Wheel of Public Health Interventions

A Collection of “Getting Behind the Wheel” Stories 2000-2006
Preface

The feature, “Getting Behind the Wheel,” first appeared in the MDH/Public Health Nursing Newsletter in September, 2000. Every issue since has highlighted one or more of the seventeen public health interventions. Most were submitted by public health nurses and nursing students and provide real stories about their experiences in the field. Some are short; some are long. Some are humorous; some are sad. All 34 stories provide good opportunities to investigate how the Intervention Wheel was applied. They are organized and color-coded by the Wheel wedges.

We know that “Getting Behind the Wheel” is used by journal clubs and as the subject(s) of so-called “bag lunch” seminars in local health departments. We understand that schools of nursing around the country use the feature as discussion in public health nursing courses; some lucky students even get extra credit for writing short essays based on the questions at the end of each feature.

However you decide to use “Getting Behind the Wheel” we hope this collection enriches your practice. And send us your stories about the Wheel. That enriches our lives!

Keep it rolling…

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Surveillance

The public health agency provides the central intake function for children with special needs for the entire county. Physicians, schools, the local follow-along program, public health nurse, social workers, and others refer children. Intake PHNs attend weekly meetings with the multi-disciplinary early intervention team, which includes public health nursing, speech, occupational therapy, special education, social work, and others. The team determines who will coordinate the initial assessment and service plan. The PHNs’ central intake responsibilities include compiling quarterly reports on the types of special needs that are being referred, the timeliness of the team response, and the types of services the child and family ultimately receive.”

Questions for Discussion:

1. This is an example of an intervention at the systems level for surveillance. The population is all children with special needs. What are possible interventions at the community and individual/family levels for this same population?

2. As found in Public Health Interventions, Applications for Public Health Nursing Practice, surveillance “describes and monitors health events through ongoing and systematic collection, analysis, and interpretation of health data for the purpose of planning, implementing, and evaluating public health interventions.” Identify examples of surveillance in your own practice.

— January, 2002
Surveillance

This past summer many county public health departments in Minnesota agreed to participate in dead bird reporting, i.e. making “dead bird calls.” Through widespread media outreach including newspaper articles, radio and TV news reports, persons were asked to report the sighting of a dead bird to a health department. This request was made as part of surveillance activities for the West Nile virus. Birds tested were those found in a place not normally associated with a dead bird. This might have been the middle of a backyard or on a hiking trail. Testing was also done on birds that appeared sick. This included such behaviors as not being able to fly and vomiting. Birds were tested until one was found positive in the county or until a bird tested positive for the virus in a contiguous county. The goal of the surveillance was to validate the presence of West Nile virus throughout the state.

Questions for Discussion:

1. What intervention is being described in this scenario? What is the level of practice?

2. This scenario is an example of an activity of an epidemiological surveillance program. Define epidemiology.

3. What other examples of epidemiology can you identify in your public health nursing practice?

[To read more about applied epidemiology, you might read Guns, Germs and Steel by Jared Diamond, Plagues and People by William McNeill or The Secret Life of Germs by Philip Tierno.]

— September, 2004
**Disease and Other Health Event Investigation**

The long and short of the situation is that a family in Marshall County, MN had Labrador puppies to sell and advertised them in local newspapers. Before being sold, a skunk attacked the puppies. When two puppies died from rabies the State Veterinarian at the Minnesota Department of Health became involved. She contacted the Public Health Director to alert her to the situation. One of the puppies had contact with numerous children before it died. The puppy had attended several school and sporting events and also lived across the street from an elementary school. The whereabouts of the other four puppies from the litter was unknown. School officials sent letters home with students as the media notified parents to expect the letters. The media also informed the public of the situation, providing information about the known location of the rabid puppies. The media alerted the public that there were puppies whose location was not known, and advised individuals to seek advice from public health or a health care provider regarding concerns.

Rabies is a viral disease spread by the bite of infected mammals. The virus affects the nervous system and eventually invades the brain. If an exposed person is not treated the virus is almost always fatal. The incubation period for rabies in humans is typically 4 to 6 weeks. The incubation period for dogs is 3-12 weeks, and they are not contagious to people during this time. Dogs only shed rabies virus in their saliva for one to four days prior to the onset of clinical signs of the disease, and then they die of rabies within a few days of that. If a dog had rabies virus in their saliva at the time a person was exposed to the animal through a bite or other saliva contact, the dog would be sick or dead within a few days of contact. In this case, anyone who had saliva contact with the puppy within 10 days (a 2.5x safety factor is included) before the onset of clinical signs of rabies in the puppy, were advised to seek medical care. The post exposure prophylaxis regimen for an exposed person included 5 doses of rabies vaccine and one dose of human rabies immune globulin.

Call from parents started flooding the telephone lines at the public health department, the hospital and clinics. Not having the staff to vaccinate the number of people needing rabies vaccination, the hospital requested that the public health department do a public rabies vaccination clinic at the hospital. Vaccine was ordered to cover the number of exposed persons. The regional epidemiologist and public health nurse consultant were in contact with the public health director providing information and support. Other counties were informed of the situation and asked to be on alert in case more assistance was needed for vaccinating. While planning for the clinic, the preparedness guidelines for mass dispensing clinics were considered. This was done since so many people, primarily children, needed the vaccine and to better accommodate anxious parents accompanying each child. Planning was also done to accommodate needs of those potentially exposed over the month long period during which the vaccine series would be administered.
Local public health, in partnership with the hospital and clinic, ended up being able to handle the initial vaccination and follow-up vaccinations for the 198 people who decided to receive the vaccine series.

As a result of this experience, a policy change is in the works at the school to not allow animals at school events.

Questions for Discussion:

1. Work around the perimeter of the Intervention Wheel to identify which interventions were used in responding to this situation.

2. What was the level that each intervention was applied?

3. Effective risk communication is critical to gaining public trust in a situation that requires educating the public and asking them to take action based on that information. What is risk communication? In the above scenario, what actions can you identify that demonstrate effective risk communication?

— November/December, 2004
Disease and Health Event Investigation

The following is a quick reverie of one public health nurses she gets ready to participate in a regional pandemic flu conference call. It showcases several interventions from the manual, Public Health Interventions, Applications for Public Health Nursing Practice.

“I sat waiting for others to connect to the pandemic flu conference call. I had raced back from a home visit to be able to participate in the monthly calls. By the time I reviewed my “home work” assignment all but two of the 10 tribal and local health departments had staff connecting to the call. Together we cover an area of 18,200 square miles (one of our counties is bigger than the state of Rhode Island) and have 320,000 people living in the region. This number increases by 60,000 in the summer due to our abundance of lakes and recreational opportunities. Pandemic flu had started to get both national and local “press” as the incidence of avian flu has moved from Vietnam and China to Turkey and now to Iraq. We as public health workers, including nurses, health educators and environmental health specialists, realized we did not know enough or had done little planning in regards to meeting the challenges of a potential pandemic flu outbreak occurring in our jurisdictions. We needed to get up ourselves up to speed in order to respond to the public health need, i.e. being ready for a possible pandemic flu outbreak, of our respective communities.

The state regional epidemiologist had sent out an agenda. The items included one, reporting of the role of local public health roles identified in the Federal Pandemic Plan, the WHO plan and in the plan of a neighboring city in Canada; two, commenting on a pandemic flu power point prepared based on discussion during our last conference call; three, a beginning conversation of surge capacity and finally, continuing our discussion on volunteer recruitment.

This was our third conference call. So far I was pleased with how the process was unfolding. I did not have to travel any distance to have conversations with my public health colleagues working three hours away and we were making progress in developing both local and regional plans. We as public health staff, including public health nurses, had decided we wanted to prepare as a region to this new challenge of the possibility of pandemic flu. We wanted the information to be similar; we wanted to strategize together how to outreach to key stakeholders and wanted to be able to support each other in the case of an actual outbreak.

Now for the call....”

Questions for Discussion:

1. Identify interventions and the level of their application highlighted in this regional readiness effort.

2. What is your local health department doing to prepare for a possible pandemic flu outbreak here in the United States?
3. As a staff public health nurse what is your role in helping your community get ready for a possible pandemic flu outbreak?

— January/February, 2006
Disease and Other Health Event Investigation

This past week has been a real humdinger! A mother brought her daughter to the school nurse to have her child's head looked at. Since my preceptor was across the hall eating lunch I thought 'sure I can do this.' The girl said her head had been itching for the past few days and she had noticed some white dandruff type flakes all over her head. I am thinking, 'Oh no! This is going to be head lice and I have never seen it before and I am really not sure what to do!!' But I put on gloves and tried to remain calm. My preceptor and I did a head lice check a week before so at least I knew what to do. This girl had jet-black hair and I could see the dandruff type flakes that the mother was talking about. I made my way through her hair and noticed a zillion 'flakes.' I told the mom that I was going to go and get the nurse to 'double check' my findings! Sure enough, it was head lice! ALL OVER!! AHHH!! So then we had to call down her sister, close friends and contacts and check them. We sent six girls home with head lice! I was checking one child's head and found a live louse, which is a brown bug, compared to the white eggs that the other girls had! We saved it in a plastic zip lock bag! Head lice suddenly became our weeklong project. Once we got all six girls home for treatment, my preceptor decided that since these girls were so infested we better check all of the 5th and 3rd graders since those were the ages of the girls who were sent home. So one by one the kids came down and we checked all of their heads. It took us from 1 until 4 pm when the bell rang for the kids to leave and we still were not done. It was a stressful and very itching experience. The next day the parents brought their daughters back to be re-checked to see if they could stay in school. Unfortunately all six had to be sent back home for further scrubbing! The school district has a no-nits policy so the kids cannot return to school until all their nits are gone. We found one additional girl who had lice making for a grand total of 7 girls. It was interesting because I have never had or ever seen head lice or the nits that are often present in hair. I remember my preceptor saying to me, 'once you see lice you will never forget it!' I will take those words with me because they are so true. I will never forget what I saw and what they looked like. I am glad that I was able to see it because now I know what to look for if I ever become a school nurse."

Questions for Discussion:

1. This scenario is a colorful description of looking for head lice. The student nurse and preceptor used several interventions in addressing the situation. Identify interventions and identify which level they are applied at.

2. It seems as if this student and preceptor had a relationship that supported learning on the student’s part. Describe qualities of an effective preceptor.

3. What does your health department do to facilitate student learning? Is it effective? What more might you do to enhance student's learning about public health nursing?

— November/December, 2005
Disease and Other Health Event Investigation

During a flood, “the PHNs spend part of the day doing ‘rounds’ among the rows of people living in a large emergency shelter set up in a gymnasium. The PHNs talk to the people and ask how everything is going, given the circumstances. They have concerns about the mental health of this population who has gone through so much, so they assess for withdrawal, depression, and inability to cope. While the PHNs note that most adults are coping, they observe that the children are not coping as well. They question parents and hear stories about night terrors and atypical behavior. To prevent further development of problems among children, the PHNs request child mental health counselors from the Emergency Response team. They also work with the parents in the shelter to set up a ‘toddler corner where children can play and act like children. Parents take turns staffing the corner. They also set up a ‘reading corner for older children to simulate their school environment.”

Questions for discussion:

1. Explain why this is an example of the intervention Disease and other Health Event Investigation.

2. What system and individual/family level activities can you suggest for this intervention?

3. What planning and preparations for a disaster has your agency made?

– August, 2002
Outreach

The Hmong Health Care Professionals Coalition received a grant to do community education to the elderly Hmong population regarding depression. Depression was considered a risk for Hmong elders because there had been several suicides in that population. Many Hmong elders were isolated and did not view depression as a disease. In addition, other agencies serving this population had also identified depression as an issue for elders. In doing outreach to the target population several adaptations specific to the Hmong culture were made. One was in regards to eligibility criteria. Even though the program targeted persons over 50, people were allowed to determine their own eligibility. That is, if they “felt old,” they qualified. Second, although the Coalition had a booth at the annual Hmong Health Fair, the Coalition members considered it unlikely that the elders would come to the booth. Therefore, the interviewers decided to walk around and talk with elders in a more relaxed setting. They approached elders while sitting under shade trees, selling products at the market booth and the like. Third, interviews were done entirely in the Hmong language. Elderly persons were screened, provided information about depression and given a listing of community resources.

Questions for Discussion:

1. This is an example of outreach intervention at the community level. Why are there no activities at the individual level for outreach?

2. What system level interventions might you suggest in this situation?

3. Think about your own target populations, what cultural adaptations have you incorporated into your programs?

— April, 2001
Outreach

A PHN returns to a local turkey processing plant to do follow-up with workers having positive Mantoux tests after exposure to a fellow worker with confirmed active tuberculosis. All of the workers, except one, kept their appointments with the PHN. A co-worker says he hadn’t seen that person at work since the day the PHN confirmed his Mantoux as positive. The PHN checks his work absence with the plant’s personnel manager, who has also been trying to contact him without success. The personnel manager supplies the worker’s last known address; no telephone number is listed. Recognizing the address as a unit in a trailer court where many families newly arrived from Mexico live, the PHN devotes the rest of the workday and many subsequent hours in attempting to locate the person. The PHN is finally able to speak with a cousin in a meeting arranged by the Catholic priest sewing a parish frequented by people newly arrived from Mexico. The PHN provides materials in Spanish for the cousin to give to the worker, plus a voucher to see a physician. The PHN also uses the opportunity to help the cousin understand his personal risk of contacting tuberculosis.

Questions for Discussion:

1. Explain case finding and its relationship to the intervention “outreach.”

2. How does the intervention “case finding” fit with the concept of population-based practice in public health? (Refer to the criteria: public health interventions are population-based if they focus on entire populations possessing similar health concerns or characteristics.)

3. When might you as a public health nurse apply the intervention of case finding in your own practice?

— November/December, 2001
Screening

A student nurse and her colleagues noticed that a number of their postpartum clients were experiencing depression. As part of a school assignment she searched the literature for further understanding of their observations. She discovered that postpartum depression is a very serious condition. It has an onset during the first six months after birth and affects 10-20% of new mothers (Depression after Childbirth, Dobie, S.A., & Walker, E.A., *J Am Fam Pract*, 5:303-11, 1992). She also learned of a screening tool that is effective in screening women for postpartum depression. The tool is the Edinburgh Postnatal Depression Scale. It takes approximately 5 minutes to administer and identifies postpartum women at high risk for depression.

The students were convinced that they could improve the health status of postpartum women by systematically screening for depression. They proposed that all nurses in their agency screen all postpartum women for depression using the Edinburgh Postnatal Depression Scale. It will be placed in the client’s record, women will be screened between 4-6 weeks postpartum, and referrals will be made based on written protocols. The long-range plan is to gather baseline data that demonstrates the effectiveness of screening postpartum women for depression. The data will be presented to primary care practitioners in Chisago County with the goal of having all practitioners screen for postpartum depression using the Edinburgh Postnatal Depression Scale.

Questions for Discussion:

1. The manual, *Public Health Interventions*, published by the Section of Public Health Nursing at the Minnesota Department of Health, outlines eleven basic steps to planning effective screening programs. Use the above scenario to discuss the steps listed.

2. Identify the screening programs your agency has. Do they meet the eleven basic steps listed under the screening intervention?
Case Finding

I followed up on a baby born in early October with a positive hypothyroid newborn screen. On calling the primary clinic, I was told the mom and baby missed their appointment. Staff at the clinic had heard the mom and baby left the state, possibly the country. The clinic had no forwarding information. I called a contact number provided by the mom and learned from that person that the mom was single and had lived in Minnesota only temporarily. I pressed the person to contact the mom ASAP to alert her that the baby needed medical care urgently. I also called a PHN at the local health department who knew the mom. She reported that the Mom was indeed from Mexico and spoke no English. The PHN made a home visit to the friends listed as a contact for the mom and relayed the same message regarding the baby’s urgent need to see a physician Nothing more was heard. Then mid-January the PHN called to let me know that the mom had returned and brought the baby in for medical evaluation. I followed up with the clinic. The diagnosis of hypothyroidism was confirmed, treatment started and a referral to an endocrine specialist was made. As hypothyroidism is a condition that requires life long treatment I then discussed a referral to the Follow-Along Program. Plans for monitoring a baby whose family is transient was also discussed along with funding options for a family who was in the country illegally. The extent of the baby’s disability was unknown but services will maximize progress towards living a healthy life."

Questions for Discussion:

1. Identify the public health interventions highlighted in this story. Also note the level at which they were applied.

2. What experiences have you had in working with an immigrant client who speaks no English?

3. This story describes a situation in which efforts to intervene on behalf of a client did not prevent disability. What experiences have you had in which, in spite of your best efforts, you have not been successful in helping a client do well/maintain a healthy life?

– March/April, 2005
Referral and Follow-Up

I received this referral in a most interesting way. A bartender of a local tavern asked for assistance. He described a situation in which a man would come into his bar and after having a ‘few beers,” the man would become incontinent of stool. In experiencing incontinence, this patron would end up with stool on himself, the chair he sat on, and on the bathroom floor. My school assignment was to involve this man in identifying his health concerns and developing a plan to address the problems.

I approached the man, explained who I was and told him how I got his name. His reply to my questions of whether or not he would be open to home visits and if he had any health concerns was, without prompting, “I have a problem with shifting my pants.’ As background, this man was sixty-one years old. He had a CVA at the age of forty-five. Currently, he worked three days a week at the local landfill. He earned enough money to purchase his medications and pay rent. He lived by himself in a small, one bedroom house. Neither the bathroom sink nor the shower was usable. On my first visit, the kitchen sink was overflowing with dirty dishes and one wall of the room was lined with coffee cans filled with coffee grounds and cigarette butts.

We quickly developed a mutually agreed upon plan of interventions. It built on a number of strengths identified during the assessment, primarily that he was employed, he followed through with what his doctors recommended, and that he lived in a small community where the people looked after him regarding his health and welfare. Because of the urgency of the problem we worked on his incontinence problem first. I did teaching on nutrition and bowel incontinence. We talked about how alcohol affects smooth muscles and how it accentuates the residual effects of the stroke he had so many years before. The result was that he did not experience incontinence as frequently as before. He learned to toilet himself when he first felt the urge to defecate.

The second thing we did was to work on cleaning up his house. My client purchased garbage bags so together we were able to clean the clutter and garbage in his home. He continued to maintain a cleaner house throughout the duration of my visits.

Next, he agreed to a bath. I was able to coordinate a learning experience for a student in a home health aid program. She gave my client a bath while I supervised and offered suggestions in regards to bed bathing. During the bath he mentioned that his toenails were long and that the ball of his right foot was tender. We found that his toenails were at least ½ inch long and that his toes were covered with dried b.m. The skin on the bottom of both feet was brownish black in color and breaking down. Because of the condition of his feet I determined it was important for him to see a physician immediately. We went to the emergency room. The physician there ordered bleach soaks. His feet healed and regained a smooth, pink condition.

On the following visit I took my client’s blood pressure and got a reading of 190/102. Although he reported taking his medicines as directed, it was clear they were not maintaining his blood pressure at a safe level. I referred him to his primary care
physician who in turn referred him to a cardiologist. By our last visit my clients B/P was down to 158/90 with his physician planning to continue to monitor his B/P.

At the end of my visits, my client was pleased with the changes in his life. His fecal incontinence was under control, he bathed regularly, his house was cleaner and he had a plan to follow through with chores. He was again connected with his primary care physician. Although the plumbing of his bathroom had not been repaired, my client did not want to work on that issue.”

Questions for Discussion:

1. This case situation is an example of referral and follow up at the individual level. What are possible community and system level interventions for referral and follow up?

2. A bartender is an unusual referral source, but nonetheless this was an appropriate referral for public health nursing. Does your agency receive referrals from non-traditional sources? If yes, where do they come from and how does your agency encourage this?

— June, 2001
Case Management

I received a referral on a 22-year-old and her two-month-old baby. At my initial home visit the baby appeared overweight and overfed. The young mom had started him on rice cereal in a bottle at two weeks. Every time he cried she gave him a bottle, even though he often struggled and tried to pull away from the nipple. I talked to her about feeding the baby and my concern about his weight, but she responded with ‘once he starts moving around the weight will come off.’

By four months of age the baby was 27 pounds. By now I was very concerned and called both the nurse and the doctor at the clinic, but no action was taken. Next I arranged a joint home visit with a nutritionist from WIG. Both of us counseled the mom to feed the baby only when he was truly hungry.

Two weeks later I returned to do an NCAST feeding interaction and videotaped the mom feeding the baby. We watched the tape together and talked about hunger cues and how the baby did not appear hungry. The young mother listened but continued to feed the baby whenever he fussed or cried. It was as though she had no other way to comfort him other than to feed him. I was also becoming concerned about the baby’s development as he exhibited several delays in fine motor and language when I tested him.

At this point I started visiting every two weeks and placed a family health aide in the home for two hours one day a week. The aide’s assignment was to role model appropriate parenting and feeding. I also arranged to get a high chair for feeding the child through a nutrition program grant. Currently, I continue to coordinate services from the clinic, nutritionist, and family health aide. At the present time the baby’s weight has stabilized and he has not gained any more weight.”

Questions for Discussion:

1. This is an example of case management at the individual/family level. What community and system level interventions might you suggest for this situation?

2. What information would you need in order to determine whether or not the specific intervention described is part of a population-based program?

— May, 2001
Delegated Functions

An eight-year-old child is diagnosed with active infectious tuberculosis. PHNs coordinate with the school nurse to screen all potential contacts at the child’s school -- over 800 students, faculty and staff. The screening clinics detect another student with active TB and many others with latent tuberculosis infection. The PHNs subsequently screen the families of all positive students and staff. After X-rays and diagnostic work-ups, over 35 people in eleven families are determined to require directly observed therapy of prescribed medications.

Questions for discussion:

1. Explain why this is an example of a delegated function at the community level.

2. What systems and individual level activities could you suggest for the same intervention (delegated functions) in communities with potential tuberculosis infection?

3. What is the difference between active TB and latent tuberculosis infection?

— February, 2002
Health Teaching

I work with pregnant and parenting teens at an alternative high school program that provides educational options for teens whose lives don’t fit the traditional school day. Our program includes teens from a variety of cultures and backgrounds. The program currently has eight young women who will deliver their babies during the school year. This year we also have four young fathers enrolled. The program has an onsite child care center, so these students bring their children to school with them and are able to visit their child during the school day. Another PHN and I share this assignment. We teach weekly prenatal classes in conjunction with the life skills class that all our students are required to take for graduation. Each student spends time working in the child care rooms, both in their own child’s room as well as the next age group’s room. This provides us with the opportunity to discuss growth and development, health care, and to role model parent-child interactions. We also work with each student to look at family planning options for him or her and are very proud of a program we started called “The Pregnancy Free Club.” This is a voluntary “club” that allows each student to have private time with a PHN to talk about how to use birth control correctly and look at barriers that prevent the student from effectively using birth control. Peer support has also become an unexpected part of this program, making it easier and more acceptable for the students to talk about their birth control choice or their choice of abstinence. Our program currently has a repeat pregnancy rate significantly lower than the national average.

Questions for Discussion:

1. The primary focus of this case example is Health Teaching at the individual level. What are potential community and system level interventions for Health Teaching in this scenario?

2. This case example also has elements of interventions at the community and system level. Identify the specific activities that are indicative of community and system level interventions.

3. What information would you need in order to decide whether or not this program is population-based?

— February, 2001
Health Teaching

A group of students were identified as having issues with hygiene. I volunteered to talk with them about proper hygiene. The group consisted of 10 girls, some of who were in special education and some in mainstream. In preparing for my teaching session I searched web sites, spoke with a woman who had discussed this same topic with her own daughter and reviewed books to get ideas for specific topics to cover. I also searched for games and activities to use as an alternative to using a lecture format. I piloted my ideas on my fiancé’s daughter who is almost 9 years old. I was able to acquire such hygiene products as toothbrushes, toothpaste, dental floss, facial soap and body soap from community resources. In addition I purchased nailbrushes and the school had a supply of deodorant and Clearasil. With all of the products I was able to have a “starter kit” for each girl in the group.

I had outlined specific topics in my teaching plan that we would cover in our time together. The topics included hair care, body odor, mouth care, hand and foot cleanliness, appropriate and clean clothing, and the importance of nutrition and rest. My preceptor and I selected a small, private conference room and scheduled 45 minutes on a Friday afternoon for the session.

On arriving at the school I was informed of a scheduling change that reduced our meeting length to only 30 minutes and that nine of the ten girls invited would be present for my teaching session.

I began with an introduction of myself and to the topic, personal hygiene. I wasn’t sure how the kids would feel. Would they ask themselves, “Am I the dirty girl?” Instead they were open and comfortable with the topic and excited about the “starter kits”. I began the group with open-ended questions as a way to do introductions and to let me know what they thought good hygiene was. I originally had planned on giving a small lecture and then doing a game to reinforce the main points of my lecture, but with the time constraint I changed my plan. Instead, I used the game to initiate a discussion on good grooming practices adding my own comments as needed or to reinforce main points. All the girls participated and we covered all the topics listed in my teaching plan.

Questions for discussion:

1. Explain why this is an example of health teaching at the individual level.

2. What levels of prevention were incorporated into this teaching experience?

3. Using the five criteria of population based practice (Public Health Interventions, Applications for Public Health Nursing Practice, p 2-5), how did or how might this intervention meet each of the five criteria?

4. Discuss how you as a public health nurse incorporate a variety of community resources into your practice

— ????
Health Teaching and Counseling

Jill hated her life. She was 15. She lived with her mom, her mom's boyfriend, her two younger step-brothers and a new baby sister. Jill cared for her brothers and younger sister as well as taking care of her mom who was unable to cope with the family because of depression. It was Jill's responsibility to get the younger kids up, fed and off to school. Jill often cried herself to sleep. She felt sad and alone. One of Jill's few escapes from her family was to go out with friends on Saturday nights. These nights were filled with drinking beer, smoking pot and having sex.

I met Jill when she was two months pregnant. The house was a disaster. Jill's mom was in bed. Jill was feeding her sister; the two boys were arguing and eating junk food while watching TV. As I spoke Jill did not make eye contact and generally ignored me. My first reaction was that this was going to be a tough case. When I talked with Jill about whether or not she wanted to participate in the Nurse Family Partnership program, her reaction was, "Why should I, my mom never had some nurse visiting her."

In spite of this initial response, Jill did decide to work with me. She contracted to meet with me throughout her pregnancy and through the first two years of her baby's life. We met anywhere from two to four days a month. We worked together to help Jill stop smoking and using alcohol and marijuana, to eat well, to stay in school, and perhaps most importantly, to identify her dreams and goals for herself and her baby. I knew that by working together Jill's life could be different from her mom's. It wasn't easy. Initially Jill was clearly overwhelmed. On one of my visits she looked at me and said, "I feel like I'm in a swamp." I looked her in the eye, gently squeezed her hand and said, "I will stand with you in the swamp until you are ready to walk out."

Almost two years after meeting Jill she is a few months away from high school graduation and has plans to enter community college in the fall. Her daughter, Heather, is safe and a healthy two-year-old. Jill no longer feels sad and alone. On my last visit with Jill, she hugged me and said, 'You changed my life!'

Questions for Discussion:

1. What public health interventions are highlighted in this story?

2. Discuss how the interventions are applied at all three levels--individual, community and systems. (Feel free to make assumptions filling in information gaps you may identify.)

3. Identify evidenced-based programs being implemented in your health department.

— May/June, 2005
Ellen, our Agency Nurse Practitioner, was preparing to do a routine family planning exam, when the 22 year old client, Annie, said, “That’s me you know, that poster.” There were several posters on the wall so Ellen looked up to check them out. The young woman was looking at the poster that described a relationship based on a house of cards with the words jealousy, control, deception and insecurity. “My boyfriend watches everything I do. The only time he is not with me is when I am at work. I lost my last job because there were days he wouldn’t let me out of the house. Sometimes he roughs me up when we have sex. One night he left me naked in the bedroom with the windows open. He took the blankets. He wouldn’t let me out. I screamed but no one came to help. I was so cold.”

Ellen asked Annie more questions about her relationship with her boyfriend. Ellen found out that he was much older than she was. He drifted into town about 6 months ago and was currently unemployed. He spends a lot of time hanging out in Annie’s apartment. He is not the father of her toddler. Ellen asked if her boyfriend had harmed her daughter or handled the child roughly. Annie hesitated and then said, “He’s never hit her but some times he keeps me from comforting or holding her when she is crying.”

It was clear from Annie’s responses that the violence in her relationship was escalating. It was also clear that Annie had reached out for help for the first time even though she used the Agency services frequently and was well known to Agency staff. All client intake procedures have questions about a woman’s safety in their home. Annie had participated in numerous interviews and had numerous contacts with staff but had never indicated that she was a victim of domestic abuse.

Ellen made some suggestions, “Annie, you know there is help. There are restraining orders, safe homes, people who are trained to deal with these situations. You don’t deserve to be treated like this.” Not surprisingly, Annie started backing off from her earlier remarks. She began to minimize the problem, “Don’t worry about me. I can handle it.” Ellen kept gently prodding with questions, pointing out the bruises on Annie’s inner thighs and the black and blue marks on her arm. Annie tearfully acknowledged that her boyfriend was the cause. Annie also shared that one night her boyfriend locked me in the bedroom. I have neighbors on both sides of me, above and below. I screamed; I can’t believe no one heard me.”

Ellen asked if she could call someone from the program for victims of domestic abuse to talk to her. Annie agreed but was concerned about the time, “My boyfriend is sitting in the car; he is going to wonder what is taking so long. My daughter is with him.” Ellen assured her that if he came in, he would be told that our clinic was running behind schedule. Ellen placed a call. No one answered the call so left a message. Meanwhile, Annie was getting more and more agitated saying she had to leave. Patiently, Ellen sought and received Annie’s permission to call the local police department. The police chief, after hearing the situation, said he would send an officer over in plain clothes and in an unmarked car using the back entrance.
It only took a few minutes for the officer to arrive but it seemed like hours. Ellen continued to talk to Annie, encouraging her to think about her safety and that of her child’s. Annie met with Officer Murphy, told him some of the stories, and showed him some of the bruises. The officer said, “Annie, based on what you told me and what I have seen, I am going to arrest your boyfriend. I will call for back up to make sure your little girl does not get hurt. I will go out and talk to him; the nurse will come with me to get her. We need to make sure you are safe tonight so you can think about things. We will have someone from the domestic abuse program come and talk to you.”

Questions for Discussion:

1. What interventions from the Public Health Intervention Wheel were used in this scenario?

2. What was the level that each intervention was applied at?

3. How does Annie’s story reflect what you know about domestic abuse? How do you and your staff make it comfortable for women to disclose that they are in an abusive relationship?

— January/February, 2005
Counseling

The public health nurse partners with the mental health center, schools, and faith community to raise community awareness about depression in teens. Their goal is to change community acceptance of depression as just 'something that teens go through' to a realization that depression is a real, treatable problem. They use billboards, radio spots, and theater trailers to disseminate the message.

Questions for Questions:

1. Identify and provide the rationale for the practice level this case example represents.

2. What more information would you need in order to determine whether or not this intervention addresses each of the five characteristics of population-based practice?

3. Evaluate a program from your health department to determine if it meets the five characteristics of population-based practice. What suggestions do you have so that the program does reflect all five characteristics?

— March/April, 2003
Counseling

The following is a story shared at a recent meeting.

With the first sentence I heard after picking up the phone I realized I was in for a long conversation. The woman on the other end of the phone challenged me by asking “Couldn’t someone from the health department do anything for the health of my child?” After listening and responding with quick statements of support I was able to piece together a situation I could understand.

Sarah was calling on behalf of her three year old child. She was concerned about air quality and what it was doing to the lungs of her child. Sarah said she did have two children until her special needs child died 6 months previous to this conversation. She explained that she lived with her child and husband on the edge of a gravel pit. Since the advent of warm weather and the lifting of road restrictions Sarah said the pollution in the air was overwhelming. Every day she counted up to ninety trucks hauling gravel. She said there was a lot of dust to contend with but because they still had the air filters provided on behalf of her now deceased special needs child, that was not so much of a problem. It was the exhaust from the truck that she found overwhelming. Their house was situated close to the corner where trucks waited before pulling onto the highway. She said some days she felt sick to her stomach and she was concerned for her young child.

Sarah had called several agencies but kept getting referred on. She had spoken with planning and zoning, the Pollution Control Agency, and her county commissioner. The pit owner was meeting all the required standards according to zoning and the PCA even monitored the air once. Everything was in compliance.

The PHN just listened, acknowledging the frustration of the situation. After it seemed like there was a lull in the conversation I asked a gentle question about how she was doing after the death of her child.

Questions for discussion:

1. What public health nursing intervention does this article highlight?

2. What level, individual/family, community or systems, is this account an example of?

3. Describe what you know about grief and the many forms in which it can be manifested.

4. What programming might a local health department have to address grief issues?

– May, 2006
Consultation

A PHN responds to a request from community leaders and stakeholders for information about domestic abuse after yet another woman is murdered by her husband in a domestic dispute. They call a meeting and the PHN presents an analysis on domestic abuse in the community. He presents not only the data, but also anecdotal information from the women with whom he works at the battered women’s shelter. The stakeholders pick up on the information that the PHN presents on the impact of children witnessing violence. They decide to make “children witnessing violence in the home” a priority issue and seek consultation from the PHN about potential effective strategies for addressing this problem.

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

Questions for discussion:

1. Identify and explain what level of practice this example of consultation is indicative of.

2. Given the information provided in this scenario, what are possible activities at the other two levels of practice?

3. How are your agency and your community addressing the problem of domestic abuse?

4. What are the dynamics of having a male PHN work with in a shelter for battered women?

— May/June, 2002
Collaboration

This case example was submitted on behalf of the public health nurses working on the Leech Lake Indian Reservation located in northern Minnesota.

On a visit recently made to the Leech Lake Health Clinic in Bemidji, MN, I was greeted with a big smile and an exclamation of “Well Hi, How are ya doin?” Artwork by a local American Indian artist adorns the walls of the small waiting area. Health posters with pictures of American Indian people decorated the wall space as well. A nurse was at her computer busy checking on a client’s status. Charts lay ready on the desk for the Nurse Practitioner/Physician Assistant to review before clients arrived for their visits. The area was bright, cheery and welcoming.

I marvel at how this clinic has grown. It started with a PHN recognizing that American Indian people living outside the boundaries of the three surrounding reservations were unable to access health care that was culturally sensitive. In addition, finding transportation to attend a clinic on a reservation was sometimes difficult. A grant to the Minnesota Department of Health was applied for and approved to fund a small public health nurse clinic. A one-room space was secured and a nurse set up shop. Flyers and signs were created and sent to the offices of the reservations in the Bemidji area, to tribal and area schools, Head Starts, all county agencies, the Cass Lake Indian Hospital and the Cass Lake Indian Clinic. Meetings were attended both on the reservations and countywide to introduce area professionals to the clinic services and to encourage referrals. Articles were written for the tribal and local newspapers. With all the publicity and communication, people soon started to come into the clinic. It was not long before it became apparent that a practitioner was needed to be on site to treat the ear infections, strept throats, etc. that were being seen. Arrangements were made to have a nurse practitioner at the clinic two times per week. Women’s clinics were added, as well as a podiatrist to see individuals with diabetes.

When a new family center was built in Bemidji, the PHN Clinic was invited to move in with other county agencies. For a while space was shared, however, it did not provide privacy or a sense of “our own space” for the American Indian clients. They felt “out of place” in the larger, shared waiting area that included many people and several agencies. Attendance at the PHN Clinic started to decline. A move within the building again provided a private waiting area and exam rooms. Soon the numbers started to increase. An open house was held and over 350 people attended. Personal invitations had been given to tribal and area physicians and tribal council members. The open house resulted in increased community awareness and increased referrals both to the clinic and also to other agencies.

Currently the clinic offers a wide variety of services. American Indians can now visit and receive personalized care, health teaching and are referred to other agencies as needed. The number of clients being seen has doubled from the same six-month period last year. An average of ten clients are seen each half day that the clinic is open.
Presently, an LPN who is a Leech Lake Band member and is pursuing her license as a registered nurse manages the clinic.

When I asked the nurse if any clients stood out for her, she recalled a 43 year-old gentleman with a traumatic brain injury who was homeless and depressed. Clinic staff made referrals to agencies throughout the state and assisted with needed follow-up. With a big smile she reports that he is doing well and now owns his own home. She also related the story of a mother with four children, ages 4, 5, 7 and 9 years old. All of the children needed physicals. The children were scheduled for the same day and time, rather than schedule separate appointments and have the mother worry about how she was going to get transportation for each appointment. “We pretty much just held clinic that day for this family. It was a hectic clinic and a good thing we had toys to keep the children busy. The mother did appreciate being able to have all of her children seen at the same time.”

A tribal PHN who does diabetic teaching would like to expand the services at the clinic to include more targeted teaching on the prevention of diabetes. The nurse states, “We are hoping to add more clinic days so we can see more people since our numbers have grown so much.”

This all started with a PHN assessing the needs of American Indian people living off their reservation and identifying the barriers they shared in accessing health care. She identified and pursued the means to meet the needs of the people in a way that would be culturally acceptable.

Questions for Discussion:

1. Identify the interventions from the intervention wheel used in setting up this public health nursing clinic.

2. Discuss how all levels of practice (system, community, individual/family) are included in this case example.

3. Identify examples from your own agency in which PHNs recognized a need, assessed the situation and went on to develop a program to meet the identified need.

— September, 2001
Collaboration

The county public health agency forms a collaboration to prevent falls in older adults with the ambulance service, fire department, Senior Center, CAP agency, Extension Services, and several hospital departments including Emergency, pharmacy, rehabilitation services, physical therapy, and home care. The collaboration’s goal is that all service providers bring up the topic of fall prevention any time they provide a service to an older adult, that they complete a short screen for risk of falls and automatically make referrals for a home assessment if needed. One of the project’s goals is to change how providers approach seniors and their potential for falls.”

Questions for discussion:

1. What level of intervention, individual, community, or system, is this scenario an example of? Discuss the rationale for your answer.

2. Identify possible collaborative interventions at the other two levels of practice.

3. What do your local statistics indicate about the morbidity and mortality related to falls and other unintentional injuries for older adults? for children and younger adults?

4. What interventions is your agency using to address unintentional injuries?

— September/October, 2002
Coalition Development

There is a frequent observation that public health workers spend a great deal of time attending meetings. It is quickly apparent why this statement can be made. Merely pick up your appointment book or go to your electronic planner. Count all the in-person and video conferencing meetings and telephone conference calls you attended or participated in. How many meetings or calls did you have in the past week? How many in the last month? Consider the following questions as you think about the work that is accomplished in the time spent together.

Questions for Discussion

1. Identify a group with which you have on-going, regular scheduled meetings. This might be a public health advisory committee meeting, a Family Collaborative Meeting, or a staff meeting. Why do you meet? What do you discuss? What accomplishments have resulted from the meetings?

2. Analyze the answers to the previous questions using the definitions of the 17 public health interventions described in, Public Health Interventions, Applications for Public Health Nursing Practice. Identify the interventions you are using in accomplishing the work of your group. At what level are you applying the interventions, systems, community or individual? Are you intervening at more than one level?

3. What can you do as an informal leader and/or formal leader to increase the efficiency of your meetings?

4. How might you describe to others the work that you do as a public health nurse different from, “I attend a lot of meetings.”

— July, 2004
Coalition Building

Most public health agencies face the reality of not having enough resources to meet the needs of clients. This can be a powerful impetus to working with other agencies and the results are often beyond those they would achieve on their own. This is the case in Carlton County in Minnesota. Public health is working with Mercy Hospital in Moose Lake, MN to provide lactation services to all new moms giving birth at the hospital.

After establishing the goal of increasing breastfeeding rates, Carlton County Public Health approached maternity nurses at Mercy Hospital in Moose Lake to partner with them in achieving this goal. The county agency had a PHN trained as a lactation consultant. Public Health offered to provide hospital nurses with breastfeeding information and consultation knowing that the time immediately after birth is critical to successful initiation of breastfeeding. It also promoted consistent information being given to breastfeeding moms by the hospital and public health and provided a bridge between hospital and home for new moms.

The program proved to be effective and gained support from physicians and hospital administrators. The moms were happy with the program and therefore it was a good marketing strategy for the hospital. It also provided a needed service to clients leading to increased breastfeeding rates.

Currently the public health nurse who provides lactation consultation services has hospital privileges. She is scheduled four hours a week in the hospital and in that time she does rounds on new moms and is available for consultation to nurse. Because the service is collocated in the hospital, public health is receiving additional referrals for their universal home visiting program for new moms. The program is financially supported by both public health and the hospital.

Questions for Discussion:

1. This is an example of coalition building at the systems level. Please explain why.

2. How might this systems level intervention bring about a change in community norms?

3. Why are there no activities at the individual level for coalition building?
Community Organizing

A local newspaper reported that a statewide student health survey revealed their school district had one of the highest teen alcohol-use rates in the whole state. Numerous letters to the editors questioned why the community was not doing anything about the problem. Some viewed the report as an affront to the community’s reputation (in the words of their city welcome sign) as a great place to raise children.” A demand was put out for community action.

A PHN from the public health agency partnered with other community groups and organizations to develop a plan to address alcohol use in the community. The plan included recommendations for enforcing existing laws (such as tightening sales of alcohol and enforcing “not a drop” laws with minors), as well as developing acceptable (that is, “cool”) alcohol-free activities for adolescents. The group’s other major thrust was a decision to study assets and protective factors in adolescents to see if the community could find ways to develop assets in addition to preventing risk-taking behaviors. The representatives of each organization (including the PHN) were asked to take back this idea and get a commitment from their respective boards for the plan.”

Questions for discussion:

1. Explain why this is an example of community organizing at the system level.

2. What community level activities might you suggest for this intervention?

3. Why does community organizing not apply to the individual/family level?

4. What are examples of community organizing that your public health agency has participated in?

— July, 2002
Advocacy

I received a referral on a nine-month old little boy with a recent diagnosis of meningitis secondary to active tuberculosis. The child’s parents were a young Hispanic couple that did not speak English. The child’s mother was pregnant and stayed at home with her two small children. The family had no telephone and neither parent had a driver’s license. The entire family reacted positively to their Mantoux tests that I administered. At this point, I arranged an appointment at the local clinic for the entire family, complete with transportation and interpreters. The father was found to have active infectious tuberculosis. He was ordered not to return to his job at the meat packing plant and consequently lost his insurance. I assisted the family in applying for medical assistance and other services for which they were eligible.

At the same time I was advocating for this family, I was also involved with other PHNs in advocating for the health of the man’s coworkers and overall community. The meat packing plant where the man worked employed over 1000 people who spoke 12 different languages. Initially the plant managers were more concerned about losing production than being exposed to tuberculosis. We worked with the managers to convince them that exposure to tuberculosis was a serious problem and that they could cooperate with public health and not lose production. Although the plant managers would not mandate testing, they did allow us to offer free Mantoux tests during work time on all three shifts to any employee who wanted to be tested. Over 700 employees were tested, with over 70 positives. Many of the employees with positive Mantoux tests lacked access to health care. We negotiated reduced clinic fees and secured community grant funds to pay for x-rays and prescribed treatment for infected persons who were uninsured and without resources."

Questions for Discussion:

1. What community norms can you infer from this case example regarding migrants and communicable disease?

2. What advocacy interventions at the systems level might you, as a PHN, work on related to this situation?

— March, 2001
Social Marketing

Obesity is one of the health problems the local health department is addressing. Data collected from national sources reported that 15% of the child/adolescent population is overweight and 60% of the adult population is either overweight or obese. This was comparable to the percentages identified in the three local schools that were assessed.

Physical activity and nutrition were chosen as a focus of the health promotion campaign to address obesity. Goals of this campaign included increasing physical activity and increasing awareness of healthy eating, healthy body weight and the relationship between excess weight and disease. Knowing this is a complex problem, a social marketing plan was developed.

The first step was the creation of a slogan that was to be used throughout the campaign, “It’s Time for a Healthy Future, Start Today for a Healthy Tomorrow.” Next we identified specific variables of the campaign. Our *product* was good health, self-esteem, more energy, and a longer life free of disease and disability. The *price* of this product included such things as the person’s time, walking during 15 minutes of a lunch break, or substituting nutritious snacks and meal choices for less healthy ones. The *place* for marketing our product could be almost anywhere, schools, churches, workplaces, malls, and health fairs. The final step in the planning was to decide how to *promote* all of these activities. A variety of approaches were identified including radio, TV, newspaper, tri-fold displays, and collaboration with community groups. In addition, the planning group considered policy changes that would address the goals of the health campaign. These policies included selling water instead of pop from school vending machines, using dieticians to plan school meals, requiring physical education classes for all grades, putting in sidewalks in all neighborhoods, and developing school walking programs.

The implementation of the campaign has been extensive. The local radio station was a great partner. It aired public service announcements about health promotion, developed a weight loss challenge of its own, and has a weekly radio show hosted by one of the public health nurses. The American Cancer Society and American Heart Association shared pamphlets for distribution. The local TV station is producing a health and nutrition show in conjunction with public health staff. Topics have included kids cooking healthy foods, interviews with local grocers about healthy produce items and how to prepare fruits and vegetables in a quick and economical way. Parish nurses are displaying tri-folds with information about exercise and nutrition at their respective churches. They also serve as a resource for people with questions and who want to change specific behaviors. Corporations have provided healthy product samples to hand out. And finally, articles have also been published in the local newspapers.

The outcomes of the health promotion campaign and effectiveness of the social marketing plan are difficult to evaluate. Thus far the number of comments received on specific activities, the number of program requests received, and the number of radio and TV spots aired are being tracked. In time, the hope is to have people who are more
active and eating better.” The overall goal is to improve the health status of residents of the county.

Questions to consider:

1. Discuss the specifics of any social marketing plan that has been developed for programs in your health department.

2. What impact did the plan have on the effectiveness of the programs?

3. Identify one program in your health department that would be well served by having a social marketing plan developed for it. Use the planning steps as outlined in the book Public Health Interventions, Applications for Public Health Nursing Practice to discuss the beginnings of a social marketing plan.

4. What is the overarching or overall goal of any public health intervention?

— January, 2004
Social Marketing

The following is loosely based on the experience of a public health department in Minnesota.

The Family Service Collaborative was willing to financially support addressing the situation that immunization data was not being sent to the public health department. This was in spite of a countywide plan agreed upon by clinics and the hospital that public health would be the repository of immunization records. Because several large metropolitan counties border the county a significant percentage of children are taken to clinics located in other counties. After administering a written survey to parents a decision was made to use financial incentives to improve the reporting of immunization data to public health. Ten dollars was to be awarded if parents brought records indicating immunizations were up-to-date, $5 if the immunizations were not up to date with a cap of $50 set for each family. Letters were sent out when children were six and fifteen months old asking parents to bring in their child’s immunization record to public health for review. As a result of improved immunization reporting public health was able to better monitor the immunization status of children in the county. Parents would be apprised of missing immunizations and of immunization providers. Additionally, public health was able to monitor immunization practices at a number of clinics. Public health identified patterns of giving incorrect doses, giving doses too early or sometimes missing an immunization dose completely. If patterns were identified, clinics were contacted with the information and as necessary, teaching provided based on up-to-date standards.

Questions:

1. What are the interventions that are indicated in the above scenario?

2. What levels of practice were the interventions applied at?

3. What are resources for children to receive immunizations in your county? Are they sufficient and do they accommodate the needs of parents?

— September, 2003
Social Marketing

A PHN working in a small rural county is assigned to work on a FAS prevention grant in partnership with the local hospital. The PHN coordinates the grant activities, which include mass media efforts (e.g., billboards, radio spots read by local celebrities, and newspaper articles). One newspaper article highlights local pharmacists’ agreement to insert information on the effects of alcohol during pregnancy in all prenatal vitamin prescriptions. Multiple posters (available through the grant) are placed in every bar in the community. Local bartenders are engaged as partners in the effort to reduce alcohol use among pregnant women. Since the American Legion and VFW posts are key to the community’s social life, a special effort is made to engage these organizations in reducing alcohol use among pregnant women. After two years, the project is able to document an increase in community awareness, but is not yet able to document a decrease in alcohol use among pregnant women."

Questions for discussion:

1. This is an example of social marketing at the systems level. What are examples of social marketing at the individual and community level for preventing alcohol use by pregnant women?

2. Apply the “Basic Steps for Social Marketing” found on page 287 of the Public Health Intervention manual to one of your agency’s programs. Use a program that would be well served by increased visibility and participation of the intended audience.

— April, 2003
Policy Enforcement

A co-worker referred an elderly woman to me who was affectionately called "Cat Lady." Cat Lady was given this name because she lived with so many cats. She was receiving supportive services but there was a concern that she was living in a house contaminated with cat feces. It also appeared her basement provided a breeding ground for malformed cats.

Cat Lady lived alone in her own home in a small town. She was widowed with only one relative, a nephew. I learned that it was through her nephew that she started taking in cats. She told me that within a short time of acquiring the first one, she had cats everywhere.

When I first met Cat Lady, I was struck by how she acted like a cat. She had graceful, subtle movements and would tuck her legs under herself while sitting at the kitchen table. It was as if she became a cat herself.

At first I increased services to help with cleaning her home. I also counseled my client about the need to limit the number of cats she took into her home. Within a short time I realized I was losing the battle. The stench in the house increased, there were more sick and malformed cats and the neighbors were continuing to complain.

I had to tell Cat Lady that her home was not habitable and that the city couldn't afford to have all those sick cats on the loose. In spite of her fierce independence and attachment to the cats, she agreed to the condemnation of her home.

I worked closely with the zoning department, a local veterinarian and the city police and fire departments. We set up a day to capture as many cats as we could. In the meantime, I worked with senior services to get Cat Lady a new place to live.

On a spring day the plan went into action. We donned our "haz mat" suits. The veterinarian had cages and lassos and we proceeded to "catch cats". We lost count of how many cats we caught or who got away but you get the idea - there were a lot of cats! Throughout this chaos Cat Lady sat at her kitchen table all the while with her legs tucked under her, smoking a cigarette and watching. She didn't cry or say anything.

After we were done we sat around the fire truck in the alley and drank sodas that the fire department had brought. Neighbors came out offering kind support to Cat Lady. Everyone knew what had happened and there was an understanding of her loss, but also great relief.

I visited Cat Lady after she was in her new apartment. I thought she would be feeling sad about her home and the loss of her cats. However when I talked with her she said, "I am relieved. I didn't even like cats that much. My nephew brought some over and I don't know how it got so bad. Someone had to feed them."
(As a postscript, the fire department used the house for a training exercise that summer.)

Questions for Discussion:

1. Identify interventions and the level of their application highlighted in this description of the Cat Lady experience.

2. Describe experiences you have had in working with families in similar housing situations. What do you think were the underlying circumstances that allowed the situation to get so out of hand?

3. This is one example of using knowledge of environmental health in public health nursing practice. What are other examples from your own practice?

— March/April, 2006
Multiple Interventions

The five-county agency located in southwestern Minnesota had already submitted the 2000-03 Community Health Services Plan when I accepted the role of administrator in November, 1999. The staff had written the plan based on the core functions and the public health intervention wheel. They were dedicated to putting the plan into practice. Because North Dakota (where I previously worked) does not require a state plan, a lot of work laid ahead for me in understanding the conceptual framework and implementing it. I studied the plan and, needless to say, felt overwhelmed at the task that lay ahead.

The planning process had considered each of the 12 areas of problems and determined measurable goals and strategies. Using the Intervention Wheel framework, we then determined the appropriate public health nursing intervention. Below is one example taken from the disease and disability category.

**Problem:** Are we meeting the needs of our elderly population?

1. The agency will survey all home care providers in our five counties to provide direction regarding our sliding fee contracts.

2. The agency held meetings with community partners to identify unmet needs of our elderly population. (Risk assessment for clients receiving home-delivered meals will be done in 2001.)

3. The agency holds quarterly meetings with the family service directors, supervisor’s and staff (as appropriate) to build linkages, solve problems and build local leadership for our aging population.

4. The agency will be conduct a survey at the Senior Sites to survey the elderly of our five counties regarding home care services.

5. In one of the member counties, a notice from the hospital was released that no meals would be delivered on the weekends. A community meeting was setup with over 20 partners to address this issue.

Using the Intervention Wheel, we then asked ourselves, “What public health nursing intervention fits with each task listed above? (Answers below)

Everyday nurses are putting public health nursing interventions into practice. (We do it without even realizing it). Countryside set up our daily coding system to reflect our public health nursing intervention wheel and CHS Plan. It keeps us mindful daily of the work being done. I must admit the CHS Plan was quite scary when I first arrived, but I feel Countryside is putting the plan into practice with the Intervention Wheel providing a framework for our work.
Answers:

1. Policy Development
2. Consultation and Health Teaching
3. Coalition Building
4. Surveillance
5. Community Organizing

– October 2000
Multiple Interventions

In this issue of Getting Behind the Wheel, activities related to Phase 1 of the National Smallpox Vaccination Program are used as the case example. Phase 1 was implemented by presidential declaration in December of 2001. This decree authorized the administration of smallpox vaccinations to members of key civilian groups. The expectation is that the vaccinees would be key responders in the event of a smallpox outbreak on the United States. Previous to this, smallpox was considered eradicated from the world. The last case of smallpox occurred in the United States in 1949; the last naturally occurring case in the world was in Somalia in 1977. Routine vaccination against smallpox in the general population was stopped as the only remnants of smallpox were research samples stored in the laboratories of the US and the former USSR. The eradication of smallpox from the world was considered one of the successes of modern public health!

A multitude of activities went into the planning and implementation of Phase 1. The success of these efforts can be measured in part by the fact that as of March 7, 2003, 1349 smallpox vaccinations had been given in Minnesota. (See [www.bt.cdc.gov/agent/smallpox](http://www.bt.cdc.gov/agent/smallpox), go to Vaccination Info, then Vaccination Report for numbers of vaccinations done in all states and territories.)

For this exercise, you are asked to identify by intervention and level of practice activities used to implement Phase 1. Consider all activities, anything your agency did to support the smallpox vaccination clinics conducted in Phase 1. This list might include such things as trainings attended by staff, telephoning in order to get needed equipment for the clinics, and regional meetings. Print a copy of the Public Health Intervention Wheel. ([www.health.state.mn.us](http://www.health.state.mn.us), go to Program by Name, Center for PHN, Linking PHN…, Click Here for resources) For each intervention on the outer ring of the Wheel, identify an activity specific to Phase 1 that meets the definition of that particular intervention. Next, determine which level of intervention your activity is indicative of, mark or color in that particular cell. The following is an example for this exercise. During an initial planning meeting the “Smallpox Operations Manual” was used as a reference for developing a plan on how to proceed in planning for the Phase 1 vaccination clinics. This would be an example of policy enforcement at the systems level. (Note, if you have time, you might identify an activity at each level of practice of each intervention for a total of 43 activities!)

By the time you have finished identifying activities and coloring in cells, your wheel will be a visual showing the multitude of activities needed to successfully complete smallpox vaccination clinics. It is worth noting that the smallpox wheel is only one of many wheels that could be completed for this same period of time. If you were to complete wheels for all the programs and initiatives your agency is involved with, there would be tangible evidence for why we are all feeling stretched!

— March, 2003
Promoting Adoption of the Intervention Wheel

In addition to identifying seventeen interventions used by public health nurses in their practice, The Public Health Interventions model also outlines basic steps and best practices related to each intervention. “Basic steps” describe how to implement an intervention. They maximize efficiency and ensure a comprehensive approach to addressing needs of populations. They are particularly useful for new PHNs or for PHNs taking on new assignments requiring new skills. “Best practices” are derived from theory, research and expert opinion and when applied increase the success in meeting the needs of populations. They can be used to both plan and evaluate programs and services.

So how can both “basic steps” and “best practices” be used in a real life situation? The following is an example of both being applied within the context of the intervention of advocacy, one of the seventeen interventions in the Public Health Interventions model.

The public health worker has been seeing an increasing number of new immigrants in her community, who lack access to basic primary care not only due to being uninsured, but also due to inability to speak English. The primary care providers are not consistently providing translators as required under the Civil Rights Act of 1964. Because there are only a few members of this population who speak English, the worker takes some basic steps to:

1. Assure that primary health care providers are aware of their responsibility to provide translation for health care services;
2. Identify a potential pool of translators from the immigrant group to meet translations needs;
3. Identify community resources or agencies who might take on translation needs as a role;
4. Evaluate the consistency with which translation services are being provided.

Best practices in this situation might include:

1. Encouraging the members of the community who do speak English to organize paid translation services or to approach major health care service providers themselves (to insist) on appropriate use of translation;
2. Contacting the media to do a story about the new immigrant arrivals in such a way to develop support for meeting the needs of this population;
3. Pressing unresponsive health care providers to comply with civil rights law (a letter from the Health Office, perhaps?);
4. Approaching church groups to take on support and advocacy for the immigrant population’s needs, assuring an emphasis on the moral

5. Aspects of fairness to those in need.

As you can see, the basic steps address the problem while the best practices component is intended to step beyond the basics and assure the excellence of the intervention provided. Both concepts are helpful in determining how to meet the public health needs of populations.

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