

Public Health Nursing Newsletter



FALL 2011: THE OMAHA SYSTEM

The Omaha System in Family
Home Visiting Documentation

Getting Behind the Wheel
Transitions and Accomplishments

The Omaha System in Family Home Visiting Documentation:

Electronic Health Records in Public Health Nursing

By **KAREN MONSEN**, Assistant Professor, University of Minnesota School of Nursing

Note: Names starred below have been changed.

In Minnesota, many public health nurses use the Omaha System for family home visiting (FHV) documentation. In addition, a grassroots collaborative of Minnesota public health nurses, the Minnesota Omaha System Users Group (<http://omahasystemmn.org/>) meets regularly to advance public health nursing data and practice quality using the Omaha System. The following case example can help illustrate the use of the Omaha System to document FHV practice.

Ms. Green* is a 17-year-old mother of newborn Lily;* they live together, independently, in a subsidized apartment. Lily's father is not involved with the family. Ms. Green's mother lives in a nearby town, with Ms. Green's siblings. Ms. Green left home during her pregnancy, because she "wanted a better life for herself and her baby." She has weekly contact with her mother, but is estranged from her father due to prior alcohol-influenced abuse.

Ms. Green receives public assistance for income, health care, and nutritional needs, and attends an alternative high school where she has good relationships with a few friends and teachers. She hopes to finish high school in two years, and would like to go to college. Ms. Green is currently unemployed, but has previously worked as a cashier in a gas station and at a fast food restaurant.

Rose,* Ms. Green's PHN, is employed by a government public health agency. Rose provides FHV services to high-risk adolescents, emphasizing attaining self-sufficiency by finishing high school and seeking gainful employment. Ms. Green agreed to meet with Rose at the suggestion of a school counselor, shortly after Ms. Green learned she was pregnant.



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Rose visited Ms. Green at her apartment once or twice per month during her pregnancy. They talked about Ms. Green's goals for staying healthy during pregnancy, preparing for childbirth and parenting, breastfeeding, and Ms. Green's future family and education plans. Ms. Green shared that she has struggled with depression during her adolescence and especially early during her pregnancy, but has been feeling better in recent months. Rose visited Ms. Green in the hospital when Lily was born, and again at home for breastfeeding support. Ms. Green and Rose agreed to continue meeting once or twice per month, "for now." Ms. Green says that she enjoys and looks forward to meeting with Rose. Rose follows evidence-based home visiting protocols, and documents her interventions using the Omaha System, a recognized interface terminology.

The Omaha System has three components: the **Problem Classification Scheme**, the **Problem Rating Scale for Outcomes**, and the **Intervention Scheme**.

Problem Classification Scheme

The Problem Classification Scheme logically classifies health information into 42 non-overlapping concepts (called "problems"), each of which is identified by a unique definition and set of signs/symptoms (s/sx).

Example

In Rose's local public health agency, the required assessment for pregnant adolescent clients consists of evaluating signs/symptoms for eight problems: income, residence, mental health, caretaking/parenting, abuse, pregnancy, substance use, and family planning.

After visiting Ms. Green for the first time, Rose used the Problem Classification Scheme to document the following five problems during Ms. Green's client assessment: income (s/sx: low/no income), pregnancy (s/sx: prenatal complications/preterm labor), family planning (s/sx: dissatisfied with present family planning method), mental health (no s/sx, however, Ms. Green has a history of depression and may be at risk for postpartum depression after delivery, and therefore Rose will monitor this problem), and caretaking/parenting (no s/sx, but low knowledge of parenting skills; therefore Rose will teach parenting skills as needed).



Image: Microsoft Corporation

Problem Rating Scale for Outcomes

The Problem Rating Scale for Outcomes consists of three five-point rating scales for client knowledge, behavior, and status, which are used for every Omaha System problem addressed with a client. Scores range from 1 (most negative) to 5 (most positive). Problems are typically rated at admission and discharge.

Example

Rose used the Problem Rating Scale for outcomes to rate Ms. Green's knowledge, behavior, and status for each of the previously identified five problems (see Table 1). Rose and her colleagues use the Minnesota rating guide supplement (found at http://omahasystemmn.org/KBS_care_plans.php) to support data reliability.

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Table 1. Admission Ratings for Omaha System Problems

Problem	Knowledge	Behavior	Status
Pregnancy	2 (minimal)	4 (usually appropriate)	4 (minimal s/sx)
Family Planning	2 (minimal)	2 (rarely appropriate)	2 (severe s/sx)
Mental Health	3 (basic)	4 (usually appropriate)	5 (no s/sx)
Income	3 (basic)	4 (usually appropriate)	3 (moderate s/sx)
Caretaking/Parenting	2 (minimal)	4 (usually appropriate)	5 (no s/sx)

Rose identified and addressed five priority areas (problems) with Ms. Green, including income, mental health, postpartum, parenting, and family planning.

Intervention Scheme

Interventions in the Omaha System are related to a specified problem. The intervention scheme includes four levels (problem, category, target, and care description), four “categories,” or action terms (teaching, guidance, and counseling [TGC]; treatments and procedures [TP]; case management [CM]; and surveillance [S]), and 75 defined “target” terms that serve to further define the intervention action or client need. Finally, the care description level includes suggested examples, and can be customized to capture specific program or client characteristics.

Example

Rose used the Omaha System to document intervention content for each visit with Ms. Green, by selecting interventions from an evidence-based standardized care plan in the electronic health record, and typing relevant notes in free text associated with the intervention as needed. Documentation from a brief visit is shown in Table 2.

Table 2. Documentation of Home Visit using Omaha System SCP

Problem	Category	Target	Care Description (Text Note)
Pregnancy	TGC	Anatomy/Physiology	Childbirth process (what to expect)
Pregnancy	CM	Continuity of Care	Coordination among providers (permission to talk with
Pregnancy	S	Medical/Dental Care	Access to care (has appointment in one week)
Family Planning	S	Family Planning Care	Methods (will ask provider about IUD)
Mental Health	S	Coping Skills	Adaptation (feels well/happy)
Income	S	Education	Attendance (in compliance with requirements)
Caretaking/Parenting	TGC	Coping Skills	Adaptation/flexibility to meet demands
Caretaking/Parenting	CM	Day Care/Respite	Child care arrangements (infant providers)
Caretaking/Parenting	S	Feeding Procedures	Methods (has decided to breastfeed baby)

TGC = Teaching, Guidance, and Counseling; CM = Case Management; S = Surveillance; IUD = Intrauterine Device

There are over 150 Omaha System care plans and practice tools developed by Omaha System users available online (<http://omahasystemmn.org/>), and everyone is welcome to use these resources. For further information or to participate in the Minnesota Omaha System Users Group, please contact Karen Monsen (mons0122@umn.edu).

Getting Behind the Wheel

By **MARIE MARGITAN**, Public Health Nurse Consultant, Northeast Region

The Omaha System can be rewarding to use at the local level, despite its challenges. Two public health nurses working in different local health departments in Minnesota were asked about the benefits challenges of using the Omaha System (or just “Omaha”) to document public health nursing practice. Their combined experience with Omaha includes using it in their own practice, and orienting new PHNs to Omaha. Each PHN’s department has used Omaha for several years.

One PHN noted challenges in using the Omaha System in her health department:

“We continue to be challenged by nurses not consistently entering data into the system, by maintaining inter-rater reliability among nurses, and in orienting newly hired nurses to the system,” she said. “New public health nurses are not used to looking at clients through a ‘strengths’ or ‘wellness’ lens.” She also shared that her department does not currently use the data to evaluate programs. “We could use this data to tell us if we needed to change something with our program, but we struggle to use the data in that way.”

However, she quickly also noted the benefits of using Omaha, which she perceived as outweighing the system’s challenges. She and the other public health nurse agreed on these benefits:

Client Assessments

“We rate clients more realistically,” she said. “Interestingly, my ratings are generally less positive than before. Terms are clearly defined so I am more comfortable in indicating the true situation because I know I am not being biased. Also, because [the system uses] reassessments, Omaha is quick to show the change the client has experienced because of interventions. We can share with the client how they have grown!”

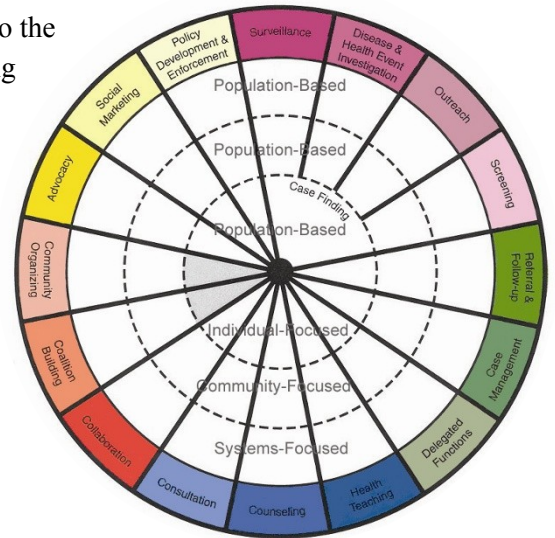
She continued: “The assessments also suggest priorities for our work, and interventions to use with clients. Priorities are important because sometimes it is difficult to determine where to start [after identifying] so many problems. Problems are grouped together into pathways, creating a client care plan. The pathways and the resulting interventions are evidence-based, incorporating the most up-to-date research.”

Defining and Explaining PHN Practice

The PHNs also thought it was beneficial to have a more concrete manner to talk about their work and activity as public health nurses. They felt they could talk about knowledge, behaviors, and health status of clients, as well as how clients are impacted by interventions in those areas.

Throughout each interview, both PHNs described the Omaha System with phrases like:

- Supports nursing practice
- Validates the impact of the work we do
- Provides a common language to describe our practice
- Helps us talk about why public health nursing is important



Discussion Questions

1. What intervention and level of practice do these PHNs highlight in describing the use of the Omaha System in their respective health departments?
2. How do you describe the impact and value that your interventions have for clients?

Transitions

Sheri Altepeter, Polk County, has resigned September 30, 2011, after almost 25 years of nursing service in the county. Most recently, Sheri was the Polk County Public Health Director and CHS Administrator.

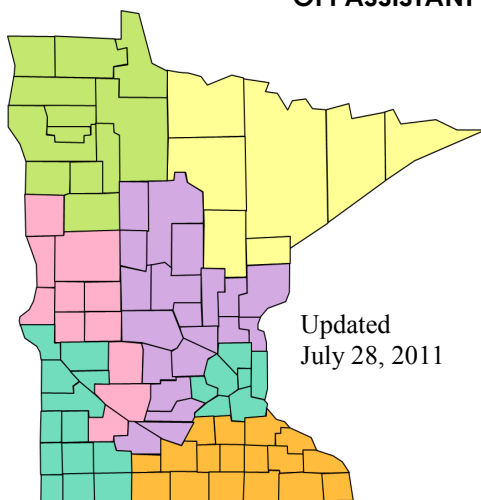
Awards and Accomplishments

Deb Smith, Public Health Nursing Coordinator for the Fond du Lac Band of Lake Superior Chippewa, was awarded the Jim Parker Leadership Award in September at the annual Community Health Services Conference. This award is given to persons or groups who have demonstrated significant statewide leadership in public health. Deb's many accomplishments include working with Nurse-Family Partnership (NFP) Founder Dr. David Olds on cultural adaptations to NFP; playing an instrumental role in opening a ten-bed assisted living facility for tribal community elders; and collaborating during outbreaks of H₁N₁ and hepatitis C clusters. She is also past president of the National Alaska Native American Indian Nurses Association, 2006-2008.

Judy Voss, retired Associate Director of the Olmsted County Health Communities/Health Children and Families Division, received the Barbara O'Grady Excellence in Public Health Nursing Leadership Award at the Second International Public Health Nursing Conference. This award recognizes and honors public health nurses working in management or educational settings in Minnesota for outstanding leadership and contribution to public health. Judy has provided leadership on maternal child health issues, including on a pilot project to provide mental health services in a charter school for at-risk youth, by creating peer education programs, on school-based clinics, and in one of Minnesota's first Coordinated School Health Councils. She was also instrumental in creating and documenting the effectiveness of Baby Steps, a home visiting program.

Minnesota's Public Health Nurse Consultants

OPI ASSISTANT DIRECTOR: LuAnne McNichols, Saint Paul (651-201-3880, health.ophp@state.mn.us)



NORTHWEST

Wendy Kvale, Bemidji
218-308-2116
wendy.kvale@state.mn.us

NORTHEAST

Marie Margitan, Duluth
218-723-4644
marie.margitan@state.mn.us

WEST CENTRAL/ SOUTH CENTRAL

Brenda Menier, Fergus Falls
218-332-5156
brenda.menier@state.mn.us

CENTRAL/SOUTH CENTRAL

Linda Bauck, Saint Cloud
320-223-7344
linda.bauck@state.mn.us

METRO/SOUTHWEST

Mo Alms, Saint Paul
651-201-3867
maureen.alm@state.mn.us

SOUTHEAST/ SOUTH CENTRAL

Mary Orban, Rochester
507-206-2733
mary.orban@state.mn.us

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