format for storing data, which reflects the analytical approach, involved in diagnosing and evaluating care and the interpersonal process involved in patient care delivery. Patient records serve the provider in three ways:

- Document that a transaction has occurred between patient and provider.
- Document the process of patient care, the decision-making that has occurred between provider and client. They are an account of the assessment process.
- Allow the provider to demonstrate that the process of care is dynamic.

What is the purpose of Health records?

Health Records:

- Are the diary of what has been done and a program for what needs to be done. They not only record the care but also help to ensure it.
- Serve as a communication tool between health members and administration.
- Document care and therapy.
- Serve as a basis for quality care.
- Serve as legal documents for both provider and client.
- Is a starting point for collecting patient facts.

Electronic Health Record

Health information technology (HIT), a subject that is much discussed by federal and local policy-makers and health care leaders, refers to a variety of electronic methods used to manage information about people's health and health care, on both an individual and a group level. An electronic health record (EHR) is the most commonly known example of health information technology. Electronic health records are intended to replace many of the health care functions now documented on paper, although EHRs can go beyond paper documentation and electronically collect, store, and organize information about individual patients, which can be used as the electronic equivalent of patient charts. Many health care experts promote the widespread adoption of EHRs because of the potential for far-reaching and beneficial effects on the delivery of health care services. EHRs could have a direct effect on provider and patient decisions at the point of care by providing necessary information about a patient's health and care history in a timely fashion. EHRs are also touted for their potential to yield a generation of richer, less expensive, and more relevant clinical information that could capture health care quality at the practice, organizational, and regional level. This type of data could serve a number of different purposes, like helping providers and patients better understand variations in health care quality, compelling providers to improve, and allowing patients to choose high-performing health care practitioners and organizations.

Resources

1. Robert Wood Johnson Foundation. [Health information technology in the United States: Where we stand, 2008](#)  [PDF - 410 KB] . 2008.
2. [White House. Executive Order: Incentives for the use of health information technology and establishing the position of the National Health Information Technology Coordinator](#) . 2004.
3. [ONC Final Rule on Initial Set of Standards, Implementation Specifications, and Certification Criteria for EHR Technology](#)

Medical Records Management

Guidelines for Client Record Retention

[Kansas Records Retention Schedules](#)

Each local department should have written guidelines for client record retention, which have been concurred with Standards by the Kansas Historical Society and signed by the board, county attorney, and county health administrator.

Clinical records should be maintained ten years following closure for adults and one year after reaching age of majority (age 18 in Kansas), whichever is longer. This covers the statute of Limitations provision for filing suits in relation to negligence (K.S.A. 60-513(a)(7)).

Home Health Agency fiscal records should be kept for five years. In the event of closure, records should be retained for five years following acceptance of the final cost report.

Immunization card files should be maintained for 20 years.

Informed consent slips should be kept indefinitely.

Communicable disease and venereal disease records do not need to be retained longer than two years if no treatment is involved. If client information is needed on a person with venereal disease beyond that point, it would be obtained from the Kansas Department of Health and Environment registry. The treatment record should be maintained for five years.

Employee time report cards must be retained at least three fiscal years and then may be destroyed.

Childcare licensing files have no maintenance requirement at the local level. The official childcare licensing files are in the Child Care Licensing Section of the Kansas Department of Health and Environment. Federal auditors can be referred to the Kansas Department of Health and Environment office where the source document can be reviewed.

The Kansas Historical Society has statutory responsibility for determining length of retention and record disposition. The guidelines are available by request. Statutes that refer specifically to the issue of record retention are: K.S.A. 45-401 and K.S.A. 45-404.

Sample - [Medical Records Policy](#)

Transfer of Records and Release of Information Impact of HIPAA on Local Health Department Operations

The client must sign an authorization for release of information before any information regarding the client can be transferred to another agency or provider. When the client requests a transfer of the record, the public health nurse should prepare a summary of the record or make a copy of the record to be sent to the other agency or provider. The original record must stay within the health agency. The exception to this would be in honoring an interagency contact providing for the official transfer of original records such as the KAN-Be-Healthy agreement with the Department of Social and Rehabilitation Services. Another exception is when a law requires the exchange of information such as with suspected cases of child abuse.

In the case of legal investigation, client information cannot be released without the client's written authorization or a court subpoena for the record. The county attorney is available for consultation regarding legal matters. Agency policy for patient access and transfer of records should include:

1. Person who is identified as "keeper of records,"
2. Defined content of the record to be transferred,
3. Time and process for viewing records,
4. Assurance that no records leave agency,
5. Cost for record copies, and
6. HIPAA privacy regulations

Federal HIPAA Regulation website <http://www.hhs.gov/ocr/privacy/>.

Freedom of Information Act

On occasion, a health department will encounter someone who wants certain medical or disease intervention records and who cites the Freedom Of Information Act (F.O.I.A) as the basis for his or her demand. Such demands are groundless, as affirmed by the United States Supreme Court in the case of Forsham vs. Harris, Sup. Ct. No. 78-1118, 3/31/80. The F.O.I.A. is a federal law, which has limited application. State and local government agencies are not affected by it. In Forsham vs. Harris, the court also held that the F.O.I.A. does not require the federal government to obtain or release records held by a grantee. Specifically, the opinion of the court states:

"Federal participation in the generation of data by means of a grant from H.H.S. does not make the organization a federal 'agency' within the terms of the Act. Nor does this federal funding in combination with a federal right of access render the data 'agency records' of H.H.S. which is the federal 'agency' under the terms of the Act."

Confidentiality

Health care personnel are to regard as confidential all client information in order to limit the disclosure of personal or sensitive data. The American Nurses Association's Code of Ethics directs the nurse to "safeguard the client's right to privacy by judiciously protecting information of a confidential matter."

Confidentiality is recognized in our society as a basic human right and its purpose is to encourage people to seek help in a timely manner. The Kansas Statutes states that "information should not be disclosed in such a manner that reveals the identity of the individual without the individual's consent in writing." Disclosure of confidential information without the individual's written consent abridges both legal and ethical codes.

Kansas Open Record Act

The purpose of [the Kansas Open Records Act \(KORA\)](#) is to make government accessible to the citizenry. It requires that public records be open for inspection.

K.S.A. 45-216(a). KORA does not require government agencies to do research or to create records. It should not be confused with the Federal Freedom of Information Act (this section).

The law requires that public records shall be open to inspection upon request by any person. K.S.A. 45-218.

1. Virtually any record in the possession of a public agency is subject to the law. K.S.A.45-217(f)(1).
2. There is an exception, however, for records, which are owned by a private person or entity and are not related to functions, activities, programs or operations funded by public funds. K.S.A. 45-217(f)(2).
3. Public Agency means the state or any political or taxing subdivision of the state, or any entity supported by public finance.

Exceptions to KORA fall into two categories, records that may be withheld, and records, which must be withheld.

1. Certain records are protected by federal or state statute. Access to these records must be denied. K.S.A. 45-221(a). There are several state statutes providing that certain records are confidential. Note especially K.S.A. 65-118 infectious disease information, and K.S.A. 65-6002 HIV information. Note, however, new statute requiring notification of health care provider of victim of sex crime of HIV status of perpetrator. 1993 Sess. Law. Ch 242.
2. Many statutes providing for confidentiality also have exceptions to the confidentiality requirements. In these cases the material must be made available if the exceptions are met.

Privileged information must also be withheld. K.S.A. 45-221(a)(2).

1. Physician/patient communication is privileged. K.S.A. 60-427.
2. Attorney/client communication is privileged. K.S.A. 60-426.
3. Communication with a pharmacist and records of prescriptions filled by pharmacist are given the same status as physician/patient communications. K.A.S. 65-1654.

There is an extensive list of other documents, which may be withheld. K.S.A. 45-221. Better practice is to deny access to these documents.

It is a misdemeanor to give lists of names and addresses for commercial purposes. K.S.A. 21-3914. The best practice is to make anyone who requests a list of names and addresses to sign an affidavit.

Compliance with KORA:

1. Access to public records must be afforded during regular business hours or at other time specified, but public records may not be removed. K.S.A. 45-218(a).

2. The agency may demand advance notice, but may not require that the notice be in writing. Access must be afforded within three working days. K.S.A. 45-218(d).
3. If an agency refuses to allow access to the record, it must do so in writing, and explain the reason for the refusal. K.S.A. 45-218(d). The agency may refuse for the reasons discussed above, or if a request "places an unreasonable burden in producing public records or if the custodian has reason to believe that repeated requests are intended to disrupt other essential functions of the public agency." K.S.A. 45-218(e).

The agency must permit copying of public records, but need not provide copies of radio or recording tapes or discs, video tapes or films, pictures, slides, graphics, illustrations or similar audio or visual material, unless those materials were shown or played at a public meeting. K.S.A. 45-219.

1. May charge a reasonable fee.
2. May require a written request.
3. May require written certification that the records will not be used for an improper purpose.

References

[Kansas Department of Labor: Kansas Open Records Act:](#)

Guidelines for Clinical Protocols

Clinical protocols generally refer to guidelines between advanced practice nurses and the consulting physician. Written practice protocols assure consistent practice of high quality by specifying what history must be obtained, what physical findings examined, what laboratory tests performed and what plan implemented. They clarify the scope of nursing practice and the consultation arrangement by stating the circumstances under which the nurse should consult a physician. Written protocols are required for the prescriptive authority of nurse practitioners.

The clinical staff may decide to write its own practice protocols, either as adjuncts to a published text or as the sole guide for the practice. Thus the protocols developed will be appropriate for the particular patient population, clinical setting, and expertise of the staff. Staff can therefore give the best care of which they are capable, without artificial limitations, the protocols need to be updated whenever new knowledge becomes available, and they should be reviewed at least annually to assure currency.

A new protocol is started whenever a nurse determines that one is needed. Usually the nurse who noted the need or one with particular expertise in a given area, agrees to write the initial draft. A search of the current literature starts the process. Next protocol is written. One format that may be used is:

- Definition
- Subjective
- Objective
- Labs
- Assessment
- Consultation/Referral
- Plan
 - Diagnosis
 - Treatment
 - Patient education
 - Follow-up
- References

The writer submits the initial draft of the protocol to his/her peers for critique. The colleagues give the writer input and consensus is reached about any disputed areas using the literature. The writer modifies the protocol, which is then formally adopted when it is signed by the Clinical Director and the consulting physician. All staff members review protocols annually, modify them as needed, and then the director and physician re-sign the protocols.

Guidelines for Medical Record for Employees

The health and safety of public employees is important to personnel managers because these issues have become a significant concern of the employee-employer relationship and because there is increasing evidence that healthier employees are more productive and happier than unhealthy ones. Employees have the right to constitutional protections against violations of privacy in their personal lives. Yet management must create conditions, which support the maintenance and rehabilitation of employees as human resources.

Pre-employment physicals are routinely used to exclude applicants whose medical history places them at risk. Requirements for the physical exam should be listed in employee policies.

Additionally policies may be established to have physical exams or certain health screenings done annually or every two or three years. Policy should state how often, who may do the exam, on what form or what is to be included, and where that form is to be kept. Documentation of required immunizations (as stated in policy) should be included. TD, MMR, documentation of polio series (OPV contraindicated in persons over age 18), Hepatitis B, and TB skin test are usually required. Most local health departments will provide the immunizations free to their employees and if so this should be stated.

Guidelines for Medical Record for Client

Each agency should establish a confidential medical record for every client receiving services. This record includes any necessary permission for services, personal data, health/medical history, problem list, physical exam results, appropriate laboratory results, treatment and or education provided, and scheduled revisits.

In addition to the common core elements of all records, applicable program forms or records should be included as well. Examples of these are provided in program manuals.

References

Buttery, C.M.G. (1991). [Handbook for Health Directors by C. M. G. Buttery](#)
New York: Oxford University Press.

Administrative Forms Defined

Contract:

An agreement between two or more persons/parties, which creates an enforceable obligation to do or not to do a particular thing. Essential components of a contract include: 1) competent parties, i.e., of legal age and legally competent, 2) a legal consideration, 3) mutuality of agreement, and 4) mutuality of obligation. The writing contains the agreement of parties, with the terms and conditions, and which serves as proof of the obligation. Consideration means that each party offers something of value to the contract. A contract is established for a specific amount of time or it has an automatic expiration or renewal clause that stated the contract is in force unless either party gives notice of termination, i.e., 30 days.

Incident Report:

A mechanism, established by an agency, by which staff is to inform the agency and its staff of any unusual occurrence/injury to clients/families for which the agency might be held legally responsible for damages.

Injury Report:

A mechanism, established by an agency, by which staff is to report injury or possible injury to a member of the staff for the purpose of protecting the agency and staff member in regards to Workers Compensation.

Interlocal Agreement:

An understanding or intention between two or more parties, usually local governmental agencies that is enforceable and binding, with respect to their rights and duties.

Memorandum of Understanding:

An informal instrument or briefly written statement outlining the terms of an agreement between two or more parties under which they will operate when the law is not specific. Its purpose is to guide the agencies and staff and is not binding by law. An example might be an agreement between SRS and the LHDs concerning the responsibilities assumed in the investigation of allegations of child abuse.

References

Black, H.C. (1979). Blacks Law Dictionary. 5th Edition. St. Paul, MN: West Publishing Company.

Organizational Management / Quality Assessment
OF
Health Department Facilities

Several things are to be considered when choosing a location for a local health department facility. Although often the "ideal" facility is not available, negotiations and modifications may result in an adequate worksite.

High priority needs:

- Handicapped accessibility for entrance and restroom facilities.
- Hot and cold running water and working drains.
- Adequate heating and lighting.
- Adequate parking for clients.
- Private areas for exams, interviews, and education.
- Refrigerator with alarm system for storing biologicals.
- A filing system that can be locked.
- A working telephone.
- Modern professional equipment in working order with which to conduct examinations and take measurements.

Other Needs:

- Computer with modem, internet access, and printer.
- Method of sending and receiving FAX messages.
- Quiet room for audiometric testing.
- Spacious waiting room with educational items of interest.

OSHA and Blood borne Pathogens

In 1970, the U.S. Congress established the Occupational Safety and Health Administration as a division of the Department of Labor. Its purpose was simply to assure a safe and healthy working environment. In general, OSHA regulations cover employees in the 50 state, the District of Columbia, Puerto Rico, the Virgin Islands and other territories under U.S. jurisdictions.

There are 10 regional offices of OSHA that direct the activities within the states assigned to each region. In addition, individual states may petition to develop their own state OSHA programs. Such programs must be at least as effective as the federal OSHA program and are more stringent in some cases. In Kansas, the private sector is regulated by federal OSHA guidelines while the public sector is regulated by Kansas Department of Human Resources (KDHR), Industrial Safety and Health section.

Kansas Statutes Annotated (K.S.A.) 44-636 gives KDHR the authority to protect public employees in the workplace including those employees by state, city, county, region, and schools. This section provides advice to Kansas businesses concerning workplace safety and health, inspects and advises state government, local government and schools concerning workplace safety and health, offers education and training programs for Kansas businesses and workers, inspects for occupational health hazards, hazardous chemicals and maps underground mines. It is this agency that regulates the blood borne pathogen standard for public and governmental agencies in Kansas and has stated that it will use the federal standard for routine public inspection.

The OSHA standard involving blood borne pathogens can basically be divided into six broad categories collectively referred to as the **Exposure Control Plan**. These categories include (1) exposure determination, (2) universal precautions, (3) engineering and work practice controls, (4) hepatitis B prophylaxis, (5) training and education, and (6) record keeping. All employers having an employee(s) with occupational exposure as defined in the plan are required to establish a written Exposure Control Plan addressing each of these categories. A model (generic) blood borne pathogens exposure control plan is available for U.S. Dept. of Labor-OSHA offices in Wichita and Mission, KS.

The Hazard Communications Standard (HCS) is published in the Federal Register 29 CFR 1910.1200. It is enforced by OSHA and pre-empts all state and local laws except in state with OSHA-approved state programs. In Kansas, it is referenced by OSHA for private employees and by Kansas Department of Human Resources for employees of governmental agencies.

The HCS is based on the concept that employees have both a need and a right to know the hazards and the identities of the chemicals they are exposed to when working. They also need to know what protective measures are available to prevent adverse effects from occurring. This program ensures that all employers receive the information they need to inform and train their employees properly and to design and put in place employee protection programs. Employees can thus participate in, and support, the protective measures in place at their workplaces. By understanding the hazards involved, employees can take steps to protect themselves, thus preventing the occurrence of adverse effects caused by the use of chemicals in the workplace.

References

[Blood borne Pathogens Final Standard: Summary of Key Provisions](#)

[OSHA Blood borne Pathogens Standard Informational Materials](#)

[CDC: Blood borne Pathogens in Healthcare Settings](#)

[KDHE: Right-to-Know Right-to-Know Regulations](#)

[U.S. Dept. of Labor Hazsard Communications Standard Fact Sheet](#)

Disaster Management/Emergency Response

According to K.S.A. 48-904, disaster may be defined as the “occurrence of imminent threat of widespread or severe damage, injury or loss of life or property resulting from any natural or manmade cause, including, but not limited to, fire, flood, earthquake, wind, storm, epidemics, air contamination, blight, drought, infestation, explosion, riot or hostile military or paramilitary action.”

Every agency offering public health services should be a part of a specific written disaster plan with clearly identified procedures. In Kansas, the statute authority (K.S.A. 48-904 et seq) for a “state disaster emergency plan” lies within the “Division of Emergency Management” led by the adjutant general under the direction of the governor of the state. This division cooperates with similar federal agencies, those in other states, and in Kansas with city, county, regional, and intrajurisdictional disaster agencies. It has authority to require and direct the cooperation and assistance of state and local governmental agencies and officials. Immunity from liability for workers including volunteers in time of declared disaster is explained in K.S.A. 48-915. Authority for declaring and rescinding a state of disaster emergency in Kansas lies with the governor.

According to K.S.A. 48-929, each county within the state “shall establish and maintain a disaster agency ... or shall participate in an intrajurisdictional arrangement for such purposes...” Thus county, city, and other jurisdictions should in turn have their own written disaster plans. All employees should be aware of the plan and at least know their expected duties. A call list should be in place so that the proper information reaches all employees. This list should include or interface with other health care personnel in the area to maximize skills and avoid duplication. In the case of the local health department, provision of continued service to some existing caseloads may be necessary because many public health clients are vulnerable or at risk populations.

Suggestions for inclusion in agency policy:

- Inclusive, up to date call list (telephone tree) to insure prompt activation of plan.
- Central place for employees to report in person or by phone for assignment.
- Identification badges or other readily visible ID for all personnel.
- Persons designated to monitor emergency frequency radio broadcasts and other sources for instructions to disaster service workers.
- Guideline to address service priorities. The level and priority of services should be determined relative to the nature and scope of the disaster.
- Person with authority to declare a public health emergency and to supervise implementation of the Public Health Disaster Plan. (Usually the Health Officer).

The Role of the Public Health Nurse in Disaster Management

The PHN can be expected to exercise leadership and judgment in assessing clients for priority of care, treatment of the sick and injured, use of supplies and equipment, utilization of nursing personnel, and assisting the community in aggregate and individual living situations. The local health department's Community Disease Containment Standard Operating Guide provides specific guidance regarding these functions and roles.

A communicable disease outbreak or pandemic may require the immunization or post-exposure prophylaxis of large numbers of people; even entire community populations. The local health department's Mass Dispensing Standard Operating Guide provides guidance on the responsibilities of various positions during Point of Dispensing (POD) operations. In addition, the following general guidelines should be observed when possible:

Special immunization activity:

- Consult with the Health Officer regarding the need for special immunization services, particularly regarding decisions on administration of Gamma Globulin.
- Maintain existing immunization services and develop additional services based on need.
- Set up and participate in immunization clinics when requested.
- Serve as resource to the Community for immunization recommendations and advice.
- Provide education regarding the need for immunizations and prevention of communicable disease.

A disaster that damages housing on a large scale will result in the establishment of many kinds of aggregate living situations. Official Red Cross Shelters have existing standards for communicable disease control. Other group living settings may not have standards developed or experience in health matters. The following guidelines should be followed:

Special shelter activity:

- Wear identification badge and/or other identifiers at all times.
- Strive to maintain cooperative working relationships with shelter managers and staff.
- Provide written documentation of:
 1. Visits to shelters or other group living situations.
 2. Consultation and training on communicable disease control given to shelter staff.
- Assess adequacy of hand washing and toilet facilities in the area.
- Provide written materials on communicable disease control, particularly hand washing.
- In cooperation with the Health Officer and Environmental Health, determine when the risk of communicable disease requires action by the Health Department to take remedial action or to close the shelter.

For more information, consult the Community Disease Containment Standard Operating Guide and the Mass Dispensing Standard Operating Guide that are maintained by your local health department. Additional information is available on the KDHE Preparedness website at www.ksprepared.org.

References

Langan, Joanne C., & James, Dotti C. (2005). Prepering Nurses for Disaster Management. Upper Saddle River, NJ: Pearson-Penyice Hall

U.S. Department of Health and Human Services. (August 2007). [Public Health Emergency Response: A Guide for Leaders and Responders](#).

Formation of Local Health Department Advisory Council

Among the statutory requirements to meet the conditions of participation for home health agencies is to have an advisory council. However, certainly health departments as a whole can benefit from such a structure.

The advisory council should be outside the legal framework of the agency and without decision-making power. It would serve in an advisory capacity to the local health department and board of health. Through this group, the community learns what the local health department has done, is doing, and is planning for the future to meet the public health needs of the community.

Regular meetings with a written agenda for this council should be planned. Meetings should be held at a frequency which is great enough to keep the council informed and seek their assistance—but not so often that there is no purpose to the meetings. Quarterly meeting may be a good beginning.

Membership should represent the geographic area served. Examples of membership might be:

- physician representing the local medical practicing physicians
- minister
- attorney
- nurse employed outside of the agency
- business/industry leader
- school representative
- local government representative
- homemaker
- consumer of service
- accountant
- board of health member representative

The council should have no fewer than nine and no greater than twenty-five members depending on the population of the area served. It would be wise to make an effort for all commission districts to be represented in the membership. Summarizing some of the functions of this council might be as follows:

1. Advise and recommend policy.
2. Suggest the expansion of the geographic area served or services provided.
3. Evaluate programs, services, adequacy of facilities, and staffing.
4. Act as liaison between the agency and public.
5. Create public understanding and support.
6. Initiate the development of volunteer services.
7. Maintain a display booth at community fairs and functions.
8. Monitor legislation affecting community health.

Some Group Dynamics Issues for Boards and Committees

The field of group dynamics/human relations has much to teach those of us who serve on boards and committees and must make decisions in a group setting. Among some of the important issues are:

1. **It is important to realize that each of us plays a role in each gathering of the group** (board, committee). Sometimes we play multiple roles. Some roles are related to the task or "business at hand." Such roles include the functions of seeking information (being willing to appear "dumb"), providing information, offering opinions relative to the merits of what is being discussed, clarifying and/or elaborating on the material involved in the discussion, synthesizing ideas, and summarizing the discussion. It isn't only the presiding officer who is charged with these functions.

Besides the task functions, there are numerous functions and roles which serve to build the group as a functioning unit, to build trust among the members of the group (which helps the group make better decisions). Such roles include "gate keeping" (helping others to make a contribution to the discussion); "following" (thoughtfully accepting ideas of others), and summarizing apparent group feeling.

Other functions that accomplish task and group maintenance objectives are diagnosing (determining sources of difficulties and analyzing the main blocks to progress), testing for consensus, mediating (trying to conciliate differences), and relieving tension (when appropriate).

Nonfunctional behavior includes being aggressive, blocking the progress of the group by going off on a tangent, self-confessing (using the group as a sounding board inappropriately), competing, horsing around, and withdrawing from the discussions (e.g., by whispering to others or daydreaming).

2. **Groups work on two levels: the level of the "task" or agenda and the level of hidden, undisclosed needs and motives of the individual members.** Everyone has personal needs, some more apparent than others. These personal needs do not always cause a problem in a group, but sometimes there are needs which are in conflict with the purpose of the group and/or which are in conflict with other individuals in the group. If these needs get in the way of the group purpose, they need to be dealt with, usually by the presiding officer, but sometimes by an alert member of the group who can try to surface the "hidden agenda."
3. **We live in a society dominated by a win-lose philosophy.** This win-lose climate can contaminate group process to the point that individual members of the group try to get their point of view adopted at all costs. My personal favorite antidote to win/lose is to choose to believe that everyone is "partly right." In that way, we can respect each person's input; we can truly listen to another's point of view when it differs from our own and take the chance that we may then have to change our point of view somewhat. "Active listening" is a learnable skill and ought to be on all board training agendas because it is a skill most notable in its absence at group meetings.

References

Resource center news. (1982, March). Milwaukee Associated in Urban Development. Milwaukee, WI.

Collaboration

Definition:

Collaboration occurs when two or more parties/agencies, which are not directly connected, establish a working relationship in a cooperative effort that is in their mutual interest, and allows them to put their ideas and resources together to accomplish a particular objective.

Collaborative undertakings are complicated. In reality, many times potential partners come to the table to achieve their own agenda and/or to protect their turf. To be successful, each partner must be willing to compromise; each gains from and each gives to the others. All collaborations must have some common ground. This may become threatening to the partners, if they perceive that another party will take them over.

Differences among partners work because they each contribute complementary resources, skills, and expertise to the endeavor. By bringing diverse building blocks together, the group is able to achieve results that no single partner could achieve alone.

Tensions can develop when partners have different "languages" and values as well as different resources and skills. In these situations, the viability of the collaboration depends on its capacity to foster tolerance, respect, and trust. When partners are very foreign to each other, it is important to engage in a narrowly focused, non-controversial project that can lead to short-term benefits.

For Collaborative Efforts to Succeed:

- All partners should be involved in the enterprise from the planning stage.
- Partners roles and responsibilities (what each is expected to contribute) and clarified early in the endeavor.
- The partners must perceive a compelling need to work with professionals/organizations in other sectors, and be willing to do so.
- The potential partners must value the enterprise that they enter with the partners.
- The benefit for each partner must be expected to be worth the investment and commitment.
- Partners must recognize that they do not have to agree about everything to work together; but they must find common ground.
- Don't expect other partners to be like you.
- Potential partners must have confidence and trust in the leaders of the enterprise.
- The partners seek to achieve early success, then build on that to extend further collaboration.
- Partners must be cognizant of each other's burdens; financial contributions expected of each partner must be realistic, administrative support must be adequate, and partners should take on the roles that they do best and most efficiently.
- When partners are very different, it may be valuable to identify a neutral, skilled facilitator who has the trust and respect of all partners.
- Be up front about competition and control issues.
- There must be effective strategies for promoting understanding and communication, for building a common language, for fostering trust and respect, for supporting group decision making, for keeping partners fully informed about what is happening, for learning about each other's concerns, values, and work, for airing disagreements, and for responding to changes and emerging problems.

Obstacles/Barriers to Success:

Collaborations fail for a variety of reasons:

- Most collaborations fail because of relationships; confidence and trust between partners dissipated, they are separated by deep cultural difference, they are competitors, and they lack a history of working together.

- Partners are concerned about losing control; over their professional and institutional destinies, over the direction of the collaboration, over the limits of their participation, and because they fear their partners will attempt to take them over.
- Policy barriers include requirements of health programs, strings attached to funding streams, and market forces that threaten funding for research, professional training, and population based health programs.

Benefits for the partners and the clients of health care agencies can be greatly enhanced through community collaborations. This pursuit of self-interest within the context of the collaborative enterprise needs to be limited; benefits for one partner cannot be achieved at the expense of others.

References

Medicine & Public health: The power of collaboration: <http://www.cacsh.org/mph.html> or <http://www.cacsh.org/pdf/MPH.pdf>

Community Health Assessment

The assessment process has become increasingly important in determining priority objectives, program planning, funding, and policy formulation for any defined service area. Social mobilization in support of public health objectives will happen with community involvement through the community assessment process.

Several models for community health assessment are in use. A community-based view of health implies that real health for all individuals can only be achieved when the community as a whole is healthy. That requires a community that encourages and supports not only physical health, but economic, environmental, social, psychological, and political health as well

The PATCH Process was initiated and later revised by CDC and focuses well on getting the community working together on health promotion and risk reduction activities. The Assessment Protocol for Excellence in Public Health (APEXPH) is a product of NACCHO (National Association of County and City Health Officials) and is particularly suited to better define the public health agency's leadership role in the community and establish a wide range of intervention strategies. The Kansas Community Health Assessment Process (CHAP) was written especially for Kansas and has been adapted to the needs of Kansas communities. Materials and technical assistance for this process are available through KDHE.

The CHAP process is:

- **community-controlled** – CHAP is performed **by** a community, not **to** it.
- **data-driven** – CHAP guides the community members in collecting and interpreting data to make informed decisions.
- **comprehensive** – CHAP incorporates a broad range of community data and guides the community in assessment and planning.

According to CHAP, community health assessment is a process of collecting and using information that helps define the community's problems and determine what that community can do about them. The long-term goal of Community Health Assessment is to improve and promote the health of community members.

For more information on the CHAP process or for printed materials, call KDHE Office of Local and Rural Health at 785-296-1200.

References

Community Tool Box: http://ctb.ku.edu/en/tablecontents/chapter2_section13_main.aspx

Community health assessment Example: KDHE

PUBLIC HEALTH NURSING PRACTICE

Standards

Kansas Nurse Practice Act: Definitions & Standards of Practice

<http://www.ksbn.org/npa/npa.htm>

[PLEASE NOTE: THIS DOCUMENT CHANGES FREQUENTLY AND THIS ENTY IS INTENDED FOR REFERENCE ONLY. FOR LEGAL QUESTIONS AND ISSUES OR TO REQUEST A COMPLETE CURRENT COPY, CONTACT THE KANSAS STATE BOARD OF NURSING, LANDON STATE OFFICE BUILDING, 900 SW JACKSON, SUITE 1051, TOPEKA, KS 66612-1230. PHONE (785) 296-4929.

American Nurses Association Code of Ethics for Nursing

[The Code of Ethics for Nursing](http://www.nursesbooks.org/Main-Menu/Ethics/Code-of-Ethics-for-Nurses-With-Interpretive-Statements.aspx) may be reviewed or maybe purchased online at <http://www.nursesbooks.org/Main-Menu/Ethics/Code-of-Ethics-for-Nurses-With-Interpretive-Statements.aspx>

American Nurses Association Standards of Clinical Nursing Practice

When professional nursing organizations develop standards of practice, they are establishing a framework for delivery of care and assurance of quality outcomes. Used in legal arenas, such standards serve a different purpose, illustrating inadequacies and incompetence. By considering the legal aspects of the practice, this text provides a basis for determining liability when standards have been allegedly compromised. To purchase book for go to:

Role of Public Health Nursing

Scope and Standards of Public Health Nursing Practice

Association of State and Territorial Directors of Nursing

Public Health Nursing Practice Model

QUAD Council PHN competencies

Public Health Nursing Practice

(Excerpts from "The tenets of public health nursing by the Quad Council of Public Health Nursing Organizations", Josten, LaBohn, PhD, RN, 1997.)

The Tenets of Public Health Nursing include:

The process of population-based assessment, policy development and assurance is systematic and comprehensive. This process includes consideration of all of the determinants of health (social, economic, and physical environmental, personal/lifestyle health practices, human biology, community capacity, and health services) as they affect the population's health (Federal, Provincial and Territorial Advisory Committee of Population Health, 1994). The process includes assessment of the needs, strengths and expectations of all the people guided by epidemiological methods. Policies are developed with a view toward the priorities set by the people with consideration of effectiveness of intervention and program options on influencing the health goals of the people. Assurance strategies that carry out developed policies include interventions and programs delivered by both public health nurses and other health care professionals or organizations aimed at assuring the availability and access of needed services. Data collected systematically from individuals receiving community-based nursing services can be a method of obtaining information on the people's meaning of the health experience. However, data from assessment of individuals and families may be aggregated to the whole population only when biostatistical approaches are used to determine if the individuals/families are truly representatives of the whole.

In all processes partnerships with representatives of the people are essential. Facilitation of the inclusion of the people's meaning or perspectives is stressed so that their perspective are reflected in interpretation of the data, policy decisions and planning programs. This is necessary so policies and programs can be oriented by the priorities and values of the people. This can be achieved by having the people elect representatives to work in partnership with the public health nurse. Representatives of multiple communities is emphasized so that decisions are made with consideration of what is in the best interest of all of the people, not just those in one community.

Primary prevention is given priority. The practice places emphasis on primary prevention in all of its processes (assessment, policy development and assurance). Primary prevention includes health promotion and health protection strategies.

Creating health environmental social, and economic conditions in which people live guides selection of intervention strategies. The practice is to intervene to eliminate harmful social, physical or economic environment conditions and to create conditions that support leading healthy lives. It also involves changing the system of care so it promotes the peoples' health. Although all nurses are concerned about the environment in which their individual clients live, public health nurses concentrate on interventions aimed at improving those environments to benefit the health of the whole population. Interventions include educational, community development, social engineering, and policy development and enforcement strategies. Interventions tend to emerge from the political or community participation

process resulting in governmental policies and laws, administrative rules and budget processes or to emerge from policy and resource control mechanisms within public or private organizations. Some interventions will support functions and systems that promote health while others will protect the health of the people by prohibiting harmful practices.

The practice incorporates an obligation to actively reach out to all who might benefit from an intervention or service. Often, those most likely to benefit are those who are the most marginal to the benefits of society. Provision of services only to those who present themselves for services is not public health nursing without actions to gain participation of the entire population who might benefit from that service.

The dominant concern is for the greater good of all the people or the population as a whole. Public Health Nurses also carry with them an obligation to promote the health needs of each individual. This is done with recognition that it may not be possible to meet all identified individual needs when they are in conflict with other priority health goals that benefit the whole population.

The wise stewardship and allocation of the available resources is supported in order to gain the maximum population health benefit from the use of those resources. This includes providing members of the population and leaders with information they need so that available resources can be used to attain the best overall improvement in the health of the entire population. Information should include scientific data on potential outcomes of various policy decisions as well as where possible, the cost benefit or cost effectiveness of the multiple potential intervention strategies.

The health of the people is not effectively promoted and protected through collaboration with members of other professions and organizations. Creating conditions in which people can be healthy is an extremely complex, resource intense process. Public health nurses facilitate inclusion of the expertise of members of multiple professions and organizations in efforts to improve population health.

Processes include:

- Promoting systems that provide populations with access to and high quality individual nursing care. Public Health Nursing practice includes providing leadership to assure that all of the people have their individual nursing needs met. This includes collaborating with other nurses in developing public policies that assure an adequate supply of well prepared nurses to work in all earth settings, developing and enforcing public and organizational policies which assure access to quality nursing services, and supporting nursing research and appraisal so that the quality of care by all nurses is promoted.
- Providing or assuring care to individual families in the community (community-based care) when their health condition creates a risk to the health of the population. The decision to provide community-based care is based on its contribution to improvement of the health of the whole population, and emerges out of a population-based process of assessment, policy development and assurance. Community-based care is a public health nursing strategy when it directly benefits the whole population by reducing their exposure to risk factors.

Public Health Nursing in a Reformed Health Care System

The public health nursing community believes a strong public health system must have population-focused health care and primary care services. The role of public health nursing includes the core functions of public health: assessment, policy development, and assurance, as well as health education and appraisal.

A strong public health structure must have:

Appropriations specific for local/community needs instead of or in addition to block granting;

Delivery of an essential package of public health care services available and accessible to all individuals;

Funding for public health nursing services to provide population-focused care and primary care.

In those instances where primary care services are not readily accessible or available in a privatized setting, assurance means that primary care services need to be provided by public health nurses. Public health nurses function as case managers for those who under-utilize services. Their cost effective outreach, intervention, and care coordination efforts result in disease prevention and health promotion.

Public health nurses, within a primary care practice, empower individuals and families. By doing physical assessment, including early childhood screening, these nurses enable their clients to use primary care centers, immunization programs, and community agencies. Health outcome indices of public health nursing interventions include reductions in family violence, poor pregnancy outcomes, communicable disease, morbidity and premature mortality.

Public health nurses, with their broad-based knowledge and experience, can reduce health care costs through early detection and prevention of health problems, thus reducing the need for costly tertiary care.

Population Focused Practice

The goal of population-focused practice is to promote health communities. Public health nurses bring expertise to the collaborative, interdisciplinary process of assessment, policy development, and assurance activities to promote healthy outcomes in a community.

Competencies of the public health nurse include:

1. Community assessment of health risk factors and disease indicators:

Public health nurses:

- Evaluate demographic, epidemiologic, and biostatistical data to anticipate and identify risks and patterns of morbidity and mortality.
- Evaluate changing health behaviors and patterns that have the potential to place people at risk.
- Determine other indicators to monitor the dimensions of health status valued by the community.

2. Policy development to reduce health problems:

Public health nurses:

- Analyze assessment data to identify potential and actual health problems.

- Work to develop partnerships and strategies to address identified health problems.
 - Participate in health policy development as advocated for the needs of children, families, groups, and communities.
3. Assurance activities to promote the effective implementation of policy at the service delivery level:

Public health nurses:

- Assure appropriate service delivery to achieve targeted health care outcomes.
- Monitor health service access, utilization and appropriateness for the community, including underserved and target populations.
- Participate in developing systems and programs to promote positive health outcomes for the community.
- Work to implement continuous quality improvement for health care systems in the community.
- Provide expert public health nurse consultation to groups and organizations in the community.

Reference

Linda Olson Keller, MS, RN, CS, Center for Public Health Nursing, Minnesota Department of Health:
Population-based public health: Connecting the pieces:
http://apha.confex.com/apha/132am/techprogram/paper_90216.htm

Nursing Competencies Based on Essential Services

The Core Competencies for Public Health Professionals (Core Competencies) are **a set of skills desirable for the broad practice of public health**. They reflect the characteristics that staff of public health organizations (collectively) may want to possess as they work to protect and promote health in the community. The Core Competencies are designed to **serve as a starting point** for academic and practice organizations to understand, assess, and meet training and workforce needs.

Resources

[Association of District and Territorial Directors of Nursing \(ADTSN\)](#)

[National Association of County and City Health Officials \(NACCHO\)](#)

[CORE Competences Public Health Foundation](#)

[The Quad Council](#) (Association of State and Territorial Directors of Nursing; Association of Community Health Nursing Educators; American Public Health Association, Section of Public Health Nursing; American Nurses Association, Council of Community, Primary and Long Term care)

[Public Health Foundation: Council on Linkages: Core Competencies for Public Health Professionals](#)

Professional Growth

The professional growth of the public health nurse is a dynamic, continuous process necessitated by the magnitude of new information. To provide "state of the art" nursing care, the nurse must be knowledgeable of new techniques and theories on a continuing basis because what was current yesterday may be obsolete today. The public health nurse is expected to perform many functions beyond providing quality nursing care such as collaborating with community agencies and elected officials, and participating in legislative movements. Therefore, the American Nurses' Association and American Public Health Association both recommend the bachelor's degree as the beginning preparation for the nurse in public health practice.

Continuing professional growth is the responsibility of every nurse. For the nurse who has not attained a Bachelor's degree, it is recommended that an educational plan be established with a college of choice. Continuing education programs are offered across the state to provide current information and skills needed by the progressive practitioner.

Membership and active participation in the professional nursing and public health organizations are encouraged to further the development of the nurse and the nursing community. Active membership in the Kansas Public Health Association and Kansas Association of Local Health Departments also provides opportunities for professional growth. Continuing education provides the foundation for the practice of the creative, adaptable public health nurse.

The numerous responsibilities the public health nurse fulfills in a variety of settings necessitate independent nursing judgment and accountability. As a measure of risk management, each nurse is encouraged to carry adequate professional liability insurance. Liability insurance may be purchased from the American Nurses Association, other nurse organizations, and commercial insurance companies.

RN to BSN Completion

Ten colleges and universities offer the associate degree or diploma prepared nurse an opportunity for professional growth through degree completion courses. A bachelor's degree gives a nurse the accepted entry-level preparation as a professional public health nurse. It also serves as a base for career development and understanding population based nursing.

While all of these schools have slightly different admission and course requirements, they have many features in common. These include state and N.L.N. accreditation, a means to give credit for past nursing education and experience, course work in community and public health, and accommodation for part time students. Other features offered by some of the schools are off site classes, accelerated degree completion, Masters programs, and R.N. to Masters programs.

The following is a list of these schools of nursing and how to contact them:

[Baker University](#)

School of Nursing
Pozez Education Center
1500 W. 10th St.
Topeka, KS 66604
785-354-5850

[Fort Hays State University](#)

Department of Nursing
Stroup Hall 120
600 Park St.
Hays, KS 67202-3802
1-800-684-2242

[Emporia State University](#)

Department of Nursing
1127 Chestnut
Emporia, KS 66801
620-343-6800 ext. 5641

[Newman university, Kansas](#)

Division of Nursing
3100 McCormick
Wichita, KS 667213
1-877-639-6268

[Kansas Wesleyan University](#)

Division of Nursing Education
100 East Claflin Ave.
Salina, KS 67401
1-800-874-1154 ext. 7220

[Mid America Nazarene University](#)

Division of Nursing
2030 E. College Way
Olathe, KS 66062-1899
913-782-3750 or 1800-800-8887

[Pittsburg State university](#)

Department of Nursing
1701 S. Broadway
Pittsburg, KS 66762-5885
620-231-7000

[Southwestern College](#)

Nursing Department
100 College Street
Winfield, KS 67156
620-229-6207

[University of Kansas](#)

School of Nursing
Office of Student Affairs
3901 Rainbow Blvd.
Kansas City, KS 66160-7501
913-588-1619

[Washburn University](#)

School of Nursing
1700 SW College Ave.
Topeka, KS 66621
(785) 231-1010 ext. 1533 or ext. 1525

[Wichita State University](#)

School of Nursing
1845 Fairmount
Wichita, KS 67260-0041
1-800-516-0290

Cultural Competency

Growing Diverse Populations

The United States is a nation with a rich mix of people and groups with diverse racial, ethnic, and cultural background with tremendous growth over the past several decades. As a result, public health and health care providers must be able to respond to a variety of perspectives, values, and behaviors about health and well-being. Failure to understand and manage these differences may result in health care needs not being met as well as other negative consequences. For a healthy society, all individuals and groups should be supported in staying healthy, active and independent and have equal access to quality health care. To this end, it is essential to use approaches and interventions that respect cultural values and beliefs and to appropriately address health needs.

Barriers to Access

Health and other disparities that separate diverse populations have multiple causes but are due, in part, to problems experienced in accessing and using health and human services. One reason for this may be that service systems are not responsive to the needs of diverse clients. Often services are not “**culturally sensitive.**” Barriers may include:

- language
- lack of appropriate information
- lack of experience with traditional delivery systems
- low income or limited resources
- low education levels or literacy levels

Culture Defined

Culture has been defined as an integrated pattern of learned beliefs and behaviors that can be shared among groups. It includes thoughts, styles of communicating, ways of interacting, views on roles and relationships, values, practices, and customs. Culture is shaped by multiple influences, including race, ethnicity, nationality, language, and gender, but it also extends to socioeconomic status, physical and mental ability, sexual orientation, and occupation, among other factors. These influences can collectively be described as “socio-cultural factors,” which shape our values, form our belief systems, and motivate our behaviors.

Cultural Competency Defined

Cultural competency is a set of behaviors and attitudes integrated into the practices and policies of agencies or professional service providers that enables them to understand and work effectively in cross-cultural situations. Translating and integrating knowledge about individuals and groups of people into specific practices and policies applied in appropriate cultural settings can achieve cultural competence. When professionals are culturally competent, they establish positive helping relationships that engage the client and improve the quality of services they provide.

Characteristics of Culturally Competent Service Delivery

- ❖ **Cultural appropriateness** – being sensitive to the cultural norms, values, and beliefs of the particular individual, the situation, and the environment as they pertain to the needs of the client and the types of services to be utilized.
- ❖ **Cultural access** – providing information and services in languages or through media that facilitates delivery to non English speaking clients.

- ❖ **Cultural acceptability** – developing structures and services that reflect the experience of clients and encouraging diverse clients to actively seek services.

Creating Culturally Competent Programs that Work

In a society as diverse as the United States, health and social service providers and others who deliver services must be able to relate to and communicate with diverse clientele. Essential elements that contribute to an organization's ability to become more culturally competent include:

1. **Valuing diversity:** Organizations must value diversity in order to establish the policies and procedures needed to become culturally competent.
2. **Having the capacity for cultural self-assessment:** Organizations must establish and understand their own identity in order to develop and implement goals.
3. **Being conscious of the dynamics inherent when cultures interact:** How and where the services are provided are critical to service delivery.
4. **Having institutionalized cultural knowledge:** All levels of the organization must be culturally aware.
5. **Adapting service delivery based on understanding of cultural diversity:** Programs and services must be delivered in a way that reflects the culture and traditions of the people served.

Suggested Resources

Agency for Healthcare Research and Quality <http://www.ahrq.gov/research>

Unnatural Causes. A seven part documentary series exploring racial and socioeconomic inequalities in health. <http://www.unnaturalcauses.org/>

Cultural and Linguistic

[National Standards on Culturally & Linguistically Appropriate Services \(CLAS\)](#)

U.S. Dept of Health & Human Service, Office of Civil Rights, Limited English Proficiency. <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/>

U.S. Department of Health and Human Services, Office of Minority Health. <https://www.thinkculturalhealth.org/>

Public Health Nursing Policies

The local health department should have written policies and procedures for all programs to serve as a guide and standard to be used in making judgments and decisions regarding client care. As a licensed practitioner, the nurse is accountable for his or her nursing practice and for the quality of nursing care delivered. Client care guidelines should be developed for each service offered, i.e. immunizations, maternal-infant, family planning, child health conference, child assessment, early intervention screening and education, W.I.C., prenatal risk reduction, newborn home visits, high risk infant care, healthy start, healthy families, communicable disease, infection control, home health, etc.

Referrals

Clients may be referred to the public health nurse from an agency or institution, another health professional, family or interested person, or as a self-referral. Upon receipt of a referral, the public health nurse should assess the client's needs, determine needed action, and provide nursing care. If medical care is indicated, referral to a physician or other appropriate health care provider should be made. In many cases, collaborative care is appropriate and the nurse and the other health care provider are both engaged to meet the client's health care needs. Written referrals provide a permanent record of the case referred. Referral forms provide pertinent information and feedback.

Medical Orders

There should be a written policy within the agency signed and approved by the medical consultant to assure that telephone orders are managed properly. Such policy should specify that orders may only be received from and given to a physician or licensed professional nurse. The policy should specify the method and time frame to obtain written confirmation and the action required if written confirmation is not obtained. A confirmed order should then be attached to the client's chart.

Standing orders are appropriately used in a health department for some services (e.g. immunizations, anaphylaxis, STD, or family planning). When standing orders are utilized, they should be reviewed or revised and signed annually by the responsible physician. Re-signing is necessary whenever there is a physician change, retain replaced, signed orders in accordance with agency record-retention policy.

When the nurse is working in collaboration with the physician on cases such as home care, the medical orders must be received and renewed according to written agency policy.

Emergency Treatment

Written, standing orders should be established and signed by the physician responsible for emergency care and be posted in treatment areas. These orders should be reviewed and signed each year by the physician. It is recommended that all health department personnel maintain current CPR certification. Records should be maintained confirming timely review and checking of emergency orders, procedures, equipment, drugs and dosages by the nursing staff. It may be advisable to assign this responsibility to one nurse.

Drawing Blood

Registered nurses may draw blood from a client with a written order from a physician for a specific client or by written policy for a clinic or program (e.g., family planning, communicable disease control).

Delegation

American Nurses Association Position Statement

Registered Nurse Utilization of Unlicensed Assistive Personnel

Summary: The American Nurses Association (ANA) recognizes that unlicensed assistive personnel provide support services to the RN, which is required for the registered nurse to provide nursing care in the health care settings of today.

The current changes in the health care environment have and will continue to alter the scope of nursing practice and its relationship to the activities delegated to unlicensed assistive personnel (UAP). The concern is that in virtually all health care settings, UAP's are inappropriately performing functions that are within the legal practice of nursing. This is a violation of the state nursing practice act and is a threat to public safety. Today, it is the nurse who must have a clear definition of what constitutes the scope of practice with the reconfiguration of practice settings, delivery sites and staff composition. Professional guidelines must be established to support the nurse in working effectively and collaboratively with other health care professionals and administrators in developing appropriate roles, job descriptions and responsibilities for UAP's.

The purpose of this position statement is to delineate ANA's beliefs about the utilization of unlicensed assistive personnel in assisting in the provision of direct and indirect patient care under the direction of a registered nurse.

Unlicensed Assistive Personnel

The term unlicensed assistive personnel applies to an unlicensed individual who is trained to function in an assistive role to the licensed nurse in the provision of patient/client activities as delegated by the nurse. The activities can generally be categorized as either direct or indirect care.

Direct patient care activities are delegated by the registered nurse and assist the patient/client in meeting basic human needs. This includes activities related to feeding, drinking, positioning, ambulating, grooming, toileting, dressing and socializing and may involve the collecting, reporting and documentation of data related to these activities.

Indirect patient care activities focus on maintaining the environment and the systems in which nursing care is delivered and only incidentally involve direct patient contact. These activities assist in providing a clean, efficient, and safe patient care environment and typically encompass categories such as housekeeping and transporting, clerical, stocking, and maintenance supplies.

Utilization

Monitoring the regulation, education and utilization of unlicensed assistive personnel to the registered nurse has been ongoing since the early 1950's. While the time frames and environmental factors that influence policy may have changed, the underlying principles have remained consistent:

- IT IS THE NURSING PROFESSION that determines the scope of nursing practice;
- IT IS THE NURSING PROFESSION that defines and supervises the education, training and utilization for any unlicensed assistant roles involved in providing direct patient care;
- IT IS THE RN who is responsible and accountable for the provision of nursing practice;
- IT IS THE RN who supervises and determines the appropriate utilization of any unlicensed assistant involved in providing direct patient care; and
- IT IS THE PURPOSE of unlicensed assistive personnel to enable the professional nurse to provide nursing care for the patient.

It is the assumption of the ANA that the provision of safe, accessible and affordable nursing care for the public may include the appropriate utilization of unlicensed assistive personnel and that the changes in the health care environment have and will continue to alter the activities delegated to UAP's.

Therefore, it is the responsibility of the nursing profession to establish and the individual nurse to implement the standards for the practice and utilization of unlicensed assistive personnel involved in assisting the nurse in the direct patient care activities. This is accomplished through national standards of practice and the definitions of nursing in state nursing practice acts.

In order to understand the roles and responsibilities between the RN and the UAP the ANA recognizes that the key to understanding is the clarification of professional nursing care delivery and the activities that can be delegated within the domain of nursing. The act of delegation is: the transfer of responsibility for the performance of an activity from one person to another while retaining accountability for the outcome.

In delegating, it is the RN who uses professional judgment to determine the appropriate activities to delegate. The determination is based on the concept of protection of the public and includes consideration of the needs of the patients, the education and training of the nursing and assistive staff, the extent of supervision required, and the staff workload. Any nursing intervention that requires independent, specialized, nursing knowledge, skill or judgment cannot be delegated.

References

[ANA Principals for Delegation](#)

Kansas Nurse Practice Act. K.S.A. 65-1113 et seq.; KAR 60-15-101 et seq. Also see this manual.

<http://www.kslegislature.org/legsrv-statutes/searchKeyword.do>

<http://www.kslegislature.org/legsrv-statutes/getStatuteFile.do?number=/65-1134.html>

National Council of State Board Of Nursing:

https://www.ncsbn.org/323.htm#Delegation_Decision-Making_Process

Pharmacy Regulations Pertinent to Public Health Departments

Several public health department services involve storing and dispensing of pharmaceutical products. These activities are controlled in Kansas by State Statute K.S.A. 65-1648 and administrative regulation KAR 68-7-18.

[K.S.A. 65-1648](#).

Distribution and control of prescription medications by a medical care facility pharmacy, health department, indigent health care clinic, federally qualified health center or family planning clinic; maintenance and use of emergency medication kit by adult care home; rules and regulations.

- (a) Any medical care facility pharmacy registered by the board may keep drugs in such facility and may supply drugs to its inpatients and outpatients. Distribution and control of prescription medications in a medical care facility pharmacy shall be under the supervision of a pharmacist in charge. A designated registered nurse or nurses or a licensed physician assistant approved by the pharmacist in charge and under the supervision of the pharmacist in charge shall be in charge of the distribution and control of drugs of a medical care facility pharmacy when a pharmacist is not on the premises. Drugs supplied to outpatients when a pharmacist is not on the premises shall be limited to the quantity necessary until a prescription can be filled.
- (b) Nothing contained in this act shall be construed as prohibiting an adult care home which utilizes the services of a pharmacist, from maintaining an emergency medication kit approved by the adult care home's medical staff composed of a duly licensed practitioner and a pharmacist. The emergency medication kit shall be used only in emergency cases under the supervision and direction of a duly licensed practitioner, and a pharmacist shall have supervisory responsibility of maintaining said emergency medication kit.
- (c) Every adult care home which maintains an emergency medication kit under subsection (b) shall comply with the following requirements:
 - (1) Drugs in an emergency medication kit shall be maintained under the control of the pharmacist in charge of the pharmacy from which the kit came until administered to the patient upon the proper order of a practitioner.
 - (2) Drugs contained within the emergency medication kit may include controlled substances, but in such case a pharmaceutical services committee shall be responsible for specifically limiting the type and quantity of controlled substance to be placed in each emergency kit.
 - (3) Administration of controlled substances contained within the emergency medication kit shall be in compliance with the provisions of the uniform controlled substances act.
 - (4) The consultant pharmacist of the adult care home shall be responsible for developing procedures, proper control and accountability for the emergency medication kit and shall maintain complete and accurate records of the controlled substances, if any, placed in the emergency kit. Periodic physical inventory of the kit shall be required.
- (d) (1) The state department of health and environment, any county, city-county or multi-county health department, indigent health care clinic, federally qualified health center and any private not-for-profit family planning clinic, when registered by the board, may keep drugs for the purpose of distributing drugs to patients being treated by that health department, indigent health care clinic, federally qualified health center or family planning clinic. Distribution and control of prescription medications in a health department, indigent health care clinic, federally qualified health center or family planning clinic shall be under the supervision of a pharmacist in charge. A designated registered nurse or nurses or a licensed physician assistant approved

by the pharmacist in charge shall be in charge of distribution and control of drugs in the health department, indigent health care clinic, federally qualified health center or family planning clinic under the supervision of the pharmacist in charge when a pharmacist is not on the premises. Drugs supplied to patients when a pharmacist is not on the premises shall be limited to the quantity necessary to complete a course of treatment as ordered by the practitioner supervising such treatment.

- (2) The board shall adopt rules and regulations relating to specific drugs to be used, to record keeping and to storage of drugs by a health department, indigent health care clinic, federally qualified health center or family planning clinic as are necessary for proper control of drugs.

KAR 68-7-18

Health departments and private not-for-profit family planning clinics.

The distribution and control of drugs provided by health departments and private not-for-profit family planning clinics authorized under K.S.A. 65-1648(d)(1), and amendments thereto, shall conform to the following requirements:

- (A) The approved drugs that may be stored and distributed by health departments and not-for-profit family planning clinics shall be only noncontrolled drugs that are approved by the food and drug administration. In determining the formulary for each health department or not-for-profit family planning clinic, the pharmacist-in-charge shall consult with the medical supervisor and director of nursing for that facility. No state or federal controlled drugs shall be allowed.

(B)

- (1) The pharmacist-in-charge shall review the procedures outlined below for the distribution and control of all drugs within health department facilities and family planning clinics and shall be responsible for the following:

- (a) Ensuring the development of programs for supervision of all personnel in the distribution and control of drugs;
- (b) ensuring the development of a policy and procedure manual governing the storage, control, and distribution of drugs;
- (c) maintaining documentation of at least quarterly checks of drug records, drug storage conditions, and drugs stored in all locations within the facility;
- (d) establishing a drug recall procedure that can be effectively implemented; and
- (e) ensuring the development of written procedures for maintaining records of distribution and prepackaging of drugs.

- (2) Labels for prepackaged drugs shall contain the following:

- (a) The brand name or corresponding generic name of the drug;
- (b) the name of the manufacturer or distributor of the drug , or an easily identified abbreviation of the manufacturer's or distributor's name; the strength of the drug;
- (c) the strength of the drug;
- (d) the contents in terms of weight, measure, or numerical count;

- (e) the lot number of the drug, if the lot number is not recorded on a suitable log; and
 - (f) the beyond-use date of the drug.
- (3) Prepackaged drugs shall be packaged in suitable containers and shall be subject to all other provisions of the Kansas State Board of Pharmacy regulations under the uniform controlled substances act of the state of Kansas and under the Pharmacy Act of the State of Kansas.
- (C) The procedures for the control and distribution of drugs within health department facilities and family planning clinics shall be consistent with the following requirements:
- (1) Adequate records of the distribution of drugs by the designated registered professional nurse or nurses shall be maintained and shall include the physician's order or written protocol.
 - (a) If the physician's order was given orally, electronically, or by telephone, the designated registered professional nurse or nurses shall reduce that order to writing. The written copy of the order shall be signed by the designated registered professional nurse and maintained in a permanent patient file.
 - (b) The records shall include the following:
 - (i) The full name of the patient;
 - (ii) the date supplied;
 - (iii) the name of the drug, the quantity supplied, and strength of the drug distributed;
 - (iv) the directions for use;
 - (v) the prescriber's name. The record shall include the name of the practitioner and, if involved, the name of either the physician's assistant (PA) or the advanced registered nurse practitioner (ARNP);
 - (vi) the expiration date of the drug; and
 - (vii) the lot number of the drug.
 - (2) A supply of drugs shall be provided to a patient by a designated registered professional nurse or nurses pursuant to a prescriber's order. Only a designated registered professional nurse or nurses may access the pharmacy area and remove the supply of the drugs. The supply shall conform to the following labeling requirements:
 - (a) the name, address, and telephone number of the health department or family-planning clinic from which the drug is supplied;
 - (b) the full name of the patient;
 - (c) adequate directions for use of the drug;
 - (d) the name of the prescriber. The label shall include the name of the practitioner and, if involved, the name of either the physician's assistant (PA) or the advanced registered nurse practitioner (ARNP);

- (e) the date the supply was distributed;
 - (f) the identification number assigned to the supply of the drug distributed by the health department or family planning clinic;
 - (g) the brand name or corresponding generic name of the drug;
 - (h) necessary auxiliary labels and storage instructions, if needed; and
 - (i) the beyond-use date of the drug issued.
- (3) Repackaged drugs shall be packaged in suitable containers and shall be subject to all other provisions of the Kansas State Board of Pharmacy rules and regulations under the Pharmacy Act of the State of Kansas.
- (D) The appointment of any Kansas licensed pharmacist as pharmacist-in-charge of a health department or family planning clinic shall be subject to the provisions of K.A.R. 68-1-2a and 68-7-13. (Authorized by and implementing K.S.A. 65-1648; effective, T-84-3, Feb. 10, 1983; effective May 1, 1984; amended July 23, 1999; amended **April 28, 2000**.)

Resources:

<http://www.kslegislature.org/legsrv-statutes/index.do>

Epidemiology and Nursing Practice

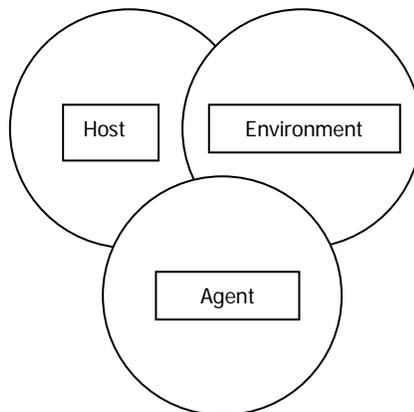
Epidemiology is the study of the distribution and determinants of state of health and illness in human populations. The goals of epidemiology are to prevent or limit the consequences of illness and disability in humans and maximize their state of health.

Scope of Epidemiology

The Science of epidemiology emerged from the need to determine the cause of disease conditions so that prevention and control measures could be implemented. By observing groups of people rather than individuals, similarities and difference between those who have a health problem and those who don't can be identified. The scope of epidemiology has expanded in recent years from psychosocial problems, occupational injuries, and environmental concerns.

Epidemiologic Model

The basic epidemiologic model used in studying the distribution and determinants of states of health involves interaction of the host, agent, and environment. Host factors include age, sex, race and genetic makeup, nutrition, lifestyle, and motivation. Agents include physical, chemical nutrient, psychological and biologic stressors. Environmental factors can be biologic, physical, and social.



The Epidemiologic Model

The principles of epidemiology are used in planning and evaluating health services. Individual lifestyles and health habits are strong determinants of health and disease. Characteristics that increase the probability that diseases will develop are called risk factors. Programs that enable peoples to control and improve their states of health by reducing risk factors. The process of health promotion, should be based on outcomes of epidemiology.

Levels of Prevention

Prevention of communicable and non-communicable diseases can be attained at three levels: primary, secondary, and tertiary. Primary prevention is aimed at reducing the incidence of disease through health promotion and education by preventing disease before it occurs. Secondary prevention is aimed at reducing prevalence of disease or diminishing its morbidity through early diagnosis and treatment, tertiary prevention is aimed at reducing complications and disabilities related to the disease through treatment and mental and physical rehabilitation.

Disease Surveillance

Surveillance of diseases is an important public health function at both the state and local levels. It should include a continual method of close observation of all aspects of the occurrence and distribution of a disease through systematic collection. Orderly consolidation and analysis, and prompt dissemination of all relevant data. A surveillance system must be current, accurate, complete, purposeful, and dynamic to be useful for planning, implementation, and appraisal of disease prevention and control programs. It requires close communication and cooperation between the local and state agencies. The Kansas Department of Health and Environment maintains an [Office of Epidemiology](#) with a staff of health and environmental epidemiologists whose jobs it is to assist local health departments in disease surveillance. Early involvement of this staff provides a highly valuable resource in investigating and controlling prevalent diseases. (For the address and phone number of the [Office of Epidemiology](#), the [Epidemiologist on call](#), and the [After Hours Pager Number](#), see the KDHE directory.) Another important desktop resource that provides a quick reference to understanding communicable diseases is the [Control of Communicable Diseases Manual](#) that is available from the American Public Health Association (see address below).

Objectives of Surveillance System include:

- Estimate the magnitude of a health problem
- Understand the natural history of a disease of injury
- Detect epidemics and evaluate control strategies
- Describe the distribution and spread of a health event
- Test hypotheses about etiology
- Monitor isolation activities
- Detect changes in health practices

Data Sources

Any health-related information that has been compiled about a group of people can be a source of data used to describe the distribution and determinants of health. Epidemiologic data sources include but are not limited to: disease registries, health care institutions, insurance companies, industries, private physician offices, accident and police records, surveys, vital statistics maintained by the Kansas Department of Health and Environment, and schools.

Investigation

In order to accomplish a timely investigation, an active surveillance system must be in place. A method of having regular and timely contact with other health related agencies, doctors' offices, and with schools located in the jurisdiction of the local health department is helpful in identifying disease outbreaks. The first step in investigation the occurrence and distribution of health concerns is to describe the magnitude of the problem and the characteristics of the people who have or do not have the illness in terms of person, place, and time. It is important to attempt to identify the source of the disease and all persons exposed to the source of the disease and all persons exposed to the source or to a person who contracted the disease from a secondary source. Tools are available on the KDHE [Infectious Disease Epidemiology and Response](#) for investigating communicable diseases.

Tools for certain other communicable diseases may be found in the following manuals produced by KDHE:

["Control of Enteric Disease Outbreaks in Daycare"](#)

["Food borne Disease Outbreak Investigations"](#)

Data Analysis

Data must be analyzed in order to determine whether or not there is a health problem, and if so, the extent of the problem. The primary measurement used to describe either the existence of a problem or the occurrence of a problem is the rate. Rates are ratios that measure the quantity of a health related

event in a specific population with a given time period. For information on how to calculate rates and for other epidemiology methods, see the Harkness reference listed below.

Disease Reporting

Requirements for disease reporting in the U.S. are mandated by state laws and regulations. Reporting to the Office of Epidemiology should occur immediately upon identification of the outbreak. In Kansas, physicians, nurses, hospitals, and laboratories are mandated to report to the Local Health Officer and/or the Office of Epidemiology. Kansas Statutes provide immunity for those who report and confidentiality for those who are reported. The list of reportable diseases in each state differs. PLEASE NOTE: OUTBREAKS OF ANY DISEASE ARE REPORTABLE.

[Kansas Reportable Disease List](#)

Case Definitions

When identifying cases of any communicable disease, it is important that the cases meet the "Case Definition" as established by CDC and the Council of State and Territorial epidemiologists. Do not hesitate to report any suspected case to the Office of Epidemiology; the epidemiologists will assist you in determining whether or not a case meets the definition. Case Definitions may be found in the MMWR Recommendations and Reports, May 2, 1997, Vol. 46, No. RR-10 or you may obtain a copy from the Office of Epidemiology. The following are several other definitions of terms used in case classifications:

Clinically compatible case: A clinical syndrome generally compatible with the disease, as described in the clinical description.

Confirmed case: A case that is classified as confirmed for reporting purposes.

Probable case: A case that is classified as probable for reporting purposes.

Suspected case: A case that is classified as suspected for reporting purposes.

Laboratory confirmed case: A case that is confirmed by one or more of the laboratory methods listed in the case definition under Laboratory Criteria for Diagnosis.

Epidemiologically linked case: A case in which the patient has had contact with one or more persons who either have/had the disease or have been exposed to a point source of infection (i.e., all cases linked with the same source in a food borne outbreak) and in which transmission of the agent by the usual modes of transmission is plausible.

References

Benenson, A.S. (Ed.) (1995). Control of Communicable Diseases Manual. 16th Edition. Washington, DC: American Public Health Association.

Centers for Disease Control. (1997, May). MMWR: Recommendations and Reports. Vol. 46: RR10. Atlanta, CA: Author.

Harkness, Gail A. (1995). Epidemiology in Nursing Practice. St. Louis: C.V. Mosby, Co.

Stanhope, M. & Lancaster, J. (1996). Community Health Nursing: Promoting Health of Aggregates, Families, and Individuals. 4th Edition. St. Louis: C.V. Mosby, Co.

To obtain copies of Control of Communicable Diseases Manual. ISBN # 0-87553-182-2:

Address: American Public Health Association
Publication Sales
PO Box 753
Waldorf, MD 20604-0753

Web Page: <http://thenationshealth.aphapublications.org/content/40/4/3.2.full?sid=2b11a966-8b04-435f-b5d4-f42938931cf5>

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CDC Universal Precautions Recommendations

General Recommendations

- All health care workers should routinely use appropriate barrier precautions to prevent skin and mucous membrane exposure when contact with blood or other body fluids of any patient is anticipated. These barriers include gloves, masks, protective eyewear, gowns or aprons according to risk of exposure for the employee.
- Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands should be washed immediately after gloves are removed.
- All health care workers should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures.
- Although saliva has not been implicated in HIV transmission, to minimize the need for emergency mouth-to-mouth resuscitation. Mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which there may be a need for resuscitation.
- Health care workers who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.
- Pregnant health care workers are not known to be at greater risk of contracting HIV infection than health-care workers who are not pregnant; however, if a health-care worker develops HIV infection during pregnancy, the infant is at risk of infection resulting from perinatal transmission. Because of this risk, pregnant health care workers should be especially familiar with and strictly adhere to precautions to minimize the risk of HIV transmission. Pregnant laboratory employees are to report a possible or confirmed pregnancy to their supervisor according to the laboratory safety policy.

Gloves

Gloves must always be worn when touching blood or other body fluids to which universal precautions apply. Gloves should be worn when touching contaminated instruments or surfaces. Gloves that have been contaminated should be removed as soon as possible. **Do not reuse gloves.** Dispose of contaminated gloves in leak-proof containers.

Hands should be thoroughly washed before gloving and after removing gloves, and immediately after contamination with blood, other body fluids, or articles contaminated by blood or body fluids that require universal precautions.

Masks and Protective Eyewear

Masks and protective eyewear should be worn when splashing of blood or other body fluids that require universal precautions is likely to occur.

Gowns

Gowns should be worn when soiling from blood or other body fluids that require universal precautions is likely to occur.

Needles/Instruments

Used needles should not be recapped, bent or broken by hand, removed from disposable syringes, or otherwise manipulated.

Disposable needles and syringes, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal. Puncture-resistant containers should be located in the use area.

Instruments that penetrate tissue should be sterilized after each use. Those that do not penetrate tissue may receive high-level disinfections.

Clean-up and Disposal

Countertops, work areas, and surfaces soiled with blood or body fluids that require universal precautions should be disinfected with an EPA-approved germicide or a 1:10 solution of household bleach. Gloves should be worn while cleaning the areas. "International orange" plastic bags should be available for removal of contaminated items. For disposal of infectious waste in Kansas, see K.A.R. 28-29-27.

Soiled clothing and linen should be handled as little as possible and with minimum agitation. All soiled linen should be placed in leak-proof bags at the location where it was used. Personnel involved in the bagging, transport, and laundering of contaminated linen and clothing should wear gloves. Normal laundry cycles with detergent should be used.

References

Centers for Disease Control (1998). "Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Blood Borne Pathogens in Health Care Settings." MMWR. 1988: 37(24): 377-88.

Centers for Disease Control (1989). "Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health Care and Public Safety Workers." MMWR. 1989:38(S-6).

See Administrative Section this manual for Blood borne Pathogen Standard.

Infant, Child, and Adolescent Health Assessment

[Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents](#), is a guide for provision of health services. "Bright Futures® is a set of principles, strategies and tools that are theory based, evidence driven and systems oriented that can be used to improve the health and well-being of all children through culturally appropriate interventions that address their current and emerging health promotion needs at the family, clinical practice, community, health system and policy levels" (Hagan J.F., Shaw J.S., & Duncan P.M., 2008, p. ix). The standard of practice for health supervision and provision of services to infants, children and adolescents is the same regardless if a child is on HealthWave 19 (Medicaid), HealthWave 21 (State Children's Health Insurance) and private insurance or has no coverage.

Components of the Health Assessment

A comprehensive child health assessment includes: health history; physical examination; and vision, hearing, dental, nutrition and physical activity, speech and language, and development screens. The child's immunization status is reviewed and, if needed, vaccine administered. Laboratory tests are used to screen for lead levels and anemia, with other done as the history and exam indicate. Anticipatory guidance and referral for treatment including the development of a follow-up plan complete the health assessment.

Child health assessments are provided by physicians, Advanced Registered Nurse Practitioners (ARNP) and professional registered nurses (RN) for children 0-21 years of age. Professional registered nurses are employed in public health departments, schools and day care centers, private physician offices, state institution and agencies, and private nursing practice. Health assessment is not within the scope of practice of a Licensed Practical Nurse (LPN). LPN's can perform many of the screening components within the assessment but the professional registered nurse, ARNP or physician must complete referral recommendations and develop a health supervision plan in collaboration with the family or guardian based on sound medical theory and professional practice.

Registered nurses seeking KBH certification to conduct KAN Be Healthy EPSDT screens should have graduated from a nursing program requiring a physical assessment course. Although a pediatric assessment course would be ideal, an adult assessment course provides a base of knowledge for the independent-study certification course. Nurses with little pediatric assessment experience are encouraged to seek out a colleague that can serve as a mentor and offer guidance/supervised clinical practice of skills during the self-study course.

Process for Kan-Be-Healthy Certification or the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program

Effective July 1, 2009, the KAN Be Healthy (KBH) registered nurse (RN) training program through Washburn University transferred to the [Kansas Health Policy Authority](#) (KHPA). **Nurses wanting to be KBH certified need to do the following:**

- **KBH Physical Assessment Certification (required)**
It is recommended that only registered nurses who have had a basic undergraduate physical assessment course utilize the independent study program. Nurses can access the [KBH Manual](#).
 - ✓ The registered nurse is to study the manual
 - ✓ When ready to take certification test, contact [the KHPA Medicaid and HealthWave Senior Manager at 785-296-3982](#). A copy of the test will be faxed to the nurse wanting to take the test as well as instructions for faxing the test back to KHPA.
 - ✓ Once the test is received at KHPA, the test is graded and if passed, KBH certification is given through KHPA.

- **Hearing Screening Certification (required)**
Hearing screening certification is required once for registered nurses to provide hearing screening as under KSA 72-1204. This assures that nurses are screening according to accepted guidelines.

[Hearing screening certification courses](#) can be found through the University of Kansas Medical Center (KUMC) Area Health Education Centers website. [Hearing Screening Guidelines and Resource Manual](#) provides requirements in school and early childhood programs.

- **Vision Screening & Assessment Certification (recommended)**

[Vision screening certification](#) is not required, but is highly recommended to assure that nurses can provide vision screening for diverse ages and populations of children and adults. Vision screening certification courses can be found through the University of Kansas Medical Center (KUMC) Area Health Education Centers (AHEC).

References

Hagan J.F., Shaw J.S., & Duncan P.M. (2008). *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition. Elk Grove Village, IL: American Academy of Pediatrics.

KUMC AHEC
1501 S. Joplin Avenue/PO Box 296
Pittsburg, KS 66762-0296

Telephone: 620-235-4040
Fax: 620-235-4041
Website: <http://kuahec.kumc.edu/>

Local Health Department/Correctional Facility Issues

In the past fifteen years correctional facility health care services have literally transformed from basic emergency maintenance to complex and comprehensive total care including ancillary services such as dental, orthopedic, prenatal, and inpatient-convalescent care. In addition to burgeoning health care costs and increased inmate populations, correctional facilities must also confront nationwide nursing shortages, escalating salaries for technical medical personnel, the AIDS epidemic, new legislation, heightened regulation, and standards of care. In many cities, correctional facilities have become the caretakers in the community, the medical shelters and barometers by which we judge the level of caring and compassion.

In many states including Kansas, local correctional facilities (city and county) are autonomous and under the direction of the sheriff or director of the local facility in question. The state agency, Kansas Department of Corrections (KDOC) only has jurisdiction over the state correctional facilities and parole offices. Operational responsibility of local facilities is frequently delegated or contracted to a city, county, or private health services provider, thus many local health departments have become involved with inmate care to perform a variety of duties often with no standard guidelines or contracts.

A primary concern in this area is protecting the nurse personally and professionally. Without standards or contracts, responsibility can become an extremely gray area. There must be a clear understanding of who is in charge of health care in the facility and it is **not** the local health department nurse.

Written memoranda of understanding with clearly defined lines of authority and communication, defined roles and responsibilities for medical and custody programs and personnel, and an orientation program for all new staff must address, among other things:

1. The distinct yet mutually supportive roles of medical and custody staff
2. Security policies and procedures
3. Special needs of the health services program (e.g., confidentiality of medical information).

Nurses providing services to prison inmates should ask themselves the following questions:

- Is there a written signed contract?
- Is there extra reimbursement for this service?
- Is it specifically listed in my current job description?
- Do I have a job description?
- Are there standardized protocols?
- Who is ultimately in charge of inmates' health care?
- Who is responsible to whom?
- What about weekends or after hours? Vacations?
- What about liability?

Growing concerns in litigation include lack of access to health care services, and disregard of physician's orders by both medical and custodial personnel. For example, dispensing medications—who does it, under whose supervision, under what circumstances—is often raised in litigation. At the same time, inmates have a right to refuse medical care unless that refusal poses a threat of serious bodily harm.

These clients are "high risk" for several reasons: 1) most are not in good health or physical condition; 2) many are mad at the world, and particularly at those whose name or face they can remember; 3) they have time on their hands, time to plan and write letters; 4) they may have devious reasons for complaining, i.e., wanting out, in, moved, or attention.

Historically in the smaller institutions, correctional facilities health services personnel have been assigned functions without regard to their legal parameters of professional practice as defined by individual professional license provisions and common practice in the health care community. These practices are no longer acceptable as courts insist on qualified licensed, competent health care personnel working within

their scope of practice in correctional health care programs. These personnel can be held personally liable, risk the loss of their licenses, and leave their employer open to the very real hazard of being sued for their acts and omissions. And if county health department personnel, (i.e., nurses), are sued, the county government employer, (i.e., county commissioners) is likely to be named in the suit also. Thus, it becomes even more important to be aware of current "scope of practice" regulations (i.e., the Nurse Practice Act).

There are, however, some specific advantages to county/city health agency operated programs. These include management by health care professionals oriented toward public health service delivery, who know county/city resources and have established linkages with other services in the community such as substance abuse programs, social services, nutritional services, etc. Also there may be enough personnel within the system to provide back-up coverage. Negative aspects include the fact that the correctional facility will not be the only or top priority, and often they are the provider of last resort and unwilling or unenthusiastic about providing the service.

The American Medical Association has written a set of "Standards for Health Services in Jails" to bring medical resources into a facility for routine care and allow for transferring out inmates with extra-ordinary needs. This standard is not mandatory but should provide a local facility with some guidelines in order to set up specific policies. Completion of this task is the responsibility of the person in charge of the facility, not the public health nurse who may be providing services. A copy of the American Medical Association Standards should be available through KDOC, Landon state Office Building, Suite 404N, 900 SW Jackson, Topeka, KS 66612-1284. Materials are also available through the National Institute of Corrections, 1860 Industrial Drive, Longmont, CO 80501.

References

AMA Standards for Health Services in Jails (1980, July). "AMA Program to Improve Medical Care and Health Services in Jails Reference Guide and Practical Workbook."

Arizona Department of Corrections Quality Assurance Plan (1988). AZ Department of Corrections, Health Services Bureau.

Jail Medical and Health Care Services: Relevant National Standards for Inclusion in Policies and Procedures. Prepared by Martin Drapkin, Director, Jail Policy Consultants, PO Box 9062, Madison WI 53715.

State of California Board of Corrections. Guide to Planning and Evaluating Inmate Medical/Mental Health Services. Prepared by Norman & Cotton Associates, Inc.

Nursing Models

School Nursing

School nursing developed in our country shortly after the turn of the century as an outgrowth of the public health movement at the time and as an extension of public health nursing into the schools for the purpose of both communicable disease control and to assure that children were healthy and attending school. Given their direct access to children, families and school personnel, school nurses are in a unique position and have the skills and knowledge to improve children's health and their ability to learn. Changes in society, structure of the family, special education legislation, and changes in the health care and educational systems have increased the need and demand for health services and clinical nursing services in schools.

The school setting is a venue for the delivery of health services and educational health promotion and prevention programs that are population-based. In Kansas, educational services are provided to children in Infant-Toddler Programs, early childhood programs, at-risk 4-year old programs, Early Head Start and Head Start, residential schools for the deaf and blind, alternative schools, private and parochial schools, as well as the public school system. The potential for provision of health-related screenings, services and education for this population is notable as the birth to age 18 population comprises 28 percent of the Kansas population (KIC, 2010) <http://kic.kdhe.state.ks.us/kic/Populate.html>

There are statutes and regulations designed to assure that students receive minimal health screening, have competent personnel to meet health needs and provide information that school districts can use to develop policy. Information about the statutes and regulations pertinent to school health services are found on page 142 of *Kansas Health Services Manual: Maternal and Child Health* http://www.kdheks.gov/c-f/downloads/MCH_Manual.pdf

Services Provided by School Nurses

The primary role of the school nurse is to support student learning. The nurse accomplishes this by implementing strategies that promote student and staff health and safety. As the health services expert, the school nurse serves as the health professional for the school community and provides services to support learning. Health services provided in a school can include the following:

- Assessment and interventions for students with mental health concerns
- Pediatric nursing procedures that may include ventilators, gastrostomy feedings, tracheotomy care, catheterization
- Transmitted diseases, tobacco use and alcohol and substance abuse
- Chronic disease management and education
- Individualized Healthcare Plans and services for students with disabilities and/or health conditions that interfere with learning
- Medication administration and monitoring
- Crisis team participation
- Health curriculum recommendations
- Guidelines for school district health policies, goals and objectives
- School/community/health care provider liaison
- Provide school health/nursing expertise at community, state and national levels to promote initiatives and policy development

Resources for Provision of School Health Services as Contracted Provider

There are resources available that are useful in providing school nurse services. These resources include:

- Guidelines for Medication Administration in Kansas Schools. (2010). http://www.kdheks.gov/c-f/downloads/2010_GUIDELINES_FOR_MEDICATION.pdf

- Hearing Screening Guidelines and Resource Manual. (2004). <http://www.ksde.org/LinkClick.aspx?fileticket=BU9hNBDF2N0%3D&tabid=3757&mid=8918>
- Kansas Health Services Manual: Maternal and Child Health. (2009). *Guidelines for School Health Services*. Kansas Department of Health and Environment, Bureau of Family Health, 136-144. http://www.kdheks.gov/c-f/downloads/MCH_Manual.pdf
- National Association of School Nurses Web page. <http://www.nasn.org/>
- School Health Resources. Web page provides access to documents, forms, and additional resources. <http://www.kdheks.gov/c-f/school.html>
- School Nurse Manual: Guidelines for Nursing Management of Students with Chronic Disease or Health Conditions in School Settings. (2007). http://www.kdheks.gov/c-f/downloads/School_Nurse_Chronic_Disease_Manual.pdf
- Vision Screening Guidelines: For Infants, Toddlers, Children and Youth. (2004). <http://www.kdheks.gov/bcyf/download/VisionGuidelines2004.pdf>

Kansas Nurse Practice Act and School Nurse Practice

Kansas Board of Nursing regulates the Nurse Practice Act regardless of the setting. Delegation - The transfer of responsibility for the performance of an activity from one individual to another, with the former retaining accountability for the outcome (ANA, 1994).

- K.A.R. 60-15-10 definitions
- K.A.R. 60-15-102 delegation procedures
- K.A.R. 60-15-103 supervision of delegated tasks
- K.A.R. 60-15-104 administration of medications in the school setting

The Kansas Board of Nursing, in partnership with the Kansas Department of Health and Environment and the Kansas School Nurse Organization, has created *Delegation of Specific Nursing Tasks in the School Setting for Kansas Grid* to assist registered nurses in determining what nursing tasks may be delegated and to whom. The grid is found on page 25 of the guidelines at http://www.kdheks.gov/c-f/downloads/2010_GUIDELINES_FOR_MEDICATION.pdf

The Kansas Nurse Practice Act is an essential document for public health nurses and should be consulted with any question related to nursing practice in any setting. The regulations for school nursing practice, as well as other practice settings and nurse licensure/certification levels can be accessed at <http://www.ksbn.org/npa/npa.htm>

Delivery of School Health Services

School health services are needed by students whether or not there's a health professional in the school. Access to education and extra-curricular activities is needed regardless of health status. There are considerations for health service provision that need to be based on the following:

- Increased complexity of health care needs of students
- Increase in students not eligible for insurance
- Children and families who do not have access to health care, including dental services
- Federal and State statutes and regulations for health services and health screenings
- Early introduction of preventive health services and health promotion activities

In Kansas, securing a health professional to meet the aforementioned needs is at the discretion of school districts and based on how the district wishes to appropriate their funds. Many school districts, but not all, have secured the services of a professional registered nurse to oversee health services in the school district. These services may be provided on a full or part-time basis by a nurse with the school district or by a nurse contracted through a local clinic, hospital or health department. Contracting with local health

departments for school nurse services is an option for local school districts. Consideration of statutes, regulations, the Nurse Practice Act, and the role of a school nurse are important in assuring that both the needs of the students in schools are being met by the contracting agency.

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Kansas Health Services Manual: Maternal and Child Health. (2009). Guidelines for School Health Services. Kansas Department of Health and Environment, Bureau of Family Health: Topeka. http://www.kdheks.gov/c-f/downloads/MCH_Manual.pdf

Parish Nursing

The Church has always been a source of hope and healing, the place where people turn in time of need. In the Early Church, deacons, church workers, and women were providers of health care, with a commitment to the whole person (Beal). Over the years, with the establishment of institutions to care for the ill, the availability of health insurance, and the recognition of health care as a business, churches relinquished their health and healing ministries to secular agencies (Matthaei & Stern).

The modern concept of congregation-based health ministries was founded in the U.S. as recently as 1983 by Dr. Granger Westberg, a Lutheran Pastor who served as a hospital chaplain at Lutheran General Hospital in Chicago (Beal). Parish nursing, the fastest growing specialty nursing practice and the fastest growing lay ministry in the church, best exemplifies the delivery of wholistic care, physical, emotional, mental, and spiritual. With congregational support, the health ministry of the parish nurse fulfills the church's mission to its members and to the community. It extends into the community system and collaborative with other community health agencies as well as with the public health department.

The goal of the parish nurse program is to help individuals from church populations stay well, to bring the church to the individual member and families in times of need, to create a feeling of deeper caring within the church membership, and to bring Christ to those in physical, mental, emotional, and spiritual distress. The parish nurse, a registered professional nurse, brings her knowledge and professional experience into her service to Christ. Because of the different professional backgrounds of parish nurses and the demographics of the church, each health ministry is unique to the congregation in which it exists.

Parish nurses assess congregation for distribution of age groups, church setting, general socio-economic of church members, health status and health needs. They serve all ages, socio-economic, and ethnic groups in their church (Mikulencak). Parish nurses work in a team ministry with the Pastor, consulting, making referrals, visiting patients/families, and praying for the sick. The parish nurse also works as a coordinator with other health care professionals and laypersons as they work in teams to provide needed care. The nurse is often a calm and prayerful presence in a family crisis and often is called on to find needed health related resources. For those who cannot be cured, parish nurses offer a healing of the spirit for patient and family.

The parish nurse, an integrator of faith and health, accomplishes the tasks through five major roles. These include serving as health educator, health counselor, health promoter, recruiter and trainer of volunteers, and a referral resource. It is important to emphasize that parish nurses do not generally provide invasive or direct hands on physical care. Parish nurses do not provide home health care. Rather the nurse finds appropriate needed resources, i.e., an established home health agency. It is notable, however, that as resources become scarce, parish nurses are asked with increasing frequency to provide home care. Most parish nurses are also employed as full time nurses in a health care agency, serving on a part-time, volunteer basis in the church, and would not have time to provide 24 hour, 7 day a week service. Medical supplies and liability are also two reasons that the parish nurse is not in a position to provide home health care.

Care provided is documented and information obtained, whether written or verbal, is confidential. Parish nursing practice is governed by the State Nurse Practice Act, the American Nurse's Association Code of Ethics and the Scope and Standards of Parish Nursing, and the HIPAA Act.

The models of parish nursing are either church-based or institutional bases, i.e., hospital, nursing home, or other community agency. Nurses may be a salaried or unsalaried and they may serve on a full-time or part-time basis. Most parish nurses are part-time and they volunteer their services. In a few instances, churches may contract with a nurse for specific services for which she is paid.

A Health Board or Cabinet should be established within the church structure to assist in the development and maintenance of the health ministry, support and advise the nurse(s), and to collaboratively plan new and ongoing programs. The Health Board is composed of other health care professionals in the church, as well as other interested persons. Usually five to nine people make up this working group. The Board members may also assist with preparing the budget for the parish nurse ministry program (Westberg and McNamera).

Considering today's trends toward managed care, per capita reimbursement, and decline in government supported research programs, all efforts that support wellness in our communities are welcome. Churches, through the use of health and healing ministries, are active contributors to this goal.

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- Westberg, G. & McNamara, J. (1987). The Parish Nurse. Park Ridge, IL: Parish Nurse Resource Center.

Resources

Kansas Parish Nursing: <http://www.kansasparishnurseministry.com/>

The American Nurse Association In collaboration with the Health ministries association: <http://parishnurseministry.net/>

Journal of Christian Nursing
PO Box 7895
Madison, WI 53707
608-274-4823
email: ncf@ivc.org

Health Ministries Association
980 Canton St. Bldg 1, Suite B
Roswell, CA 30075
800-280-9919
770-640-9955
770-640-1095 (fax)
email: hmassoc@mindspring.com
<http://www.healthministriesassociation.org>

Environmental Nursing

Environment health concerns, the historical development of the nursing profession and core nursing values all fit together for the environmental nurse. Early in the nineteenth century, Florence Nightingale emphasized that the nature and quality of the patient's physical environment are determinants of the patient's recovery of health. As nursing evolved, however, more emphasis was placed on other types of social relationships and their impact on human health.

Environmental issues have mushroomed, however, so that today the environment is considered as one of the primary determinants of individual and community health. Environmental health refers to freedom from illness or injury related to exposure to toxic agents and other environmental conditions that are potentially detrimental to human health. Its practice is interdisciplinary. Environmental hazards are ubiquitous, insidious, and often poorly understood. They may be sentinel disease or involve the entire community or they may be small nuisance or pollution issues. The key is having a potential detrimental effect on the health of a population. Exposures occur in the home, work place, and community.

Nurses are well positioned for addressing environmental health concerns of individuals and communities. They are the largest group of health professionals, have greater variety in their settings and locations of practice, environmental health fits with values of the nursing profession regarding disease prevention and social justice, and nurses are trusted by the public. Nurses are often the first point of contact, talk in-depth with patients and frequently provide on-site care. Assessment and appraisal of the population, including environmental health, is a core function of public health nursing.

Environmental nursing can easily be considered a specialty, and several other closely related specialties do exist. All nurses, however, should have an increasing environmental health awareness and content, regardless of their particular practice or educational preparation. For example, maternal and child health nurses screen children who may have been exposed to residential lead-based paint or pesticides on farms; emergency room nurses see individuals exposed to toxic wastes or environmental poisons, occupational health nurses may screen for workplace exposures, and pediatric nurses might link childhood illnesses to toxins transported from a parent's workplace to the home. Any nurse caring for economically disadvantaged patients should be aware that these populations face increased risk of exposure to hazardous pollutants.

The 1994 IOM report which dealt specifically with environmental nursing practice produced a set of general **environmental health competencies for nurses** which extend but are continuous with, nurses' existing roles as investigators, educators and advocates.

I. Basic knowledge and concepts

All nurses should understand the scientific principles and underpinnings of the relationship between individuals or populations, and the environment (including the work environment). This understanding includes the basic mechanisms and pathways of exposure to environmental health hazards, basic prevention and control strategies, the interdisciplinary nature of effective interventions, and the role of research.

II. Assessment and referral

All nurses should be able to successfully complete an environmental health history, recognize potential environmental hazards and sentinel illnesses, and make appropriate referrals for conditions with probable environmental etiologies. An essential component of this is the ability to access and provide information to patients and communities, and to locate referral sources.

III. Advocacy, ethics, and risk communication

All nurses should be able to demonstrate knowledge of the role of advocacy (case and class), ethics, and risk communication in patient care and community intervention with respect to the potential adverse effects of the environment on health.

IV. Legislation and regulation

All nurses should understand the policy framework and major pieces of legislation and regulations related to environmental health.

Occupational Nursing

Occupational nursing is environmental nursing in the workplace. Nurses are by far the largest group of health professionals providing care in occupational settings. This proximity to the workplace enables nurses to identify and initiate measures to remediate workplace hazards if adequately educated to do so. Nurses must also recognize their professional obligation to advise employers and employees of real or potential hazards and where necessary to initiate steps to control or eliminate hazardous conditions.

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LEGAL ASPECTS OF PUBLIC HEALTH

Public Health Law

The reach of public health law is as broad as the reach of public health itself. Public health and public health law expand to meet the needs of our society. At the turn of the century, public health and its legal regulation covered the prevention of communicable disease and environmental sanitation, which included some concern for water purity and housing hygiene, limited interest in food and milk sanitation, some incipient school health controls, and very little else. Today, the field has expanded to encompass enlarged and more sophisticated concerns for physical and mental health, including vast new systems of social insurance to provide for the medical care of the aged (Medicare) and the “medically indigent” (Medicaid); broad environmental concerns such as the control of air and water pollution, conventional waste, toxic and hazardous waste, and pollution by ionizing radiation; the control of food, drugs, and a variety of aspects of human reproduction; population control; and the control of the uses of addictive substances such as alcohol, drugs, and tobacco.

1. The Relationship Between Public Health and the Law

The professions of public health and public health law have changed and expanded, not only in the subject matter covered, but also in the nature of their work. The programs that existed at the turn of the century were almost exclusively regulatory—that is, they told industry and people what to do and what not to do. Public health and public health law today do a great deal more. Although many public health programs are regulatory, most are service oriented. They seek to enhance public health not only by prohibiting harmful activities or conditions but also by providing preventative and rehabilitative services to advance the health of people, instead of regulation. Policing, and prohibiting unwholesome conduct or conditions, public health and public health law provides services to create a more healthful environment and provide the facilities and the trained professionals to prevent disease, to treat disease, to educate people, and to improve conditions.

The expansion and development of the field of public health rely on law. No single service or regulatory program of public health exists without legal authorization. Law is essential to public health because public health programs are entirely dependent on *legislative* authorization. Any doubt on that score can be readily resolved by looking at the authorization or appropriation for any health related activity. Any remaining doubts may be set to rest by examining the provisions of the U.S. Code that deal with public health, the public health law of any of the 50 states, and the provisions of local codes and ordinances that deal with matters of health and safety. It is an impressive, all-encompassing legal structure. It must be extensive because every public health activity must find its origins in some part of that legal aggregate.

2. Bases of Authority for Public Health Programs and Activities

Governments—federal, state and local—exercise great powers in the field of public health. Because of the nature of our federal system of government, public health law has an origin at the state and local levels different from its basis in federal law.

Source of State and Local Power

In the states, government authority to regulate for the protection of public health and to provide health services is based on the “police power”—that is, the power to provide for the health, safety and welfare of the people. It is not necessary that this power be expressly stated, because it is a plenary power that every sovereign government. For purposes of the police power, the state governments—which antedate the federal government—are sovereign governments. It might be added that the exercise of the police power is really what government is about: It defines the very purpose of government. Thus, on the state level, the power to provide for and protect the public

health is a basic, inherent power of the government. The state also delegates the exercise of the police power to lower levels of government: at the level of divisions of state governments; at the county or parish level; or at the municipal, city, or village level. Many state and local regulatory programs rely on the police power, which includes the promulgation of health and sanitary codes, hospital and nursing home codes, and housing and plumbing codes, as well as health services such as municipal hospital systems and school health services.

Sources of Federal Power

Although public health powers were first exercised at the state and local levels, today the federal government plays a major part in the regulation of public health and the provision of health services. The federal government, unlike the states, is not a government of plenary powers. It only has the powers that the states originally delegated to it through the federal Constitution. It does not have the police power, because a reading of the powers delegated to Congress will show that the police power—to provide for general health, safety and welfare—is not one of the powers delegated.

Federal powers in public health rest largely on the “commerce power,” the power of Congress to “regulate commerce with foreign nations, and among the several States, and the Indian tribes,” under Article I, section 8, Clause 3, of the U.S. Constitution. Public health powers also rest on the so-called taxing and spending power, to “collect taxes...to...provide for the...general welfare of the United States,” under Article 1, Section 8, Clause 1.

The power to regulate interstate commerce allows Congress to regulate whatever passes in commerce between states as well as whatever affects interstate commerce. The interstate commerce power provides authority to Congress, and to the federal government, to regulate *directly* the commercial transactions between the states, as well as everything that passes in interstate commerce. The Federal Food, Drug, and Cosmetic Act furnishes a notable example of the exercise of direct regulatory powers. Under that law Congress has provided for the wholesomeness of food, and for the safety and efficacy of drugs and medical devices sold in interstate commerce. Because large businesses that manufacture and sell foods and drugs generally operate nationwide, the Food and Drug Administration (FDA), by delegation from Congress under the Act, controls or regulates what goes into virtually every bottle of medicine, pill, salve, or ointment. The commerce power involves direct federal regulatory control by a federal agency that promulgates its own regulations pursuant to law and that employs and oversees its own staff of professionals, administrators, inspectors, and other enforcement personnel.

The range of direct federal regulatory activities with public health implications under the commerce power is very broad. It includes, for example, the slaughter of beef and the manufacture of beef products under the Federal Meat Inspection Act and the production, slaughter, and sale of poultry under the Poultry Products Inspection Act. It includes the production and sale of pesticides and other economic poisons under the Federal Insecticide, Fungicide, and Rodenticide Act, as last amended in 1978, the production and sale of toxic substances, under the Toxic Substances Control Act, and the control of unsafe consumer products under the Consumer Product Safety Act. All of the laws and many other involve direct federal controls, and all of them, in their legislative findings and in their standards, refer to the protection of health as their main purpose.

Other federal legislation—for example, that relating to wages and hours of workers under the Fair Labor Standards Act, and the health and safety conditions under which work is performed under the Occupational Safety and Health Act (OSHA)—were enacted under the commerce power and have far-reaching implications for public health.

Kansas Public Health Statutes and Regulations

State public health statutes are enacted by the state legislature. Regulations, on the other hand, are set by administrative agencies, such as the Kansas Department of Health and Environment. The legislature generally delegated authority to administrative agencies to establish regulations that support statutory policies.

State statutes including those pertaining to public health are referenced in [Kansas Statutes Annotated](#), and state regulations are referenced in [Kansas Administrative Regulations](#). These references may be found in government offices, libraries, law offices, and law libraries. In addition, individual city, county, and township ordinances are referenced at local libraries and government offices.

For current reference regarding Kansas public health laws, each county public health office is encouraged to obtain and maintain the manual, [A Selection of Kansas Public Health Statutes and Regulations](#), published by the Kansas Public Health Association (KPHA) and the Kansas Department of Health and Environment. The manual is available from KPHA headquarters.

The following list highlights some frequently referenced Kansas public health statutes:

- | | |
|------------------|---|
| K.A.R. 28-1-5 | States that "when conditions of isolation and quarantine are not otherwise specified by regulation, the local health officer of the secretary of health and environment shall order and enforce isolation and quarantine of persons afflicted with or exposed to infectious or contagious disease." That same regulation sites the "isolation or quarantine shall be ordered in conjunction with investigation of infectious or contagious disease cases and outbreaks for the examination of person reasonably suspected of having these diseases, and to obtain specimens form these persons for laboratory evidence suggestive of infectious or contagious disease." |
| K.S.A. 47-125 | Impoundment of biting animal |
| K.S.A. 65-118 | Reporting of contagious diseases; immunity from liability, confidentiality of information; disclosure |
| K.S.A. 65-126 | Gives Secretary of KDHE authority to "quarantine any area in which any of these diseases may have a tendency to become epidemic" and implies that the same power is give to the local health officer. |
| K.S.A. 65-129 | Reinforces the authority of the local health officer to establish a quarantine |
| K.S.A. 65-159 | Duties and powers of local health officers in contagious diseases |
| K.S.A. 65-163 | Public water supply systems |
| K.S.A. 65-201 | Local boards of health; local health officers |
| K.S.A. 65-241; | |
| K.S.A. 65-242 | State financial assistance to local health departments |
| K.S.A. 65-6001 - | |
| K.S.A. 65-6007 | AIDS/HIV |
| K.S.A. 72-5214 | Health assessment at school entry |

[CHILD ABUSE \(web link\)](#)

In Kansas, physical, mental, or emotional abuse or neglect means the infliction of physical, mental, or emotional injury or causing of a deterioration of a child and may include, but shall not be limited to:

1. Failing to maintain reasonable care and treatment
2. Negligent treatment or maltreatments
3. Exploiting a child to the extent that the child's health or emotional well-being is endangered

A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not, for that reason, be considered a negligent parent. However, this exception shall not preclude a court from entering an order.

NOTE: Abuse and neglect statutes do not differentiate between accidental and no-accidental injury, nor is there any provision to exclude spanking from application of Kansas statutes. A child is defined as any child under age 18. The reporter does not have to determine if child abuse or neglect exists-only that there is reason to believe or suspect such concerns. Other children in need of care means a child less than 18 years of age who:

1. is without adequate parental care, control, or subsistence and the conditions are not due solely to lack of financial means of the child's parents or other custodian.
2. is without the care or control necessary for the child's physical, mental or emotional health
3. has been placed for care or adoption in violation of law
4. has been abandoned or does not have a known living relative
5. is not attending school as required by K.S.A. 72-1111 and amendments thereto.
6. while less than ten years of age, commits an act that if done by an adult would constitute the commission of a felony or misdemeanor as defined by K.S.A. 21-3105 and amendments.

Sexual Abuse

The exploitation of a child sexually includes fondling, salacious language, forced sexual touching, sodomy, intercourse, and other sexually stimulating activities such as porno photograph and exhibitionism.

Who Shall Report

1. Persons licensed to practice healing arts or dentistry
2. Persons licensed to practice optometry
3. Persons engaged in post-graduate training programs approved by the Board of Healing Arts
4. Certified psychologists
5. Licensed professional or practical nurses examining, attending, or treating a child
6. Teachers, school administrators, or other employees of a school which the child is attending
7. Chief administrative officers of medical care facilities
8. Child care facilities and employees where care is being provided to the child
9. Licensed social workers
10. Fire fighters
11. E.M.T.s
12. Law enforcement officers

Penalty for not Reporting

K.S.A. 38-15-22: Willful and knowing failure to make a report required by law is a Class B misdemeanor. Punishable up to a fine of \$1,000 and six months imprisonment.

Prohibition from Imposing Sanctions on Employee Making Reports

No employer shall terminate the employment of, prevent or impair the practice or occupation of, or impose any sanction on any employee because the employee made an oral or written report. Violation of this section is a Class B misdemeanor.

Immunity from Liability

Anyone participating without malice in making an oral or written report to law enforcement or the Department of Social and Rehabilitation Services (SRS) relating to an injury inflicted upon a child less than 18 years of age as a result of physical, mental, or emotional abuse or neglect or sexual abuse **shall have immunity** from any liability, civil, or criminal. Any such participant shall have the same immunity with respect to participation in any judicial proceedings resulting from the report. SRS does not reveal the name of the reporter. This information will **only** be revealed upon specific order of the judge (extremely rare).

When are Reports Made?

Reports shall be made when any of the mandated persons has reason to suspect that a child has been injured as a result of physical, mental, or emotional abuse or neglect or sexual abuse. **Report promptly!**

Note: the SRS *Kansas Youth Services Manual* defines "reasonable" as the faculty of the mind by which it distinguishes truth from falsehood and which enables the processor to deduce inferences from facts or from propositions. Reports may be made orally and **shall be followed by a written report if requested** (K.S.A. 38-1522). Report to the SRS district office or law enforcement officials in your area.

Reporting Information Needed by SRS

Every report (in person, by phone, or written) shall contain, if known:

1. Names and addresses of the child and parents or caretaker
2. Child's age
3. Nature and extent of injury (including evidence of previous injuries)
4. Any other helpful information

Reports to Coroner

Children not Attending School

Effective July 1, 1986, children ages 7-13 who are not attending school shall be reported to SRS. Children 13-16 and children under 18 who are receiving Special Education Services and are not attending school shall be reported to the county attorney.

When a Child needs Protective Custody

1. SRS can only take a child into protective custody when a written court order is received. (SRS cannot transport or otherwise take possession of a child without written court order.) To obtain a court order, a child in need of care petition must be filed by the district attorney's office.
2. Law enforcement can take a child into protective custody. If it is their judgment a child is in danger, law enforcement may take a child into protective custody for 48 hours (excluding Saturday, Sundays, and legal holidays). The district attorney has the authority to release the child prior to or at the ending of 48 hours. (If no petition is filed, the child is released.) Law enforcement does not need a court order if the child is in danger. Law enforcement may take protective custody of a child if an order of the court has been made.

Confidentiality

The Kansas Code for Care of Children mandates the confidentiality of all records and reports concerning child abuse and neglect filed with SRS or with law enforcement agencies and sets forth when disclosure of information may be authorized by the Secretary of SRS, the judge of the court where the report is filed, or by the law enforcement agency.

Specific rules on disclosure of all records and reports of child abuse and neglect Section 38-1507, Kansas Code for Care of Children:

1. Records and reports concerning child abuse and neglect shall be disclosed to the court upon the order of any court of record.
2. The judge of the court where the report is filed, the Secretary of SRS, the district manager acting in behalf of the secretary or the law enforcement agency may authorize access to such records and reports to:
 - a. a person licensed to practice the healing arts who has before him or her the child the named in the report whom he/she reasonable suspects may be abused or neglected;
 - b. an agency having the legal responsibility or authorization to care for, treat or supervise the child who is subject of a report record;
 - c. the parent, guardian, or other person(s) named in a report of record with protection for the identity of reports and other appropriate persons;
 - d. police or an other law enforcement agency investigating a report of known or suspected child abuse or neglect; and
 - e. an agency of another state charged with the responsibility of preventing or treating physical or mental abuse or neglect of children within the state, if the state agency requesting the information has standards of confidentiality as strict as or stricter than the requirements of the Kansas Code for Care of Children, Section 7, 38-1507.

Comments on Confidentiality

1. Information may be released to a non-custodial parent if parental rights have not been severed.
2. When a reporter makes a report to SRS, he/she may request a response. SRS is authorized in this instance to inform the reporter of the completion of the investigation. The reporter may be told that the investigation has been completed, the child has been seen, and the safety/welfare of the child ensured (*Kansas Youth Services Manual*).
3. SRS should inform the school administrator when a child is placed in protective custody.
4. SRS may not share information with a school as to whether or not a case is open if the school is not making a report.

Interviewing the Child in a School Environment

SRS guidelines recommend that a child be interviewed at school when a report alleges that a child:

1. has been injured by a parent or caretaker.
2. is fearful that such an injury or further abuse might occur imminently
3. has been sexually abused or exploited.
4. is a victim of serious neglect, the effects of which can be readily observed.

A child may be interviewed at school as authorized by K.S.A. 1982 Supp. 38-1532 Re: Cooperation between school personnel and investigative agencies. Administrators of elementary and secondary schools shall provide employees of SRS and law enforcement access to a child in a setting on the school premises determined by the school personnel for the purpose of the investigation of a report of suspected child abuse or neglect. SRS staff:

1. are expected to contact the designated school administrative staff when requesting an interview.
2. are expected to properly identify themselves.
3. are informed that the school cannot authorize an appropriate person to be present at the interview. This will be left to SRS and law enforcement discretion.
4. are expected to advise school personnel of any immediate action being taken.
5. may interview a child at school without parental consent, (K.S.A. 38-1526 amended).

ADULT ABUSE (Web Link)

There is legislation requiring the reporting of abuse or neglect of certain adults. Adults covered under legislation include "residents" which are all individuals kept, cared for, treated, boarded, or otherwise accommodated in any adult care home. "Adult care home" (as defined by section 29-923) includes any skilled nursing home, intermediate nursing care home, intermediate personal care home, one- or two-bed adult care home, and any boarding care home.

The reporting requirements also extend to adults cared for in an adult family home which is a private residence in which care is provided for not less than 24 hours in any week for one or two adult clients who are not related by blood or marriage within the third degree of relationship to the owner or provider. These residents, by reason of aging, illness, disease, or physical or mental infirmity are unable to live independently but essentially are capable of managing their own care and affairs. Additionally, the reporting requirement applies to any individual kept, cared for, treated, boarded, or otherwise accommodated in a medical facility that is operated by the state or federal government.

The reporting requirements mandatory for any person who is:

1. licensed to practice any branch of the healing arts,
2. a certified psychologist,
3. the chief administrative officer of a medical care facility,
4. an adult care home administrator,
5. a licensed social worker, or
6. a licensed professional nurse or licensed practical nurse.

There must be reasonable cause to believe that a resident is being or has been abused or neglected, or is in a condition which is the result of such abuse or neglect, or is in need of protective services. "Abuse" includes neglect, willful infliction of physical or mental injury, or willful deprivation by a caretaker of services that are necessary to maintain physical and mental health. "Neglect" is defined as the failure of a caretaker to maintain reasonable care and treatment to such an extent that the resident's health or emotional well-being is injured.

The report is to include the following:

1. the name and address of the person making the report;
2. the name and address of the caretaker caring for the resident;
3. the name and address of the involved resident;
4. information regarding the nature and extent of the abuse, neglect, or exploitation;
5. the name of the next of kin of the resident; and
6. any other information, which the person making the report believes, might be helpful in an investigation of the case and the protection of the resident.

Notice of the requirements of this act and identification of the department to which a report is to be made must be posted in a conspicuous place in every adult care home and adult family home in Kansas.

The failure for any person required to report information or cause a report of information to be made, who knowingly fails to make such report or cause such report to be made, will be guilty of a Class B

misdemeanor. This is punishable by a maximum fine of \$1,000 and a term of imprisonment not to exceed six months.

Anyone participating in the naming of a report in any follow-up activity to or an investigation of such report will not be subject to civil or criminal liability unless the person acted in bad faith or with malicious purpose. This immunity also extends to an individual who testifies in any administrative or judicial proceeding arising from the report. Additionally, no employer may terminate the employment, prevent or impair the practice or occupation of, or impose any other sanction on any employee solely for the reason that such employee made or caused to be made a report under this act.

The law now requires licensed nurses and other health care providers to report abuse, neglect, and exploitation of adults not in long-term care facilities in Kansas.

Incident reports must be filed within six hours of discovery and must include the name of the reporter, the name of the abused adult, the nature and extent of abuse, names of any known next of kin, and any other helpful information. Failure to file such a report would be criminal immunity. Furthermore, hospitals are specifically required to permit the SRS access to any records needed for investigation.

If you suspect abuse or neglect of an older person, call:

1-800-922-5330 (Domestic/Community)

Department of Social and Rehabilitation Services

1-800-842-0078 (Nursing Homes)

Department of Health and Environment

Legal Issues in Public Health Nursing

1. Legal Obligations

Public health, community health and home health nurses must be aware of basic legal issues relevant to nursing practice in general, and to public health legal issues specifically. The sources and purposes of public health law must be understood in addition to other statutory, administrative, and common law principles that apply to all nurses. The legal responsibilities of public health nurse vary somewhat from those of nurses working in hospitals.

Public health nursing practice may impose greater legal obligations because of the autonomy enjoyed by persons who are practicing "in the field," where independent judgments must be made. Professional autonomy and accountability demand special attention to legal and ethical dilemmas faced by persons who must establish a professional nurse-patient relationship in community settings. Additionally, the community-based nurse must be aware of the employing agencies' policies and procedures and the differing expectations, of public versus private agencies. Qualified legal immunities may exist for nurses working in public agencies because of the legal principle of sovereign immunity. The nurse in a public agency is the agent of the people, and when the nurse is sued, public funds may be used to settle the claim. Public policy for qualified immunities exists to preserve the public funds. If the nurse is grossly negligent or intentionally causes harm to the client, the nurse does not qualify for this immunity protection.

Public health nurses' legal responsibilities evolve as society identifies patient needs and rights that must be protected. Many advocacy groups have developed to educate the public, including health care providers, about the needs of community-based clients. The public media are also an unlikely, yet ongoing source of information related to problems with the public's health.

Public health nurses must be aware of state and federal statutory laws as well as legal case decisions that pertain to the public's health. Numerous administrative rules and regulations, enacted by state boards of nursing, for example, also relate directly to community health practice.

Legislation and regulations to protect the public's health are primarily enacted by the state governments. However, some federal guidelines exist and are issued through agencies such as the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA). Data collection, analysis, surveillance of programs, and issuance of guidelines are mainly the role of the federal Congress or administrative bodies, including the Public Health Service and the CDC. OSHA requirements relate mainly to providing a safe and healthy working environment for employees.

Public health nurses have the responsibility to become familiar with health codes at both the local and state levels. Orientation to the laws specific to public health nursing should be discussed at the nurse's orientation to employment. If this service is not provided, the nurse must consult with his or her supervisor, local health officer, or the legal counsel for the agency to become familiar with these legal responsibilities. Continuing education programs may be another source for becoming aware of the public health nurse's specific legal obligations. Additionally, common law or case precedence discusses legal issues in the community. These case decisions can also guide the public health nurse's development of an awareness of specific legal obligations.

The nurse working in a public health setting who has questions regarding the legality of procedures that are included in a job description or the scope of nursing within the state would be wise to request that his or her supervisor verify the nurse's role with the attorney general. The attorney general is the official legal counsel for public agencies. If the legal issues are of such concern that the nurse believes his or her liability risks are great, a written formal opinion may be requested from the attorney general's office. It is recommended that the nurse work through the correct channels of communication in the agency to make such a request.

2. Avoiding Malpractice Claims

Nurses can limit their potential liability in several ways. Possibly the first and most important concept to remember is that the patient and the patient's family who are treated honestly, openly, and respectfully and who are apprised of all facets of treatment and prognosis are not likely to sue. Communications done in a caring and professional manner have been shown time and time again to be a major reason why more people do not sue, despite adequate grounds for a successful lawsuit. Even given untoward results and a major setback, the patient is less likely to file suit if there has been an open and trusting nurse-patient relationship or physician-patient relationship. Remember that it is people who sue, not the action or event that triggered a bad outcome.

Second, nurses should know relevant law and legal doctrines, and they should combine these concepts with the biological and psychological, and social sciences that form part of the basis of all rational nursing decisions. The law can and should be incorporated into everyday practice as a safeguard for the health care provider as well as the health care recipient.

Third, nurses should stay well within their areas of individual competence. To remain competent, nurses should upgrade technical skills consistently, continuously attend pertinent continuing education and in-service programs on a regular basis and undertake only those actual skills that they can perform competently.

Fourth, joining and actively supporting professional organizations allows nurses to participate in either excellent educational programs and to become active in the organizations' lobbying efforts, especially if it means a stronger nurse practice act or the creation or expansion of advanced nursing roles. Far too many nurses are reluctant to become politically involved. Yet, as a unified profession, nursing could have a very strong voice, particularly in upgrading and strengthening nurse practice acts.

Fifth, recognize the concept of the *suit-prone patient*. This type of patient is more likely than other patients to initiate malpractice action in the event that something untoward happens during the treatment process. Because the psychological make-up of these persons breeds resentment and dissatisfaction in all phases of their lives, they are more apt to initiate a lawsuit.

Suit-prone patients tend to be immature, overly dependent, hostile, and uncooperative, often failing to follow a designated plan of care. Unable to be self-critical, they shift blame to others as a way of coping with their own inadequacies. Suit-prone patients actually project their fear, insecurity, and anxiety to health care providers, overreacting to any perceived slight in an exaggerated manner.

Recognizing such patients is the first step in avoiding potential lawsuits. The nurse should then attempt to react on a more human, or personal, basis such as expressing satisfaction with these patient's cooperation, showing empathy and concern with unknown treatments and procedures. An atmosphere of attentiveness, caring, and patience helps prevent the suit-prone patient from filing future lawsuits.

Sixth, recognize that nurses' personality traits and behaviors may also trigger lawsuits. So-called *Suit-prone nurses* (1) have difficulty establishing close relationships with others, (2) are insecure and shift blame to others, (3) tend to be insensitive to patients' complaints or fail to take the complaints seriously, (4) have a tendency to be aloof and more concerned with the mechanics of nursing as opposed to establishing meaningful human interactions with patients, and (5) inappropriately delegate responsibilities to peers to avoid personal contact with patients. These nurses need counseling and education to change these behaviors into more positive attitudes and behaviors toward patients and staff. Such positive changes lessen future potential lawsuits.

Seventh, while it may not prevent lawsuits, nurses are urged to investigate having professional liability insurance. This will better protect them should a lawsuit be filed.

3. Professional Liability Insurance

Regardless of the policy chosen, all **professional liability** policies share some common elements. The policies provide payment for a lawyer to represent the insured nurse in the event of a claim or lawsuit. Most insurance carriers insist that the nurse use a lawyer whom the insurance company has on retainer because this ensures both the nurse and the insurance carrier that the selected lawyer will be versed in medical malpractice issues. All policies specify the limits of legal liability.

Insurance policies are classified in essentially two ways. The first way is as either occurrence-based or claims-made insurance coverage. **Occurrence-based policies** cover the nurse for any injuries arising out of incidents that occurred during the time that the policy was in effect, known as the *policy period*. This holds true even if the subsequent lawsuit is filed after the policy has expired and the policy was not renewed by the policy holder. **Claims-made policies** provide coverage only if an injury occurs and the claim is reported to the insurance company during the active policy period or during an uninterrupted extension of that policy period. The uninterrupted extension, or tail, allow the claims-make policy to be enforced for specific periods of time following the policy period.

The occurrence-based policy is preferable for most nurses since lawsuits may not be filed immediately, particularly in cases involving children and infants. Claims-made coverage is adequate if the policy is continuously renewed and kept active or if a tail is purchased of extended coverage. If you have any doubt regarding the coverage needed, consult the insurance agent.

A second way of classifying insurance policies is as individual, group, or employer-sponsored coverage. **Individual coverage** is broadest type of coverage and is specific to the individual policy holder. This type of policy covers *the named policy holder* on a 24-hour basis, as long as actions fall within the scope of professional nursing practice, including both paid services and voluntary services. This type of policy is tailored to meet the needs of the individual nurse. **Group coverage** involves insuring a group of similarly licensed professionals and may be advantageous in some private clinics or businesses. Group coverage is frequently obtained by professional practitioners where all the insured individuals practice during office hours and have essentially the same job descriptions. **Employer-sponsored coverage**, which is obtained by institutions, is perhaps the narrowest of coverage for individual nurses since they must first show that they are practicing within the scope of their employment as well as within the scope of professional nursing practice. Those covered are called the *insured*, or they may be referred to as *former insured for acts committed while insured*. Employer-sponsored coverage is favored by the institution since the coverage is written specifically for the business and its major concerns.

The insurance policy should have a section marked **limits of liability**. This section usually has language about two separate dollar figures. For example, it could read \$500,000 each claim, \$1,000,000 aggregate, or \$1,000,000 each claim, \$3,000,000 aggregate. These dollar figures

indicate what the insurance company will pay during a given policy period. The company will pay up to the lower limits for any claim or lawsuit and up to the upper limits of the policy during the entire policy period.

4. Summary of Legal Principles and Applications

The role of the public health nurse interfaces with public health laws as well as other legal standards applicable to all nursing roles. Laws are constantly being enacted as revised, and it is therefore impossible to discuss all of the potential laws that a public health nurse must be aware of to enforce and abide by in his or her jurisdiction. Nurses must consistently and constantly update their knowledge of their legal responsibilities. It is difficult to separate and isolate the legal responsibilities of public health nurses because of the natural interrelatedness of the responsibilities to inform patients of their rights to benefits and teach wellness and preventative measures, while recognizing and referring actual and potential problems.

Even laws related to housing and the rights of renters are important to understand. The public health nurse may be faced with the problem of patient-family being evicted from their home or apartment. The impact of this legal action is a legitimate concern for the public health nurse. Laws related to environmental hazards are also being legislated and may be managed under state health departments through sanitation departments, but enforced by nurses. Preventative teaching related to laws requiring the use of seat belts and infant car seats also should be offered. Food preparation and food handler laws are also applicable to public health nursing practice. Nurses can help their patients avoid unsuspected problems by informing them of the legal responsibilities applicable to all people in our society. However, the nurse is not expected, or recommended, to give legal advice to community patients. Ignorance of the law will not protect either the consumer or the nurse from legal liability.

Because the law is constantly changing as our society identifies whose rights need to be protected, the public health nurse must remember the following:

- Keep current regarding the legal standards that govern all nursing practice as well as the regulation and laws specifically enacted to protect the public's health.
- Protect the confidentiality of the information gained by virtue of the therapeutic relationship. Be prepared to disclose information that must legally be reported.
- Share private information regarding patients only with those who need to know, and have the patient's consent in writing for release of information to anyone outside the agency.
- Contracts are evidence of mutually agreed upon terms that should be put in written form to clarify the parties' understanding and serve as evidence of the agreement.
- Public health nurses have professional responsibilities to maintain the standards of care within the scope of nursing practice as defined by their state's nurse practice act.
- Commonly recognized legal duties include the responsibility to maintain a safe working environment and protect the individual safety of patients; teach, inform, and refer patients; communicate in a timely and accurate manner with members of the health care team; enforce the reporting laws; and be knowledgeable of the laws and programs designed to benefit patients.
- It is unwise for public health nurses to transport patients in their personal vehicles.
- Infectious diseases are considered a disability and therefore persons with HIV/AIDS are legally protected from discriminatory treatment by the Americans with Disabilities Act.
- Dangerous products and equipment must be identified by the nurse to reduce the risk of patient injuries.
- The Occupational Safety and Health Administration and Centers of Disease Control and Prevention are administrative bodies that enact rules and regulations of importance to nurses who work in the community.

- The public health nurse has the responsibility to be familiar with the programs and procedures for assessing these programs, such as Medicare, Medicaid, Early and Periodic Screening, Diagnosis and Treatment Program and Worker's Compensation, for the benefit of their patients.
- Advocacy and professional involvement are appropriate roles for public health nurses who represent vulnerable patients and groups.
- Patients, including psychiatric patients, must be considered to be competent until legally judged by a court of law to be incompetent.
- An expert witness in a legal case involving a public/community health nurse should have experience in the specific area of practice of the defendant as well as comparable educational credentials.
- An employer's expectations of public health nurses must not conflict with the legal scope of nursing practice.
- Standing orders must be reviewed and updated regularly and signed by the physician in a timely manner when acted upon by the nurse.
- Verbal orders are more likely to be misunderstood, and therefore increases the risk of harm to the patient and liability for the nurse. Verbal orders should be avoided and must be followed up with a signature.
- Timely, written documentation of the nurse's actions and the patient's response is necessary evidence of the care provided in the community.
- Supervisory liability may occur when care is delegated to providers who, the supervisor should know, are not prepared to safely perform the task or skills and the patient is harmed.
- Violence is of major concern to nurses who work independently in clinics, homes, schools, and industry, as these environments are impacted by crime that exists in our society.

Web Link to Kansas Statutes: <http://www.kslegislature.org/legsrv-statutes/index.do>

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APPENDIX

A – Glossary of Helpful Acronyms

AACN	Association of American Colleges of Nursing
AAN	American Academy of Nursing
AAOHN	American Association of Occupational Health Nurses
ABOHN	American Board for Occupation of Health Nurses
ACHNE	Association of Community Health Nurse Educators
AHCPR	Agency for Health Care Policy & Research
ANA	American Nurses Association
ANCC	American Nurses Credentialing Center
APHA	American Public Health Association
APN	Advanced Practice Nurses
ASTDN	Association of State and Territorial Directors of Nursing
ASTHO	Association of State and Territorial Health Officials
ASTLHLO	Association of State and Territorial Local Health Liaison Officials
ATSDR	Agency for Toxic Substances and Disease Registry
BLS	Bureau of Labor Statistics
CAI	Computer-Assisted Instruction
CD-ROM	Computer Disk Read-Only Memory
CDC	Centers for Disease Control and Prevention
CFCs	Chlorofluorocarbons
DHHS	Department of Health and Humans Services
DoD	Department of Defense
EPA	Environmental Protection Agency
FQHC	Federally Qualified Health Center
HCFA	Health Care Financing Administration
HRSA	Health Resources and Services Administration

ICN	International Council of Nursing
IOM	Institute of Medicine
IRB	Institutional Review Board
LPN	Licensed Practical Nurse
MFS	Medical Fee Schedule
NACCHO	National Association of County and City Health Officials
NACNEP	National Advisory Council for Nurse Education and Practice
NALBOH	National Association of Local Boards of Health
NANDA	North American Nursing Diagnosis Association
NAPHIC	National Public Health Information Coalition
NAPHSIS	National Association for Public Health Statistics and Information Systems
NBCSN	National Boards for Certification of School Nurses
NCEH	National Center for Environmental Health
NCLEX	National Council Licensure Examination for Registered Nurses
NCSBN	National Council of State Boards of Nursing
NIEHS	National Institute of Environmental Health Services
NIH	National Institute of Health
NIJ	National Institute of Justice
NINR	National Institute of Nursing Research
NIOSH	National Institute for Occupational Safety and Health
NLN	National League for Nursing
NP	Nurse Practitioner
OSHA	Occupational Safety and Health Administration
PHF	Public Health Foundation
PPRC	Physician Payment Review Commission
RN	Registered Nurse

STTI Sigma Theta Tau International

TRI Toxic Chemical Release Inventory

USPHS United States Public Health Services

B – Managed Care – Glossary of Terms
(Prepared for Kansas Health Foundation Leadership institute 1995)

Alliance: An organization of consumers that is responsible for purchasing health insurance as a large group.

Basic Health Services: Benefits that all federally qualified HMOs must offer; defined under Subpart A, 110.102 of the Federal HMO Regulations.

Benefit Package: A collection of specific services or benefits that the HMO is obligated to provide under terms of its contracts with subscriber groups or individuals.

Capitation payment: A method of payment for health services. The health care provider is paid a fixed (per capita) amount for each person receiving care regardless of the number or nature of services provided. It is the usual form of payment for Health Maintenance Organizations and Preferred Provider Organizations (HMOs and PPOs). Its goal is to reduce health care costs by encouraging more conservative health care delivery.

Coinsurance: The portion of the cost for care received and for which an individual is financially responsible. Usually this is determined by a fixed percentage, as in major medical coverage. Often coinsurance applies after a specified deductible has been met.

Community Rating: a method for determining health insurance premiums based on actual or anticipated costs in a specific geographic location as opposed to an experience rating that looks at individual characteristics of the insured.

Co-payment: A payment made by an HMO enrollee at the time that selected services are rendered. Some employer benefit packages require a co-payment between \$2.00 and \$20.00 for each doctor's office visit. Some impose a fixed dollar amount for inpatient hospitalization. Co-payments are subject to limitation as defined in subpart 1, 110-101 of the Federal HMO Regulations.

Deductible: The part of an individual's health care expenses that the patient must pay before coverage from the insurer begins.

Diagnostic related groups (DRGs): Classification used by the federal government to establish prospective prices paid to hospitals for patients covered by Medicare. Each of the 467 groups is based upon a diagnosis or illness category.

Fee-for-Service (FFS): The patient is charged according to a fee schedule set for each service and/or procedure to be provided and the patient's total bill will vary by the number of services/procedures actually received. The patient is billed at the time of service.

Gatekeeper: A primary care physician is an HMO who makes referrals. His/her function is to reduce health care utilization and costs.

Group Model HMO: There are two kinds of group model HMOs. The first type of group model is called the closed panel, in which medical services are delivered in the HMO owned health center or satellite clinic by physicians who belong to a formed but legally separate HMO. The group is paid a negotiated monthly capitation fee by the HMO, and the physicians in turn are salaried and generally prohibited from carrying on any fee-for-service practice. In the second type of group model, the HMO contracts with an existing, independent group of physicians to deliver medical care. Usually, an existing multi-specialty group practice adds a prepaid component to its fee-for-service mode and affiliates with or forms an HMO. Medical

services are delivered at the group's clinic facilities (both to fee-for-service patients and to prepaid HMO members). The group may contract with more than one HMO.

Health Maintenance Organization (HMO): An organization of health care personnel and facilities that provides a comprehensive range of health services to an enrolled population for a fixed sum of money paid in advance for a specified period of time. These health services include a wide variety of medical treatments and consults, inpatient and outpatient hospitalization, home health service, ambulance service, and sometimes dental and pharmacy services. The HMO may be organized as a group model, an individual practice association (IPA), a network model or a staff model.

Hold Harmless: Managed care contracts often include a clause stating if either the HMO or physician is held liable for malpractice or corporate malfeasance, the other party is not.

Individual Practice Association (IPA): Under this structure physicians practicing in their own offices, participate in a prepaid healthcare plan. The physicians charge agreed-upon rates to enrolled patients and bill the IPA on a fee-for-service basis.

Long-term care: Persons who are chronically ill, elderly, or physically and/or mentally disabled may require health care on a long-term basis either in their home or in an institution. For some people, the costs of long-term care may be covered by private insurance or Medicare, but generally there are upper limits after which all costs must be paid by the patient.

Managed Care: Use of a planned and coordinated approach to providing healthcare with the goal of quality care at a lower cost. Usually emphasizes preventive care and often associated with an HMO.

Managed Competition: A system proposed in 1993 by the Jackson Hole Group that suggests the individual employee receive a fixed sum from his/her employer and the individual employee chooses the health plan they prefer. If the plan they choose costs more than the employer's fixed sum, the employee is responsible for the difference. The individual employee would have a tax incentive to select the lower priced options because they would only be able to deduct the amount of the lowest cost option. The proposal's proponents believe this would encourage individual consumers of healthcare to be more price conscious and they also believe this will cause healthcare insurers to hold down the cost of their plans to make them more competitive. Because insurance under this proposed system is not tied to the employer, employees would not lose coverage when they change jobs. Under this proposed system there is no provision to set premiums that appropriately cover the risk of an individual patient or specific patient population.

Market Share: That part of the market potential that an HMO or a fee-for-service/prepaid medical group has captured; usually market share is expressed as a percentage of the market potential.

Medicaid: A state-administered program financed by federal and state funds offering medical aid to the financially needy of all ages. Covers all persons who receive federal welfare assistance. Provides for inpatient hospital care, outpatient care, doctors' services, nursing home care, lab and X-ray services, and some home health care. A wide variety of optional services may be available in individual states.

Medicare: A federal health insurance program available to everyone age 65 or older, persons under age 65 who have been disabled for two years and most people requiring kidney dialysis. Consists of two parts—Part A, which covers hospital and limited nursing home stays, and Part B which covers physician services.

Nurse practitioner: There are different types of nurse practitioners. All are registered nurses who receive additional training and work under their own professional license. Nurse practitioners do health

exams, treat minor and chronic illnesses, and provide patient education and counseling. In most states, nurse practitioners can prescribe certain types of medications.

Physician Assistants: Physician Assistants receive two years of special training in human biology, diagnosis, and treatment. They generally work under a supervising physician who is responsible for the medical care they provide. Physician assistants provide direct medical care, such as giving shots and treating minor illnesses, as well as patient education.

Pre-existing condition: A health ailment that the insured person had before purchasing insurance. Generally, pre-existing conditions are not covered by insurance policies.

Preferred Provider Organization (PPO): A group of physicians and/or hospitals that contract with an employer to provide services to their employees. In a PPO the patient may go to the physician of his/her choice, even if that physician does not participate in the PPO, but the patient receives care at a lower benefit level.

Preventive Health Services: Services aimed at preventing a disease from occurring, or preventing or minimizing its consequences. This includes care aimed at warding off illnesses (e.g., immunizations), at early detection of disease (e.g., pap smears) or at stopping further deterioration (e.g., exercise).

Primary Care Network: The structure for these networks will vary considerably depending on the specific network. It may range from a loose association of physicians in a geographic area with a limited sharing of overhead, patient referral, etc. to a more structured association with community owned satellite clinics, etc.

Primary Care Physician (PCP): Provides treatment of routine injuries and illnesses and focuses on preventive care. Serves as gatekeeper for managed care. The American Academy of Family Practice defines primary care as "care from doctors trained to handle health concerns not limited by problem origin, organ systems, gender or diagnosis."

Prospective Pricing: A method by which the amount paid to hospitals for services rendered to Medicare patients is determined in advance, based on the diagnostic related group into which the patient is categorized. It was enacted as part of the Social Security Amendments of 1983.

Providers: Those institutions and individuals who are licensed to provide health care services (for example, hospitals, skilled nursing facilities, physicians, pharmacists, etc.) Providers in a defined service area are principally owned by, affiliated with, employed by, or under contract to an HMO.

Quality Assurance Program: An internal peer review process that audits the quality of care delivered. The program should include an educational mechanism to identify and prevent discrepancies in care.

Rationing: Limiting the amount of health care provided a patient, based on the availability of services or the patient's ability to pay for services.

Risk: The chance or possibility of loss. For example, physicians may be held at risk if hospitalization rates exceed agreed-upon thresholds. The sharing of risk is often employed as a utilization control mechanism within the HMO setting. Risk is also defined in insurance terms as the probability of loss associated with a given population.

Risk Pool: Funds are set aside to cover over-utilization or to encourage limits on utilization. More commonly seen in primary care than with specialists.

Single payer system: A health reform plan that would designate one entity, usually the government, to function as the only purchaser of health care services.

Total Quality Management (TQM): Also called continuous quality improvement and uses the concepts originally developed by W. Edward Deming to study systems and processes at medical groups to identify and improve sources of error, waste or redundancy. Uses input and feedback from all staff and patients to understand and improve on problems in current procedures.

Underinsured: Health insurance policies vary in the degree to which hospital and other medical costs are covered. Some plans cover only hospitalization and critical medical care and require co-payments and have large deductibles. Persons are underinsured if they must pay most of their health care costs.

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C – Selected Resources

Organizations

National Organizations

Association of State and Territorial Directors of Nursing
c/o Association of State and Territorial Health Officers (which see)

Association of State and Territorial Health Officials
1275 K Street NW, Suite 800
Washington, D.C. 20005-4006
202-371-9090
<http://www.astho.org>

American Nurses Association
600 Maryland Avenue SW
Washington, D.C. 20024
800-274-4262
<http://www.nursingworld.org>

American Public Health Association
800 I Street NW
Washington, D.C. 20001
202-777-2742
<http://www.apha.org>

Centers for Disease Control and Prevention
1600 Clifton Road NW
Atlanta, GA 30333
404-639-3311
<http://www.cdc.gov>

CDC Public Health Training Network (PHTN)
1600 Clifton Road NW
Atlanta, GA 30333
800-311-3435
<http://www.phppo.cdc.gov/phtn/default.asp>

National Association of City and County Health Officials
1100 17th Street NW, Second Floor
Washington, D.C. 20036
202-783-5550
202-783-1583 (fax)
<http://www.naccho.org/index.cfm>

National Association of Local Boards of Health
1840 East Gypsy Lane Road
Bowling Green, OH 43402
419-353-7714
4190352-6278 (fax)
nalboh@nalboh.org
<http://www.nalboh.org>

National Council of State Boards of Nursing, Inc.
111 East Wacker Drive, Suite 2900
Chicago, IL 60601
312-525-3600
312-279-1032 (fax)
866-293-9600 (testing)
<http://www.ncsbn.org>

Public Health Foundation
1220 L Street NW, Suite 350
Washington, D.C. 20005
202-898-5600
202-898-5609 (fax)
info@phf.org
<http://www.phf.org>

Public Health Service
Office of the Chief Nurse
U.S. Department of Health and Human Services
Parklawn Building, Room 11-05
5600 Fishers Lane
Rockville, MD 20857
301-443-6853
301-443-1164 (fax)

Regional Organizations

Department of Health and Human Services
Region VII Office (for FLSA Medical Leave Act of 1993)
601 East 12th Street, Room 501
Kansas City, MO 64106
816-426-2821
<http://www.hhs.gov/about/regions/r7contacts.html>

OSHA, Region VII
Two Pershing Square Building
2300 Main Street, Suite 1010
Kansas City, Missouri 64108-2416
Phone: (816) 283-8745
FAX: (816) 283-0547

OSHA Region VII
271 W. 3rd Street N., Room 400
Wichita, KS 67202
316-269-6644
316-296-6185 (fax)
800-362-2896 (toll free for Kansas residents only)

U.S. Environmental Protection Agency (USEPA) Region VII
Office of External Programs
901 N. 5th Street
Kansas City, KS 66101
913-551-7003

913-551-7066 (fax)
800-223-0425
<http://www.epa.gov/region7>

State Organizations

Kansas Action for Children, Inc. (for: "Kids Count" data book)
720 SW Jackson, Suite 201
Topeka, KS 66603
785-232-0550
785-232-0699 (fax)
kac@kac.org
<http://www.kac.org>

Kansas Association for the Medically Underserved
1129 South Kansas Avenue, Suite B
Topeka, KS 66612
785-233-8483
785-233-8403 (fax)
kspca@kspca.org
<http://www.kspca.org/>

Kansas Association of Local Health Departments
300 SW 8th Avenue, 3rd Floor
Topeka, KS 66603
785-271-8391
785-272-3585 (fax)
<http://www.kalhd.org/>

Kansas Department of Human Resources
Commission on Disability Concerns (ADA)
1430 SW Topeka
Topeka, KS 66612
785-296-1722
800-295-5232 (outside Topeka)
<http://www.kdheks.gov/health/servguid.html>

Kansas Department of Social and Rehabilitation Services
Docking State Office Building
915 SW Harrison, Room 603N
Topeka, KS 66612-1570
785-296-3959
785-296-2173 (fax)
888-369-4777
<http://www.srskansas.org>

Kansas Department of Health and Environment
Bureau of Local and Rural Health
Curtis Building
1000 SW Jackson, Suite 340
Topeka, KS 66612-1365
785-296-1200
785-296-1231 (fax)
<http://www.kdheks.gov/olrh/index.html>

Kansas Health Foundation
309 E Douglas Avenue
Wichita, KS 67202-3405
316-262-7676
316-262-2044 (fax)
800-373-7681 (outside Wichita)
info@khf.org
<http://www.kansashealth.org>

Kansas Hospital Association
215 SE 8th Avenue
Topeka, KS 66603-3906
785-233-7436
785-233-6955 (fax)
<http://www.kha-net.org>

Kansas Public Health Association
PO Box 67085
Topeka, KS 66667-0085
785-233-3103
785-233-3439 (fax)
director@kpha.us
<http://www.kpha.us/>

Kansas State Board of Nursing (source for Nurse Practice Act)
Landon State Office Building
900 SW Jackson, Suite 1051
Topeka, KS 66612-1230
785-296-4929
785-296-3929
<http://www.ksbn.org>

Kansas State Historical Society
6425 SW 6th Avenue
Topeka, KS 66615-1099
785-272-8681
785-272-8682 (fax)
<http://www.kshs.org>

Kansas State Nurses Association
1109 SW Topeka Blvd
Topeka, KS 66612-1602
785-233-8638
785-233-5222 (fax)
ksna@ksna.net
<http://www.nursingworld.org/snas/ks>

Kansas State University, Community Health
101 Umberger Hall
Manhattan, KS 66506-3403
785-532-7750
785-532-7733

healthyplaces@k-state.edu
<http://healthyplaces.ksu.edu/HealthyPlaces>

Poison Control Center
University of Kansas Medical Center
3901 Rainbow Blvd, Room 400B
Kansas City, KS 66160-7231
913-588-6633
913-588-2350 (fax)
Kansas 800-332-6633
Nationwide 800-222/1222
poisoncenter@kumc.edu
<http://www.kumed.com/poison>

Community Tool Box
University of Kansas
4082 Dole Human Development Center
1000 Sunnyside Avenue
Lawrence, KS 66045-7555
785-864-0533
785-864-5281 (fax)
toolbox@ku.edu
<http://ctb.ku.edu>

Web Addresses for Information KDHE

Service guide to the Division of Environment maybe found at:
<http://www.kdheks.gov/environment/servguid.html>

Service guide to the Division of Health maybe found at:
<http://www.kdheks.gov/health/servguid.html>

Kansas Annual Summary of Vital Statistics maybe found at: <http://www.kdheks.gov/ches/>

Division of Health:

Bureau of Child Care and Health Facilities: <http://www.kdheks.gov/bcchf/index.html>

Bureau of Disease Control and Prevention: <http://www.kdheks.gov/bdcp/index.html>

Bureau of Environmental Health: <http://www.kdheks.gov/beh/index.html>

Bureau of Family Health: <http://www.kdheks.gov/bcyf/>

Bureau of Health Promotion: <http://www.kdheks.gov/bhp/index.html>

Bureau of Local and Rural Health: <http://www.kdheks.gov/olrh/index.html>

Bureau of Oral Health: <http://www.kdheks.gov/ohi/index.html>

Bureau of Public Health Informatics: <http://www.kdheks.gov/ches/index.html>

Bureau of Public Health Preparedness: <http://www.kdheks.gov/cphp/index.htm>

Bureau of Surveillance and Epidemiology: <http://www.kdheks.gov/beh/index.html>

KDHE Home Page: <http://www.kdheks.gov/>