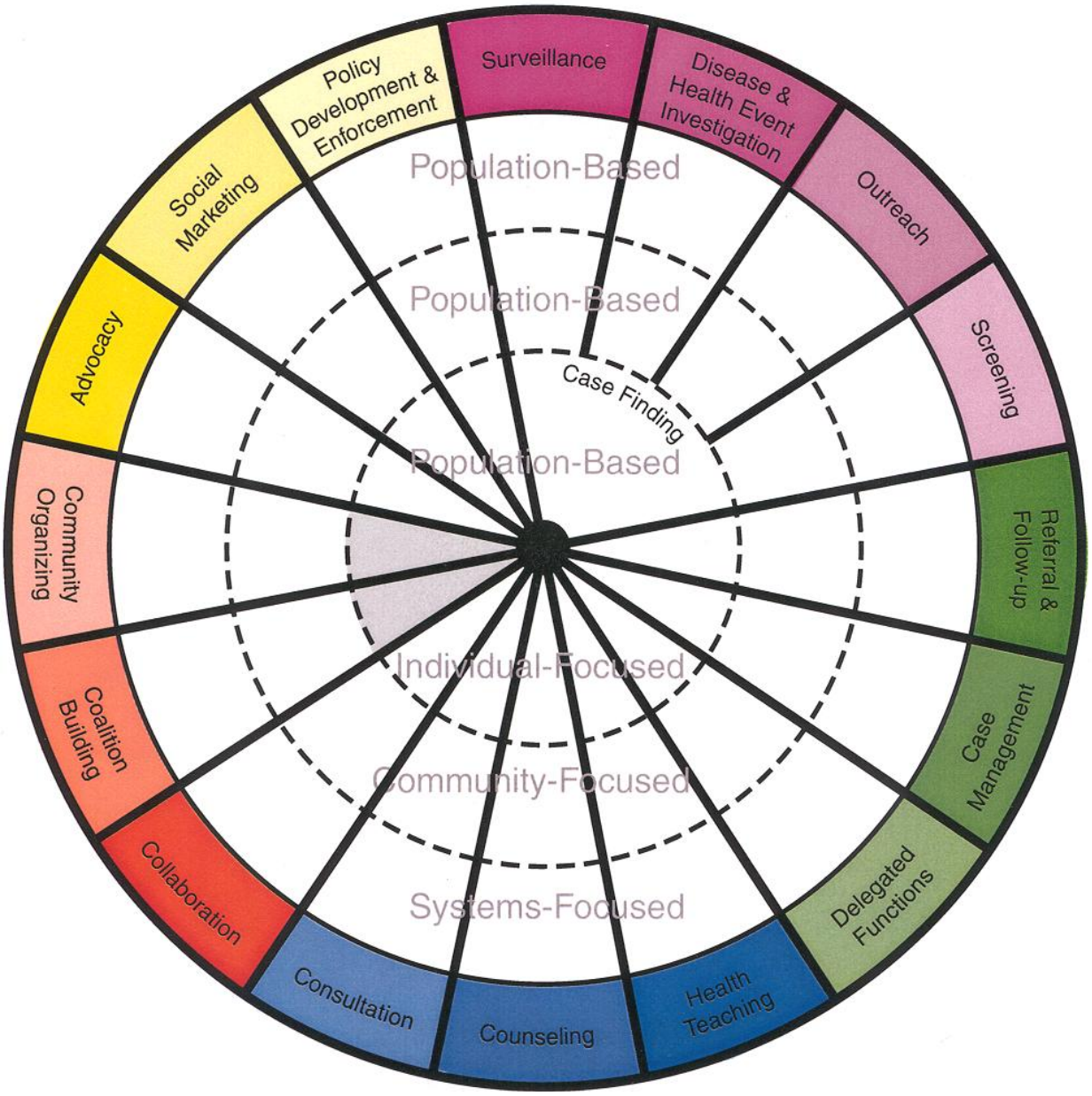
Public Health Interventions

Applications for Public Health Nursing Practice



March 2001

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

Public Health Interventions

Applications for Public Health Nursing Practice

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Public Health Nursing Practice for the 21st Century
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We are interested in learning more about how the model is being used or adapted. If you have comments or questions, please contact us.

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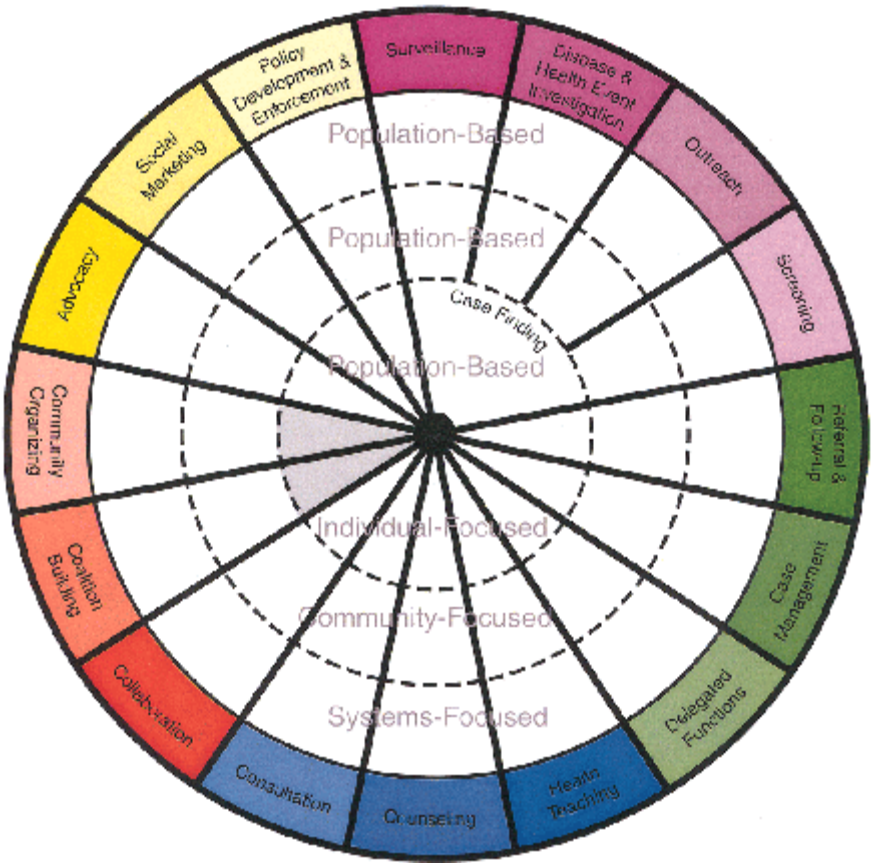
Public Health Nursing Interventions

Public health nurses (PHNs) work in schools, homes, clinics, jails, shelters, out of mobile vans and dog sleds. They work with communities, the individuals and families that compose communities, and the systems that impact the health of those communities. Regardless of where PHNs work or whom they work with, all public health nurses use a core set of *interventions* to accomplish their goals.

Interventions are actions that PHNs take on behalf of individuals, families, systems, and communities to improve or protect health status.

This framework, known as the "intervention model," defines the scope of public health nursing practice by type of intervention and level of practice (systems, community, individual/family), rather than by the more traditional "site" of service, that is, home visiting nurse, school nurse, occupational health nurse, clinic nurse, etc. The intervention model describes the scope of practice by what is similar across settings and describes the work of public health nursing at the community and systems practice levels as well as the conventional individual/family level. These interventions are not exclusive to public health nursing as they are also used by other public health disciplines. The public health intervention model does represent public health nursing as a specialty practice of nursing. (See The Cornerstones of Public Health Nursing, Appendix A)



An enlarged black and white copy of the wheel can be found in Appendix B.

The Intervention Wheel

The model, or the "intervention wheel," as it has come to be known, integrates three distinct and equally important components:

1. The population-basis of all public health interventions
2. The three levels of public health practice:
   - Community
   - Systems
   - Individual/family
3. The 17 public health interventions:
   - Surveillance
   - Disease and Health Threat Investigation
   - Outreach
   - Screening
   - Case-Finding
   - Referral and Follow-up
   - Case Management
   - Delegated Functions
   - Health Teaching
   - Counseling
   - Consultation
   - Collaboration
   - Coalition Building
   - Community organizing
   - Advocacy
   - Social Marketing
   - Policy Development and Enforcement

The model itself consists of a darkened outside ring, three inner rings and seventeen "slices." Each of the inner rings of the model are labeled "population-based," indicating that all public health interventions are population-based. A population is a collection of individuals who have one or more personal or environmental characteristics in common.[1] A population-of-interest is a population that is essentially healthy, but who could improve factors that promote or protect health. A population-at-risk is a population with a common identified risk factor or risk-exposure that poses a threat to health.

1. Public health interventions are population-based if they focus on entire populations possessing similar health concerns or characteristics.

This means focusing on everyone actually or potentially impacted by the condition or who share a similar characteristic. Population-based interventions are not limited to only those who seek service or who are poor or otherwise vulnerable. Population-based planning always begins by identifying

[1]Williams, C. A., Highriter, M. E. (1978). Community health nursing–population and practice. *Public Health Reviews, 7*(4), 201.

everyone who is in the population-of-interest or the population-at-risk. For example, it is a core public health function to assure that all children are immunized against vaccine-preventable disease. Even though limited resources may compel public health departments to target programs toward those children known to be at particular risk for being under or unimmunized, the public health system remains accountable for the immunization status of the total population of children.

2. **Public health interventions are population-based if they are guided by an assessment of population health status that is determined through a community health assessment process.**
A population-based model of practice analyzes health status (risk factors, problems, protective factors, assets) within populations, establishes priorities, and plans, implements, and evaluates public health programs and strategies.[2] The importance of community assessment cannot be emphasized enough. All public health programs are based on the needs of the community. As communities change, so do community needs. This is why the core function of assessment is so important.[3] Public health agencies need to assess the health status of populations on an ongoing basis, so that public health programs respond appropriately to new and emerging problems, concerns, and opportunities.

3. **Public health interventions are population-based if they consider the broad determinants of health.**
A population-based approach examines all factors that promote or prevent health. It focuses on the entire range of factors that determine health, rather than just personal health risks or disease. Examples of health determinants include income and social status, housing, nutrition, employment and working conditions, social support networks, education, neighborhood safety and violence issues, physical environment, personal health practices and coping skills, cultural customs and values, and community capacity to support family and economic growth.[4]

4. **Public health interventions are population-based if they consider all levels of prevention, with a preference for primary prevention.**
Prevention is anticipatory action taken to prevent the occurrence of an event or to minimize its effect after it has occurred.[5] A population approach is different from the medical model in which persons seek treatment when they are ill or injured. Not every event is preventable, but every event does have a preventable component. Thus, a population-based approach presumes that prevention may occur at any point–before a problem occurs, when a problem has begun but before signs and symptoms appear, or even after a problem has occurred.

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[2] Population-based practice assessment, planning and evaluation model. (1999). *CHS planning guidelines*. Minnesota Department of Health (attached as an Appendix).

[3] Institute of Medicine. (1988). *The future of public health*. Washington DC: National Academy Press.

[4] See, for instance, Evans, R. G., & Stoddard, G. L. (1990). Producing health, consuming health care. *Social Science and Medicine, 31*, 1347-1363, or, Wilkinson, R., & Marmot, M. (1998). *Social determinants of health: The solid facts*. World Health Organization. Available http://www.who.uk/document/e59555.pdf.

[5] Turnock, B. (1997). *Public health: What it is and how it works.* Gaithersburg, MD: Aspen Publishers.

Primary prevention both promotes health and protects against threats to health. It keeps problems from occurring in the first place. It promotes resiliency and protective factors or reduces susceptibility and exposure to risk factors. Primary prevention is implemented before a problem develops. It targets essentially well populations. Primary prevention promotes health, such as building assets in youth, or keeps problems from occurring, for example, immunizing for vaccine-preventable diseases.

Secondary prevention detects and treats problems in their early stages. It keeps problems from causing serious or long-term effects or from affecting others. It identifies risks or hazards and modifies, removes, or treats them before a problem becomes mroe serious. Secondary prevention is implemented after a problem has begun, but before signs and symptoms appear. It targets populations that have risk factors in common. Secondary prevention detects and treats problems early, such as screening for home safety and correcting hazards before an injury occurs.

Tertiary prevention limits further negative effects from a problem. It keeps existing problems from getting worse. It alleviates the effects of disease and injury and restores individuals to their optimal level of functioning. Tertiary prevention is implemented after a disease or injury has occurred. It targets populations who have experienced disease or injury. Tertiary prevention keeps existing problems from getting worse, for instance, collaborating with health care providers to assure periodic examinations to prevent complications of diabetes such as blindness, renal disease failure, and limb amputation.

Whenever possible, public health programs emphasize primary prevention.

5. **Public health interventions are population-based if they consider all levels of practice. This concept is represented by the inner three rings of the model. The inner rings of the model are labeled community-focused, systems-focused, and individual/family-focused.**
A population-based approach considers intervening at all possible levels of practice. Interventions may be directed at the entire population within a community, the systems that affect the health of those populations, and/or the individuals and families within those populations known to be at risk.

Population-based community-focused practice changes community norms, community attitudes, community awareness, community practices, and community behaviors. They are directed toward entire populations within the community or occasionally toward target groups within those populations. Community-focused practice is measured in terms of what proportion of the population actually changes.

Population-based systems-focused practice changes organizations, policies, laws, and power structures. The focus is not directly on individuals and communities but on the systems that impact health. Changing systems is often a more effective and long-lasting way to impact population health than requiring change from every single individual in a community.

Population-based individual-focused practice changes knowledge, attitudes, beliefs, practices, and behaviors of individuals. This practice level is directed at individuals, alone or as part of a family, class, or group. Individuals receive services because they are identified as belonging to a population-at-risk.

Interventions at each of these levels of practice contribute to the overall goal of improving population health status. Public health professionals determine the most appropriate level(s) of practice based on community need and the availability of effective strategies and resources. No one level of practice is more important than another; in fact, most public health problems are addressed at all three levels, often simultaneously. Consider, for example, smoking rates, which continue to rise among the adolescent population. At the community level of practice, public health nurses coordinate youth led, adult supported, social marketing campaigns intending to change the community norms regarding adolescents' tobacco use. At the systems level of practice, public health nurses facilitate community coalitions that advocate city councils to create stronger ordinances restricting over-the-counter youth access to tobacco. At the individual/ family practice level, public health nurses tach middle school chemical health classes that increase knowledge about the risks of smoking, change attitudes toward tobacco use, and improve "refusal skills" among youth 12-14 years of age.

The interventions are grouped with related interventions; these "wedges" are color coordinated to make them more recognizable. For instance, in practice, the five interventions in the **red (pink) wedge** are frequently implemented in conjunction with one another. Surveillance is often paired with disease and health event investigation, even though either can be implemented independently. Screening frequently follows either surveillance or disease and health event investigation and is often preceded by outreach activities in order to maximize the number of those at risk who actually get screened. Most often, screening leads to case-finding, but this intervention can also be carried out independently or related directly to surveillance and disease and health event investigation. The **green wedge** consists of referral and follow-up, case management, and delegated functions–three interventions which, in practice, are often implemented together. Similarly, health teaching, counseling, and consultation (the **blue wedge**) are more similar than they are different; health teaching and counseling are especially often paired. The interventions in the **orange wedge** –collaboration, coalition building, and community organizing–while distinct, are grouped together because they are all types of collective action and all most often carried out at systems or community levels of practice. Similarly, advocacy, social marketing, and policy development and enforcement (the **yellow wedge**) are often interrelated when implemented. In fact, advocacy is often viewed as a precursor to policy development; social marketing is seen by some as a method of carrying out advocacy.

Where did this model come from?

Health care reform in the 1990s challenged public health nurses to define their contribution to improving population health. In response, the Section of Public Health Nursing at the Minnesota Department of Health constructed a set of interventions that public health nurses use in their practice. The model began as a set of examples of PHN practice collected in 1994 from over 200 experienced Minnesota PHNs. A panel of practice experts from the section identified the common themes within those examples–and the initial set of interventions (Public Health Interventions: Examples from Public Health Nursing, October 1997) was created, depicted as spokes of a wheel. Hundreds of copies of the interventions were distributed within the state and throughout the nation. Reports from PHNs using Interventions I suggested the framework could be quickly adopted to both teach and enrich practice.[6]

The initial interventions framework was practice-based. In July 1998, the Section began intensive work to determine the evidence underlying the interventions. With the award of a grant from the federal Division of Nursing, current public health nursing, nursing, public health, and related literature were explored to identify the theory, research, and expert opinion supporting and enhancing the interventions. In June 1999, forty-six public health nursing practice experts and academics from Iowa, Minnesota, North Dakota, South Dakota, and Wisconsin participated in a consensus meeting and created the bases of the revised intervention set. The recommendations of the regional experts were reviewed and critiqued by a national panel of public health nursing experts. The model withstood the challenge of rigorous examination with only a few changes to the original set of 17. The results of that process are presented in this document. (See Appendix C)

What Is the Relationship Between the Interventions Wheel and the Core Public Health Functions/Essential Services?[7]

Public health nurses fulfill the public health's essential services by implementing interventions to address public health problems and opportunities identified through a community assessment. The specific set of interventions selected and implemented will vary from community to community, from population to population, from problem to problem, and from department to department. Additionally, PHNs will most often accomplish these as part of a team with members from other public health disciplines and other community partners.

[6]Keller, Strohschein, Lia-Hoagberg, & Schaffer. (1998). Population-based public health nursing interventions: A model from practice. *Public Health Nursing, 15*(3), 207-215.

[7]Harrell, J. A. & Baher, E. L. (1994). The essential services of public health. *Leadership in Public Health, 3*(3), 27-31.

How to Use This Framework:
Population-based PHN Interventions at Three Practice Levels

Each of the seventeen interventions is presented separately, using the same format, to increase their usefulness. Here are the components:

1. Definition of an "intervention" and underlying assumptions.

At the top of each intervention's first page is the same set of information in a **box.** This box contains the definition of an "intervention" and the practice assumptions which underlie it, regardless of where it is implemented, or at what level. This box serves as a reminder to the user and includes:

Definition of an Intervention:

Interventions are actions taken by PHNs on behalf of communities and the individuals/families living in them.

> ***Interventions*** **are activities taken by PHNs on behalf of communities and the individuals and families living in them.**
>
> *Assumptions about all PHN Interventions...*
>
> " They are population-based; that is, they:
> - **S**are focused on an entire population
> - **S**are guided by an assessment of community health
> - **S**consider broad determinants of health
> - **S**consider all levels of prevention
> - **S**consider all levels of practice

" The public health nursing process applies at all levels of practice.

2. Definition of the specific intervention.

Next is the "definition" of each intervention. For example:

> **Screening identifies individuals with unrecognized health risk factors or asymptomatic disease conditions in populations.**

3. Example at all practice levels.

Under each definition are examples from public health nursing practice. The intervention is applied at the community, systems, and individual/family levels to a given population and a problem. For example:

Case Management

Population-of-interest: *All children with special health care needs and their families*
Problem: *Fragmented service delivery system*

Community Example:

A PHN works with a local advocacy organization to present programs about the rights of children under the American Disability Act (ADA) to various parents groups within the community. The programs emphasize potential roles for parents to advocate on their children's behalf.

Systems Example:

A variety of professionals who provide services to children with special needs, including public health nursing and school nursing, cooperatively design a centralized intake process to simplify access to services for children with special needs.

Individual/Family Example:

A PHN serves a family with a school-aged boy who uses a wheelchair due to his cerebral palsy. The PHN assists the boy's parents and their primary care practitioner in negotiating a plan to meet the child's educational and physical needs during the school day with the school district.

4. Relationship to other interventions...

Next you will find a description of the relationship of that particular intervention to the others. Remember that interventions may be implemented alone or in conjunction with other interventions. For example:

Relationships to Other Interventions

Policy development and enforcement relates to a variety of other interventions. Since its intent is to bring health issues to the attention of decision-makers for the purpose of changing laws, rules, regulations, ordinances, and policies, it is frequently paired with the other interventions operating predominantly at the community or systems practice levels, such as **collaboration, coalition building,** and especially **community organizing.** The system's level of health teaching, **provider education,** often follows policy development and precedes or is implemented in conjunction with policy enforcement. **Advocacy** is a frequent co-intervention at this level. In contagious disease outbreaks, policy development and enforcement is frequently paired with **surveillance, disease and health event investigation, screening, outreach, case-finding, referral and follow-up, and case management.** At the individual/family level, policy development is often paired with **health teaching, counseling, consultation, case management, and advocacy.**

5. Basic Steps

Next is a list of basic steps describing how to implement this intervention. The basic steps are particularly useful for new PHNs or for PHNs taking on new assignments requiring new skills. While most of the interventions have one set of basic steps for all three levels, some (collaboration, referral and follow-up, case management, and health teaching) have basic steps for individual/family separate from those for community/systems. For example:

BASIC STEPS for Counseling

Working alone or with others, PHNs...

1. **Meet the "client"–the individual, family, system, or community.**
2. **Explore the issues.**
3. **Identify priorities.**
4. **Establish the emotional context**.
5. **Identify alternative solutions**.
6. **Agree on a contract**.
7. **Support the individual, family, system, or community through the change**.
8. **End the relationship.**

6. Best Practices

"Best practices" are derived from the theory, research, and expert opinion reviewed by the expert panel. The best practices are a combination of what the literature suggests and the collective wisdom of the expert panelists who considered them. A PHN's success in implementing an intervention should be increased if the best practices are considered. Best practices foster excellence in intervention implementation. For example:

Best Practices for Advocacy

- **foster the development of the client's capacity to advocate on their own behalf**.
- **use mass media in conjunction with advocacy.**
- **assume the adversarial role when appropriate.**
- **exhibit self-confidence, strength of conviction, and a commitment to social justice**.

7. Notes from Abby...

You will find "Notes from Abby..." throughout this document. "Abby" is a real-life PHN from the mid-1920s who exemplifies public health nursing. She is the logo for the Division of Nursing grant. Her "notes" include resources, tips, and related research findings for enhancing public health nursing practice. Her "words of wisdom" are geared for the PHN who has had some experience with that particular intervention.

8. Best Evidence

The "best evidence" contains citations and abstracts for the articles and texts that were reviewed by the expert panel. This evidence supports the best practices. It is organized into review articles, research reports, expert opinion, and texts and monographs. The scores from the expert panelists are included in the abstracts. An example:

Best Evidence for Coalition Building

Review Articles

Wandersman, A., Goodman, R., & Butterfoss, F. (1997). Understanding coalitions and how they operate: An "open systems" organizational framework. In M. Minkler (Ed.), ***Community organizing and community building for health*** **(pp. 261-277). New York: Rutgers Univ. Press.**

The authors suggest it is useful to think of coalitions (and partnerships and consortia) as organizations and apply Katz and Kahn's open-systems framework to advance the understanding of them. Coalitions are defined as "interorganizational, cooperative, and synergistic working alliances" (p. 263) which serve several purposes. [Note: Katz, D. & Kahn, R. (1978). *The social psychology of organizations* (2nd ed.). New York: Wiley.]

Review=34%

Research Reports

Parker, E., Eng, E., Laraia, B., et al. (1998). Coalition building for prevention: Lessons learned from the North Carolina community-based public health initiative. ***J Public Health Management Practice, 4*****(2), 25-36.**

The authors identify six factors important to coalition functioning and success, based on findings of a four-year observation of four separate North Carolina county coalitions funded by the Kellogg Foundation's Community-Based Public Health Initiative. Rather than focusing on a specific disease category to prevent, this study looks at aspects of coalition development itself. The authors apply Alter and Hage's framework for conceptualizing how stages and levels of collaboration are operationalized in coalition functioning and found the six factors which effected it.

Qualitative=68.5%

9. How to use these interventions...

In general, the intervention framework provides PHNs with a reasoned, systematic approach to practice.

- Use the basic steps to make sure that you are making the most effective use of your time.
- Use these interventions for problem solving when you are stuck or your strategies are not going as you had expected.
- Apply the best practices for planning and evaluating public health nursing interventions.

Specifically, this framework can be used for:

- program planning to assure that all three levels of intervention are considered (that is, have you considered interventions at the community, systems, and individual/family levels)
- examining the scope of an agency's practice

  Do the programs delivered by PHNs cover the entire scope of practice? Are there certain interventions or levels not used?
- describing public health nursing's contribution to collaboration or coalition building
- explaining public health nursing to other disciplines and community members
- orienting new PHN staff
- building and enhancing intervention skills with PHN staff
- determining what changes may be evaluated (health status or intermediate changes at the community, systems, and individual/family levels) as a result of the intervention.

In addition, many schools of nursing have found this framework useful in teaching public health nursing interventions.

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Applications for Public Health Nursing Practice

Surveillance

Public Health Nursing Practice for the 21st Century

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

INTERVENTION: SURVEILLANCE

***Interventions* are activities taken by PHNs on behalf of communities and the individuals and families living in them.**

Assumptions about all PHN Interventions...

- They are population-based; that is, they:
  - Are focused on an entire population
  - Are guided by an assessment of community health
  - Consider broad determinants of health
  - Consider all levels of prevention
  - Consider all levels of practice
- The public health nursing process applies at all levels of practice.

Definition

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.[8]

Examples at All Practice Levels

Population-of-interest: *All children*
Problem: *Developmental delays that prohibit optimal growth*

Community Example:

Parents participate in a follow-along program that identifies children from birth-48 months who are at risk of experiencing health or developmental problems. Parents are solicited to participate in the program at the birth of their child. The child is initially assessed at enrollment in the program. Parents complete mailed questionnaires about their child's development at 4, 8, 12, 16, 20, 24, 30, and 36 months. They return the questionnaire and are contacted if it reveals any delays. Those not returning questionnaires are sent two reminders. If no response is received, the PHN contacts the family.

Systems Example:

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 nurses, 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 ed, 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 received .

[8] Guidelines for evaluating surveillance systems. (1988, May 6). *MMWR, 37*(S-5), 1A.

Individual/Family Example: [Case-Finding]

The results of a questionnaire returned by a parent of an eight-month-old infant suggested possible delays in some developmental areas. This triggered the PHN to make an appointment to see the parents in their home. After administering the Denver Developmental Screening Tool-II, the PHN discussed the results with the parents and answered their questions and concerns. Various referral options for further assessment were established.

Relationships to Other Interventions

Surveillance focuses on significant health threats such as contagious diseases but is also used with other health events such as chronic diseases, injury, and violence. Like **investigation of disease and other health events**, surveillance collects and analyzes health data. Unlike **investigation**, however, surveillance is an ongoing process which detects trends and seeks to identify changes in the *incidence* (that is, the occurrence of new cases over a set period of time) and *prevalence* (that is, the combined number of old and new cases at any one point in time). Many texts treat surveillance and investigation of disease and health events as a single intervention.

Surveillance is often confused with monitoring and/or screening. It is important to differentiate.

Surveillance...	**Monitoring...**
•is used to assess population health status before and after health events	•implies a constant adjustment of what is being done
•looks at whole populations	•looks at specific groups or individuals

Surveillance...	**Screening...**
•measures the population health status	•detects previously unknown cases in a population
•may serve as the method to track cases	•may serve as the method to find cases

BASIC STEPS for Surveillance[9]

Working alone or with others, PHNs...

1. **First consider whether surveillance is appropriate for the circumstances.**
   Consider some or all of the following:
   - importance of the problem as a threat to population health
   - need to learn more about the problem, its patterns of occurrence, and the populations at risk
   - need to establish baseline data (very often the trigger to implement surveillance) and determine the extent to which available data are inadequate.

2. **Acquire necessary knowledge of the problem, its natural course, and its aftermath**
   The PHN should make sure that their knowledge about the problem is up to date and complete. An understanding of the problem's "natural course of history" is especially important. This is the course that the condition would predictably take if nothing were done to intercede. For example, progressive pulmonary tuberculosis kills 50 percent of those infected within 5 years if left untreated. Dental caries continue to decay without treatment. Children with amblyopia, without treatment, eventually lose vision in the affected eye.

   At times, urgency for public health action to prevent negative impacts on health status means making decisions before exact causes are known. Often, PHNs must rely on epidemiological evidence that supports strong associations between risk factors rather than waiting for research findings.

3. **Establish clear criteria for what constitutes a "case."**
   Criteria include person, place, and time (that is, who is at risk, where the event occurs, and when it occurs).

4. **Collect sufficient data from multiple valid sources.**
   - Use existing data sets to provide data for surveillance whenever feasible. The PHN should consider data readily available in your agency or community such as vital records, hospital-discharge data, medical-management-information and billing systems, police records, school records, etc.
   - Check existing registries and surveys for data useful to the population-of-interest.
   - Do not reveal personal identifiers; PHNs must assure confidentiality and protection of privacy.

5. **Analyze data using appropriate scientific and epidemiological principles.**
   The level of analysis required varies from condition to condition. In general, analyses includes such elements as:
   - an assessment of the crude *number of cases* (that is, the number of actual cases) and *rates* (the number of cases per a given denominator, such as 100 persons or 10,000 or 100,000)

[9] Adapted from Teutsch, S., & Churchill, R.E. (1994). *Principles and practice of public health surveillance*. New York: Oxford Press.

- a *description* of the population in which the condition occurs (for example, age, gender, race, and ethnicity)
- *where* the condition occurs
- the period of *time* over which the condition occurs.

6. **Interpret and disseminate the data in such a way that decision-makers at all levels can readily identify and understand the implications.**
   This means the dissemination plan must be developed to fit the intended data users. Disseminate the information on a regular basis, not just during times of crisis.

7. **Evaluate the impact of the surveillance system:**
   - Was the data collected sufficient to support accurate analysis?
   - Did it generate answers to problems?
   - Was the information timely?
   - Was it useful to those interested?
   - How was the information used?
   - How can it be made of greater use?

Notes from Abby

The February 2000 issue of the *AAOHN Journal* (Vol. 48, No. 2) includes a series of articles describing surveillance and screening interventions as "vital roles" for the PHN working in occupational and environmental health. See Pap, E., & Miller, A. Screening and surveillance: OSHA's medical surveillance provisions, pp. 59-72; Stone, D. Health surveillance for health care workers: A vital role for the occupational and environmental health nurse, pp. 73-79; Rogers, B., & Livsey, K. Occupational health, surveillance, screening, and prevention in occupational health nursing practice, pp. 92-99.

Notes from Abby

Classifications of Surveillance Systems

Surveillance systems usually exemplify one of each of the following classifications. For instance, a cancer surveillance system is usually passive, ongoing, and formal.

1. Surveillance systems are conventionally classified as either passive or active.

Passive:

Systems in which the health jurisdiction (that is, federal, state, or local health departments) receive reports of disease or health events from physicians or other individuals or institutions often mandated by state law. States' reportable disease systems are examples. Most surveillance systems are passive.

Active:

Systems in which the health jurisdiction regularly contacts reporting sources to elicit reports, including negative reports (that is, no cases). Active systems collect more complete data but are labor-intensive and, therefore, expensive to implement. They are usually only indicated in unusual or unpredictable circumstances, such as evidence of a new or rarely seen pathogen.

2. Surveillance systems may be either ongoing or time-limited.

Ongoing:

Systematic collection of data over time on selected diseases or health events that impact the health of the population. Examples include registries (for example, immunization, birth defect, cancer) or child maltreatment and vulnerable adult reporting systems. **Sentinel surveillance systems** are special cases of surveillance that track single key health indicators in the general or special populations. A sentinel health event is a "case of unnecessary disease, unnecessary disability, or untimely death whose occurrence is a warning signal that the quality of preventive and/or medical...care may need to be improved."* For example, an infant death from methemoglobinemia is a sentinel event for water contamination, as is the occurrence of mesothelioma for asbestos exposure, a maternal death from any cause, or an outbreak of rubeola.

Time-Limited:

Systematic collection of data on specific problems or concerns for a specific time period. This may identify all cases in order to assess the level of risk or threat or, when resources are limited, estimate the size through sampling. Most active surveillance systems are limited systems. For example, a state instituted a "rash" surveillance system in a recent rubella outbreak among a migrant Hispanic population, but only for a few months.

*Seligman, & Frazier. (1992). Surveillance: The public health approach. In Baker and Monson (Eds.) *Public health surveillance* (pp. 16-25). NY: Vaurbstrand Reinhold. As quoted in Friis, & Sellars. (1996). *Epidemiology for public health practice* (p. 359). Gaithersburg, MD: Aspen Publishers.

Notes from Abby

Classifications of Surveillance Systems (continued)

3. Surveillance systems may be formal or informal.

Formal:

Systems with multiple reporters, frequently mandated by law and most often at the state or federal levels of government. Events selected for development of formal systems meet all or most of the following criteria:

- Frequency (that is, a combination of incidence, prevalence, mortality, and years of potential life lost (YPLL)
- Severity (that is, case-fatality ratio, hospitalization rates, disability rates)
- Cost (both direct and indirect)
- Preventability
- Communicability (that is, the risk of spread from person to person)
- Public interest.

Informal:

Surveillance can also be an *informal process* of systematic data collection, often in conjunction with **case-finding.** Implementing the surveillance intervention can be as simple as regularly reviewing the case records in your drawer or laptop to determine what similarities they might have. The PHN is a trained observer, the "eyes and ears on the community," always looking for events, changes, and trends in the community that may impact population health status.

Examples of informal surveillance include:

- *PHN day care consultants initiate a system to collect data on the prevalence and incidence of peanut allergies in young children (ages birth-7) in day care after they observe a dramatic increase in the numbers of day care centers requesting consultation on how to respond to peanut allergy reactions.*
- *At a staff meeting, a PHN who serves children with special needs remarked on how many children in her caseload were multiple births resulting from some sort of technology such as fertility treatments or in vitro fertilization. Several other PHNs commented that they were seeing the same thing in their caseloads. The PHNs decided to initiate a agency-wide data collection system to track this data over time.*
- *PHNs expand their senior clinic assessment by adding an item asking about involvement in motor vehicle crashes after noticing the large number of residents with poor vision and hearing who still hold drivers' licenses.*

Notes from Abby

Surveillance and Epidemiology

Surveillance, as with the **disease and other health event investigation**, requires PHNs to use epidemiology, the science of public health. Epidemiology is "the study of the distribution and determinants of diseases and injuries in human populations." Mausner, J.S. & Kramer, S. (1985). *Epidemiology: An introductory text (2nd ed.)*. Philadelphia: WB Saunders, p. 1. The conventional epidemiology model is the "epidemiology triangle:" [Ibid, p. 33]

- *agent* = whatever is thought to cause the disease or risk
- *host* = whatever is affected by the agent
- *environment* = all the factors external to the host and agent which allow or promote the disease or risk.

The model is commonly used to explain infectious* disease transmission, such as Lyme Disease. In this disease,

- the *agent* = the bacterium *Borrelia burgdorferi*, which is transmitted by the bite of infected deer ticks (in the Northeastern and North-Central US) and western black-legged ticks (on the Pacific Coast)
- the *host* = humans and other mammals
- the *environment* = the woods and overgrown brush or residential sites bordering these areas.

The epidemiological triangle may also be used to explain behavioral risk factors and other threats to health, such as obesity. In this condition:

- the *agent* or causal factor = an imbalance between caloric intake and kilocalories burned through physical activity
- the *host* = the person who is born with certain metabolic characteristics as well as learned (i.e., behavioral) characteristics such as eating and exercise habits
- the *environment* = all the social factors promoting overeating and underexercising, such as fast food establishments, 32-ounce servings of soda, sedentary lifestyle, lack of safe walking trails.

Regardless of the disease or event, using the agent-host-environment model to organize the information collected can help identify connections or patterns. These points of connection often serve as the focal points for prevention strategies.

**infectious* - communicable conditions (i.e., diseases) caused by microbes, such as bacteria or viruses
communicable - a condition that readily spreads from person to person
contagious - a condition that is very communicable, or which spreads rapidly from person to person
[From: Bacteriophage Ecology Group glossary at <www.phage.org/microbiology.htm>]

BEST PRACTICES for Surveillance

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who developed theory blending from the literature with their practical expertise. These best practices are <u>not</u> presented in any ranking or particular order; each may not apply to every implementation of the intervention.

1. IDENTIFIES AND UTILIZES SUCCESSFUL SURVEILLANCE SYSTEMS.

Best Evidence: Centers for Disease Control and Prevention, 1988

Recognized attributes of successful surveillance systems include:

- simplicity of design and flexibility in data collection that allow changes to the system without adding cost to the process
- acceptability to those participating
- sensitivity, in that they detect what they are supposed to
- predictiveness, or the extent to which the rates found can be trusted to apply to a larger or different group
- representativeness, or the quality of the data (including sufficiency)
- timeliness, or the speed between steps in the process**.**

2. PERFORMS THE ROLES WARRANTED BY THE SPECIFIC CIRCUMSTANCES AND AGENCY RESOURCES.

Best Evidence: panel recommendation based on practice expertise

Roles in surveillance include leader, contributor, or user of information. At times the PHN may assume multiple roles within the same surveillance process. If the PHN is involved in infectious disease surveillance, for instance, the PHN may well participate in the collection of data from suspected cases (contributor role) and, based on analysis of that data, determine what appropriate next steps might be (user role).

However, PHNs should also keep in mind that implementing surveillance does not need a large and complex system if the problem is not large and complex. Relying on data routinely collected in the course of a workday can be extremely useful. For instance, by tracking the addresses of clients who constantly do not keep clinic appointments and connecting them with availability of public transportation, patterns may be noted that might lead to different conclusions than "willful noncompliance."

The critical issue in the surveillance intervention is to assure that data collected must be consistently and reliably recorded in order for it to be used. Remember the old axiom from nursing documentation, "What doesn't get recorded doesn't count." The same applies here.

3. DESIGNS SURVEILLANCE SYSTEMS (FORMAL OR INFORMAL) THAT UTILIZE MULTIPLE DATA SOURCES WHICH INCLUDE PERSON, PLACE AND TIME ELEMENTS.

Best Evidence: Teutsch & Churchill; Valanis; Stroup & Teutsch; Swanson and Nies

Numerous useful data bases exist; PHNs implementing surveillance need to be at least familiar with the following data bases for the populations they serve:

- vital statistics (birth and death numbers and rates, marriages, and dissolutions/annulments)
- maternal and child health statistics (fetal and infant mortality, birth weight, maternal mortality)
- census data (population size and change, age, gender, race and ethnicity, residence location, housing stock)
- registries (immunization, cancer, etc.)
- surveys
- administrative data sets (for example, hospital discharge data).

4. UTILIZES DATA COLLECTION METHODS THAT ARE INTEGRATED, COLLABORATIVE, COORDINATED, AND GENERATE USEFUL DATA.

Best Evidence: Meservy, Bass & Toth; Pottinger, Herwaldt & Perl; Stroup & Teutsch; Bakhshi; Meriwether

Surveillance is most effective when done in conjunction with other systems in the community (for example, the health care system, education, or social services) and/or with interest groups also concerned about the same problem. Collaborating on data collection has advantages:

- access to other data sets such as those routinely used by education systems or hospital or ambulatory care facilities
- potential to design coordinated data collection systems among the partners from the start of a process (rather than each system collecting their own data), which insures comparability for analysis
- potential for shared technological capacity
- discussion with collaborators regarding the measures or indicators to collect invariably leads to discussion and clarification of the reasons and concerns leading to the collection; this, in turn, leads to a stronger product and greater commitment among those involved.

While all authors cited noted the advantages of collaboration, Meriwether perhaps states it most clearly. She reports on the 1996 the Council of State and Territorial Epidemiologists' recommendation to the CDC that it develop a national surveillance system with improved capacity and flexibility. Among the nine principles noted is the requirement for "collaboration within and across systems."

5. COLLECTS DATA WHICH SUPPORT THE DEVELOPMENT OF STRATEGIES AT MULTIPLE LEVELS OF PREVENTION.

Best Evidence: Meservy, Bass & Toth; Halperin; Spradley & Allender

Given that effectiveness of public health strategies is almost always designed with the three levels of prevention in mind, surveillance systems should also yield data that reflect those levels– primary, secondary, and tertiary. Although limited resources often force public health to deal with immediate issues at the expense of long-term prevention, the more PHNs can anticipate a disease or health event, the more likely they can design effective counter measures. The most effective strategies, that is, primary prevention prevent an event from occurring in the first place. The classic examples of primary prevention are vaccinating against infectious diseases, chlorinating public water supplies to prevent pathogen growth, and promoting optimum nutrition to prevent anemia in pregnant women.

Not all health events are preventable. Natural disasters cannot be prevented, but public health can reduce the severity of their impact by taking preventive measures. Building levees to control floods, for instance, or designating tornado shelters for residents of trailer home parks lessen the impact. In these circumstances, public health usually calls the measures "mitigation" rather than "prevention."[10]

6. SEEKS OUT AND UTILIZES SURVEILLANCE DATA TO INFLUENCE POLICY DEVELOPMENT.

Best Evidence: Stroup and Teutsch; Mercy, Ikeda & Powell; Peterson & Chen; Pottinger, Herwaldt & Perl

A primary reason for implementing surveillance is to support action. Implementing and maintaining surveillance is a waste of resources if it is not used to change something. In fact, Stroup and Teutsch suggest that the analysis, interpretation, and use of the data (i.e., the changes) is the defining difference between surveillance and data collection systems (p. 22). The change may be small, such as altering agency policy on scheduling immunization clinic hours. Or it may be large: allowing the use of public assistance funds to pay for telephone service for families with medically fragile children results in reduced emergency room utilization, since the families can call the emergency room first to determine whether or not the child needs to be seen.

The literature search also revealed surveillance issues related to special populations or problems. For instance, Peterson and Chen report that minor changes to a case definition of undernutrition can lead to significantly different policy paths. Similar implications for firearm-related injury prevention policy are described by Mercy, Ikeda, and Powell. They illustrate that, although developing useful systems is complex, once completed, such systems are extremely useful in designing strategies at multiple levels. Pottinger and others discuss infectious disease surveillance in a hospital setting and, in doing so, illustrate how this data is useful in establishing hospital policy.

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[10] Bringing together different disciplines adds multiple perspectives to the understanding of the situation and possible responses. It may also add confusion. The three-level model of prevention cited above is commonly understood by most public health professionals. However, other disciplines use these same terms with very different meanings.

Notes from Abby

For PHNs interested in further developing their knowledge and skills in surveillance, CDC offers a training manual used in conjunction with Teutsch and Churchill's book. The 14-lesson web-based course is called "Surveillance in a Suitcase," and includes two work exercises. Contact: www.cdc.gov/epo/surveillancein/

The Internet allows access to numerous data bases. For starters, take a look at the variety available from the National Center for Health Statistics at www.cdc.gov/nchs. Many of the data bases also have direct links to state- and county-level related data.

BEST EVIDENCE for Surveillance

Each item was first reviewed for research quality and integrity by graduate students in public health nursing and then critiqued for its application to practice by at least two members of a panel of practice and academic experts. The nature of the material and a score expressed as a percentage are included at the end of each annotated citation. The percentage is the average of scores assessed by the experts who reviewed it. It reflects their opinion of the strength of the item's contribution to practice.

Review Articles

none

Research Reports

none

Expert Opinion

Meservy, D., Bass, J., & Toth, W. (1997, October). Health surveillance: Effective components of a successful program. *AAOHN JOURNAL, 45*(10), 500-512.

The authors, writing from an occupational health perspective, define occupational health surveillance as the process of systematically monitoring the health status of worker populations to gather data about the effects of workplace exposures and using the data to prevent illness or injury. The purpose is to link workplace exposures to adverse health outcomes and, thus, design control measure to prevent illness and injury in other individuals" (p. 500). Screening and monitoring are seen as surveillance's two major components. Surveillance is described as a special application of the nursing process: assessment=exposures; diagnosis=populations, rather than individuals; planning=answers to the questions of who should be screened, for what, how often, what will be done with results, and referral mechanisms in place; implementation=integration of health education; evaluation=outcomes.
Expert Opinion=67%

Bakhshi, S. (1997). Framework of epidemiological principles underlying chemical incidents surveillance plans and training implications for public health practitioners. *J Public Health Medicine, 19*(3), 333-340.

Describes the application of principles of the epidemiologic investigation of infectious disease to exposure to hazardous materials. Surveillance is used synonymously with disease investigation in this article. Preliminary steps: 1) Establish the "adverse exposure factor" through analysis of descriptive statistics related to the event; 2) Determine the appropriate geographic area and nature of the exposure, and define the population at risk; 3) Determine demographic and injury details, and produce the case definition based on the most commonly recurring symptoms or factors; 4) Determine appropriate denominators (e.g., whole population or targeted), and calculate rates.
Response Steps: 1) Establish the case definition; 2) Define the population at risk, i.e., the population group or groups in which the disease or problem could occur; 3) Collect needed data; 4) Manage collected data; 5) Analyze collected data to determine where the event is occurring, when it occurs, and its rate of occurrence; 6) Develop causal hypothesis taking into account exposure potential and dose load;
7) Evaluate.
Expert Opinion=51%

Halperin, W. (1996). The role of surveillance in the hierarchy of prevention.*Am J of Industrial Medicine, 29,* 321-323.

Surveillance is posed not as a prevention intervention in and of itself but "rather a technique for collecting, analyzing, and using information about the intervention techniques." Halperin describes surveillance in occupational health as "the systematic collection and analysis of information concerning hazards, disease, or injury for the purpose of prevention of occupational disease or injury."

Expert Opinion=51%

Meriwether, R. (1996). Blueprint for a national public health surveillance 21st century. *J. Public Health Mgmt Practice, 2*(4), 16-23.

The author, a physician with the Louisiana State Health Department and a member of the Council of State and Territorial Epidemiologists, proposes a new "National Public Health Surveillance System" as the conceptual framework for all public health surveillance and assessment activities into the next century. The organizing principles include: 1) public health surveillance for any health event (disease, condition, injury, or other outcome) or determinant (behavioral and biological risk factors, exposures, and medical care) means the ongoing collection, analysis, interpretation, and dissemination of data for a stated public health purpose; 2) public health assessment includes ongoing surveillance activities, analytic studies to evaluate hypotheses arising form surveillance data and other sources, and program or service evaluation; 3) surveillance and assessment efforts need to be prioritized because of limited resources; 4) adequate resources are needed; 5) collaboration within and across systems will be required; 6) goals differ at different levels of the public health system and over time; 7) surveillance methods and resources should be matched to surveillance goals; 8) high quality data are needed if surveillance and assessment information are to be relied upon in public health decision making; 9) confidentiality of public health surveillance data must be assured.

Expert Opinion=50%

Mercy, J., Ikeda, R., & Powell, K. (1998). Firearm-related injury surveillance: An overview of progress and the challenges ahead. *Am J Prev Med, 15*(3S), 6-16.

The authors critique current firearm-related injury surveillance systems and elaborate on special issues relating to firearms injury data. These include: 1) determining the case definition (i.e., the focus of the surveillance system): should it be limited to firearm-related injury, violence-related injury, or all injury? 2) data collection: reliance on ICD-9-CM E codes is not consistent and will be irrelevant (and replaced) when the ICD-10 is implemented; lack of standardization across states and within states; lack of product-specific injury data (that is, type of gun); difficulty in linking data systems.

Expert Opinion=46.5%

Peterson, K. E., & Chen, L. C. (1990). Defining undernutrition for public health purposes in the United States. *J Nutrition, 120,* 933-942.

This 1989 presentation on the identification and prevalence of undernutrition in the U.S. reviews both the necessity of inconsistent definitions of undernutrition and the dilemmas that causes. The article presents a thorough review of the impact of manipulating variables within a case definition.

Expert Opinion=42%

Pottinger, J., Herwaltdt, L. A., & Perl, T. M. (1997, July). Basics of surveillance—an overview. *Infection Control and Hospital Epidemiology, 18*(7), 513-526.

Although this article uses cases from hospital infection control for examples, its discussion of components and processes is relevant to other settings. Surveillance is a dynamic process for gathering, managing, analyzing, and

reporting data on events that occur in a specific population" (p. 513). Its components include: 1) Defining the event and the population to be studied; 2) Collecting data either concurrently or retrospectively; 3) Organizing and managing the data; 4) Analyzing and interpreting the data; 5) Communicating the results. Specific surveillance methods are described, including:
1) Periodic surveillance: performed on a regular, scheduled, intermittent, and not ongoing basis;
2) Prevalence survey: determine the number of active cases during a specified time period;
3) Targeted surveillance: limit the scope of a process to a single population or sub-population;
4) Outbreak thresholds: determine baseline data.
Expert Opinion=24%

Texts and Monographs

Valanis, B. (1992). Disease control and surveillance. In *Epidemiology in nursing and health care* (2nd ed.). Norwalk: Appleton-Lang.
Establishes a list of questions to be answered in preparation for planning a surveillance system:

1. How is a case to be defined, and what is to be reported?
2. Where is the information to come from?
3. Who reports it?
4. Who is responsible for it?
5. How frequently is it to be reported or analyzed?
6. What is to be done with the raw data once it is in hand?
7. How is it to be evaluated?
8. Who needs the information?
9. Who will evaluate the generated information? (p. 312)

Valanis suggests that the need for investigation is flagged when interpretation of surveillance data is impossible or inconclusive.
Text=62%

[**NOTE**: Valanis heavily relied on the CDC document *Guidelines for Evaluating Surveillance Systems* (1988, May 6) (*MMWR Supplement, 37*(S-5), 1-18) in preparation of her chapter. Although it was not presented to the panel of experts for review, the following information from it is pertinent:
Definition "Epidemiologic surveillance is the ongoing and systematic collection, analysis, and interpretation of health data in the process of describing and monitoring a health event. This information is used for the planning, implementing, and evaluation of public health interventions and programs. Surveillance data are used both to determine the need for public health action and to assess the effectiveness of programs."
Components of a surveillance system answer the following questions: 1) What is the population under surveillance? 2) What is the period of time of the data collection? 3) What information is collected? 4) Who provides the surveillance information? What is the data source? 5) How is the information transferred? 6) How is the information stored? 7) Who analyzes the data? 8) How are the data analyzed, and how often?
Attributes of a successful surveillance system: 1) simplicity (i.e., the complexity of the system design and its size), 2) flexibility (i.e., the ability to adapt to changing information needs or operating conditions with little additional cost), 3) acceptability (i.e., the willingness of individuals and organizations to participate), 4) sensitivity (i.e., the proportion of cases detected by the system and its ability to detect trends), 5) predictiveness (i.e., the proportion of persons

identified as having cases who actually do have the condition under surveillance), 6) representativeness (i.e., the quality of data), 7) timeliness (i.e., the speed or delay between steps in a system).
Not Reviewed]

Teutsch, S., & Churchill, R. E. (Eds.). (1994). *Principles and Practice of Public Health Surveillance*. New York: Oxford Press.

Chpt 1: Historical Development– Authors point out that public health surveillance has been used since the late 1960s as a broader concept than its earlier restricted use in relation to contagious diseases. They suggest it is inherently an official (i.e., government) function and serves to "tell the health officer where the problems are, who is affected, and where programmatic and prevention activities should be directed" (p. 8).

Chpt 2: Considerations in Planning a Surveillance System– High-priority health events should be the focus of surveillance systems, selected based on the following criteria: frequency (e.g., incidence, prevalence, mortality, YPLL); severity (e.g., case-fatality ratio, hospitalization rate, disability rate); cost (direct and indirect); preventability; communicability; public interest (p. 20).

Methods for establishing a surveillance system include: 1) achieving a clear case definition that includes criteria for person, place, and time, criteria to differentiate between a suspected versus a confirmed case, and epidemiological features; 2) systematic data collection; 3) field testing the system; 4) data analysis; 5) interpretation and dissemination, including recommendations for action; 6) evaluation. The author acknowledges that "a clear understanding of how policymakers, voluntary and professional groups, researchers, and other might use surveillance data is valuable in garnering the support of these audiences for surveillance systems" (p. 27).

Chpt 7: Communicating Information for Action– Suggests adapting a model proposed by Hiebert, Ungurait, and Bohn as the basis for communicating surveillance results and what they suggest: 1) establish the message; 2) define the audience; 3) select the channel for communication; 4) market the message by limiting it to the single over-riding communication objective (i.e., SOCO) which should establish what is new, who is affected, and what works; 5) evaluate the impact.

Chpt 9: Ethical Issues– Suggests an ethical "checklist" for public health surveillance: 1) Justify the system in terms of maximizing potential public health benefits and minimizing public and individual harm; 2) Justify use of identified data and the maintenance of records with identifies; 3) Have surveillance protocols and analytic research reviewed by colleagues, and share data and findings with colleagues and the public health community at large; 5) Assure the protection of confidentiality of subjects; 6) Inform health-care providers of conditions germane to their patients; 7) Inform the public, the public health community, and clinicians of findings of surveillance.

Text=60%

Swanson, J., & Nies, M. (1997). *Community Health Nursing* (2nd ed.). Philadelphia: W.B. Saunders, 103-105.

Discusses surveillance as distinct from, but similar to, screening as a "mechanism for the ongoing collection of health information in a community." Describes various national data sets and their use for surveillance.

Text=59%

Declich, S., & Carter, A. O. (1994). Public health surveillance: Historical origins, methods and evaluation. *Bulletin of the WHO, 72*(2), 285-314.

This document reviews the historical evolution of surveillance as distinct from epidemiology. Although both surveillance and monitoring involve the routine and ongoing collection of data with methods which are pragmatic and rapid, surveillance is used to assess population health status before and after an intervention of "health events," whereas monitoring implies a constant adjustment of performance in relation to the results. Surveillance deals with population health events; monitoring looks at specific groups or individuals (p. 288).

The authors use CDC's criteria for evaluating surveillance systems. If establishing a new system, they suggest the following components: 1) justifying need based on the importance of the event, the availability of prevention or control measures, the need to learn more about the event, its patterns of occurrence and the population at risk, the need to establish baseline data, and/or available data and alternative sources are not adequate; 2) describing the objectives (describing the ongoing pattern of disease occurrence and/or linking with public health action and/or studying the natural history and epidemiology of the event; to provide information and baseline data); 3) defining the event and the population of concern; 4) collecting and processing data; 5) analyzing and interpreting data; 6) recommending and disseminating public health action; 7) personnel and other resources required; 8) evaluating.
Monograph=48%

Spradley, B., & Allender, J. (1996). Control of communicable diseases: Surveillance measures. *Community health nursing: Concepts and practice* (4th ed.). Lippincott, 507-509.
Surveillance is defined in the context of communicable disease control involving three steps: systematic collection of data pertaining to the occurrence of specific diseases; analysis and interpretation of data; dissemination of aggregated and processed information for the purposes of program interventions. Uses for surveillance data include providing a well-accepted basis for planning community interventions as well as measuring change as a result of those interventions, and identifying population groups at highest risk.
Text=46%

Stroup, D., & Teutsch, S. (1998). Statistics in public health: Qualitative approaches to public health problems. New York: Oxford Press.
Chpt 3: Data Sources for Public Health (p 39-57)
Surveillance is defined as "the ongoing and systematic collection, analysis, and interpretation of outcome-specific data, closely integrated with the timely dissemination of those data to those responsible for preventing and controlling disease and injury (p. 40). The authors see surveillance as one of a variety of sources of data for public health decision making, along with vital statistics and the census; surveys; registries; epidemic investigations; research; program evaluations.

Chpt 4: Monitoring the Health of a Population (p 59-90)
The term "monitoring" applies to the process used to achieve public health surveillance (p 60). Four basic types of applications are suggested, including identifying new health problems; characterizing geographic and demographic distributions of health problems; determining temporal trends of known health problems; assessing effectiveness of interventions or control measures for a health problem.
Steps: 1) Identify the health problem and quantify the geographic and demographic distribution; 2) Decide what will be monitored, and develop good working definitions for the phenomena being monitored (e.g., causal agents, risk factors, and health problems); 3) Establish the extent of the geographic area to be monitored; 4) Establish the frequency with which data will be collected and over what period of time; 5) Establish the nature of the population to be monitored; 6) Determine how data will be managed; 7) Provide for quality review of the data and its interpretation.
Text=41%

Public Health Interventions

Applications for Public Health Nursing Practice

Disease & Health Event Investigation

Public Health Nursing Practice for the 21st Century
March 2001

For Further Information please contact:
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Minnesota Department of Health
Division of Community Health Services
Public Health Nursing Section

INTERVENTION: DISEASE AND OTHER HEALTH EVENT INVESTIGATION

***Interventions* are activities taken by PHNs on behalf of communities and the individuals and families living in them.**

Assumptions about all PHN Interventions...

- They are population-based; that is, they:
  - Are focused on an entire population
  - Are guided by an assessment of community health
  - Consider broad determinants of health
  - Consider all levels of prevention
  - Consider all levels of practice
- The public health nursing process applies at all levels of practice.

Definition

Disease and other health event investigation systematically gathers and analyzes data regarding threats[11] to the health of populations, ascertains the source of the threat, identifies cases and others at risk, and determines control measures.

The threats may be actual or potential. While investigation traditionally focuses on contagious diseases, it also may be used with chronic diseases, injury, and other health events. The investigative process consists of identifying and verifying the source of the threat; identifying cases, their contacts, and others at risk, determining control measures, and communicating with the public, as needed.

Examples at All Practice Levels

Population-of-interest: *Persons displaced by flooding*[12]
Problem: *Potential for disease outbreak*

Community Example:

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

[11] Examples of "threats to health" include acts of bioterrorism, chemical or other hazardous waste spills, and natural disasters such as tornadoes, floods, hurricanes, earthquakes, extreme heat or cold.

[12] Not all health events are preventable. Natural disasters cannot be prevented, but public health can reduce the severity of their impact by taking preventive measures. In these circumstances, public health usually calls these actions "mitigation" rather than "prevention."

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.

Systems Example:

The PHNs coordinate with local physicians and the Federal Emergency Management Agency to collect information on contagious diseases systematically among persons who have been displaced by massive flooding. Most people are living in a large emergency shelter in an old armory. The group is particularly concerned about potential water-borne disease, since drinking water is in short supply. They set up a protocol and team for immediate response to isolate all suspected "cases" and to minimize the potential for disease spread.

Individual/Family Example [Case-Finding]:

The PHNs hold a daily sick call in the emergency shelter. A mother brings in her three-year-old with obvious signs and symptoms of chicken pox. The PHN questions the woman about exposure, and the mother volunteers that she has received a letter from day care about chicken pox right before the flood. The PHN asks the names of other children who attended the day care and are also in the shelter. The PHN seeks them out to determine if they should be isolated.

Relationships to Other Interventions

Investigation is a key component of **surveillance**; these two interventions are often discussed as a single process. However, the investigation process also stands alone when broadly applied as a data gathering or "fact finding" methodology. In addition, surveillance is prospective, looking ahead for expected events; investigation is usually retrospective, or initiated in response to an unexpected event. Investigation frequently leads to **case-finding** and **referral and follow-up**.

Notes from Abby

The PHNs commonly conduct or participate in many different types of disease and other health event investigations in their regular practice. Examples include investigation of:

- garbage houses
- lice and scabies
- maltreatment of vulnerable individuals
- lead
- food-borne and water-borne outbreaks
- communicable diseases, such as tuberculosis, meningitis, and giardia
- vaccine-preventable disease, such as measles, mumps, rubella, pertussis, and diphtheria
- rabies
- sexually transmitted diseases, such as gonorrhea, syphilis, and chlamydia
- chemical spills
- suicide
- cancer
- flooding, tornadoes, and other natural disasters
- asbestos

BASIC STEPS for Disease and Other Health Event Investigation[13]

Working alone or with others, PHNs...

1. Define the problem:

The PHN should correctly identify the disease or event and its source. This frequently requires gathering data from multiple sources simultaneously to understand the etiology (that is, the cause), natural course, and expected sequella (that is, the resulting conditions of the disease or health event).

2. Establish clear criteria for what constitutes a "case."

Criteria include: person, place, and time; that is, who is at risk, where the event occurs, and when it occurs.

3. Consider existing data.

Determine what is currently known about identified cases in terms of persons, places, and time. Collect and analyze data from multiple valid sources using appropriate scientific and epidemiologic principles. This includes both primary data (that is, data directly obtained by the PHN) and secondary data (that is, data received from others).

- **Person:**

  Who and how many are affected? Who else might be affected? Is there a connection between the people affected and their age, sex, race, and socioeconomic status ?

  For example, in investigating playground injuries among children, are all injuries reported or only those directly observed? Are all injuries requiring first aid attention reported, only those referred to a physician, or only injuries resulting in loss of school attendance reported?

- **Place:**

  Does it matter where people live or work? Are the cases limited to a certain area or widely dispersed? Does the area naturally harbor certain disease agents?

  Again, in investigating playground injuries, does the type of equipment relate to the types of injury? Does the nature of the surface (that is, grass, asphalt, or sand) on which the injury occurred make a difference? Does the presence of other children also using the equipment matter? What other circumstances surround the injuries?

- **Time:**

  Does the time of day or association with a specific event, such as weather conditions, appear to make a difference?

  For the playground injury investigation, what time of day, what weather conditions, and under what supervision conditions did the injuries occur?

[13]Adapted from: Friis, R., & Sellers, T. (1996). *Epidemiology for public health practice (pp. 324-325).* Gaithersburg, MD: Aspen Publishing.

4. Generate and analyze additional data using appropriate scientific and epidemiological principles.

Depending on the nature of the suspected disease or event, this may include:

- direct observation
- clinical data such as:
  - < interviewing cases
  - < performing physical assessment
  - < collecting specimens.
  - < reviewing available lab data.

Specific interview and assessment protocols are often used to assure consistency in data gathering.

5. Determine, based on the analysis, what factors are likely to cause the problem or risk.

Arriving at an accurate conclusion requires careful and thorough consideration; be as sure as possible. Accuracy may be enhanced by:

- reviewing and comparing reports from previous similar investigations
- conferring with others involved in the investigation
- sharing and comparing data
- carrying out secondary data collection to confirm suspicions.

6. Determine and communicate an appropriate response.[14]

Based on the analysis and conclusions about the problem, its causes, and the conditions in which it occurs, offer options for prevention. First, consider primary prevention options, then secondary prevention options (if primary prevention is infeasible), and, finally, tertiary prevention options (if neither primary or secondary prevention is possible). **Referral and follow-up** should be provided for those in need of treatment.

7. Evaluate the effectiveness of any action taken.

Determine the extent to which the problem or risk was eliminated or prevented. Calculate the resources required and areas where greater efficiencies could be achieved. It is always useful to provide a list of "lessons learned" applicable to future investigations.

[14] Those PHNs working with prevention or protection from specific diseases or other threats to health, such as active tuberculosis, cancer clusters, hazardous exposures, or disaster response, should familiarize themselves with protocols for specific investigations developed by the federal Centers for Disease Control and Prevention (CDC) and other organizations. For reference, see the *Control of Communicable Diseases Manual* published by the American Public Health Association. See also: Pope, Synder, & Mood. (Eds.). (1995). *Nursing, health, and the environment*. Washington D.C. National Academy Press.

Disease and Health Event Investigation and Epidemiology

Disease and other health event investigation, like **surveillance**, requires PHNs to use epidemiology, the science of public health. Epidemiology is "the study of the distribution and determinants of diseases and injuries in human populations."* The conventional epidemiology model is the "epidemiology triangle:"**

- *agent* = whatever is thought to cause the disease or risk
- *host* = whatever is affected by the agent
- *environment* = all the factors external to the host and agent to allow or promote the disease or risk.

The model is commonly used to explain infectious*** disease transmission, such as Lyme Disease. In this disease,

- the *agent* = the bacterium *Borrelia burgdorferi*, which is transmitted by the bite of infected deer ticks (in the Northeastern and North-Central U.S.) and western black-legged ticks (on the Pacific Coast)
- the *host* = humans and other mammals
- the *environment* = the woods and overgrown brush or residential sites bordering these areas.

The epidemiological triangle may also be used to explain behavioral risk factors and other threats to health, such as obesity. In this condition:

- the *agent* or causal factor = an imbalance between caloric intake and kilocalories burned through physical activity
- the *host* = a person who is born with certain metabolic characteristics, as well as learned (i.e., behavioral) characteristics such as eating and exercise habits
- the *environment* = all the social factors promoting overeating and underexercising, such as fast food establishments, 32-ounce servings of soda, sedentary lifestyle, lack of safe walking trails.

Regardless of the disease or event, using the agent-host-environment model to organize information collected can help identify connections or patterns. These points of connection often serve as the focal points of prevention strategies.

Bacteriophage Ecology Group glossary@ <www.phage.org/microbiology.htm>

* Mausner, J.S. & Kramer, S. (1985). Epidemiology: An introductory text (2nd ed.). Philadelphia: WB Saunders, p. 1.

** p. 33.

*** *infectious* - communicable conditions (i.e., diseases) caused by microbes, such as bacteria or viruses

communicable - a condition that readily spreads from person to person

contagious - a condition that is very communicable, or which spreads rapidly from person to person

BEST PRACTICES for Disease and Other Health Event Investigation

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who blended evidence from the literature with their practice expertise. These best practices are <u>not</u> presented in any ranking or particular order; each may not apply to every implementation of the intervention.

1. ESTABLISHES WHAT CONSTITUTES A "CASE."

Best Evidence: Valanis

Criteria considered for infectious or environmentally related cases are commonly found in the literature. While the set below may not fit all problems or risks the PHN may wish to investigate, subsets could be adapted:

- date of *onset*
- *precipitating factors*, or anything that happened before the disease or health event that may have contributed
- date of likely *exposure*
- *symptoms or evidence* of cause for concern
- *duration* of symptoms
- *age*

In addition, use *as specific a name or label* for the problem or threat as possible. Spend sufficient time researching the problem or threat to know how it is commonly named by experts. For instance, "motor vehicle crashes" is more specific than "car accidents." Also, if *confirming laboratory tests* or other scientific measures are available, use them. For instance, a serum titer for rubella antibody is more conclusive evidence of a pregnant woman's immunity than is her memory of having the disease as a child.

2. CONSIDERS WHETHER INVESTIGATION IS THE APPROPRIATE INTERVENTION GIVEN THE CIRCUMSTANCES.

Best Evidence: Hinman

Appropriateness of implementing investigation depends on the following criteria:

A. Assess whether the threat to health poses significant risk to individuals beyond those directly affected.

- If the threat is an *infectious agent*, is it communicable and under what circumstances? For instance, measles, which is a person-to-person airborne transmission, presents a greater urgency for investigation than rabies, which is transmitted by direct contact.
- Is it a *new or unexpected agent* for this population or this geographic area?
  The lowly mosquito serves as a marker, for instance, for disease threat migration.
- Is the *threat limited* to a single location or widely dispersed?
  For example, Lyme disease is limited to habitats that harbor deer ticks or western black-legged ticks.

B. Determine which persons or groups are at greatest risk, where they are located, and what barriers will make it difficult to find them.

Estimate how many persons or groups will need to be investigated to be confident that you have sufficient data to draw conclusions.

C. Determine if it is realistic to investigate everyone who should be investigated, or if a sample would be appropriate.

Although the preference is to investigate everyone, resources often prohibit this. Considerations for determining a sample include:

- Is a particular *age cohort*, such as the very young or the very old, more vulnerable than others?
- Is the available *treatment or intervention* more effective in one group than in others?
- What does the *natural course* of disease suggest, for example, as the incubation period?

D. Consider whether the result of investigation will likely lead to other interventions, and, if so, if resources are adequate to manage them.

Investigation often finds individuals who require further intervention such as **case-finding** or **referral and follow-up** for further diagnosis and treatment.

E. Weigh whether the costs related to the investigation will be offset by the benefits gained.

Consideration of costs must include associated *indirect costs* and *opportunity costs.* Indirect costs include:

- costs of hiring temporary staff to cover for those involved in the investigation
- increased supervisory and administrative time related to implementation
- related training requirements

Opportunity costs include the other activities the resources would have supported had the investigation not been implemented. Given how expensive investigation can be, ask yourself if this is a "need to know" situation or a "nice to know" situation.

F. Assess current staff competency to carry out the investigation.

Additional training resources and/or requests for outside assistance may be needed if greater or different competencies are required.

3. UTILIZES MULTIPLE DATA SOURCES THAT INCLUDE PERSON, PLACE, AND TIME ELEMENTS.

Best Evidence: Valanis; Spradley and Allender

This is key to the investigation intervention. The purpose of investigation is to discover rapidly as much as possible regarding who is at risk, where the event is occurring, and when it is occurring. Based on the data

collected, investigation also includes making an educated guess regarding the "why" or the probable cause(s) of the disease or event.

4. COLLECTS DATA THAT SUPPORT THE DEVELOPMENT OF INTERVENTIONS AT MULTIPLE LEVELS OF PREVENTION.
Best Evidence: Spradley and Allender

Given that effective public health strategies are always designed with the three levels of prevention in mind, investigations should collect data that reflect those levels (i.e., primary, secondary, and tertiary). Although limited resources often force public health to deal with immediate issues at the expense of long-term prevention, the more a disease or health event is anticipated, the more likely effective countermeasures can be designed. The most effective strategies (i.e., primary prevention) prevent an event from occurring in the first place. The classic examples of primary prevention are vaccinating against infectious diseases, chlorinating public water supplies to prevent pathogen growth, and promoting optimum nutrition to prevent anemia in pregnant women.

Not all health events are preventable. Natural disasters cannot be prevented, but public health can reduce the severity of their impact by taking preventive measures. Building levees to control floods, for instance, or designating tornado shelters for residents of trailer home parks lessen the impact. In these circumstances, public health usually calls the measures "mitigation" rather than "prevention."[15]

5. IS ABLE TO PERFORM THE ROLES WARRANTED BY THE SPECIFIC CIRCUMSTANCES AND AGENCY RESOURCES.
Best Evidence: panel recommendation based on practice expertise

Roles in investigation include that of leader, contributor, or user of information. At times the PHN may assume multiple roles within the same investigation process. If the PHN is involved in an infectious disease outbreak investigation, for instance, the PHN may well both participate in the collection of data from suspected cases (contributor role) and, based on analysis of that data, determine the appropriate next steps (user role). Generally, the more frequently an agency is called upon to participate in a given type of investigation, such as food-borne or infectious disease outbreak, the more feasible it becomes for the agency to maintain its own staff trained for these purposes.[16]

However, PHNs should also keep in mind that implementing an investigation does not require a large and complex system if the problem is not large and complex. For instance, in investigating why certain clients consistently missed clinic appointments, a PHN discovered that most of them had addresses in the same

[15] Bringing together different disciplines adds multiple perspectives to the understanding of the situation and possible responses. It may also add confusion. The three-level model of prevention cited above is commonly understood by most public health professionals. However, other disciplines use those same terms with very different meanings.

[16] When rapid response is required, such as in emergency situations, investigation is usually carried out through protocols and procedures developed by public heath agencies and its partners and rehearsed on a regular basis.

neighborhood. With a little more investigation, she connected their missed appointments with the availability of public transportation. This connection led to a different conclusion than "willful noncompliance" and also a different resolution to the problem.

The critical issue in the investigation intervention is to assure that data collected must be consistently and reliably recorded in order for it to be used. Remember the old axiom from nursing documentation, "What doesn't get recorded doesn't count." The same applies here.

6. SEEKS OUT AND UTILIZES INVESTIGATIVE DATA TO INFLUENCE POLICY DEVELOPMENT.

Best Evidence: panel recommendation based on practice expertise

Data collected through investigation of diseases and other health events can serve to support policy recommendations, since it is systematically collected from multiple valid sources using appropriate scientific and epidemiological principles. In other words, investigation contributes to the science base on which policy (that is, legislation, regulation, ordinances, and guidelines that support healthful living) should be based. PHNs use it to influence policy development by informing policy-makerss about actual and potential threats to health and sorting out what part of the popular perception of cause and effect is supported by science, how much is myth, and how much is truly unknown.

BEST EVIDENCE for Disease and Other Health Event Investigation

Each item was first reviewed for research quality and integrity by graduate students in public health nursing and then critiqued for its application to practice by at least two members of a panel of practice and academic experts. The nature of the material and a score expressed as a percentage are included at the end of each annotated citation. The percentage is the average of scores assessed by the experts who reviewed it. It reflects their opinion of the strength of the item's contribution to practice.

Review Articles

none

Research Reports

none

Expert Opinion

Hinman, A. (1998). Evaluating interventions for prevention and control of infections diseases, part I. *J. Public Health Management Practice, 4*(4), 106-113 and Hinman, A. (1998). Evaluating interventions for prevention and control of infections diseases, part II. *J. Public Health Management Practice, 4*(5), 82-90.

In this two-part series, Hinman, who was with CDC at the time the articles were written, suggests criteria for evaluating the effectiveness of prevention and control of infectious diseases. Although not titled "investigation," and developed under the assumption of infectious disease, the components that address investigation are relevant. He suggests that, initially, the following questions be asked (adapted):

1. Is investigation needed? Does the condition present such a significant problem that action is warranted to counteract it? The answer depends on the nature of the threat (e.g., is it new to this population or this geographic area? Is it communicable? Does it pose a real or potential threat to more than one person?).
2. Who or what should be investigated? The answer depends on the risk or threat presented, as well as the ability to investigate thoroughly. For instance, the very young and the elderly are frequently more vulnerable to infectious diseases, but resources may be insufficient to investigate both. On which group should an investigation be focused? For which is there the most effective therapy? Which would provide the "best" return on the resources invested in an investigation? The answers must be weighed separately in each circumstance.
3. Is investigating all who should be investigated realistic? Can those at risk be identified early enough to turn around the results if investigated? Will the results of investigation necessarily result in remediation of the threat or risk?
4. Will the result of investigation likely lead to other interventions, and, if so, are resources adequate to manage them?
5. Will the costs related to investigation be offset by the benefits seen? Note that the indirect costs of investigation and opportunity costs must be considered in addition to the direct costs involved.
6. Does the nature of the investigation require knowledge and skill beyond what a given program or agency has? Will extra costs be incurred training staff or contracting for investigation?

7. What has been the experience related to other similar investigations? Did the benefits equal or exceed the costs involved?

Expert Opinion=47%

Pottinger, J., Herwaldt, L.A., & Perl, T.M. (1997, July). Basics of surveillance–An overview, *Infection Control and Hospital Epidemiology, 18*(7), 513-526.

The first part of this article focuses on surveillance; the rest looks at case-finding methods. Data sources suggested as useful in locating infectious disease trends include total chart review; lab reports; review of client summary data (i.e., "kardex" review); clinical rounds for direct observation; and postdischarge data. When assessing for system effectiveness, consider: Did the system detect events or disease? Were practices changed based on data collected? Were the data disseminated?

Expert Opinion=25%

Texts and Monographs

Valanis, B. (1992). Disease control and surveillance. *Epidemiology in Nursing and Health Care*. (2nd ed.). Norwalk, CT: Appleton-Lane.

Phase I: Preliminary Investigation: This is the time during which additional information is collected to broaden the understanding of the health event or problem considered. It includes possible factors unrelated to the problem itself, such as artifacts inherent in the data, or the reporting process, or introduction of a new or improved diagnostic procedure. If these can be accounted for, then enter the next phase.

Phase II: Active Follow-up: 1) Determine what additional information needs to be collected; 2) review and verify case definition and case status, making modifications of the definition as necessary; 3) delineate an appropriate companion group; 4) seek out additional cases that may not have been reported before; 5) collect, analyze, and interpret new data; and 6) determine implications.

Valanis also includes a list of control measures (i.e., "those activities which reduce or eliminate the epidemic or the problem than has been identified," p. 326): quarantine, immunization, preventive therapy (e.g., gamma globulin), eradication or reduction of host vector, medical treatment, early diagnosis, reduction or removal from exposure, market ban or selective restriction of an agent (e.g., thalidomide utilization), nutritional supplements (e.g., folic acid), product modification (e.g., child-proof safety caps).

Text=62%

Spradley, B. & Allender, J. (1996). Control of communicable diseases: Surveillance measures. *Community Health Nursing: Concepts and Practice* (4th ed.). (pp. 507-509, 520-529). Lippincott.

These authors treat investigation of disease and health events in two ways. In their general discussion of assessing community health status through application of epidemiological methods, they suggest research approaches (i.e., descriptive, analytic, and/or experimental) for investigating the causal mechanisms of health and illness (pp. 272-279). However, in their later discussion of communicable disease control, they present investigation as a secondary prevention method entailing data gathering regarding exposure, contact determination and finding (i.e., case-finding), and referral and follow-up for treatment.

Text=46%

Public Health Interventions

Applications for Public Health Nursing Practice

Outreach

Public Health Nursing Practice for the 21st Century

March 2001

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INTERVENTION: OUTREACH

Interventions **are activities taken by PHNs on behalf of communities and the individuals and families living in them.**

Assumptions about all PHN Interventions...

- They are population-based; that is, they:
  - **S**are focused on an entire population
  - **S**are guided by an assessment of community health
  - **S**consider broad determinants of health
  - **S**consider all levels of prevention
  - **S**consider all levels of practice
- The public health nursing process applies at all levels of practice.

Definition

Outreach locates populations-of-interest or populations-at-risk and provides information about the nature of the concern, what can be done about it, and how services can be obtained.

Outreach activities may be directed at whole communities, targeted populations within those communities, and/or systems that impact the community's health. It includes risk communication. Outreach success is determined by the proportion of those considered at risk who receive the information and act on it.

Examples at All Practice Levels

Population-of-interest: *All women aged 50 and over*
Problem: *Undetected Breast Cancer*

Community Example:

The PHNs provide information on the need for mammography and where to go for low-cost mammography screening to older women at craft fairs, senior living facilities, and congregate dining centers. Included in the packet of information the PHNs present to the women in their audience is a postcard to give to their health care provider when they go in for their mammogram. The PHNs collect these and are able to track the number of women who responded to the outreach message.

Systems Example:

A local health department is participating in the federal breast and cervical cancer program that provides low-cost mammography and cervical screening to women over 50. The PHNs convince pharmacists and grocers in a community to display information on mammography screening prominently on the shelving where feminine hygiene products are sold. The display includes cards explaining how and where women can access affordable mammography screening. The PHNs also convince the owners of the local dress shop and department store to put up posters with mammography information in the dressing rooms in the women's clothing section.

Individual/Family [Case-Finding] example:

The PHN responds to a referral from the local breast and cervical cancer clinic of a woman with positive mammography results who has not responded to their calls. The PHN visits the home and discovers that the woman has not returned to the clinic because of her fear and anxiety. The PHN discusses the woman's fears with her, counsels her about options, and eventually gets her to call the clinic while she is there to set up an appointment for the next day.

Relationships to Other Interventions

At the community practice level, outreach operates similarly to **social marketing**. Principles of social marketing can be used to design and deliver an effective outreach message. A broadly focused social marketing intervention to raise a community's awareness about HIV/AIDS, for instance, can be paired with an outreach intervention designed specifically for those at high-risk, such as IV-drug users or men engaging in sex with men. More commonly, however, outreach is used in conjunction with **health teaching** to inform those at risk about that risk and encourage them to seek attention. Outreach is also often implemented as a precursor to **screening, disease and other health event investigation**, and **case-finding.**

BASIC STEPS for Outreach

Working alone or with others, PHNs…

1. Develop an outreach plan using information from an assessment of the community's health.

A. Identify and specify the issue to be addressed:

- develop a list of what is known and what additional information is needed
- seek out the additional information
- invite participation from other groups, agencies, and providers in the community who share concern about the issue.

B. Describe the "population-of-interest," also known as the target population.

Identify relevant demographic information including:

- number of persons
- age characteristics
- gender characteristics
- racial/ethnic characteristics
- residence/geographical location
- average household income
- educational level of head of household
- occupation of head of household
- economic indicators for the geographical area, such as unemployment rates, job sources, transportation to jobs, etc.

C. Analyze how demographic[17] and other information may be used to develop effective outreach.

Given the population, consider:

- What persons or groups are seen as creditable sources of information? Elders? Parents? Teachers? Peers? How might they be engaged?
- In what language and at what reading levels should written materials be developed?
- Where do people in the population gather? Churches or other places of worship? Clubs or social organizations? Work sites? Schools? Grocery stores? Laundromats? Neighborhood corners?

This information is critical in developing effective outreach.

D. Test the outreach plan to be sure it:

- communicates the right message
- is communicated by the right person or group

[17] Demographic information comes mostly from the U.S. Census, which is collected every ten years. The most recent census was collected in 2000 but reports will not be available immediately. Considerable information is available at the U.S. Census website (www.census.gov). Additionally, state level data is available from each state's demographer's office.

- reaches the right group or persons
- provides the right incentive for change.

Ask other PHNs in your agency and co-workers from other disciplines who also work with the target population to critique the outreach plan before implementation. If possible, recruit a small number of individuals from the target population to critique the outreach plan, as well. This is especially important for any materials developed, whether they are delivered orally or in writing.

2. Implement and monitor the outreach plan.

The greater the amount of time and attention spent in plan development, the greater the likelihood outreach will go smoothly. Once the plan is set, it is important to monitor outreach activities to make sure the plan is followed. This includes supervising any paraprofessional workers who may be involved in the outreach intervention.

3. Evaluate the results of the outreach implementation:

- **Did the target population hear the message?**
  Determine the proportion of the target population who were found and received the message.
- **Who acted on the message?**
  Determine the proportion of the target population who were found, received the message, and acted on it.
- **Who received the message but did not act on?**
  Determine the proportion of the target population who were found, received the message, but did not act on it.
- **Who did not receive the message?**
  Determine the proportion of the target population who were not found and thus did not receive the message.

Identify what barriers prevented people from receiving and/or acting on the message.

- Barriers *external to the population* the PHN is trying to reach; for example, printed information might be above their reading level or transportation might be unavailable.
- Barriers *internal to the population* the PHN is trying to reach; for example, the recommended changes are not in keeping with cultural or ethnic understanding or individuals see no benefit to changing.

Identify what factors contributed to outreach success.

- What factors facilitated success?
- What conditions or factors had to be present in order for facilitation to work?

4. For people who encountered barriers, design supplemental outreach activities that eliminate or overcome them.

This may include activities that are sensitive to characteristics of the target population or concentrated in areas where many people did not receive the message or did not act on the information. For those persons deemed at highest risk, this could include **case-finding**.

Notes from Abby

"Outreach" as a term is ordinarily reserved for informing those at risk who are unknown to the agency. "In reach," on the other hand, refers to methods used to inform or alert clients with whom there has been previous or ongoing contact. Issuing client reminders for scheduling routine preventive health assessments is an example. A considerable literature has formed on the effectiveness of such methods in relationship to mammography appointments. The most effective in-reach methods were found to be :

- women received a letter signed by their personal physician announcing an appointment date and time in the future
- women were asked to respond only if the appointment needed to be rescheduled
- the letter was followed up with a phone call reminder just prior to the scheduled appointment.

[See: Wagner, T.H. (1998). The effectiveness of mailed patient reminders on mammography screening: A meta-analysis. *Am J Prev Med, 14*(1), 64-70.]

Using a method such as focus group interviews with members of the population-of-interest can provide useful information about what outreach methods might work. For example, prior to launching a universally offered home visiting program for newborns, focus group interviews reveal that the best ways to encourage women to participate in the program were to:

- be recommended by someone new moms trust, such as physicians, nurses, other moms
- introduce the program early, so it is not a surprise after delivery
- have program staff visit Lamaze and other childbirth education programs, WIC, early childhood development classes, etc.
- put advertisements in neighborhood papers
- send letters or postcards announcing the program to pregnant people
- make hospital visits to moms after delivery
- promote the program to adopting parents through adoption agencies
- offer an open invitation so women can call for a visit if they change their minds
- include photos of visitors on business cards and brochures.

[From: Minnesota Department of Health, Family Health Division. (1998, June). Promoting healthy beginnings: Findings from focus groups with expecting moms and new parents.]

BEST PRACTICES for Outreach

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who blended evidence from the literature with their practice expertise. These best practices are <u>not</u> presented in any ranking or particular order; each may not apply to every implementation of the intervention.

1. ACCURATELY INTERPRETS AVAILABLE COMMUNITY ASSESSMENT DATA TO DETERMINE POPULATION HEALTH PROBLEMS, RISK, SERVICE NEEDS, AND PROMOTERS AND BARRIERS TO SERVICE ACCESS.

Best Evidence: Blozis, Moon, Cooper; Lambert; Gwyther and Jenkins; May et. al.

The process of clearly identifying the target population suggested by the data requires considerable knowledge of:

- the determinants of health, that is, social, biological, physical, genetic, and economic factors thought to affect health
- current and historical health status indicators and their trends
- knowledge of community norms and cultural influences
- other influencing factors, that is, recent occurrences of natural disasters, such as tornadoes or flooding.

Specific examples include:

- Blozis, Moon, and Cooper found that enrollment in a work-site health promotion program increased when it incorporated worker values determined through an employee survey.

- Lambert improved utilization of health services for migrant farm worker families through:
  - delivering outreach services through an interdisciplinary team at their work or living sites
  - establishing messages that portrayed healthy goals realistic for the families
  - maintaining cultural sensitivity.

  They also found that aggressive **referral and follow-up** was related to improved service utilization.

- Gwyther and Jenkins, also working with migrant farm worker families, observed many of the same factors associated with outreach effectiveness, but also provided mobile vans and an information tracking system.

2. SHAPES OUTREACH ACTIVITIES THAT ADDRESS THE UNIQUE CHARACTERISTICS OF THE TARGET POPULATION.

Best Evidence: May et. al.

Effectiveness depends on the extent to which outreach activities are acceptable and appropriate to the target population. In other words, "know your audience."

Key factors influencing outreach effectiveness include:

- understanding and promoting personal preferences of those in the population-of-interest
- attending to the importance of cultural sensitivity
- involving individuals indigenous to the community is important during outreach development.

May and colleagues describe a particular strategy carried out in the late 1980s in Arizona to recruit urban high-risk women into early prenatal care. They did extensive survey and focus group work prior to developing the outreach activities and found the results to be very useful in determining what types of outreach would or would not work. For instance, they found these factors to be critical for recruitment:

- receiving personal contacts from health workers fluent in the women's first language (in this case, Spanish)
- going door to door to recruit, rather than mailing information
- knowing someone already enrolled in the program.

3. UTILIZES A HOLISTIC, COMPREHENSIVE OUTREACH APPROACH.

Best Evidence: Hurley and others; Clover and Redman; Lambert; Gwyther and Jenkins

Almost all outreach strategies start with a media campaign to increase general awareness and then supplement with more intensive methods to reach a specific target population. A summary of outreach elements found consistently in successful strategies as presented in the literature reviewed include:

- focusing on multiple levels of outreach simultaneously; that is, individual/family, community, neighborhood, or environment
- using every opportunity to do **case-finding** in addition to outreach
- accommodating cultural and ethnic preferences
- utilizing both formal and informal support networks to spread the message
- designing flexible outreach plans that incorporate new information as it becomes available.

4. ADDRESSES POTENTIAL BARRIERS TO OUTREACH IN DEVELOPING AN OUTREACH PLAN.

Best Evidence: Blozis, Moon, Cooper; Jones and Scannell; Gwyther and Jenkins; May et. al.

A well-thought-out, planned approach to outreach is enriched when potential barriers are also considered during plan development. A summary of barriers discussed in the literature includes:

- **geography**
  When the nature of the physical environment prohibits people gathering at, or traveling to, a common place, such as in severe climates or isolated, sparsely populated areas, outreach becomes a greater challenge.
- **time, natural daily rhythms, and schedules**
  If public services announcements on TV are used, broadcasting them at 3 a.m., for instance, is probably not effective outreach, unless you are confident the target population will be watching at that hour. Similarly, accommodating shift-workers' schedules means personally delivered outreach methods cannot all be done between 9 a.m. and 5 p.m.

- **socioeconomic factors**
  Hurley and others found that in Australia a personal letter that included an appointment time increased attendance at free, publicly funded mammography clinics, especially for women from higher socioeconomic status.
- **preferences for service delivery**
  Outreach efforts are most effective when delivered by indigenous workers who speak the same language.
- **ongoing patterns of behavior and lifestyles**
- **health beliefs in general, but those influenced by cultural and ethnic practices and preferences, in particular**.

While the requirement to be sensitive to cultural and ethnic beliefs and practices is noted by all authors reviewed, Lambert and Gwyther and Jenkins offer particular insights. Both report on observations made working with migrant farm laborers:

- Lambert cautions PHNs should be careful not to apply generalized observations made about one cultural group to another. Lambert found that within migrant farm worker women, it was important to understand both the implications of their Mexican culture regarding health beliefs, as well as the sub-culture of women workers.
- Gwyther and Jenkins note Martaus' work in the late 1980s regarding the impact of cultural beliefs on symptom interpretation, treatment actions, and provider-patient relationships:
  - explanation of symptoms involves three basic understandings: emotional origin, germ theory (held by the younger immigrants), and hot/cold imbalance
  - treatment actions are implemented by the women in the culture but must first be approved by the male head of the household
  - expectation that the provider relieve symptoms quickly and effectively while approaching the patient in a personal and warm manner.

5. USES OUTREACH METHODS WITH DEMONSTRATED EFFECTIVENESS.

Best Evidence: panel recommendation based on practice expertise

The PHN should consider the following elements, which are consistently found in effective outreach strategies:

- include some type of personal involvement
- implement multiple outreach strategies, for example, media, community campaigns, informal networks
- utilize trained volunteers drawn from the target population
- incorporate principles of **social marketing**
- build on existing formal networks to which the target population is already connected, such as organizations, associations, and clubs
- build on pre-existing informal networks; for example, social groups, friends, extended family.
  In the opinion of the expert panel, nothing is quite as effective as word of mouth, that is, being endorsed or approved by a person or group who is trusted.

6. INVOLVES ALL KEY STAKEHOLDERS IN DEVELOPING OUTREACH PLANS.

Best Evidence: Hurley and others

Stakeholders include physicians, community organizations, cultural groups, faith-based organizations, service organizations, and others. The composition of the stakeholder group will vary according to the issue addressed.

There are many kinds of motivators for stakeholders. Some are interested in proposed program outcomes because they see a personal benefit in the outcome. Opponents may be interested because they perceive a personal threat. Both types of stakeholders are important to "bring along" in the outreach development process.

When planning outreach strategies, include those who consider themselves invested in the outcome of the effort. This especially pertains to representation from the target population you are attempting to reach. Clover, Redman, and others, found, for instance, that attendance at a free, publically funded mammography clinic was significantly greater in communities where a community participation component was included.

Note: This article was not reviewed by panelists, but the content contributes to the evidence.
[Tyson and Coulter[18] provide insight into what motivates stakeholders. They start with what is known about individual motivation: some people are motivated by the personal benefit they see from their efforts; others do so because they wish to avoid a threat and choose to act defensively. The authors then applied these basic motivations for individual change to test the likelihood of individuals' involvement in community-level outreach strategies. In summary, they concluded that linking threats or benefits to community health to what it could mean to individuals' health promoted involvement. In other words, if an individual believed that his or her own personal health could be affected by whatever happens to the health of the community as a whole, they were more likely to participate in community-level efforts. Conversely, it would appear that promoting action based on altruism or the betterment of the "public good" is not likely to prove motivating in and of itself.]

7. INTEGRATES THE OUTREACH INTERVENTION WITH RELATED ACTIVITIES ADDRESSING THE SAME TARGET POPULATION.

Best Evidence: Jones and Scanell

Jones and Scanell's work with the homeless mentally ill can be reasonably generalized across other populations of concern. Examples from their work include:

- **collaboration** and **coalition building** among organizations focusing on the same target population
- physical co-location across systems
- building community ownership through involvement
- supporting efforts to stimulate resource development
- coordinating simultaneous outreach to individual/families and community providers.

[18] Tyson, B. & Coulter, R. (1999, March). Marketing enlightened self-interest: A model of individual and community oriented motivation. *Social Marketing Quarterly*, *5*(1), 34-49.

Coordinated and comprehensive outreach delivery requires that someone or a group must monitor outreach efforts in order to reduce overlap and maximize impact. This is especially important with hard-to-reach groups, where duplication of effort becomes very costly.

Notes from Abby

Maija Selby-Harrington and colleagues published a series of studies they carried out in the mid-1980s to increase utilization of early and periodic screening, diagnosis, and treatment (EPSDT) services by families with children eligible for Medicaid in North Carolina. A variety of outreach methods were employed, including mailed pamphlets, phone contacts, home visits, and combinations of these. All families received the same basic information about EPSDT on intake to the Medicaid program; a sampling of families who only received this contact served as the comparison in the studies. Their findings included:

- families without phones differed in health-related characteristics far beyond the fact that phones could not be used to contact them regarding the EPSDT program; the authors concluded that lack of phone service served as a proxy indicator for those families who were the poorest of the poor; they had more and younger children, and the parents themselves were younger
- home visits were associated with somewhat greater use of EPSDT services by these families; however, of those families without phones, 44 percent did not receive home visits
- compared outreach strategies (i.e., mailed pamphlets, phone contacts, and home visits) were all associated with greater utilization than informing individuals about the service availability at the time of intake; however, the greater utilization was only true for those families with phones
- among families with phones, a home visit was the most effective, but a phone call was the most cost-effective
- overall, none of the strategies produced the utilization rates desired.

Selby-Harrington, M. et. al. (1995). Increasing medicaid child health screenings: The effectiveness of mailed pamphlets, phone calls, and home visits. *AJPH, 85*(10), 1412-1417. See also Selby-Harrington, M., Tesh, A., Donat, P., & Quade, D. (1995, Dec.). Diversity in rural poor: Differences in households with and without telephones. *Public Health Nursing, 12*(6), 386-392.

BEST EVIDENCE for Outreach

Each item was first reviewed for research quality and integrity by graduate students in public health nursing and then critiqued for its application to practice by at least two members of a panel of practice and academic experts. The nature of the material and a score expressed as a percentage are included at the end of each annotated citation. The percentage is the average of scores assessed by the experts who reviewed it. It reflects their opinion of the strength of the item's contribution.

Review Articles

Gwyther, M., & Jenkins, M. (1998, March/April). Migrant farmworker children: Health status, barriers to care, and nursing innovations in health care delivery. *J. Pediatric Health Care, 12*(2), 60-66.

The authors review the literature and determine major barriers to health care access for migrant children are largely due to their mobility, minimal family incomes, and cultural barriers. They consider addressing the latter a critical factor if health outcomes for migrant families are to improve. They suggest the following interventions as important: use of trained lay community outreach workers; provision of alternative delivery models, such as mobile vans; and development of information tracking systems.

Review=75%

Research Reports

Hurley, S., Huggins, R., et. al. (1994, Oct.). Recruitment activities and sociodemographic factors that predict factors at a mammographic screening program. *AJPH, 84*(10), 1655-1658.

Australian women eligible for free mammography who had not utilized the service after the general information campaign were randomly sent one of two invitations to participate. One had a preset appointment; the other did not. Both groups were sent a follow-up letter without an appointment if they had not attended a clinic within four weeks of the first letter. The strongest predictor of attendance proved to be the personal invitation that included the appointment date. However, comparing costs, the letter without an appointment, plus a follow-up letter, proved more cost-effective. In all, 38 percent of all women attending did so without any outreach; an additional 5.8 percent self-enrolled after the general information campaign; the invitation with a preset appointment, plus a follow-up letter, yielded 42.7 percent; the invitation without a preset time, plus a follow-up letter, yielded 29.5 percent. Other predictive factors included a higher socioeconomic level and living closer to the clinic site.

Experimental=64%

Clover, K., & Redman, S., et. al. (1996). Two sequential trials of community participation to recruit women for mammographic screening. *Preventive Medicine, 25,* 126-143.

Eight smaller rural Australian towns were matched to compare outreach methods in the mid-1900s. Results indicate that community participation or family physician involvement are effective strategies for recruiting women and that both are superior to media promotion alone.

Experimental=58%

Tanner, E., & Feldman, R. (1997, Nov/Dec). Strategies for enhancing appointment keeping in low-income chronically ill clients. *Nursing Research, 46*(6), 342-344.
The authors first present a meta-analysis of literature regarding compliance with appointment keeping, which shows an average compliance rate of 58 percent. The rate consistently increases with the use of mailed reminders and telephone prompts. However, mailed reminders must be sent with sufficient "lead time" to accommodate clients' schedules. These findings hold across middle-income groups, but less-so among lower-income groups. If clients' perceive they feel better after follow-through, they are more likely to keep further appointments. Conversely, if clients experience no change in their well-being or are pessimistic that they can be helped to improve, no change is noted in appointment keeping. The authors then report on a study to determine the impact of social support (i.e., engaging family and friends in promoting clients' appointment keeping) in improving compliance among low-income chronically ill clients. Findings show that providing social support counseling at the exit of an appointment improves compliance with successive appointments. However, the addition of a post-card reminder and a phone call prompt only improved compliance among females; for men, the compliance rate fell with their addition.
Experimental=45%

Huggins, D. (1998, March/April). Parish nursing: A community-based outreach program of care. *Orthopaedic Nursing*, 27-30.
Huggins provides a detailed description of successful outreach (called "partnering") to Spanish-speaking populations in Tucson, delivered by parish nurses under the auspices of the Carondelet Health Network, The Catholic Diocese of Tucson, with assistance from the Tucson Hispanic Nurses Association and the Tucson Chapter of the Catholic Nurses Association. Indicators of success included the client's selection of a medical provider; knowledge of the provider's name; personal gifts to the provider; joint spiritual practices or devotions; sharing of nontraditional health practices. The author concludes that success depended on "a supportive environment, giving permission to express one's cultural practices of healing, respecting choice, and culture...."
Descriptive=59%

Blozis, K., Moon, S., & Cooper, M. (1988, March/April). What blue collar employees want in health promoting programs. *Health Values, 12*(2), 24-28.
The demographic characteristics and health promotion program preferences of blue collar employee participants in worksite health promotion programs were determined via a survey. Worker participation in worksite health promotion increased when their preferences were accommodated (e.g., workers preferred certain kinds of exercise over others, and women's and men's preferences differed).
Descriptive=18%

Expert Opinion

May, K., McLaughlin, F., & Penner, M. (1991, June). Preventing low birth weight: Marketing and volunteer outreach. *Public Health Nursing, 8*(2), 97-104.
The authors describe a pregnancy outreach program in the late 1980s as a component of a strategy to reduce low birth weights in Arizona. Although the major intervention was social marketing, outreach was also provided through volunteer community workers which PHNs recruited, trained, and supervised. They pretested proposed outreach activities with a sample of the population-of-interest and determined the following:

activities should not be planned during prime viewing hours of daytime television; door-to-door distribution of written materials is necessary, as mailed items with any kind of organization's or service's return address are tossed without being read, in most cases; invitations to group events should offer the member of the population-of-interest the opportunity to bring along a friend for support; outreach workers who provide considerable referral/follow-up services, need frequent feedback from the PHN that this is viewed as a valuable service. These outreach workers also provide valuable insight to the PHNs regarding the influence of culture on the motivation to use the prenatal service available. Due to the short timeframe of the overall project, the authors' conclusions have significant shortcomings (which they acknowledge).
Expert Opinion=73%

Alexy, B., & Elnitsky, C. (1996, Dec.). Community outreach: Rural mobile health unit. *JONA, 26*(12), 38-42.
A hospital-sponsored project to provide primary health care services to isolated rural elderly via a mobile unit staffed by advanced nurse practitioners is described. Key to its success was engagement of community members in planning for the unit; promotion through marketing designed to reach the target population; outreach to and linkage with other organizations providing services to the same target population; development of a trust relationship with potential clients' groups. [Note: Initially, the authors describe development of the mobile service as an example of "vertical integration with community outreach represent[ing] one strategy to capture a larger market segment." However, this theme is never further developed in the article.]
Expert Opinion=61%

Jones, A., & Scannell, T. (1997). Outreach intervention for the homeless mentally ill. *British J. of Nursing, 6*(21), 1236, 1238, 1240-43.
A thorough literature search supported field observations of mental health nurses that, among the homeless, the mentally ill homeless are particularly difficult to reach due to the need to "recognize the diversity and complexity of the needs of this client group and the value of working alongside other agencies in promoting [care]." Outreach programs successful in reaching this population may have lessons for other hard-to-reach populations, as well as outreach in general. Conclusions include the following outreach programs need to include individual contacts with members of the target populations, services needed are easily accessible, peer support needs to be available, and the community in which the outreach occurs itself needs to be supportive.
Expert Opinion=60.5%

Lambert, M. (1995, March/April). Migrant and seasonal farm worker women. *JOGNN, 24*(3), 265-268.
Outreach to these women is considered critical due to their higher-than-expected accident rates, dental disease, mental health problems, malnutrition, diabetes, and hypertension, among other adverse health conditions. Successful outreach was found to relate to the use of a multidisciplinary team, visits to living and work sites, maintenance of cultural sensitivity, establishment of realistic health goals with families that consider their circumstances, and aggressive assurance of referral and follow-up.
Expert Opinion=55%

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Public Health Interventions

Applications for Public Health Nursing Practice

Case Finding

Public Health Nursing Practice for the 21st Century

March 2001

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INTERVENTION: CASE-FINDING

Interventions **are activities taken by PHNs on behalf of communities and the individuals and families living in them.**

Assumptions about all PHN Interventions...

- They are population-based; that is, they:
  - **S**are focused on an entire population
  - **S**are guided by an assessment of community health
  - **S**consider broad determinants of health
  - **S**consider all levels of prevention
  - **S**consider all levels of practice
- The public health nursing process applies at all levels of practice.

Definition

Case-Finding locates individuals and families with identified risk factors and connects them to resources.

Case-finding is a one-to-one intervention and, therefore, operates only at the individual/family level. As such, case-finding serves as the individual/family level of intervention for surveillance, disease and other health event investigation, and outreach. Case-finding is frequently implemented to locate those most at risk.

Examples

Example of Case-Finding Resulting from Surveillance:

A school nurse reviews her weekly medications administration log and confirms her observation that a 15-year-old girl has been coming in more often for acetaminophen. The school nurse is concerned about the increasing frequency of the girl's acetaminophen use, especially when she considers her other observation that the girl is rapidly losing weight. The school nurse closely monitors the girl's visits to the sick room and continued weight loss. When the pattern continues for another month, the school nurse arranges for an appointment with the girl and her parents. She consults with them on the possibility of an eating disorder and recommends an evaluation by their primary care provider.

Example of Case-Finding Resulting from Disease and Health Event Investigation:

A PHN providing consultation to a local day care center routinely reviews the center's attendance records and notes that a three-year-old in the toddler program has been sent home four times in the last two weeks because he's failed the center's "no nit" policy. The center director explains she's gone over the lice treatment protocol with the toddler's father several times. He claims the protocol has been followed carefully and is as frustrated as the director with the situation. The PHN arranges for a home visit to identify potential barriers to lice eradication.

Example of Case-Finding Resulting from Outreach:

The 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 the workers except one keep their appointments with the PHN. A co-worker says he hasn'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 to attempting to locate the person. The PHN is finally able to speak with a "cousin" in a meeting arranged by the Catholic priest serving a parish frequented by many of those 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.

Example of Case-Finding Resulting from Screening

The PHN performs a DDST-II screening as part of a battery of screening methods scheduled for two-year-olds participating in the agency's early and periodic screening program provided for young children. Several delays are found. The PHN works with the toddler's parent to identify preferences for needed referral and follow-up with the family's primary care clinic.

Relationships to Other Interventions

Case-finding is linked with **outreach**, **screening**, **surveillance**, and **disease and other health event investigation**. Case-finding is the individual/family practice level of surveillance, diseases and other health event investigation, and outreach. It often leads to **referral and follow-up**. Case finding is also closely linked with **screening** of individuals and families. In fact, some use the terms interchangeably.

At times the PHN is presented opportunities for case-finding without seeking them out. A PHN–always vigilant, always watching for actual or potential threats to health–may come across events or observations expectedly. These are cues for at least further assessment and, perhaps, identification of new cases. **[See Disease and Other Health Event Investigation.]**

BASIC STEPS for Case-Finding[19]

Working alone or with others, PHNs...

1. Identify those individuals and families at particular risk through information from surveillance, disease and health event investigation, and/or outreach.

Risk severity is intensified by factors that make individuals and families unaware, unable, or unwilling to respond. Risk increases when individuals and families are:

- Unaware of risk
  - < lacking information or understanding of the risk
  - < isolated from the media

- Unable to respond
  - < unable to receive or understand the message, due to causes such as illiteracy, hearing and vision impairments, or cognitive impairment
  - < being non-English speaking or having other language barriers
  - < having contrasting cultural beliefs
  - < lacking resources, such as financial, transportation, child care, or social skills

- Unwilling to respond, that is, fearing that negative consequences will exceed any benefits
  - < refusing, as an illegal alien, medical services for fear of deportation if discovered
  - < being a single mom whose children need immunizations but whose insurance does not cover "preventive services" and being unable to afford them out-of-pocket

2. Connect with formal and informal networks to find those identified as at-risk.

Formal networks include those professionals and agencies *with whom you communicate* regularly and maintain a relationship, for example, hospital and outpatient discharge planners, follow-along program coordinators for children with special needs, social workers, epidemiologists, etc.
Informal networks are individuals and organizations *with whom the individual/family communicate* regularly and maintain a relationship. Successful case-finding often depends on the PHN developing a trust relationship with such members of the individual's or families' network.

3. Initiate activities to provide information about the nature of the risk, what can be done about it, and how services can be obtained.

The PHN should base the approach to the individual or family on their rationale for not seeking services on their own.

[19] In many instances of case-finding related to contagious diseases, specific protocols have been developed. These are not included in this document; rather, effective general case-finding activities are described.

- If the individual or family is unaware of the risk or does not understand its severity or full potential for harm, the PHN should provide **health teaching** to reduce the knowledge deficit and further engage them using a **teaching and counseling** strategy.

- If the individual or family is unable to respond, the PHN should work with them to resolve the barriers they face. This could range from providing **counseling**, **consultation**, and/or **advocacy** to **referral and follow-up** for transportation, financial assistance, arrangement for interpreters, child-care provision, etc.

- If the individual or family is unwilling to respond, the PHN should first establish a trust relationship with them and then identify the source, such as fear or anxiety, of the unwillingness. Once established, the PHN should provide **health teaching**, **counseling**, **consultation, advocacy**, or **referral and follow-up** as needed.

4. If the level of risk suggests endangerment to the individual, family, or community, the PHN should provide direct access to necessary services.

Examples of endangerment demanding immediate PHN response include:

- A man whom the PHN has followed for management of his psychotropic medications regimen fails to show up for his every-other-week office visit. In attempting to contact him, the PHN discovers that his phone has been disconnected. The PHN visits his apartment, talks with the landlord, checks with his family to try to locate him, and assures his well-being.

- A newborn fails to make a reasonable weight gain over a series of visits. The PHN determines the mom is ambivalent and not bonding well with the infant. The PHN arrive for your third in a series of planned home visits and hears the baby crying inside the apartment, but no one answers the door. After checking with neighbors (who do not know of the mom's whereabouts) the PHN finds the building manager, convinces him to open the door, and then contacts child protection.

- A member of the caregivers' support group the PHN is staffing arrives wearing dark glasses and a scarf covering her head and neck. She excuses her appearance, saying she had been cleaning her mother's house and has gotten dust in her hair and eyes. She seems unable to relax during the group, however, and lingers after the others leave. She divulges she is afraid to go home, because her boyfriend has started to beat her. He is accusing her of having an affair because she is gone so much of the time and refuses to believe that she is really caring for her ailing mother. The PHN helps her develop a plan to protect herself, considering all relevant state laws and regulations.

5. Fulfill all reporting requirements mandated by state laws and regulations, such as those regarding reportable contagious diseases or indicators of child maltreatment.

BEST PRACTICES for Case-Finding

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who blended evidence from the literature with their practice expertise. These best practices are <u>not</u> presented in any ranking or particular order; each may not apply to every implementation of the intervention.

1. UTILIZES DATA FROM THE INTERVENTIONS THAT PRECEDE CASE-FINDING: SURVEILLANCE, DISEASE AND HEALTH EVENT INVESTIGATION, AND/OR OUTREACH.
Best Evidence: panel recommendation based on practice expertise

Case-finding most often follows implementation of other interventions. Surveillance and disease and health event investigation and outreach identify individuals and families who have, for whatever reason (unawareness of risk, inability or unwillingness to act), not responded to the interventions. These individuals and families warrant the more intensive activities associated with case-finding.

2. RESORTS TO MORE INTENSIVE AND LESS CONVENTIONAL MEANS, DEPENDING ON THE RESOURCES AVAILABLE AND THE URGENCY ASSOCIATED WITH LOCATING THE PERSON OR PERSONS OF CONCERN; THAT IS, THE "CASE."
Best Evidence: Bechtel and Shriver; Johnson, Williams, Chatham

Bechtel and Shriver write specifically on methods to find community-dwelling elders whose functional levels may be putting them at risk for injury or illness. Johnson et al.'s study targeted heroin addicts at risk of HIV exposures. While the differences between these sub-groups may seem great, the similarities in methods used to locate them are striking. Both offer many of the same recommendations:

- The client's situation must be addressed in its entirety. The PHN should address the underlying cause of the circumstance or risk, not just the symptom itself
- The PHN should address cultural and ethnic values in the context of family and environment
- The PHN should throughly discuss each of the reasons for the concern with the individual or family.

Based on their review of the literature and collective practice experience, the expert panel developed the following list of case-finding strategies with demonstrated effectiveness:

- door-to-door canvassing of a neighborhood
- enlisting the help of service workers and others likely to encounter the individual or family such as paper boys, utility workers, bank tellers, hairdressers, etc.
- dropping in on places, such as laundromats, shopping malls, video stores, bars, etc., you might not ordinarily go during the work day, but the individual or family might
- training persons from the target population to do case-finding within their community
- providing private investigator skills training, which involves, among other activities
  - convincing those close to, or who keep in touch with, the individual how important it is for that individual to respond or take action
  - presenting, in ways that are compatible to their culture or ways of understanding, the benefits to the individual of being located.

Notes from Abby

Outreach as Case-Finding...

In the mid-1980s Brooks-Gunn et al. evaluated a process of case-finding to enroll high-risk women in prenatal care in Central Harlem. Four indigenous health care workers were hired, trained, and given freedom in designing case-finding methods. Their best success came in enrolling women at welfare offices and other clinic settings, and simply approaching pregnant women on the streets–including well-known drug corners. They were least successful in canvassing apartment buildings and projects, because of the general mistrust of anyone knocking on a door in the neighborhood. They found their most successful "hook" was convincing the mother that prenatal care was essential for the health of the baby. Overall, the evaluators found the average cost per enrollee was $850. Measured against NICU costs at the time, the project needed to prevent three low-birth outcomes in order to "break even." Based on the findings, the authors concluded that "current marketing methods [should be used] to find them and then follow-up with 'high touch' personal contact to enroll them."

[Brooks-Gunn, J., et al. (1989, February). Outreach as case finding: The process of locating low-income pregnant women. *Medical Care*, *27*(2), 95-102.]

Disease or Risk-specific Case-Finding

Excellent protocols for specific case-finding strategies are available from various organizations. For instance, the Centers for Disease Control and Prevention's national Center for HIV, STD, and TB Prevention maintains a website on major TB guidelines:

http://www.cdc.gov/nchstp/tblpubs/mmwr.htl/maj_guide.htm

Or see ANA's Nursing links website and select "specific health conditions" to access specialty organizations and their guidelines: http://www.nursingworld.org

CDC's National Council for Environmental Health's Lead Poisoning Prevention Program 1997 publication includes case-finding information. See: http://www.cdc.gov/nch/lead

BEST EVIDENCE for Case-Finding

Each item was first reviewed for research quality and integrity by graduate students in public health nursing and then critiqued for its application to practice by at least two members of a panel of practice and academic experts. The nature of the material and a score expressed as a percentage are included at the end of each annotated citation. The percentage is the average of scores assessed by the experts who reviewed it. It reflects their opinion of the strength of the item's contribution to practice.

Review Articles

Gwyther, M., & Jenkins, M. (1998, March/April). Migrant farmworker children: Health status, barriers to care, and nursing innovations in health care delivery. *J. Pediatric Health Care, 12*(2), 60-66.

The authors reviewed the literature and determined that major barriers to health care access for migrant children were largely due to their mobility, minimal family incomes, and cultural barriers. Keeping track of these families and assuring that needed resources for health follow them is difficult and often results in repetitions of case-finding. The latter is considered a critical factor to address if health outcomes for migrant families are to improve. The authors suggest the following strategies as important: use of trained lay community outreach workers; provision of alternative delivery models such as mobile vans; and development of information tracking systems.

Review=75%

Research Reports

Johnson, Williams, & Chatham. (1995, June). Notes from the field: The Houston advance DATAR follow-up project: Private investigator techniques for public health. *Am. J. Public Health, 85*(6), 868-869.

This study involved evaluating and improving psychosocial adjustment and reducing HIV-risky behaviors of heroin addicts through counseling, education, and methadone therapy. Follow-up by workers to measure change was complicated by the participants' transient nature. Results indicated that follow-up success (i.e., locating participants or case-finding) was increased when the following occurred: 1) Workers operated in communities where they blended in (they found participants more quickly and more efficiently); 2) Workers employed techniques used by private investigators to locate missing persons, in particular the "back tracing to the anchor" technique."

[Note: This article was originally read and considered by expert panelists focusing on follow-up, not case-finding. Follow-up can merge with the case-finding intervention at a high-level of intensity.]

Experimental=43%

Expert Opinion

Bechtel, G., & Shriver, C. (1997, Oct). Guidelines for developing instruments to enhance case-finding among older adults. *J. Gerontological Nursing*, 20-23.

Case-finding is described as the application of instruments to detect variables such as high-risk behaviors, socioeconomic factors and/or environmental circumstances, which have the potential to diminish health functioning. The intent is to apply the instruments among asymptomatic, but potentially at-risk, populations (in this case, the elderly) to detect actual or potential deviations from optimal functioning and correct them early, thereby avoiding more intense–and costly–services. The authors view case-finding as "more deliberate and intense" than screening and applied to populations with known risk indicators (as opposed to the generally well).

Guidelines for developing case-finding instruments include:

, Case-finding tools must never be used as the sole diagnostic criteria or the standard

, The client's situation must be addressed in its entirety–the underling cause of the circumstance or risk-factor, not the symptom itself–should always be addressed

, Cultural and ethnic values must be addressed in the context of family and environment

, Findings must always be discussed with the client

, Each item within the instrument must be addressed.

Expert Opinion=62.5%

Texts and Monographs

Note: Most of the community health nursing texts reviewed, describe case-finding only in reference to communicable disease control measures. [See, for instance, Spradley and Allender (4th edition), p. 529-530; Smith and Maurer, p. 507-508; Swanson and Nies (2nd edition), p. 691.] Helvie speaks of case-finding more broadly, in the sense of identifying those in need of services, such as case management (p.12). Stanhope and Lancaster (5th edition) define case-finding as "careful, systematic observations of people to identify present or potential problems" (p. 624). They also note that "the role of casefinder is historically a basic part of public health nursing....It is important to bear in mind that, although the nurses' efforts are for a particular client, the focus on casefinding is on monitoring the health status of entire groups or communities" (p. 629).

Public Health Interventions

Applications for Public Health Nursing Practice

Screening

Public Health Nursing Practice for the 21st Century
March 2001

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

INTERVENTION: SCREENING

***Interventions* are activities taken by PHNs on behalf of communities and the individuals and families living in them.**

Assumptions about all PHN Interventions...

" They are population-based; that is, they:
- **S**are focused on an entire population
- **S**are guided by an assessment of community health
- **S**consider broad determinants of health
- **S**consider all levels of prevention
- **S**consider all levels of practice

" The public health nursing process applies at all levels of practice.

Definition

Screening identifies individuals with unrecognized health risk factors or asymptomatic disease conditions in populations.

Three types of screening are described in the literature:

- *mass*: a process to screen the general population for a single risk–such as cholesterol screening in a shopping mall–or for multiple health risks–such as health fairs at work sites or health appraisal surveys at county fairs *(community level)*
- *targeted*: a process to promote screening to a discrete sub-group within the population–such as those at risk for HIV infection *(individual/family level)*
- *periodic*: a process to screen a discrete, but well, sub-group of the population on a regular basis, over time, for predictable risks or problems; examples include breast and cervical cancer screening among age-appropriate women, well-child screening, and the follow-along associated with early childhood development programs *(individual/family level)*

Examples at All Practice Levels

Population-of-interest: *All sexually active persons*
Problem: *Sexually transmitted disease*

Community Example:

Some PHNs operate an STD/HIV testing site near a downtown metropolitan area. The clinic targets populations known to be at disproportionate risk for STDs (i.e., adolescents and young adults, women, and men who have sex with men). The PHNs screen for gonorrhea, syphilis, chlamydia, and other STDs. They provide health teaching and counseling to all clients during the assessment rather than waiting for results because many clients do not return or do not choose to give their real names.

Systems Example:

A public health agency receives both federal and state family planning monies, which are contracted out to local clinics for the provision of family planning services to low-income women. The PHNs in the agency negotiate a requirement in the contract that clinics must routinely screen all family planning clients for STDs.

Individual/Family Example:

The PHN nurse practitioner performs a physical examination on a young woman at a student health clinic and, with her consent, includes tests for gonorrhea and chlamydia. The PHN counsels the woman regarding her risk and STD prevention.

Relationships to Other Interventions

The screening intervention is frequently implemented in conjunction with other interventions; for example,

- implementation of **social marketing** and **outreach** prior to screening are imperative when mass screening is planned
- opportunities for **health teaching and counseling** almost always present themselves, either implemented simultaneously with screening or as a feature of the interview conducted immediately afterward
- screening often transitions into **referral and follow-up** for those requiring further assessment of risk or symptoms.

BASIC STEPS for Screening[20]

Working alone or with others, PHNs...

1. **Determine if the health risk or disease is an important threat to the population's health.**

   The **incidence** (that is, the number of new cases observed over a set period of time) and the **prevalence** (that is, the number of cases, old and new, that exist at any one point in time) serve as good measures of the extent to which the risk or problem may be considered severe. Usually, the greater the incidence and prevalence, the more intense the demand for screening.

   Mass screening should always result in some benefit to overall population health, as well as to the individuals screened. For instance, most states require newborn screening for a variety of congenital problems such as phenylketonuria, hearing impairment, galactosemia, and other conditions. Not only is there an obvious benefit to the newborns in terms of preventing serious medical and developmental problems, but society benefits in terms of a healthier overall population.

2. **Consider the extent to which the population believes the health risk or disease an important health problem.**

   At times the population's level of concern or anxiety is elevated to the point where screening is demanded for a given risk/disease despite a lack of evidence. Cancer frequently falls into this category. The PHN must screen if the public or political concern is significant and not screening would be perceived as irresponsible. Even though the science may be weak, the effect of doing nothing may be worse. On the other hand, the data may suggest a very real risk or threat, but the population may be uninterested or difficult to motivate. Motivating an apparently well population to participate in hypertension screening, for instance, can be challenging.

3. **Determine if adequate information exists about the outcomes expected from screening.**

   Screening is *early* detection of risk or disease in its preclinical state, that is, before symptoms occur.
   - If a risk or disease cannot be detected sufficiently early so that its natural clinical course can be stopped or altered, then screening may not be appropriate.
   - If a screening program only identifies risk or disease after it becomes symptomatic, then the gains of early intervention will be reduced.

4. **Determine if the risk or disease has a recognizable latent or early symptomatic state which makes early identification feasible.**

   To be most effective, screening is used with conditions that have a natural asymptomatic (preclinical or prodromal) state. There must be a long enough period of time before symptoms to intervene. While early treatment of conditions that are already symptomatic may be beneficial to a given individual, the overall population effect is greatly reduced.

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[20]This process is adapted from Wilson J.M.G. & Junger G. (1968). Screening for disease, In J.M.G. Wilson (Ed.), *Principles and practice of screening for disease* (pp. 26-29). *Public Health Papers* (Geneva: WHO).

5. Decide if the risk's or disease's natural course of history is understood sufficiently to allow early intervention.

The PHN should make sure that his/her knowledge about the problem is up-to-date and complete. An understanding of the problem's "natural course of history" is especially important. This is the course that the condition would predictably take if nothing were done to intercede. For example, without treatment, progressive pulmonary tuberculosis kills 50 percent of those infected within 5 years; dental caries continue to decay; without correction, children with amblyopia eventually lose vision in the affected eye.

At times, urgency for public health action to prevent negative impacts on health status means making decisions before exact causes are known, so PHNs often rely on epidemiological evidence that supports strong associations between risk factors, rather than waiting for research findings.

6. Consider whether an acceptable treatment for the risk or disease exists.

Screening is unethical when it creates a situation for an individual where he/she knows that they have a disease or condition but:

- there is no known treatment, or
- there is no known benefit to self or others from knowing, or
- the "cure" is perceived as worse than the disease itself, or
- acceptable treatment exists, but is too expensive or too far away to access.

7. Determine whether a suitable test exists.

"Suitable" means screening tests should meet the following criteria[21]:

- valid
  That is, a test has sufficient **sensitivity** to identify correctly all screened individuals who actually have the risk or condition. In other words, the number falsely identified as "positive" (having the risk or condition when they actually do not) is low. A test must also have sufficient **specificity**. That is, the ability of a test to identify correctly those who do not have the risk or condition. Acceptable specificity means a test can accurately identify those who truly do not have the risk or condition. Tests should be able to differentiate between true positives and true negatives, while minimizing the number of false positives and false negatives. Test sensitivity and specificity are important because screening outcomes producing false security (people think they do not have a risk or disease when, indeed, risk or disease is present but undetected) or needless worry (those referred for diagnosis when they are actually risk or disease free) can do more harm than good.
- reliable
  That is, the test gives consistent results when performed more than once on the same individual under the same conditions.
- easy and quick to administer
- minimally intrusive
  That is, little disrobing or divulging of private information in a public situation is required.
- yield
  The amount of previously unknown risk or disease identified as a result of screening is the yield.

[21] See Mausner, J. & Kramer, S. (1985). *Epidemiology: An introductory text* (2nd Ed.) (pp. 217-229). Philadelphia: WB Saunders.

Advancing technology provides increasing opportunities for screening tests that meet the criterion of detecting the presence or absence of risks or diseases, but fail to meet the criteria for quick, unintrusive, low-cost tests. Of more importance, testing for such conditions as Huntington's Chorea or Trisomy X have significant importance for individuals and families but minimal impact on the overall population health.

8. Determine if the screening test is acceptable to the population of interest.[22]

If the screening test is too costly, or requires too much time, creates too much physical or mental discomfort, or does not fit with a given culture's beliefs about health and disease, it is less likely to be utilized. Screening tests that are unacceptable to the population will reduce the effectiveness of a screening effort.

9. Arrange for further assessment/diagnosis and treatment for those with positive findings.

Positive results indicate the need for further assessment of the individual/family situation, which then leads to either diagnosis and treatment or a "clean bill of health." It is unethical to carry out a screening program identifying people with positive findings but have no available treatment resources.

10. Establish agreed-upon policies regarding whom to treat.

If resources are inadequate to provide care for all who have positive findings, PHNs must establish policies on how treatment resources will be prioritized.

11. Determine whether adequate funds or resources exist to support the entire process.

Costs of providing screening programs should include all costs ranging from **outreach** to **follow-up** and treatment. Total costs per screen include the costs associated with **referral**, diagnosis, treatment, and **follow-up**. The total cost must be used in determining the benefit ratio of a given screening program. Costs borne by an insurer, employer, or "other" beyond the local public health agency, are still costs.

The costs for potential **case-finding** should also be included in the estimate.

- A certain proportion of those screened will require referral for further assessment and diagnostic work-up.
- A proportion of those referred will also require follow-up of some intensity to assure the referral is acted upon.
- Not every person is able to navigate the referral process alone, and some may require additional assistance.
- Others may see follow-up as too intrusive and resist follow-up recommendations.
- In some instances, one case may escalate into numerous other possible cases, creating a significant time and resource demand.

[22] In addition to the screening test being acceptable to the population, the PHN needs to determine that it is acceptable to his/her board of nursing. If the test exceeds the definition for a state's independent nursing practice and requires administration as a delegated medical function, then the required protocols, standing orders, etc., will need to be developed. Screening tests vary across time and are dependent on allowable functions under each state's nurse practice act. For example, as recently as the mid-1960s, nurses' use of sphygmomanometers was considered outside many states' scope of nursing practice.

Notes from Abby

Screening is occasionally confused with **monitoring.** It is important to understand them as separate activities since their purpose and intent differ.

Screening	Monitoring
• purpose is to identify those with risk	• purpose is to track the progress once a risk has been identified
• fact finding	• after the fact
• affects many	• affects only a few
• focuses on apparently well populations	• focuses on persons with known risks

The difference is **not what the test** is or what condition it is testing for; the same test may be used for both screening and monitoring. The determining factor is **how the test is applied** to the population. For example, blood pressure checks may be screening or monitoring.

Screening:

Blood pressure checks at a community health fair where:

- *apparently well individuals with no previous history of hypertension are actively sought*
- *positive results automatically lead to health teaching, counseling, referral and follow-up*
- *preparatory work in the community assures participation of high-risk groups (such as 25 to 50-year-old African-American males), and*
- *follow-up resources for diagnosis and treatment are provided.*

Monitoring:

Community citizens stop by the local PHN agency anytime and have their blood pressure checked. Readings outside normal limits automatically lead to health teaching, counseling, referral and follow-up; readings within normal levels lead to reinforcement of successful self-care methods exhibited.

Clinics to detect changes in status of those with known risk fail the screening criterion for "seeking undetected or asymptomatic conditions." They do not result in overall population health benefits. Taking blood pressures at senior centers or worksites may only be considered screening if you are targeting individuals who do not know they have hypertension. However, if you are taking blood pressures for individuals with known hypertension, this constitutes monitoring, not screening. Monitoring has considerable benefit to the individual but minimal benefit in terms of the health status of the overall population.

Notes from Abby

"Screenings" commonly conducted by PHNs:

- *tuberculosis screening in a correctional facility*
- *HIV screening at an AIDS/STD testing site*
- *anemia screening of pregnant women and infants in WIC*
- *blood lead level checks in at-risk children during well-child examinations*
- *hypertension screening at work sites*
- *growth and development screening with Headstart children*
- *pregnancy testing at family planning clinics*
- *hearing and vision screening with school-aged children*
- *screening for violence risk with women on MCH caseload**
- *DDST II (Denver Developmental Screening Test-II) screening of children with suspected developmental delays*
- *home hazard screening of elder homes with the "Home Safety Checklist for Older Adults"***
- *blood glucose screening at senior health clinics*

* An example is the Abuse Assessment Screen, a five-item screen developed by the Nursing Research Consortium on Violence and Abuse. One of its questions is "Within the last year have you been hit, slapped, kicked, or otherwise physically hurt by someone? If yes, who and how many times?" For more information see Soeken, Parker, McFarlan, Lominah. (1998). The abuse assessment screen: A clinical instrument to measure frequency, severity, and perpetration of abuse against women. In J. Campbell (Ed.), *Beyond diagnosis: Changing the health care response to battered women and their children.* Newbury Park, CA: Sage.

** For further information, contact the Minnesota Department of Health/Injury and Violence Unit at 651-281-9857.

Other disciplines and community partners may not be aware of the Centers for Disease Control and Prevention's excellent resource on prevention guidelines available at

http://www.epo.cdc.gov/wonder/PrevGuid/PrevGuid.htm

In addition, the US Prevention Task Force's *Guide to Clinical Preventive Services,* 2nd Ed. (1996) is available from Williams and Wilkins Publishing or your local library.

The February 2000 issue of the *AAOHN Journal* (Vol. 48, No. 2) includes a series of articles describing surveillance and screening interventions as "vital roles" for the PHN working in occupational and environmental health. See Pap, E., & Miller, A. Screening and surveillance: OSHA's medical surveillance provisions, 59-72; Stone, D. Health surveillance for health care workers: A vital role for the occupational and environmental health nurse, 73-79; Rogers, B. & Livsey, K. Occupational health , surveillance, screening, and prevention in occupational health nursing practice, 92-99.

BEST PRACTICES for Screening

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who blended evidence from the literature with their practice expertise to develop them. These best practices are <u>not</u> presented in any ranking or particular order; each may not apply to every implementation of the intervention.

1. FIRST CONSIDERS WHETHER SCREENING IS THE APPROPRIATE INTERVENTION GIVEN THE CIRCUMSTANCES

Best Evidence: Braveman and Tarimo; Morrison; Shickle and Chadwick

The screening intervention, whether mass or targeted, can be expensive because the cost of follow-up diagnostic, and treatment services must be included. Braveman and Tarimo point out that screening efforts can actually divert attention from primary prevention of pressing threats to health.

Prior to planning and implementing a mass screening, the PHN should first determine if the number of persons expected to be found with previously undetected risk or disease will be large enough to warrant the cost of screening. The potential gains must be carefully weighed against the potential negative effects. Morrison notes that the satisfaction of those screened must be considered:

True Positives

- Those with true positives whose deaths are postponed by early treatment have the most to gain. However, those true positives whose deaths cannot be postponed may not feel anything has been gained.

True Negatives

- True negatives are likely to feel that knowing they are risk- or disease-free was worth any pain or discomfort associated with the screening process.

False Positives

- False positives are likely to feel dissatisfaction when the results from their referral for diagnostic follow-up are negative.

False Negatives

- Perhaps those with the most reason for dissatisfaction are those with false negatives who risk believing they are risk- or disease-free when they are not. Such false security can lead to the possibility of ignoring symptoms when they do appear and delaying further assessment and diagnosis.

Besides assuring acceptable levels of positive gains versus negative losses, the value of screening is dependent on the extent to which early diagnosis and treatment may impact the health status of the population. To be of value, screening must go beyond the direct benefit to those individuals with positive results and benefit the population as a whole. Adherence to the basic steps of screening discussed earlier will assist in determining the value of a proposed screening activity.

2. DESIGNS THE INTERVENTION WITH INPUT FROM THOSE TO BE SCREENED

Best Evidence: Morrison; Wilson and Junger

PHNs must always determine the population's perspective on the need for, value of, and urgency for any screening activity.

- Wilson and Junger's "first principle" of screening says that the screening condition should be an important health problem from the perspective of both individuals and the community in which they live.
- Morrison suggests that "the success of a screening program...depends on interrelations between the disease experience of the target population, the characteristics of the screening procedures, and the effectiveness of the methods of treating disease early" (p. 6).

The screening's support or endorsement by leaders of the target population is key in communicating its importance. In addition, input from the population to be screened can significantly improve the effectiveness of the **outreach** and follow-up associated with screening.

3. INCLUDES HEALTH TEACHING AND COUNSELING IN ALL SCREENING, REGARDLESS OF WHETHER RESULTS ARE POSITIVE OR NEGATIVE

Best Evidence: panel recommendation based on practice expertise

People participate in screening because they have some sense that they are at risk for a possible condition or disease. Certainly, those with positive results require counseling on what the results mean and what they should do next. Depending on the individual's or family's capacity to carry out the recommended follow-up, the PHN should make appropriate **referrals.** However, it is equally important that the PHN offer **health teaching** and **counseling** to those with negative results. The same sense of risk that motivated the client to be screened may also increase receptivity to preventive **health teaching** and **counseling**. The point at which a person has been screened and declared negative is often a key "teachable moment" not to be missed.

4. THOROUGHLY CONSIDERS ALL RELEVANT LEGAL, SOCIAL, CULTURAL, AND LANGUAGE ISSUES

Best Evidence: Busen and Beech; Shickle and Chadwick; Kurland and Robbins; Miller; Wilson with Junger

PHNs should thoroughly anticipate and plan the mechanics of screening, providing for quick, inexpensive, and effective screening tools, adequate facilities, appropriate interpreters, and well-trained staff. However, it is just as important to tailor those mechanics to accommodate local customs, attitudes, and values. A good fit greatly increases the potential for actual participation.

Busen and Beech, for instance, recruited homeless youth off Houston streets and paid them to participate in a screening to identify their health risks. This data proved very useful in later negotiating increased primary care services for them. However, the study also documented that to be effective in providing this primary care, practitioners needed to "understand not only the clients' living situation but also their language and their personal perspective on how they live. No matter what these youth say, [practitioners] must not lose their [composure], must not appear shocked nor sit in judgment" (p. 323).

The legal issues in screening are significant beyond those noted in the basic steps, so PHNs must be aware of related information, such as state laws on:

- data confidentiality
- the types of information that can be shared without a client's consent
- those with whom information can be shared without a client's consent
- the age at which a minor may legally arrange for medical treatment without parental presence or permission
- the circumstances under which registered professional nurses are mandated to report their observations.

5. DESIGNS THE SCREENING INTERVENTION COLLABORATIVELY WITH OTHERS THAT SHARE CONCERN FOR THE SAME HEALTH RISK OR DISEASE

Best Evidence: panel recommendation based on practice expertise

No single community agency ordinarily has sufficient resources or expertise to implement all phases of screening on its own, nor is it likely any one agency has access to an entire targeted population. Planning the role that each organization will play is important for both screening efficiently and arranging follow-up.

6. EXTENDS EXPERTISE TO OTHER HEALTH CARE PROVIDERS/PAYERS REGARDING THEIR SCREENING ACTIVITIES

Best Evidence: panel recommendation based on practice expertise

For target populations that are "shared" by health care providers, it is important that PHNs assure all providers offer appropriate screening. In a recent editorial in *Public Health Reports*, for instance, Kurland and Robbins note, "Public health agencies have always made realistic allowances for screening programs that had to depend on outreach and public education to bring citizens in....Managed care, with enrolled members, should not be granted such a handicap....[It] seems reasonable that managed care plans should be expected to reach 100% of their enrolled members."[23] What expertise the PHN extends to these screening partners or how it is extended will obviously vary, depending on the specific circumstances. However, if portions of the target population do not have access to needed screening services, it is clearly within the PHN's core assurance function to make it happen.

The activity just described, where PHNs reach out to others in the community outside of their own clientele, is an example of population-based public health practice. However, PHNs must also remember to "in-reach," or make sure that those who are public health clients also benefit from screening.

[23] Kurland, J. & Robbins, A. (1998, July/August). A public health standard for screening managed care populations. *Public Health Reports, 113,* 352.

BEST EVIDENCE for Screening

Each item was first reviewed for research quality and integrity by graduate students in public health nursing and then critiqued for its application to practice by at least two members of a panel of practice and academic experts. The nature of the material and a score expressed as a percentage are included at the end of each annotated citation. The percentage is the average of scores assessed by the experts who reviewed it. It reflects their opinion of the strength of the item's contribution to practice.

Review Articles

none

Research Reports

none

Expert Opinion

Busen, N. & Beech, B. (1997, Sept/Oct). A collaborative model for community-based health care screening of homeless adolescents. *J. Professional Nursing 13*(5), 316-324.

The nature of homeless youth's life-style puts them at extremely high-risk for life-threatening and debilitating diseases, such as HIV and HepB. The authors report on a project to investigate the social and health services needs of homeless youth in Houston, Texas, in preparation for initiating a comprehensive health care service aimed at prevention and early intervention. A "screening questionnaire" was administered to 150 homeless youth recruited off the streets to participate anonymously in a health interview, history, and physical assessment that included a TB skin test; blood tests for HIV, HepB, and syphilis; and urine analysis to screen for drug use and alcohol. Participants received $30, plus an extra $5 if they returned to have their TB test read. Those with positive findings were referred on. The results of the "screening"–significant history of STD's, prostitution, sexual and physical abuse, with laboratory findings demonstrating substance use/abuse and seroprevalence of HepB, HepC, and/or HIV in 12-15% of those tested–served as the basis for structuring the clinical services available and appropriately training the workforce. [Note: The use of "screening" in this article is not its conventional use, although the tests used may have been those also used in traditional screening activities. The purpose of the project was more in the framework of needs assessment and program planning.]
Expert Opinion=61%

Braveman, P. & Tarimo, E. Health screening, development, and equity. *J. Public Health Policy 17*(1), 14-27.

This article summarizes concepts presented in the authors' book, *Screening in Primary Health Care* (Geneva: WHO) 1994. After applying Wilson and Junger's criteria for screening to various examples (mostly in developing countries), they conclude, "Screening can divert attention from primary prevention of a society's most important threats to health, especially when primary prevention faces political challenges and screening costs are viewed in isolation from the overall strategy required to make it useful....In any country, but perhaps especially in developing countries, screening may waste scarce resources, it could also lead to widening inequities" (p. 27).
Expert Opinion=51%

Shickle, D. & Chadwick, R. (1994). The ethics of screening: Is 'screeningitis' an incurable disease? *J. Medical Ethics 20*, 12-18.
The authors thoroughly review the ethical conflicts associated with screening stemming from the reality that false-positives may cause needless anxiety and false-negatives may result in false security. In the end they conclude that "the harm consequent from a screening test for any individual will usually be trivial, in comparison with the potential harm from not offering screening and saving a life by providing effective treatment" (p.16). Or, as they quote Singer, "If we can prevent something bad without sacrificing anything of comparable moral significance, we ought to do it."
Expert Opinion=46%

Kurland, J. & Robbins, A. (1998, July/Aug). A public health standard for screening managed care populations. *Public Health Reports 113*, 351-352.
The authors, representing the perspective of official public health, applaud MCOs for utilizing chronic disease screening with their enrolled populations. However, they also suggest that MCOs must be held to the same high standard for screening as applied to public health agencies in "order to get the full benefit of an increasingly organized medical care system" (p. 352).
Expert Opinion=29%

Khoury, M. for the Genetics Working Group. (1996, Dec). From genes to public health: The applications of genetic technology in disease prevention. *Am J Public Health 86*(12), 1717-1722.
The author discusses the potential of genetic testing in fulfilling the core public health functions of assessment, policy development, and assurance. While acknowledging that most current genetic tests are not yet suitable for use in screening for preventable conditions, Khoury concludes that, when they are, it is "essential that public health agencies evaluate the effectiveness of genetic testing programs and ensure the quality of genetic testing in the US population" (p. 1720).
Expert Opinion=26%

Mitchell, H. (1995). Cancer screening: Protecting the public's health. *Diagnostic Cytopathology*, *12*(3), 199-200.
In this editorial the author, a physician, offers three reasons why the inevitable false findings associated with screening techniques should not be held to the same standards as results from testing in clinical care: 1) Screening programs are public health programs, not clinical interventions. They are designed to "reduce the community burden of cancer by detecting some of the individuals who have asymptomatic disease." 2) Screening programs are "deliberately designed to lack the luxury of multiple information sources....Screening programs use a single inexpensive test so as to be logistically achievable and financially affordable across a whole community." 3) "Screening programs involve a predication for the future which adds to the uncertainty of any report that is made." For these reasons, Mitchell argues that screening as a public health activity should be afforded indemnity from prosecution since it "makes no promises."
Expert Opinion=23%

Texts and Monographs

Smith, C. & Maurer, F. (1995). Screening and referral. *Community health nursing: Theory and practice* (pp. 430-433). Philadelphia: B. Saunders.

The authors delineate several key factors regarding screening. They are:

1. The first goal of screening is to differentiate correctly between persons who have an illness, developmental delay, or other health alteration and those who do not.
2. The second goal of screening is to refer those with alterations for diagnosis and initiation of appropriate interventions at a stage earlier than the onset symptoms or obvious problems.
2. Screening is intended to detect previously unrecognized problems and, therefore, is conducted with apparently healthy populations.
3. Screening is not in itself diagnostic; it only identifies findings that do not match the expected results. Because screening tests and procedures must be applied rapidly and inexpensively, they are not always 100 percent accurate. Those found with abnormal findings must be referred for follow-up assessment and testing.
4. The term "mass screening" denotes the application of screening tests to large populations, either in general or selectively (i.e., those at risk because of general factors such as age, area of residence, or nature of occupation).
5. Multiphasic-screening denotes the application of multiple screening tests on the same occasion, such as at health fairs. The advantage of access to, and convenience for, large numbers of persons must be balanced against the disadvantage of increased occurrence of false-positive test results inherent in the large numbers of tests done.
6. Case-finding is screening that occurs with individuals on a 1:1 basis.

Text=69%

Valanis, B. (1992). Screening. *Epidemiology in nursing and health care* (2nd ed., pp. 331-353). Norwalk, CT: Appleton-Lang.

Valanis defines screening as: "the presumptive identification of unrecognized disease or defect by the application of tests, examinations, or other procedures that can be applied rapidly and inexpensively to populations; its purpose is to distinguish among apparently well persons, those who probably have a disease from those who probably do not; it is not intended to be diagnostic" (p. 331). Types of screening include case finding (application of screening tests to an individual within a provider's own caseload); multiphasic screening (use of a variety of screening tests on the same occasion); and mass screening (unselective application to entire populations). Valanis offers the following criteria for acceptable screening programs:

a. The test or procedure used has high sensitivity and specificity
b. The test or procedure meets acceptable standards of simplicity, cost, safety, and patient acceptability.
c. The disease that is the focus of screening should be sufficiently serious in terms of incidence, mortality, disability, discomfort, and financial cost.
d. The evidence suggests that the test procedures detect the disease at a significantly earlier stage in its natural history than if it presented with symptoms.
e. A generally accepted treatment that is easier or more effective than treatment administered at the time of symptom presentation is available.
f. The available treatment is acceptable to patients, as established by studies on compliance with treatment.
g. The prevalence of the target disease is high in the population to be screened.
h. Follow-up diagnostic and treatment service must be available and accompanied by an adequate notification and referral service for those positive on screening (p. 342).

The author concludes that "clearly, screening procedures are best used in conjunction with a longitudinal program of periodic health assessment rather than sporadic, one-shot screening programs" (p. 352).
Textbook=46.5%

Miller, A. (1996). The public health basis of cancer screening: Principles and ethical aspects. In *Cancer Treatment and Research:* Vol. 86 (pp. 1-7).

Although the author supports screening as "an important component of cancer control" (p. 6), he describes its shortcomings, estimating that screening would only contribute about 3 percent of the reduction in cancer mortality anticipated by the year 2000. The stated shortcomings include:

1. Necessary components for organized screening programs are difficult to achieve [Note: Miller references his own list from a 1995 editorial]:
    a. Identifying the at-risk individuals within the target population
    b. Implementing methods to guarantee high coverage and attendance, such as a personal letter of invitation
    c. Assuring adequate field facilities to handle related lab and clinical procedures
    d. Providing an organized quality-control program for procedures and interpretation of results
    e. Assuring adequate facilities for diagnosis and appropriate treatment for those found with positive findings
    f. Providing a carefully designed and agreed-upon referral and follow-up system
    g. Providing on-going monitoring of screening program performance and evaluation
2. Failing to attend to ethical issues inherent in screening:
    a. Screening programs should not be offered if their effectiveness in distinguishing between false and true findings has not been demonstrated; the overall health benefit to the community must be guaranteed while reducing the potential for harm to any individual
    b. Assuring informed consent from those being screened
    c. Assuring that the quality control of the screening methodology is maintained
    d. Reducing unnecessary anxiety
    e. Ensuring that appropriate follow-up resources are available to those with positive findings
    f. Ensuring that resources used to provide screening is not being diverted from higher-order utilization
3. Failing to anticipate the policy implications of screening findings.

Textbook=44%

Morrison, A. (1985). *Screening in chronic disease.* NY: Oxford Press.

Chapter One: Introduction (pp. 3-20)

Screening is defined as "the examination of asymptomatic people in order to classify them as likely, or unlikely, to have the disease that is the object of the screening. People who are likely to have the disease are investigate further to arrive at a final diagnosis....The goal is to reduce morbidity or mortality from the disuse among people screened by early treatment of the cases discovered" (p. 3). Morrison suggests that "the success of a screening program...depends on interrelations between the disease experience of the target population, the characteristics of the screening procedures, and the effectiveness of the methods of treating disease early" (p. 6).

Other key points include:

a. A disease must have a preclinical phase during which it is undiagnosed, but detectable, so that early treatment can have some advantage over later treatment. There is no point in screening for a disease that cannot be detected before symptoms emerge.

b. If early treatment is ineffective in significantly reducing the impact of a disease, there is no point in early detection.

c. Screening for diseases with rare prevalence is not an effective use of resources.

d. It is only feasible to detect and treat cases early for diseases in which the preclinical phase is long. If the preclinical phase is short, virtually continuous rescreening would be necessary.

e. Tests/procedures used must be valid and reliable.

f. Lead time is the interval from the point of detection, via screening, to the time at which diagnosis would have been made without the screening. This reflects the pressure to diagnose created by screening; it is the amount of time by which treatment is "early." For screening programs to be effective in reducing morbidity or mortality in a population, there must be enough lead time in a sufficient number of cases.

Chapter Seven: The Feasibility of Screening Programs (pp. 138-156)

In general, the "gain" from resources devoted to screening programs can be enhanced if:

1) The number of cases detected (i.e., true positives) is increased by
    a. lowering the measure which divides "positive" from "negative" findings
    b. increasing the frequency of screening
    c. using two or more different tests and considering a positive result on anyone as an indication of need for further assessment
    d. employing a test or procedure with improved sensitivity (i.e., ability to determine positive findings), and/or
2) The number of false positives is reduced by
    a. adjusting the screening frequency in diseases with a long preclinical phase
    b. employing a test or procedure with improved sensitivity, and/or
3) Screening is limited to groups with known risk factors for the condition of concern, and/or
4) The satisfaction of persons screened remains high–i.e., they think they have been well served or have gained. Possible gains and costs must be considered in each case:
    a. true positives whose deaths are postponed by early treatment obviously benefit from screening
    b. true positives whose deaths cannot be postponed may not feel anything has been gained.
    c. true negatives may feel knowing they are disease-free is worth any pain or discomfort associated with the screening event itself
    d. false positives end up undergoing diagnostic evaluations with their related costs, discomforts, and possible risks as a result of test error.
    e. false negatives end up believing they are disease free when indeed they are not, leading to the possibility of ignoring symptoms when they do appear and delaying further assessment and diagnosis.

In the end, before proceeding with any program of screening, the gains versus the costs must first be carefully weighed.

Text=38%

Wilson, J.M.G., with Junger, G. (1968). ***Principles and practice of screening for disease*** **(pp. 9-39). Geneva: WHO.**

Considered a "seminal article" on screening practice, this article has withstood the test of time and is frequently used as a lateral reference in journal articles. It suggests the following definitions:

1. Mass screening: large-scale screening of whole population groups; no prior selection of groups.
2. Selective screening: screening of selected high-risk groups; one form of population screening
3. Multiple (multiphasic) screening: application of several screening tests at one point in time per person
4. Surveillance: a long-term process where screening examinations are related at intervals of time for data comparison
5. Case-finding: application of tests or procedures for the purpose of detecting disease in individuals and getting them into treatment

Sets out criteria for screening tests or procedures, building on the earlier publication by the Commission on Chronic Illness' "Prevention of Chronic Illness":

a. The test or procedure used must be valid, meaning it accurately separates those who have the condition sought from those who do not, and is reliable, meaning it consistently produces the same results

b. The test or procedure must also be

- •simple to carry out,
- •able to be done rapidly in field (vs. clinical) conditions,
- •acceptable and cause minimal pain or discomfort,
- •inexpensive

c. The yield (i.e., the number of previously unrecognized diseases diagnosed as a result of screening) is acceptable, given the cost of implementation; the yield is often a factor of disease prevalence and the efficiency of the screening test itself

Sets out principles of screening:

a. The condition sought should be an important health problem from the perspective of both individuals and the community

b. There should be an accepted treatment for patients with recognized disease

c. Facilities for diagnosis and treatment should be available

d. There should be a recognizable latent or early symptomatic stage (necessary to achieve early intervention)

e. There should be a suitable test or examination

f. The test should be acceptable to the population

g. The natural history of the condition, including development from latent to declared disease, should be adequately understood

h. There should be an agreed-upon policy on whom to treat as patients

i. The cost of case-finding (including diagnosis and treatment of patients diagnosed) should be economically balanced in relation to possible expenditure on medical care as a whole

j. Case-finding should be a continuing process and not a "once and for all" project (pp. 26-38).

Monograph=37.5

Public Health Interventions

Applications for Public Health Nursing Practice

Referral & Follow-Up

Public Health Nursing Practice for the 21st Century
March 2001

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Division of Community Health Services
Public Health Nursing Section

INTERVENTION: REFERRAL AND FOLLOW-UP

***Interventions* are activities taken by PHNs on behalf of communities and the individuals and families living in them.**

Assumptions about all PHN Interventions...

- They are population-based; that is, they:
  - **S**are focused on an entire population
  - **S**are guided by an assessment of community health
  - **S**consider broad determinants of health
  - **S**consider all levels of prevention
  - **S**consider all levels of practice
- The public health nursing process applies at all levels of practice.

Definition

Referral and follow-up assists individuals, families, groups, organizations, and communities to utilize necessary resources to prevent or resolve problems or concerns.

Referral may include developing resources that are needed, but unavailable to the population. The key to successful referral is follow-up; making a referral without evaluating its results is both ineffective and inefficient.

Examples at All Practice Levels

Population-of-interest: *Older adults*
Problem: *Diminished capacity to manage activities of daily living safely*

Community Example:

*A community's PHNs serve on a committee with social services and the Area Board on Aging to develop a Senior Hotline, which provides information on resources and services for older adults. Despite the large number of elders in the community, very few utilize the hotline. The committee is not really surprised about the lack of hotline use, given the elder generation's tendency to believe that "self care" means "without help." The committee decides to try to change this community attitude among elders and adults with elderly parents. They design a social marketing intervention that emphasizes the benefits of "help in **your** home" versus "help in **the** home" (meaning nursing home placement). Brochures and refrigerator magnets with the hotline number are distributed at the check-out counters of local grocery stores and pharmacies, and the campaign is announced in the local newspaper.*

[Note: Developing the Senior Hotline was a systems-focused intervention. Systems- and community-focused interventions are often implemented simultaneously or sequentially.]

Systems Example:

A community assessment reveals that there is a great need for adult day activity centers, especially for working families caring for an older adult. Families are frustrated because they want to keep their loved ones at home, but there are no services available for elders while the adult children are

at work. The PHNs work with organizations in the community to develop incentives to provide adult activity centers. Transportation for elders is quickly identified as a barrier, so the PHNs and the group trying to develop the adult day activity centers present this need to various community service organizations. The local Lions Club responds with an offer to make "transportation" a project and eventually pledges to purchase a handicapped-accessible van. The group then approaches the social services department to discuss the possibility of their hiring a van driver. A small center opens, but it is not enough to meet the need. The PHNs continue their efforts to develop more adult day activity center resources in the community.

Individual/Family Example:

A PHN staffs a support group for caregivers of persons with dementia. He closely monitors the group discussion to identify emerging needs that could be met by referral to services. He listens carefully to their stories to identify barriers and gaps in services in the community. He also vigilantly monitors the status of the caregivers in the group to identify the point when they need to seek additional assistance or make other arrangements. When he identifies that this is happening, the PHN meets with the caregiver and starts the referral process by identifying needs and available resources with the caregiver and client, if possible.

Relationships to Other Interventions

Referral and follow-up most often follows the implementation of another intervention, such as **health teaching, counseling, delegated functions, consultation, screening, and case-finding (as related to surveillance, investigation of disease and other health events, or outreach)**. It is also an important component of **case management**. On occasion, it is implemented in conjunction with **advocacy**.

Notes from Abby

Referral and follow-up...

- Implementing the referral and follow-up intervention is a hallmark of public health nursing. In fact, it has been said that PHNs are "walking 'First-Calls for Help,'" reflecting PHNs' extensive knowledge of resources and established linkages within a community. The PHNs are often the persons to whom community members turn when they want to know where to go for help.

- The "intake" function in a public health nursing agency is carried out in a variety of ways. Sometimes a single PHN manages that function full- or part-time, or it is "rotated" among all PHNs. Sometimes the task is delegated to support staff who carry it out under the direction of a PHN. Either way, the task is to review requests or referrals made to an agency and determine a preferred course of action. At times this means referring a request internally. Other times it may mean re-referring it on to more appropriate vendors. Regardless, it is important to distinguish an "information and referral" function [I&R] from referral and follow-up. An I&R simply provides information on available resources; the family or other inquirer takes it from there. Follow-up, on the other hand, occurs when the PHN either accepts or makes a specific referral on behalf of an individual or family.

- Less recognized "hallmarks" of public health nursing are the efforts PHNs have invested in developing and sustaining referral systems within a community, such as those with clinics, hospitals, social service agencies, food shelves, battered women shelters, schools, etc.

- PHNs are both the "senders" of referrals (that is, the initiators of referrals on behalf of clients) and "receivers" (that is, the recipients of referrals from others).

BASIC STEPS for Referral and Follow-Up

Individual/Family Practice Level[24]

Working alone or with others, PHNs…

1. Establish an effective working relationship with the client.

Because referral often follows the implementation of preceding interventions, in most instances a relationship is already established. Regardless, the PHN needs to be open and honest with clients, communicating genuine concern for their well-being. In order to promote self-care, it is important for the client to carry out as much of the actual referral process as they are capable of doing.

2. Clarify the need for the referral with the client.

To be effective, the referral must be appropriate to the client's needs and objectives. This means the PHN must be familiar with, and have an established working relationship with, an array of referral resources within the community.

3. Assist the client in establishing realistic outcomes for the referral.

Often, the client will have a clear idea of what they want, but little idea of how to accomplish it. The opposite may also happen: the client may have a clear preference for the use of a specific resource but be unable to provide a reason why.

4. Explore the availability of resources with the client.

Depending on the client's capacity to work independently, the PHN assists the client in generating a list of possible referral resources. The PHN and client should explore informal resources (such as family members or friends), and resources and services available through neighborhood groups and the faith community should also be explored.

5. Encourage the client to select the resources they prefer and to initiate the contact whenever reasonable.

The PHN provides guidance as needed. Depending on the client's capacity, this may range from:

- dialing the phone and making the contact while the client watches how it is done
- standing behind the client coaching them through the interaction
- helping the client prepare a set of questions to ask
- assisting them in completing any required paperwork
- leaving a list of resources and phone numbers

[24] Adapted from Clemen-Stone, Eigsti, McGuire. (1996, Sept/Oct). *Nursing outlook, 44*(5), 218-22.

If the client is hesitant or resistant to referral, the PHN explores his/her rationale. *In the end, however, the client's choice must be respected.*

The exception to this rule is a situation, such as instances of child maltreatment or suspected abuse of vulnerable adults, in which the PHN is legally compelled to report. In such cases of involuntary "referral," it is important for the PHN to retain a supportive relationship with the client to the extent possible.

6. Facilitate the referral process when necessary.

In addition to the preparatory work described above, the PHN should anticipate and reduce barriers to a successful referral (for example, the need for interpreters and transportation, as well as financial requirements). The PHN may also need to communicate with the referral resource to prepare for the client.

7. Follow up after the referral has been made to determine with the client the extent to which the referral was successful.

In collaboration with the client, the PHN:

- assesses whether the desired outcomes were achieved
- identifies any unmet outcomes and barriers
- modifies the plan, including consideration of different referral resources

8. Recognize that all steps in this process must be completed to assure success.

Notes from Abby

A PHN may have to perform the role of conflict manager in the referral process. Whether working with individuals, families, systems, or communities, differences may arise between what the "client" *wants* versus what your professional judgement suggests is *needed* to meet the desired outcomes safely and effectively.

The PHN can anticipate that individuals and families will want to maximize whatever benefits they believe they are entitled, while a community or system will want to maximize its market share. The PHN's role in this debate is to:

- serve as the steward of any public funding resources involved, and
- provide assurance that no one group potentially needing the resource will encounter access barriers greater than any other group.

BASIC STEPS for Referral and Follow-Up

Systems and Community Practice Levels

Working alone or with others, PHNs…

1. Utilize linkages with other providers, organizations, institutions, networks, etc., to monitor the community's capacity to provide the resources and services needed by populations at risk.

The PHN may use **social marketing, provider education, collaboration,** and/or **coalition building** to create a compelling reason why other community partners would want to become involved in developing resources. For instance, if the PHN deems it important for the faith community (that is, churches, synagogues, mosques, etc.) to be engaged, they may first have to be convinced how their members would benefit. Likewise, if community businesses are seen as important in developing referral resources, they will need to see how it would benefit their customers and their "bottom line."

2. Produce strategies for services and resources development.

It is important the PHN share his/her extensive knowledge of the special needs and unique characteristics of target populations with those in the community who are considering developing resources or services. This may mean working with local businesses, community service organizations (such as the Lions, Rotary, or Business and Professional Women), other health care providers, housing agencies, nonprofit agencies, etc. The more compelling the information, the greater the potential for resource development. For the PHN, this may mean researching how other communities have addressed similar needs, determining what grants are available, knowing what their own agency's contribution can be, and generating the initial list of strategy ideas.

3. Participate in implementing those strategies selected which fall within the public health agency's mission and goals.

Depending on the gaps in services and resources the community assessment identifies, the public health agency may or may not decide to alter the services and resources offered. The health board for the agency makes those determinations based on the extent to which the needs fit with the agency's mission and overall plan. The PHNs' extensive knowledge of the target populations is critical to building the case for changing agency services.

4. Participate in evaluating the strategies' effectiveness in developing needed services and resources.

With all the referrals that PHNs make and receive, they are in a good position to observe the functioning of referral systems, their strengths and weaknesses. Developing objective ways to gather this data contributes to the evaluation process. For instance, information on the average number of contacts required to complete a referral, a listing of barriers encountered, and observations on what worked well are all critical feedback.

BEST PRACTICES for Referral and Follow-Up

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who blended evidence from the literature with their practice expertise to develop them. These best practices are <u>not</u> presented in any ranking or particular order; each may not apply to every implementation of the intervention.

1. DEVELOPS REFERRALS WHICH ARE TIMELY, MERITED, PRACTICAL, TAILORED TO THE CLIENT, CLIENT CONTROLLED, AND COORDINATED.

Best Evidence: Wolff [25]

Timely:

It is never too soon to initiate discussion with the referral network. This does not mean that the PHN supplies specific client data. Rather, the PHN prepares the referral network for the possibility of a referral. This allows the PHN to determine resource availability. Timely processing of a referral is facilitated when the PHN achieves and maintains relationships with others in the referral network.

Timeliness involves knowing when the client and/or family is best approached about referral. In general, the best time is when the client can focus beyond the immediate crisis or circumstance.

Merited:

Before initiating a referral, the PHN and client together determine if additional resources are really necessary. Sometimes the client and family want to use community resources because they think they have a "right" to use them, even though the PHN's assessment does not support it. Appropriate and judicious use of resources is almost always the result of negotiation between the PHN and client.

Practical:

The PHN should thoroughly assess:

- the client's perception of need
- preferences for meeting those needs
- accessibility and availability of personal and family resources
- current knowledge and past utilization of community resources.

The PHN uses this information to develop a referral the client and family believe can work for them. It also supports the concept of client control and provides the information critical to developing reasonable, attainable outcomes.

Tailored to fit:

What seems "right" for one person cannot be assumed to be right for the next. The greater the extent each person's unique individuality, preferences, and needs can be accommodated, the more likely the referral will be successful.

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[25] This best practice is based on a 1962 article by Ilse Wolff published in *Nursing Outlook*. Titled "Referral: A Process and a Skill," it is considered the seminal article on referral and follow-up in public health nursing.

Client controlled:
The client's right to accept or not accept a referral is a basic assumption for this intervention. Acting on this requires the PHN set aside assumptions about what is best for a client.

Coordinated with other interventions:
The referral process is most efficient when it is carried out in conjunction with other interventions.

Frequently **health teaching** and **counseling** are utilized to change the client's and family's knowledge and attitude about reasonable outcomes of the referral.

2. ESTABLISHES A RELATIONSHIP BASED ON TRUST, RESPECT, CARING, AND LISTENING.
Best Evidence: panel recommendation based on practice expertise

Effectiveness in referral and follow-up depends heavily on the PHN's capacity to develop and maintain relationships, an underlying cornerstone of all public health nursing practice. [26]

3. THE CLIENT IS AN ACTIVE PARTICIPANT IN THE PROCESS AND THE PHN INVOLVES FAMILY MEMBERS AS APPROPRIATE.
Best Evidence: McGuire, Eigsti Gerber, Clemen-Stone; Wolff; Will; Stanhope and Lancaster, 1984

Engaging the client and family in the referral process to the extent they are able reflects the PHN's respect for the client. While the PHN has a professional duty to present a plan of action, the plan should be open to negotiation at all points. The greater the extent to which the client and family agree to each phase of the referral, the greater the potential for successful implementation.

Ilse Wolff's observation–although written in the style of the 1960's–is clear: "No referral should ever be made in a routine way; this is especially important when the reason for it is to bring about a change in behavior, relationship, or attitude. It is well known that no referral of this type will work unless it is based on the individual's own wish and desire for it" (p. 255).

4. ALLOWS FOR CLIENT DEPENDENCY IN THE CLIENT-PHN RELATIONSHIP UNTIL THE CLIENT'S SELF-CARE CAPACITY SUFFICIENTLY DEVELOPS.
Best Evidence: McGuire, Eigsti Gerber, Clemen-Stone

The PHN's ability to "meet the client where they're at" is an enduring hallmark of public health nursing practice. Promoting a client's self-care capacity sometimes requires the PHN to allow a period of client dependency.

[26] Minnesota Dept. of Health/Section of Public Health Nursing. (1999, June). *The Cornerstones of Public Health Nursing.*

McGuire and others state it most clearly. They acknowledge that PHNs may need to take on relatively more responsibility for the referral process in situations where the client and family lack the knowledge and skill necessary for the task. This period of "doing for" the client can serve as an opportunity for teaching and modeling what is required under the circumstances. At other times the client and/or family may possess the necessary knowledge and skill but are unable to act because they are overwhelmed by the complexity or emotionally depleted by the nature of their circumstances.

5. RESPECTS THE CLIENT'S RIGHT TO REFUSE A REFERRAL.
Best Evidence: McGuire, Eigsti Gerber, Clemen-Stone; Wolff; Will; Stanhope and Lancaster, 1984

Respecting choice reflects the nature of the PHN-client relationship. This "right to refuse" also applies to those circumstances in which the PHN believes the choices the client makes may not be in their best interest.

The exception is those circumstances where referral is legally mandated of the PHN, although this constitutes reporting and not referral. Often, however, a "gray area" exists between what is "not in the client's best interest" and the point at which the client's choice exceeds legal limits. Follow-up (or follow-along) by the PHN is critical in these situations. The consequences of their choices may make some clients more open to the referral process. The reality for a frail but determined elder living alone in his home may be much different than anticipated.

In addition, this "gray area" is often defined by unwritten but well-understood "community standards." For example:

- How much "self-neglect" is tolerable for an elderly man whose standards of personal hygiene offend others?
- How many pets are too many pets for an eccentric woman living alone in the community?
- When exactly does a person become incompetent to manage their own affairs?
- What are acceptable and culturally sensitive methods of child discipline?

In these circumstances, the PHN must resolve the ethical dilemma presented by the need to respect clients' rights of self-determination versus society's need to protect the vulnerable. Consulting agency policy and/or discussing the dilemma with a supervisor is appropriate action in these situations.

This does not mean that the PHN ignores client choices that exceed legal limits for jeopardizing their own health and welfare (such as states' laws regarding self-neglect by adults) or that of others (such as states' laws regarding child maltreatment or domestic abuse). In many states the PHN is a mandated reporter of those circumstances and has a legal as well as a professional duty to report to the proper authorities.

6. DEVELOPS COMPREHENSIVE, SEAMLESS, CLIENT-SENSITIVE RESOURCES THAT ROUTINELY MONITOR THEIR OWN SYSTEMS FOR BARRIERS.
Best Evidence: panel recommendation based on practice expertise

Examples of barriers could include:

- inaccessibility and unavailability of resources
- systems' inefficiencies or design flaws
- a community's belief that "self-care" means "without help."

The need for effective referral systems is identified through community assessment. Once identified, the PHN works with systems within the community, either adapting current referral systems or creating new referral resources. Assuring that there are appropriate resources in the community is just as critical as making referrals.

7. USES MULTIPLE METHODS OF FOLLOW-UP TO REINFORCE THE REFERRAL PROCESS.
Best Evidence: Manfredi, Lacey, et al.

Although referral and follow-up are presented as one intervention, effectiveness research often focuses on them separately. Conventional follow-up methods are:

- personal contacts such as home visits
- telephone calls
- written motivators/reminders.

Manfredi, Lacey, and others tested the effectiveness of four methods of follow-up for patients served at Chicago Department of Health in the mid-1980s. These individuals were referred for further diagnosis or treatment of suspected cancer.
Participants received the following additional follow-up services:

- an interview with a nurse using a structured mini-questionnaire designed to facilitate questions about follow-up expectation
- a form, which participants were requested to return in a pre-stamped, pre-addressed envelope after follow-up was completed
- a reminder note mailed to participants who did not return the form
- a telephone reminder to non-respondents three weeks after sending the reminder note.

They found two factors strongly associated with improved follow-through:

- when participants were able to get return appointments for the needed diagnostic work-up or treatment within two weeks of the initial appointment, and
- when participants received the extra attention of the nurse-interviewer.

Notes from Abby

Follow-up activities are critical to referral success. When working with individuals and families, this means the PHN should assure that barriers are resolved or reduced.

Yawn, Kurland, and others investigated why school children who failed school-based vision screening did not receive the recommended follow-up care. Through focus group interviews with parents, school personnel, and health care providers, the following issues were identified:

- School Related
  - concern that the screening results were not valid since the volunteers doing the screening had only minimal training
  - confusion about the school's intent to screen, expectations of parents, and resources available for follow-up.
- Community Related
  - expense of eye-care services and glasses
  - available appointment times with eye-care specialists were inconvenient and required a long wait
  - affordable lenses were not "cool"; children refused to wear them
  - care was not seen as a priority by enough parents
  - lack of general awareness of the significance of vision problems by the community as a whole.

A community-school task force developed a 22-point plan to address the issues, including such things as:

- facilitating an agreement among eye-care providers to schedule evening and weekend appointments
- starting a regular health column in the school newsletter where parents could anticipate getting information
- communicating the need for follow-up to parents at parent-teacher conferences
- investigating concern about screener training and the validity of results
- increasing awareness within the community regarding the seriousness of vision problems in children.

Yawn, B., Kurland, M., Butterfield, L., & Johnson, B. (1998, Oct). Barriers to seeking care following school vision screening in Rochester, MN. *J. of School Health, 68*(8), 319-324.

BEST EVIDENCE for Referral and Follow-Up

Each item was first reviewed for research quality and integrity by graduate students in public health nursing and then critiqued for its application to practice by at least two members of a panel of practice and academic experts. The nature of the material and a score expressed as a percentage are included at the end of each annotated citation. The percentage is the average of scores assessed by the experts who reviewed it. It reflects their opinion of the strength of the item's contribution to practice.

Review Articles

none

Research Reports

Mitchell, A., Van Berkel, C., Adam, V., Ciliska, D., et al. (1993, July-Aug). Comparison of liaison and staff nurses in discharge referrals of postpartum patients for public health nursing follow-up. ***Nursing Research, 42*****(4), 245-249.**

This study compares hospital staff nurses to public health liaison nurses in terms of the accuracy and cost of postpartum referrals for public health nursing follow-up in the community. After completing the postpartum contacts, the PHNs receiving community referrals judged whether the referral was appropriate; they were blinded as to whether the referral was generated by a hospital staff nurse or the PH liaison nurse. Results show that the hospital nurses correctly identified a higher proportion of referrals requiring PHN follow-up than the liaison nurses; however, they also referred more clients who did not require follow-up. Cost analysis determined that it was less expensive to have the hospital staff nurses generate all referrals. As a result, the allocation of time for the PH liaison nurses was reduced and converted to that of a consultant role to the hospital staff.

Experimental=80%

Manfredi, C., Lacey, L., & Warnecke, R. (1990, Jan.). Results of an intervention to improve compliance with referrals for evaluation of suspected malignancies at neighborhood public health centers. ***Am J Public Health, 80*****(1), 85-87.**

This study evaluated procedures to improve compliance with referrals of patients at risk for oral cancer. Intervention consisted of a standardized communication from the exit nurse, a patient form to be returned after compliance, and one written and one telephone reminder, as needed.

Compliance was 68.2 percent in a control group and 89 percent among patients who received the experimental intervention, a statistically significant increase.

Experimental=70%

Johnson, J., Williams, M., & Chatham, L. (1995, June). Notes from the field: The Houston advance DATAR follow-up project: Private investigator techniques for public health. ***Am J Public Health, 85*****(6), 868-869.**

This study involved evaluating and improving psychosocial adjustment and reducing HIV risky behaviors of heroin addicts through counseling, education, and methadone therapy. Follow-up by workers to measure change was complicated by participants' transient nature. Results indicated that follow-up success (i.e., locating participants) was increased when the following occurred: 1) Workers operated in communities where they blended in; 2) Workers who employed techniques

used by private investigators to locate missing persons, in particular the "back tracing to the anchor" technique." [Reference: Thoms RD How to Find Anyone Anywhere: New Expanded and Revised Third Ed. (Austin, TX: Thomas Investigative Publications) 1992]
Experimental=43%

Expert Opinion

McGuire, S., Eigsti Gerber, D., & Clemen-Stone, S. (1996, Sept-Oct). Meeting the diverse needs of clients in the community: Effective use of the referral process. *Nursing Outlook, 44*(5), 218-222.
Nurses face a significant challenge in meeting the diverse needs of clients who are moving quickly from one care setting to another. To address this challenge, organizations need to develop a well-established referral system to assist in the process of linking clients to community resources, and practitioners need to understand of the basic principles and clinical and theoretical aspects of the referral process. The article largely builds on the authors' textbook and includes much of the same material.
Expert Opinion=64%

Wolfe, I. (1962, April). Referral—A process and a skill. *Nursing Outlook, 10*(4), 253-256.
In what many considered a seminal article, Wolff establishes a set of referral and follow-up principles which have stood the test of time, despite the vast changes in health care delivery. These include:
1) A client's successful follow-through with a referral depends largely on his/her motivation which, in turn, depends largely on the extent to which what's asked of the client meshes with their personal perception of importance. The PHN's spending sufficient time getting to know the client ahead of the referral allows him/her to present it to the client in a way which fits those issues or concerns which do motivate the client. Wolff refers to this as "the long patience" and promotes it as saving time and resources in the long run. In other words, it's better to do it effectively the first time, rather than have to go back and redo referrals.
2) Consider these factors before approaching the client about a referral:

- •Does the referral have merit, that is, is the referral really necessary in order to meet the client's established goals?
- •Is it practical, that is, is it reasonable to expect that a given client can follow through given their current resources?
- •Does it fit the client's individuality, that is, to what extent are the referral resources able to accommodate the client's unique characteristics?
- •Is the client's right to refuse a referral respected?

3) No referral or follow-up procedure should ever be used as a "one size fits all" process. Each referral and follow-up must be tailored to the unique characteristics and needs of each client. The PHN must be cautious in his/her counseling not to continue to press for the way he/she thinks things should go as this only alienates the client and puts them into a defensive position.
Wolff concludes that to be successful, a referral must be "commonsensical" meaning that "[E]ven the simplest form of referral requires that the public health nurse know exactly what she is talking about, that she make sure how the referral she has made strikes home and whether it is understood in all of its implications. In this sense, even the most factual form of referral involves much more than writing an address on a piece of paper and handing it to the patient or some member of his family." (p. 253)
Expert Opinion=59%

Will, M. (1977). Referral: A process, not a form. *Nursing 77,* 44-55.

The author urges nurses to consider "that referral is much more complex than simply giving some information about a community resource or filling out a form" (p. 44). She identifies referral as a therapeutic process including the following phases:

1. Define the need: Observations include the client and the client's perception of the circumstances; an assessment of the physical, psychosocial, and environmental status; the extent to which the PHN can respond under agency policies; the PHN's own capability with this type of situation
2. Offer a suitable choice: Present a case for the referral that includes clear statements of the client's choices, including the right to refuse a referral
3. Anticipate possible barriers and work to eliminate them: This holds when considering either the client's acceptance of a referral or barriers to implementation when/if the client agrees.
4. Follow along with the client's follow-through on the referral: A nurse's ultimate goal "is to help the patient and his family feel free enough to turn, on their own to any community resource they need" on their own. However, there may need to be allowance for a period of dependency on the nurse until the client and/or his families has "learned the ropes." This transference of knowledge could include such things as role playing, assisting in the preparation of a list of questions to be asked of the resource, etc.
5. Evaluate for effectiveness, i.e., provide follow-up: Were the client's objectives met? If not, why not? Where your needs met? If not, examine whether your expectations meshed with those of the client's? Does some or all of the referral process need to be repeated?

"Referral [and follow-up are] a significant part of nursing care, not just an extension of it. Indeed, it is meant to extend you" (p. 45).

Expert Opinion=51.5%

Texts and Monographs

Stanhope, M., & Lancaster, J. (1984). *Community health nursing: Process and practice for promoting health*. St. Louis: Mosby.

In their textbook, the authors present the referral process as "another community health nursing strategy related to family health...[which purpose] is to introduce the family to community resource, and the goal is to enhance family self-care capabilities in using resources." The following eight steps describe the referral process:

1. Establish a working relationship
2. Establish the need for referral
3. Set objectives
4. Explore resource availability
5. Allow clients to decide what to do
6. Implement referral
7. Facilitate referral
8. Evaluate success and perform follow-up.

Families' capacity to carry out the referral process will vary, depending upon the level of families' skill and coping and the complexity and availability of community resources. However, to the largest extent possible, the client and family should always be involved.

Text=53.5%

Public Health Interventions

Applications for Public Health Nursing Practice

Case Management

Public Health Nursing Practice for the 21st Century
March 2001

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

INTERVENTION: CASE MANAGEMENT

***Interventions* are activities taken by PHNs on behalf of communities and the individuals and families living in them.**

Assumptions about all PHN Interventions...

" They are population-based; that is, they:
- **S**are focused on an entire population
- **S**are guided by an assessment of community health
- **S**consider broad determinants of health
- **S**consider all levels of prevention
- **S**consider all levels of practice

" The public health nursing process applies at all levels of practice.

Definition

Case management optimizes self-care capabilities of individuals and families and the capacity of systems and communities to coordinate and provide services.

Case management is characterized by:

- focus on development of the self-care capabilities of communities, systems, individuals, and families
- promotion of the efficient use of resources
- stimulation of the creation of new services where needed
- assurance of quality care along a continuum of service delivery
- decrease in the fragmentation of care across settings
- enhancement of clients' quality of life
- cost containment

Examples at All Practice Levels

Population-of-interest: *All children with special health care needs and their families*
Problem: *Fragmented service delivery system*

Community Example:

A PHN works with a local advocacy organization to present programs about the rights of children under the American Disability Act (ADA) to various parents groups within the community. The programs emphasize potential roles for parents to advocate on their children's behalf.

Systems Example:

A variety of professionals who provide services to children with special needs, including public health nursing and school nursing, cooperatively design a centralized intake process to simplify access to services for children with special needs

Individual/Family Example:

A PHN serves a family with a school-aged boy who uses a wheelchair due to his cerebral palsy. The PHN assists the boy's parents and their primary care practitioner in negotiating a plan with the school district to meet the child's educational and physical needs during the school day.

Relationships to Other Interventions

Case management is frequently carried out in conjunction or sequence with other interventions.

- It often generates referrals to others, but it can also be the result of a referral. In fact, **referral and follow-up** is often considered a key component of case management
- **Outreach** often precedes case management, especially in public health nursing case management models
- **Case-finding** may precede case management or vice versa, depending on the circumstances
- Implementing case management frequently relies on **health teaching, counseling, consultation, advocacy**, and **collaboration**
- Case management often leads to **advocacy** and **collaboration** at community or systems levels and is paired with **provider education**.

Notes from Abby

Case management has long been a key service provided by public health nursing. The origins of this intervention are attributed to PHNs who staffed the settlement houses prevalent around the turn of the century, such as Lillian Wald's Henry Street Settlement House in New York City. In fact, the article by Tahan describes a system of cards used by settlement house staff to do their case management which would be familiar to PHNs today: **"list family needs, establish a mechanism for follow-up, facilitate the delivery of services, and ensure that families were connected with the appropriate resources."**

Source: Tahan, H. (1998, March/April). Case management: A heritage more than a century old. *Nursing Case Management, 3*(2), 55-69.

BASIC STEPS for Case Management

Individual/Family Practice Level[27]

Working alone or with others, PHNs...

1. **Provide effective outreach and case-finding to *all* individuals and/or families considered at risk or otherwise meeting your agency's priority criteria and offer case management.**

2. **Involve those individuals and/or families in assessing their level of functioning. Determine the resources and services necessary to attain and/or maintain an adequate and safe quality of life. Through the process, develop a trust relationship; this step is essential to successful case management.**

3. **Involve those individuals and families in investigating available resources and services and designing a plan to access them.**

   Effective plans include the following:
   a. clearly defined priority service needs
   b. short- and long-term measurable objectives
   c. specific actions needed to reach these objectives
   d. identification of agencies and resources that will be utilized
   e. establishment of realistic timeframes
   f. identification of potential barriers (for example, waiting lists, client resistance, cost) and possible solutions.

4. **Link the individuals and/or families with needed service and resources, including financial resources.**

5. **Work cooperatively with other disciplines as the complexity of the circumstances requires.**

6. **Collaborate with individuals and/or families in coordinating the services and implementing the plan in a logical sequence.**

7. **Provide advocacy or "troubleshooting" to resolve potential or actual barriers in service provision.**

8. **Evaluate progress toward the established health outcomes with the individuals and/or families; revise plan elements as needed.**

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[27] Adapted from: Weil, M., & Karls, J. (1985). *Case management in human service practice: A systematic approach to mobilizing resources for clients* (pp. 29-71). San Francisco: Jossey-Boss.

Notes from Abby

In public health nursing, assuring efficient use of available resources has long been a key component of case management. However, it has never been in the context of withholding needed services. Whether working with individuals or families, a PHN may encounter differences between what the "client" *wants* versus what professional judgement suggests is *needed to promote self-care capabilities*. Individuals or families may want to maximize whatever services they believe they are entitled, even though the PHN deems them unnecessary. This is the balancing act PHNs inevitably face and manage; it is often referred to as the "need versus want" debate.

BASIC STEPS for Case Management

System and Community Practice Levels

Working with others, PHNs…

1. **Identify discrete sub-groups within the population (for example, *all* frail elderly living alone or *all* families with children with disabilities) whose quality of life is at risk.**

2. **Gather and analyze information regarding services and resources that are needed but unavailable, inaccessible, or unacceptable (e.g., services that are culturally inappropriate).**

3. **Communicate with community organizations and systems in a position to address these gaps.**

4. **Collaborate with community organizations and systems to assure adequacy and equity of resources and services developed.**

5. **Routinely evaluate the community's capacity to meet the quality-of-life needs of populations-at-risk identified through community assessment.**

Notes from Abby

The basic steps for case management at the systems and community levels are similar to those for referral and follow-up. They both largely function to create needed resources where resources do not exist or are inadequate. Case management and referral and follow-up at these levels share far more similarities than differences.

BEST PRACTICES for Case Management

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who blended evidence from the literature with their practical expertise. These best practices are not presented in any ranking or particular order; each may not apply to every implementation of the intervention.

1. USES A PUBLIC HEALTH NURSING FRAMEWORK FOR CASE MANAGEMENT.

Best Evidence: panel recommendation based on practice expertise

After reviewing the case management literature, the expert panelists concluded that a case management plan reflecting a public health nursing framework is characterized by:

- goals with a prevention focus
- inclusion of **health teaching** and **counseling** interventions
- consideration of the entire array of health determinants that affect a client's quality of life
- coordination of services and resources.

In addition, the values and beliefs of the individual, family, or population-of-interest whose care is being "managed" is respected at all times. As experienced PHNs know well, no one wants to be a "case," and no one wants to be "managed."

Not all nurse case managers use a *public health* nursing framework. The emphasis of case management may change depending on the setting in which it is implemented. For example:

- A nurse working in a hospital may understand case management as disease management, where critical pathways or protocols based on diagnoses or procedures are followed
- A nurse working in long-term care focusing on chronic disease management may understand case management as providing needed services in order to prevent hospitalization or other higher-cost resources
- A nurse working for a managed care or insurance company may see case management as benefits management or utilization review.

All may be appropriate within their specific environments, although none may be relevant for public health nursing.

2. SELECTS THE CASE MANAGEMENT MODEL WHICH BEST MATCHES THE NEEDS OF THE INDIVIDUAL, FAMILY, OR POPULATION-AT-RISK.

Best Evidence: Weil and Karls

General models of case management include:

- service brokers
- interdisciplinary teams
- primary service providers
- family case management
- volunteer case management.

Weil provides a comprehensive overview of the variety of case management models. Her review is useful in selecting the model that best fits a given individual or family's situation:

Professional Models

A. **Broker Model**, also known as the **Generalist Model**

An individual or family works with one professional in implementing the entire case management process. "Broker" means that part of the case manager's responsibility is to "get the best deal" for the client by making all the necessary connections with the services and resources required

B. **Primary-Therapist-as-Case Manager Model**

In this model the case management function is an extension of a therapeutic relationship a professional has with a client. It is primarily used with clients with limited capacity to function, such as the chronically and persistently mentally ill

C. **Interdisciplinary Team Model**

This model is usually implemented in one of two ways:

- each discipline represented on the team manages only those aspects of a given client's needs that relate to their particular specialty, such as social work, speech therapy, public health nursing, or physical therapy, or
- separate disciplines contribute to the design of the plan, but one professional is designated as the "lead" or "primary" manager. The person is usually designated, depending on the nature of the client's greatest need.

The PHNs must carefully consider their involvement in programs where case management services are provided by nonprofessionals. Even though the PHN's role may only be training the case manager, the issue of who is ultimately responsible and accountable for the services that nonprofessionals provide needs to be carefully considered.

In this category, PHNs provide training and guidance to those assuming the role of case manager.

A. **Family Model**

In this case, a relationship is developed between the PHN and the family member serving as case manager, in which the PHN acts as a mentor or consultant in problem-solving.

B. **Supportive Care Model**

This model has been developed and used almost exclusively with the chronically and persistently mentally ill population living in the community. Nonprofessionals supervised by a PHN develop supportive relationships with clients and develop linkages to needed services.

C. **Volunteer Model**

The volunteer model is similar to the supportive care model in that the volunteers are trained and supervised by a professional. However, volunteers are not paid and carry out the function as a service to their community. Like supportive care, this model has been mostly applied with the chronic and persistently mentally ill population living in communities. Guardian ad litem programs associated with family or juvenile courts are also examples of this model.

The assumption of a supervisory relationship between the PHN and nonprofessionals or volunteers needs to be clearly understood by all parties and PHNs should consult their states' nurse practice act and their agencies' policies regarding these kinds of situations.

3. DEVELOPS EXTENSIVE KNOWLEDGE OF COMMUNITY RESOURCES AND ESTABLISHES LINKAGES WITH THEM.

Best Evidence: Beilman, Sowell, et al.; Bower/ANA; Kellogg; Erkel, Morgan, Staples, et al.

The linkages serve to assure the following major outcomes of case management:

- continuity of care
- achievement of desired health outcomes
- cost effectiveness.

Several authors point out that "linkages" depend on the PHN's ability to develop and maintain relationships based on mutual trust.

Weil[28] points out that "linking is not simply making a referral, it requires doing whatever needs to be done to get the client to the service." This demands the case manager have both formal and informal relationships with an array of those service providers and other resources commonly used by the population-at-risk whose needs are being addressed. Establishing and sustaining those relationships, in turn, requires that the case manager has skill in communication, negotiation, interpersonal collaboration, and comfort in using positional and personal power, when needed, to implement a plan successfully.

4. PROVIDES CASE MANAGEMENT THAT IS CLIENT-CENTERED AND RELATIONSHIP-BASED.

Best Evidence: Beilman, Sowell, et al.; Bower/ANA; Kellogg; Weil and Karls; Erkel

Effective case management incorporates the following elements:

- respecting that the intervention is client-centered, not systems-centered
- anticipating the relationship-based nature of the intervention
- understanding that although much of case management is episodic, it can require sustaining a relationship for a long time; usually, the longer the relationship, the more likely the desired outcome will be achieved.

From the perspectives of individuals or families, the effectiveness of case management is clearly related to the nature and extent of their interpersonal relationship with the PHN. Individuals and families are most satisfied when their case manager is someone with whom they have a longstanding relationship.

Research by Elizabeth Erkel and colleagues demonstrates:

- for those with mental illness diagnoses, case management provided in the client's place of residence, rather than at an office, resulted in reduction of hospitalization, fewer case manager-client contacts, and compliance with established care plans
- among Medicaid-eligible families with young children seen in public health clinics, families who related to only one PHN for access to a variety of primary care services (an integrated model of case management) were significantly more likely to utilize preventive services than families who related to a different PHN for each clinic service (known as the fragmented model).

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[28] Weil, M. & Karls, J. (1985). *Case management in human service practice: A systematic approach to mobilizing resources for clients*. San Francisco: Jossey-Boss, 35.

In her 1995 doctoral dissertation on PHN case management, Kellogg supports the central importance of attaining and sustaining PHN-client relationships. In her study, PHNs describe strategies for establishing effective PHN-client relationships:

- conveying *genuine caring* about the family and its circumstances by accepting them as they are and not judging them by their current behaviors, even when those activities may have been illegal or in opposition to a PHN's own personal system of values and beliefs
- *persistence* in attempting to develop a relationship with the individual or family, despite multiple prior refusals.

5. DEMONSTRATES THE KNOWLEDGE AND SKILLS CRITICAL FOR EFFECTIVE CASE MANAGEMENT.

Best Evidence: Bower/ANA; Kellogg; Weil and Karls; Cohen; Lamb

Knowledge and skills critical for effective case management include:

- interpersonal skills: highly interactive, engaging clients with genuine interest, that is, "being with the person"
- effective communication skills: listening, counseling, teaching, problem-solving
- knowledge of community resources
- advocacy skills, including functioning as a liaison to community resources
- ability to work as a member of a multi-disciplinary team and with unlicenced assistive personnel
- fiscal management skills.

Skill in negotiating is often noted as critical for trust development. The main points to remember in negotiation are:

- approach all discussions with a positive attitude; make emotions explicit
- focus always on the objective or the problem–not the people involved
- know any timelines that may apply to the process
- know as much about the situation as possible before beginning the negotiation
- be aware of any power positions being used (either by you or others)
- have a clear idea of acceptable outcomes and what you are willing to concede, before beginning negotiations
- negotiate with someone who has the authority to make decisions, whenever possible.

Public health nurses must also have substantial clinical knowledge about the target populations they serve. Those PHNs coming into the field in the last 20 years most likely have learned about case management as it applies to a particular population-at-risk, such as children with special health care needs, persons with active tuberculosis, or frail elderly maintained in the community. Case management for these specialized or "targeted" sub-groups often are accompanied by a prescribed model or protocol for case management. Regardless of the model, however, the basic steps for case management are evident.

6. ROUTINELY EVALUATES CASE MANAGEMENT OUTCOMES AND REFINES THE PLAN ACCORDINGLY.

Best Evidence: Beilman, Sowell, et al.; Bower/ANA; Kellogg; Erkel, Morgan, Staples, et al.

The major outcomes of case management are:

- continuity of care
- achievement of desired health outcomes
- cost effectiveness.

Depending on the mission of a given nurse's employer, one part of the case management process may be emphasized over others. However, the theme of cost-containment as the major purpose of case management has strongly emerged since the early 1980s when health care reform discussions first began. As long ago as 1989, noted PHN leader Ruth Knollmueller warned that the value of case management would be found in improved care for people and not only containment of costs.[29]

The literature suggests a growing tension in attempting to achieve all three outcomes in an era when cost-containment dominates.

Beilman and Sowell particularly address this issue in their article, "Case Management at What Expense? A Case Study in the Emotional Costs of Case Management" (1998). They analyze a nurse case manager struggling with competing expectations from clients, physicians, professional organizations, and employers and they arrive at three conclusions:

- a realistic balance must be struck between cost-containment from the payer's perspective and what is needed to deliver quality care to patients
- health professionals must join together in advocating for quality care
- management of a hospitalized client's care must, from the time of admission, incorporate discharge planning.

[29] Knollmueller, R. (1989, October). Case management: What's in a name? *Nursing Management, 20*(10), 42.

Notes from Abby

For examples and further reading on population-specific case management, see:

- Rife, J., et al. (1991, February). Case management with homeless mentally ill people. *Health and Social Work, 16*(1), 58-67.
- Gonzalez-Calvo, J., et al. Nursing case management and its role in perinatal risk reduction: Development, implementation, and evaluation of a culturally competent model for African American women. *Public Health Nursing, 14*(4), 190-206.
- Smith, A., et al. (1997, Fall). Current applications of case management in schools to improve children's readiness to learn. *J. of Case Management, 6*(3), 105-113.
- Ardito, M., et al. (1997, Summer). Delivering home-based case management to families with children with mental retardation and developmental disabilities. *J. of Case Management, 6*(2), 56-61.
- Krout, J. (1997, Winter). Barriers to providing case management to older rural persons. *J. of Case Management, 6*(4), 142-150.
- Mitchell, E. (1997, Spring). Medicaid, Medicare, and managed care: Case management for dually eligible clients. *J. of Case Management, 6*(1), 8-12.

For PHNs interested in pursuing further information on case management:

Case Management by Nurses (1992), written by Kathleen Bower, was approved by the American Nurses Association Congress of Nursing Practice and reflects the perspective of the professional nursing organization (Pub. #NS-32). Contact: American Nurses Publishing, Washington, DC, 800/637-0323.

A variety of certification examinations for case management are available:

- American Nurses Credentialing Center (202/651-7000) offers certification in case management as a role component (module) of advanced practice certification in each clinical specialty, including community health nursing; limited to nurses with BSN preparation
- Foundation for Education and Research/Commission for Case Manager Certification offers a Certified Case Manager credential (847/818-0292) which targets "any professionals promoting physical, psychosocial, and vocational well being"
- National Academy of Certified Care Managers offers a Care Manager, Certified credential (800/962-2260) which targets social workers, nurses, mental health counselors, and psychologists.

[Note: Inclusion of the above sources does not represent their endorsement, nor does it represent encouragement to seek credentialing.]

BEST EVIDENCE for Case Management

Each item was first reviewed for research quality and integrity by graduate students in public health nursing and then critiqued for its application to practice by at least two members of a panel of practice and academic experts. The nature of the material and a score expressed as a percentage are included at the end of each annotated citation. The percentage is the average of scores assessed by the experts who reviewed it. It reflects their opinion of the strength of the item's contribution to practice.

Review Articles

Lamb, G. (1995). Case management. ***Annual Review of Nursing Research, 13,*** **117-136.**

Lamb provides a history of case management (CM) research from perspectives other than nursing; she suggests that the concept began as a research topic in the late 1970s for such disciplines as behavioral health, social work, and health services' research as a tool to improve quality and cost outcomes for high-risk adults in the community. In the 1980s, the focus shifted to Medicare recipients, although the issues remained the same. In both decades, considerable attention was given to case management in relationship to improving outcomes of care for individuals with chronic mental illness. The lessons learned included:

1. CM should be clearly linked to a theoretical framework in order to show significant changes in outcomes
2. CM intervention must be defined and specified, including listing task activities
3. Samples should consist of homogeneous groups of individuals most likely to benefit from case management (that is, to show a change)
4. Researchers should strive for consistency in the selection of sensitive outcome indicators.

Lamb then goes on to describe nurse case management "state of the art" (as of the early 1990s):

1. Considerable confusion exists about the purpose, scope, and functions, largely attributable to the absence of operational definitions of CM, lack of studies that control for the effects of extraneous variables, and a dearth of nursing-sensitive outcomes
2. Case studies abound in the literature which are "rich with description," but unexamined. Lamb sees the following common themes:
   - •nurse case managers appear to work with individuals, families, and populations at high risk of adverse health outcomes
   - •they are responsible for applying the nursing process in ways that potentially enhance both quality and cost outcomes
   - •they have access to individuals and families in more than one localized setting
   - •most of what has been analyzed has been in relationship to cost with little focus on structure (e.g., organizational supports, educational and experiential preparation of case mangers, caseload size, etc.) or process (e.g., operationalization of often-mentioned functions, such as maintaining long-term caring relationships, monitoring, pattern recognition, teaching, coordination, and advocacy
   - •most research that has been done on nurse case management has fallen into two categories: hospital-based models in which nurse case managers coordinate care for high-risk individuals across nursing units using managed care tools (such as critical paths), or continuum-based models in which nurse case managers work with clients and coordinate care across multiple settings.

Review Article=54%

Erkel, E. (1993, January). The impact of case management in preventive services. *J. Nursing Administration (JONA), 23*(1), 27-32.
Erkel cites Parker, Quinn, Viehl, et al.'s definition of case management (CM) as "a systematic process of assessment, planning, service coordination and/or referral, and monitoring and reassessment through which the multiple service needs of clients are met" (p. 27). She asserts CM is a well-known intervention in public health nursing, but suggests that greater effectiveness and cost effectiveness could be realized if preventive services were included as part of the care being managed. Erkel defines these services as "counseling, screening, immunizations, or chemoprophylatic interventions," which are cost effective because they replace high-cost tertiary medical care with relatively low-cost primary care. She reports on a study by Buescher et al. which found that Medicaid women receiving nursing CM service had lower rates of low-birthweight babies and infant mortality and participated to a greater extent in preventive services. In addition, the study suggested CM effectiveness was influenced by the intervention's length. However, Erkel also reviewed studies of CM services with chronically and medically fragile populations and found that while it consistently increased the use of community-based services, CM also increased the cost of maintenance care to those populations (p. 30). Erkel concludes that further research is needed to determine if the key to effective case management is a factor related to the client population, the health problem, or the qualifications of the case manager.
Review Article=53%

Research Reports

Erkel, E., Morgan, E., Staples, M., et al. (1994, October). Case management and preventive services among infants from low-income families. *Public Health Nursing, 11*(5), 352-360.
Erkel et al. compared differences in utilization of child health preventive services (counseling, anticipatory guidance, health education, health assessment and screening, monitoring of growth and development, immunizations at periodic intervals, and newborn home visits) among African-American mothers with Medicaid-eligible infants when case management was provided by one PHN (labeled as the "innovative method") versus different PHNs for each component of the preventive services. They demonstrated that continuous care from one PHN was associated with a 5.5 times greater likelihood of achieving adequate child preventive services.
Experimental (quasi)=90%

Kellogg, B. (1995, June). Public health nursing case management: Bridging the gap in health care. Excerpts from doctoral dissertation, Loma Linda Univ School of Nursing, 36-39, 167-186, 190-191.
This qualitative research sought to determine the common themes of case management (CM) as practiced among PHNs from four county health departments in southern California in the early 1990s. Chief among the themes was that case manager effectiveness depended on the PHN's ability to establish relationships in three areas: most importantly in relating to clients, their families, and the community; second, in the ability to relate to other social systems; thirdly, in the ability to relate to their own agencies. Based on her work with the county health departments and an extensive literature search, Kellogg sees CM's intent among PHNs as "establish[ing] a connection between the most vulnerable population groups and community services. Fundamentally, the purpose of CM in the public health sector is to optimize the self-care capabilities of families by promoting the efficient use of resources and decreasing fragmentation of care. Public health CM's major intent is to improve the overall health of the family, with the ultimate goal of improving the general health of the community in which the family

resides" (p. 170). The PHN does this by "assess[ing] the entire situation, determin[ing] which problems were amenable to interventions, and link[ing] the family to essentials services" (p. 172).

Kellogg also documents the characteristics of the "cases" with whom the PHNs worked; she portrays them as extremely complex family situations with multiple social and health problems who were experiencing rifts with their health care systems. The following critical strategies were employed by the PHNs to intervene effectively: 1) establishing rapport with the family through demonstrations of caring conveyed to the family as respect, acceptance, non-judgement, and persistence, despite frequent rejections early in the relationship; 2) developing extensive skills in coordinating care across disciplines and services. This, in turn, depended on the PHNs' ability to complete extensive paperwork, keep agency administrators informed and updated, provide information to other disciplines involved in a timely and efficient manner, and supervise other staff; 3) providing health education effectively by considering the learning needs of the families and using methods ranging from sharing information, serving as a role model, and demonstrating; and 4) achieving and maintaining a personal presence in the community. Personal characteristics of the PHNs providing effective CM included possessing extensive knowledge about the community, resources, and health care delivery system; skill in implementing health education; and a capacity to function with high levels of autonomy.
Qualitative=74%

Expert Opinion

Beilman, J., Sowell, R., et al. (1998, March/April). Case management at what expense? A case study of the emotional costs of case management. *Nursing Case Management, 3*(2), 89-93.
The authors offer a review of the conventional understanding of case management (CM) and then describe what happens when the cost-management component is given priority over all others. They begin by stating that "CM which has its historical roots in community and public health, seeks to coordinate care, decrease costs, and promote access to appropriate levels of services. Traditionally, CM had most often been used in community settings, focusing on vulnerable populations such as the elderly, the medically fragile, or the chronically ill. The objective of community-based CM has been to link persons with appropriate types and levels of services with the aim of balancing quality and cost of services across the trajectory of the wellness-illness continuum that exists in chronic illness or aging" (p. 89). They then describe a scenario where the nurse, as case manager for an elderly woman with a hip fracture and various other problems, is confronted with an ethical dilemma, i.e., a client and her husband whom the nurse believes require additional services beyond those allowed by the couple's medical coverage and the hospital and physician who are concerned about the cost of providing them. The authors conclude that 1) nurses serving as case managers be given the authority to seek a realistic balance between cost savings from the employer's viewpoint and the delivery of quality (i.e., necessary) services to the client; 2) physicians become a more integral part of the system; 3) the case manager must have effective working relationships with a variety of community service providers; and 4) nurses serving as case managers must have knowledge and training in negotiation and conflict management such as those associated with advanced practice.
Expert Opinion=49%

Kersbergen, A. (1996, July/August). Case management: A rich history of coordinating care to control costs. *Nursing Outlook, 44,* 169-172.
Although not always called case management (CM), CM functions have been carried out in nursing for at least 100 years. She asserts there is no consensus on definition or models, but there is on desired outcomes: maintaining quality while controlling the costs of health care through coordination and management of care (p. 169).
Expert Opinion=33%

Knollmueller, R. (1989, October). Case management: What's in a name? *Nursing Management, 20*(10), 38-42.
In this opinion piece, Knollmueller, at the time speaking from a public health nursing career spanning 20 years, reviews 17 models she identifies as being understood as "case management" (CM) in the late 1980s. She then goes on to describe who was providing CM services (mostly nurses, followed by social workers) and concludes from her analysis that their major role was that of gatekeeper to services and resources. Knollmueller acknowledges public health nursing's long history of doing exactly the same service in the community, stating that the "only difference now is that people can get paid for doing it" (p. 40). She also warns, however, that before local agencies jump into case management, they should first consider the field as it seemed to be evolving in the late 1980s: "a scheme for rationing services [by] limit[ing] the scope of service to management of the benefit or funding package and disregard[ing] the human faces behind the service." Knollmueller concludes that the value of CM should be measured, instead, in improved care (for the dollars spent).
Expert Opinion=30%

Lyon, J.C. (1993, June). Models of nursing care delivery and case management: Clarification of terms. *Nursing Economics, 11*(3), 163-169.
This articles seeks to clarify use of the term "case management (CM)" across care settings. The author attributes origination of the concept of CM to community health and, in particular, to "community service coordination," as practiced in public health in the early 1900s, adapted to the need for follow-up with the mentally ill moving into community settings in conjunction with "deinstitutionalization" during the 1960s-1970s, and related to the movement to prevent premature institutionalization of frail elderly following the passage of Medicare and Medicaid programs.

The purpose of CM is to "provide a service delivery appropriate to: a) ensure cost-effective care; b) provide alternatives to institutionalization; c) provide access to care; d) coordinate services; e) improve the patients' functional capacity." [This definition is attributed to Simmons and White, (1988). Case management and discharge planning: Two different worlds. In Volland (Ed.), Discharge planning: An interdisciplinary approach to continuity of care. Owings Mills, MD: National Health Publication. Characteristics of CM include identification of the target population; screening, intake, and eligibility determination; assessment; service arrangement; monitoring and follow-up; reassessment; care planning; assistance of clients through a complex, fragmented health care system; continuity of care; no provision of direct care; resource allocation; and comprehensive coordination along a continuum of care.

Nursing care delivery systems (i.e., team nursing, primary nursing, modified primary nursing, and managed-care models), on the other hand, manage patient assessment and delivery of nursing care during hospitalization (that is, "manage the case" of an in-patient). Hospital-based CM is a misnomer and should be understood as utilization review. Some hospital-based CM models include discharge planning and brief follow-up, but this is usually only

with a pre-set post-hospital service system (often connected with the hospital) and not an opportunity to explore all community options.
Community CM Models, on the other hand, do explore all options in the community with the client.
Expert Opinion=22%

Texts and Monographs

Spradley, B., & Allender, J. (1996). *Community health nursing: Concepts and practice* (4th ed.). Philadelphia: Lippincott, 108-109, 498-501.
The authors use Knollmueller's definition of case management (CM): "a systematic process b which the use assesses clients' needs, plans for and coordinates services, refers to other appropriate providers, and monitors and evaluates progress to ensure that clients' multiple service needs are met" (p. 109). They discuss CM in relation to coordination of home care services for the elderly, however, and in the context of managed care.
Text=66%

Bower, K. (1992). Designing case management programs. *Case management by nurses*. Washington, DC: American Nurses Pub, 11-22.
Case management (CM) is a mechanism through which nurses act as advocates for their clients. However, how it is done (i.e., the process of CM) varies according to the context, purpose, objectives, and scope. Some call CM the "Rorschach test" of an organization because, through it, organizational intent and priorities are revealed. Elements to consider include the nature of the client population to be served and the nature of the organization (i.e., hospital, community-based, third-party payer, or social service program). Are case managers also providers of services? Is their purpose clinical, administrative, or a combination of both?
Characteristics of a conventional CM program include that it is episode-based (meaning the same case manager is assigned to the same client across the continuum of care); longitudinally based (meaning it assures continuity of care); directed toward targeted or selected client populations; focused on care coordination; quality driven; fiscally aware and responsive; centered on clients and families; results in increased accessibility to services; proactive and looking ahead to prevent problems in the future. Nursing CM is not a patient care delivery system.
The Nursing CM process includes:

1. Develop a trusting, supportive relationship with client and the family through communication during early interaction: initial case finding, screening, and eligibility assessment
2. Complete an initial assessment of physical health status, functional capability, mental status, personal and community support systems, financial resources, and environmental condition. The completion of the assessment component is the review of the client's problems, strengths, and needs with the client and the family and negotiation of case management outcomes
3. Develop the plan of care with the client and family
4. Implement the plan of care; the case manager may or may not also provide direct services, depending on the policy of the employing agency; the case manager remains an advocate on behalf of the client, assuring that services negotiated are delivered in a way that is respectful and meets the plan's intention.
5. Monitor and evaluate process and outcomes throughout, modifying plan goals as needs change.

The core functions of CM is coordination of care and services. In addition, other functions typically included are listed below. The specific mix is determined by the nature of the setting and circumstance:

1. Coordinating care and services; may include directly providing services and/or managing payment/reimbursement for those services
2. Case-finding and screening to identify appropriate clients for case management
3. Assessing comprehensively the client's goals, as well as physical, functional, psychological, social, environmental, and financial statuses
4. Assessing the client's informal and formal support systems
5. Analyzing and synthesizing all data for formulating appropriate problem statements
6. Developing, implementing, monitoring, and modifying a plan of care with the client and his/her family
7. Linking the client with appropriate institutional and community resources, advocating on behalf of the client for scarce resources, and developing new resources where gaps exist
8. Procuring services, including eligibility decisions, and authorizing hospitalization and home care
9. Solving problems
10. Facilitating access
11. Providing direct patient care
12. Providing liaison services
13. Educating the client, family, and community support services; facilitating the goal of self-care
14. Facilitating communication
15. Documenting
16. Monitoring progress toward goal achievement, including periodic reassessment of health status
17. Monitoring activities to ensure that services are actually being delivered and meet the needs of the client
18. Evaluating outcomes

In addition, issues of the extent and limits of authorities and to whom the case manager is accountable must be established.

Text=52%

Weil, M. (1985). Key components in providing efficient and effective services. In M. Weil & J. Karls (eds.), ***Case management in human service practice: A systematic approach to mobilizing resources for clients*** **(pp. 29-71). San Francisco: Jossey-Boss.**

Weil identifies and describes eight key functions necessary to any case management (CM) model. These, in turn, are supported by three underlying processes: recording and documenting, monitoring service delivery and client response, and, interacting with the agencies involved in the service network. She also notes that the client is continually involved in the process.

The eight functions are:

1) Client identification and outreach: identifying the target population and the individual clients within this population
2) Individual assessment: requires establishing a relationship with the client and developing the data base to be used for service planning
3) Service planning and resource identification: considers such typical items such as:
    - •defined priority areas requiring services
    - •long- and short-term objectives to measure progress for each priority area

•specific actions related to each objective
•referral(s) planned
•realistic timeframes for completion
•identification of potential barriers to service utilization and delivery

4) Linking clients to needed services: requires establishing and using both formal and informal service agreements with other service providers; Weil also points out that simply making the referral is insufficient–the client may also have to be helped to use it

5) Service implementation and coordination: includes "troubleshooting" in the service network as the plan is implemented

6) Monitoring service delivery: assures that the client is receiving the expected services and that these services are necessary and appropriate for the client. This requires an ongoing relationship with the client, as well as skill in interprofessional collaboration and expediting problems

7) Advocacy: carried out at two levels–pressing for the needs and best interests of clients and working at the systems level for changes that will benefit the entire target population; Middleman and Goldberg's "principle of least contest" describes advocacy as a progression of intensity from "conferee" to "broker" to full-blown advocate and suggests using the least amount of intensity necessary to make the change occur; to make this decision, the following questions should be addressed (from McGowan):

•What is the source of the problem?
•What is the appropriate target system?
•What is the objective?
•What is the sanction for the proposed intervention?
•What resources are available for the intervention?
•With whom should the intervention be carried out?
•At what level should the intervention take place?
•What methods of intervention should be employed?
•What is the desired outcome?

8) Evaluation: includes looking at the outcomes realized by the client, as well as the functioning of the CM system itself.

Weil and Karls provide numerous models for case management, but emphasize that, while the look of the models differ in order to best accommodate the needs of a particular target population, all must address these eight functions. In addition, regardless of the model, the professional serving as case manager will need to fulfill three basic types of services: 1) direct work with clients and families; 2) coordination of services; 3) advocacy for access to services, creating them where they do not exist, and assuring the appropriateness and quality of the services. Text=46%

Cohen, E. (Ed.). (1996). *Nurse case management in the 21st Century*. St. Louis: Mosby.

Chpt 1: The New Practice Environment by V. DeBack, E. Cohen

The authors summarize recent dramatic changes in the delivery of U.S. medical services and predict that we are moving away from the "medical model paradigm" thinking (described as "diagnoses/treatment/cure") to "holism," where "disease and the associate symptoms are seen as information rather than the focus of heath care....The old paradigm sees persons as machines in either a state of good or bad repair. The new approach sees persons as open systems of energy in constant exchange with the environment" (p. 4). The authors predict that in future the

emphasis will be on provision of community-based primary care by advanced practice nurses. Besides providing direct care services, these nurses-of-the-future will also provide care coordination and case management, to advise clients on health behaviors, triage and monitor, advocate for families, help clients choose health services wisely, and evaluate outcomes of care and services. To be community-based, future nurses will also need to function at the systems and community levels, which will require the following (from Farley): respect for individual and community values; emphasis on issues that are important to the community; continuous leadership development; and community celebration.

Chpt 18: Case Management as a Response to Quality, Cost, and Access Imperatives by K. Bower, C. Falk

The authors propose case management (CM) as one of several strategies to use in assuring effective and efficient coordination of care, along with care management, critical paths, program management, and resource management. The result of improved care coordination is maximal quality, managed costs, and accessibility. The authors promote Bower and Falk's five principles of case management:

1. Focus on clients and families with complex issues where "complex issues" are defined as "the interaction of multiple concerns, including health, social, economic, spiritual, psychological, emotional, and environmental" (p. 163). They further suggest that "all patients need their care managed; not every patient needs a case manager," again borrowing from Bower and Falk.
2. Involves negotiating, coordinating, and procuring services and resources needed by clients and families
3. Entails using a clinical reasoning process, often exemplified in the development of critical paths. Minimally, the process includes referral and screening; assessment of needs, issues, resources, and goals; definitions and integration of goals; coordination and implementation of a plan through direct or indirect interventions; evaluation of the plan's effectiveness and efficiency; and revision of the plan based on changing needs and assessments
4. Involves developing a network based on multiple, interdisciplinary relations appropriate to the case manager's specialty (if any)
5. Is episode- or continuum-focused, meaning the case manager may be involved just through one episode of care coordination, or may work with a given client and family throughout several episodes.

Text=41%

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Public Health Interventions

Applications for Public Health Nursing Practice

Delegated Functions

Public Health Nursing Practice for the 21st Century
March 2001

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

INTERVENTION: DELEGATED FUNCTIONS

Interventions **are activities taken by PHNs on behalf of communities and the individuals and families living in them.**

Assumptions about all PHN Interventions...

- They are population-based; that is, they:
  - Are focused on an entire population
  - Are guided by an assessment of community health
  - Consider broad determinants of health
  - Consider all levels of prevention
  - Consider all levels of practice
- The public health nursing process applies at all levels of practice.

Definition

Delegated functions are direct care tasks a registered professional nurse carries out under the authority of a health care practitioner, as allowed by law. Delegated functions also include any direct care tasks a registered professional nurse entrusts to other appropriate personnel to perform.

Examples at All Practice Levels

Population-of-interest: *entire community*
Problem*: potential for tuberculosis infection*

Community Example:

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.

Systems Example:

Public health nursing directors from several counties meet with managed care plans to negotiate a reimbursement plan for directly observed therapy for the students and families, including the costs of interpreters.

Individual/Family Example:

Physicians prescribe the proper treatment and prophylactic tuberculosis medications, and per CDC recommendations, PHNs negotiated directly observed therapy (DOT) schedules with the families. This means appointments in clinic for some people and home visits for others. The PHNs also follow up everyone who does not keep their DOT appointments in clinic. Many of these families are non-English speaking and require coordination with interpreters.

Relationships to Other Interventions

Delegated functions focuses on a single aspect of nursing practice, that of delegation. The intervention is described in two ways–the PHN as the initiator of delegated functions to others (that is, the *delegator*) and as the recipient of delegated functions from other health professionals (that is, the *delegatee*). For PHNs whose assignment involves the delivery of home health services or other personal health functions under delegation from a physician, the concept of the nurse as the delegatee is undoubtedly very familiar. However, it is just as important that PHNs have a thorough understanding of their role as delegators or initiators of delegated functions.

Delegation primarily occurs at the individual/family level of practice. The act of delegation by the PHN to other health personnel is theoretically possible in every other intervention. For example, a PHN may delegate a family health aide to do health teaching on parenting to a young family, or delegate parts of vision and hearing screening to a school health aide, or delegate certain outreach tasks to a community paraprofessional.

In each of these examples, however, the PHN is exercising *independent* nursing functions. "Delegated functions" is the *only* intervention with the potential for PHN actions to be directed by another health professional with the legal authority to delegate. *None* of the other public health nursing interventions–health teaching, counseling, consultation, screening, outreach, surveillance, referral/follow-up, case management, disease investigation, case finding, collaboration, coalition building, community organizing, advocacy, social marketing, or policy development and enforcement–requires another health professional's authority. The PHNs practice these interventions independently under the authority of their states' respective nurse practice act.

This is not to suggest it is not important to communicate often and thoroughly with other health professionals with whom you regularly collaborate. However, communication is done in the spirit of good practice, not as a legal requirement.

BASIC STEPS for Delegated Functions [30]

Working alone or with others, PHNs…

Within the scope of nursing practice, **delegation** is highlighted, since it is a critical judgement professional nurses frequently make. The nurse must consider a variety of factors in making the judgement to accept delegation **from** a health care professional or delegate **to** nursing personnel. It is not unusual for some of these factors to be in conflict with one another.

When accepting delegation from other health care professionals such as physicians or advanced practice nurses, as allowed by law, the nurse must determine its appropriateness. When deciding to delegate independent nursing functions to nursing personnel such as home health aides or school health aides, the nurse must decide what is appropriate under the circumstances, since the accountability for the consequences of the action remains with the person who has the authority to delegate–the professional nurse.

When the PHN is the delegator (that is, giving delegation to nursing personnel), consider these five R's:

1. Right Task

Is this a delegatable task?

- In many states, assessment may not be delegated to others.
- Is the complexity of the task relatively simple? In general, if the task requires extensive training in order to perform it reliably, consistently, and safely, it probably cannot be delegated
- Does the task require alteration based on client response? If so, recognizing the signs for the need to alter the task requires professional judgement and, therefore, cannot be delegated.

2. Right Circumstances:

Are the care setting, available resources, and other relevant factors conducive to assuring client safety?

- Is there a low potential for harm to the client?
- Is the complexity of the nursing activity low?
- Is there minimal required problem solving and innovation?
- Is the outcome of the task predictable?
- Is there ample opportunity for patient interaction?
- Is the RN available to supervise adequately?

3. Right Person:

Is the right person delegating the right task to the right person to be performed with the right client?

- An RN may delegate all functions to another RN, as long as that individual agrees.
- Others to whom a RN delegates should have reasonable knowledge, training, and experience to assure consistent and safe performance of the task.

[30] The National Council of State Boards of Nursing has produced an excellent resource on the topic of delegation: *Delegation and UAP Issues*. Developed beginning in 1995 and regularly updated, it is available at <www.ncsbn.org>.

- Likewise, an RN should not accept the responsibility for carrying out tasks without the proper training or experience to assure safe and effective care.
- The client's stability and/or response to the task must be predictable and not require judgements in order for effective response.

4. Right Direction/Communication:

Is what is expected clearly and concisely stated, including objectives, limits, and expectations?

- If the task is new to the RN or developmental in nature or its description requires complex or multiple steps, the task probably cannot be delegated.

5. Right Supervision:

- Is the supervising RN accessible for answering questions and directly supervising?
- Are appropriate monitoring, evaluation, and feedback assured? As a rule, the more complex the task, the less experienced the delegatee, and/or the more unstable/unresponsive the client, the more physically close the supervising RN should be.

The Five Rights of Delegation

Right task?
Right circumstances?
Right person?
Right directions or communication?
Right supervision?

Although the "five rights" are written assuming the nurse is the delegator, the same set can be adapted for situations in which the nurse is the delegatee (that is, accepting delegation from a health care professional as allowed by law):

1. Right task?

Is this within my given scope of practice? [Note: This has nothing to do with whether you are knowledgeable or skilled enough to carry out a given task safely. If it is outside the legal scope of practice, it is not "right."]

2. Right circumstances?

A task which might be appropriate to carry out in the acute care setting might not be in a home, where environmental conditions are very different and supportive services likely unavailable. Just because a task can be done does not necessarily mean it should be done. The major question is whether the task or function being delegated also fits within the framework of the agency's policies and procedures.

3. Right person?

Do I have the needed knowledge, training, and experience to assure safe performance of the task?

4. **Right directions or communications?**
   Are the orders accurate and clear?

5. **Right supervision?**
   Who is responsible? Who is accountable? Although physicians can legally delegate whatever task they wish to whomever, the nurse still is limited by the legal scope of nursing practice.

Remember: A registered professional nurse can delegate *responsibility* but not *accountability,* unless it is to someone with the same licensure.

BEST PRACTICES for Delegated Functions

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who blended evidence from the literature with their practical. These best practices are not presented in any ranking or particular order; each may not apply to every implementation of the intervention.

1. ACCURATELY INTERPRETS THE NURSE PRACTICE ACT AND RELATED RULES. [31]
Best Evidence: NCSBN Delegation: Concepts and Decision-Making Process, 1997

This includes knowledge of the scope of practice and authorities and constraints regarding direct-care tasks and procedures, including delegation. Whether the PHN is considering accepting delegation from other health professionals or is considering delegating independent nursing functions to nursing personnel, the **"Five Rights of Delegation"** should be reviewed:

- Right task?
- Right circumstances?
- Right person?
- Right directions or communication?
- Right supervision?

2. OPERATES UNDER ESTABLISHED AGENCY AND/OR PROFESSIONAL STANDARDS, PROCEDURES, AND PROTOCOLS.
Best Evidence: NCSBN Delegation: Concepts and Decision-Making Process, 1997

This applies whether the RN is the initiator or the recipient of delegation. When relevant policies and procedures do not exist within an agency, it is the PHN's responsibility to prompt the agency to generate them. They promote consistency and establish what is "usual and customary" action.

3. RELIES ON QUALITY IMPROVEMENT MECHANISMS TO DIRECT THE DEVELOPMENT AND IMPROVEMENT OF DELEGATION PROCESSES.
Best Evidence: NCSBN Delegation: Concepts and Decision-Making Process, 1997

Quality improvement process should include a systematic review of delegation appropriateness. Improvement actions include developing procedures, promoting compliance assessments, imposing sanctions, and providing education and counseling.

[31] An additional resource in the relationship between professional nurses and unlicenced assistive personnel (UAP) is ANA's document #NP89A (1997, July). Discussion on delegation is included.

4. MONITORS PRACTICE TRENDS AND INTERPRETS THEIR IMPACT ON DELEGATION.
Best Evidence: NCSBN Delegation: Concepts and Decision-Making Process, 1997

This recognizes that what is understood to be acceptable practice, including delegation, evolves over time. Acceptability will be affected by economics, technological advancements, social changes, trends in the health care work forces, and community standards over time.

5. DOCUMENTS DELEGATION ACTIONS EITHER TO THE NURSE OR BY THE NURSE.
Best Evidence: NCSBN Delegation: Concepts and Decision-Making Process, 1997

Documentation, a required function under most states' nurse practice acts, includes all actions reflecting use of nursing judgment, including delegation.

Notes from Abby

The National Council of State Boards of Nursing (NCSBN) document offers definitions to keep in mind:

- **Accountability:**
  being responsible and answerable for actions or inactions of self or others in the context of delegation.
- **Delegation:**
  transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse retains accountability for the delegation.
- **Supervision:**
  providing guidance or direction, evaluation, and follow-up by the licensed nurses for accomplishment of a nursing task delegated to unlicenced assistive personnel.
- **Unlicenced assistive personnel (UAP):**
  any unlicenced personnel, regardless of title, to whom nursing tasks are delegated.

BEST EVIDENCE for Delegated Functions

The National Council of State Boards of Nursing has produced an excellent resource on the topic of delegation which serves as the major reference for this intervention. Although considerable literature exists regarding delegation in home health care, little literature specific to the context of public health nursing was available. The council's material is titled *Delegation and UAP Issues* and can be downloaded from <www.ncsbn.org>.

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Public Health Interventions

Applications for Public Health Nursing Practice

Health Teaching

Public Health Nursing Practice for the 21st Century

March 2001

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Minnesota Department of Health
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INTERVENTION: HEALTH TEACHING

***Interventions* are activities taken by PHNs on behalf of communities and the individuals and families living in them.**

Assumptions about all PHN Interventions...

" They are population-based; that is, they:
- **S**are focused on an entire population
- **S**are guided by an assessment of community health
- **S**consider broad determinants of health
- **S**consider all levels of prevention
- **S**consider all levels of practice

" The public health nursing process applies at all levels of practice.

Definition

Health teaching communicates facts, ideas, and skills that change knowledge, attitudes, values, beliefs, behaviors, and practices and skills of individuals, families, systems, and/or communities.

- **Knowledge** is familiarity, awareness, or understanding gained through experience or study.[32]
- **Attitude** is a relatively constant feeling, predisposition, or set of beliefs directed toward an object, person, or situation, usually in judgment of something as good or bad, positive or negative.
- **Value** is a core guide to action.*
- **Belief** is a statement or sense, declared or implied, intellectually and/or emotionally accepted as true by a person or group.
- **Behavior** is an action that has a specific frequency, duration, and purpose, whether conscious or unconscious.
- **Practice** is the act or process of doing something; performance or action or doing or performing habitually or customarily; making a habit of. *
- **Skill** is proficiency, facility, or dexterity that is acquired or developed through training or experience.*

Examples at All Practice Levels

Population-of-interest: *All pregnant and childbearing women*
Problem: *Alcohol use during pregnancy*

[32]*From *The American heritage college dictionary* (3rd ed.). (1993). New York: Houghton Mifflin); all other definitions are from Green, Kreuter, et al. *Health education planning: A diagnostic approach*. (1980). Palo Alto, CA: Mayfield Pub.

Community Example:

A PHN participates in a coalition working to reduce alcohol use by women during preconceptual and child-bearing years. The coalition develops a series of relevant posters and distributes them to bars, restaurants, other establishments serving alcoholic beverages, and liquor retailers.

Systems Example:

A PHN provides an inservice training to physicians, midwives, and family planning specialists highlighting new research findings on the effect of alcohol on pregnancy. The PHN promotes providers screening all pregnant women for alcohol use and consistently giving the message "absolutely no alcohol use during pregnancy."

Individual/Family Example:

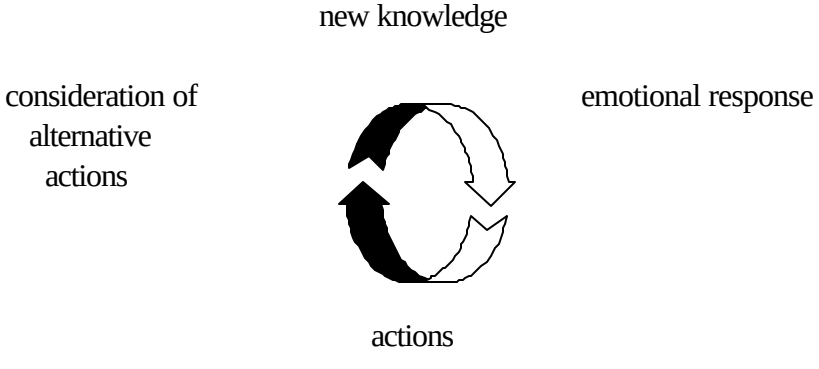
The PHN incorporates information on the impact of alcohol use on fetal development into the reproductive health class that the PHN teaches to high school and community college students.

Relationships to Other Interventions

Health teaching is used in conjunction with virtually all interventions. It is frequently implemented in conjunction with, or sequentially to, **counseling** and/or **consultation**. **Health teaching** influences the knowledge, attitudes, values, beliefs, practices, skills, and behaviors of individuals, families, systems, or communities. While **counseling** focuses on the emotional component inherent in any attempt to change, **consultation** seeks to generate alternative solutions to problems.

For example, if you provide **health teaching** about the prevalence, incidence, and causes of family violence at a community meeting, the information is likely to trigger emotional responses. Implementing **counseling** strategies in conjunction with **health teaching** allows you to build on the energy associated with the emotional response and further enhance the learning opportunity. A community may respond to information on family violence with powerful emotions like anger, outrage, fear, and grief. These emotions can motivate it to learn more about the problem and its causes. If the community accepts this new information and decides that something must be done to change its tolerance of family violence, you may assist it in exploring alternatives. That is, you provide **consultation.**

While you can effectively implement each of the three interventions alone, they most often occur together, or in succession, and are often repeated in a cycle:



This cycle is repeated until an acceptable solution is found.

BASIC STEPS for Health Teaching[33]

Working alone or with others, PHNs…

Step 1: Assess the client's knowledge and perception of the risk or threat to health.

Premise: A client (that is, an individual, family, group, organization, system, or community) whose beliefs and values prioritize good health is more likely to take action to promote health than one who does not care about health or who enjoys ill health.
Example*: Does the client believe that smoking is related to lung disease?*

Step 2: Personalize risk based on a client's current behavior or characteristics.

Premise: Clients believe they are at risk for acquiring a problem are more likely to act than those who perceive minimal or no risk. Likewise, a client who believes acquiring a condition would have serious negative consequences is more likely to take action.
Example: *What is the client's smoking or tobacco use history? What does that suggest for levels of risk?*

Step 3: Identify the perceived susceptibility, if too low.

Premise: If a people do not believe that they are at risk, they are not likely to take any action for change. The reality of their vulnerability and susceptibility needs to be challenged.
Example: *Can providing new facts and information change the client's belief about personal risk? Could specifying the consequences of the risk and/or the condition increase perceived susceptibility?*

Step 4: Define actions to take: How, where, when. Assist the client in understanding what can be done, what needs to be done, and that change is possible.

Premise: Client who believe themselves capable of successfully performing the suggested behavior are more likely to take action.
Example: *Review the variety of ways to reduce or eliminate use of tobacco products; help the client see how to master what needs to be done.*

Step 5: Provide training and/or guidance to perform the desired action.

Premise: Rehearsing the action provides clients with confidence that they are able to take it.
Example: *Role playing, or coaching the client through a walk-through of the action.*

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[33] Adapted from: Glanz, K. & Rimer, B. (1997, September). *Theory at a glance: A guide for health promotion practice* (NIH Pub. # 97-3896) National Cancer Institute, pp. 18-20. The Health Belief Model is highlighted because of its wide use and over 40 years of development. However, other conceptual frameworks are certainly also applicable in the resolution of public health issues. Those PHNs seeking further information are advised to see Glanz and Rimer's text edited with Frances Lewis (1997), *Health behavior and health education: Theory, research, and practice* (2nd ed). San Francisco: Jossey-Bass.

Step 6: Clarify the positive effects to be expected by personalizing benefits to the client's particular situation.

Premise: Clients' perceptions of risk, benefits, and self-efficacy are modified by three sets of variables:

- **Demographic:** age, sex, race, ethnicity, education, and income
- **Interpersonal:** expectations of significant others, family patterns of health expectations, and interactions with health professionals
- **Situational:** cultural acceptance of health behaviors, reference-group norms, and information from nonpersonal sources (such as mass media)

Example: *If a pregnant teen understands that smoking during pregnancy is related to babies with lower birth weights, she may perceive that as a benefit, allowing an easier labor and delivery and quicker return to her pre-pregnancy weight.*

Step 7: Identify and reduce barriers through reassurance, incentives, and assistance.

Premise: In order for the individual to act, the perceived benefits from taking action (pros) must outweigh the perceived costs (cons). This step focuses on anything an individual might believe to inhibit or prohibit taking action. Cost, inconvenience, unpleasantness, and extent of required change in lifestyle are all examples.

Example: *Determine what the client believes to be barriers and assist in their resolution.*

Step 8: Provide how-to information, promote awareness, and provide reminders.

Premise: An individual with equally weighted pros and cons to taking action may be motivated finally by the addition of just a few variables. This category includes experiential motivators meaningful to the individual that prompt immediate action, or the "final straw that broke the camel's back." Cues can be just about anything, but typically include such things as a sudden heightened awareness of vulnerability (such as having a same-age friend unexpectedly die), intensified availability of information or new information (such as gaining computer access to the Internet), natural life transitions, such as aging, or an intensified sense of self-efficacy.

Example: *Break down whatever action is required into small, doable steps; pair the client with others who have been successful in taking the desired action; provide reinforcement and assurance.*

Step 9: Evaluate progress.

Premise: Providing feedback on progress toward goals is in itself reinforcing. Small concrete measures of progress are best; celebrate success.

Example: *The client now has a workable plan of how she will get herself and her children to safety the next time her partner becomes violent in their home.*

BEST PRACTICES for Health Teaching

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who blended evidence from the literature with their practical expertise. These best practices are not presented in any ranking or particular order; each may not apply to every implementation of the intervention.

1. ASSESSES THE KNOWLEDGE, ATTITUDES, VALUES, BELIEFS, BEHAVIORS, PRACTICES, AND SKILLS OF THE LEARNER AND THE LEARNING ENVIRONMENT. [34]

Best Evidence: Boyd, Graham, and others

The PHN collects data through:

A. Observations regarding the learner
- cognitive developmental characteristics
- presence/absence and nature of support system
- general health status
- current health maintenance practices
- risk factors
- access to care
- psychological status
- culture
- belief and values system.

B. Observations regarding the learning environment
- facilities
- physical aspects
- organization of services available
- philosophy, policies, procedures of setting
- health delivery system
- community orientation and values
- roles of other health-care providers
- government intervention in health care
- geographic location of practice site.

[34] Much of the best practices material cited is from Marilyn Boyd's chapter on teaching strategies in her book co-authored with Graham, Gleit, and Whitman, *Health Teaching in Nursing Practice* (1998). She notes that "effective teaching is a combination of the use of good communication skills, an in-depth assessment [of learners' capabilities and preferences], and effective teaching strategies" (p. 203).

2. POSSESSES CONTENT KNOWLEDGE OF WHAT IS TO BE TAUGHT AND SELECTS THE APPROPRIATE TEACHING METHODS.

Best Evidence: Boyd, Graham, and others; Spradley, and Allender

Not only do you have to know what you are teaching, but you have to know how to deliver it. The Expert Panel strongly recommends that PHNs must have complete, up-to-date knowledge and theory of any subject they teach.

A. Effective methods for oral communication in 1:1 teaching

- Provide comfortable learning environments, free from outside distractions
- Provide "advance organizers" or previews of what the learner will learn in order to shape learning expectations
- Present the most important information in the first third and last fourth of the presentation, as that is when the learner retains the most information
- "Check-in" with the learner to test understanding throughout the presentation by asking open-ended questions as time permits
- Use vocabulary and language style at the level of the client's understanding; be as simple and clear and plain as possible
- Use repetition to strengthen learning
- Do not overload the learner with inessential information; people forget about half of what they hear within five minutes.

B. Effective methods of nonverbal communication in 1:1 teaching

Be alert and sensitive to cultural differences in the meaning conveyed by such nonverbal communication as eye contact and the distance between persons.

Be alert and sensitive to immediacy, or the degree of "closeness" between individuals who are interacting:

- touching
- physical distance between teacher and learner
- forward lean (distance from your shoulders to your hips, if you are leaning sideways)
- looking directly into the face of the other
- measure of the body's torso rotation (how much you turn at the hips).

Be alert and sensitive to relaxation:

- hold your arm asymmetrically increases the look of relaxation (arms not straight)
- lean sideways (away from the vertical)
- place leg asymmetrically (do not stand with ankles together)
- relax hands
- relax neck
- relax with a backward lean.

Be alert and sensitive to responsiveness:

- face
- voice
- speech rate
- speech volume.

Learning occurs most effectively when verbal and nonverbal communication are in synch with one another; nonverbal behavior can either reinforce or negate what is being said.

C. Effective methods for group teaching[35]

For maximum interaction, limit the size of the group to 6-8 persons; if larger groups are necessary, arrange for small-group interactions within the session. It is the interaction which is critical to learning. Be alert and sensitive to group development and adapt teaching methods to group stages:

Stage One: establishment of a sense of belonging and identification of goals, facilitated by creation of an open and accepting environment.

Stage Two: role assumption within the group. In general, members assume the function of one or more of the following roles:

a. *Task Roles* (that is, those with formal purpose in the group)
- Clarifier – interprets and seeks understanding of group goals
- Informer – shares information from personal experience or knowledge
- Evaluator – measures group progress toward goals

b. *Maintenance Roles* (that is, those with informal purpose in the group)
- Gatekeeper – helps keep communication lines open within the group and keeps members engaged
- Compromiser – seeks acceptable decisions or actions; is willing to yield or admit error
- Encourager – praises individual contributions to the group; serves as morale booster

Stage Three: attachment to group solidifies, and it becomes more independent from facilitator

Barbara Graham points out that, whether an educational activity is planned for an individual or a group, principles of teaching and learning apply. In group teaching, however, there are more individual differences to consider (p. 308). She notes that, besides the obvious efficiency which group teaching provides, it also has the following advantages:
- provision of a supportive environment in which members can learn new skills and behaviors
- interactions fulfill members' need for belonging and importance
- potential of rich learning from others' experiences

[35] Much of the best practices material cited for group teaching is from *Health Teaching in Nursing Practice* (1998).

D. Effective methods of written communication

Preparing written materials is an important teaching tool for PHNs. Boyd provides important tips in this area, noting that most written material tends to be beyond its readers' ability. The last grade of formal education is **not** a good indicator. Studies have shown that average reading levels do not exceed the eighth-grade level. Twenty-five percent of the adult population is functionally illiterate, meaning they read below the eighth-grade level.

Keeping the following tips in mind can improve the chances your writing will be understood:

- when describing a procedure, use a question-and-answer format
- use one idea per paragraph; limit each paragraph to no more than three or four sentences
- use questions to engage the reader
- limit sentences to 10 words or less, and avoid complex structures
- use the active, rather than the passive, voice
- limit words to those with three or fewer syllables

3. ADAPTS TEACHING METHODS TO MEET THE NEEDS OF THE LEARNER.

Best Evidence: Freimuth and Mettger

In their article on "hard to reach" audiences (such as persons of low socioeconomic status, ethnic minorities, and/or those with low literacy) Freimuth and Mettger (1990) challenge readers to stop thinking about these groups as *difficult* to reach and teach and start thinking about them as *different* to reach and teach.
They suggest:

- emphasizing differences rather than deficits
- acknowledging that all people have the same underlying competence as those in the mainstream of the dominant culture (that is, operating from the position that all people can learn)
- placing responsibility for changes in health behaviors on the social system within which a person lives, rather than only on individuals themselves
- saying, "What would you like to know?" rather than, "Here's what I think you need to know."

4. ADAPTS THE TEACHING METHODS TO ACCOMMODATE THE CULTURAL PREFERENCES[36] OF THE LEARNER.

Best Evidence: Heiss in Smith and Mauer; Swanson and Nies; Malavisic

The effective teacher considers the influence of cultural beliefs and values on well-being, health, illness, and disease. Public health nurses must be knowledgeable about the health beliefs of cultures other than his or her own, given the

[36] The American Academy of Nursing produced a report on culturally competent care in 1995 that serves as an excellent resource. *Diversity, Marginalization, and Culturally Competent Health Care: Issues in Knowledge Development*, written by Davis, Dumar, and Ferketich, is available as Pub. # G-189 by calling 1-800-637-0323.

increasing mobility of populations across the globe. Thus, it is particularly important for the PHN to address the challenging health needs of immigrant and refugee populations.

Swanson and Nies provide advice from Davis and others regarding how to increase cultural sensitivity:

- confront your own racism and ethnocentrism
- be sensitive to both commonalities and diversity within ethnic minority populations
- seek knowledge about the dynamics of biculturalism (that is, how a particular ethnic group may be a synthesis of several cultures)
- seek understanding of how social and structural factors influence and shape behaviors
- avoid a "blame the victim" ideology (p. 169).

5. APPROPRIATELY APPLIES ADULT LEARNING PRINCIPLES AND THEORIES.

Best Evidence: Arnold; Freimuth and Mettger; Swanson and Nies

Several authors focus on the importance of the teacher understanding differences when the learners are adults. Swanson and Nies, for instance, report on Knowles' assumptions about adult learners:

Need to know:

adults need to know why they should learn this new thing; therefore, the PHN must present the direct benefits early in the teaching.

Self-concept:

adults are accustomed to independence and self-direction and, therefore, need to be provided choices and options.

Experience:

adults have many life experiences from which they have learned; this will transfer to new situations and may bias their perspective on new or differing information; the PHN can reduce potential barriers by using experiential methods, problem solving, case studies, and discussion.

Readiness to Learn:

the PHN understands that adult learners' capacity to learn is influenced by their age and life stage (such as being a parent to children or providing care for aging parents).

Orientation to Learning:

adults respond best to "present oriented" teaching, which provides information and problem solving within the context of their everyday lives.

Motivation:

adults are driven by powerful internal factors such as self-esteem, life goals, quality of life, and responsibility; the more the PHN can use these factors to "hook" the learner, the greater the likelihood of success.

6. COLLABORATES WITH OTHERS IN THE COMMUNITY COMMITTED TO IMPACTING THE SAME ISSUE.

Best Evidence: panel recommendation based on practice expertise

Since most health teaching strategies are planned and implemented in conjunction with other partners, PHNs must know how to promote effective mass communication. (Media used in mass communication include radio, television, films, e-mail, Internet, newspapers, magazines, flyers, etc.) Although this is often where health teaching overlaps with some aspects of **social marketing**, Helvie cites Flay and Burton's principles:

Acceptability:

the message of what is to change and the credibility of the source promoting the change must be acceptable to the audience

Message Dissemination:

- the selection of media to promote the change must include the benefit to the media provider (that is, it is to their benefit to be associated with the change project)
- the message should be repeated often and consistently over a long time in order to be effective

Attention Grabbing:

the communication must grab the audience's attention and provide a memorable message

Stimulates Interpersonal Communication:

the more the message is discussed among audience members, the more likely those discussing it will take action

Instigates Change:

the more society changes, the more individuals within society change (pp. 299-300).

7. EVALUATES EFFECTIVENESS OF THE INTERVENTION.

Best Evidence: panel recommendation based on practice expertise

An important part of the initial planning for health teaching is to select relevant measures or indicators of change in a personal or community health capacity. For instance, each component of the Health Belief Model has indicators that can be tracked and measured for change.

If health teaching is intended to change, for instance,...

- **knowledge,** then measure cognitive changes, such as increased or decreased retention of information and/or accuracy in applying that new information
- **attitude,** then measure increased positive or decreased negative responses to a person, action, or idea
- **values**, then measure changes in certainty about core guides to action
- **belief,** then measure changes in what a person believes to be true
- **behavior,** then measure increased frequency of the desired behavior or decreased frequency of the undesired behavior
- **practice,** then measure changes in actions or the process of doing something
- **skill,** then measure observed changes in an individual's accuracy, proficiency, and/or speed in carrying out desired tasks or functions

Provider Education

Definition

Provider education is the application of health teaching to change the knowledge, attitudes, values, beliefs, behaviors, practices, and skills of *systems* within communities, whose missions also impact the health status of populations.

Occasionally, PHNs encounter circumstances where their professional partners lack current knowledge of issues. Or, as is more often the case, because of the training and socialization other professionals experience, they prefer different models or styles of working. This is challenging, when members of a multidisciplinary group are expected to function as a team. When a PHN needs to change attitudes, behaviors, beliefs, knowledge, practices, and/or skills of groups and organizations in the community (that is, create a systems' change), **provider education** is the intervention of choice.

The basic steps of health teaching at the systems level are the same as the basic steps of health education at any other practice level. However, there is a small, but growing literature surrounding the specifically focused provider education intervention. **Thus, provider education has its own set of best practices.** While the majority of the literature focuses on providing education to physicians, the findings have general application across disciplines.

BEST PRACTICES for Provider Education

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who blended evidence from the literature with their practical expertise. These best practices are <u>not</u> presented in any ranking or particular order; each may not apply to every implementation of the intervention.

1. COMPLETES A COMPREHENSIVE ASSESSMENT OF SYSTEMS IN A COMMUNITY THAT INFLUENCE HEALTH.

Best Evidence: Neff, Gaskill, Prihoda, and others; Sechrest, Backer, and Rogers

As with any health teaching activity, the first step is to find out as much as one can about the "audience," or those whose knowledge, attitude, and beliefs you are attempting to influence or change. Of particular interest are:

- social influences
- level of knowledge
- nature of the practice setting
- perceived barriers
- level of interest or motivation to change
- openness to change
- anticipated barriers to change.

Thorough assessment of these areas allows for selection of strategies more likely to succeed.

2. TARGETS THE EDUCATIONAL CONTENT TO THE LEVEL OF THE PROVIDER.
Best Evidence: Mittman, Tonesk, and Jacobson

Many methods designed to alter knowledge and attitudes of professionals, especially physicians, are described in the health care literature. Most of these rely on the traditional model of providing information, education, and financial incentives to achieve behavioral change; however, at best, these have demonstrated only modest, if any, effectiveness.

Given that traditional models have not worked well, Mittman and others developed models based on social influence theory. These models activate other more subtle, but powerful influences, such as:

- emphasizing shared beliefs and assumptions
- group norms
- organizational culture
- related behavioral factors.

These models basically fall into three groups.

- strategies using *interpersonal influence,* such as academic detailing, providing training such as apprenticeships, consultation and peer discussions, and socialization programs (for example, orientation to a new position); these are usually 1:1 or small groups
- strategies using *persuasion,* such as opinion leaders, quality assurance programs, study groups, involvement in generating solutions to perceived problems, and socialization efforts (for example, grand rounds); these are usually moderate-sized groups
- Strategies using *mass media*, such as cable-TV inservice programs, distribution of printed materials, etc.; these accommodate large groups.

In general, *interpersonal strategies* such as training or apprenticeships and *persuasion strategies* such as implementing and maintaining quality assurance programs, study groups, and rounds resulted in the greatest transfer of knowledge *and* norm change, but required considerable effort. Conversely, none of the strategies requiring minimal effort (for example, distribution of printed material) resulted in significant change in both knowledge and norms.

Notes from Abby

Academic detailing is a method widely used to influence knowledge and attitude of health care professionals. Soumerai and Avorn (1990) offer an in-depth view of the process of academic detailing:

- assess and analyze motivators for change using such methods as focus group interviews
- establish credibility; attach yourself to someone with known credibility if need be
- approach the most significant opinion leaders available to you within the group you are trying to influence
- anticipate arguments and address them as one of several ways to see an issue; do not discount arguments that may be offered
- get the person or group that you are attempting to influence to ask questions; engaging them in a dialogue is essential for them to "buy" your concept
- concentrate on a small number of important messages that you want understood and repeat them
- provide feedback and positive reinforcement for even the smallest steps toward change in the desired direction
- provide well-illustrated written material that emphasizes the main points in a straightforward way as important complements; they will not trigger change by themselves, but will serve as reminders after you leave
- always have a practical alternative if you cannot achieve the entire change desired; some movement in the desired direction is better than no movement
- be well prepared to "make your case" in five to eight minutes

3. ENHANCES THE BASIS OF HIS/HER PROFESSIONAL CREDIBILITY.

Best Evidence: Tomson, Hasselstrom, and others; Sechrest, Backer, and Rogers

Most professionals prefer to learn new information from someone they consider of the same or higher stature within their own discipline. Tomson and others found, for instance, that, to improve physicians' prescribing behavior, it took sending a team of a clinical pharmacologist and a pharmacist to provide short, intense teaching on the best use of drugs to control asthma.

Those PHNs involved in provider education activities need to present themselves as credible. Being well read in the related scientific literature and as knowledgeable as possible about the issue are crucial. The PHN's credibility can also be enhanced by considering what researchers have learned attempting to change physicians' knowledge levels. For instance, researchers determined whomever was delivering the new information was most successful when they could:

- present it in the language physicians were accustomed to using
- do it within a minimum amount of time
- frame it in a way that quickly identified their benefit.

Likewise, Sechrest, Bacher, and Rogers noted that it is critical to determine accurately the way an audience prefers to get its information. Persons with highly scheduled time use, for instance, are unlikely to use reading material to any extent. They suggest one of the most powerful strategies to change provider behavior is to influence the opinion

leader within the group. Other group members are more likely to value the opinion of a peer whom they respect than take the time to research and formulate their own opinion.

4. STRUCTURES THE APPROACH.
Best Evidence: Soumerai; Gomel; Tomson; Davis; Soumerai and Avorn

A structured approach to provider education should include both targeted and balanced messages, use of complementary methods, active participation of providers, intermittent reinforcement and follow-up, and practice application.

These authors' suggestions for effectively changing professionals' practices apply the principles of adult education and learning. In general, their recommendations use principles of altering knowledge, attitudes, and behaviors described in the HBM and other models for change.

- A literature review by Dave Davis, a physician at the University of Toronto, found that attempts to change physicians' performance, using both appeared more effective
  - *external methods* (such as academic detailing and opinion leaders)
  - *practice-based methods* (such as reminders and patient-satisfaction information) in changing practice than audit and educational materials. In addition, providing training seminars without enabling or practice reinforcement follow-up resulted in little change
- Gomel and others tested three methods to increase physicians' use of a brief intervention to reduce alcohol use among patients. The physicians received information through direct mail, telemarketing, or academic detailing. While academic detailing was found to result in the greatest change, telemarketing was found to be most cost effective. Based on the evidence reviewed, both **personalizing the information when delivered** (that is, assisting the physician in anticipating how practice and/or patient outcomes would be improved) and **providing some kind of reinforcement as follow-up** were important to adoption of a change.

5. CAREFULLY CRAFTS THE PROCESS TO EFFECTIVELY DISSEMINATE INFORMATION.
Best Evidence: Mittman, Tonesk, and Jacobson; Sechrest, Bacher, and Rogers

The PHN should keep in mind the clear findings from research that simply mailing or delivering statements of the desired change (such as written standards, guidelines, evidence summaries, etc.) does not work. It is reported that for every dollar spent to research and develop new information, an additional dollar should be expended for effective dissemination. That is, dissemination that results in *actual use* of the information. In a summary of ideas for effective dissemination of health information presented at a national conference in 1991, Sechrest, Bacher, and Rogers provide the following insights:

Regarding Audiences...

- Know the audiences' general capacity to understand and tailor information accordingly. What is obvious to a PhD-prepared researcher is not going to be obvious to those with lesser preparation. Conversely, what

is obvious to a practitioner with years of "front line" experience may not be understood by a researcher unless expressed in academic language

- Know what will motivate audience members to care about the message or "attend" to it
- Understand that, within a given audience, members can vary greatly in their motivation toward change. Audience segmentation (that is, knowing the age, sex, and occupation of the audience) is useful in understanding those variances.

Regarding Messages...

- Short and succinct is best
- "Repetition and redundancy are the allies of communicators and disseminators" (p. 191)
- Relatively small "chunks" of information are more easily absorbed by most audiences; use serial messages to convey a larger amount of complex information
- Most audiences do not care about the source of a message, as long as it is thought to have come from a reliable source relevant to the topic.

Regarding the Methods...

- Know the audience and their prime sources of information
- Understand the informal network of information sharing among peers, identify opinion leaders within the network, and know how to access them
- Every audience will require multiple communication approaches to assure the message is heard
- The most effective communication methods will likely be highly interactive, allowing users a high degree of discretion in how the message is received and when.

Notes from Abby

In a recent article published in *Public Health Nursing*, Lia-Hoagberg and others report on the outcome of a project by the Minnesota Department of Health/Section of Public Health Nursing to develop and disseminate guidelines for public health nursing in two practice areas: promoting positive parenting in two age groups (school-aged children and adolescents) and preventing violence against women and children. The dissemination process consisted of a two-hour inservice for PHN staff held at convenient regional sites. The inservice introduced staff nurses to the purpose and intent of practice guidelines and ways to use the manuals, but provided no training on the content itself. Six months after dissemination, follow-up surveys and telephone interviews found a high value placed on the guidelines, but minimal utilization. Barriers identified included lack of time in the work day, complex guideline structure, and competing agency demands and priorities. Recommendations included assuring agency management support for guideline use, developing a simplified guideline format, and providing mentorship in their use.

Lia-Hoagberg, B., et al. (1999, December). Public health nursing practice guidelines: An evaluation of dissemination and use. *Nursing Outlook, 16*(6), 397-404.

BEST EVIDENCE for Health Teaching

Each item was first reviewed for research quality and integrity by graduate students in public health nursing and then critiqued for its application to practice by at least two members of a panel of practice and academic experts. The nature of the material and a score expressed as a percentage are included at the end of each annotated citation. The percentage is the average of scores assessed by the experts who reviewed it. It reflects their opinion of the strength of the item's contribution to practice.

Review Articles

Kok, G., van den Borne, B., & Mullen, P. D. (1997). Effectiveness of health education and health promotion: Meta-analyses of effect studies and determinants of effectiveness. *Patient Education and Counseling, 30*, 19-27.

Kok and van den Borne use models for health education and promotion developed by American researchers (and especially the work of Patricia Mullen) to analyze recent efforts in the Netherlands. As they introduce concepts and findings from earlier meta-analyses on the subjects [see note], they provide a good overview of the issues for anyone new to the topic and its related issues. They rely on Greene and Kreuter's (1991) definitions:

> Health promotion is "the combination of educational and environmental supports for actions and conditions of living conducive to health."
>
> Health education is "any combination of learning experiences designed to facilitate voluntary behavior conducive to health."

The authors conclude that "health education often is only useful, when other means are chosen as well, such as means for action or laws" (p. 21). They also conclude that health education interventions can only be effective when the "epidemiological and psycho-social bases are sound" and suggest three major pitfalls: designing a health education campaign against a non-existing problem; focusing on the wrong behavior to change; or directing a program toward the wrong determinant of behavior. To avoid these, the authors drew these conclusions from their analyses:

1. Health education effectiveness depends on an intervention's quality and especially on the extent to which it adheres to social learning theory: the program must be relevant to the learner; it must provide learners with the opportunity to individualize new information to their own circumstances; learners must receive relevant feedback; the program must provide reinforcement of the new behavior through social supports; the program must reduce any barriers to the learners' taking action.
2. Health education must be clearly positioned in the health promotion program.
3. Systematic planning includes analysis of behavioral determinants, development of an intervention based on those determinants, and implementation of the interventions.
4. Use of learning principles in developing the intervention is critical.
5. Systematic implementation of the intervention to its conclusion is crucial for success. The authors note that findings of ineffective health education are often related to incomplete implementation or deviation from the planned approach.

[Note: These authors' work is based on a subset of an earlier work: Lipsey, M. W., & Wilson, D. B. The efficacy of psychological, education, and behaviors treatment: Confirmation from meta-analysis. *Am Psychologist, 48,* 1181-1209.]

Meta-analysis=46.5%

Research Reports

Reutter, L., & Ford, J. (1997, July). Enhancing client competence melding professional and client knowledge in public health practice. *Public Health Nursing, 14(3),* 143-150.
Part of a larger study looking at changing PHN practice in Canada, this qualitative study includes interviews with 28 Alberta PHNs. The article describes how PHNs exchange information with their clients to improve the clients' competence in self-care. The authors conclude that PHNs do this primarily through sharing their own professional knowledge (by providing information for immediate concerns, being direct, providing options, and presenting a different viewpoint) and building on the client's experiential knowledge (by acknowledging and valuing the client's current situation, giving positive feedback, "being there"–or supporting the clients' right to pursue a course of action based on their experience, and using gentle persuasion). This is described as "the strategy of validating, and then building on, client strengths [which] is a cornerstone of public health nursing and foundational to health promotion" (p. 149). The authors suggest that PHNs are successful when their "expertise lies in knowing how to provide informational, emotional, and appraisal support" (p. 149).
Qualitative=68%

Cantrell, J. (1998). District nurses' perceptions of health education. *Journal of Clinical Nursing, 7,* 89-96.
In this study from Scotland, the author, a nurse educator, interviewed a convenience sample of district nurses regarding their perceptions of health education, their own practice in regard to health education, and facilitators and barriers to their accomplishing health education. [Note: In this case, Downie et al.'s (1990) definition of heath education was used: "Health education is communication activity, aimed at enhancing positive health and preventing or diminishing ill-health in individuals and groups, through influencing the beliefs and attitudes and behaviours of those with power and of the community at large."] Although the purpose of the interviews was to gather information for a survey design, the author saw the findings as compelling on their own. She concludes: 1) Health education is seen as a core function of the district nurse, but evaluation of its impact is needed; 2) Nurse managers and general practitioners need to acquire a greater awareness (and support) of the district nurse's health education role; and 3) a broader investigation should be carried out to determine the value placed on health education by clients.
Qualitative=25.5%

Expert Opinion

Freimuth, V., & Mettger, W. (1990, June). Is there a hard to reach audience? *Public Health Reports, 105(3),* 232-238.
The authors offer alternative conceptualizations of audiences typically considered "hard to reach" or "difficult" in community health campaigns. They review characteristics attributed to these groups and conclude that they reflect the "communicators' frustration in trying to reach people unlike themselves in the failure of many campaigns to change high-risk behaviors" (p. 232). They select three characteristics in particular–SES, certain ethnic minorities, and low literacy–plus several preconceptions, as they target their own investigation. The preconceptions include that the "hard to reach" are fatalistic, with a pervasive sense of helplessness, have poor information processing skills, have limited access to communication channels (that is, rely almost totally on TV as their information source),

and distrust any dominant institution. They proceed to debunk these and offer alternative conceptualizations: 1) that differences among people, rather than deficits should be emphasized; 2) that blame should be directed toward society, rather than individuals; 3) that communication should be seen as a dialogue, rather than a "telling to"; this suggests that any attempt at successful communication considers Dervin's approach (see note): people inform themselves primarily at moments of need, and people rely first on their own cognitive responses. If these are insufficient, they turn to sources close to them or those contacted habitually. People judge information on how it helps them, rather than on its expertise or credibility. The authors conclude that health education will be successful if, 1) the unique strengths possessed by the audience are respected and, 2) communication is defined as an active exchange between participants. [Note: see Dervin, B. (1989). In Rice, R. E. & Atkin, C. K. (Eds.), *Audience as listener and learner, teacher and confidante: The sense-making approach in public communication campaigns (pp. 67-86).* Newbury Park, CA: Sage Publications).
Expert Opinion=47.5%

Malavisic, A. (1996, June 26). Power to the people. *Nursing Times, 92*(26), 54-55.
An international health worker, this author provides firsthand evidence of what happens when the importance of health is placed in the context of individuals' daily lives rather than of foreign or other inappropriate concepts (such as those of Western culture). She suggests that "when learning is a two-way process, where the individual's ideas and opinions are respected and where people are encouraged to question and criticize openly, only then can positive change occur" (p. 54).
Expert Opinion=44%

Stubblefield, C. (1997, July/Aug). Persuasive communication: Marketing health promotion. *Nursing Outlook, 45*(4), 173-177.
The author, a nurse educator, proposes that nurses can increase their effectiveness as health educators by integrating marketing principles into their health promotion efforts; she suggests adopting the "message-learning" approach to persuasion. Characteristics of the message "sender" which promote acceptance include: if the message is heard from someone considered an authority or professionally competent regarding the subject and, when the topic is serious, alternating rates of speech (but not pitch) is associated with improved recall. Characteristics of the message itself that improve its being heard (that is, "message framing") include using persuasive messages that arouse fear; using messages that intentionally create some cognitive dissonance; providing vivid, concrete information (e.g., using case studies) versus abstract information, or using negative, rather than positive, appeals for health behavior change. (For instance, telling women about the risks of not obtaining mammography proved more motivational than telling them about its benefits.) For those concerned that using "marketing" strategies to change health behaviors is manipulative, Stubblefield offers Lefebvre and Flora's list of "ethics" questions to consider: 1) What are we selling? 2) Who are we selling it to? 3) How are we selling it? 4) Whose side are we on?
Expert Opinion=29%

Texts and Monographs

Swanson, J., & Nies, M. (1997). The nurse's role in health education: The cement. *Community Health Nursing* (2nd ed.). (pp. 168-177). Philadelphia: WB Saunders.

The authors suggest that although PHNs must be familiar with learning theories and health education models, "[a]t the core of health education is a therapeutic relationship that develops between the nurse and individuals, families, and the community. Nurses are the cement of the process and serve as catalysts for change by delivering humanistic care..." (p. 168). The capacity to include all involved sets up the trust or "cement" necessary in order for learning to happen. "Educating does not begin with the first instructional word but rather starts with establishing an atmosphere conducive to learning" (p. 169). This requires PHNs to 1) confront their own racism and ethnocentrism; 2) be sensitive to intergroup and intragroup cultural diversity and commonalities in ethnic minority populations; 3) seek knowledge about the dynamics of biculturalism; 4) seek understanding of how social and structural factors influence and shape behaviors; and 5) avoid "blame the victim" ideology. Swanson and Nies offer the National Cancer Institutes' six-stage framework based on principles of social marketing, health education, and mass communication theory as a framework that works at all levels of health education intervention. The stages are: 1) planning and strategy selection that requires understanding the learning needs and preferences of the target audience; 2) selecting channels (that is, how will the target audience be reached?), choosing format (that is, one-on-one, use of groups, lecture, role playing, brainstorming, etc.), and materials/media (that is, what tools to use in getting out the message); 3) developing materials and pretesting to help assure comprehension, acceptability, and personal relevance to the audience; 4) complementing implementation with continuous monitoring to assure the right message is getting to the correct audience; 5) assessing effectiveness with both formative and summative evaluation; 6) using feedback (i.e., such questions as what was learned?) to refine the program. What can be improved upon? What worked well, and what did not? Are the goals and objectives relevant? What changed? Complete assessment? Audience perceptions of the problem? How can this information be used to refine the process? Text=94%

Boyd, M., Graham, B., Gleit, C., & Whitman, N. (1998). *Health teaching in nursing practice.* Stamford, CT: Appelton-Fairchild.

Chpt 1: Health Teaching in Nursing Practice

The authors assert that education about health is important in the U.S. because of American society's belief that people are its most valuable resource and that by "protecting and promoting the health of its members, the best interests of society will be served. The higher the level of health in a population the more likely that individuals will be productive..." (p. 3). A 1995 review of the cost effectiveness of health education by Bartlett finds that, for every dollar invested in health education, $3-$4 is saved. [See: Bartlett, E. E. (1995). Cost-benefit analysis of patient education. *Patient Education and Counseling, 26,* 87-91.] Health teaching is traced as a core component of professional nursing from its inception. A teaching model developed by the University of Virginia School of Nursing is used as a framework for the book. The components include:

1) *Social Services Ideal*, meaning that society grants nurses (and other professionals) the right to practice, provided certain principles are maintained: operating in the best interest of the public (as opposed to themselves or a small group); assuring a high level of quality practice through self-governance, codes of ethics, licensure, and standards of practice; emphasizing the client, rather than tasks or functions; providing client advocacy; maintaining professional autonomy.

2) *Nature of the Client State,* meaning that the nurse adapts the teaching to meet current client needs and expectations;
3) *Practice Environment*, meaning that the social, cultural, and physical environments in which nurses practice contribute to the manner in which health teaching is accomplished;
4) *Practice Strategies,* or the techniques used to communicate with clients.

Chpt 4: Theories of Learning

The author (Gleit) proposes that above all, nurses must be able to adapt their methods of teaching to meet their clients' learning preferences. The chapter outlines the three major perspectives on learning with this in mind:

1. Behaviorist Perspective: This approach emphasizes learning as a result of conditioning, where conditioning is the changing relationships between stimuli and responses and the attachment of a particular response to a particular stimulus. Examples of learning theories based on this perspective include operant conditioning, behavior modification, social learning theory, and behavioral therapy. The assumption is that what a person does is a function of his or her environment and not such "internal events" as thinking, forgetting, or wanting. Reinforcement is the key to behavioral change, with positive reinforcers (the nature of which vary from person to person) being used to help the learner identify which behaviors are desired and which are not. Shaping is used to change pattern characteristics gradually over time. Once the behavior is established, the teacher gradually decreases participation with reinforcers, or "fades" it out. When no reinforcement occurs, the behavior becomes less frequent and finally disappears or becomes extinct. The behaviorist perspective also supports the self-control approach, where individuals establish self-management regimens and provide their own reinforcers. Modeling, where one individual attempts to match the behavior of another in order to gain the same reward, is a variation of behaviorism and the basis for Bandura's widely used social learning model. He maintains that people choose what and whom they will model, although their imitation may be conscious or unconscious. The four processes involved in modeling are: A) attention, B) retention (remembering), C) reproduction, and D) reinforcement. It is not the random copying of behaviors, but something a person must willfully carry out. It is generally considered better to encourage an individual to use his or her own style of remembering, so that the use of the behavior will more likely be correct for reinforcement.

2. Cognitive Perspective: Cognitive approaches to learning are the mainstay of client education and are directed at helping clients improve their thinking ability. The structure of knowledge is important to the cognitive process and ranges from the concrete to the abstract, and from data and facts to concepts and then on to generalizations and rules. Bruner's, Gagne's, and Bloom's specific taxonomies are reviewed The latter, for instance, developed a six-level hierarchy, with retention of knowledge occupying the lowest step; next are comprehension, translation, interpretation, extrapolation, application, analysis, synthesis, and evaluation. The implications of cognitive structure for health teaching include knowing A) it is critical to deal with the concrete before introducing the abstract and B) better conceptual growth tends to occur when a wide variety of experiences is provided.

3. Humanist Perspective: These theorists are also concerned with the mechanics of cognitive learning, but place more emphasis on the development of "self-hood." There is "a focus on self and interpersonal awareness in personal development as well as creative problem solving and effective information-processing capacity" (p. 85). The teaching approach is non directive and focuses on the teacher's facilitating learning instead of imparting knowledge. A prime example of this perspective is the work of Carl Rogers.

The author also discusses the following as important concepts to learning, although not theories:
1) Self-Care and Self-Efficacy (near theories). These include the work of Orem and others. They are not strictly theoretical, but they surface often and should not be ignored. In self-care, patient teaching is the primary intervention used by nurses to promote self-care. Orem proposes three types of self-care: *universal,* or those associated with life processes and maintaining the integrity of human structures; *developmental,* or those conditions and events that occur at various stages of life; and *health deviation,* or self-care that arises from genetic and constitutional defects and human structural and functional deviations and their effects. Self-efficacy is the belief that one can respond effectively to a situation by using available skills and the belief that he or she can actually implement a skill. The more capable and confident the individual feels about performing health-related activity, the more likely the individual will proceed with behavioral change.
2) Empowerment: This is not a learning theory, but an interactive process of cultivating power in others through the sharing of knowledge, experience, and resources. One cannot empower someone else, only facilitate self-empowerment.

Chpt 11: Strategies for Effective Health Teaching
The author (Boyd) states that the "nurse does pick and choose the strategies based on the assessment, time available, patient preference, and guiding educational principles" (p. 202). She also notes that the two most common mistakes nurses make are 1) using too few strategies, and 2) using inappropriate strategies for the situation. She then outlines various strategies effective in changing clients' knowledge and behavior:

1. Teaching strategies
a) 1:1 teaching: This strategy relies on oral communication, which has the advantage of ease in establishing rapport, giving information and instruction quickly, and allowing for immediate feedback. However, it is often not done effectively. Effectiveness depends on:
- =minimizing external barriers to learning, such as noise and comfort
- =reducing internal barriers, such as fear, anxiety, worry, tiredness, and pain
- =accurate assessment of a client's learning preferences and capabilities
- =using "advance organizers," or telling the client ahead of time what they will learn
- =being as specific as possible when providing description
- =providing a summary and clear closure to the learning session

b) Nonverbal communication considerations
- =Immediacy: touching, distance, forward lean, observation, and body orientation
- =Relaxation: arm position asymmetry
- =Sideways lean
- =Leg position asymmetry
- =Hand relaxation

=Neck relaxation
=Reclining angle

c) Responsiveness
=Facial activity
=Vocal activity
=Speech rate
=Speech volume

[Note: For further information on nonverbal communication, the author suggests: Mehrabin, A. (1971). *Nonverbal Communication.* New York: Aldine-Atherton.

2. Educational Strategies (adapted from Green, 1979):

a) Be as specific as possible when giving instructions

b) Repeat the content, appealing to a variety of the client's senses

c) Be brief; individuals tend to forget half of what they hear within five minutes; present, emphasize, and summarize key information; do not overload the learner with "nice to know" information

d) Organize the material from simple to complex and from concrete to abstract

e) Recognize primacy: learners remember the first third and last fourth of the information best, so organize material considering this

3. Behavioral Strategies (i.e., techniques used to facilitate the adoption of specific behaviors)

a) Contracting (i.e., learner and teacher establish rules regarding what is expected)

b) Graduating behavioral change (this may be the most feasible way of altering behavior)

c) Tailoring the teaching plan to meet the client's interests and needs

d) Encouraging client self-monitoring, whenever appropriate

4. Teaching Aids

a) Written materials (i.e., be aware of client reading levels; as a "rule of thumb," most people read two to five grade levels below the last grade of formal school completed)
=use one idea for each paragraph; no paragraph should have more than four sentences
=space new concepts with the use of analogies or examples
=use questions to involve the reader
=avoid complex sentences; each sentence should be less than 10 words
=use active, rather than passive voice; make sure a verb follows the noun in each sentence
=limit words to two syllables or less; use shorter words whenever possible
=normal vision requires 8-10 point type; 12-14 is best for those with vision problems and children
=use lines no more than 70 characters long, with white space and serif type to rest the eyes
=consider using the SMOG rating scale for readability of written materials [See: McLaughlin, G. (1969, May). SMOG grading–A new readability formula. *Journal of Reading, 12,* 639-646.]

b) Displays (i.e., chalkboards, bulletin boards, and flannel boards); good when used as reinforcers for simple material

c) Graphics (i.e., nonlanguage elements of print such as graphs, flow charts, line drawings, and illustrations); pictures are better than words when concrete concepts are involved

d) Overhead transparencies and slides

e) Audio and audiovisual aids: self-learning by tapes can be as effective as 1:1, when prepared well
f) Video and TV: good but costly
5. Computer-assisted instruction: allows for self-paced learning, but is expensive to develop
6. Use of Internet sites: promotes independence of learning, but accuracy of information must be scrutinized
7. Three-dimensional teaching aids: good for kinetic learners or when psychomotor skills are emphasized
8. Games, simulations, and demonstrations: good for learning, but time consuming

Chpt 15: Strategies for Group Teaching

The author (Graham) suggests that, because much of the work of nursing is accomplished through team effort, skill in group teaching is essential. Groups allow for efficiency, provide a supportive environment to learn new skills and behaviors, and allow for sharing feelings. Several elements of group teaching are reviewed:
1. Group size: 6-8 members is ideal; the larger the group, the less it is likely to accomplish and the less likely that individual needs will be met; if a large group is unavoidable, try breaking it down into smaller groups
2. Group process: groups develop or "gel" by recycling through three basic stages:
A) establishment, that can be facilitated by having a specific plan with clear group objectives
B) role differentiation, in which the members sort out task roles (i.e., initiator, clarifier, informer, or evaluator) and maintenance roles (i.e., gatekeeper, compromiser, or encourager); this can be facilitated by designing group activities that force interaction among the participants
C) identification, in which the group functions with greater independence.
3. Group methods
A. Lecture: cost-effective, but must be well-delivered and dynamic to engage the varied learning styles inevitable among group members; hand-outs, breaks for questions and answers, short exercises related to the material, and use of media (even chalkboards or flip charts) to emphasize points help to keep participants engaged
B. Demonstration: most productive when each member of a group performs a "back demonstration" until they reach a level of comfort with the new skill
C. Case Study: most productive when used as the basis for small group discussions with reporting back to the larger group for further discussion, if warranted
D. Role Playing: useful when consequences of actions or behaviors need demonstrating; videotaping can serve as a useful alternative, if group members are resistant to assuming roles
Text=88%

Swanson, J., & Nies, M. (1997). Community health education. *Community health nursing*: *Promoting the health of aggregates* (pp. 168-177). Philadelphia: WB Saunders.

The authors suggest, "At the core of health education is a therapeutic relationship that develops between the nurse and individuals, families, and the community. Nurses are the cement of the process and serve as catalysts for change by delivering humanistic care....The critical step of inclusion sets the foundation for possible health action to occur. It is the cement that solidifies the relationship" (pp. 168-169). When working with individuals and families, it is important first to establish a "positive, proactive, and personalized relationship." With communities, it is important to promote community empowerment, which is achieved through participatory decision making and planning from the bottom up and is culturally sensitive. In planning community education programs that promote empowerment, the authors

suggest using the six-stage, continuous-loop framework developed by the National Cancer Institute [See: US Dept of Health and Human Services. *Making Health Communication Programs Work* (NIH Pub # 92-1493) Bethesda, MD: Office of Cancer Communications, National Cancer Institute]:
Stage One =selection of planning and strategy; the keys are understanding the learning needs of the target audience and targeting the program to it
Stage Two =selection of channels and materials; this stage builds on the understanding of the target audience achieved in Stage One and reaches out to include other organizations and groups within the target audience or attempts to reach it
Stage Three =development of materials and pretesting; pretesting the message(s) to be communicated and the methods of their delivery is essential
Stage Four =implementation
Stage Five =assessment of effectiveness; considers both the process and the outcomes of the implementation
Stage Six =feedback to refine the program; answers to the following questions help to fine-tune the program for increased effectiveness:

=What was learned?
=What can be improved on?
=What worked well, and what did not?
=Are the goals and objectives relevant?
=Has anything changed about the target audience?
=Was the assessment complete?
=Did the audience perceive the problem?
=Are the methods and formats tailored to the target audience?
=Were some barriers overlooked?
=What modifications would strengthen the effort?

Text=77.5%

Smith, C., & Maurer, F. (Eds.). (1995). *Community health nursing: Theory and practice*. Philadelphia: WB Saunders.
Teaching is defined as "the process of imparting cognitive knowledge, skills, and values....[However, a] basic truth about the teaching-learning process is that information alone is not sufficient to change human behavior. Telling someone what to do or how to do it will not result in modified behavior unless the person sees the relevance of the behavior to his or her values and goals and believes that the behavior change will contribute to the achievement of aspirations" (p. 17). The authors differentiate between patient education, which is learning activities designed for individuals, families, or groups who have an identified alternation in health, versus health education, which is directed toward individuals or groups who are not experiencing an alternation in health, but have been identified through a community assessment as potentially benefitting from information on healthy behaviors. They suggest clients' readiness to learn should also be assessed in two dimensions: emotional readiness (that is, the internal or external factors motivating the learner to put forward the effort needed) and experiential readiness (that is, the clients' background, skill, and ability to learn).
Text=71.5%

Helvie, C. (1998). *Advanced practice nursing in the community* (2nd ed.) (pp. 289-303). Thousand Oaks, CA: Sage.

Helvie reviews several health education models (i.e., Health Belief, Fear Drive, Dual-Process Self-Regulatory, Ajzen-Fishbein, and Behavioral Decision-Making/Stages of Change, as well as those of Monahan and Pfau). He places relatively more emphasis on the Stages of Change model proposed by Holtgrave. [See: Holtgrave, D., Tinsley, B., & Kay, L. (1995). Encouraging risk-reduction: A decision-making approach to message design. In E. Maibach, & R. Parrot (Eds.), *Designing health messages*. Thousand Oaks, CA: Sage]. Helvie offers Flay and Burton's suggestions for effective mass communication: acceptability, message dissemination, gaining audience attention, stimulation of interpersonal communication, instigation of behavioral change (that is, knowledge, skill, and behavior) by modeling the desired behavior, showing that it achieves desirable goals such as feeling good or looking better, showing the behavior as pertinent to real-life situations, nurturing the motive to avoid harm or improve well-being associated with the behavior, portraying the behavior as being approved and supported by the community, mobilizing public support, providing self-guidance for self-management of the change and coping with relapses, encouraging interpersonal social support, providing the infrastructure to support the change, and encouraging activism against those parts of the system seeming to resist the desired behavior. [See: Flay, B., & Burton, D. (1990). Effective mass communication strategies for health campaigns. In C. Aitkins, & L. Wallch (Eds.). *Mass communication and public health.* Newbury Park, CA: Sage.]

Text=64%

Rankin, S., & Stallings, K. (1996). *Patient education: Issues, principles, practices* (3rd ed.). Philadelphia: Lippincott.

Chpt 1: The Nurse as Patient Teacher: Changing Needs and Mandates

The authors view teaching as a dimension of the integral part of nursing practice known as caring. The nurse-as-educator role is traced throughout the profession's history, and current interpretations and guidelines are reviewed. The authors make clear that, although serving as patient teacher is not solely the nurse's responsibility, nurses play a crucial role in assisting the patient and family to anticipate what integrating the new knowledge and skill will mean to their daily lives.

Chpt 6: Educational Theories for Teaching and Motivating Patients

The authors' perspective is that patient education results in the empowerment of the patient and family and not in compliance to a suggested regimen. They rely on the work of Paulo Freire and view his concept of participatory education as the model for patient and community health education. [See: Freire, P. (1970). *Pedagogy of the oppressed.* New York: Continuum.] The premise is that patient/community education is never neutral and is always enmeshed in the value systems of educators. Therefore, educators must first discover the issues of concern to the target population; this means "clients" name their own problems, find their own solutions, and, through the process, transform themselves and their communities. The components of empowerment are sufficient knowledge to make rational, informed decisions; sufficient control and resources to implement decision; and sufficient experience to evaluate the effective of their decisions. The Health Belief Model, Pender's Health Promotion Model, Bandura's Social Learning Theory (a.k.a. Self-Efficacy Theory), Prochaska's Transtheoretical Model, and stress, coping, and social support theories are reviewed as frameworks for teaching.

The process of learning is also explored. Three types of learning are identified: psychomotor (learning of skills and performance); affective (learning that requires a change in feelings or belief); and cognitive (learning that requires thinking). The sequence of events in the learning process (regardless of type of learning) is organized into eight phases:
Phase 1: motivation; a belief that desired rewards will result from the changed knowledge or behavior to be learned; may be internally or externally derived
Phase 2: apprehension; learners are exposed to the stimulus, which they take in and process in a manner that requires discriminative abilities; a learner's state of mild or moderate anxiousness promotes this phase
Phase 3: acquisition; central nervous system changes undergird and concretize the new learning
Phase 4: retention; new learning is stored in the nervous system as memory
Phase 5: recall; retrieval of new learning
Phase 6: generalization; new learning is applied to situations other than the one in which it was learned
Phase 7: performance; observable changed behavior or skill
Phase 8: feedback; reinforcement; in psychomotor learning, the reinforcement is usually the successful accomplishment of the task; in affective and cognitive learning, reinforcement is generally external or provided by the educator or someone else besides the learner

Chpt 10: Designing Patient Education Program in the Community and in the Home
Two case studies, one of patient teaching and the other of a community education program, are used to illustrate their similar components: consideration of unique background and environmental circumstances; grounding in an assessment of need; and general appeal (that is, timely, well presented, and able to attract the interest of many).

Chpt 12: Community Health Promotion: Assessment and Intervention
Health education is defined as the major component through which health promotion is achieved and the accomplishment of health promotion as a major contributor to health empowerment. Community health education outcomes include learning factual information; developing self-confidence; reexamining or changing values; decreasing fear; and developing competence to make informed decisions and perform desired behaviors. Overall success in community education methods is increased by thorough assessment of the need to start; general acceptance of the goal by the majority of those involved; involvement of community members in planning; costs of production equal to, or less than, the benefits seen; enhancement of overall community (rather than just a few individuals or families); emphasis on self-help; a theory or theories providing the organizing framework; and effective media coverage. Om addition, the nature of the community and its environment are well understood, both those factors that promote change and those that hinder it. Personal health promotion strategies include informing (direct learning with or without the use of audiovisual materials); motivating (self-instruction, bibliotherapy or structured reading, mass media persuasion); skill building (demonstration/return demonstration, simulation, role play, inoculation, activism participation); modifying attitudes and behavior (imagery, cuing, tailoring, contracting, contingency contracting, graduated regimens, self-monitoring, self-confrontation, self reinforcement, external reinforcement, or self-generated aversive behavioral control); hypnosis; acupuncture; and pharmacology.
Text=55%

Spradley, B., & Allender, J. (1996). *Community health nursing: Concepts and practice* (4th ed.). Philadelphia: Lippincott.

The authors describe teaching as "a specialized communication process in which desired behavior changes are achieved. The goal of all teaching is learning....Effective teaching is a cause; learning becomes the effect" (p. 302). Three learning domains are described in depth:

Cognitive Domain: recall or recognition of knowledge and the development of intellectual abilities and skills; occurs in six major levels

1. Knowledge: lowest level of learning; involves recall
2. Comprehension: combines recall with understanding
3. Application: transfer of learning occurs; learner not only understands material, but is able to apply it to new situations
4. Analysis: preliminary step to problem solving; learner can break material down into parts, distinguish between elements, and understand the relationships among the parts
5. Synthesis: ability to not only break down and understand the elements of a situation, but to form elements into a new whole; the capacity to solve problems
6. Evaluation: highest level of learning; learner judges the usefulness of new material compared with a stated purpose or special criteria; judges the adequacy of solutions

Affective Domain: learning involves emotion, feeling, or affect; deals with changes in interest, attitudes, and values; occurs on several levels:

1. Receptive: willing to listen and be attentive
2. Actively participating: responding to information in some way
3. Valuing: learner attaches value to the information; ranges from acceptance through appreciation to commitment
4. Internalization: the new value system now controls the behavior consistently

Affective learning impacts the cognitive domain; in order for learned behavior to be maintained, the cognitive and affective domains must be consistent with each other or, at least, not in conflict. Affective learning is accomplished mainly through imitation and conditioning, using role modeling and positive reinforcement.

Psychomotor Domain: visible, demonstrable performance skills requiring neuromuscular coordination; three conditions must be met:

1. Learners must be capable of the new skill
2. Learners must have a sensory image of how to perform the skill
3. Learners must practice the skill.

The authors also provide principles of effective teaching, emphasizing that teaching is only one end of a continuum resulting in learning.

1. Client Readiness: receptiveness and knowledge level must be assessed as well as educational background and maturational level; the existence of a moderate level of anxiety promotes readiness
2. Client Perceptions: the impact of values, past experiences, culture, religion, personality, developmental stage, educational and economic levels, surrounding social forces, and the physical environment should be considered
3. Educational Environment: physical comfort must be promoted as well as atmosphere of mutual respect and trust
4. Client Participation: the amount of learning is directly proportional to the learner's involvement

5. Relevance to Client: learners gain the most from subject matters immediately useful to their own purposes
6. Client Satisfaction: learners need to feel a sense of steady progress in the learning process; afforded by establishing realistic goals
7. Client Application: application reinforces learning
Text=45%

Arnold, E. (1995). *Interpersonal relationships: Professional communication skills for nurses* (2nd ed.). Philadelphia: WB Saunders.
Health teaching is defined as "a flexible, person-oriented process in which the helping person provides information and support to clients with a variety of health-related learning needs" (p. 375). It is regarded as much broader than imparting information and results in change, restructuring, development of new perspectives, and/or problem-solving. The nurse assumes the role of guide, information provider, and partner in learning. Arnold suggests three learning models as most appropriate for health teaching:
1. *Person-Centeredness*: based on Carl Rogers' work, which suggests the teacher act as a guide and monitors learning to assure it is factual and strategically correct, responding to students' needs and motivational levels
2. *Critical Thinking*: a reflective process with cognitive and emotional components, which provides a framework for problem solving; based on the premise that it is as important to learn how to learn as it is to learn about specific content; relies on use of analogies and metaphors to help; consideration of the universal elements of similar situations
3. *Behavioral Models*: based on Thorndike and Skinner's early work, which suggests that given a stimulus in the environment, a learner responds and that response can be shaped or conditioned by a reinforcement which is of value to the responder; modeling is another behavioral approach.
Text=21%

BEST EVIDENCE for Provider Education

Each item was first reviewed for research quality and integrity by graduate students in public health nursing and then critiqued for its application to practice by at least two members of a panel of practice and academic experts. The nature of the material and a score expressed as a percentage are included at the end of each annotated citation. The percentage is the average of scores assessed by the experts who reviewed it. It reflects their opinion of the strength of the item's contribution to practice.

Review Articles

Soumerai, S. (1998). Principles and uses of academic detailing to improve the management of psychiatric disorders. *Intl. J Psychiatry in Medicine, 2891,* 81-95.
Review=44%

Davis, D. (1998). Does CME work: An analysis of the effect of educational activities on physician performance or health care outcomes? *Intl. J. of Health Services, 28(2),* 21-39.
Review=37%

Sechrist, L., Backer, T., & Rogers, E. (1994, December). Synthesis of ideas for effective dissemination. *Effective dissemination of clinical and health information: Conference summary* (DHHS/AHCPR Publ # 95-0015). 187-196.
Review=24%

Research Reports

Mazmanian, P., Daffron, S., et al. (1998, August). Information about barriers to planned change: A randomized controlled trial involving continuing medical education lectures and commitment to change. *Academic Medicine, 73(8),* 882-886.
Quantitative/experimental=52.5%

Neff, J., Gaskill, S., Prihoda, T., et al. (1998). Continuing medical education versus clinic-based STD and HIV education interventions for primary care service provides: Replication and extension. *AIDS Education and Prevention, 10(5),* 417-432.
Quantitative/non-experimental=41%

Tomson, Y., Hasselstrom, J., et al. (1997). Asthma education for Swedish primary care physicians: A study on the effects of academic detailing on practice and patient knowledge. *Eur. J. Clin Pharmacol, 53,* 191-196.
Quantitative/experimental=29%

Goldberg, H., Wagner, E., et al. (1998, March). A randomized controlled trial of CQI teams and academic detailing: Can they alter compliance with guidelines? *J. of Quality Improvement, 24(3),* 130-142.
Quantitative/experimental=29%

Butler, B., & Erskine, E. A. (1970, October). Public health detailing: Selling ideas to the private practitioner in his office. *Am J Public Health, 60(10),* 1996-2002 .
Quantitative/experimental=27.5%

Meador, K., Taylor, J., et al. (1997, February). Predictors of antipsychotic withdrawal or dose reduction in a randomized controlled trial of provider education. *J. Am. Geriatric Society, 45(2),* 207-210.
Quantitative/experimental=17.5%

Expert Opinion

Soumerai, S., & Avorn, J. (1990, January 26). Principles of educational outreach ("academic detailing") to improve clinical decision making. *JAMA, 263*(4), 549-556.
Expert Opinion=42.5%

Glass, R. (1994). An editor's perspective on dissemination. *Conference Summary: Effective Dissemination of Clinical and Health Information* (USDHHS/AHCPR Pub. # 95-0015). 159-164.
Expert opinion=11.5%

Mittman, B., Tonsek, X., & Jacobson, P. (1992, December). Implementing clinical practice guidelines: Social influence strategies and practitioner behavior change. *QRB,* 413-422.
Expert Opinion=39%

Public Health Interventions

Applications for Public Health Nursing Practice

Counseling

Public Health Nursing Practice for the 21st Century
March 2001

For Further Information please contact:
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Development of this document was supported by federal grant 6 D10 HP 30392, Division of Nursing, Bureau of Health Professions, Health Resources and Service Administration, United States Department of Health and Human Services.

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

INTERVENTION: COUNSELING

***Interventions* are activities taken by PHNs on behalf of communities and the individuals and families living in them.**

Assumptions about all PHN Interventions...

- They are population-based; that is, they:
  - Are focused on an entire population
  - Are guided by an assessment of community health
  - Consider broad determinants of health
  - Consider all levels of prevention
  - Consider all levels of practice
- The public health nursing process applies at all levels of practice.

Definition

Counseling establishes an interpersonal relationship with a community, system, family, or individual intended to increase or enhance their capacity for self-care and coping. Counseling engages the community, system, family, or individual at an emotional level.

Examples at All Practice Levels

***Population-of-interest**: All adolescents and their parents*
***Problem:** Depression and the potential for suicide*

Community Example:

The PHNs partner 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.

Systems Example:

A community suffers a devastating loss when three teens carry out a suicide pact. In response to the community's distress, the PHN partners with social workers, school service providers, and community clubs to design a teen suicide community response plan to prevent repeats of the teen suicide cluster. The plan outlines the roles that each organization will play if a teen suicide or suicide attempt occurs.

***Individual/Family Example**:*

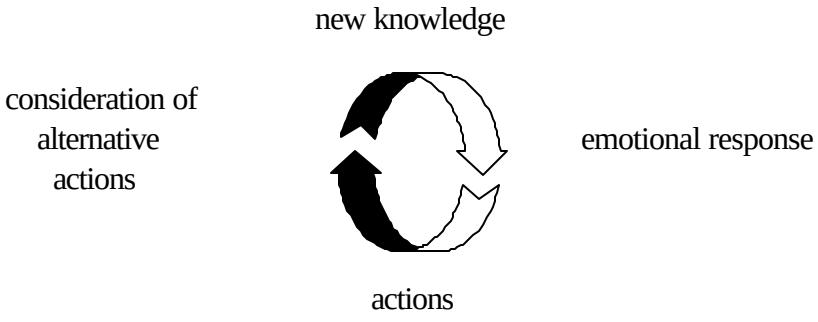
The PHN facilitates a support group for families coping with the loss of a member through suicide.

Relationships to Other Interventions

Counseling is an intervention frequently implemented in conjunction with, or sequentially to, **health teaching** and/or **consultation**. **Health teaching** influences the knowledge, attitudes, values, beliefs, practices, skills, and behaviors of individuals, families, systems, or communities. While **counseling** focuses on the emotional component inherent in any attempt to change, **consultation** seeks to generate alternative solutions to problems.

For example, if the PHN provides **health teaching** about the prevalence, incidence, and causes of family violence at a community meeting, it is likely to trigger emotional responses. Implementing **counseling** strategies in conjunction with **health teaching** allows the PHN to build on the energy associated with an emotional response and further enhances the learning opportunity. A community may respond to information on family violence with powerful emotions like anger, outrage, fear, and grief. These emotions can motivate it to learn more about the problem and its causes. If the community accepts this new information and decides that something must be done to change its tolerance of family violence, the PHN may assist the community in exploring alternatives. That is, the PHN provides **consultation.**

While each of the three interventions can be effectively implemented alone, they most often are done together or in succession and are often repeated in a cycle:



This cycle is repeated until an acceptable solution is found.

Notes from Abby

Differentiating Counseling from Psychotherapy...

Although PHNs do not provide psychotherapy, much of public health nursing deals with emotionally charged "client situations." These range from individuals attempting to cope with chronic pain, a couple grieving for the loss of their infant to SIDS, women involved with partners who batter them, or an elderly couple attempting to cope with the loss of all their possessions in a flood. Public health nursing also occurs at systems and community levels of practice. Examples include such situations as mediating a heated debate between providers competing for the same public contract to provide home health services or a PHN facilitating a community meeting on teen pregnancy prevention where the members are polarized around their beliefs.

While counseling as practiced by a PHN should have a therapeutic outcome (that is, have a healing effect), it should not be confused with providing *psycho*therapy. Counseling is intended to clarify problems, relieve tension, facilitate problem solving, encourage friendship and companionship, enhance understanding, encourage insight, and relieve stress.

See: Burnard, P. (1992). Counseling, a guide to practice. In *Nursing* (p. 17). Oxford, England: Butterworth-Heineman.

BASIC STEPS for Counseling[37]

Working alone or with others, PHNs…

1. **Meet the "client"–the individual, family, system, or community.**
   Establishes *rapport* by listening and attending to what the client is saying and how it is said.

2. **Explore the issues.[38]**
   Gains the client's *perception* of the nature and cause of the identified problem or issue and what needs to change.

3. **Identify priorities.**
   Gains the client's *perspective* on the urgency or importance of the issues; negotiates the order in which they will be addressed.

4. **Establish the emotional context.**
   Explores, with the client, emotional responses to the problem or issue.

5. **Identify alternative solutions.**
   Establishes, with the client, *different ways* to achieve the desired outcomes and anticipates what would have to change in order for these to happen

6. **Agree on a contract.**
   Negotiates, with the client, a plan for the nature, frequency, timing, and end point of the interactions.

7. **Support the individual, family, system, or community through the change.**
   Provides *reinforcement* and continuing *motivation* to complete the change process.

8. **End the relationship.**
   Brings *closure* at the point the PHN and client mutually agree that the desired outcomes are achieved.

---

[37] Adapted from : Burnard, P. (1992). *Counseling: A guide to practice in nursing.* Oxford, England: Butterworth-Heineman.

[38] Understanding the client's cultural or ethnic context is important to perception. For further information, please see Sue, D. W., & Sue, D. (1999). *Counseling the culturally different: Theory and practice* (3rd ed.). NY: Wiley.

What to Do and Not to Do in Counseling...

Do...

- listen
- believe what the client says
- encourage further talking
- allow expression of feelings
- encourage personal problem solving
- take advice from others
- take care of yourself

Do Not ...

- "interpret" what the client says
- use "psychobabble"
- attempt psychotherapy
- moralize
- patronize
- argue
- compare your experience with the client's
- hesitate to refer the client when needed

Burnard (1992), p. 9

The Therapeutic Use of Self in Counseling

Implementing the counseling intervention depends upon the PHNs use of themselves as vehicles for change. This requires high levels of self-awareness. Burnard defines issues to consider in developing self-awareness:

- Beliefs
- Likes and dislikes
- Prejudices
- Ways others see you
- Skills
- View of self
- Religious beliefs or lack of them
- Political biases
- Strengths
- Sexual preferences
- Deficits
- Fears and anxieties
- Knowledge
- Values.

Burnard (1992), pp. 43-44

BEST PRACTICES for Counseling

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who blended evidence from the literature with their practical expertise. These best practices are <u>not</u> presented in any ranking or particular order; each may not apply to every implementation of the intervention.

1. SELF-MONITORS THE COUNSELING RELATIONSHIP.
Best Evidence: Poskiparta and others; Burnard

Three sets of questions should be asked:
- What am I getting out of this as the PHN/counselor? Am I doing this for myself or the client?
- What are the agreed-upon goals for this interaction? What progress is being made?
- What kind of evaluative feedback is the client providing? That is, is the client engaged in the interaction?

2. PHN ASSURES THAT THE CLIENT DEFINES THE FOCUS OF THE COUNSELING.
Best Evidence: Burnard; Tschudin; Lewis and others

Assuring that the "client" establishes the focus of the counseling can be complex when the individual or family believes they are without hope, or collaboration members are at odds with one another, or the community is reeling from some tragedy or injustice. Helping the client to define the focus is a long and slow-moving process, but essential for counseling effectiveness.

The PHN must heed Burnard's principles, which are supported in Tschudin and Lewis's work:
- counseling involves listening and reflection far more than providing advice
- the client knows best (whether they know it or not)
- interpretation by the nurse rarely helps
- entrance into the client's frame of reference is important
- judgement and moralizing are rarely appropriate
- the nurse's experience is not the same as the client's
- listening is the first and last principle of effective counseling.

3. ESTABLISHES AND MAINTAINS BOUNDARIES.
Best Evidence: Mullen and others; Tschudin; Burnard

Because counseling requires an interpersonal relationship that presumes an emotional level of involvement, it is critical that the PHN be aware of appropriate boundaries. Burnard's description of a therapeutic relationship is useful:
- the intention is to help, not control
- the relationship is of benefit to the client, not the PHN; the nurse may find professional fulfillment in the benefits realized by the client, but the benefits clearly must belong to the client.

, the relationship is always within the bounds of professional ethics and without risk of exploitation by the PHN–especially emotional exploitation.

"Boundaries are defined as limits that protect the space between the professional's power and the client's vulnerability."[39] In a recent three-part series, the Minnesota Board of Nursing discussed this issue and encouraged nurses to view the concept not as a line, but as a gray zone between appropriate and inappropriate actions. Based on a review of the literature, the series concludes that four elements usually appear in *boundary violations*:

- *Role Reversal*
  where the client takes care of the nurse's emotional needs
- *Secrecy*
  where the client is asked to hold some information about their relationship in confidence or only selectively share it
- *Double Bind*
  where the client is placed in the position of wanting to terminate the relationship but realizes that doing so will end any help from the professional
- *Indulgence of Professional Privilege*
  where information obtained in the relationship with a client is used for the benefit of the PHN.

Notes from Abby

Signs that you may be approaching the boundary "gray zone":

- Perception - is this what other nurses would do?
- Time - is more time spent with the client than with other clients? Is "off duty" time spent with the client?
- Location - would you see other clients in this location?
- Gifts to client - is there an accompanying sense of obligation on the part of the recipient?
- Forms of address - has it switched from friendly to familiar, or from familiar to intimate?
- Personal attire – is greater care being taken in how you look when with the client?
- Making exceptions – what is the therapeutic purpose?
- Internal cues – Do you trust what you sense and check it out? What is the nature of your behavior when with the client? Do you become defensive when questioned about client interaction?
- Dual relationships – are services being provided outside of the professional plan?
- Confidentiality – is it not being violated unless you are legally compelled to do so.
- Choosing sides – do you take the side of the client against the client's significant other?
- Self-disclosure – whose need is being met in the disclosure–yours or the client's?
- Touch – is it being used therapeutically, as long as is culturally appropriate, but never indiscriminately?
- Communication – is information recorded selectively?
- Be prepared – do you know professional standards and employer's policies?

Minnesota Board of Nursing. (1995, Fall). *For your information, 11*(3), 3-4; (1996, Winter). *12*(1), 2-3; (1996, Spring). *12*(2), 2-3.

[39] Minnesota Board of Nursing. (1995, Fall). *For your information, 11*(3), 3-4; (1996, Winter). *12*(1), 2-3; (1996, Spring). *12*(2), 2-3.

4. REMAINS SENSITIVE TO CLIENTS' UNIQUENESS AND VULNERABILITIES.
Best Evidence: panel recommendation based on practice expertise

Authors reviewed for this intervention were consistent in addressing the need for sensitivity to all persons' unique characteristics. An assessment of these characteristics produces information essential for the development of rapport and empathy, as well as an understanding of the client's perceptions, emotional response, and coping mechanisms.

5. ENHANCES CLIENTS' STRENGTHS, REGARDLESS OF PRACTICE FOCUS. (INDIVIDUAL, FAMILY, SYSTEMS, OR COMMUNITY)
Best Evidence: Tschudin; Stanhope and Lancaster 1st ed; Lewis

Enhancing clients' strengths results in their increased capacity to solve their own problems. All authors noted that it is impossible to develop necessary rapport if the PHN cannot find a point of genuine regard (that is, strength) for the client–no matter how far removed the client may be from the PHN's own beliefs or values system.

Notes from Abby

The skill most critical to effective counseling is **communication**–the capacity to say what is meant and accurately hear what others say. William Howell, in his book *The Empathetic Communicator*, discusses how the following elements give meaning to words being said and heard:

- *Style* is the way we say what we say; style includes most nonverbal elements of communication such as posture, facial expression, and tone of voice
- *Content* is the cognitive material in what is being said, conveyed by both words and "nonverbal word equivalents" such as head shakes or hand gestures
- *Context* is the flow of events or the situation in which the communication occurs. Experts estimate that in any communication only 10-20 percent of understanding comes from words or content. The majority of what is communicated and understood comes from nonverbal content.

We all learn communication patterns and non-verbal meaning within the context of the culture in which we were raised. No matter how much life experience or education we go through, the way we give and receive information is culturally ingrained. This is why understanding other cultures is essential if we are to be an empathetic communicator. Howell maintains that it is this capacity for empathetic communication which provides the "counter force that keeps power from dominating our relationships" (p. 3).

Adapted from: Howell, W. (1982). *The empathetic communicator.* Prospect Heights, IL:Waveland Press.

Notes from Abby

Qualities Essential for Effectiveness in Counseling

- Personal warmth
- Genuineness
- Empathy
- Unconditional positive regard
- Intuition (i.e., knowledge and insight that arrives independently of the senses)
- Caring, including knowledge of the other person/entity, learning from experience, patience, honesty, trust, humility, hope, and courage
- Sense of humor
- Sense of the tragic
- Self-awareness

Burnard (1992), pp. 32-44.

Consider the saying commonly seen hanging
over the desk of many experienced PHNs...

No one cares how much you know
Unless they know how much you care.

BEST EVIDENCE for Counseling

Each item was first reviewed for research quality and integrity by graduate students in public health nursing and then critiqued for its application to practice by at least two members of a panel of practice and academic experts. The nature of the material and a score expressed as a percentage are included at the end of each annotated citation. The percentage is the average of scores assessed by the experts who reviewed it. It reflects their opinion of the strength of the item's contribution to practice.

Review Articles

none

Research Reports

Mullen, P., et al. (1997). A meta-analysis of trials evaluating patient education and counseling for three groups of preventive health behaviors. *Patient Education and Counseling, 32,* 157-173.
The authors reviewed 71 randomized and non-randomized clinical control trials measuring behavioral changes regarding smoking and weight loss in patients without diagnoses. The studies were analyzed for the principles of education adhered to (i.e., tailoring to patients' needs, individualization of instruction, feedback and reward/reinforcement provided, use of multiple communication channels), the nature of the intervention (i.e., whether cognitive only, behavioral only, or both), and the number of contacts. The results demonstrated that using behavioral techniques (particularly self-monitoring) and using several communication channels (such as media plus personal communication) produced larger effects.
Meta-analysis=39%

Poskiparta, M., et al. (1999). Nurses' self-reflection via videotaping to improve communication skills in health counseling. *Patient Education and Counseling, 36,* 3-11.
In teaching nurses to understand the importance of personal attitudes and affective faculties, as well as the use of cognitive functions in effective counseling, the authors videotaped nurses interacting with clients, provided them with education on self-reflection, and then videotaped them six months after the training. On both occasions nurses self-rated themselves using Meziorw's levels of reflectivity. Self-rating was found to be a useful tool in improving nurses competence in communication during counseling.
Quantitative/Observational=32.5%

Expert Opinion

Minnesota Board of Nursing. (1995, Fall). *For your information,11*(3), 3-4; (1996, Winter). *12*(1), 2-3; (1996, Spring). *12*(2), 2-3; copies may be obtained by contacting the board at Minnesota Board of Nursing, 2829 University Ave. SE #500, Minneapolis, MN 55414-3253.

Texts and Monographs

Tschudin, V. (1995). Models for counseling. In *Counselling skills for nurses*. (pp. 38-55). Bailliere Tindall Publishing.

The author differentiates between the nursing process, which is directed toward problem solving, and counseling, which is directed toward problem management. Counseling is focused on the person, not the problem. Its intent is to help people solve their problems themselves through focusing on their feelings, first of all, and then on the meaning of those feelings to them. The author analyzes several models and then proposes her own, which she labels "the four questions": What is happening? What is its meaning? What is your goal? How are you going to do it? The counselor's role is to assist the client in progressing from one question to the next by viewing them as stages where the answer to one question automatically moves the client into addressing the next.
Text=60%

Lewis, J., et al. (1998). *Community counseling: Empowerment strategies for a diverse society,* (2nd ed.). Brooks-Cole.

The authors, mental health professionals, propose a comprehensive helping framework of intervention strategies and services that promote the personal development and well-being of all individuals and communities. They identify four "service components" to achieve this: direct work with clients, indirect work with clients, direct work with communities, and indirect work with communities. The authors suggest that individual mental health potential is impacted by the overall health of the community (that is, a group or gathering of people who share common interests and needs) in which they live, and therefore, work must be done in all components. Community counseling is defined as "a multifaceted approach combining direct and indirect services to help community members live more effectively and to prevent those problems most frequently faced by people who use the services" (p. 20).
Direct Community Services = educating or training the population at large
Direct Individual Services = outreach and counseling to vulnerable populations
Indirect Community Services = systemic changes and public policy
Indirect Individual Services = advocacy and consultation
Persons providing counseling to individuals from the community counseling framework focus on strengthening clients' sense of hope and personal mastery by encouraging them to take responsibility for solving each problem, but not necessarily to shoulder the blame for it; this is known as the compensatory model (p. 123-124).
Persons providing community counseling must be well versed in systems theory to understand the impact of the community itself on health and behavior.
Text=47%

Burnard, P. (1992). Counselling: A guide to practice in nursing. Oxford, England: Butterworth-Heineman and Burnard, P., & Hulatt (1996). Nurse counselling: The view from the practitioners. Oxford, England: Butterworth-Heineman.

[NOTE: material from the Burnard's later book is presented in italics for contrast}
Chpt 1: Counselling in Nursing (pp. 7-21)
Burnard describes the common elements of the counseling process, which he suggests is "essentially a

practical enterprise in that its aim is problem solving" (p. 7):

- It involves two people, one of whom is the counselor and the other the client
- The role of the counselor is to help the client
- The client presents a situation to the counselor, sometimes clearly identified and sometimes not
- A relationship exists that is different from plain conversation and yet not psychotherapy.

Counselling "aims to help the person recognize what may be changed and how; and what must be left for acceptance....Counselling is assumed to be mainly about helping someone to review a specific life situation, consider, and (perhaps) to enact options. The counsellor is under no obligation to 'change' the person" (pp. 8-9).

Burnard also describes the characteristics of a therapeutic relationship, such as that within the scope of nursing practice:

- The nurse's intention is to help
- The relationship benefits the client
- The nurse cares about the client
- The relationship is reciprocal to some extent, but the client's needs are the focus
- The relationship is always an ethical one and never exploited by the nurse.

A therapeutic relationship with a nurse differs from a friendship in that professional boundaries are held, it does not continue outside of the counseling setting, and it is always geared toward the client. At the same time, it is not psychotherapy, in that general academic and experiential preparation for the practice of professional nursing does not provide the necessary depth of knowledge and skill required.

Burnard advises that at its core, counseling involves listening and reflection more than talking and providing advice. He also acknowledges that counseling works best with people who can clearly articulate their problems and who are prepared to self-disclose. The following principles of counseling are provided:

- The client knows best
- Interpretation by the nurse rarely helps
- It is important to enter into the client's frame of reference
- Judgement and moralizing are rarely appropriate
- The nurse's experience is not the same as the client's
- Listening is the first and last principle of good counseling.

Offering a counseling relationship is appropriate when the client desires such outcomes as:

- Clarification of problem issues
- Relief from tension
- Enhanced problem solving
- Encouragement of worthiness for friendship and companionship with others
- Improved clarity of understanding and insight
- Relief from stress.

Chpt 3: Qualities of the Counsellor (p. 31-47)

Burnard offers a list of qualities essential for a nurse to provide effective counseling. He states, "We need to be able to face the other persons as a reasonably normal, ordinary human being....We need to be natural. Unfortunately, it often takes a long time to learn to be natural!" (p. 31).

- Personal warmth, meaning the nurse is approachable, open to others, and assures the client regard, absence of blame, non-defensiveness, and closeness. It is offered by the nurse, whether reciprocated or not
- Genuineness, or owning real interest, not so much in or about the client's problems, but in the fact the nurse-client relationship is functional
- Empathy, or the ability to enter the perceptual world of the other person and to see it as they see it, without judging or placing value; empathy does not include sympathy
- Unconditional positive regard and valuing the client as a person
- Trust in intuition, or knowledge and insight the nurse arrives at independently of the senses
- Caring, in the sense of offering the other person opportunities for personal growth which, in turn, requires self-knowledge, capacity to learn from experience, patience, honesty, trust, humility, hope, and courage
- Sense of humor, allowing for diffusion of tension, stress relief, and a sense of perspective on a situation
- Sense of the tragic, allowing for true understanding of another's suffering
- Self-awareness, precluding the nurse from confusing personal problems with those of the client. [Note: Burnard provides a 55-item checklist to assist the nurse in exploring depths of self-awareness.]

Text=45%

Stanhope, M.O., & Lancaster, J. (1984). *Community health nursing: Process and practice for promoting health* (1st ed.).* St. Louis: Mosby.

Health counseling is defined as "a helping process used to facilitate the client's development of independence, ability in decision making, and ability to take action related to the family's health. There are aspects of anticipatory guidance (defined as assisting in developing resistance to situational or development stress events) and anticipatory problem solving (defined as assisting in estimating risks and stresses likely to occur in relation to anticipated problems) in health counseling" (pp. 356-357). It is intended to assist in clarifying beliefs, values, and feelings associated with problems and their resolution.

Text=45%

*[Note: In Stanhope & Lancaster's 5thed. (2000), counseling is defined as "Helping people achieve workable solutions for their problems or conflicts" (pp. 6-8). Counseling is treated briefly as a function of public health nurses.]

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Public Health Interventions

Applications for Public Health Nursing Practice

Consultation

Public Health Nursing Practice for the 21st Century
March 2001

For Further Information please contact:
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Minnesota Department of Health
Division of Community Health Services
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INTERVENTION: CONSULTATION

Interventions **are activities taken by PHNs on behalf of communities and the individuals and families living in them.**

Assumptions about all PHN Interventions...

- They are population-based; that is, they:
  - Are focused on an entire population
  - Are guided by an assessment of community health
  - Consider broad determinants of health
  - Consider all levels of prevention
  - Consider all levels of practice
- The public health nursing process applies at all levels of practice.

Definition

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 acts on the option best meeting the circumstances.

Examples at All Practice Levels

Population-of-interest: *Entire community*
Problem*: Domestic abuse*

Community Example:

The 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.

Systems Example:

Local police in a community refer all domestic violence calls to public health nursing for a follow-up home visit. The PHNs who do these home visits meet quarterly with a team of local law enforcement officers to review the domestic referrals. The police use this information to improve their response to domestic disputes.

Individual/Family Example:

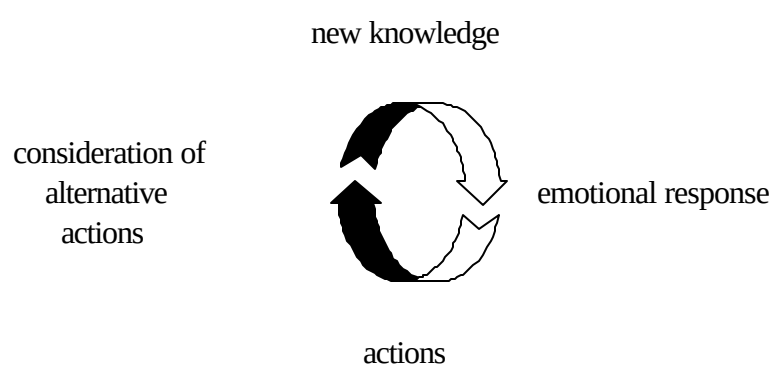
The PHN works with a client temporarily living in a shelter for battered women to develop a plan for moving into the community. They discuss options available to her, identify financial requirements and community resources, and establish a list of actions to be made by the client before the next visit.

Relationships to Other Interventions

Consultation is an intervention frequently implemented in conjunction with or sequentially to **health teaching** and/or **counseling**. **Health teaching** influences the knowledge, attitudes, values, beliefs, practices, skills, and behaviors of individuals, families, systems, or communities. While **counseling** focuses on the emotional component inherent in any attempt to change, **consultation** seeks to generate alternative solutions to problems.

For example, if you provide **health teaching** about the prevalence, incidence, and causes of family violence at a community meeting, the information is likely to trigger emotional responses. Implementing **counseling** strategies in conjunction with **health teaching** allows you to build on the energy associated with the emotional response and further enhance the learning opportunity. A community may respond to information on family violence with powerful emotions like anger, outrage, fear, and grief. These emotions can motivate it to learn more about the problem and its causes. If the community accepts this new information and decides that something must be done to change its tolerance of family violence, you may assist in exploring different alternatives. That is, you provide **consultation.**

While you can effectively implement each of the three interventions alone, they most often are done together or in succession and are often repeated in a cycle:



This cycle is repeated until an acceptable solution is found.

BASIC STEPS for Consultation[40]

Working alone or with others, PHNs…

1. Establish an interpersonal relationship with the client by engaging in actions that establish the PHN's credibility and promote a sense of trust on the part of the client.

Effectiveness in consultation depends heavily on the PHN's capacity to develop and maintain relationships, an underlying element of all public health nursing practice.[41]

2. Clarify the client(s)' perception of the problem or issue, the underlying causes, and the expected results from the consultation process.

The "client" may be an individual, family, group, organization, system, or community. You must allow sufficient time for this dialogue to assure a mutual understanding of the issue and the expected outcomes. Information gained in subsequent steps may require you and the client to return to this step for clarification of the problem and/or expectations.

3. Assess the client(s)' circumstances, involving them in data collection.

The following factors should be included:

- describe the client(s)' experience resulting from the problem/issue
- identify the stakeholders involved in the problem/issue and the way they are affected
- determine to what extent the client(s)' attitudes, beliefs, and behaviors may contribute to the problem/issue
- discover what environmental factors may contribute
- determine what factors might serve as promoters or barriers to solving the problem/issue
- identify what assets the client(s) bring to the process
- anticipate what will be gained or lost by solving the problem or addressing the issue
- determine how a solution might affect the client(s) and the client(s)' family or stakeholders. Who stands to win or lose?

4. Establish a plan of action or contract.

Together, the PHN and the client:

- determine the desired outcome
- develop options for achieving this outcome
- weigh the advantages and disadvantages of each outcome

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[40] Adapted from *Nurses as Consultants: Essential Concepts and Processes* by Susan Norwood (New York: Addison-Wesley) 1998.

[41] As expressed in *The Cornerstones of Public Health Nursing*. Minnesota Department of Health/Section of Public Health Nursing, June 1999.

Client(s) select the preferred option. Action steps are developed based on this decision. You may or may not be involved at this point, as the client desires.

5. Identify the support necessary to facilitate plan implementation.

This step is included regardless of whether or not you become part of the action steps. This step assists client(s) in anticipating barriers to implementation and designing contingency plans.

6. Evaluate the process and outcome.

You and the client must establish a plan for closure or come to a mutual agreement about when the consultation will end.

BEST PRACTICES for Consultation

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who blended evidence from the literature with their practice expertise to develop them. These best practices are <u>not</u> presented in any ranking or particular order; each may not apply to every implementation of the intervention.

1. DEVELOPS A CONTRACT WITH THE CLIENT.
Best Evidence: Stanhope and Alford; Gebelein

While this may appear obvious, PHNs must spend sufficient time with the client discussing expectations of the consultation. This holds whether the PHN implements consultation as a problem-solving follow-up to **health teaching** or as a component of **case management.** It also holds regardless of the practice level at which consultation may be implemented–individual/family, system, or community.

A "contract" means that both the PHN and the client clearly understand what is expected. It does not necessarily mean anything in writing. It ordinarily requires considerable discussion and allows both the PHN and client to establish a relationship if one does not already exist. Ulschak and SnowAntle [42] offer a model for contracting. In the CPR + F Model, the PHN and client repeat a loop consisting of **"C**ommitment X **P**urpose X **R**oles + **F**eedback" until they both are satisfied that they mutually understand what the request is and what the expected outcomes are. In the model:

- **C**ommitment = investment both PHN and client are willing to put into this endeavor
- **P**urpose = what client wants/what PHN can provide
- **R**oles = who will do what and when
- **F**eedback = planned points of evaluation where client and PHN evaluate how they are doing and if they should continue

Ulschak and SnowAntle also identify common contracting pitfalls:

- promising more than can be accomplished, given the resources available
- taking on a problem or decision for which a PHN does not have appropriate training or experience
- agreeing to provide consultation in situations where intuition suggests something is not being fully disclosed or the client has a "hidden agenda"
- agreeing to provide consultation without measurable desired outcomes; without them, success can never be determined
- agreeing to a contract despite lack of clarity in any of the CPR + F model elements

[42] Adapted from Ulschak, F and SnowAntle, S *(1990) Consultation Skills for Health Care Professionals* San Francisco: Jossey-Boss

2. ADAPTS THE CONSULTATION ROLE TO CLIENT NEED.
Best Evidence: Lippitt and Lippitt; Stanhope and Alford; Puetz and Shinn

PHNs fulfill multiple roles when they provide consultation. Most authors reviewed describe similar types of roles, all reflecting "providing advice to others":

Puetz and Shinn identify a list appropriate for adaptation to public health nursing:

- coach
- motivator
- mentor
- teacher
- facilitator
- confidant
- sounding board
- change agent
- fact finder
- expert
- observer
- counselor

Ulschak and SnowAntle[43] suggest these consultation roles:

- *advocate*
  the PHN is actively engaged with the client in directing the problem solving
- *joint problem-solver*
  the client and PHN collaborate to determine optional solutions
- *identifier of alternatives and linker to resources*
  see **referral and follow-up**
- *fact finder*
  The PHN acts as a researcher, finding information the client requires in order to consider options
- *process consultant*
  The PHN and client work together through the problem-solving process, with the PHN offering advice on improving process steps
- *information specialist*
  the client defines the problem and the desired outcomes, and the PHN proceeds to supply the optional solutions

3. COLLABORATIVELY FORMULATES OPTIONS WITH THE CLIENT.
Best Evidence: Norwood

Norwood [p. 22] makes the case that consultation plans are most effective when they are:

- developed collaboratively with the client
- specify clearly the sequence in which plan components are to be implemented

[43] Adapted from Ulschak, F and SnowAntle, S (1990) *Consultation Skills for Health Care Professionals* (San Francisco: Jossey-Boss) 39-42.

- identify resources needed [and at whose cost] [44]
- verify the availability of needed resources
- acknowledge and explore client's objections to the plan, if any.

4. ASSISTS ALL CLIENTS IN IDENTIFYING OPPORTUNITIES FOR CHANGE AND IMPROVEMENT.

Best Evidence: panel recommendation based on practice expertise

Even though most PHNs initially learn about consultation through their work with individuals, families, and groups, the expert panel was clear that the consultation intervention is also applicable to work with systems and communities.

[44] Nurse authors consistently identified other "resources" such as education and support systems in addition to financial resources.

Notes from Abby

Ulschak and SnowAntle* provide a checklist useful for the PHN to complete a self-appraisal of skills and traits considered essential for consultation effectiveness. Although these were developed on the assumption of providing consultation to organizations, the list has general applicability.

Nurses are asked to rate themselves as **+** if they believe themselves to be well-skilled and competent, **0** if okay, or **-** if lacking in the following areas:

General

1. Listening to others
2. Asking direct questions
3. Listening to self and awareness of own feelings
4. Understanding organizations
5. Getting site-specific information
6. Thinking before reacting
7. Comfort with education and skill background
8. Understanding why
9. Separating personal from professional issues
10. Building an atmosphere of trust and openness
11. Not needing to be needed
12. Saying no
13. Letting go
14. Taking risks
15. Asking for help
16. Exhibiting flexibility

Establishing a Plan

1. Negotiating
2. Reaching agreements (i.e., closing a contract)
3. Managing conflict and anger directed at you
4. Managing conflict and anger directed at someone else
5. Offering suggestions appropriately
6. Drawing out others
7. Accepting the client's definition of the problem
8. Helping the client solve the client's own problems
9. Being realistic about what you can deliver
10. Setting realistic goals
11. Helping the client clarify the problem
12. Costing out projects in terms of resource consumption
13. Thinking through the problem with the client in a logical sequence
14. Offering your own ideas freely
15. Providing feedback in a manner that will be heard and understood
16. Working with another whom you do not necessarily like or appreciate
17. Exhibiting flexibility in consulting styles

**Ulschak, F., & SnowAntle, S. (1990). Consultation skills for health care professionals*, p. 98. San Francisco: Jossey-Boss.

BEST EVIDENCE for Consultation

Each item was first reviewed for research quality and integrity by graduate students in public health nursing. It was then critiqued for its application to practice by at least two members of a panel of practice and academic experts. The nature of the material and a score expressed as a percentage are included at the end of each annotated citation. The percentage is the average of scores assessed by the experts who reviewed it. It reflects the strength of the item's contribution to practice in the opinion of the experts.

Review Articles

none

Research Reports

none

Expert Opinion

Gebelein, S. (1989, March). "Profile of an internal consultant: Roles and skills for building client confidence" ***Training and Development Journal*****, 52-58.**

Gebelein describes internal consultants as those individuals charged with influencing fellow employees over whom they have no direct job responsibility. She sets out six functional areas of internal consultation and identifies 20 skills required.

Influence: leadership, organizational savvy, coaching and advising
Administrative: priority and time management, project management
Communication: speaking and informing, listening
Problem-solving: diagnosis, decision making, business and technical knowledge
Interpersonal: relationship building, facilitation skills, conflict management, ability to give feedback
Personal: adaptability, trust and integrity, results orientation, service orientation
Expert Opinion=override

Texts and Monographs

Puetz, B. & Shinn, L. (1997). ***The consultants's handbook*** **(pp. 1-21). New York: Springer.**

The authors define consultation as "providing advice to others. The advice might be in the form of guidance, information, knowledge, expertise, or solutions" (p. 1). The book was developed from the responses of 18 nurse consultants surveyed in 1995. The authors report that "successful consulting is a two-way street involving a mix of the consultant's skills and the client's needs with both participating thoroughly in the process":

Roles: coach, motivator, mentor, teacher, facilitator, confidant, sounding board, change agent, fact finder, expert, observer, counselor
Frameworks: process consultation, expert or content consultation
Skills: diagnostic ability, problem-solving skills, specialized knowledge, communication skills, marketing expertise, business sense
Personal Traits: listener, observant, objective, flexible, patient, persistent, self-confident, humble, possessing integrity

The book is intended as advice to other nurses considering providing consultation as a business.
Text=61.5%

Stanhope, M. & Alford, R. (1984). The community health nurse consultant role. In M. Stanhope & J. Lancaster. *Community health nursing: Process and practice for promoting health* (pp. 689-703). St. Louis: Mosby.

The authors provide no particular definition of consultation but do suggest its goal is "to stimulate clients to take more responsibility, feel more secure, deal constructively with their feelings and with others in interaction, and internalize skills of a flexible and creative nature....The real thing is a cooperative effort between consultant and client, established to share equally in the resolution of a problem" (p. 690). They compare and contrast several models of consultation, but promote adoption of Schein's Process Model, as it closely parallels the nursing process. Schein defines consultation as "a process involving a set of activities on the part of the helper which assists the client to perceive, understand, and act on events occurring in the client's environment" (p. 699). The process model is portrayed as a triangle, with "client + consultant" at the top, assessing the situation. Together, they determine the "client" (that is, the one who has the "problem" and needs to change); they then plan the action interventions, implement them in order to solve the problem, and finally, at the base, evaluate outcomes.

The authors offer Blake and Mouton's five intervention "modes" for problem-solving (p. 695-696):

Acceptance, or the use of "a catharsis process to clear emotional blockages [in order to] engage in more objective problem solving"

Catalytic, "whereby the consultant assists clients to broaden their view of an existing situation by gaining additional information or by unifying existing data"

Confrontation, which "provides clients with an objective look at how their values and beliefs control their behavior"

Prescriptive, which tells the client what to do but is most effective when used in conjunction with other modes

*Theory-principle*s, in which the consultant teaches the client appropriate theories which the client then applies to the situation

The client and the problem determine which mode is appropriate for which situation. In general, when the problem at hand is either a morale/cohesion issue (that is, when the client has lost confidence in the ability to solve problems and feels powerless to institute corrective action) or power/authority issue (that is, a questioning of who has the right to make decisions), the best mode is usually acceptance. When the issue is one of norms/standards (that is, group norms, professional or organizational standards are violated or changed) or goals/objectives (that is, new or changed goals or the inability to meet them), the preferred mode is catalytic. The theory-principles mode is useful in situations where additional insights are needed. The prescriptive mode is best reserved for situations in which the client is unable to cope and needs immediate direction or answers to solve the problem.

The authors suggest there are three stages of consultation, each with related tasks:

1. Trust-building: initial contact, definition of the relationship, selection of the setting and intervention approach
2. Problem-solving: gathering data, formalizing the problem, and intervening

3. Closure: disengagement and termination
Text=57.5%

*Note: Stanhope and Lancaster's fifth edition of their test, published by Mosby in 2000, retains the material from their first edition but greatly expands it. It includes consultation concepts such as service leadership, client empowerment, and balance between people and tasks, as well as an enhanced section on the interpersonal skills required for effective consultation.

Norwood, S. (1998). ***Nurses as consultants: Essential concepts and processes*****. Menlo Park, CA: Addison-Wesley.**

Chpt. 1: The Nature of Nursing Consultation (p. 1-13)
Consultation is a process intended to solve problems and, by doing so, to bring about change. Its purpose is to help the "client" learn to solve problems, and it is a recognized component of nursing practice, regardless of the setting. However, consultation is not counseling; counseling is a direct service provided for the purpose of stimulating self-awareness and promoting personal growth, whereas consultation is an indirect service to clients that focuses on work-related issues. Consultation is also not teaching; teaching is a direct intervention directed at patients, whereas consultation is indirect.

Chpt. 2: The Nursing Consultation Process (p. 14-28)
Phase 1: *Gaining Entry* includes environmental scanning, contracting, gaining physical entry, initiating psychological entry
Phase 2: *Problem Identification* utilizes assessment, diagnostic analysis, presentation of findings
Phase 3: *Action Planning* consists of goal setting, selecting an intervention, developing the action plan, facilitating implementation
Phase 4: *Evaluation* utilizes formative, summative, process, and outcome methods and measures
Phase 5: *Disengagement* relies on determining readiness, maintaining change, managing psychodynamics, achieving closure

Chpt. 3: Interaction Patterns for Nursing Consultation (p. 29-43)
Norwood proposes three basic patterns:
, Purchase Expertise, suitable when the client says "Solve this problem for me."
, "Doctor-Patient" Pattern, saying "Tell me what my problem is and how to solve it."
, Process Consultation Pattern, where client says, "I don't know what I need, but I need help."

Chpt 4: Nurse Consultant Roles and Skills (p. 44-60)
Roles Set:
- Task Oriented: fact-finding, diagnosing, advocating, directing solution implementation, educating, coordinating resources
- Process Oriented: joint problem solving, process counseling
- Universal: providing expertise, presenting information, role-modeling, providing leadership

Skills Set: technical and human
Text=51%

Lippitt, G. & Lippitt, R. (1978). *The consulting process in action.* La Jolla, CA: University Associates, Inc.

Consultation is defined as a general label for many variations of relationships.

Chpt 3: Multiple Roles of the Consultant; pp. 27-44

The authors provide a continuum of roles based on the extent to which the consultant is directly involved in the problem solving:

Consultant-As-Advocate (most directive), in which the consultant proposes guidelines, uses persuasion, and directs the problem-solving process

Informational Expert, where the consultant provides policy or practice decisions and linkages

Trainer/Educator, where the consultant trains the client

Joint Problem Solver, where the consultant offers alternatives and participates in decisions

Alternative Identifier and Linker, where the consultant identifies alternatives and resources for the client and helps assess consequences

Fact Finder, where the consultant gathers data, stimulates thinking, and provides interpretation

Process Counselor, where the consultant observes the problem-solving process and raises issues, mirroring feedback

Objective Observer/Reflector (least directive),where the consultant raises questions for the client's reflection

Chpt. 4: Intervention Decisions and Actions: Dilemmas, Strategies, and Learning

The authors suggest using two frameworks to identify and classify intervention decisions.

1. Five areas or focal points of consultative interventions
    - **P**helping with the task work of clarifying the job to be done and the tools and methods needed
    - **P**helping with the process work, or assessing the extent to which the use of procedures and relationship sensitivity is functional
    - **P**clarifying the value orientation underlying a client's decision making
    - **P**working on resources, or assuring they are sufficient to manage the problems needing solving
    - **P**assessing, or monitoring, progress toward established goals

2. Review of the inventory of 58 decisions to be made within the 6 consultation phases:
    - **P**initial contact and entry
    - **P**formulation of a contract and establishment of a working relationship
    - **P**problem identification and diagnosis
    - **P**goal setting and planning
    - **P**conversion of plans into actions
    - **P**contract completion

Text=36%

Public Health Interventions

Applications for Public Health Nursing Practice

Collaboration

Public Health Nursing Practice for the 21st Century

March 2001

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

INTERVENTION: COLLABORATION

***Interventions* are activities taken by PHNs on behalf of communities and the individuals and families living in them.**

Assumptions about all PHN Interventions...

- They are population-based; that is, they:
  - **S**are focused on an entire population
  - **S**are guided by an assessment of community health
  - **S**consider broad determinants of health
  - **S**consider all levels of prevention
  - **S**consider all levels of practice
- The public health nursing process applies at all levels of practice.

Definition

Collaboration commits two or more persons or organizations to achieving a common goal through enhancing the capacity of one or more of them to promote and protect health.[45]

Examples at All Practice Levels

Population-of-interest: *Older adults*
Problem: *Potential for injury due to falls*

Community Example:

A PHN join forces with the local senior citizens to plan a program for seniors to change the community perception that falling is inevitable as a person ages. The PHN provides home safety checklists and educational materials. The seniors add stories of their experiences and what they would have done differently had they known more about fall prevention. The seniors and the PHN present the program together at congregate dining centers throughout the community.

Systems Example:

PHN 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, and that they complete a short screen for risk automatically make appropriate referrals for home assessment. One of the project goals is to change how provider's approach seniors and their potential for falls.

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[45] Adapted from Henneman, Lee, & Cohen. (1995). Collaboration: A concept analysis. *J. Advanced Nursing, 21,* 103-109.

Individual/Family Example:

Senior citizens self-refer themselves to a program in which PHNs make home visits to older adults to prevent falls. Together the PHN and the older adult make a plan to remove/reduce injury risks that includes a review of medications that may affect balance, home modifications to reduce fall hazards, such as installing grab bars, improving lighting, and removing items that may cause tripping, and exercise to improve strength, balance, and coordination.

Relationships to Other Interventions

Collective action is the generic term for interventions characterized by groups of people or organizations that come together to address issues that matter to them jointly. Community organizing, coalition building, and collaboration are all examples of collective action. Because of this, they share many features, especially at the community level of practice.

Like **community organizing** and **coalition building**, collaboration is one method of building collective action.

Similarities

- *Empowerment* is an enabling process through which individuals or communities take control of their lives and environment. It is a basic concept of collective action, although it is not always called "empowerment."
- Emphasis is placed on *"beginning where the people are."*
- Reliance on the process of *community engagement* at the level of community-focused practice; all reflect the principles of collective action *[see next note from Abby]*.

Differences

- Unlike **coalition building** and **community organizing**, collaboration requires a willingness to enhance the capacity of one or some of the collaborative's members over and above one's own interests in order to achieve the desired collective goals. In this sense, by collaborating, a person or organization agrees to the risk (or benefit) of becoming transformed or changing themselves through their involvement. In that regard, collaboration represents the highest level of collective action short of total merger.
- Unlike **coalition building** and **community organizing**, collaboration can and should occur at the individual/family level of PHN practice. In most of the current literature, this client/PHN relationship is referred to as "partnering," which proposes the PHN has as much to learn from the encounter as does the client.

Collaboration also relates to other interventions. Like coalition building and community organizing, collaboration can be implemented in conjunction with **policy development** to change the way systems in a community operate or to change a community-held norm or belief. Collaboration is also often a co-intervention with **advocacy** and a preferred co-intervention with **delegated functions**. In fact, collaboration, with its intent on accomplishing a common goal through enhancing the capacity of one or more of its members, has potential for use with any activity in which the PHN partners with others. At the individual/family level of practice, collaboration is often paired with **health teaching, counseling, consultation,** and **case management.**

Notes from Abby

Collective action, or groups of people or organizations coming together for mutual gain or problem solving, is part of the American democratic tradition. Alexis de Tocqueville, writing in *Democracy in America* in 1840, notes: "...Americans are a peculiar people....If, in a local community, a citizen becomes aware of a human need that is not met, he thereupon discusses the situation with his neighbors. Suddenly a committee comes into existence. The committee thereupon begins to operate on behalf of the need, and a new common function is established. It is like watching a miracle."

Effective collective action generally incorporates the following principles, or tenets, described by Leavitt and Herbert-Davis:

- *The whole is greater than the sum of its parts.*
  This is the underlying assumption of all collective action. It acknowledges that the group process will increase the power of the collective, reflect the broadest perspective, and create a process that results in an outcome that is likely to be more innovative and comprehensive than if an individual or organization acted alone.

- *While the goals and outcomes of collective action may vary, the process of coming together for joint action is the same.*
  The requirements of working together demand expertise in communication, negotiation, and conflict management.

- *All politics is local: organizing a collective at the local level has more of an impact on the national level than the other way around.*
  Those closest to the problem or issue are most affected and therefore more likely to be committed to action.

- *All collective action involves a challenge to the existing power structure.*
  The resulting conflict is inevitable, and, since it can be anticipated, efforts should be made to depersonalize it. This is true whether the collective is between two individuals or two hundred. The most effective collective action finds ways to share power.

- *The goals of any collective action should include not only a change in a particular problem or issue, but the empowerment of large numbers of people to be active participants in the process.*
  The ultimate goal of acting collectively is to empower those involved.

Source: Leavitt, J. K., & Herbert-Davis, M. (1993). Collective strategies for action. In Mason, Talbott, & Leavitt (Eds.), *Policy and politics for nurses: Action and change in the workplace, government, organizations and community* (2nd ed.). Philadelphia: WB Saunders.

BASIC STEPS for Collaboration[46]

Systems and Community Practice Levels

Working alone or with others, PHNs...

1. Decide whether or not to collaborate (that is, to work together mindful of the potential to be transformed in the process). A decision is made through the following steps:

A. Convene or join an *originating group*.

Originating groups are informal groups of community members (that is, constituencies) or representatives of organizations who come together to discuss whether a collaboration could or should be formed to address a community issue. If the group finds the issue is substantial and the community would support addressing it, they move to the next step.

B. Organize an *initiating committee*.

The initiating committee accomplishes the following tasks:

- determines the goal
- drafts a mission statement
- develops a list of potential members
- gathers data about the issues to be addressed
- determines if other existing groups are already addressing the issue
- negotiates, if other groups are active, to join forces
- considers if...
    - the identified issue is verified through data
    - no other relevant groups exist
    - consensus is clear to continue

If so, proceeds to plan the organizational meeting step.

C. Plan the *organizational meeting*.

The purpose of the organizational meeting is to broaden the membership to capture all necessary representation and decide whether or not to proceed.

If a decision is made to proceed, the next step is developing the planning committee.

[46]Adapted from: The National Assembly of National Voluntary Health and Social Welfare Organizations. (1991). *The Community Collaboration Handbook* (pp. 8-27). For more information contact: National Collaboration for Youth at 202/347-2080.

D. Convene the *planning committee*.

The planning committee's charge is to:

- design the collaboration
- define or refine the proposed mission, goals, and objectives
- define or refine roles and responsibilities of the participants
- recommend possible priority activities for the collaborative
- determine whether sufficient support exists
- report recommendations to the originating group.

If a decision is made to proceed, the planning committee can either continue as a transitional leadership team or officers can be elected.

2. Select structure for the collaborative.

Structure options include:

- *ad hoc versus ongoing*
  an ad hoc collaborative accomplishes a given task over a specified length of time and then disbands
- *informal versus formal*
  collaborations often start as informal groups and evolve into more formal ones with established leadership and decision-making systems
- *unincorporated versus incorporated legal status*
- *open versus closed membership*
  members do or do not need to meet criteria for commitment of resources
- *outward versus inward-directed*
  focus is on the needs of the community (or a population-of-interest) or inward, focusing on enhancing the capacity of the member organizations to better meet the community's needs.

3. Determine method of leadership selection.

Leadership options include:

- rotated leadership among members
- elected leadership
- board appointed.

4. Structure the decision-making process.

Decision-making options include:

- consensus
- rule of majority
- members representing their respective organizations
- members representing themselves

The collaboration group must also determine criteria for deciding which decisions need broad action.

5. Fashion a list of collaborative actions that fit the collaborative's goal and mission.

Collaborative actions include:

- planning and research
- advocacy
- communication and public relations
- service.

6. Develop the plan.

Elements of a plan include:

- review/refine community assessment
- review/refine/adopt mission statement
- review/refine/adopt goals and objectives
- specify resources needed and develop a budget
- prepare a work plan
- design a monitoring plan
- design an evaluation plan.

7. Minimize barriers to collaborative action.

Actions to reduce barriers include:

- keep the commitment and activities simple at first
- make clear communication a priority
- spend time getting to know the other members
- make an extra effort, when new members join the collaboration, to include them in the social and business activities of the group
- encourage members to be "up front" about their needs
- do not avoid turf issues and hidden agendas
- develop clear roles for members and leaders
- plan activities that are fun.

8. Evaluate results.

Notes from Abby

Michael Schrage (1990) takes a somewhat less serious (but probably just as meaningful) tack to his discussion of collaboration.

The Rules of Collaboration

- Competence:
  a collaboration of incompetents, no matter how diligent or well-meaning, cannot be successful
- A shared understood goal:
  a collaborative is not described in terms of the relationships among its members, but by the goals and objectives it seeks to achieve
- Mutual respect, tolerance, and trust:
  successful collaborations do not require friendship (or even that members like each other), but members must agree to at least a base level of mutual respect, tolerance, and trust to be successful; they focus on managing one another's strengths, rather than on one another's lesser qualities
- Creation and manipulation of shared spaces:
  the requirement to come together around shared physical space is the tool that assures that the whole of the relationship is greater than the sum of the individuals' experience. Closeness fosters joint problem-solving or other creative activities.
- Diverse representation:
  the goal of collaborative work must–to assure mutual understanding–be described separately for each participating member in language and form that best suits that member's discipline
- Play with the possibilities:
  by tinkering with the goal or model or asking the "what if" questions (as in, "What if we were to do it this way?"), insights or new possibilities may be found
- Continuous, but not continual communication:
  communication is necessary, but must be done on a basis that does not interfere with members' individual work, while still assuring the collaborative work is on pace
- Formal and informal environments:
  taking the collaborative process into new and different environments can stimulate creativity among members
- Clear lines of responsibility, but no restrictive boundaries:
  collaborators should have a clear understanding of their functional role and what is expected, but not how it should be done
- Decisions do not have to be made by consensus:
  collaborators should have an unwritten agreement about where they are going, but leave enough room for debate and disagreement
- Physical presence is not necessary:
  communication is
- Selective use of outsiders:
  successful collaborators constantly look for those people and information that will help them achieve their mission but only some will be invited
- Collaborations end:
  "successful collaborations are more like trysts than great romances"

See: Schrage, M. (1990). *Shared Minds.* New York: Random House.

BASIC STEPS for Collaboration

Individual/Family Practice Level

Working alone or with others, PHNs…

Examples of collaboration between PHNs and individuals or families abound. However, references are rarely found when searching the literature under the key word, "collaboration." What is found are numerous articles emphasizing the importance of developing a relationship based on mutual regard and trust. This is a requirement for collaboration, as well as a cornerstone of public health nursing.[47] In current literature, however, this relationship basis is increasingly described in terms of "empowerment" and "partnering." *[See related Abby Note for more on this.]*

Of these, the partnering process described by Courtney and Ballard[48] comes closest to the spirit of collaboration used in this intervention. It serves here as the basic steps for practice at the individual and family level, although the authors are clear regarding its applicability at the community level, also.

1. Explore Potential Partners

A. Familiarize yourself with potential partners

- assess for their unique personal perspective; that is, determine "where they are coming from"
- gain an awareness of the community context
- use traditional means of community assessment blended with the personal experience of being in the community to gain this awareness

B. Initiate facilitated dialogue

- create opportunities for dialogue (for example, a home or clinic visit)
- listen carefully to discover or identify the individual's or family's goals; this is not to create an action plan, but, rather, to serve as a catalyst for their thinking and reflecting about what they want to accomplish through this partnership
- ask questions such as
  "What would you like to see happen?"
  "What role do you want to take?"
  "How would you like to begin?"
  "Who else should be involved?"

[47]Minnesota Department of Health/Section of Public Health Nursing. (1999, June). *The cornerstones of public health nursing*.

[48]Courtney, R., & Ballard, E. (1996, June). The partnership model: Working together with individuals, families and communities toward a new vision of health. *Public Health Nursing, 13*(2), 177-186.

2. Invite Partners

A. Risk Taking

- for the PHN, this means abandoning the professional role and assuming a co-equal, nonhierarchical relationship
- for the partner, it means assuming more responsibility for taking action and creating solutions and results

B. Commitment to Role Change

- changing roles requires time, patience, considerable trial and error, and more than an intellectual understanding of the process

3. Develop Partnership Action

A. Initiation of action once the partner agrees

- facilitate deeper exploration of issues and concerns
- assist the partner in developing a list of possible issues to be addressed
- ensure the PHN's role is that of facilitator and enabler, not "fixer"; this can be frustrating at first for the client, who may prefer to have the PHN assume the role of the "expert"

B. Working phase cycle

Action

- develop a plan with mutually agreed-upon steps to be taken by both partner and the PHN
- allow sufficient time and resources for the partner to develop any new skills required to carry out his/her steps

Evaluation/Renegotiation

- have partner and PHN regularly reflect on progress toward goals
- renegotiate changes in action steps as needed
- revise and re-initiate action plan, as needed

C. End

The partnership ends when both parties agree to end.

Notes from Abby

Empowerment implies the development of a person, family, group, system, or community's capacity to take charge, make choices deliberately, and believe that the future can be influenced. Although Joyce Zerwekh, associate professor of nursing at Florida Atlantic University, calls her third foundation of public health nursing practice "building strength" and not "empowerment," by definition and usage, they are very much the same concept. In fact, in earlier writing, Zerwekh used the term empowerment extensively.

[See: Zerwekh, J. (1992, March). Laying the groundwork for family self-help: Locating families, building trust, and building strength. *Public Health Nursing, 9*(1), 15-21. Also, Zerwekh, J. (1992, Summer). The practice of empowerment and coercion by expert public health nurses. *IMAGE: Journal of Nursing Scholarship, 24*(2), 101-105.]

Partnering is usually used to differentiate the approach used by PHNs (that is, "doing with") from that of the "professional" model (that is, "doing for" or "doing to"). Courtney and Ballard, for instance, define partnership as "the sharing of power between health professional and individual, family, and/or community partners. These partners agree to be involved as active participants....The ultimate goal of the partnership process is to enhance the capacity [of others] to act more effectively on their own behalf" (p. 180). As another example, note the change in title between Anderson and McFarlane's first, second, and third editions of their text on the community-focused level of practice. The 1988 edition is titled *Community As Client*. The 1996 and 2000 editions are titled *"Community As Partner."* Additionally, the third edition includes a new chapter on "Community empowerment and healing" which are described as the "theoretical underpinnings to the concept, community as partner" (p. 92).

[See: Courtney, R., & Ballard, E. (1996, June). The partnership model: Working with individual, families, and communities toward a new vision of health. *Public Health Nursing, 13*(2), 177-186.

Anderson, E., & McFarlane, J. (1996, 2000). *Community as partner: Theory and practice* (2nd and 3rd eds.). Philadelphia: Lippincott.]

It would appear that these are overlapping concepts, each derived from a somewhat different school of thought, but essentially pointed in the same direction. The one difference noted is that collaboration implies a risk of transformation for *both* the PHN and client; the literature reviewed on empowerment and partnering attributes transformation only to the client.

BEST PRACTICES for Collaboration

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who blended evidence from the literature with their practical expertise. These best practices are not presented in any ranking or particular order; each may not apply to every implementation of the intervention.

1. SELECTS THE MODEL OF COLLECTIVE ACTION THAT BEST MEETS THE CIRCUMSTANCES.

Best Evidence: Himmelman, 1993; Hoffman; Public Health Practice Program Office (PHPPO)

Collaboration is considered the most intensive form of collective action and, as such, requires the greatest commitment of time and resources. Collaboration is the preferred model, if the goal is to transform the way communities and organizations "do business." However, if less intensive ways of working together can achieve the goals desired, developing collaborative action may be excessive.

Himmelman provides a useful framework to assist in this model selection:

Networking: exchanging information for mutual benefit

- is the most informal
- is the easiest to form
- reflects an initial level of trust and commitment among member organizations
- is a good structure if only exchange of information is needed

Coordination: exchanging information AND altering activities for mutual benefit and to achieve a common purpose

- is a good strategy to use when persons or organizations choosing to link have neither worked together in the past nor have experience with coordination
- works best when all affected persons or organizations share in decisions about their intended and unintended outcomes

Cooperation: exchanging information, altering activities, AND sharing resources for mutual benefit and to achieve a common purpose

- requires greater commitments, even legal arrangements in some cases
- shares a wide variety of human, financial, and technical resources

Collaboration: exchanging information, altering activities, sharing resources, AND enhancing the capacity of another for mutual benefit and to achieve a common purpose

- requires sharing risks, resources, responsibilities, and rewards, all of which can increase the potential of collaboration beyond other ways of working together
- involves seeing each other as partners, not competitors, and seeking to enhance their partners' individual capacities to help accomplish a common purpose
- is best used only when networking, coordination, or cooperation cannot achieve mutual goals
- challenges values of others frequently
- involves complex processes
- requires considerable time

2. ASSURES THAT THE COMPONENTS OF EFFECTIVE COLLABORATION ARE PRESENT.
Best Evidence: Bailey and Koney; Hennemen; Hoffman; Mattessich and Monsey; Polivka,1995; Polivka, 1997; Spradley and Allender; White and Wehlage; Wimpfheimer, Bloom, and Kramer

The core components of effective collaboration include:

- effective *leadership*, both formal and informal
- members who, with the leaders, are *committed* to the work
- *shared values* and sense of purpose among leaders and members
- functioning *linkages* or relationships between the collaborative and related groups and individuals
- effective *strategies* and sufficient *resources* for achieving goals
- functional *structure* that supports the collaborative work
- *internal systems* that are adequate to support the structure.

Collaboration is challenged by several *paradoxes***,** or seemingly contradictory, but true circumstances. Bailey and Koney provide insight into some of these:

- Leaders of collaboratives must be simultaneously *assertive* (in terms of keeping the collaborative partners focused on the jointly held goal) and *responsive* to those same partners' interests, since they are the ones setting the agenda
- Collaborative partners must work with the collaborative leadership, while at the same time being leaders themselves in their respective organizations
- The interorganizational structures and systems that provide for collaborative action must be both rigid and loose, open and closed (that is, flexible) in order to be effective.

3. NEGOTIATES WIN/WIN OUTCOMES, COMMUNICATION, SHARED RISKS AND BOUNDARIES.
Best Evidence: Gray; Henry and others; Hennenman; Himmelman,1993; Lindeke and Block; Mattessich and Monsey; McCloskey and Maas; Spradley and Allender; Uphold and Graham; Wimpfheimer, Bloom, and Kramer

Effective collaborative action depends on the following conditions:

- Perception of potential "win-win" outcomes for all collaborators
- Existence of an open communication system among the partners, which allows for ownership of the problem, as well as responsibility for its resolution
- Shared risks among all partners; risks become the essential motivators for working together
- Early establishment of those boundaries which an agency or its representative will not go beyond

Collaboratives vary from other forms of collective action in the level of risk involved. The risk is that the person or their organization may be transformed (or change how they do business) as a result of their involvement with the collaborative. The commitment to the mutual goal makes the risk of change necessary. It is made tolerable only by the existence of open communication among the partners (that is, no one has a hidden agenda). Because of this risk of transformation, however, PHNs (and other collaborators) must be clear about their boundaries or limits.

Lindeke and Block, for instance, describe the ethical dilemmas encountered in interdisciplinary collaboration for delivering health care. They found that four main sources of constraints or barriers to true collaboration are:

- communication styles and assumptions
- power and authority differences
- professional socialization
- structural factors such as salary differences.

These barriers were resolved by remaining focused on client outcomes, while at the same time modeling nursing's core values and principles.

McCloskey and Maas share this perspective, but broaden the discussion to a more political level. They contend that interdisciplinary collaboration does not mean that the participating disciplines take on each others' features and become something different. They propose that the heart of collaboration is recognizing and building on each others' strengths to provide a complementary, rather than a competitive, approach to health care delivery.

4. PROVIDES LEADERSHIP TO THE COLLABORATIVE WORK.

Best Evidence: Bailey and Koney; Flynn; Gray; Wimpfheimer, Bloom, and Kramer; Wood and Gray

The PHN provides leadership to the collaborative work by:

- interpreting accurately data about the issues being addressed and their actual or potential impact on health
- enhancing partners' understanding of the multiple determinants of health
- modeling the appropriate use for, and resolution of, conflict
- listening to those who will be affected by the decisions made and assuring their inclusion in the decision-making process
- contributing to the development of consensus
- understanding volunteerism in collaborative work and helping to manage its consequences
- providing information on the effectiveness of strategies implemented elsewhere which address similar issues
- planning, developing, and implementing community-based health services
- advocating for health-promoting policy.

Providing leadership to a collaborative effort is frequently referred to as serving as "convener," or someone who facilitates the forum through which the work is done. However, this role is more than facilitation; the convener is often also the person who has to keep the group focused on accomplishing the collaborative goal and prevent the group's energy or resources from being diverted to competing interests.

Most members of collaboratives are not paid to serve. In that sense, they are "volunteers"–although they may be "volunteered" by their respective organizations. This guarantees a certain frequency of turnover in the collaborative's membership, as individuals change jobs or functions. Another barrier is that serving in a collaboration is usually "added" to an individual's other job responsibilities. Thus, the collaboration competes for time with the person's "real" job.

Wood and Gray describe the main "tools" available to the convener to influence the collaboration:

- *legitimation*, or the recognition by collaborative members of the conveners' right to lead
- *facilitation*, or expertise in group process and communication
- *mandate*, or leadership specified by some outside authority such as a legislative order
- *persuasion*, or capacity to motivate others to act

5. DEVELOPS INTERPERSONAL TRUST RELATIONSHIPS WITH PARTNERS.

Best Evidence: Flynn; Henry and others; Hennenman; Himmelman, 1993; Mattessich and Monsey; McCloskey and Maas; Paavilaninen and Astedt-Kurki; PHPPO; Spradley and Allender; Stanhope and Lancaster

This best practice holds true regardless of the level of practice. Public health nurses are "naturals" for collaborative work, given that the relationship-basis is one of the cornerstones of the discipline.[49] Examples from all levels of practice are found in the literature reviewed. For instance:

At the *individual/family level of practice*:

Paavilaninen and Astedt-Kurki's qualitative research study of PHNs' work in Finland provides an analysis of collaboration. They found that the initial step of trust development takes place over time during which the client "tests" the PHN in a variety of ways. These tests begin with demonstrations of dependability and reliability and move toward building confidence in each other's trustworthiness.

The extent to which the PHN communicates "friendliness" or true caring is critical to the development of "the experience of togetherness," or the mutual understanding that, together, they are "engaged in a joint mission to help the client better cope with his or her situation." Once this stage is reached, movement toward goal attainment proceeds.

At the *systems level of practice*:

Lindeke and Block found in their work with multiple disciplines that they first had to develop interpersonal relationships with other health professionals before those health professionals could recognize the need for a therapeutic relationship with clients.

At the *community level of practice*:

Henneman and others' concept analysis of collaboration, as found in nursing literature, provides several principles:

- collaboration depends on respect for and trust of self as well as others
- developing collaborative efforts requires extensive time and patience
- collaboration really can occur only between people, not institutions; in the end, it is the relationships that develop between the people who happen to be representing those institutions that make collaboration successful or not

[49] Minnesota Department of Health/Section of Public Health Nursing. (1999, June). *The cornerstones of public health nursing*. St. Paul, MN.

6. ANTICIPATES AND INTERCEDES WITH PREDICTABLE GOVERNANCE PROBLEMS.
Best Evidence: White and Wehlage; Wood and Gray

Predictable governance problems include:

- slippage between policy and action
- disagreement over policy
- disconnection between policy decisions and community conditions.

Collaborative efforts require significant energy and resources to maintain, once they are developed. When they run into difficulty or get "off track," it is usually related to one or more of the factors listed above. This occurs more often in large and/or longstanding collaboratives. Frequently, these slippages may be the result of:

- the natural turnover inherent in collaboratives, as old members leave when the collaborative goal no longer fits with their own organization
- job changes resulting in changes in representatives to the collaborative
- failure to adequately orient new members to the collaborative's mission and goals
- failure to renew that commitment with current members to assure continuing agreement with the mission and goals.

Disagreement among members over problem definitions, causes, and remedies also creates rifts, especially in collaboratives attempting to unite public and private agencies. White and Wehlage note, "Though noble in purpose, mixing public agencies and private sector organizations (both for profit and nonprofit) required a level of organizational complexity that taxed the intellectual and political skill of the communities [attempting to build a collaborative]" (p. 24). Bad policy stemming from a disconnection between decision-makers and community reality is most often related to collaborative boards which have too many administrators and too few "front line" workers in their membership mix.

7. ACCURATELY ASSESSES THE DEVELOPMENTAL PHASE OF THE COLLABORATIVE AND ADJUSTS HIS/HER BEHAVIOR ACCORDINGLY.
Best Evidence: Gray; Paavilainen and Astedt-Kurki; Polivka and others, 1997; Spradley and Allender; Stanhope and Lancaster

The developmental phases of a collaboration are:

- Problem-solving:
  partners negotiate issues of legitimacy and come to appreciate the interdependence that exists among them
- Direction-setting:
  partners articulate the values that guide their individual pursuits and begin to identify and appreciate a sense of common purpose
- Structuring:
  partners create long-term structures to support and sustain their collective actions and problem-solving activities; this includes establishing goals and assigning roles and tasks

The PHN must be flexible and able to alter behavior to match the collaborative's developmental phase. However, in all phases, it is critical that the PHN have sufficient self-knowledge and confidence to articulate the

role and contribution of public health nursing. *Often, what appears to be lack of appreciation for what public health nursing offers is related not so much to outright rejection or disregard but, rather, to a general lack of knowledge about the discipline.*

This was the finding of Polivka, Kennedy, and Chaudry (1997) in their study of collaboration between PHNs and mental health agencies in Ohio. They found that although mental health center directors indicated they were satisfied with their center's relationship with local public health nursing agencies, the PHN directors were strongly dissatisfied, based on service utilization. Further analysis showed that the mental health center directors were largely uninformed about the potential a collaborative could offer their clientele. The authors concluded that "...the more [staff] in other agencies know others in different agencies, the more clients are referred between the agencies, the more funds and information are exchanged, [and] the greater satisfaction with interagency relationships" (p. 160). In other words, to assure a place for public health nursing at the collaborative "table," PHNs cannot afford to wait for an invitation or be shy. As the saying goes, "The world belongs to those who show up."

A Humorous Note from Abby

Collaboration is Like Teenage Sex Because...

- Everyone is talking about it all the time.
- Everyone thinks everyone else is doing it.
- Those who are doing it are:
  - < doing it poorly
  - < sure it will be better next time
  - < not practicing it safely
- Everyone is bragging about their successes all the time, although few have truly experienced success.
- Done right, it multiplies.

Deb Wells

BEST EVIDENCE for Collaboration

Each item was first reviewed for research quality and integrity by graduate students in public health nursing and then critiqued for its application to practice by at least two members of a panel of practice and academic experts. The nature of the material and a score expressed as a percentage are included at the end of each annotated citation. The percentage is the average of scores assessed by the experts who reviewed it. It reflects their opinion of the strength of the item's contribution to practice.

Review Articles

Mattessich, P., & Monsey, B. (1992). ***Collaboration: What makes it work; A review of research literature on factors influencing successful collaboration.*** **St. Paul: Amherst H. Wilder Foundation.**
[Note: See also the companion document, *Collaboration Handbook: Creating, Sustaining, and Enjoying the Journey* (1994) by M. Winer & K. Ray (St. Paul: Amherst H. Wilder Foundation).]

Collaboration is defined as "a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationship includes a commitment to: a definition of mutual relationships and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards" (p. 7). Based on an extensive literature review, the authors identify six factors influencing a collaboration's success:

1. Environment
    a. History of collaboration or cooperation in the community
    b. Collaborative group seen as already in the community
    c. Political/social climate favorable
2. Membership
    a. Mutual respect, understanding, and trust exist
    b. Appropriate cross-section of members
    c. Members seeing collaboration as in their self-interest
    d. Ability to compromise
3. Process/Structure
    a. Members share a stake in both process and outcome
    b. Multiple layers of decision-making
    c. Flexibility
    d. Development of clear roles and policy guidelines
    e. Adaptability
4. Communication
    a. Open and frequent communications
    b. Established information and formal communication links
5. Purpose
    a. Concrete, attainable goals and objectives
    b. Shared vision
    c. Unique purpose
6. Resources
    a. Sufficient funds
    b. Skilled convener.

Review=55%

Wood, D., & Gray, B. (1991, June). Toward a comprehensive theory of collaboration. *J. of Applied Behavioral Science, 27*(2), 139-162.

Collaboration is defined broadly as "an interorganizational phenomenon designed to achieve desired ends that no single organization can achieve acting unilaterally" (p. 140). The authors then review a series of studies and reviews on the topic to reach the following conclusions:

Revised Definition: Collaboration occurs when a group of autonomous stakeholders of a problem domain engage in interaction process, using shared rules, norms and structures. To act or decide on issued related to that domain" (p. 146).

1. Convener role
    - **P**to influence the collaborative through legitimation, facilitation, mandate (i.e., formal authority), and/or persuasion
    - **P**to develop alliances among the levels of collaboration within collaboratives, it is necessary to convene only the necessary stakeholders, not all
2. Reducing environmental complexity and enhancing control
    - **P**accessing resources
    - **P**using resources efficiently
    - **P**developing rules governing resource use
    - **P**shared versus individual control
    - **P**using complexity as a resource
3. Sorting Interests
    - **P**often, collaboratives work because the collective interest of the collaborative also meets the self-interests of those in the collaborative
    - **P**there are three types of self-interests in this analysis:
        - **S**shared–those held in common by the stakeholders
        - **S**differing–self-interests present which do not interfere with each other
        - **S**opposing–self-interests present which do interfere
    - **P**as long as the collective interest (i.e., the belief in benefits to be gained by collaborative effort) exceeds the sum of the self-interests, the collaborative effort will not be lost

Review=52.5%

Research Reports

Paavilainen, E., & Astedt-Kurki, P. (1997, July). The client-nurse relationship as experience by public health nurses: Toward better collaboration. *Public Health Nursing, 14*(3), 137-138.

The authors report on a study of PHNs in Finland that explored the nature of the client-PHN relationship and identified key elements of collaboration. Public health nurse practice in Finland is described as "promoting the client's health, social well-being, security, and quality of life; to strengthen and increase the client's independent control over his/her life; to eliminate health risks and to assist in diagnosing and treating illnesses as early as possible; to help clients with rehabilitation; to generate in the public a genuine interest in health promotion and encourage efforts at active self-care" (p. 137). This is carried out in a model known in Finland as "population responsibility nursing" which, as described, is similar to PHN-generalists assigned to geographic districts in the U.S.

On the premise that achieving these goals required the establishment of relationships with both clients and communities and that relationships that are collaborative in nature best promote progress to self-care in either clients or communities, the authors designed a qualitative study of the practice of eleven experienced, respected PHNs. The authors concluded that PHN-client collaboration was experienced as a sense of "togetherness...of being engaged in a joint mission to help the client better cope with his or her situation" and that this condition had to exist before change could occur (p. 140).
To develop collaboration, the client and the PHN first had to establish trust, a friendly and confidential relationship, common actions, experience of togetherness, client's well-being, and the ability to cope.
Qualitative=65%

Polivka, B., Kennedy, C., & Chaudry, R. (1997). Collaboration between local public health and community mental health agencies. *Research in Nursing and Health, 20,* 153-160.
As part of a study of current and potential roles for PHNs in the care of individuals with severe mental disabilities in Ohio, a sample of PHN directors in local public health agencies, and executive directors of community mental health agencies were surveyed. The survey included nine items on interagency relationships, on the assumption that interagency processes have a direct, positive effect on outcomes (p. 154). The items, in turn, were derived from a conceptualization of community interagency collaborative model that included five factors:

environmental context: relationships with the broader social environment
situational factors: organizational antecedents that contribute to the likelihood of the formation of relationships
task factors: the nature of the technologies occurring in the system
interagency processes: structure and processes of relationships among the organizations
outcomes (e.g., satisfaction among collaborators and programmatic successes)

In general, they found that mental health center directors perceived greater collaboration between the systems than did directors of nursing and also greater satisfaction, although, in fact, very little evidence of collaborative action was found. The simple act of being acquainted with the people in other agencies impacted the client referral and decision-making process to the greatest extent and supports the imperative that PHNs get to know staff from other agencies with whom they need to collaborate in the best interests of the clientele.
Quantitative/non-experimental=46%

Expert Opinion

Uphold, C., & Graham, M. (1993, September/October). Schools as centers for collaborative services for families: A vision for change. *Nursing Outlook, 41*(5), 204-211.
The authors offer the challenge that if we, as a society, are truly committed to promoting and improving child and family development, then schools should be reconceived as Family Service Centers. These would include primary health care services. Since school nurses have traditionally been the linkages between the educational and health care systems, the authors suggest the school nurse lead the development of such collaborative models. They provide a rationale supporting their premise and offer a case study of a Family Services Center prototype in a Gainesville, Florida middle school in collaboration with that state's health department. Although the article does not speak to the interpersonal or interorganizational aspects of developing such collaboratives, it does provide substantial discussion of need and reasoned response.
Expert Opinion=82.5%

Kang, R. (1997). Building community capacity for health promotion: A challenge for public health nurses. In B. Spradley & J. Allender, *Readings in Community Health Nursing* (pp. 221-232). Philadelphia: Lippincott.
[Note: Kang also published this piece in 1995 in *Public Health Nursing, 12*(5), 312-318.]

Kang asserts that PHNs are "vital for building the capacity of communities to create a responsive public health system for health promotion and disease prevention [in response to health reform's focus on cost-containment]." She goes on to suggest that PHNs' strength in developing community capacity is their familiarity with the internal working of communities and the lives of people in them" (p. 222). She reviews PHNs long history in community development and places it within the context of "contemporary challenges" (i.e., the IOM's 1988 *Future of Public Health*).
Kang sees communities' "mediating structures" (i.e., entities which formally or informally structure a means of inter-organizational or interpersonal communication, such as schools, churches, social groups, etc.) as potential PHN partners for creating community health change. She goes on to describe how this partnering can be a critical component of PHNs' developing communities' capacities for assessment, policy development, and assurance and suggests that "guiding principles of respect, distributive justice, and beneficence undergird partnerships between public health nurses and communities" (p. 231).
Expert Opinion=76%

Henry, V., Schmitz, K., et al. (1992, December). Collaboration: Integrating practice and research in nursing. *Public Health Nursing, 9*(4), 218-222.
A research collaboration between two rural PHN agencies and faculty in a small-college BSN program is described and analyzed for key components of collaboration as proposed by Lancaster.
[See: Lancaster, J. (1985). The perils and joys of collaborative research. *Nursing Outlook, 5,* 231-232, 238.]:

1. Communication: openness and accessibility between the faculty serving as researchers/consultants and the agency staff was deemed critical
2. Commitment: both the BSN program and the agencies operated with limited resources, and, despite the availability of a small amount of grant funding to support the collaborative research effort, time had to be carefully negotiated
3. Compatibility: pre-existing positive mutual regard assisted in the development of a negotiated collaboration
4. Consensus: compromise between the needs and demands of PHN practice versus those of the research process had to be carefully balanced
5. Credit: respectful attribution of credit is important

Benefits of collaboration to both practice and research are discussed in the conclusion.
Expert Opinion=71%

Polivka, B. (1995, Summer). A conceptual model for community interagency collaboration. *IMAGE: J. of Nursing Scholarship, 27*(2), 110-115.
Polivka describes the development of her model for community interagency collaboration based on an extensive literature of the factors. She suggests, "Traditionally, it has been assumed that organizations only reluctantly enter into inter-organizational relationships because of the costs and potential loss of control. Yet because of limited resources, collaborative relationships must often be formed" (p. 110).

The model elements and their function are as follows:

Environmental Context: the political, economic, demographic, and social factors affecting organizational behavioral factors currently promote collaboration among organizations

Situational Factors: pre-existing organizational elements that contribute to the need or desire to enter into relationships, such as

- **P**awareness of other organizations (i.e., knowledge of their resources, goals, capacities, and personnel) increases collaboration
- **P**resource dependence on external sources decreases collaboration
- **P**domain similarity (i.e., the amount of overlap of clients, funding sources, activities, etc.); the more complementary the domains, the greater the motivation for collaboration
- **P**consensus (i.e., the degree to which organizations agree or disagree with each other's goals, tasks, etc.); the greater the concordance, the greater the likelihood of collaboration

Task Characteristics:

- **P**Scope: extent of collaboration required
- **P**Complexity: time and duration of collaboration; the greater the complexity, the more likely to collaborate
- **P**Uncertainty: unpredictability of the outcome

Transactional Factors:

- **P**Intensity: quality and quantity of inter-organizational information and resources exchanged; the greater the exchange, the more likely to collaborate
- **P**Joint Decision-making Strategies: extent to which organizational management is carried out jointly
  - **S**Mutual adjustment: few resource demands, few joint decisions, and power is decentralized; few common goals exist and collaboration is focused on specific cases
  - **S**Corporate collaboration: an umbrella or overarching authority is developed and relationships become intense, formalized, and centralized
  - **S**Alliance collaboration: intermediate form of collaboration between mutual adjustment and corporate strategies; alliances can be either a
    - *federation model (a centralized administration exists), or
    - *coalitions or councils (no centralized administration)

Structure:

- **P**size: number of participating organizations
- **P**centralization: extent to which resource and information flow are focused on one or more agencies
- **P**connectiveness: number of interagency linkages
- **P**inter-organizational pattern types: pairs, sets, networks

The model suggests that the development of multi-agency coordinated community health efforts are a function of:
Environmental Conditions + Pre-existing Organizational Situational Factors +
Task Characteristics

Once alliances are formed, the structure and operation of collaborative effort are a function of inter-organizational

Intensity + Formalization + Decision-Making Methods +
Size + Centrality + Relationship Patterns

Outcome of these relationships include:

Organizational Changes + Inter-organizational Relations

9

Achievement of Mutually Set Goals Related to Clients and Communities

Expert Opinion=67%

Himmelman, A. (1993, May). An introduction to community-based collaboration. (Arthur T. Himmelman Assoc., 1406 West Lake St., Suite 209, Minneapolis, MN 55408)

In this paper, the author describes four options for organizations to form inter-organizational linkages:

Networking: exchanging information for mutual benefit

- **P**most informal
- **P**easiest to form
- **P**reflecting initial levels of trust and commitment among member organizations
- **P**structurally good if the goal is only exchange of information

Coordination: exchanging information AND altering activities for mutual benefit and to achieve a common purpose

- **P**strategically good when organizations choosing to link are both internally and inter-organizationally disorganized
- **P**best when all parties affected share in decisions about their intended consequences, as well as in consideration of the unintended ones.

Cooperation: exchanging information, altering activities, AND sharing resources for mutual benefit and to achieve a common purpose **P**requires greater organizational commitments, even legal arrangements in some cases

- **P**results in shared resources encompassing a wide variety of human, financial, and technical contributions.

Collaboration: exchanging information, altering activities, sharing resources, AND enhancing the capacity of another for mutual benefit and to achieve a common purpose

- **P**enhancing the capacity of another organization requires sharing risks, resources, responsibilities, and rewards, all of which can increase the potential of collaboration beyond other ways of working together
- **P**involving members who see each other as partners, not competitors, and seek to enhance their partners' capacity to achieve their own definitions of excellence to help accomplish a common purpose
- **P**best used only when other inter-organization strategies cannot achieve mutual goals
- **P**often challenges values of member organizations

Pinvolves complex processes

Prequires considerable time

Prequires an understanding that sharing risks, responsibilities, resources, and rewards is central to effective collaboration

Sall partners take the risk together and do not let one member "go first to test the waters"

Seach partner must share resources to the best of their ability (broadly defined to include such things as community goodwill)

Srewards must also be shared.

Two types of collaboratives exist:

1. Collaborative betterment

Pbegins outside the community within public, private, or nonprofit institutions and is brought into the community

Pinvites community involvement

Pis good for short-term gains but tends not to produce long-term ownership in communities or significantly to increase communities' control over their own destinies

Ptypical of most multisector collaboratives

Betterment principles:

Plarge and influential institutions initiate the process primarily within institutional frameworks, assumptions, and value systems.

Pstaff are responsible to institutions, and, although they seek advice from target communities, staff are not directly accountable to them

Paction plans are usually designed with some direct community involvement, but normally emphasize the ideas of institutionally related professionals and experts

Pimplementation processes include more community representation and require significant community acceptance, but control of decision-making and resource allocation is not transferred to the community during the implementation phase

Palthough advice from the community is considered, the decision to terminate the collaborative is made by the institution that initiates it.

2. Collaborative Empowerment

Begins within the community and is brought to public, private, or nonprofit institutions. In this context empowerment refers to the capacity to set priorities and control resources that are essential for increased community self-determination.

Pempowerment includes two basic activities:

a. Organizing a community in support of a collaborative purpose determined by the community

b. Facilitating a process for integrating outside institutions in support of this community purpose

Pthese are likely to produce long-term ownership of the collaborative's purpose, processes, and products in communities and to enhance their capacity for self-determination

Empowerment Principles:

Process is initiated in a community and is assisted by community organization; the early problem identification process involves both data-based trend analysis and narrative examples from community residents; equal importance is ascribed to each

- **P**community priorities are reflected in collaboratives' purposes
- **P**negotiations with outside agencies and institutions produce agreements to proceed on a collaborative basis under the purpose established by the community, and within a governance and administrative process in which power is equally shared by the community and outside organizations
- **P**governance and management structure includes a policy board, an executive committee, action groups for implementing plans, and staff agreeable to the community to assist the collaborative
- **P**substantial attention is given to balancing administration goals and community participants' goals
- **P**goals are implemented through action plans fully supported by community residents, as well as by representatives from the public, private, and nonprofit institutions from outside the community
- **P**commitments to assessment and evaluation in public settings provide community-based organizations with opportunities for monitoring the progress of the collaborative
- **P**community control of resources needs to continue efforts beyond the termination of the collaborative.

General observations about effective collaboration:

1. Requires maturity beyond an ego-centered state of development.
2. Multisector collaboration (i.e., among private, nonprofit, and governmental entities) is part of a long tradition in which the appropriate respective roles for each have been debated and changed over time; previous history regarding these debates needs to be kept in mind.
3. Multisector collaboration is complex and requires considerable time, which might make it inappropriate for some settings.
4. Empowerment should begin in the community and be guided by community members who will share real power with larger institutions.
5. Collaborations designed to better communities, but not to empower them, should not be discounted. They do good things for communities, but do not necessarily build community capacity.
6. Collaboration requires a common vision, so that the direction and possible outcomes of the effort can be seen from the outset.
7. The importance of trust and its role in encouraging the sharing of information and expertise among all participants should be reinforced.
8. There is no "they" in collaboration; shared responsibility and accountability should be at the core of all problem-identification and problem-solving processes.
9. Consistent attendance at meetings is essential as is coming to meetings prepared.
10. Communication within participating organizations is as important as communication among participating members.
11. When representatives of organizations are replaced, they should provide as much advance notice as possible and fully orient the new person.
12. Clarity in the collaborative's governance structure and lines of accountability is essential.
13. Communication among collaborative members should be continually fine-tuned so that the collaborative knows what it is doing and can easily explain its activities to those not directly involved.
14. Time constraints should be considered realistically and early.
15. Collaborative membership should be diverse.

16. Organizations participating in collaborative efforts would do well to "walk the talk" by reflecting collaborative and supportive policies and practices in their own organization. There is a close relationship between how a person feels as part of an organization and how that organization participates in community problem-solving activities.
17. Community-based collaborations are well-suited to participation from a diverse array of institutions.
18. Those seeking to participate in collaboratives as leaders, organizers, facilitators, and members should discuss and practice participatory democratic processes.
19. Common courtesy is one of the most essential characteristics of collaboration.

In designing a collaborative, Himmelman suggests the following steps:
1. What is your vision?
2. Who is involved?
3. What expectations should you have for each?
4. What is your mission?
5. What are your goals and objectives?
6. What can each partner contribute ?
7. Who will be responsible for getting the work done?
8. How good is leadership, management, and staffing?
9. How is your collaborative governed? Who makes decisions and what authority do they have to make them?
10. How will people find out about by your activities?
11. How much money do you need, and how will you secure it?
12. How will evaluate your processes and products?

Expert opinion=54.5%

McCloskey, J., & Maas, M. (1998, July/August). Interdisciplinary team: The nursing perspective is essential. *Nursing Outlook, 46*(4), 157-63.

The authors admonish nurses "not to abandon the nursing perspective when they participate in an interdisciplinary team" (p. 157). They believe the potential for loss of discipline identity through the "melding, molding, and further concealing of the professional identity of nursing" promoted by some schools of thought on interdisciplinary practice poses a "real danger for the profession of nursing...and that patient care will suffer from the loss of the nursing perspective and the accountability of nurses for their interventions" (p. 157). As evidence for this loss, they offer the fact that the word "nurse" has been deleted from many nurse executive positions in institutions, the adoption of critical paths as the basis for nurse-provided case management of patient care in lieu of nursing care plans, the implementation of clinical documentation systems which do not accommodate nursing language. They suggest that rather than adopting features and aspects of other disciplines' practices, the real advantage of interdisciplinary practice is the opportunity for partnership and enhanced practice as a team of members, each representing different, but complementary, disciplines, who work in collaboration with each other.

Principles of such practice should include:
1. Functioning in the true sense of a "team," or, as "a small group of people with complementary skills who are committed to a common purpose, performance goals, and a common approach to which they hold themselves mutually accountable."
2. As a team, they must acknowledge the stages of group development described by Tackman (i.e., forming, storming, norming, and performing).

3. Team practice is expensive and should be reserved for situations where multiple perspectives on a given problem are absolutely essential to problem-solving.
4. As with every discipline, nursing has its own knowledge, some of which may be shared with other disciplines, but applied within the unique framework of the nursing process.
5. In collaborative relationships, colleagues work together as partners with trust and mutual respect for each other's skills and in an environment of equal power. For nurses, the last aspect may mean practicing assertiveness and confrontation in establishing an equalized power base.

The authors complete the article by describing how the adoption of nursing-specific language in software development for health care data systems is critical for the capacity to document the contributions to patient outcomes attributable to nursing. They state, "No clear-thinking nurse would deny the importance of interdisciplinary care or that many patient outcomes are influenced
by more than one discipline. Yet clear-thinking nurses all should recognize the necessity of showing how the intervention of individual nurses and groups of nurses influence patient outcomes" (p. 163).

Expert Opinion=53%

Gray, B. (1985). Conditions facilitating interorganizational collaboration. *Human Relations, 38*(10), 911-936.

The author synthesized research findings from organization theory, policy analysis, and organizational development to arrive at conclusions regarding conditions essential to achieving collaboration. The conditions are organized under the three phases of McCann's model for collaborative development among organizations: problem setting, direction setting, and structuring.

<u>Conditions Facilitating Problem-Setting</u>

1. The stakeholders brought together need to reflect the complexity of the problem under consideration, if collaboration is to occur.
2. Problem-setting efforts are enhanced when stakeholders expect that the benefits of collaborating will outweigh its cost and when prevailing norms support collaboration. If positive expectations are not present, incentives to induce participation will be necessary.
3. The greater the degree of recognized interdependence among stakeholders, the greater the likelihood of initiating collaboration.
4. Shared perceptions of legitimacy are necessary to initiate problem-setting. Perception of legitimacy will be adopted by hostile relations and by the existing power distribution among stakeholders.
5. Collaboration will be enhanced by conveners who possess legitimate authority and appreciative skills and who understand the mission and potential with vision

<u>Conditions Facilitating Direction-Setting</u>

1. Direction-setting is greatly facilitated by coincidence in values among stakeholders. Joint information search by the stakeholders contributes to the emergence of coincident values and mutually agreeable direction of the effort.
2. Collaboration will be enhanced when power is dispersed among several, rather than among just a few, stakeholders. An equal power distribution is not necessary and may prove undesirable, since it can provoke stalemate and inaction. However, a sufficient distribution of power is necessary to insure that all stakeholders can influence direction-setting.

Conditions Facilitating Structuring

1. Structuring will occur when stakeholders perceive that continued dependence upon each other is necessary to implement their desired direction.
2. Mandate alone will not generate conditions conducive to collaboration. However, coupled with other conditions (e.g., recognition of interdependence and balance of power), mandate can provide a structural framework for ongoing effort.
3. Effective structuring involves negotiation among all stakeholders about how to regulate the effort, holding negotiations about the implementation of actions and the power distribution necessary to do so. One outcome of structuring is an agreed-upon allocation of power within the effort.
4. Geographic proximity facilitates structure. Local level initiatives can best capture the advantages associated with geography.
5. Successful implementation of collaborative agreements is contingent upon the stakeholders' collective ability to manage changes positively in their own spheres. This involves building relationships with others outside of the immediate effort to provide some level of accountability.

Expert Opinion=52%

Henneman, E., Lee, J., & Cohen, J. (1995). Collaboration: A concept analysis. *J. Advanced Nursing, 21*, 103-109.

The authors analyze various understandings of "collaboration" in an attempt to promote a common construct in its use across nursing practice. In the process, they look for defining attributes, antecedents, consequences, and empirical referents. Key findings include:

1. Respect and trust for self and others is key.
2. Building that respect and trust requires patience, nurturence, and time.
3. Collaboration is a "process which occurs between individuals, not institutions, and only the persons involved ultimately determine whether or not collaboration occurs" (p. 108).
4. Nursing's "obsession with the 'uniqueness' of nursing as a discipline" presents a significant barrier to developing collaborative action in nursing, since these "philosophical approaches and socialization processes...fail to recognize the contributions of other disciplines to health" (p. 108).

Expert Opinion=52%

White, J., & Wehlage, G. (1995, Spring). Community collaboration: If it is such a good idea, why is it so hard to do? *Educational Evaluation and Policy Analysis, (17)1,* 23-38.

The authors report on their evaluation of several city-wide collaborative efforts funded by the Annie E. Casey Foundation in the late 1980s to "build formal collaborative structures among public and private organizations to address the problems of at-risk youth" (p. 23). The collaboratives were to reduce dropout rates, increase young adult employment after highschool, and reduce rates of adolescent pregnancy and parenthood." They employed the case management intervention. The theory of action was that the case managers—in fulfilling their roles of broker services for youth and their families; being an advocate, mentor, and significant adult for youth at risk; and serving as "eyes and ears" in the community for the collaborative—would provide information which, on an aggregated basis, would identify institutional problems among youth-serving organizations, which the collaborative could then attempt to fix. While case managers were successful advocates for youth, they were less successful at brokering services, and least successful in providing useful information back to the collaborative. In addition, the collaborative themselves never acquired adequate power to hold member agencies accountable for bringing about suggested policy changes.

Several lessons learned about collaborative governance through the evaluation have broad application for the collaborative in general:

1. Slippage between policy and action

While some slippage is expected in any organization, the amount experienced by the collaborative is extensive and related to

- **P**disagreement about how best to implement the policy
- **P**disagreement over attempts by professionals to protect their interests within an organization
- **P**policy-makers' general disregard for the validity of the information provided to them by their "front line workers" (in this case, the case managers): "Collaborative found it very difficult to give voice to the concerns of case managers, because inevitably that would result in challenges to professional expertise and prerogatives of mainstream human service institutions" (p. 27).

2. Discord over policy, related to fundamental disagreements among collaborative members over the definitions, causes, and remedies of problems. The evaluators found that the difficulty in building consensus in communities was almost always underestimated (p. 28).

3. Disjuncture between policy and community conditions, resulting in bad policy. This was related to the collaborative boards, which tended to be top-heavy with agency heads and other high-level bureaucrats who were necessarily isolated and operating at some distance from those being served by their agency.

In general, they concluded that, where the collaborative failed, it was mainly due to

- **P**"The commitment to reform institutions [through collaborative] appears to have resulted in too much attention to the problems of co-ordinating organizations and agencies and not enough attention to understand and addressing the problems of the people who were to be served"
- **P**"Though noble in purpose, mixing public agencies and private sector organizations (both for profit and nonprofit) required a level of organizational complexity that taxed the intellectual and political skill of the communities [attempting to build collaborative]" (p. 24).

They recommended that the focus should shift from trying to find more efficient ways to deliver services to autonomous individuals and, instead, to using collaborative action to implement a strategy to build social capital or revitalize neighborhoods "from the inside out" (p. 35).

Expert Opinion=52%

Hoffman, S. (1998, July-August). The three new C's for nursing–Collaboration, cooperation, and coalition [Editorial]. ***J. Professional Nursing, 14*****(4), 194.**

While written to urge schools of nursing to follow service settings into partnering in order to maximize resources and potentially reduce costs, the descriptions offered by Hoffman are applicable across settings:

Collaboration: highest level of partnering, because it initiates new shared structures

- **P**commitment to a common mission and vision
- **P**new decision-making authority
- **P**pooled resources
- **P**task specialization and division of effort
- **P**interdependence

Cooperation: lowest level of partnering

- **P**organizations retain their own decision-making authority and control of resources
- **P**informal relationships
- **P**usually task or function specific

Prelationship ends after accomplishment of task or function

Coalition: union of organizations that maintain their own identity but work together to influence a particular outcome

Poften come together to influence policy or community norms

Pconserves resources and provides a forum for sharing information

Pexpands the scope of accomplishment beyond what one partner could accomplish.

Hoffman concludes by saying utilization of the "3 C's" is no longer optional for the advancement of nursing, but "foundational."

Expert Opinion=49%

Wimpfheimer, R., Bloom, M., & Kramer, M. (1990). Inter-agency collaboration: Some working Principles" ***Administration in Social Work*** **14(4) 1990 89-102.**

The authors assert that "inter-agency collaboration is a creative process of melding organizational and personal attributes (strengths and limitations) within a common situation so as to achieve mutually shared objectives at some level of parity" (pp. 90-91). Eight conditions promoting development of effective collaboratives are described as aids negotiating collaborative efforts:

Preconditions

1. Mutuality: recognition of a common problem and the acceptance of cooperation as a potential resolution; a "shared vision of a common reality sets the ground for future discussions" (p. 91).
2. Timing: problem must be high enough on each agency's agenda for it to be recognized as needing resources to be assigned toward its resolution.
3. Authority and Influence: authority must exist within an agency to commit resources to the resolution of the problem.
4. Creativity: desirability of solving problems beyond the customary processes must be agreed upon.

Conditions

1. Everyone Is a Winner: every party in the collaborative effort must perceive itself as having something to gain by involvement.
2. Acknowledgement of Responsibility for the Problem: sufficient openness in communication must exist for all parties to acknowledge their part in the problem and, with it, the commitment to resolution.
3. Common Risk: all parties must perceive themselves at some level of risk, should the problem not be resolved
4. Acceptance of Limits: each agency should establish the limits of what they can contribute or commit early in the process.

Expert Opinion=49%

Flynn, B. (1997, July). Are we ready to collaborate for community-based health services. ***Public Health Nursing*** **(editorial),** ***14*****(3), 135-136.**

Flynn suggests that health care is in the middle of an unparalleled paradigm shift which, for nursing, will mean work shifted from institutional to community foci. This will require nurses learn to work in partnership with others, contributing and getting information and other resources in the process. Some PHN contributions in this endeavor include:

Phelping to bring the right people to the table at the right time

Phelping partners understand the multiple determinants of health

Precognizing that conflict is okay

Plistening to and involving those to be affected in the decision process

Ppromoting consensus development
Punderstanding volunteerism and its inherent turnover
Pproviding information and analysis
Pplanning, developing, implementing, and evaluating community-based health services
Padvocating for health promoting policy.

Expert Opinion=48%

Lindeke, L., & Block, D. (1998, September/October). Maintaining professional integrity in the midst of interdisciplinary collaboration. *Nursing Outlook, 46*(5), 213-8.

The authors participated as nursing faculty in a teaching collaborative consisting of nine health care-related disciplines to demonstrate and test the belief that "better care results from interdisciplinary collaboration" (p. 213). They speak to often disparate underlying professional values experienced within multidisciplinary team functioning, which places different emphases on ethical principles related to patient care and creates competition among values. They also describe how this is exacerbated by the collision of differing professional paradigms. A large investment of time and energy was required to achieve collaboration within the team, with each member reaching an "understanding across disciplinary chasms [which finally resulted in] productive discourse, mutual respect, and creative thinking" (p. 214).

The authors identify four main sources of constraints working against achievement of true collaboration:

1. Communication Constraints: the language of interdisciplinary collaboration must reflect shared values, goals, processes, and outcomes, such as the use of "we" rather than "I," and "health care" rather than "medical care."
2. Power and Authority Constraints: In order to achieve the equalization of power within the team required for interdisciplinary collaboration, members had to work assertively to keep power negotiable.
3. Professional Constraints: Boundaries between disciplines are inherent due to differences in education, socialization, and the use of jargon. In addition, other disciplines find nursing's multiple educational pathways, specialties, and credentials difficult to comprehend.
4. Structural Constraints: Differences in salaries and access to reimbursement for services work against the development of interdisciplinary collaboration.

The resolution of these constraints lies in all disciplines, remaining focused on what the client needs, rather than what the discipline has to offer, while at the same time modeling the discipline's core values and principles.

For nursing, this means promoting the principle of client self-determination and choice in health care decision-making; demonstrating respect for human beings; the imperative of caring; advocacy (especially for disenfranchised and at-risk populations); an obligation toward person, family, and community; and promotion of personal and community empowerment. The authors end by acknowledging the potential interdisciplinary collaboration has for improving health care outcomes, but also recognizing the requirement for involvement of "mature professions with strong identities, self-confidence, and integrity" (p. 217).

Expert Opinion=42%

Himmelman, A. T. (1998, July/August). Inside/out change agents and community partnerships. *Healthcare Forum Journal,* 40-42.

This time writing from the perspective of hospitals participating in collaborative work, Himmelman offers the "Nine Principles for Community Partnerships":

1. Going against the grain involves personal risks.
2. You can't build bridges without a support based outside the institution.

3. Institutional commitment can be illusory.
4. Understand and effectively use or alter institutional rewards and sanctions about change.
5. Weeding out new ideas helps nurture those that will actually succeed.
6. Without broad and deep membership, the fabric of change is likely to unravel.
7. Languishing in a problem doesn't get it solved.
8. Expertise can be found almost anywhere.
9. Large societal issues cast a big shadow; ignore them at your peril.

Expert Opinion=38%

Bailey, D., & Koney, K. (1996, November). Interorganizational community-based collaboratives: A strategic response to shape the social work agenda. *Social Work, 41*(6), 602-610.

The authors propose that developing community-based collaboratives is essential to maximizing the capture of declining resources (i.e., "devolution") available to support human services, rather than competing for the same limited funding. The authors pose the term "interorganizational collaboratives" as the blanket term for all "interactive structures that emphasize the creation of a partnership among parties in which joint participation ideally leads to the achievement of a common goal" (p. 605). Thus, "collaboratives" in this case include consortia, coalitions, alliances, networks, or federations. Based on previous research, they offer eight core components of collaboration and describe related paradoxes:

Leadership

Leadership in collaboratives must be simultaneously assertive and responsive. Leaders must be pathfinders in the sense of seeing problems as possibilities and conflicts within the collaborative membership as complementary strengths: "Attending to the paradoxical nature of a collaborative's leadership by working with a sense of selflessness actually evokes a greater power of self" (p. 606).

Membership

Members of collaboratives must work with the collaborative leadership and be leaders themselves in their own organizations. The powerful vision of the collaborative effort serves as a powerful motivator to tolerate this paradox.

Environmental Linkages

Linkages with other organizations become critical in collaborative efforts, rather than ancillary, as they would be to a single organization. Evolution and change of linkages is collaboratives' lifeblood.

Strategy, Purpose, Task

The function of a collaborative effort is not to create an new organization, but to capitalize on the strengths of individual member organizations.

Structure and Systems

Effective interorganizational structures must be simultaneously rigid and loose, open and closed, in order to keep the shifting of power among the collaborating members balanced. Collaboratives must have a high tolerance for ambiguity, relative to their single-organization counterparts.

Expert Opinion=30%

Texts and Monographs

Public Health Practice Program Office. (1998). Principles of community engagement. Atlanta, GA: USDDHS/Centers for Disease Control and Promotion.
[Note: The entire document may be downloaded from CDC's Website at www.cdc.gov/phppo/dphs.]
The principles presented in this document are extracted from a broad literature review carried out by CDC in the mid-1990s in response to a growing recognition on the part of public health professionals that affecting or changing health-related behaviors of communities and their members requires the involvement. Literature reviewed focuses on the following key concepts: social ecology, cultural influences, community participation, community empowerment, capacity building, coalitions, social exchange theory, community organization, and stages of innovation diffusion.

Community engagement is defined as "the process of working collaboratively with groups of people who are affiliated by geographic proximity, special interest, or similar situations with respect to issues affecting their well-being" (p. 1/Executive Summary). The process of community engagement can take many forms, ranging from *cooperation*, where relationships are informal and where there may not necessarily be a commonly defined structure, to *collaboration*, or partnerships, where previously separate groups are brought together with full commitment to a common mission. *Coalitions* are viewed as "useful vehicles for mobilizing and using community assets for health decision-making and action" (p. 10/Part 1).

Principles of Engagement
1. Be clear about the purposes or goals of the engagement effort, and the populations and/or communities to be engaged.
2. Become knowledgeable about the community in terms of its economic conditions, political structures, norms and values, demographic trends, history, and experience with engagement efforts. Learn about the community's perceptions of those initiating the engagement activities.
3. Go into the community, establish relationships, build trust, work with the formal and informal leadership, and seek commitment from community organizations and leaders to create processes for community mobilization.
4. Remember and accept that community self-determination is the responsibility and right of all people it comprises. No external entity should assume it can bestow on a community the power to act in its own self-interest.
5. Partnering with the community is necessary to create change and improve health.
6. All aspects of community engagement must recognize and respect community diversity. Awareness of the various cultures of a community and other factors of diversity must be paramount in designing and implementing community engagement approaches.
7. Community engagement can only be sustained by identifying and mobilizing community assets, and by developing capacities and resources for community health decisions and action.
8. An engaging organization or individual change agent must be prepared to release control of actions or interventions to the community, and be flexible enough to meet the community's changing needs.
9. Community collaboration requires long-term commitment by the engaging organization and its partners.
[Note: The last 22 pages of the document describe eight successful community engagement case studies.]
Monograph=76%

Spradley, B., & Allender, J. (1996). Communication and collaboration in community health. In *Community health nursing: Concepts and practice* (4th ed). (pp. 291-299). Lippincott.

Collaboration is defined as a "purposeful interaction between nurses, clients, community members, and other professionals based on mutual articulation and joint effort" (p. 297). It is described through five key characteristics:

1. Shared goals: PHN partners with others to accomplish a joint task or achieve a common goal
2. Mutual participation: all partners (and especially the "client") contribute, resulting in a mutual exchange of resources
3. Maximized use of resources: effective collaboration requires the involvement of those with the most expertise, the most authority, the greatest access to funding, etc.
4. Clear responsibilities: each partner has a stated and understood set of tasks or activities for which he/she is responsible
5. Set boundaries: each partner is aware of time or task completion excitations, as well as the expected life cycle of the collaborative.

Phases of collaborative relationships:

1. Establishing and defining relationships among collaborating partners; includes establishing trust and developing communication patterns
2. Working toward achievement of shared goals
3. Terminating collaborative efforts when the task is completed or the goal achieved

At the individual/family level of practice, collaboration between the PHN and the "client" is most effective when a contract or negotiated work agreement is established. These are flexible and change, based on mutual understanding and trust. Characteristics of contracting include:

1. Partnership is articulated.
2. Commitment is implied.
3. Time and tasks or goals are stated or formatted.
4. It is always negotiated.

Sloan and Schommer's eight phases of contracting are provided as steps:

1. Explore needs; assess.
2. Establish goals.
3. Explore resources.
4. Develop plan.
5. Divide responsibilities.
6. Agree on a timeframe.
7. Evaluate (periodically and at end).
8. Renegotiate or terminate (p. 295).

[For further reading see: Sloan, M., & Schommer, B. (1991). The process of contracting in community nursing. In B. Spradley (Ed.). *Readings in Community Health Nursing* (4th ed.). Boston: Little, Brown.]

Text=76%

Stanhope, M., & Lancaster, J. (1984). *Community health nursing: Process and practice for promoting health.* St. Louis: Mosby, 357-358.

The authors conceive of collaboration as teamwork, either with other professionals or other organizations. They suggest collaboration requires the following knowledge base and attributes:

Knowledge	Attributes
group process	professional confidence
conflict resolution	respect for own ability
problem solving	flexibility
evaluation	trust in others' abilities
	sensitivity to different approaches to problem solving
	sensitivity to others' need for self-esteem acceptance of professional conflicts

Text=53%

Public Health Interventions

Applications for Public Health Nursing Practice

Coalition Building

Public Health Nursing Practice for the 21st Century

March 2001

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

INTERVENTION: COALITION BUILDING

***Interventions* are activities taken by PHNs on behalf of communities and the individuals and families living in them.**

Assumptions about all PHN Interventions...

- They are population-based; that is, they:
  - are focused on an entire population
  - are guided by an assessment of community health
  - consider broad determinants of health
  - consider all levels of prevention
  - consider all levels of practice
- The public health nursing process applies at all levels of practice.

Definition

Coalition building promotes and develops alliances among organizations or constituencies for a common purpose. It builds linkages, solves problems, and/or enhances local leadership to address health concerns.

Examples at All Practice Levels

Population-of-interest: *All adolescents and their parents*
Problem: *Early onset of sexual activity and unintended teen-age pregnancy*

Community Example:

During a high school class on sexual health, several students who were "mentors" in a mentor program for younger students indicated an interest in talking more about the role of "males" in teen pregnancy. They were fascinated with the concept of "male responsibility." This interest was largely due to several widely known incidences of males in the community fathering children with more than one girl. The PHN teaching the class facilitated a meeting of teachers and teens who had this interest. They formed a coalition to work with the teens who were mentors to middle-school students and incorporate messages of "male responsibility" into their mentoring activities.

Systems Example:

In partnership with the social worker who coordinates the "birth to teens program," the PHN brings together adolescents, parents of adolescents, organizations that work with teens, school personnel, and representatives of the faith community. They meet and discuss reasons for the community's increasing number of teen births. The group decides to meet again and identifies additional community members who might have an interest in teen pregnancy. They invite them to the next meeting. Several new community members join the original group for the second meeting. At its end, the group decides to form an ongoing coalition that eventually determines the community's response to the problem.

Individual/Family Example: *This intervention does not apply at this level.*

Relationships to Other Interventions

Collective action is the generic term for interventions characterized by groups of people or organizations that come together to address jointly issues that matter to them. Community organizing, coalition building, and collaboration are all examples of collective action and have many common features–especially at the community level of practice.

Like **community organizing and collaboration,** coalition building is one method of building collective action.

•**Similarities**

- *Empowerment* is an enabling process through which individuals or communities take control of their lives and their environment. It is a basic concept of collective action, although it is not always called "empowerment."
- Emphasis is placed on *"beginning where the people are."*
- Reliance on the process of *community engagement* at the level of community-focused practice; all reflect the principles of collective action *[see next Note from Abby, p. 3]*.

•**Differences**

- Unlike **community organizing**, coalition building may be brought about by outside organizations or influences rather than the community itself.
- Unlike **collaboration**, coalition building does not require enhancing the capacity of other organizations or constituencies within the coalition.
- It is *primarily a systems level of practice*.

Coalition building also relates to other interventions. Frequently, coalition building is used in conjunction with **policy development** to change the way systems in a community operate or community-held norms or beliefs. Coalition building is similar to **advocacy** at the systems or community level; coalitions often exist to implement advocacy at the systems or community level around a single issue. Coalitions may also use **outreach** interventions at the systems and community level to connect with their target populations; **social marketing** is often paired with outreach in these situations.

Notes from Abby

Collective action, or groups of people or organizations coming together for mutual gain or problem solving, is part of the American democratic tradition. Alexis de Tocqueville, writing in *Democracy in America* in 1840, noted: "...Americans are a peculiar people....If, in a local community, a citizen becomes aware of a human need that is not met, he thereupon discusses the situation with his neighbors. Suddenly a committee comes into existence. The committee thereupon begins to operate on behalf of the need, and a new common function is established. It is like watching a miracle."

Effective collective action generally incorporates the following principles, or tenets, as described by Leavitt and Herbert-Davis:

- *The whole is greater than the sum of its parts.*

  This assumption underlies all collective action. It acknowledges that the group process will increase the power of the collective, reflect the broadest perspective, and create a process that results in an outcome likely to be more innovative and comprehensive than if an individual acts alone.

- *While the goals and outcomes of collective action may vary, the process of coming together for joint action is the same.*

  The requirements of working together demand expertise in communication, negotiation, and conflict management.

- *All politics is local: organizing a collective at the local level has an impact on the national level more than the other way around.*

  Those closest to the problem or issue are most affected and, therefore, more likely to be committed to action.

- *All collective action involves a challenge to the existing power structure.*

  The resulting conflict is inevitable, and, since it can be anticipated, efforts should be made to depersonalize it. This is true whether the collective is between two individuals or two hundred. The most effective collective action finds ways to share power.

- *The goals of any collective action should include not only a change in a particular problem or issue but the empowerment of large numbers of people to be active participants in the process.*

  The ultimate goal of acting collectively is to empower those involved.

Source: "Collective Strategies for Action" (1993). by J.K. Leavitt and M. Herbert-Davis. In Mason, Talbott, and Leavitt (Eds). *Policy and politics for nurses: Action and change in the workplace, government, organizations and community* (2nd ed.), WB Saunders.

BASIC STEPS for Coalition Building [50]

Systems and Community Practice Levels

Working alone or with others, PHNs...

1. Decide whether or not to coalesce, that is, to come together.

This decision is based on:

- recognition of a community's need to respond to a perceived health issue
- recognition that a coalition would help fulfill an organization's goals
- estimation of resource requirements
- determination that dedicating resources to coalition building is the best use of those resources.

2. Recruit the right members.

Consider the following points:

- the goal of the coalition should determine the type of membership
- members should have authority to commit resources of the organization they represent
- size should be kept workable (for example, 12-18).
  - < A group larger than 20 people requires considerably more resources and will often take longer to develop group identity and common purpose
  - < At times it may be preferable to bring together a narrow group with more closely defined interests to accomplish objectives quickly and then broaden membership at a later time.

3. Devise a set of preliminary objectives and activities.

This step is critical to coming together around a common interest. The following points will guide you:

- all members should have a stake in the outcomes
- short-term reachable goals should be planned
- the realities of working with groups of individuals should be considered:
  - < It is not always possible to avoid "turf" struggles. However, coalitions should try to avoid exacerbating them. Formal and informal opportunities to understand differences in agency history, mandates, and funding may reduce turf struggles
  - < Select activities that coalition members will experience as successful–activities to which they can make unique contributions
  - < Make objectives compelling

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[50] Adapted from Cohen L., Baer N., & Satterwhite P. (1994, Spring). Developing effective coalitions: An eight-step guide, written for the Contra Costa County Health Services Department Prevention Program, Pleasant Hill, CA; also, the same source serves as the basis for Carl Helvie's chapter on community interventions in his text, *Advanced Practice Nursing in the Community* (1998). See also *From the ground up: A workbook on coalition building and community development.* (1997). Amhurst, MA: AHEC/Community Partners.

- < Be sensitive to the fact that coalition work is not the main job of coalition members, and keep assignments simple and achievable.
- < Keep reminding people that it is okay to say "no" or to set limits.

It may be helpful for staff of member agencies to communicate on a regular basis, clarify objectives, and assist one another with strategies.

4. Convene the coalition.

The convening group should present a strong proposal for the coalition's structure, mission, and membership at the initial meeting. Encouraging member response to a prepared proposal is usually more productive than expecting the group to create the proposal.

5. Anticipate human, material, and financial resources required to accomplish the goal.

Effective coalitions generally require minimal financial outlay for materials and supplies but require substantial time commitments from people. It is important to:

- Estimate how much of the work will be the responsibility of the lead agency and how much of the work to realistically expect of others. Anticipate that members will not always fulfill their commitments
- Be appreciative of what is done, rather than "moralistic" when people cannot accomplish everything they planned
- In calculating needed resources, estimate the hours needed per month for the following categories and then double that number:
  - < clerical
  - < meeting support
  - < membership support
  - < research and fact gathering
  - < public relations and public information
  - < coordination of activities
  - < fund-raising.

6. Select an appropriate structure.

The technical details of a coalition structure are vital to achieving success. Consider the following elements in designing the structure:

life expectancy of the coalition

- shorter term, single-purpose coalitions that intend to disband usually require less formal structures

location, frequency, and length of meetings

- poll members to see which times and locations present the least conflict in terms of both personal and work commitments
- avoid meeting times that cause members to face traffic jams and sites with difficult parking

membership criteria

- add vitality with new members
- provide an orientation session for new members to reduce their need to interrupt coalition meetings to catch up with the topics

decision-making process

- minimize complaints, maximize relevance, and encourage participation

agenda setting

- never lose track of the true purpose of the coalition; coalitions sometimes turn inward and begin discussing their own internal processes rather than resolving the community issue they came together to address

rules for participation

- State that the coalition's position represents the "opinion of the majority of participating groups"; in other words, sometimes the positions of the coalition need to be distanced from that of an individual member.

7. Maintain the vitality of the coalition.

Warning signs of coalition problems are not always easy to spot, since every coalition has ebbs and flows. Possible problems include:

- poor group dynamics
- membership or participation concerns
- focus on too many long-term goals without enough short-term "wins" to add energy to the group
- poor planning or inadequate resources that make goal attainment difficult
- external changes affecting the coalition's mission.

The following activities are important in avoiding problems:

- *sharing power and leadership*
  it is ironic that the characteristics that indicate a strong coalition–a heightened sense of collective identity and a high degree of commitment to collaborative work–can also exacerbate tension in defining the direction of the coalition
- *anticipating and dealing with conflict*
- *recruiting and involving new members*
  every member will bring to the coalition his or her own perspective; therefore, a broad framework, a common vocabulary, and a set of principles for participation must be presented early in the coalition's formation
- *providing training and challenging work*
  anticipate that coalition work is frustrating and exhausting at times; therefore, renewal opportunities need to be provided
- *celebrating successes*
  successes need to be celebrated and shared to maintain morale.

8. Make improvements through evaluation.

Evaluation should be an ongoing process throughout the life of a coalition.

Process evaluation considers the coalition's process of goal achievement (that is, formative evaluation). It includes such methods as:

- member surveys regarding satisfaction with participation
- content analysis of meeting agendas, minutes, and attendance lists.

Outcome evaluation asks whether the goals were achieved (that is, summative evaluation). Outcome evaluation focuses on what the coalition set out to do, as well as considers the need for continuation.

Notes from Abby

Stephen Fawcett and others at the University of Kansas have developed a handbook for evaluating and supporting community initiatives. It includes a monitoring system; constituent surveys of coalition goals, processes, and outcomes; goal attainment reports; behavioral change surveys; interviews with key participants; and community level indicators. Much of this handbook can be downloaded from their website <http://ctb.lsi.ukans.edu>. For further information, contact Workgroup on Health Promotion and Community Development. Phone: 785/864-0533

BEST PRACTICES for Coalition Building

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who blended evidence from the literature with their practice expertise to develop them. These best practices are <u>not</u> presented in any ranking or particular order; each may not apply to every implementation of the intervention.

1. PROMOTES THE SELECTION OF THE TYPE OF COALITION THAT BEST FITS THE MISSION AND PURPOSE.

Best Evidence: Butterfoss, Goodman, Wandersman; Roberts-DeGennaro, 1986b

PHNs considering coalition building should be clear about their expected outcomes from coalition participation.

Butterfoss and others suggest that coalitions form because members believe that working together collectively will have a greater impact than working alone. They also suggest that the type of coalition formed needs to "fit" its mission and purpose. Five types are described:

- *Membership-based:*
  grassroots, professional, or a combination
- *Composition-based:*
  organizations, citizens groups, or other coalitions
- *Patterns of formation:*
  in response to an opportunity or a threat
- *Functions-based:*
  (see the following paragraph on Roberts-DeGennaro)
- *Structure-based*:
  groups of networks of organizations, cooperating organizations, coordinating, and/or collaborating

Roberts-DeGennaro offers a somewhat different list of coalition categories based on functions:

- *Information and resource sharing*
  following a clearinghouse model, assisting in the referral process
- *Technical assistance provision*
  arranging workshops, proving training, conducting needs assessment and evaluation
- *Self-regulating*
  setting standards within the coalition for member organizations
- *Planning and coordinating*
  acting similar to the referral and follow-up intervention at the systems level
- *Advocacy coalitions*
  monitoring legislation, lobbying, etc.

2. CLARIFIES HOW LEADERSHIP WILL BE PROVIDED.
Best Evidence: Bailey; Leavitt; Roberts-DeGennaro, 1997; Wandersman et al., 1996

The importance of clearly identified, effective coalition leadership cannot be overstated. A leader with charismatic style or someone who can otherwise clearly state a coalition's mission in a way that easily recruits others is critical. This leader must emerge early in the development of a coalition. Since many times organizations or constituencies come together spontaneously in response to an issue or problem, leadership must often be prompted or negotiated. *This is a critical function and should not be left to a default process in which leadership falls to the person who resists the least.*

Leavitt and Herbert-Davis provide a list of qualities a leader should possess, including:

- Is able to motivate others
- Is capable of assuming numerous roles (such as recruiter, supporter, strategist, agitator, teacher, or spokesperson) as needed
- Possesses excellent communication skills (especially listening)
- Maintains the coalition's forward momentum by creating an atmosphere of trust, acceptance of diversity, and tolerance of criticism, conflict, and confusion
- Knows when to step down as leader

The authors note that in a coalition leader role *flexibility* is more critical than *familiarity* with the issue.

Cherie Brown provides a useful "checklist" for coalition leadership:[51]

- Has each person been approached by the leader in order to build a one-to-one relationship?
- Has support been built for the leader by:
  - encouraging members' personal responsibility?
  - arranging time for feedback?
  - arranging time for appreciation?
- Is the leader able to elicit each member's thoughts and then to draw those thoughts into a concrete program?
- Does the leader acknowledge and correct mistakes?
- Can the leader help the coalition move forward after defeats and in times of discouragement, recognizing the success it has achieved?
- Have one or more replacements been selected for leadership training?
- Does the leader understand the reason behind attacks from members and effectively respond to criticism?
- Is the leader willing to disband the coalition when it has outlived its usefulness?

[51] Minkler, M. (Ed.). (1997). Appendix 3: Coalition checklist. In *Community organizing and community building for health* (pp. 359-365). Brunswick, NJ: Rutgers Univ. Press.

3. ADVOCATES FOR THE DEVELOPMENT OF FORMALIZED RULES, ROLES, AND PROCEDURES.
Best Evidence: Wandersman and others, 1997

Coalitions are more likely to be successful in reaching their goals if the "ways of doing the business" of the coalition are mutually understood, agreed upon, and stated. Wandersman and others' analysis of coalitions clearly linked the existence of rules, roles, and procedures with sustaining coalitions over time.

4. PROMOTES RECRUITMENT OF THE RIGHT POOL OF MEMBERS.
Best Evidence: Bailey; McFarlane et al.; Parker

Coalitions are only as good as their members and commitment. Recruitment needs to be ongoing, as membership is usually fluid. In other words, members will join and leave over time, as they believe the coalition continues to meet or no longer meet their own interests.

McFarlane and others, for instance, found that their coalition to improve prenatal care to pregnant Hispanic women in a Texas community required membership representation from diverse organizations outside, as well as within, the Hispanic community.

Likewise, Parker and others reviewed four North Carolina prevention coalitions and found factors, including critical to coalition-building success. These findings include:

- the most effective coalitions recruited and retained members from business, clergy, various citizen groups, police, volunteer organizations, and the university and medical sectors
- representatives of one minority group cannot be expected to represent the interests of others
- members' continuation in a coalition is dependent on their perception that the benefits to their organization outweigh the cost of staying involved
- ongoing participation is related to a high level of trust among coalition members
- members representing their organizations must also keep interest in a coalition alive within their own organizations (p. 29-32).

5. COMPARES THE BENEFITS OF COALITION MEMBERSHIP TO ITS FORMAL AND INFORMAL COSTS.
Best Evidence: Bailey; Checkoway; Roberts-DeGennaro, 1986a; Roberts-DeGennaro, 1986b; Parker

Trade-offs between benefits and costs of involvement determine the value of a coalition to its members. This is clearly a key characteristic of coalitions. Organizations and constituencies will join and maintain involvement to the extent that their own goals are met in the process.

What is considered of "value," however, is not always clear. Leavitt and Herbert-Davis, for instance, point out that organizations and constituencies do not always join coalitions for altruistic reasons.

Therefore, coalition leadership should be vigilant for signs of:

- hidden agendas
- differences in preferences for styles of action
- polarization around issues of racism, elitism, insensitivity to member limitations, or general intolerance of differences
- members forwarding their own personal views rather than that of the organization or interest they represent.

6. RELATES MEMBER COMMITMENT TO MEMBER SATISFACTION.

Best Evidence: Butterfoss, Goodman, Wandersman, Parker

Commitment to a coalition is clearly related to member satisfaction, which, in turn, is related to factors in the organizational climate, such as:

- positive relationships among members
- provision of adequate orientation to the coalition and the way it works
- clear understanding of role and function differences between staff and members
- open communication patterns
- clear and effective methods for decision-making, problem-solving, and conflict resolution

In *Community Organizing and Community Building for Health*,[52] Gillian Kaye proposes the "Six R's of Participation" that lead to coalition member satisfaction:

- *Recognition*
  both formal (for example, dinners, plaques) and informal (for example, praising contributions in a public meeting) methods are effective
- *Respect*
  respect is often shown in small ways, like scheduling meetings when members can attend, providing child care, etc.
- *Role*
  coalitions and their members must have real power and substance, not just represent "tokenism"
- *Relationship*
  coalitions should provide real opportunities for networking with other institutions and leaders
- *Reward*
  coalitions need to identify both the public and private reasons individuals have for joining and respond to those interests
- *Results*
  coalitions that cannot deliver on their goals and purposes will find dissatisfaction among their members.

[52] See *Minkler, M. (Ed.). (1997). Community organization and community building for health* (pp. 372-373). New Brunswick, NJ: Rutgers Univ. Press.

7. FACILITATES LINKAGES BETWEEN THE COALITION AND THE BROADER COMMUNITY.

Best Evidence: Butterfoss et al; Leavitt and Herbert-Davis

Effective coalitions maintain linkages with resources beyond those of their members' direct contributions, such as access to elected officials or government agencies, ties with religious or civic groups, and memberships in other neighborhood and community organizations. These linkages are essential to coalition survival, as they supply materials and expertise a coalition might not otherwise be able to afford. These include "loaned" expertise, free meeting space, mailing lists, loaned equipment, sponsorship of speakers for meetings, etc. Coalition members who provide these links to other resources are called "linking pins" and are as valuable to coalitions as gifts of money. The PHN can serve as a linking pin to the rest of the health care system.

BEST EVIDENCE for Coalition Building

Each item was first reviewed for research quality and integrity by graduate students in public health nursing and then critiqued for its application to practice by at least two members of a panel of practice and academic experts. The nature of the material and a score expressed as a percentage are included at the end of each annotated citation. The percentage is the average of scores assessed by the experts who reviewed it. It reflects their opinion of the strength of the item's contribution to practice.

Review Articles

Wandersman, A., Goodman, R., & Butterfoss, F. (1997). Understanding coalitions and how they operate: An 'open systems' organizational framework. In M. Minkler (Ed.), ***Community organizing and community building for health*** **(pp. 261-277). New York: Rutgers Univ. Press.**

The authors suggest it is useful to think of coalitions (and partnerships and consortia) as organizations and apply Katz and Kahn's open-systems framework to advance the understanding of them. Coalitions are defined as "interorganizational, cooperative, and synergistic working alliances" (p. 263) which serve several purposes. [Note: Katz D and Kahn R *The Social Psychology of Organizations 2nd Ed* (New York: Wiley) 1978]

Coalitions as organizations are seen as having four components or requirements:

1. Resource Acquisition
   a. Member resources (a coalition's main asset); should be considered in terms of size, depth of members' commitment to the coalition's mission, and members' personal and political skills and abilities
   b. External resources' can be examined in four classes: degree of formalization of the relationship with the external resource, the degree to which the procedure for linking with the external resources is standardized, the intensity of the relationship, and the degree of reciprocity (i.e., the degree of mutual exchange of resources).
2. Maintenance Subsystem
   a. Strong central leadership
   b. Formalized rules, roles, and procedures
   c. Defined decision-making and problem-resolution processes (conflict is inherent in coalitions due to the mixed loyalties of the members, i.e., to both their own organizations and the coalition; the autonomy required by a coalition at the same time accountable to its member organizations; the lack of clarity regarding the coalition's purpose; and the diversity of members' interests)
   d. Volunteer-staff relationships (this requires the ability to balance staff provision of technical assistance to the membership with the members' ability to make informed decisions)
   e. Open communications patterns (frequently implemented via meetings with members) and well-developed internal communication methods
   f. Membership commitment and mobilization (the benefits to the member organizations for participation in the coalition must be perceived as outweighing the costs of involvement.
3. Production Subsystem
   a. Target activities (i.e., those that work directly toward the coalition's intended goals and products)
   b. Maintenance activities (i.e., recruitment and orientation of new members, leadership training, conflict resolution, public relations, celebration of accomplishments, fundraising)

c. Resolution of the inherent tension between target and maintenance activities

4. External Goal Attainment
   a. Short- and long-term change measurement
   b. Addressing evaluation challenges presented by the complexity of coalition work
   c. Addressing the challenge repeating the successful activities and programs which results in institutionalization of the program or community organizing effort.

The authors conclude that "...there is enough research and experience to suggest that if a coalition is to be successful, there has to be an *organization* of roles and people. The *resources* of a coalition (its greatest potential) must be organized in a *structure* that clarifies roles and relationships and produces *activities* that work toward the goals of the coalition and sustain and renew the organization. A successful coalition yields perceivable *accomplishments* an *impacts"* (p. 274).
Review=34%

Research Reports

Parker, E., Eng, E., Laraia, B. et al. (1998). Coalition building for prevention: Lessons learned from the North Carolina community-based public health initiative. *J Public Health Management Practice 4*(2), 25-36.

The authors identify six factors important to coalition functioning and success, based on findings of a four-year observation of four separate North Carolina county coalitions funded by the Kellogg Foundation's Community-Based Public Health Initiative. Rather than focusing on prevention of a specific disease category, this study looked at aspects of coalition development itself. The authors applied Alter and Hage's framework to conceptualize how stages and levels of collaboration are operationalized in coalition functioning, and they found six factors which affected it:

1. Participation
   a. more effective coalitions (for health promotion) were able to recruit and retain members from business, clergy, senior citizen groups, police, volunteer groups, parent groups, other groups, and the university and medical sectors
   b. representatives of minority groups cannot be expected to represent the interests of other minorities in a coalition
   c. members' continuation in a coalition is dependent on their perception of the benefits to their organization versus the costs to them of staying involved
   d. ongoing participation is related to a high level of trust among coalition members; sufficient time must be allowed for this to develop
   e. members representing their organizations must also keep the interest in the coalition alive within their own organizations
2. Communication
   a. more effective coalitions develop good formal communication methods
   b. effective informal communication is also important and facilitated by the presence of a conducive environment (i.e., minimum use of professional jargon, solicitation of ideas and comments from community members)

3. Governance System
    a. This system clarifies roles of the organizational partners and that of staff and establishes accountability
    b. It designs operating procedures and identifies the need for and procures technical assistance and leadership training
4. Staff-coalition member relationships must balance staff autonomy with coalition oversight
5. Technical assistance and leadership training must be provided
6. The capacity to recognize and deal with conflict must exist.

Qualitative=68.5%

Roberts-DeGennaro, M. (1986). Factors contributing to coalition maintenance. *J Sociology and Social Welfare, 13,* 248-264.

The author looked at factors related to perpetuation of coalitions over time. Through a case-study analysis of the Community Congress of San Diego, a longstanding coalition, the author concluded that survival of a coalition depends on the extent to which member organizations are convinced of the payoffs of committing resources to it.
Qualitative=40%

Expert Opinion

Roberts-DeGennaro, M. (1997). Conceptual framework for coalitions in an organizational context. In M. Weil & M. Newsome (Eds), *Community practice–Models in action* (pp. 91-107). Birminghamton, NY: Haworth Press. [Note: This same article was also published in (1997). *J. of Community Practice, 4*(1), 9-107]

Coalition is defined as an "interacting group of organizational actors who a) agree to pursue a common goal, b) coordinate their resources in attempting to achieve this goal, and c) adopt a common strategy in pursuing this goal" (p. 92). Coalitions form to realize three major advantages:

1. Coalitions can exert more power and influence and mobilize more resources than a single organization.
2. Participation exposes members to alternative strategies applicable in future situations.
3. Provides access to information either more quickly and/or otherwise not accessible.

The author presents five coalition models adapted from the work of Croan and Lee. Coalitions may exist to perform many of these models' functions simultaneously. [Note: see Croan G and Lees J *Building Effective Coalitions: Some Planning Considerations* (Arlington, VA: Westinghouse National Issues Center) 1979]:

1. Information and Resource-Sharing Coalitions

These act as a clearinghouse to gather and disseminate information, arrange forums, develop systems to share resources, and assist in the referral process.

2. Technical Assistance Coalitions

These deliver technical services such as arranging workshops, providing grantsmanship and training, and/or conducting needs assessment and evaluation

3. Self-Regulating Coalitions

These set standards for member organizations by designing evaluation systems, monitoring members, providing certification, recommending systems for allocating funds, etc.

4. Planning and Coordinating Services Coalitions

These act as service coordinators and carry out such activities as conducting service inventories in communities, establishing master calendars, providing liaison with other groups, and developing information and referral systems

5. Advocacy Coalitions

These act as change agents and function to monitor legislation and policy-making bodies, organize public education campaigns, conduct lobbying efforts, etc.

Based on her review of these works, the author offers their practice considerations:

1. The author notes that if decisions become too controversial within a coalition, or go beyond broad issues of value and strategies, the coalition may need to change its structure, including its purpose and functions. Turnover among members often precipitates this redefinition
2. As turnover naturally occurs, an "organizing ideology needs to promote the spirit of connected ness and solidarity among members" (p. 104) in order to promote the stability necessary for the coalition's strategic effectiveness
3. Stable leadership is essential for a coalition's long-term effectiveness, and, therefore, transition of leadership needs to be planned whenever possible.

Expert Opinion=86%

McFarlane, J., Kelly, E., et al. (1994). De madres a madres: Women building community coalitions for health. *Health Care for Women International, 15,* 465-476.

The authors present a compelling case study of the development of De Madres a Madres, a project of the Texas Woman's University College of Nursing. Its intent was to develop outreach coalitions or networks enabling pregnant women to obtain early prenatal care. The coalition consisted of members from businesses, health and social service agencies, schools, and churches and relied on community health nurses training and supervising Latina women, mothers themselves, to work with other women in their communities. They found that the training and support provided to the community workers increased their sense of self-worth which, in turn, empowered them to reach out to other groups and organizations within the community to advance the cause of improved prenatal care.

Expert Opinion=77%

Butterfoss, F., Goodman, R., & Wandersman, A. (1993). Community coalitions for prevention and health promotion. *Health Education Research Theory and Practice, 8*(3), 315-330.

The authors review the literature as published in an attempt to provide a "systematized" understanding of coalitions" and pinpoint areas of needed research. They define coalitions as inter-organizational, cooperative, synergistic working alliances that unite individuals and groups in shared purpose over a sustained period of time. The authors consider coalition outcomes. Ultimate indicators of effectiveness reflect a coalition's attainment of its mission, goals, and objectives. Success as a "quick-fix" can often buy time to do a more thorough investigation, as through the application of evaluation methods. They also examine the importance of coalitions, types of coalitions, and contributing factors:

Importance of Coalitions

1. enable organizations to become more broadly involved without having sole responsibility
2. demonstrate and develop widespread public support for issues

3. maximize the power of individuals and groups through joint action
4. minimize duplication of effort and services
5. mobilize more talent, resources, and approaches to influence
6. provide an avenue for recruiting participants from diverse constituencies
7. permit exploitation of new resources in changing situations, due to their flexibility.

Types of Coalitions

1. Coalitions based on membership
    a. grassroots
    b. professional
    c. community-based (i.e., grassroots and professional)
2. Coalitions based on composition
    a. numbers of members
    b. types (i.e., other coalitions, organizations, individuals, combinations)
    c. degree of participation (i.e., core versus peripheral)
3. Coalitions based on patterns of formation (i.e., response to an opportunity or perceived adversity)
4. Coalitions based on the functions they fulfill for members
    a. information and resource sharing
    b. technical assistance
    c. self-regulation
    d. planning and coordination of services
    e. advocacy
    f. multiple functions
5. Coalitions based on organizational structure
    a. organizational-set (i.e., groups of cooperating organizations that provide resources or services under an umbrella organization)
    b. network coalitions (i.e., subgroups of organizations within an organizational system)
    c. action-set (i.e., accomplish a single purpose or common identity)

Contributing Factors

1. the current literature is predominantly "wisdom literature," meaning it is largely anecdotal and tends to be based on experiences and impressions of what seems to work
2. coalition development progresses in stages; at each stage of development, different sets of factors may be important in enhancing coalition functioning
    a. formation: stimulated by existing positive attitudes, recognition of mutual need, resource scarcity, failure of existing efforts, inspirational leadership, previous history of compatibility and ability to maintain linkages; facilitated by clear articulation of guiding mission or purpose
    b. implementation and maintenance: enhanced by the presence of formalized rules, roles, and procedures; strong central leadership; members whose combined talents and assets are equal to the coalition requirements; members' perception that the benefits of involvement outweigh the costs; satisfied and committed members; members' skills and training
3. organizational climate, or the relationship among coalition members, depends on several factors.
    a. positive relationships exist among members

b. clear understanding of the role differences between staff and members
c. open communication patterns
d. decision-making, problem-solving, and conflict-resolution processes are effective and working

4. external supports and community linkages affect
   a. formalization (i.e., official recognition?)
   b. standardization (i.e., linking procedures proscribed?)
   c. intensity (i.e., frequency and flow)
   d. reciprocity
   e. effective linkages with and access to communities.

Expert Opinion=54%

Wandersman, A., Valois, R., et al. (1996). Toward a social ecology of community coalitions. *Am. J. Health Promotion, 10*(4), 299-307.

The authors suggest that a key tenet of current health promotion thought is that "targeting the behavior of individual without also intervening at thee other social levels that shape behavior will produce less of an impact on health status" (p. 300). They call this the "social ecological perspective" on health promotion for which coalitions serve as a key vehicle. Coalitions work across multiple domains to effect change, depend on a community context, and recognize capturing the support of key community leaders as leaders as essential. The authors provide reasons for coalition development as gleaned from current literature:

1. enables organizations to become involved with broader issues without having to take on the sole responsibility
2. develops widespread support
3. maximize the power and influence of any one person or group
4. minimizes duplication of effort
5. mobilizes more talents, resources, and approaches than any one organization could achieve
6. facilitates recruitment from diverse constituencies
7. exploits newly available resources because of its flexibility.

Contextual variables necessary to consider in developing coalitions:

1. Sociopolitical Context:
   - •density of population
   - •diversity
   - •racial conflict and tension
   - •community stability
   - •patterns and history of power distribution
   - •stage of community development
   - •extension of public resources
   - •external community forces
2. Socioeconomic Context
   - •unemployment/jobs/job base
   - •poverty level/income distribution
   - •age/gender distribution

- •tax base
- •education attainment
- •citizenship
- •community exploitation/neglect
- •maturation of business base
- •availability of housing units
- •community transiency
- •housing density
- •family structure

3. Community Health Concern Context
   - •measures of abuse, duration, and prevalence of controlled substances
   - •extent of community awareness/denial
   - •measures of community mental health (i.e., domestic abuse rates, suicide, sexual abuse, gambling)
   - •community violence
   - •sexual norms
   - •extent of lawlessness/civility
4. Community Infrastructure
   - •churches/houses of worship
   - •physical infrastructure
   - •recreational services
   - •educational services
   - •criminal justices services
   - •fire
   - •distance to neighboring community
   - •transportation needs.

Expert Opinion=46%

Hoffman, S. (1998, July/Aug). The three new C's for nursing–Collaboration, cooperation, and coalition (editorial). *J. of Professional Nursing, 1494,* 194.

Although speaking to nursing education, Hoffman asserts that to thrive during this time of "constant change with concomitant chaos" in health care, nursing must do more *collaboration* (the "highest form of partnering because it initiates new shared structures"), *cooperative ventures* (where each cooperator retains organizational authority and separate resources), and/or *coalition development* (that is, a "union of organizations that maintain their own identify by working together to influence a particular outcome"). Hoffman states that increased use of these three partnering methods indicates a "maturation of the profession of nursing" which will be "foundational to our efforts to increase our influence...."

Expert Opinion=44.5%

Roberts-DeGennaro, M. (1986, July/August). Building coalitions for political advocacy. *Social Work,* 308-311.

The author proposes that human service organizations could realize increased political influence by joining efforts as a coalition to increase the power base. She refers to these as "advocacy coalitions" (p. 308). She suggests they are particularly needed as "the users of community-based services are generally unrepresented or under-

represented in the political process....” (p. 308). The author offers the following tips:

1. Coalitions work best when the scope of the forming issue is specific and time-bound, making it easier for organizations with potentially conflicting interests to set aside that potential for the greater good to be achieved through collective action. The longer the coalition must be maintained in order to achieve the common goal, the more prepared its leadership must be to deal with internal conflict
2. Establishing clarity of the central purpose of coming together must be equal in each member organization’s perspective, meaning each is aware of what they will gain in the process and what they might have to give up
3. The coalition must be able to translate their concerns into specific suggestions for policy direction that are acceptable to the majority of coalition members.

Expert Opinion=33%

Bailey, D., & Koney, K. (1995). Community-based consortia: One model for creation and development. *J. Community Practice, 2*(1), 21-42.

The authors adopt Mizrahi and Rosenthal’s distinction between a consortium and a coalition: consortia include residents from the community who do not represent any particular organization, whereas coalitions are almost always made up of organizational representatives; a consortium’s agenda is shaped by input from the community’s residents, not the organizations within the community. However, they also acknowledge that most authors use consortium and coalition interchangeably and that, in terms of development, the processes for each are similar. The four phases of consortium development are:

1. *Assembling:* a leader is either designated by the members or emerges. The leader’s first task is to recruit members, which requires a clear understanding of the consortium’s purpose and goals. The leader must also be aware of areas of perceived agreement and disagreement among the assembled stakeholders and anticipate how these will affect decision-making activities
2. *Ordering*: the group establishes operational mechanisms for conflict resolution, task assignments, flow of information, task evaluation, etc. Intense communication among stakeholders is expected during this phase, as well as turnover of members, and recruitment and integration of new members into the stakeholder group
3. *Performing:* the group first assures stakeholders understand the costs and benefits of membership, their expected roles, and the way they fit into the larger context of contributing to a greater good; compromise, collaboration, and creativity are required
4. *Ending:* evaluation findings are used to decide whether the consortium’s work is complete or requires further action; if so, the cycle is begun again from the beginning.

[Note: The authors also published a background paper on how the framework was developed and an article evaluating community-based consortia. For further reading, see respectively: “Developing Community-based Consortia: An Interactive Framework” (Cleveland, OH: Case Western Reserve

University/Mandel School of Applied Social Science) August 1992 and “An Integrative Framework for the Evaluation of Community-Based Consortia” in *Evaluation and Program Planning* 18(3) 1995; 245-252]
Expert Opinion=31%

Texts and Monographs

Helvie, C. (1998). Community interventions. In *Advanced practice nursing in the community* (pp. 327-357). Thousand Oaks, CA: Sage.

Helvie offers coalition building as one of three discussions on community level interventions. He defines coalitions as "composed of individuals and organizations working on a specific problem and having goals and plans to influence an outcome" (p. 336). Helvie suggests that Nelson's resource mobilization theory is appropriate for understanding coalitions: a coalition's outcomes are a result of its activities and processes, both of which are dependent on two factors, support from other organizations and the political climate in which the coalition exists. Helvie offers Cohen et al.'s eight steps for building effective coalitions [Cohen, Baer, O'Keefe *Developing Effective Coalitions: An Eight Step Guide* (Contra Costa, CA: Contra Costa Co. Health Services Dept.) 1991]. They are:

1. The decision is made to form or join a coalition.
    a. recognizing that a community need exists for which a coalition would be an appropriate response
        - to influence policy or legislation
        - to change the practices of an organization
        - to foster coalitions and networks
        - to educate providers
        - to promote education of the community
        - to strengthen the knowledge and skills of individuals
    b. recognizing that a coalition will facilitate goal fulfillment
    c. meeting a grant requirement or initiating a conference outcome project
2. Recruiting the right members (i.e., members of groups with similar goals and interests, including representatives of influential or supportive organizations, as well as those who might be considered obstacles) and the right number of members is key (i.e., while membership size should be influenced by the tasks involved; beyond 15 members, greater resources will be required)
3. Establishing preliminary objectives and activities that meet the needs of the participating organizations is accomplished
4. The lead agency convenes a meeting for potential coalition members
5. Resource needs and potential sources are identified
6. Structural issues are considered and determined
7. Processes to promote coalition vitality are initiated (e.g., conflict resolution methods, determination of how power and leadership will be shared, recruitment and involvement of new members, provision of training and idea infusion, etc.)
8. Effectiveness is improved through evaluation.

Text=70.5%

Leavitt, J. & Herbert-Davis, M. (1993). Collective strategies for action. In Mason, Talbott, & Leavitt (Eds.), *Policy and Politics for Nurses: Action and Change in the Workplace, Government, Organizations and Community (2nd ed)* (pp. 166-178). WB Saunders.

The authors differentiate between a *collective* ("a group that is brought together to pursue an agreed-upon goals, action, or set of actions") and a *coalition* ("a collective that is characterized as a temporary alliance of diverse

members who come together for joint action in support of a defined goal") (p. 166).
They propose five *"basic tenets" or "principles"* of acting collectively:

1. The whole is greater than the sum of its parts....Group process strengthens the collectives, reflects the broader perspective, and creates a process resulting in an outcome more likely to be innovated and comprehensive than would an individual acting alone. This makes collectives consisting of diverse communities often the most effective–but also the most difficult to form.
2. While the goals and strategies may differ, the process of forming and using them is the same.
3. All politics is local: organizing a collective at the local level can have more impact at the national level than the other way around. If those most impacted cannot be mobilized, engaging others at more removed levels is impossible.
4. All collective action involves a challenge to existing power structures and results in an effort to take or share power. Therefore, conflict is inevitable. Those participating in collective action most be prepared to effectively manage conflict by finding ways to share rather than take power away.
5. The goals of any collective action should include not only a change in a situation, but also the empowerment of large numbers of people. The result is continuing capacity for participating in social policy decisions.

Elements of an Effective Coalition:

1. Possesses a clear understanding of why it is needed
    a. to acquire a power base which exceeds that of one person attempting to act alone?
    b. to build a base of support?
    c. to prevent another group from challenging a plan?
    d. a combination of the above?
2. Possesses a clear understanding of what is to be accomplished through collective action, reflecting the values and ideas of the membership
3. Consists of groups that share an interest in the outcome because they view their own group's needs will be met in the process
4. Formed through networking or the process of developing connections with friends, colleagues, and strangers who are committed to a mutual goal more than to any sense of personal relationships with others in the group.
5. Has a critical sense of timing
    a. knows when to recruit for the issue and when to time the action
    b. knows how to frame the issue to have meaning and be of immediate concern for those being invited to join the coalition
    c. plans the action to be proactive rather than reactive
    d. times the action to enhance public awareness and support
6. A single leader must emerge or be designated who can keep the long-term perspective for the coalition and provide an unifying voice. The leader must:
    a. motivate others
    b. be capable of assuming numerous roles as needed (i.e., recruiter, supporter, strategist, agitator, teacher, spokesperson) [Note: In a coalition, leaders' role flexibility is seen as more important than familiarity with the issues or facts about the plan.]
    c. excel in communication skills (especially listening) and group process

d. maintain a forward momentum for the coalition by creating an atmosphere of trust and acceptance of diversity, toleration of criticism, conflict, and confusion
e. know when to step down as leader.

Coalition *Strategies:*

1. Shaping the message, such as developing a slogan, which motivates the membership and identifies the coalition's purpose
2. Keeping the goal in view while developing the specific activities
   a. requires thorough research of the issue, the implications, and the impact
   b. accommodates the interests of each member of the coalition
   c. utilizes a process that involves constituent members so they better "own" the final plan
   d. establishes a process of giving approval for the coalition's actions
   e. analyzes resources available
   f. states the goal and plan as specifically as possible, knowing that the narrower the goal, the more likely the success
   g. creates "fall back" plans for each action
   h. encourages members to take responsibility for a given step
   i. establishes realistic timetables
   j. develops effective methods for ongoing communication within the coalition
   k. builds in sufficient time to allow board action from participating groups and organizations
   l. deals with interpersonal conflicts openly and promptly
   m. keeps detained records
3. Being prepared to deal with internal opposition through consensus development (preferred) or conflict resolution methods (last resort). Sources of opposition:
   a. hidden agendas
   b. differences among member organizations' styles of action
   c. polarization among members around racism, elitism, insensitivity to limitations of members, and/or intolerance
   d. presentation of members' personal views rather than those of the organization or interest they represent (i.e., new members need orientation)
   e. reluctance to disband the coalition when its goal is achieved.

Text=21.5%

Checkoway. (1987). Political strategy for social planning. In F. Cox (Ed.), *Strategies of community organization (4th ed.)* (p. 335). Itasca IL: Peacock Publishers.

Coalitions are defined as "working relationships which unite individuals or groups around a common purpose. They may be short-term or relatively permanent, voluntary and occasional, or professionalized and staffed. They are important for individuals seeking to share resources and generate power beyond reach of what each could accomplish alone....Coalitions face obstacles and have costs, but the costs should be weighed against benefits during turbulent times."

Text=ratings not available

Lewis, J., Lewis, M. et al. (1998). *Community counseling: Empowerment strategies for a diverse society (2nd ed.)* (pp. 194-198). Brooks/Cole Publishing.

Coalition is defined as a "group of organizations working together for a common purpose. The combined resources of these groups can have a greater impact than can the same constituency groups working by themselves" (p. 194). The authors suggest three stages of coalition building exist:

1. Planning, where constituency groups with a common interest and stake are identified
2. Consultation, where representatives from the various organizations must discuss the ways in which joining into a coalition with others will benefit each constituency
3. Planning and Implementation, where the level of interest and commitment to the coalition's goals are determined. Coalition success depends on all members owning the work they agree to do which, in turn, depends on they extent to which the member organizations feel they have received the opportunity to express their views and feel their views have been heard and respected by the other members.

Text=not available

Public Health Interventions

Applications for Public Health Nursing Practice

Community Organizing

Public Health Nursing Practice for the 21st Century

March 2001

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

INTERVENTION: COMMUNITY ORGANIZING

Interventions **are activities taken by PHNs on behalf of communities and the individuals and families living in them.**

Assumptions about all PHN Interventions...

- They are population-based; that is, they:
  - Are focused on an entire population
  - Are guided by an assessment of community health
  - Consider broad determinants of health
  - Consider all levels of prevention
  - Consider all levels of practice
- The public health nursing process applies at all levels of practice.

Definition

Community organizing helps community groups identify common problems or goals, mobilize resources, and develop and implement strategies for reaching the goals they collectively have set.[53]

Examples at All Practice Levels

Population-of-interest: *All adolescents and their parents*
Problem: *Potential for or use of alcohol*

Community Example:

Parents of teens in the community were outraged when two teens were seriously injured after attending a party at a teen's home where the parents had supplied alcohol. The parents intended to "collect car keys" from everyone at the party, but obviously failed to do so. The PHN approached a parent committee from the school to see if they would be willing to help organize a parent-led community effort to address the alcohol issue parent to parent. The PHN suggested they frame the issue as, "Why do adults, especially parents, supply minors with alcohol?" (instead of the more typical "Why do teens drink?"). He also helped the group identify ways to reach parents who were not typically involved in school projects, and helped them identify strategies that had worked in other places. The group's goal was to convince parents of adolescents that it was not okay for them to supply teens with alcohol, and to challenge the idea that "teens were going to drink anyway, so they would be safer drinking at home." A community survey indicated that the percentage of parents who thought it was "okay" for teens to drink in their own homes went from 75 percent to 60 percent over a two-year period. The parent-led group continues, with the PHN functioning as an advisor. The group's next project targets the issue of adult use of alcohol in the community and its influence on adolescent alcohol use.

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[53] Minkler, M. (Ed.). (1997). *Community organizing and community building for health.* New Brunswick, NJ: Rutgers Univ. Press, p. 30.

Systems Example:

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.

Individual/Family Example: *This intervention does not apply at this practice level***.**

Relationships to Other Interventions

Collective action is the generic term for interventions characterized by groups of people or organizations that come together jointly to address issues that matter to them. Community organizing, coalition building, and collaboration are all examples of collective action. Because of this, they share many common features–especially at the community level of practice.

Like **coalition building and collaboration,** community organizing is one method of building collective action.

•**Similarities**

- *Empowerment* is an enabling process through which individuals or communities take control of their lives and their environment. It is a basic concept of collective action, although it is not always called "empowerment"
- Emphasis is placed on *"beginning where the people are"*
- The process of *community engagement* is relied upon at the level of community-focused practice; all reflect the principles of collective action *[see next note from Abby]*.

•**Differences**

- The *impetus* for community organizing must be identified by the community itself and not by an outside organization or change agent
- Unlike **collaboration**, community organizing does not intend to provide opportunities for organizational or personal transformation
- Unlike **collaboration**, community organizing does not occur at the individual/family-focus level of practice
- It is *primarily a community level of practice*.

Community organizing also relates to other interventions. Successful methods for implementing the **outreach** intervention at the systems and community practice levels–such as identifying and specifying the issue of concern, describing the target population, and considering demographic implications, are similar to the initial steps in community organizing. Community organizing often uses **social marketing** as a companion intervention when the community organizing intent is to change a population's health behavior. Community organizing is also implemented in conjunction with the **policy development** intervention, especially when the organizing intent is to change policy at the systems level.

Notes from Abby

Collective action, or groups of people or organizations coming together for mutual gain or problem solving, is part of the American democratic tradition. Alexis de Tocqueville, writing in *Democracy in America* (1840), noted: "...Americans are a peculiar people....If, in a local community, a citizen becomes aware of a human need that is not met, he thereupon discusses the situation with his neighbors. Suddenly a committee comes into existence. The committee thereupon begins to operate on behalf of the need, and a new common function is established. It is like watching a miracle."

Effective collective action generally incorporates the following principles, or tenets, described by Leavitt and Herbert-Davis:

- *The whole is greater than the sum of its parts.*

  This is the underlying assumption of all collective action. It acknowledges that the group process will increase the power of the collective, reflect the broadest perspective, and create a process that results in an outcome that is likely to be more innovative and comprehensive than an individual acting alone.
- *While the goals and outcomes of collective action may vary, the process of coming together for joint action is the same.*

  The requirements of working together demand expertise in communication, negotiation, and conflict management.
- *All politics is local: organizing a collective at the local level has an impact on the national level more than the other way around.*

  Those closest to the problem or issue are most affected and, therefore, more likely to be committed to action.
- *All collective action involves a challenge to the existing power structure.*

  The resulting conflict is inevitable, and, since it can be anticipated, efforts should be made to depersonalize it. This is true whether the collective is between two individuals or two hundred. The most effective collective action finds ways to share power.
- *The goals of any collective action should include not only a change in a particular problem or issue, but the empowerment of large numbers of people to be active participants in the process.*

  The ultimate goal of acting collectively is to empower those involved.

Source: Leavitt, J.K., & Herbert-Davis, M. (1993). Collective strategies for action. In Mason, Talbott, & Leavitt. *Policy and politics for nurses: Action and change in the workplace, government, organizations and community* (2nd ed.). Philadelphia: WB Saunders.

BASIC STEPS for Community Organizing[54]

Systems and Community Practice Levels

Working with others, PHNs…

The Five-Stage Model for Community Organizing

Stage 1: Community Analysis

A. Defines the community

Is the "community" geo-political? geographic? a targeted population?

B. Collects and analyzes a variety of data to produce a profile of that community.

The profile includes:

- community perception of needs and their solutions
- identification of who can get things done in the community and who is ready to provide resources
- identification of who needs to be involved in decision making
- identification of who may be opposed to addressing the issue.

C. Assesses the community's capacity to support the desired change.

D. Assesses the potential barriers to change within the community.

Frequent sources of barriers to change include:

- community does not clearly understand the change
- community has no part in bringing about the change
- community's interests and security are threatened by the change
- change is advocated by those who are not trusted or liked
- changes are a mismatch for the cultural values of the community.

E. Assesses the community's readiness for change.

Consider such factors such as:

- interest intensity
- urgency
- general level of community awareness
- attitudes of community opinion leaders
- community's previous history and response to change.

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[54] Bracht, N., & Kingsbury, L. (1990). Community organization principles in health promotion: A five-stage model. In N. Bracht (Ed.), *Health promotion at the community level (pp. 66-88).* Newbury Park, CA: Sage.

F. Synthesizes data gathered in the steps above and establishes priorities using community input.

Stage 2: Design and Initiation

A. Establishes a core planning group and selects a local organizer/coordinator who is energetic, with good listening and conflict-resolution skills

B. Selects an organizational structure (for example, advisory board, council, panels, coalition, lead agency, informal network, and grass-roots or advocacy movements); successful models are likely to use part of several models, adapted to fit the situation

C. Identifies, selects, and recruits organization members who represent a cross-section of all groups potentially affected by the changes; it is best if these individuals have the authority to speak and act on behalf of the group they are to represent

D. Defines the organization's mission and goals; these should concisely and briefly communicate what is to be achieved or changed

E. Provides training and recognition.

Stage 3: Implementation

A. Generates ongoing broad citizen participation

B. Provides adequate staff and other support

C. Develops a sequential work plan

A plan should include the following steps:

- selects priority activities
- plans activities, including establishing required knowledge, attitude, behaviors or skills, and a realistic timetable
- obtains resources and support
- designs the evaluation, including data collection protocols
- determines how feedback will be provided.

D. Uses comprehensive integrated strategies and does not assume that "one size fits all"

E. Integrates the community's values into the intervention, so it "speaks the community's language."

Stage 4: Maintenance-Consolidation

A. Integrates intervention activities into established community structures

B. Establishes a positive organizational culture which fosters cooperation, retains staff and volunteers, and sets the stage for development of community ownership

C. Establishes an ongoing member recruitment plan

D. Disseminates results to the members.

Stage 5: Dissemination/Reassessment

A. Updates community analysis, looking for changes in leadership, resources, and organizational relationships within the community

B. Assesses the effectiveness of completed activities

C. Charts future directions and modifications, especially strategies for continued collaboration and networking among members

D. Summarizes and disseminates results to the community.

Notes from Abby

Catherine Lexau and others provide a case study applying the **Five-Step Model for Community Organizing** to promote farming health and safety. They found the model worked well to change the community norm from accepting farm-related injury as just "part of the job" to seeing it as preventable and unnecessary. They also found that "overlapping of the stages of the model is common, and the process occurs differently in different communities depending on available resources and individual needs and skills."

Lexau, C., & Kingsbury, L. et al. (1993, September). Building coalitions: A community wide approach for promoting farming health and safety. *AAOHN Journal, 41*(9), 440-449.

Notes from Abby

Over the past two decades, separate literature has emerged around several similar, yet distinct, variations of community organization. Minkler and Wallerstein provide a useful list (p. 38):

Community Empowerment

Community empowerment is a "social-action process that promotes participation of people, organizations, and communities toward the goals of increased individual community control, political efficacy, improved qualify of community life, and social justice." Community empowerment is a central goal of all community organizing.

Community Development

Community organizing efforts that result in improved *community competence* (that is, problem-solving capacity) are often referred to as *community development*. The central goal of these types of community organizing is usually focused on economic development as the main mechanism for competency development.

Community Building

Community organizing efforts that emphasize *participation* in decision-making and planning by those in the community affected by the change are called *community building*. Community building places greater emphasis on enabling communities to play the lead role in their own development, so that "community empowerment occurs rather than just community embetterment."

Community Regeneration

Community building models which focus on *promoting community strengths and assets* are yet another variation of community organizing (called "*community regeneration*" by its major advocate, John McKnight).

*Minkler, M., & Wallerstein, N. (1997). Improving health through community organization and community building: A health education perspective. In M. Minkler (Ed.), *Community organizing and community building for health* (pp. 34-38). New Brunswick, NJ: Rutgers Univ. Press.

For additional information on the concepts, see: Kretzmann, & McKnight. (1993). *Building communities from the inside out.* Chicago: ACTA Publications; Anderson, & McFarlane (2000). *Community as partner* (3rd ed.). Philadelphia: Lippincott.

BEST PRACTICES for Community Organizing

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who blended evidence from the literature with their practical expertise. These best practices are <u>not</u> presented in any ranking or particular order; each may not apply to every implementation of the intervention.

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1. UNDERSTANDS THE DIFFERENCE BETWEEN POWER AND EMPOWERMENT AND IS COMFORTABLE IN USING PERSONAL POWER.

Best Evidence: Rothman; Minkler and Wallerstein; Speer and Hughey

Minkler and Wallerstein note that many are justified in criticizing "empowerment" as the "catch-all phrase of the social sciences" (p. 40). We define these terms to assure a consistent understanding of these terms.

- The dictionary defines *power* as "the ability or capacity to perform, or act effectively; a specific capacity, faculty or aptitude." *Empowerment* means to "invest someone or something with power."[55]
- *Power* in and of itself is merely a capacity and inherently neither good nor bad. Power can be used for both good or bad ends. The understanding of power is heavily dependent on social, cultural, and situational contexts.
- While every person possesses the potential for power, each person must learn self-empowerment. Others may assist in the process of learning to engage one's own power, but in the end **what you do with what you have is up to you**. *Empowerment*, then, is the process of helping others (persons, families, groups, systems, or communities) in recognizing and utilizing their own power.

At the conclusion to their review of historical and current usages of empowerment, Minkler and Wallerstein suggest that empowerment is "a social action process by which individuals, communities, and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life" (p. 40).

Other insights are provided in the literature, including:

- Rothman, Erlich, Topman, and Cox propose the exercise of power (both personal and organizational) as just as important, if not more important, to community organizing as to developing and implementing a plan (pp. 15-17)
- Speer and Hughey suggest that community organizing promotes development of both:
  - personal empowerment (empowering to the individual involved) and
  - community empowerment (empowered individuals are more likely and able to change communities using their personal power).

[55] *The American Heritage College Dictionary* (3rd ed.). (1993). New York: Houghton Mifflin, pp. 1072, 450, respectively.

This empowerment contributes to the capacity of a community to create its own destiny, which some refer to as community competence.

- Rothman and others present a power continuum that may be applied to community organizing:
  - *incentive-based*:
    providing rewards for positive behavior
  - *appealing to rational thinking*:
    imparting information with the hope that this will point those making the decision "in the right direction"
  - *persuading:*
    supplying information and reasoning in a proactive fashion
  - *normative:*
    shaping perceptions and beliefs of others to become compatible with those of the majority
  - *coercive influence*:
    using threat, force, or actual material loss or disadvantage as a consequence for resisting the change.

2. USES A STRENGTHS-BASED FRAMEWORK TO SUPPORT COMMUNITY CAPACITY DEVELOPMENT AND EMPOWERMENT.

Best Evidence: Helvie; Minkler and Wallerstein; Ross; Rothman; Speer and Hughey; Swanson and Nies

The authors reviewed suggest community empowerment as the intended outcome of community– organizing efforts. Helvie, quoting Rappaport, defines empowerment as the "process by which individuals, communities, and organizations gain mastery over their lives" (p. 246). Empowerment builds on existing assets or capacities and is, therefore, essentially a "strengths-based" perspective.

When selecting issues to address through community organizing,[56] the PHN should choose an issue that:

- can be won
- possesses potential for uniting a community and involving people in meaningful ways
- affects many people
- functions as part of a larger strategy, meaning that success is more likely when community organizing is combined with other interventions.

[56] Miller and Staples (as referenced by Minkler and Wallerstein) (1998). In Minkler (Ed.). *Community organizing and community building for health.* New Brunswick, NJ: Rutgers University Press, p. 45.

3. FOCUSES ON DEVELOPMENT OF COMMUNITY COMPETENCE. [57]
Best Evidence: Helvie; Minkler and Wallerstein; Swanson and Nies

A competent community exhibits the following characteristics:[58]

- *participation* in community goal and norm setting is common and expected
- *commitment* to the community is strong, reflected by caring and involvement, and by the extent to which the community itself is thought to influence change in one's own life
- community *awareness*, or how well each part of the community understands its own contribution and that of contributions made by other community members
- a *sense of community*, or the collective views, attitudes, needs, and intentions of the community can be described by those involved
- methods to accommodate open *conflict* and continued interaction between different parts of the community
- ability to *manage relations* within a wider society
- mechanisms for *facilitating participation*, interaction, and decision making
- existence of *social support*, or the capacity and willingness to help others, either formally (such as bank loans) or informally (such as neighbors helping neighbors)

Jean Goeppinger,[59] current chair of the Department of Community, Family, Mental and Women's, Health at the University of North Carolina School of Nursing, has written extensively about development of community competence as one of the goals of public health nursing practice.

4. UTILIZES THE WISDOM LEARNED FROM PAST COMMUNITY ORGANIZING EFFORTS.
Best Evidence: Fawcett

In a recent article, Stephen Fawcett[60] provides an overview of changes in community–organizing practices observed over the past 50 years. He calls these observations "accumulated wisdom." They are organized in categories for quick review:

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[57] For the seminal article on community competence, see: Cottrell, L. (1957). The competent community. In Kaplan, Wilson, Leighten (Eds.), *Further explorations in social psychiatry*. (pp. 195-209). New York: Basic Books.

[58] Adapted from Eng and Parker as presented in Helvie, pp. 329-339.

[59] For further readings by Goeppinger, see: Community as client: Using the nursing process to promote health. (1984). In M. Stanhope & J. Lancaster (Eds.). *Community health nursing: Process and practice for promoting health* (pp. 379-404). St. Louis: Mosby. See, also: Goeppinger, with Baglioni, A.J. (1985). Community competence: A positive approach to needs assessment. *American Journal of Community Psychology, 13*(5), 507-523.

[60] Fawcett, S. (1999). Some lessons on community organization and change. In J. Rothman (Ed.), *Reflections on community organization: Enduring themes and critical issues*. Itasca, IL: FE Peacock Publishers, 314-334.

Lessons in Community Context

- High-profile commissions and reports create conditions for experimentation and optimism about public problem solving
- Multiple models of community organization practice may be necessary to fit the variety of contexts in which community work is done
- Crosscutting issues are good context for community–organizing practice
- Community organization cannot be completely divorced from politics, or from controversy
- Poor people can make substantial gains (or losses) during periods of tumultuous change and related realignment of political parties
- Strategies used in community organizations should match the times
- Mass protest and grassroots community organization can work together
- Community organizations form when (and not before) people are ready to be organized
- Those institutions that seek to avoid conflict and controversy make a difficult base from which to do community organization work.

Lessons on Community Planning

- Societal and community problems are evidence that institutions are not functioning for people
- We must set realistic goals for community organization
- We will likely achieve less if we set only modest goals
- Social planning can engage experts in helping address societal problems, particularly when there is consensus on the issue
- Local people have the experiential knowledge to come together to define local issues
- Local control can hinder collaboration at broader levels of planning.

Lessons on Community Action and Mobilization

- Each individual has the capacity for self-determination, self-help, and self-improvement
- No one can do it alone
- Strong leaders are present in even the most economically deprived communities
- Community practitioners should never get used to the terrible conditions they see in their community work
- People's beliefs and values enable them to stay committed
- Religious institutions help shape beliefs about what is right and good, such as the responsibility to care for others
- Community practitioners have few opportunities to reflect on their work
- Responding to events and opportunities to build community often takes us beyond what we know.

Lessons on Opposition and Resistance

- Societal problems sometimes serve the interests of those in power
- Racial and ethnic tension and controversies have disrupted and destroyed many community organization efforts
- Social action tactics, such as disruptive protest, often face many opponents
- Less "in-your-face" social action approaches can produce a strong political base from which to make change
- Opposition and resistance may come in a variety of ways
- Community organizations may respond to opposition with appropriate counteraction

- Opposition to change may be like peeling an onion; workers should expect multiple layers of opposition and resistance.

Lessons on Intervention and Maintenance of Efforts

- The strategy of community organization should fit the situation
- Using multiple strategies usually has the advantage over any single strategy
- Being in two cultures promotes creativity
- The work of community organization takes time, and follow-though
- External support may be both a necessity and a trap for community organizations
- Community organizations often fade away when the issues they were formed to address fade
- Organizations needs small "wins," or "shorter-term, controllable opportunities to make a tangible difference."

Lessons on Community Change

- The central idea of community organization practice is public benefits, not creation of new professions
- Community organization must go beyond the process of bringing people together
- The primary need is not for individuals to adjust to their work, but for the environment to enable people to attain their goals
- Community organizations can function as catalysts for change.

Lessons on Systems Change

- Interventions should include systems changes that reflect the "root" causes of the problem
- Systems change does not necessarily occur simply by reporting needs to appointed or elected officials
- The great power of social movements is in communicating a different vision of the world
- Community organizations should seek changes commensurate with their power
- Community (and broader systems) change can be effected through collective action–involving alliances among groups that share risks, resources, and responsibility to achieve common interests.

Lessons on Community-Level Outcomes

- Societal problems often recur
- Most community efforts "chip" away at the problem
- Real change is rare
- Development of community leadership may be a positive by-product of even "failed" community efforts
- Optimal health and development for all people may be beyond the capacity of many communities to achieve, but it is not beyond what we should seek.

Notes from Abby

Archer and others* provide a list of skills characteristic of effective community organizers:

- knowledge of community organization and theory
- good planning and assessment skills
- knowledge of the community in which the change is to occur
- awareness of the power structure and the way power is shared in the community
- credibility within the community
- dedication to an idea or goal
- trust in others and their abilities
- ability to share responsibility
- good communication skills
- leadership qualities**
- belief in a democratic process
- flexibility to be able to react to the situation and respond appropriately
- time-management skills
- action from the perspective of the "community as the client"
- research skills
- sense of humor
- patience (p. 57).

*Archer, Kelly, & Bisch. (1984). Implementing change in communities: A collaborative process. St. Louis: Mosby.

** John Tropman, a co-author with Rothman and others on community organizing, has also written a "skills guide" on successful community leadership. For further reading, see his book (1997) by that same title published by the NASW Press (Washington, DC).

BEST EVIDENCE for Community Organizing

Each item was first reviewed for research quality and integrity by graduate students in public health nursing and then critiqued for its application to practice by at least two members of a panel of practice and academic experts. The nature of the material and a score expressed as a percentage is included at the end of each annotated citation. The percentage is the average of scores assessed by the experts who reviewed it. It reflects their opinion of the strength of the item's contribution to practice.

Review Articles

none

Research Reports

none

Expert Opinion

Fisher, R. (1997). Social action community organization: Proliferation, persistence, roots, and prospects. In M. Minkler (Ed.). *Community organizing and community building for health* (pp. 53-67). New Brunswick, NJ: Rutgers Univ. Press.

Fisher expands on Rothman's "Model C" (see p. 23), Social Action, providing a review of its evolution since its 1960s heyday. He stresses it continues to perform community organizing by "focusing on power, pursuit of conflict strategies, and challenges to the structures that oppress and disempower constituents" (p. 53). However, rather than being confined to a specific location for a short period, social action is now practiced globally and over a long period of time. The following characteristics are shared by contemporary social action community organizing:

1. Efforts are community-based, meaning is it organized around communities of interest or geography, not focused on a particular "enemy"
2. Social action actors are "transclass groups" of constituencies and cultural identities, rather than organized around a single group
3. The "ideological glue" is a neopopulist view of democracy. They reject authoritarianism at all levels, rather than a few dominant levels
4. Conflicts more often are over communities' cultural and social identity than over workplace- related issues, as they were in the past
5. Social action is more likely to overlap with locality development elements of self-help development and empowerment, also known as "community capacity building."

Fisher ends with a comprehensive review of the "historical antecedents" of social action, ranging from Saul Alinsky's work pre-WWII to "new" worldwide movements focusing on "democracy as the essence of new...insurgent consciousness and the source of its potential" (p. 62). He warns, however, that "the pursuit of democracy, without sufficient concern for equality, has resulted in the failure of the new social movements to address the material needs of the most disadvantaged. Moreover, the new social movement origins in culturally oriented, identity-based efforts tend to fragment social change efforts in general" (p. 63).

Expert Opinion (academic)=54%

Speer, P., & Hughey, J. (1995). Community organizing: An ecological route to empowerment and power. *J. of Community Psychology, 23*(5), 729-748.
The authors studied examples of community organizing (CO) associated with the Pacific Institute for Community Organizations over seven years to examine if and how empowerment (usually thought of only in terms of an individual phenomenon) may be understood as the manifestation of *social power but at three levels of analysis: individual, organizational, and community*, all realized through the process of community organizing. In this study, *power* is thought of in terms of social power, or power to change things in a community. *Social power* accomplishes this in one of three ways: 1) possession of superior bargaining positions, such as having more wealth or other resources that can be used to reward or punish various targets in the community; 2) ability to construct or eliminate barriers to participation in community decision-making, such as controlling meeting agendas; 3) perpetuation of myths and community ideology or control of information within a community to influence a shared community consciousness. Community organizing, then, results in community empowerment to the extent those carrying out the organizing can reward or punish community targets, control what gets talked about in public debate, and shape how residents and public officials think about their community.

They test their hypothesis by observing several community–organizing efforts, each of which cycles through the organizing phases. The organizing cycle consists of the *assessment phase* of clarifying and defining issues/problems; the *research phase* of examining the causes and correlates of the identified issues/problems; the *action phase* of attempting both strategy development and organizational mobilization for collective action; and the *reflection phase* of exploring the effectiveness of the implemented strategies. Individuals are empowered by participating in an organization which itself is gaining social power; for the individual, it becomes a "learning by doing" process. Organizations can be both empowering for the individuals participating in them and empowered, in the sense of an organization wielding social power.

At the community level, empowerment occurs through multisector relational development, institutional linkages across sectors, and collective attention to community issues. The ultimate level of community empowerment is multiple multisectoral organizations working together in a federation to create change. At this level they are interdependent, have power to redistribute resources, share and/or rotate organizing roles (such as public relations, organizing events jointly, etc.), and disband or refocus.
Expert Opinion=ratings not available

Texts and Monographs

Helvie, C. (1998). *Advanced Practice Nursing in the Community* (pp. 242-255). Thousand Oaks, CA: Sage.
Helvie suggests three models for effecting community change. (These resemble Rothman's work, although he is not cited.) He then reviews Bracht and others' comparisons and contrasts of them. Based on these analyses, Helvie concludes that the locality development model (also known as the community development model) "has been found to be the most effective way to bring about community change" (p. 245). He then describes concepts underlying the model:

1. *Empowerment*, or the "process by which individuals, communities, and organizations gain mastery over their lives." Helvie suggests this process occurs simultaneously at two levels in community organizing: individuals experience increased social support, which increases their sense of control, and communities gain community competence.

Community competence, in turn, is the community's ability to engage in effective problem solving. Helvie turns to Cottrell's earlier work in identifying eight conditions essential for community competence:

- Commitment
- Self-other awareness and clarity of situational definitions
- Articulateness
- Communication
- Conflict containment and accommodation
- Participation
- Management of relations with the larger society
- Machinery to facilitate participation in interaction and decision making (p. 246).

2. *Participation*, or the necessity for community members to be active, rather than passive, in the learning process**.**

3. *Relevance*, or the people must experience a need for change, if change or learning is to occur.

4. *Issue selection*, or organization around issues that are important to the community and also winnable, understandable, and specific in scope. Arriving at the selection requires extensive dialogue with community members.

Helvie references Bracht et al. (1990) for community–organizing steps. (See Bracht and Kingsbury abstract, p. 7.).
Text=73.5%

Swanson, J., & Nies, M. (1997). Community participation. *Community health nursing–Promoting the health of aggregates* (pp. 140-148). Philadelphia: WB Saunders.
Community organization is defined as "the process whereby the nurse empowers individuals, aggregates, and communities to solve priority community health problems and to achieve community heath-related goals" (p. 142).

The authors suggest that "community organization and community health nursing share common roots in theories and concepts of social change and social interaction" (p. 139). These "common roots" include:
1. Social Systems Theories (p. 139) which basically posit that a change in any part of a system will create change in the rest of the system:

a. communities are "systems that have wholeness, boundaries, organization, openness and feedback"
b. each community has interrelated subsystems
   - Aggregates, or groups within the community that share common characteristics such as age, gender, race, SES, culture, etc.
   - Sectors, functional divisions of the community such as health, welfare, education, economics, religion, government, etc.

c. each community is also part of larger suprasystems

Community health is brought about by the cooperative effort of all sectors of the community.

2. Community Participation

Significant levels of community participation are one of the indicators of healthy communities. Forms of participation include

a. coalitions or partnerships, where groups of diverse agencies, organizations, and individuals work together to address a common interest or concern

b. community empowerment is the most active level of community participation; empowerment is a process whereby individuals, organizations and communities gain mastery over their lives (p. 141).

Community organizing is simultaneously a process, a social structure, and a goal referencing a "series of activities related to developing competent community action systems and to the technical tasks associated with them" (p. 141); an operational definition for public health nursing is: **community organizing is "the process whereby the nurse empowers individuals, aggregates, and communities to solve priority community health problems and to achieve community-related goals. The process implies upstream thinking..."** (p. 143).

1. Process: suggests Bracht et al.'s five-step process for community organization, as it parallels the nursing process (p. 141). (See Bracht and Kingsbury abstract, p. 19)
2. Structure: focuses on the relationships among subsystems
3. Goal: develop "competent communities" (from Contrell and Goeppinger), that is, communities having
    a. commitment
    b. active participation
    c. articulateness
    d. effective communication
    e. self-awareness
    f. clarity of situational definitions
    g. conflict containment and accommodation
    h. management of relations with larger systems

Review of Rothman's three models for community organizing (see Rothman abstract); the selection of a particular model depends on the community's social and cultural context, the nature of the issues or problems and the cultural and ethical values of the PHN serving as community organizer.

Swanson and Nies suggest that Rothman's community development model be combined with community health concepts so that "Health-related needs are identified, and health goals are established, met, and evaluated through community-professional partnerships" (p. 144). In this application, the primary role of PHN is that of partner to the community. However, all three models are deemed appropriate for PHN action, contingent on the situation at hand.

Text=71%

Archer, S., Kelly, C., & Bisch, S. (1984). Community organization. *Implementing change in communities: A collaborative process* (pp. 51-67). St. Louis: Mosby.

Archer and colleagues provide a review of community organizing theory and practices to support their assertion that public health nurses (and health educators) have long done this work but rarely named it as such (p. 51). They review several definitions of community organization and list their common components (as opposed to offering their own definitions). These components are:

1. The process used to carry out community organizing is a "planned movement to achieve a specified outcome"
2. There is the expectation of change
3. It operates on a "democratic precept," meaning that the process is collaborative effort with others to bring about change (p. 52).

Ross' three models for community change are discussed and briefly contrasted with Rothman's models of community organization practice. (See Ross and Rothman abstracts.)

1. Community Development

   a. *External Agency Approach*: Individuals are assigned to help improve conditions for others by providing expertise and technical assistance; This is usually initiated by an agency and not necessarily in response to a request for assistance from the people themselves; Archer et al. recommend reserving use of this model only for circumstances where there is no time for, or no commitment on the part of, the target community to develop a collaborative relationship

   b. *Multiple Approach:* teams of experts provide a variety of services to assist a community in adjusting to technological changes; this is not recommended unless the community itself has been involved in the identification of problems and selects the team approach as the preferred method of addressing their needs

   c. *Inner Resources Approach*: community members are encouraged to carry out the community assessment and problem determination themselves, resulting in cooperation and mutual goal setting, the recommended community development approach

2. Community Organization

   a. *Specific Content Objective Approach*: organizations, groups, and agencies come together to implement a variety of means to eliminate a particular problem

   b. *General Content Objective Approach*: a collaborative and coordinated system is developed that allows representatives of community organizations, groups, etc., to work cohesively toward a specific area of interest; this is an ongoing process with continued development as a goal, rather than goal attainment

   c. *Process Objective Approach*: reliance on networks of community groups to provide opportunities to share responsibilities and initiate action; the focus is on the shared process, not on the outcome itself

3. Community Relations

   a. *Public Relations*: methods used to project an agency to the public

   b. *Community Service*: provision of benefits to the community to improve or solidify an agency's credibility with that community

   c. *Community Participation*: representation from community businesses and agencies serve on committees or task forces

Also from Ross, four roles played by community organizers (p. 57):
1. Guide, assisting communities to attain their goals
2. Enabler, acting as a facilitator or catalyst, encouraging the community to define common goals and to develop a cooperative atmosphere
3. Expert, providing data analysis and technical assistance, a resource person
4. Social therapist, assisting in community diagnosis and generation of solutions

Community Organizer Skills (p. 57):
1. knowledge of community organization and theory
2. good planning and assessment skills
3. knowledge of the community in which the change is to occur
4. awareness of the power structure and the transfer of power in the community
5. credibility within the community
6. dedication to an idea or goal
7. trust in others and in their abilities
8. ability to share responsibility
9. good communication skills
10. leadership qualities
11. belief in a democratic process
12. flexibility to be able to react to the situation and respond appropriately
13. time-management skills
14. operates from the perspective of the community as the client (vs. the individual/family)
15. research skills
16. sense of humor
17. patience.

Text=62%

Bracht, N., & Kingsbury, L. (1990). Community organization principles in health promotion: A five-stage model. In N. Bracht (Ed.). *Health promotion at the community level* (pp. 66-88). Newbury Park, CA: Sage.

The authors define community organizing (CO) as "a planned process to activate a community to use its own social structures and any available resources (internal or external) to accomplish community goals, decided primarily by community representatives and consistent with local values. Purposive social change interventions are organized by individuals, groups, or organizations from within the community to attain and then sustain community improvements and/or new opportunities" (p. 67). A key component is member choice in participation; a key outcome of CO is community ownership. To provide a context for CO, they review Rothman's models (see Rothman abstract) and principles for community activation (p. 72):

1. Planning must be based on a historical understanding of the community. Conditions that inhibit or facilitate interventions must be assessed
2. A comprehensive effort using multiple interventions is required, because the issue or problem is usually one of multiple (rather than single) causality.
3. It is important to focus on community context and work primarily through existing structures and values
4. Activate community participation, not mere token representatives, is desired

5. Intersectoral components of the community must work together to address the problem in a comprehensive effort for the project to be effective
6. The focus must be on both long- and short-term problem solving, if the longevity of the change is to endure beyond the project's demonstration period
7. Finally, and most importantly, the community must share responsibility for the problem and for its solution.

The five-stage model for community organizing:

Stage 1: Community Analysis

A. Define the community-of-interest: geographic only? population only? targeted population only?

B. Collect and analyze a variety of data to produce a profile of the community-of-interest. The profile includes community perception of needs and their solutions, as well as identification of who can get things done in the community, who is read to provide resources, who needs to be involved in decision making, and who may be opposed to the goals

C. Assess the community-of-interest's capacity to support the change desired

D. Assess the potential barriers within the community-of-interest. Frequent sources of barriers include

- **P**changes not clearly understood
- **P**changes they had no part in bringing about
- **P**changes that threaten their vested interest and security
- **P**changes advocated by those untrusted or unliked
- **P**changes that are a mismatch for the community's cultural values

E. Assess the community's readiness for change by considering indicators such as interest intensity, urgency, general level of community awareness, attitudes of community opinion leaders, community's previous history, and response to change

F. Synthesize data gathered in A-E, and establish priorities using community input.

Stage 2: Design and Initiation

A. Establish a core planning group, and select a local organizer/coordinator who is energetic, with good listening and conflict-resolution skills.

B. Select an organizational structure (e.g., advisory board, council, panels, **coalition**, lead agency, informal network, and grass-roots or advocacy movements); successful models are likely to use parts of several models, honed to fit the situation

C. Identify, select, and recruit organization members who, in total, comprise a cross-section of all groups or discrete sub-populations needing to be impacted; it is best if these individuals have the authority to speak and act on behalf of the sub-population or group they are to represent

D. Define the organization's mission and goals which should concisely and briefly communicate what is to be achieved or changed

E. Provide training and recognition.

Stage 3: Implementation

A. Generate broad ongoing citizen participation, and staff their work appropriately

B. Develop a sequential work plan using the following steps:

- **P**determine the priority among intervention activities

Pplan them, including establishing specific knowledge, attitude and behavior or skills required, and a realistic timetable

Pobtain resources and support

Pdesign the evaluation, including data collection protocols

Pdetermine the feedback loop

C. Use comprehensive integrated strategies, and do not assume that "one size fits all" in prompting change

D. Integrate the community-of-interest's values into the intervention, so it "speaks the community's language"

Stage 4: Intervention Maintenance-Consolidation

A. Integrate the intervention activities into established community structures

B. Establish a positive organizational culture that fosters cooperation, improves retention of staff and volunteers, and sets the stage for development of community ownership

C. Establish an ongoing member recruitment plan

D. Disseminate results.

Stage 5: Dissemination/Reassessment

A. Update the community analysis, looking for changes in leadership, resources, and organizational relationships withing the community

B. Assess the effectiveness of completed interventions or programs

C. Chart future directions and modifications, especially strategies for continued collaboration and networking among members

D. Summarize and disseminate results.

Text=61%

Minkler, M., & Wallerstein, N. (1997). Improving health through community organization and community building: A health education perspective. In M. Minkler (Ed.), Community organizing and community building for health (pp. 31-52). New Brunswick, NJ: Rutgers Univ. Press.

Community organizing is defined as "the process by which community groups are helped to identify common problems or goals, mobilize resources, and in other ways develop and implement strategies for reaching the goals they collectively have set" (p. 31).

The authors believe the concept of *empowerment* (i.e., an enabling process through which individuals or communities take control of their lives and their environment) is implicit in the definition. The authors review the history of community organizing and concur that the single distinguishing feature separating it from other means of collective action is the assumption of the involvement of an outside organizer. However, they also suggest that the current trend of pairing community organizing with community building needs to be included and predict it will have increasing importance in community change efforts. *Community building* is defined as a process that people in a community engage in themselves (p. 32).

Current Models of Community Organizing

1. Rothman's three models are discussed. (See p. 23.) However, the authors propose *community building* as the "new" "descendant" of Rothman's community/locality development model. Both emphasize self-help and collaboration. However, community building, which emphasizes the development of community strengths in

shared values and goals, de-emphasizes the external organizer and encourages, instead, the "professional as partner" model.
2. Several models of culturally relevant community building practices are reviewed.
3. Coalitions are posed as both a model of community organization practice and as a method used across models in that they span the continuum from locality development to social action models, from community organizing to community building, and can be either needs- or strengths-based.

Key Concepts (in lieu of a single, unified model of community organization or community building)

1. *Power* is central to community organizing. It occurs at different levels:
Pindividual–power to make decisions of personal choice
Porganizational–ability to define when elites and powerful organizations determine what issues become the focus
Psystems–ways in which the structure of the economic and political systems favor certain interests and disadvantage others
2. *Empowerment* is a central tenet of community organizing and community building and is defined as "a social action process by which individuals, communities, and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life" (p. 40).
3. *Community competence*, or the capacity to solve problems, depends on the development of leadership
4. *Participation* in collective action is important and must engage the community and its members in ways that are important to them
5. *Involvement* in collective action must be seen as relevant to participants' goals and issues
6. *Issue selection* should be done carefully to assure selection of an issue or problem for which the community has deep concerns
7. *Measures of success* and evaluation principles should be included.

Text=57%

Smith, C., & Maurer, F. (1995). Planning for community change. In C. Smith & F. Maurer (Eds.). *Community health nursing: Theory and practice* (pp. 342-345). Philadelphia: WB Saunders.

The authors use Rothman's three models as their framework to discuss community organization. (See Rothman abstract.) In comparing/contrasting the models, the authors conclude that locality development has the best potential for the longest lasting effect, but is very time consuming to implement. Social planning can be effective if the community is extensively involved in the gathering and analysis of the data; however, it is sure to fail when experts plan for communities, rather than involving communities in the planning. Social action's reliance on direct, confrontational methods is usually implemented when an oppressed or disadvantaged group seeks retribution from another. The authors provide little application of models to PHN practice, however.
Text=56%

Rothman, Erlich, Tropman, & Cox. (1995). *Strategies of community intervention: Macro practice* (5th ed.). (pp. 3-25, 26-63). Itasca, IL: FE Peacock.

Introduction and Background

The authors provide a historical overview of community organizing as having been a "constant element in community intervention but to varying degrees and in varying forms over time" (p. 6). They suggest that the grassroots/social action form of community organizing probably reached its peak in the late 1960s but describe

how the legacy continues with "vitality and prevalence" in such ways as the mandate for citizen involvement in many governmental programs and the fact that groups quickly learn how to influence and bypass traditional political and administrative channels in order to be heard.

Key elements of community organizing described are:

1. Arenas of intervention, or the social contexts in which community organizing takes place
   A. *Community*: the "territorial organization of people, goods, services, and commitments. [Community] is an important subsystem of the society, and one in which many [community organizing] functions are carried on" (p. 10). The "community and its various elements both limit possible actions and present opportunities for action. The practitioner's task is to acknowledge the former and seize upon the latter" (p. 11)
   B. *Organizations*: An understanding of formal organizations is essential for practitioners intervening at the community level since "complex organizations are essential tools and mediating instrumentalities for achieving collective purposes. They can contribute in significant ways to realize the kinds of lives people want...[but they can also be] neither positive nor benign in their impact..." (p. 12). Practitioners need to know how to change the way organizations operate, as well as how to make carry out their mission. Change efforts can be targeted at four main areas of organizational operation:
      Pconstitutional change, or impacting on the procedures or boundaries of an organization
      Pconstituency- or resource-based change, or impacting on an organization's boards, financial contributors, grantors, etc.
      Ptarget entities, or influencing the populations to be aided, enlisted, or coerced
      Pinterorganizational relationships, or impacting on other organizations with whom the organization-of-concern is linked
   C. *Small groups*: the smallest and most intimate arena for community intervention. Groups are small enough so that each member can communicate with every other member. All small groups fulfill two main functions: task fulfillment (i.e., solving specific problems that the group was formed to tackle), and expressive functions (i.e., keeping the members together and working in relative harmony on external tasks).
2. Core elements of practice
   A. Systematic *problem-solving process*
      Pidentification or specification of a problem or need
      Pproblem/need delineation and clarification
      Psystematic data collection about the problem/need
      Pdelineation of alternative courses of action
      Pdevelopment of implementation actions/plan
      Pevaluation
   B. Use of *influence* (interpersonal and organized collective pressure)
      Pcoercive (i.e., use of threat, force, fiat, or otherwise being made to experience real, material loss or disadvantage for resisting the influence attempt)
      Pincentive-based (i.e., providing rewards for positive behavior)
      Pappealing to rational thinking (i.e., imparting information with the hope that this will point those making the decision "in the right direction")
      Ppersuading (i.e., supplying information and argumentation in a proactive fashion)
      Pnormative (i.e., shaping perceptions and beliefs of others to become compatible with those of the majority)

The authors end these introductory remarks by suggesting professionals working at the level of community interventions be considered as "macro" practitioners, whereas those working with individuals, families, and groups are considered "micro" practitioners. Generalist practitioners are those who work at both levels. All work to create change; all contribute to change in the same direction. Over time, one or some may be emphasized or preferred over others, but, in reality, all are useful and needed to create and maintain the desired change.

Approaches to Community Intervention (Rothman)

Rothman initially presented his three models of intervention in the first (1968) edition of this text and then included them in the four successive editions (each edition contains further elaboration, but retains the basic models). Each of the three models can be used singly or in combination with the others as frameworks to develop plans of action to change community values, beliefs, behaviors, or actions. Rothman notes that "planning has been defined as the art of deciding what to do about some community affair while, meanwhile, life is bringing it around to a firm conclusion" (p. 27).

Model A: Locality Development

Key characteristics: a community-building endeavor with a strong emphasis on promoting process goals of

- **P**community competency (i.e., the ability to solve problems on a self-help basis)
- **P**social integration (i.e., harmonious inter-relationships among different racial, ethnic, and class groups)
- **P**leadership is drawn from within
- **P**direction and control remain in the hands of the people

Strengths: when effective, it results in a competent, socially integrated community capable of solving future problems it may face on its own

Weaknesses: its emphasis on process requires numerous meetings and a slower pace for change; one critic "admires locality development for playing a gentleman's game in the often sordid arena of community affairs but [questions] whether it can win" (p. 30).

Practice variables:

- **P**goals: process goals heavily emphasized
- **P**assumptions about problems: local community overshadowed by the larger society
- **P**change strategy: local initiative and shared decision making
- **P**tactics: consensus development across a wide range of different factions
- **P**practitioner role: enabler or encourager, working through small task-oriented groups
- **P**power orientation: inclusive orientation within the model
- **P**beneficiaries: total community–all groups
- **P**assumptions about subsystems: varied group interests are ultimately viewed as reconcilable and responsive to influence and desire for mutual goodwill
- **P**role of beneficiaries: viewed as active participants in the process
- **P**empowerment: goal of model implementation

Model B: Social Planning/Policy

Key characteristics: emphasizes a technical process of problem solving relying on data, social science thinking, and empirical objectivity

- **P**presupposes that community change is so complex a technical expert is required to manage the problem-solving process

Passumes community participation is not a core ingredient

Prelies heavily on needs assessment, decision analysis, research evaluation, and other statistical tools

Pis concerned with task goals: conceptualizing, selecting, establishing, arranging, and delivering goods and services to people who need them

Pstresses fostering coordination among agencies, avoiding duplication, and filling gaps in services

Strengths: rational and intellectual approach make the model appealing for rational and intellectual decision-makers

Weaknesses: rational and intellectual approach make the model appealing for rational and intellectual decision-makers (and overlook the inherent political, interactive, emotional components of communities)

Practice variables:

Pgoals: stress on task goals that focus on the solution of substantive social problems

Passumptions about problems: community viewed as burdened with social problems it did not necessarily create

Pchange strategy: data points the direction

Ptactics: fact finding and data analysis

Ppower: whoever employs or hires the technician/expert

Pbeneficiaries: entire geographical or functional community

Passumptions about subsystems: no assumptions; approach is pragmatic

Prole of beneficiaries: clients, consumers, or recipients of services

Pempowerment: assumption that information=empowerment

<u>Model C: Social Action</u>

Key characteristics: aims at making fundamental changes in the community, including the redistribution of power and resources and gaining access to decision making for marginal groups

Ppresupposes the existence of an aggrieved or disadvantaged segment of the population that needs to be organized

Paims to empower and benefit the poor, the disenfranchised, the oppressed

Passumes significant fragmentation exists among social action groups; tends to be single-focused

Phas a highly adversarial "classical" style, with social justice as the dominant ideal

Phas a "new wave" style, which is more focused on political and electoral maneuvers

Strengths: conducive to joint action, especially coalition development, to gain stature and acquire a voice which will be heard

Weaknesses: current public tolerance of disruptive methods is low; coalitions are difficult to maintain when need for single-identity groups is high

Practice Variables:

PGoals: either process or task

PAssumptions about Problems: excessive power or resources among elites

PStrategy Change: identifying a common "enemy"

PTactics: conflict, militant advocacy

PPractitioner Role: organizer of mass mobilization

PPower: external power structure is the target

PBeneficiaries: oppressed community subpart

PAssumptions about Subsystems: interests of community subparts make them inherently at odds with one another

PBeneficiaries Role: employer of the change agent/practitioner

PEmpowerment: becoming an equal party in decision making processes and boards

Text=50.5%

Ross, M. (1967). *Community organization: Theory, principles and practice* (2nd ed.) (pp. 40-72). Harper and Row.

Many authors on community organizing regard Ross as its "father." He defines community organizing as:

> "...a process by which a community identities its needs or objective, orders (or ranks) these needs or objectives, develops the confidence and will to work at the needs or objectives, finds the resources (internal and/or external) to deal with these needs or objectives, takes action in response to them, and in so doing extends and develops cooperative and collaborative attitudes and practices in the community" (p. 40).

Related comments include:

1. The task of the professional worker in community organizing is to "help initiate, nourish, and develop this process...[through methods] which make the process conscious, deliberative, and understood" (p. 41). Ross clarifies, however, that community organizing can also develop in a community without the presence of a professional worker
2. Communities are defined as either 1) all people in a specific geographic area, or 2) groups of people who share some common interest or function, i.e., functional communities. Regarding functional communities, Ross notes that frequently the first task of the professional worker is to assist a group of people to become aware of their commonalities and develop a sense of community. In either focus, Ross suggests it is impossible to work with all the people, and, therefore, it is essential to identify major subgroups or subcultures in the community in which one is working (p. 44)
3. For community organizing to be successful, it must result not only in the achievement of the established objectives but also in an increased capacity to undertake other cooperative projects (p. 49). This requires the ability to use the inevitable tension and conflict associated with community change for constructive ends
4. The community organizing process has two tasks: planning and community integration.

   Planning includes working with community representatives to identify problems, explore their nature and scope, consider various solutions, select those that appear feasible, and take action.

   Community integration is a process in which the exercise of cooperative and collaborative attitudes and practices leads to

   Pgreater identification with the community

   Pincreased interest and rational action in the affairs of the community

   Psharing of common values and the means for expressing them.
5. Ross relates community organizing as a natural extension of the social work process and assumptions used for case and group work, but applied at the community level:

   Pthe intent in all cases is to remove blocks to growth, release potentialities, make full use of inner resources, and develop the capacity to manage one's own affairs (p. 62)

   Prespect the inherent dignity and worth of the individual, the resources possessed by each to deal with personal problems, the inherent capacity for growth, and the ability of the individual (or group or

community) to choose wisely in managing personal affairs

Pthe need to accept the "client" where he is

Pthe need to develop a professional relationship

Pat the community level, the professional worker is interested in "the social forces playing in a community which facilitate or block community integration, and which help or prevent individuals from identifying themselves with the community as a whole, which facilitates or handicaps cooperative work which create or ease social tension" (p. 67)

6. Critical individual characteristics required of the professional worker to be effective in community organizing include:

Punderstanding that the objectives of all community organizing interventions include the development of community attitudes and practices in support of social responsibility and cooperative work

Pbeing in sympathy with the community development objectives of community organizing

Pbeing able to regard behaviors in the community setting, especially group process, objectively

Phaving skill in association with the community organizing process: having the ability to help define and clarify goals; encourage priority setting among goals; encourage frank exchange of views and full participation of all involved; understand other cultures and their perspectives; help the inarticulate or insecure to express their opinion; and to help the articulate and secure achieve consensus

Punderstanding the difference between being a lecturer to a group versus being a participant offering useful information.

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Public Health Interventions

Applications for Public Health Nursing Practice

Advocacy

Public Health Nursing Practice for the 21st Century

March 2001

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

INTERVENTION: ADVOCACY

Interventions **are activities taken by PHNs on behalf of communities and the individuals and families living in them.**

Assumptions about all PHN Interventions...

- They are population-based; that is, they:
  - **S**are focused on an entire population
  - **S**are guided by an assessment of community health
  - **S**consider broad determinants of health
  - **S**consider all levels of prevention
  - **S**consider all levels of practice
- The public health nursing process applies at all levels of practice.

Definition

Advocacy pleads someone's cause or acts on someone's behalf, with a focus on developing the community, system, individual, or family's capacity to plead their own cause or act on their own behalf.

Examples at All Practice Levels

Population-of-interest: *All persons*
Problem: *Lack of access to affordable health care*

Community Example:

A PHN who provides directly observed therapy for tuberculosis prevention to persons living in a homeless shelter observes the lack of primary medical care for this population. Some of the homeless refuse to seek medical care even when they need it; some want care, but cannot figure out how to access it; still others have been treated so badly when they sought care that they refuse to try again. The PHN also gathers data, including diabetes, heart disease, tuberculosis, and mental illness, on the numerous conditions that the homeless population experiences. She approaches her agency director and advocates for an onsite clinic at the shelter; together, they advocate the cause to the county board and the executive board of the United Way. After some time and a lot of work, an on-site clinic is established at the homeless shelter, staffed by nurse practitioners and operated by the public health nurses.

Systems Example:

A PHN agency is very aware of the general lack of available dental care in a rural community, particularly for low-income residents whose insurance source is Medical Assistance. A staff PHN is asked to contact a school of dentistry at the state university about possibly treating some people without access. The school of dentistry responds, and a provider agreement is established between the public health agency, the university, and the state department of human services. A portable dental clinic is set up, utilizing dental faculty and students. The clinic provides dental services, including transportation and interpretive services for non-English-speaking clients. The community response is overwhelming, and plans are made to make the dental clinic a permanent service option in the community.

Individual/Family Example:

A PHN meets several times with a group of Somali women who recently immigrated to America. They have little understanding of the American health care system. The PHN explains how the health care system works, emphasizing what is meant by "insurance" and "appointments." The PHN helps them complete insurance applications, and then has them role play making an appointment, requesting an interpreter, and talking to a health care provider.

Relationships to Other Interventions

Advocacy is often discussed in relation to **case management** and rightfully so; selection of **case management** as an appropriate intervention assumes that the PHN assessed a client's need for someone to "plead their cause or act on their behalf." However, the discussion here is broader than that typically presented in conjunction with case management

Advocacy is frequently used with other interventions, such as **referral and follow-up**, **community organizing,** and **policy development and enforcement.** In fact, policy development is often not successful unless carried out in conjunction with advocacy.

For a discussion of media advocacy, see the **social marketing** intervention**.**

BASIC STEPS for Advocacy [61]

Working alone or with others, PHNs...

1. Assess the nature and source of the issue to be addressed.

You must listen carefully to the client's perception of what is needed and why. The first assessment probably will not reveal everything there is to know. The client's willingness to disclose and explore issues will depend on the nature and longevity of the PHN-client relationship.

2. Determine the appropriate "target" for the advocacy intervention.

The advocacy target may be individuals, service agencies, other parts of your own agency, bureaucracies, billing systems, dog pounds...the list is endless! Find out as much as you can about the organization or person with whom you will advocate. Then find out which person or what entity (for example, a board) has the authority to override your first contact's decision. You need to know whom to go to if you do not get the answer you want.

3. Establish the objectives with the client.
Agreeing with your client on reasonable, attainable objectives is critical.

4. Negotiate the action plan with the client (individual, family, group, system, or community). The plan must consider the client's capacity to speak or act on their own behalf and the assistance they desire from the PHN.

Advocacy is a partnership between the PHN and client in which the client also has responsibility for taking some action. Establishing a clear mutual understanding of "who is going to do what by when" is important.

Before agreeing to the action plan, the PHN should first consider whether the requests are:
- within the scope and practice of the PHN's state's nurse practice act
- within the limits of the PHN agency's policies and job description
- within the limits of the PHN's competencies.

When working at the individual/family level of practice, advocacy with other health care or human services systems on behalf of clients is often required. The PHN must watch for patterns of issues occurring regularly within certain systems, as well as for recurring systems' issues
noted by agency coworkers. Together, these observations may point to a larger system's issues, which may need addressing at a higher level.

[61] Adapted from: Weil, M. (1985). Key components in providing efficient and effective services. In M. Weil & J. Karls (Eds.), *Case management in human service practice: A systematic approach to mobilizing resources for clients* (pp. 29-43). San Francisco: Jossey-Boss.

5. Determine resource availability.

If other resources already provide advocacy for the identified concern, **referral and follow-up** is appropriate. For instance, many social action-oriented voluntary groups have persons trained to serve as "advocates" or "ombudsmen" who may be in a better position than the PHN to speak or act on a client's behalf. Examples include battered women's advocates, mental health ombudsmen, and ombudsmen for seniors.

If other resources are unavailable, the PHN provides the advocacy within the available resources.

6. Assess to what extent the advocacy "target" may be receptive, and adjust the action plan accordingly.

As with any other action requiring communication between people, the quality of any pre-existing relationship plays a large part in how organizations, providers, services, or other advocacy targets respond to your advocacy. Before approaching them, anticipate their possible responses, and prepare alternative ways of "pleading your cause" with them.

7. Implement.

Developing competencies in more than one style of communication is an asset for the PHN–including comfort with confrontation. Be prepared with alternative ways of presenting issues to the same person or entity.

8. Evaluate.

Notes from Abby

Spradley and Allender offer four *actions characteristics* of advocacy that are relevant:

- *being assertive*: do not take "no" for an answer until you absolutely must
- *taking risks*: know the difference between rule-bending and rule-breaking
- *communicating and negotiating well*: identify "win-win" circumstances whenever possible
- *identifying resources and obtaining results*: see **referral and follow-up**.

Adapted from: Spradley, & Allender. (1996). *Community health nursing: Concepts and practice* (4th ed.). Philadelphia: Lippincott, pp. 105-106.

Notes from Abby

Advocating for the client can, at times, place the PHN in a dilemma, caught between the policies of the employing agency and the client's physician or community norms and unwritten standards. This is not a new event for PHNs in practice for a period of time. Eventually all PHNs encounter those circumstances. What guides PHNs in their decision making at those times? Does advocacy translate into bending or breaking rules, or, rather, into questioning and changing them? Sally Hutchinson wrote a provocative article on this subject based on her research looking at nurses in hospitals who reported "bending the rules for the sake of the client."

For further reading, see: Hutchinson, S. (1990). Responsible subversion: A study of rule-bending among nurses. *Scholarly Inquiry for Nursing Practice: An International Journal, 4*(1), 3-16; see, also: Munhall, P. (1990). Response to responsible subversion.... *Scholarly Inquiry for Nursing Practice: An International Journal, 4*(1), 19-22.

BEST PRACTICES for Advocacy

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who blended evidence from the literature with their practical expertise. These best practices are not presented in any ranking or particular order; each may not apply to every implementation of the intervention.

1. FOSTERS THE DEVELOPMENT OF THE CLIENT'S CAPACITY TO ADVOCATE ON THEIR OWN BEHALF.

Best Evidence: Gadow and Schroeder; Bernal; Labonte; Lassiter; Mallik; Millette; Peternelj-Taylor

The concept of the nurse as advocate for client self-determination is relatively new to the nursing profession. Both Bramlett (p. 157) and Millik (1995, p. 28) note the fact that it was not until 1973 that the International Council for Nurses code for nursing ethics dropped the language that a nurse's first loyalty was to the physician.

Bramlett describes nursing's current concept as "consumer-centric advocacy," which combines an emphasis on the client's rights in decision making with the nurse's role in supporting those rights. It has *three major aspects*:

- **maximum transfer of knowledge to the client**, which requires the nurse to assure that the client has all the information needed to make an informed decision, and that such information is presented in an understandable form
- **prominent client participation in decision making**, which requires the nurse to support the client's decision, regardless of the extent to which it may or may not be in agreement with the perspective of the health care system or that of the nurse
- **the client's freedom to implement decisions,** which requires the nurse to assist the client, as necessary, in accomplishing the necessary actions.

Millette suggested *three advocacy models* found in nursing based on her review of the literature:

- **bureaucratic advocacy,** in which the nurse owes primary allegiance to the institution, with secondary allegiance to the patient and herself/himself
- **physician advocacy,** in which the doctor is given the chief consideration, and all other factors are subordinate
- **client advocacy,** in which the client is the primary focus, with all providers acting together to attain the self-directed goal.

Millette proposes that all models are appropriate at times, but that the client advocacy model requires a high level of moral development on the part of the nurse. In her research, Millette found that while the client advocacy model was strongly favored by practicing nurses, it rarely happened, in reality, due to negative consequences anticipated from supervisors.

Chafey and others also found evidence of the general movement of nursing thought toward client-centeredness rather than physician- or institution-oriented advocacy. The nurse decides to implement advocacy based on:

- whether or not the client is personally unable to mediate the situation satisfactorily
- whether or not the nurse possesses the traits necessary to carry out advocacy (such as self-confidence and strength of conviction)
- whether or not countering factors exist in the environment (such as rude physicians, challenges to clients' rights, or the potential for economic repercussions for actions).

Gadow and Schroeder advance the notion of advocacy yet one step further. They suggest that the concept of the nurse as a "client advocate" still holds too much connotation of the "client with deficits needing to be fixed" model and promote instead an "advocacy approach" in which community health nursing is seen as "facilitating ...development of the capacity" of the *partner* (that is, individual/family, systems or community).

In this model, a PHN "commits to enhance client autonomy and to assist clients in voicing their values" (p. 128). In doing so, the PHN becomes a partner with the "client" (at whatever level). This concept reflects the incorporation, at least to some extent, of the empowerment school of thought. *[See Abby Note.]*

2. USES MASS MEDIA IN CONJUNCTION WITH ADVOCACY.

Best Evidence: Flora and others; Jernigan

The PHN-client relationship, considered one of the cornerstones of public health nursing,[62] requires competency in interpersonal communication. At the *systems or community* practice levels, use of *media advocacy* is also often appropriate. Although discussed more thoroughly in the **social marketing** intervention, the main points are repeated here:

Flora establishes major roles played by the media in advocacy interventions:

- media as educator
- media as supporter
- media as promoter
- media as supplement.

Jernigan and Wright reviewed case studies focusing on the "4 P's" of marketing–that is product, promotion, place, and price–in conjunction with media advocacy, and came to the following selected conclusions:

- media advocacy is most successful when linked to a strong community organizing base and a long-term strategic vision; broader coalitions open the way to bigger policy gains
- attracting media attention is rarely sufficient to achieve permanent change
- permanent change requires changing policy
- clarity about long-term goals, plus the development and communication of a media strategy "frame" which focuses on policy rather than individuals and uses "symbols" (that is, famous persons serving as spokespersons) reflecting those goals, are crucial to success
- media advocacy is cumulative–successful campaigns set up further efforts

[62] Minnesota Department of Health/Section of Public Health Nursing. (1999, June). *The Cornerstones of Public Health Nursing*. St. Paul, MN.

- training and designating spokespersons keeps campaigns' messages clear
- understanding the different audiences served by different media outlets enables campaigns to reach target groups better; no media outlet or contact should be overlooked
- the media have their own agenda–advocates need to understand what motivates them, and how their motivation differ from those of advocates
- media advocacy is often controversial and as such, is not for everyone or every situation
- controversy over the accuracy of advocates' facts should be avoided
- sensational tactics can attract media attention, but sensation alone seldom achieves policy change.

3. ASSUMES THE ADVERSARIAL ROLE WHEN APPROPRIATE.

Best Evidence: Chafey and others; Jernigan; Millette; Rubin

An adversarial role is often part of the advocacy intervention, but certainly is not the only, nor even the preferred role. Weil suggests a range of approaches to consider, each successively more adversarial in nature:

- education
- persuasion
- bargaining
- campaigning
- directly contesting (p. 41).

She also notes that the "directly contesting" approach is reserved for those occasions when every other level has failed. Still, PHNs need to be competent (if not comfortable) in these conflict situations.

4. EXHIBITS SELF-CONFIDENCE, STRENGTH OF CONVICTION AND A COMMITMENT TO SOCIAL JUSTICE.

Best Evidence: Stevens; Williams

Although none of the authors reviewed spoke specifically to these attributes, the panel of experts determined it would be difficult to envision public health nurses capable of carrying out the advocacy functions as depicted without self-confidence, strength of conviction, and a commitment to social justice. Certainly this would be the case in meeting Stevens and Hall's call for PHNs to "Take a stand...; [join] in consciousness-raising dialogue with communities by asking tough questions, listening to the communities we serve, forming coalitions, and acting collectively."

Advocacy and Empowerment: Are they the same thing?

The literature on advocacy significantly overlaps with the literature on **empowerment.** Both focus on enabling others, including systems and communities, to "do for themselves." However, **empowerment:**

- adds the additional connotation of not only doing for oneself, but also controlling one's life
- is not something that can be done to, or given to, another
- assists that other (individual, families, groups, systems, or communities) to discover and use the power inherent within

At the systems and community levels of practice, empowerment literature also overlaps with that of **community organizing** (especially the community development variation) and **coalition building**.

The full discussion of the similarities and difference among these overlaps is beyond the scope of this document. Advocacy, as it is used here, may or may not also result in empowerment. While empowerment is an admirable goal, it is possible that some individuals, families, groups, systems, or communities may never be able to attain full empowerment and, therefore, continue to require someone to speak or act on their behalf. However, never assume inability; always offer the opportunity.

The advocacy literature (and, in particular, the empowerment literature) also overlaps with the literature on personal, interpersonal, and organizational power, none of which is addressed here. (See **community organizing.**)

For those interested in further reading on public health nursing and empowerment, see: Smith, & Maurer. (1995). *Community health nursing: Theory and practice,* Philadelphia: WB Saunders, pp. 7-8; Swanson, & Nies. (1997). *Community health nursing: Promoting the health of aggregates* (2nd ed.). Philadelphia: WB Saunders, pp.165-168; Spradley, & Allender. (1996). *Community health nursing: Concepts and practice* (4th ed.). Philadelphia: Lippincott, pp.587-588; Gibson, C. (1991). A concept analysis of empowerment. *J. of Advanced Nursing, 16,* 354-361. For further reading on empowerment in the context of health promotion, see: Labonte, R. Health promotion and empowerment: Reflections on professional practice. (1994, Summer). *Health Education Quarterly, 21*(2), 253-268. For the origins of empowerment education, see: Freire, P. (1970). *Pedagogy of the oppressed*. New York: Herder and Herder.

BEST EVIDENCE for Advocacy

Each item was first reviewed for research quality and integrity by graduate students in public health nursing and then critiqued for its application to practice by at least two members of a panel of practice and academic experts. The nature of the material and a score expressed as a percentage are included at the end of each annotated citation. The percentage is the average of scores assessed by the experts who reviewed it. It reflects their opinions of the strength of the item's contribution to practice.

Review Articles

Mallik, M. (1997). Advocacy in nursing–A review of the literature. *J. Advanced Nursing, 25,* 130-138.

Development of the Advocacy Role in Nursing

Mallik concludes from her review that the core condition which demanded advocacy action was the vulnerability of the client, both in terms of personal vulnerability from illness, but also of vulnerability to risks inherent in the institutional processes to which the client is exposed in the health care system. The construction of this as a potential issue of patient rights violation comes from the American movement to assure rights in health care decision making. Mallik claims this may be a peculiarity of American culture.

Advocacy Models

Mallik provides an overview of model derivation from fields outside of nursing (citizen, consumer, voluntary political activist) and within. Relying on the work of Leah Curtin and Gadow, she describes advocacy in nursing as "creating an atmosphere which is open to and supportive of the individual patient's decision-making....The professional must not define what is in the 'best interest' of the patient; only the patient can do this" (p. 132). Mallik offers Kohnke's definition as the preference with its emphasis on the central belief that individuals have a right to self-determination; it involves informing the patient with the information they need in order to make informed choices and supporting decisions made, assuring patients that they have the right and the responsibility to make their own decisions. "Interpreted positively it implies encouragement empowerment and 'self-advocacy'" (p. 133).

Justification for a Career in Patient Advocacy

Mallik continues by providing common themes found in the advocacy literature:

1. Patient advocacy is a traditional role for the nurse
2. Nurses are in the best position within the health care team to act as the patient's advocate
3. Nurses and patients can be partners in advocacy

The major limitation placed on fulfilling the advocacy role with clients is the lack of nurse autonomy: "While the moral pressure on the nurse to advocate is strong (the commitments to patients are grounded in nurses' status as moral agents) the authority to do so is weak" (p. 136).

Review=47.5%

Research Reports

Jernigan, D., & Wright, P. Media advocacy: Lessons learned from community experiences. *J. Public Health Policy, 17*(3), 306-330.

[Note: This article was also reviewed as Social Marketing]

"Media advocacy is the strategic use of mass media and community organizing as a resource for advancing a social or public policy initiative" (p. 330). Media advocacy is derived from the following:

1. Media relations provides the basic principles of how to identify and approach media
2. Social marketing provides insight into defining and targeting audiences and messages
3. "Guerrilla media" is the use of small amounts of hard-hitting advertising to bring attention to an issue and/or exert pressure on individual decision-makers
4. Community organizing is used as a means of influencing media by showing widespread public support
5. Political campaign media is important for controlling what media covers and shaping how it covers it

Through case studies focusing on the "4 P's" of marketing (i.e., product, promotion, place, and price), the authors exemplify the following about media advocacy:

1. Media advocacy is most successful when linked to a strong community-organizing base and a long-term strategic vision. Broader coalitions open the way to bigger policy gains
2. Attracting media attention is rarely sufficient to achieve permanent change
3. Permanent change requires changing policy
4. Clarity about long-term goals, and development and communication of a media strategy, frame, and symbols that reflect those goals, are crucial to success
5. Media advocacy is cumulative–successful campaigns set up further efforts
6. Who speaks for the campaign defines the campaign in the public eye. In particular, young people and "authentic voices" often frame and add power to the story being told
7. Training and designating spokespersons keeps the campaign's message clear
8. Making news–holding events, releasing research, or in some other way doing something "newsworthy"–will generally draw media attention
9. Advocates have power in relation to the media, in particular, the power to offer or withhold story ideas and information
10. Television requires visuals that tell the story in and of themselves
11. Understanding the different audiences served by different media outlets enables campaigns to target key constituencies. No media outlet or media contact should be overlooked
12. Advocates need to practice good media relations, including maintaining relationships, being accurate, using every contact, and always having a spokesperson available
13. The media have their own agenda–advocates need to understand what motivates them, and how their motivation differs from those of advocates
14. Controversy draws media attention
15. Media advocacy is often controversial, and as such, is not for everyone or every situation
16. Controversy over the accuracy of advocates' facts should be avoided
17. Sensational tactics can attract media attention, but alone seldom achieve policy change
18. Opponents of policy change may try to encourage controversy, in order to divide–or sow the appearance of division–among coalitions for better health policies

19. Computer-based electronic communications systems and other emerging technologies can help in planning and sharing information
20. Different groups or individuals can play different roles in media advocacy, depending on the personal or institutional abilities and constraints
21. Research, both scientific studies and community-based data collection and documentation, is needed and helpful
22. Funding for ongoing organizing is critical and often scarce:
"Media advocacy is about media, but more fundamentally, about advocacy, working to change public policies" (p. 327).
Qualitative=74%

Sullivan, C., Campbell, R., et al. (1994). An advocacy intervention program for women with abusive partners: Six-month follow-up. *American J. Community Psychology, 22*(1), 101-122.
The study utilized community advocates, a group of paraprofessional workers with special training in domestic abuse. The advocates were female undergrads who had 10 weeks of training and received college credit for their involvement. The women subjects were recruited from shelters. They determined that use of advocates was a helpful and inexpensive way to assist individual battered women, if the services are available on an ongoing, as-needed basis and if they are offered while systems-level change is simultaneously being addressed.
Quantitative/Experimental=58%

Chafey, K., et al. (1998, Jan-Feb). Characterization of advocacy by practicing nurses. *J. Professional Nursing, 14*(1), 43-52.
A qualitative study based on in-depth interviews with 17 practicing hospital and community nurses was conducted to determine understanding of advocacy. The authors suggest that in the years since the 1976 Tuma case, which prompted the profession's move away from a model of obedience and organizational loyalty to a more patient-centered model, not much has happened to clarify the concept and its practice application other than an ill-defined sense of the nurse as guardian against shoddy practice.

Their findings:

1. A given nurse's decision whether or not to advocate depended on the weighing of interdependent variables:
    - **P**Client: is unable to mediate satisfaction of his or her own needs
    - **P**Nurse: possesses traits supportive of carrying out advocacy (self-confidence and strength of conviction)
    - **P**Environment: has the presence of rude physicians, challenges to clients' rights, economic reasons
2. Interpersonal relatedness remains the cornerstone of nursing advocacy which included teaching, information, and supporting activities
3. Present but less strong: issues of accountability and ethics

Qualitative=54%

Millette, B. (1993). Client advocacy and the moral orientation of nurses. *Western Journal of Nursing Research, 15*(5), 607-618.
Millette's article is a synopsis of her doctoral dissertation, completed in 1989 and titled "An Exploration of Advocacy Models and the moral Orientation of Nurses." She explores the context or orientation of nurses'

moral choices, using three models of advocacy from the literature:

1. Bureaucratic advocacy, in which the nurse owes allegiance primarily to the institution with needs of both the patient and the nurse
2. Physician advocacy, in which the doctor is given the chief consideration, and all other factors are subordinate
3. Client advocacy, in which the client is the primary focus, with all providers acting together to attain the self-directed goal.

All models are seen as appropriate at various times, but the client advocate is present as the preferred model for the professional nurse (p. 608). It is also assumed that to act in this role, a high level of moral development would be necessary. However, Millette notes that previous exploration of nurses' moral development employed Kohlberg's model, which was developed with research on men. Millette also attempts to measure nurses' moral development using Gilligan's model, which include women in its development. Gilligan asserts that people approach moral dilemmas from a particular orientation, either caring or justice or a combination. "Caring" is marked by reference to relationship and connections whereas the voice of justice points to right and rules and the impartial land of competing claims.

Based on her findings, Millette made the following conclusions:

1. The concept of client advocacy has great appeal to the practicing nurse. However, its actual implementation is seen as highly problematic
2. Nurse managers tended to prefer the bureaucratic advocacy model
3. Nurses selecting the caring orientation of moral development were likelier to be inactive in nursing, hold a staff position, and have a broader educational background
4. Nurses preferring the justice orientation were more likely to be active in nursing, be a manager, and be a diploma graduate.

Quantitative/Experimental=53%

Expert Opinion

Stevens, P., & Hall, J. (1992, March). Applying critical theories to nursing in communities. *Public Health Nursing,* 9(1), 2-9.

The authors propose that public health nursing adopt critical theory as the approach to defining public health nursing practice in the future. They admonish, "We can no longer be satisfied with the exclusive focus on individuals and their immediate milieus that characterizes traditional nursing theories. The future of community health nursing depends on two things: 1) our ability to recognize social, economic, and political aspects of the environment as they affect health and 2) our willingness to intervene at the community level for structural change. Critical theories offer a process that can empower us as nurses and empower the communities we serve to gain more control over the action conditions" (p. 3).

Critical theory development is a form of listening carefully to the community and working with them to find solutions. It is "a living process created in the everyday struggles of a group of people. It is"grounded in concrete oppressive conditions experienced by a particular group" (p. 30). Critical theory is a the process of a type of social action usually referred to as "liberation movements" stemming from the teaching and writing of

Paulo Freire. The authors suggest that "community health nurses can use critical theories by explaining the political aspects of oppressing, health-damaging conditions; by joining in consciousness-raising dialogue with communities; and by acting with them for liberating change.

This means taking a stand, asking tough questions, listening to the communities we serve, forming coalitions, and acting collectively" (p. 5).
Expert Opinion=92.5%

Labonte, R. (1994, Summer). Health promotion and empowerment: Reflections on professional practice. *Health Education Quarterly, 21*(2), 253-268.
Labonte, a Canadian community health consultant, reflects on observations made during six years' worth of workshops (ending in 1992) in which he posed the question, "How could professionals, under the rubric of health promotion, engage in new practice styles that reduce or ameliorate inequitable social conditions?" In the discourse that followed, he identified an "Empowerment Holosphere," which depicts the professional practice of empowerment as a range of overlapping strategies used to reduce or ameliorate inequitable social conditions. He notes the strategies are not the responsibility of any one health worker or discipline, but, rather, are an organizational and interorganizational mandate. The individual professional's responsibility is to see that the whole process is engaged, and to find a place in this engagement" (p. 258).

Each sphere represents a different level of social organization and relationship:

1. Individual Level: Interpersonal Empowerment
2. Intragroup: small group development
3. Intergroup: community organization
4. Interorganizational: coalition building and advocacy; political action

Labonte notes that coalition building and advocacy are linked, because coalitions usually engage in advocacy as their method of enacting social change. Coalitions are defined as groups of groups with a shared goal and some awareness that "united we stand, divided we fall;" Advocacy is defined as "taking a stand on an issue, and initiating actions in a deliberate attempt to influence private and public policy choice" (p. 263). He goes on to discuss three facets of advocacy in professional practice:

1. Professionals can aid community groups in their own advocacy by offering knowledge, analytical skills, information on how the political and bureaucratic structure functions, etc. Their support for advocacy is usually associated with their support for community organization.
2. Health organizations can also support advocacy by creating policy documents and analyses that form the policy and, thereby, legitimize the advocacy concerns of community groups with which they work
3. Professionals can increase the strength of their own political voices, taking positions on policy issues: "An organized political voice of caring professionals may be crucial in moving us towards more just and sustainable forms of social organization: it is processionals who see the human cost of current economic and political practice, who have access to knowledge and information on how the governing systems work, and who have a degree of professional credibility in their statements" (p. 263).

He notes that coalition building is often used with advocacy to overcome the political limitations of community organizing (p. 263).
Expert Opinion=82.5%

Ekstrand, C., Spear, L., & Thornley, S. (1992, April). Using public health nursing data for program advocacy. *JONA, 22*(4), 32-36.
Authors describe how a revised, more complex PHN daily was able to supply data necessary to support their recommendations to policy-makers in 1990. In particular, they were able to capture time spent in indirect services related to caseload or community activities. The costs per unit of service were reduced from $200 per unit to $26.95, after factoring in this additional data.
Expert Opinion=70%

Lassiter, P. (1992, January). A community development perspective for rural nursing. *Fam Community Health, 14*(4), 29-39.
The author describes experiences of graduate students in community health nursing applying a community development model for rural practice. Five tenets of community development are highlighted as especially important to rural nursing:

1. Citizen participation and partnership are essential for community improvement and growth
2. The focus of the work must be on local concerns
3. Established citizen groups are utilized in community development
4. Implementation is suitable to the locality
5. Process outcomes for the community are as important as task undertakings.

Although Lassiter never labels her work here as advocacy, nor is it listed either by name or by function in her list of "nursing actions in community development" (p. 32), her description of the actions and their intent carried out in partnership with citizens from the rural areas meet the criteria for the advocacy approach discussed by Gadow and Schroeder.
Expert Opinion=65%

Williams, A. (1993, October). Community health learning experiences and political activism: A model for baccalaureate curriculum revolution content. *J. Nursing Education, 32*(8), 352-356.
Williams describes a change in their program's curriculum to a central focus on nursing as "caring client advocacy," which teaches students caring linked with critical thinking and including providing student experience in community activism and sociopolitical concepts. Williams documents the strong legacy of political activism in nursing and proposes that the "community-health nursing content and practice are the logical areas of the baccalaureate curriculum for political activism education" (p. 353). Students are provided experiences in collecting data about problems in the community which affect health through "mini-community assessment events," such as screening programs and health fairs. They then consider this data in light of other data sets regarding their experience and begin extracting possible policy implications and alternatives. The author concludes by suggesting, that "Advocacy for the community integrates political activism...As nursing education moves rapidly into the curriculum revolution, student nurses need political activism as part of their nursing education" (p. 355).
Expert Opinion=63 %

Flora, J., Maibach, E., & Maccoby, N. (1989). The role of media across four levels of health promotion intervention. *Annu. Rev. Public Health, 10,* 181-201.
On the assumption that media can be influential at all levels of audience organization, the authors propose a framework to support such discussions. As background information, they discuss:

1. Mass media (i.e., television, radio, and print) which are only effective if designed specifically for particular target audiences

2. Targeted media (i.e., newsletters, booklets, self-help kits, and videos) designed to reach specific target populations
3. Narrowcasting: use of mass media to target audiences by use of selected media channels.

Roles played by media in interventions:

1. Media as educator
2. Media as supporter
3. Media as promoter
4. Media as supplement.

Levels of Audience Organization and Uses of Mass Media

1. *Individual Level*: health behaviors, physical indicators, health status
   a. Awareness raising
   b. Knowledge development
   c. Attitude [Note: Mass media is effective in changing attitude, but it has not been well supported that changed attitude is associated with changed behavior]
   d. Skills (cognitive, social, behavioral): all are available through mass media
   e. Self-efficacy: mass media works to model behavior, teach needed skills, encourage interim behaviors, and reduce dysfunction arousal; authors believe that using mass media to develop self-efficacy is underutilized
   f. Behavior: mass media alone is unlikely to change behavior; however, creative uses of mass media have been successful in influencing other behaviors and antecedents; currently this is limited in impact, due to
      - Lack of understanding of how to change behavior in general
      - Lack of understanding of how to translate known behavioral principles into media campaigns
      - Limited use and understanding of intervention for high-level audience organizations

2. *Level of Social Networks*: characteristics of social networks (e.g., being married, spending a lot of time with friends or relatives, belonging to a church, etc.) have been shown to have a profound impact on health, but the mechanism is not well understood
   a. Structural Indicators: the social system and how people are linked together within it; structural indicators influence the flow of health information within a network; interpersonal influence within a given network is more effective in bringing about "higher order individual change (i.e., changes in attitude and behavior)
   b. Network Interactions: promotion of changes in communication behavior within social networks, such as looking at spousal and peer groups

3. *Level of Organizations* (i.e., worksites, school, primary health care settings, etc.); use of organizations as channels for delivery health programs has advantages
   a. Indicators: focus mostly on aggregated measures of change in individuals
   b. Information environment: all communication within an organization (i.e., sum total of all mass media, targeted media, and interpersonal communication)
   c. Physical facilities: conduciveness to the message (e.g., vending machines with healthy food)
   d. Activities offered: number, type, and timing

e. Resources: funding and personnel
f. Collective efficacy: i.e., a group's belief in its ability to solve its problems successfully
g. Policies: potentially most important variable, as it affects all the other variables within an organization; however, little is known at this point about the effect of mass media on this variable

4. *Societal Level*: normative behavior, laws and policies, the physical and information environments are important because they also impact other levels
a. Indicators: structural or physical variables (laws, policy, information channels); mass psychological variables (i.e., collective values, norms, attitudes, opinions)
b. Information environment: mass media sets our collective genre (i.e., what we think about as a society)
c. Public opinion: mass media also plays an important role in establishing and maintaining public policy and the allocation of public resources
d. Public policy: laws, policies, and allocation of resources at all levels of government have large impact on health status
e. Social norms: "media influence has an insidious effect on the perception of individuals and on normative behavior in the social systems" (p. 197)
f. Physical environment: a reflection of a commitment to health, but the influence of mass media on them is not well understood

Expert Opinion=63%

Peternelj-Taylor, C., & Johnson, R. (1995). Serving time: Psychiatric mental health nursing in corrections. *Journal of Psychosocial Nursing, 33*(8), 12-19.

The authors describe correctional nursing as a highly specialized area of nursing practice and "not simply nursing in a special environment" (p. 12); they view the conflicting philosophies of caring and custody which nurses face daily as a special challenge in ascribing to inmates the right of autonomy. Nurses constantly "'walk the line' between the requirements of security, health care, and client advocacy" (p. 14). The authors suggest reframing these as non-competing concepts and stressing, rather, the reality of correctional health care; caring and custody can coexist.

Expert Opinion=60%

Bramlett, H., Gueldner, S., & Sowell, R. (1989). Consumer-centric advocacy: Its connection to nursing frameworks. *Nursing Science Quarterly,* 156-161.

Bramlett et al. begin by tracing the concept of the nurse as a patient advocate from Nightingale's time forward. They note that it was not until 1973 that the International Council of Nurses' code dropped its language about loyalty and obedience to physicians.

The article also discusses various definitions of advocacy:

1. Kohnke (1982): the act of pleading for, or giving verbal support to, a cause
2. Military view: a situation where power is unequally distributed, where a stronger figure speaks out on behalf of a weaker individual (the weaker individual always sacrifices some loss of control to the stronger)
3. Paternalism vs. Consumerism: an authority figure establishes what is best (waning view); consumerism is the increased involvement of a better-informed public in their medical decision making

New Mode: Consumer Centric: combines the emphases on the client's rights in decision making with the nurse's role in supporting those rights.
Requires: 1) maximum transfer of knowledge to the client; 2) promotion of client participation in decision making, 3) client's freedom to implement decisions
This model requires the client be an informed participant. However, the authors argue that, since not all clients are capable of being full participants, consumer-centric advocacy is needed. This blends strict consumerism with selected components of paternalism, appropriate to
1. Promoting the implementation of decisions and acts that clients would pursue for themselves were they able
2. Promoting the restoration of individuals' decision making and participative ability as quickly as possible
The authors conclude by comparing this understanding to King, Newman, Orem, and Rogers' nursing theories. Consumer-centric advocacy is determined to be supported by all.
Expert Opinion=53%

Rubin, H. (1997). Being a conscience and a carpenter: Interpretations of the community-based develop model. In M. Weil & M. Newsome (eds.). ***Community practice–Models in action (pp. 57-90).*** **Birminghamton, NY: The Haworth Press. [Note: Also published (1997) in** ***J. Community Practice, 4*****(1), 57-90.]**
The author describes a study in which he was the participant/observer in a community development project where he collected data (i.e., stories) from development workers regarding the dilemma between balancing the "heart and the mind" they constantly face. The reality for community development workers is that the "balance between the bottom line and the obligation to help people" is a very fine line (p. 63). Advocacy (in the form of community organizing) also is weakened by a focus on community development, because individuals are forced to work with the very people they would otherwise be organizing against. However, a national survey of community-based development organizations showed that 50 percent engaged in community-organizing activities. The author proposes "new advocacy"in which community development organizations work in coalitions with traditional advocacy organizations under the notion they have more to gain than to lose.
Expert Opinion=52.5%

Bernal, E. (1992, July-August). The nurse as patient advocate. ***Hastings Center Report, 22*****(4), 18-23.**
Bernal traces the evolution of nursing thought about the basic nature of their relationships with patients from Nightingale's adoption of the military model, under which the primary relationship (and obligation) was to the physician and the promotion and protection of the patients' faith in their physician to the role of advocate for patients rights and interests. The movement has been to the far side of the continuum (in the author's opinion), which places nursing as the advocate and guardian for patients' rights against the hospital and doctor. Bernal asserts that neither are accurate and, instead, urges consideration of a covenantal model.

In this model, attention is called to the "reciprocal indebtedness" between the public and nursing: the professional power of the nurses is a gift from the public to the profession given in exchange or its expertise and orientation toward the service of others (p. 220).
Expert Opinion=35%

Mallik, M., & McHale, J. (1995, January 25). Support for advocacy. *Nursing Times, 91*(4), 28-30.
Mallik and McHale describe instances of nursing's patient advocacy role taken to the extreme of "whistle blower" status on substandard patient care in the UK. A discussion of the dilemma between nurses' loyalty to employers and responsibilities to patients is presented. They conclude by suggesting that "employment power" is a significant detractor to nurses' performance of the advocate role in that employers hold the ultimate power, loss of employment.
Expert Opinion=32.5%

Gerber, L. (1994, July). Case management models: Geriatric nursing prototypes for growth. *J. Gerontological Nursing,* 18-24.
Case management is described as both an "administrative service that 'directs client movement through a series of phased involvements with the long term care system and an advocacy system that "integrates the formal and informal care giving segments" (p. 18). However, other than a statement that nursing case management models operate in the "best interest of clients" (p. 20), in which one could assume negotiation or some other form of advocacy on the part of the client might occur, the concept of advocacy is never developed.
Expert Opinion=no rating available

Texts and Monographs

Gadow, S., & Schroeder, C. (1996). An advocacy approach to ethics and community health. In E. Anderson & J. McFarlane. *Community as partner: Theory and practice in nursing* (2nd ed.), (pp. 123-137). Philadelphia: Lippincott.
The authors explain the ideological shift in community health nursing from viewing the "community as client" to viewing the "community as partner." In the former, "client" connotes a "dependency and passivity, and neediness in conjunction with professional authority, expertise, and invulnerability" (p. 124). Nurse-community partnership, on the other hand, connotes a relationship in which the professional helps the community discern their values and needs and develop an encompassing health concept that includes all views; it is defined by the community members (not the professional) and, therefore, cannot be generalized to other communities.

This shift in perspective also requires a shift in the role of the professional to that of an advocate, or one who "commits to enhance client autonomy and to assist clients in voicing their values" (p. 128). Advocacy, then, becomes the ethical framework for community health nursing practice and demands that "everyone in the community be represented, not just those with political or professional authority" (p. 124). The authors suggest that even valuing inclusiveness of diverse views in health care decisions does not approach partnership because it is still limited by the "universalist ethical tradition that frames service delivery in the United States" (p. 125).

Universalism operates on the assumption that all individuals are identical, equal, and autonomous and as have evolved from our society's search for a single set of principles on which a system of justice could be grounded. This, however, has served to disenfranchise those who *are* different, such as the poor, underinsured, alienated, etc. It also contributes to the role definition of the health professional in these three ways:

1. Assumption that there is only one acceptable view of health and that it is the right of the professional to define it, thus ignoring the various meanings of health within a single community. Clients who do not fit the mold are labeled as "noncompliant," rather than held to a different understanding of health
2. Assumption that private lives are excluded from public life has led to the relative nonaddress of such issues as domestic violence, child abuse, child care, and reproductive health
3. Assumption that the professional is the expert authority and, therefore, has the right to establish what is "normal" in a community.

The dilemma with the universalism tradition, however, is that professional knowledge often lags behind social changes, leaving health care decisions based on invalid assumptions.

The ethical framework of advocacy is offered as an alternative to universalism. This holds that:

1. Health decisions are based on values
2. Value questions can be addressed only when choice exists.

Under the advocacy framework, the professional, while obligated to act in the client's best interest, applies the following tenets to practice:

1. Is not permitted to interpret that interest contrary to the client's definition
2. Enhances client autonomy by involving not only respect for, but also engagement with, clients in expressing their values as unique persons
3. Accepts the likelihood that for most people significant health alteration requires reorientation and a new version of personal autonomy; it is the professional's role to participate with clients in developing autonomy in the new situation by helping them discern their values
4. Involves the client in establishing a self-body relation that reconciles the extremes of subjectivity and objectiveness
5. Ultimately, self-determinism is the freedom to interpret experience and determine meaning for oneself; the professional's role is to assist the client in the process of deciding on that meaning (pp. 128-131).

Application to community health:

1. Aim is to enhance community self-determination through construction of a unique health narrative that guides delivery of services
2. Reliance on participatory research methods as the basis of data generation for decisions (methods frequently used include focus groups)
3. Collective or community knowledge and the building of relationships as the basis of collective problem solving
4. On the basis of the latter, the authors see public health nursing (as well as school-based clinics and community nurse-managed clinics) as exemplifying this new understanding of partnering and being "ideally suited" to adopting the role of PHN-as-advocate.

Text=81%

Helvie, C. (1998). *Advanced practice nursing in the community* (p. 11). Thousand Oaks, CA: Sage.

Helvie defines advocacy as speaking for those unable to speak for themselves and states this is true at the individual, group, and/or community level of practice.

Text=no rating available

Smith, C., & Mauer, F. (1995). *Community health nursing: Theory and practices* (p. 16). Philadelphia: WB Saunders.

Advocacy is defined as "any instance of speaking or writing on behalf of someone else, and using persuasion in the support of another. This requires the skill of assertive communication and the knowledge of communication channels within and among organizations."

Text=not rated

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Public Health Interventions

Applications for Public Health Nursing Practice

Social Marketing

Public Health Nursing Practice for the 21st Century
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INTERVENTION: SOCIAL MARKETING

***Interventions* are activities taken by PHNs on behalf of communities and the individuals and families living in them.**

Assumptions about all PHN Interventions...

- They are population-based; that is, they:
  - are focused on an entire population
  - are guided by an assessment of community health
  - consider broad determinants of health
  - consider all levels of prevention
  - consider all levels of practice
- The public health nursing process applies at all levels of practice.

Definition

Social marketing utilizes commercial marketing principles and technologies for programs designed to influence the knowledge, attitudes, values, beliefs, behaviors, and practices of the population-of-interest.

Examples at All Practice Levels

Population-of-interest: *Pregnant and childbearing women*
Problem: *Alcohol use during pregnancy*

Community Example:

A PHN holds focus groups with women at the WIC clinic. One focus group is with women who report no alcohol use during pregnancy; the other is with pregnant women who report using alcohol at least three times a week. The PHN asks the first group what influenced their decision not to drink during pregnancy; she asks the second group what could make them reduce their drinking. She uses the information from these groups to design posters and brochures for the WIC clinics. In addition, based on the fact that women in the focus groups reported not knowing what fetal alcohol syndrome (FAS) "looked like," she initiates at WIC a continuous showing of videotapes depicting children with FAS and what life is like for them and their families.

Systems Example:

A PHN working in a small rural county is assigned to write 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.

Individual/Family Example:

A PHN who does home visits with high-risk pregnant women in the community visits a pregnant woman who refuses to answer any questions about alcohol use. The PHN continues to establish a relationship with her by reinforcing the woman's positive behaviors, such as eating healthy foods and going to all of her prenatal appointments, during her pregnancy. The PHN occasionally repeats the message that it is important not to drink alcohol during pregnancy, but does not "press the topic" or ask about alcohol use when the woman does not respond. After several more home visits, the PHN again brings up the topic, and the woman finally shares her fears. She saw something on a TV show about alcohol use during pregnancy which said that "pregnant women should be reported for child abuse if they drink during pregnancy." She interpreted that as "the law," and was reluctant to talk to the PHN about it, because she was unsure why the PHN was visiting her in the first place! After all, her sister had just had a baby, and she hadn't had any PHN visits, so the woman assumed someone had reported her for having a beer at the local bar. The PHN uses the opportunity to explain again why she is visiting and assure the woman that she is not going to "report her." At that point, the client is at least willing to talk about alcohol use, and the PHN moves into the health teaching intervention.

Relationships to Other Interventions

Social marketing is a relatively new intervention, first introduced in 1971. In many respects it is similar to other, longer-established interventions. For instance, social marketing is like **health teaching** in that both are implemented to change attitude and behavior. In fact, some would argue that social marketing is a special application of health teaching. In public health nursing, health teaching is probably more frequently used at the individual/family and systems (that is, provider education) practice levels. Social marketing, on the other hand, is more frequently utilized at the community level of practice. At that level, social marketing overlaps with **advocacy** at the community level, where it is often implemented as *media advocacy*. *[See related Abby Note.]* In this role, it has the potential to be implemented simultaneously with any other intervention utilizing a mass media strategy.

BASIC STEPS[63] for Social Marketing[64]

Working alone or with others, PHNs...

Stage One: Planning

1. Analyze the situation

A. Study the social environment, that is, the behaviors of the community, system, individual, and/or family that you are attempting to influence and the factors contributing to that behavior. This identifies factors that could compete against social marketing efforts, such as peer pressure or tobacco advertisements. The following factors should be considered in the assessment:

- **current science**
  know what works and what does not work to change behaviors
- **social environment**
  determine the relevant protective factors (strengths) and risk factors (vulnerabilities) operating
- **past activities and results**
  assess how the factors are perceived (positive or negative) and how that might shape current attitudes
- **complementary and competing activities**
  identify what else is going on in the environment that might work for or against your planned strategy; consider the potential for partnering with others implementing related activities
- **framing of policy issues**
  analyze who makes decisions and how they are made; plan your strategy accordingly.

B. Select potential target audiences and sources of additional information.
An "audience" can be an individual, a family, a discrete sub-population, and/or the entire population-of-interest.

C. Identify and prioritize issues based on public health importance.
This step involves considering the issue's "importance" from both its science base (that is, what research suggests is important to the health of the overall population) and the public's perception of its importance. Take head lice, for instance. It has limited importance from the viewpoint of risk to population health but enormous importance from the public's viewpoint.

D. Identify strategies most likely to be effective.
Each strategy has to be considered in terms of the context of the current focus and resources available.

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[63] The basic steps for social marketing are presented in greater detail than those of other interventions, since it is a newer intervention and less familiar to public health nurses.

[64] Adapted from: Siegel, M., & Doner, L. (1998). *Marketing public health: Strategies to promote social change*. Gaithersburg, MD: Aspen.

What is effective with one individual, family, system, or community may not work the same way with the next.

2. Set goals and objectives; specify behaviors, conditions, and/or policies to be changed.

When the focus is at the systems or community level of practice, the PHN organizes a group of representatives from the audience to advise in the development of goals and objectives. They are discussed and refined until they are mutually understood and measurable. The PHN should always set goals and objectives with individuals or families who are the focus of the intervention.

3. Determine primary and secondary audiences.

The *primary audience* is the population-of-interest, discrete sub-group, family, or individual in which behavioral change is desired. The *secondary audience* is others who can help the primary audience make the desired change.

When working with audiences at the community level of practice, it is useful to break the audience into sub-groups with similar characteristics. This process is called "segmentation."

6. Understand "target" audiences.

A. Identifies and prioritizes the audiences' basic needs, desires, and values
B. Assesses how current behavior and its attributes satisfy those needs, desires, and values
C. Explores ways of framing the desired behavior to reinforce core values.

This is the crux of the social marketing intervention. **Know your "audience" well enough to understand what the current undesirable behavior provides that makes it so attractive.** Once that is determined, the challenge is finding ways to frame the desired behavior to be as attractive, if not more so, in meeting those same needs. This is easy to talk about, hard to do.

5. Develop a plan addressing product, price, place, and promotion (the "4 P's").[65]

Marketing plans, whether commercial or social, always apply the "4 P's." Product, price, place, and promotion are the variables that can be altered to sell a product successfully. Together, they are usually referred to as the "market mix."

product:
the idea, behavior, good, or service exchanged with the target audience for a price; the product can be tangible or intangible; in public health it is usually the latter.

price:
cost to the target audience of making the desired change, or "what they have to give up"; in commercial marketing this is almost always money; in public health the price is more likely to be time, effort, lifestyle, or psychological cost.

[65] Siegel and Doner add a fifth "P"–that of **Partners**. They believe social change is more attainable if all community entities interested in the change join forces (p. 216).

place:

in commercial marketing this is the outlet through which products are available; in social marketing it is often a psychological "place" or a visualization of the new "place" the changed behavior will bring; for instance, what would a smoke-free work place or a sense of well-being be like

promotion:

all activities intended to communicate the behavioral change to the audience; this includes combinations of advertising, media relations, events, personal selling, and entertainment; at systems- and community-level practice, it also includes grass-roots advocacy, lobbying, and media advocacy. *[See related Abby Note.]*

6. Develop communication strategy

A. Frames the communication to *reinforce and not to conflict* with the audience's core values.

B. Focuses on the benefit promised and the evidence supporting it.

C. Considers important questions integral to developing a communications strategy:

- Who is the audience, and what are they like? The better they are known, the more effective the communication message.
- What is the action they should take–and what are they doing now? How great a change will this be for them?
- What are the obstacles that stand between the audience and the desired behavior? Examples could be beliefs, pressures, misinformation, competing understandings of the issue, no future orientation, or a lack of feeling personally susceptible.
- What is the audience's benefit from engaging in the behavior? It must have a personal reward; a benefit to the overall health of the population will not motivate.
- What is the support for that benefit–what will make it credible to the audience? Hard data and logic can work, provided that they are understandable, relevant, and believable to the target audience. However, data and logic are difficult to make emotionally appealing.
- What are the best openings for reaching the audience–and what are the channels available and appropriate for conveying the message? That is, at what times, places, and situations will the audience most likely be receptive to hearing the message? What channel of communication best suits them (for example, mass media, print, visual, audio, etc.)?
- What image should communication convey? The goal is to portray the desired behavior as something audience members can see themselves doing, which is also consistent with their core values.

7. Conduct message concept testing.

Pre-testing the message you want to convey (that is, how to change the behavior) is critical before fully implementing the strategy. A variety of methods can be used:

- *central site interviews:* are conducted where members of the target audience gather (these are appropriate to use when needing to know how an audience will respond, but not needing much detail about why).

- *omnibus surveys*: involved adding questions about what the PHN wants to know onto other surveys being conducted (these are appropriate when the target audience is a large segment of the general population and the message requires no background information).
- *theater style testing:* requires bringing a sample of the target audience to a central site, presenting the communication, and asking them to respond to a questionnaire administered on site (this is appropriate when more in-depth information is needed).
- *in-depth interviews:* select a sample of target audience members and go to them to gather the needed information (these are appropriate if theater style testing is infeasible).
- *focus group interviews:* allow information to be collected from several people at once, but the results can be subjective and open to interpretation (these are appropriate when long materials are to be developed and responses are needed early in their development).
- *professional and field interviews:* send materials and a review form or convene a meeting in which materials are reviewed (these are appropriate when needing to ensure the credibility of the message and/or increase stakeholder buy-in).

8. Refine products and materials.

9. Build in process evaluation measures.

It is important to incorporate a plan for monitoring progress toward goal attainment before implementation. This assures regular consideration of activities that may need revision or refinement along the way. When working at the individual/family level of practice, this means seeking frequent feedback. For systems and community levels, other methods are used to gain audience feedback; these include using "bounceback" postcards or satisfaction surveys as methods for monitoring media coverage and actual policy changes.

Stage Two: Implementation

1. Produce products and materials planned.

2. Coordinate with partners.

Consider several important points when working with partners:

- think of partners as target audiences; the benefit of partnering may need to be continually "sold" to them
- consider the partner's impact on the planned behavioral change; do they add or detract from the credibility of what is being implemented?
- monitor the possibilities of legal and ethical issues that may arise; theoretically, these should have been considered during the planning phase, but not every issue can be anticipated
- consider roles that partners play; they often evolve over the lifetime of the partnership and should be evaluated routinely for continuing appropriateness
- be flexible; partners cannot always keep the size of the commitments made initially; if considerable change results, the plan's goals and objectives may need to be refined to reflect this change in resources
- put agreement in writing; partners may be subject to short-term memory loss regarding commitments made
- understand the challenges inherent in working with partners
  - < partnering is time consuming

- < true partnership means all aspects of the plan are open to negotiation
- < partners' involvement inherently means giving up some control over the process and outcome.

3. Implement intervention.

Stay faithful to the plan while at the same time remaining open to opportunities that may present themselves.

4. Conduct process evaluation.

This answers the questions, "Did we do what we said we would do?" and "How useful was the plan as a guide to action?"

5. Refine products, materials, and ways of presenting them, as needed.

Stage Three: Evaluation

1. Conduct outcome evaluation.

Outcome evaluation answers the question, "Did we change what we intended to change?" In other words, if knowledge was intended to change, then knowledge change needs to be measured. If behaviors are the intended change, then changes in behaviors need to be measured. If attitudes are intended to change, then changes in attitudes need to be measured.

- Behavioral change is a long process in most cases; since most programs are often required to produce outcomes long before the actual change could be reasonably expected, intermediate measures are often needed.
- A baseline measure must be determined prior to implementing a strategy in order to measure any change.

2. Refine social marketing strategy.

Notes from Abby

The PHNs will find many concepts of social marketing familiar. It doesn't take many years of public health nursing experience before PHNs realize that sales and the art of selling are a lot of what they do every day. Consider "Abby" knocking at the door. She has to have the skill to introduce herself and "sell" her product to get invited through that door.

While the vast majority of what is written about social marketing assumes it occurs at the systems or community level of practice, it has equal application at the individual or family level. The axiom of public health nursing at that level is, after all, to "begin where the client is." What better way to know where to begin than to apply the social marketing assessment process? If you substitute the word "client" for "audience" in the phrase "know your audience," the process applies directly.

One of the social marketing strategies for the fourth "P" is personal selling–which is much of what PHNs do, at least initially, in establishing relationships with their clients. Carmen de la Cuesta describes selling tactics used by British home visitor nurses in a qualitative research study. She finds that experienced home visitors can easily describe what they do to "get in the door" and "sell themselves and their services" using marketing language.

Source: de la Cuesta, C. (1994). Marketing: A process in health visiting. *J. Advanced Nursing, 19,* 327-353.

Media advocacy is one type of social marketing implemented at the systems and community level. It involves combining social marketing and **community organizing** through access points such as television, newspapers, radio, and billboards. Typical strategies include using paid placement of messages (as opposed to relying on free PSA's–public service announcements) and "earned media" attention or "making the news."

Examples of "earned" media attention include:

- message framing, so the message can be "pegged" or associated with some important local or national event
- breakthrough announcement regarding what is new or different about the message
- celebrity association
- controversy
- injustice
- irony
- local "peg," or why this message is important or meaningful to local residents
- milestone, or why this message is an important historical marker
- personal angle, or getting a personal story about the message to "give it a face"
- seasonal "peg," or its relationship with holidays or seasonal events (for example, National Public Health Week).

Source: Wallack, L., & Dorfman, L. et al. (1993). *Media advocacy and public health: Power for prevention*. Newbury Park: Sage Publications.

BEST PRACTICES for Social Marketing

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who blended evidence from the literature with their practice expertise. These best practices are not presented in any ranking or particular order; each may not apply to every implementation of the intervention.

1. KNOWS THE AUDIENCE.

Best Evidence: Wright, Naylor; Andreasen, 1995; Golden and Johnson; Maibach; Walsh; Siegel and Doner; Manoff, 1985

The more a PHN incorporates knowledge of the target population, especially the influence of demographic and cultural characteristics, on behavior, the more effective the social marketing intervention.

This is key to social marketing effectiveness, since behavior is learned in the family and social environments in which people are reared and live. Therefore, any measures taken to change behavior must also consider these demographic and cultural aspects. Several authors provide examples to demonstrate this:

- Golden and Johnson found that among those individuals who considered themselves at severe or extreme risk for HIV infection, giving further information about risk was actually counterproductive. It intensified their perception of HIV inevitability and led to a reduction in the use of prevention methods. The authors concluded that it is important to "use tactics which are consistent with the realities for the target individual."

- Wright and others used information gained through extensive ethnographic interviewing among Navajo regarding the influence of traditional beliefs and kinship on infant feeding practices. Breast-feeding rates among mothers delivering at an Indian Health Service hospital were dramatically increased when printed material emphasized how healthy breast-fed children are and how nursing shows a mother's love. In addition, a native foster grandmother who had successfully breast-fed her own five children was introduced as a mentor during the hospital stay.

2. CONVEYS A LONG-TERM STRATEGIC PLAN.

Best Evidence: Walsh; Andreasen, 1994; Jernigan and Wright

While social marketing alone may influence behavior, it does not always change it. For that reason, social marketing needs to be included as part of an overall, larger strategy that includes a variety of strategies. This is especially true for *media advocacy* campaigns:

- Jernigan and Wright describe successful media campaigns as "setting up" for further action
- Walsh and others' review of the evolution of social marketing in public health notes that "persistence and a long time frame" are critical to effective social marketing efforts, because changing behaviors takes considerable time. They describe examples of social marketing efforts where the project funders are demanding evidence of outcomes just when change is getting underway.

3. ENGAGES THE TARGET POPULATION IN THE PROCESS BY USING METHODS THAT ARE EMPOWERING AND CULTURALLY SENSITIVE.
Best Evidence: Andreasen, 1995; Goldon and Johnson; Siegel and Doner; Gries and others

Involving the target population can assure that social marketing does not deteriorate into a means of manipulation. For example, Gries and others tested different models for reducing alcohol use in college dorms. They found higher participation rates in dorms where the program curriculum had been modified to include issues students had identified as important. They found that emphasizing altruistic motivations about coming to the session **to get information on how to help others** is key to higher levels of participation.

4. ANTICIPATES AND MANAGES THE USE OF CONTROVERSY AND CONFLICT.
Best Evidence: Woodruff

Implementing *media advocacy* or other mass media campaigns on controversial issues will almost always draw attention to the debate. The challenge is to seize the controversy as an opportunity.

Woodruff describes a dramatic story of 80 groups coming together in California to mount a media advocacy campaign against the alcohol trade industry's use of sexist advertising. The campaign, called "Dangerous Promises," pressured the Beer Institute, the Wine Institute, and the Distilled Spirits Council of the U.S. to amend their advertising codes to include specific statements regarding:

- their portrayal of women (or any ethnic or minority group)
- violence in relationships
- suggestions of sex as an expected result of, or reward from, drinking alcohol.

The wine group agreed, but the others did not. By reframing the issue to a public health perspective of violence against women, rather than sexism in advertising, the coalition was able to get far more serious attention from the broadcast and print media. After approximately a year of sustained effort, the beer and distilled spirits trade organizations finally agreed to major revisions in their advertising codes.

5. ACQUIRES INFORMATION ON THE ISSUE AND ITS UNDERLYING FACTORS, WITH AN UNDERSTANDING THAT "PERCEPTION IS REALITY."
Best Evidence: Andreasen, 1994; Gray; Siegel and Doner

Formative research is the method often used to gain this information. Although anything with the term "research" tagged onto it can sound daunting, formative research really means listening systematically to the wants and needs of the audience and setting aside the tendency to add interpretations to what is heard. The key is not what the PHN *thinks* the audience is saying, but seeking clarification until the PHN *knows* what they are saying.

Results from such a process provide valuable information on the actions the targeted audience is willing to take and its perceptions of motivators and barriers. Examples of formative research include:

- focus groups[66]
- in-depth interviews with key informants
- in-depth interviews with a randomly selected sample of the audience.

6. THE AUDIENCE PERCEIVES THE PHN AS CREDIBLE.

Best Evidence: Stubblefield; Jernigan and Wright; Samuel

A credible spokesperson is important in social marketing applications that rely heavily on use of the mass media, such as media campaigns or *media advocacy*.

- Stubblefield promotes use of persuasive communication with a credible person "delivering the message" as an effective way to market health promotion
- Samuel, in describing "lessons learned" from Project LEAN, a national campaign to reduce dietary fat consumption, finds that selection of credible spokespersons strengthened the campaign
- Jernigan and Wright review case studies of successful media advocacy and find that "who speaks for the campaign defines the campaign in the public eye. In particular, 'authentic' voices often frame and add power to the story being told."

7. CONSIDERS THE LIMITATIONS OF SOCIAL MARKETING.

Best Evidence: Andreasen, 1994; Ling; Maibach and others; Montazeri; Siegel and Doner

The PHN should be aware of the limitations of social marketing:

- Maibach and others, for instance, reporting on a 1996 consensus conference on the future of social marketing, note that the potential for social marketing is limited by:
  - lack of adequate financial resources
  - lack of support from senior management in public health organizations
  - lack of collaboration among organizations with complementary goals
  - a workforce inadequately trained in social marketing.

- Ling and others prepare a comprehensive literature review, from which they conclude that social marketing's major weaknesses are the:
  - heavy investments of time, money, and human requirements
  - the requirement for sustained promotional effort, which public health can rarely afford.
- Montazeri stresses that social marketing has value as a tool for effective communication, but should only be used in a "proper balance" with other public health approaches.

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[66] For further reading on how to do focus groups, see: Krueger, R. (1994). *Focus groups: A practical guide for applied research, (2nd ed.)*. Thousand Oaks, CA: Sage.

, Siegel and Doner discuss the peculiar role consumer demand plays in social marketing as opposed to commercial marketing (p. 31-38). In commercial marketing, demand is always at some level of positive; the consumer is interested in the product at least to some extent. The worst cases a commercial marketer faces are those in which demand is faltering (that is, demand has decreased) or irregular (demand fluctuates).

In marketing public health's "products" (that is, behavioral change):

< demand is a greater challenge; demand is almost always some level of negative:
  - **negative demand**
    the public dislikes the product, does not want it, and/or is not willing to pay the price for it
  - **no demand**
    the public is simply uninterested in the product
  - **unwholesome demand**
    the product the public does demand is counterproductive to their health (for example, alcohol and other drug consumption).
< the environment in which the marketing takes place is hostile (for instance, counter marketing competing for the same audience occurs at the same time)
< those doing the social marketing often lack the advocacy skills necessary to be effective.

8. EVALUATES BOTH PROCESS AND OUTCOMES.
Best Evidence: Manoff, 1985; Siegel and Doner

Monitoring social marketing strategies as they are "rolled out" is critical to success. Experts also emphasize evaluating outcomes, or determining if desired behavioral changes are attained. (A program might run well without achieving its intended outcomes.)

The dilemma, as noted elsewhere, is that social marketing approaches must be sustained for long periods of time to achieve change at systems and community levels. Change occurs slowly. This places greater importance on evaluating social marketing efforts along the way through measuring intermediate outcome indicators.

Notes from Abby

Alan Andreasen offers six markers of excellence in social marketing:

- Program managers understand the target audiences' needs, wants, perceptions, and present behavioral patterns before acting
- Program managers segment target markets, where politically feasible, and devise budgets and strategies that are specifically adapted to the characteristics of each defined segment
- All major elements of strategy and tactics are pretested with members of the target audience
- Program managers utilize the six steps of the behavioral change process:
  - < acquire knowledge regarding options
  - < embrace the values that permit behavior adoption
  - < perceive the behavior as potentially real to them
  - < conclude that the positive consequences of the new behavior exceed the negative
  - < believe that they have the ability to carry out the action required
  - < believe that others who are important to them support their action.
- Program managers explicitly recognize the existence of direct or indirect competition for the target consumer's behavioral choice.
- Strategies designed to effect behavior change always comprise the "4 P's" of marketing.

Andreasen, A. (1994, Spring). Social marketing: It's definition and domain. *J. Public Policy and Marketing, 13*(1), 112.

BEST EVIDENCE for Social Marketing

Each item was first reviewed for research quality and integrity by graduate students in public health nursing and then critiqued for its application to practice by at least two members of a panel of practice and academic experts. The nature of the material and a score expressed as a percentage are included at the end of each annotated citation. The percentage is the average of scores assessed by the experts who reviewed it. It reflects their opinion of the strength of the item's contribution to practice.

Review Articles

Ling, J., Franklin, B., et al. (1992). Social marketing: Its place in public health. *Annu. Rev. Public Health*, 13, 341-362.

The authors represent a comprehensive overview of the history and evolution of social marketing (SM) as a discipline, its theory development, its strengths and weaknesses, and its potential. (Note: Includes 71 references.)

History: First labeled social marketing by Kotler and Zaltman in 1971, it was used by Manoff in the 1960s for breastfeeding and oral dehydration therapy health education campaigns in developing countries.

Definition: "Social marketing uses marketing's conceptual framework of the 4 P's: Product, Price, Place, and Promotion. Social marketers adopted several methods of commercial marketing; audience analysis and segmentation; consumer research; product conceptualization and development; message development and testing; directed communication; facilitation; exchange theory; and the use of paid agents, volunteers, and incentives" (p. 342).

Strengths:

1. It brought greater precision to audience analysis and segmentation and added psychographic data (i.e., attitudes, preferences, personality traits) and social structure data (i.e., churches, worksite, family) to the traditional demographic data set used in public health
2. The systematic use of qualitative methods, such as focus groups, was added to public health methods
3. It introduced the use of incentives and special promotion efforts
4. Tracking of progress after implementation was promoted
5. Strategic use of mass media was introduced, targeting specific audiences as opposed to general public health outreach use of media
6. The realistic use of resources available is promoted
7. It pushes for attainment of high standards
8. The concept of "price" attached to behavioral change was introduced; public health workers tend to assume "if it is good for you, you must want it," when the real question is "how can we make people want it?"

Weaknesses:

1. Marketing practices require heavy investments of time, money, and human resources
2. Constraints on the 4 P's are inherent to public health
    a. Public health does not have the flexibility to adjust products and services to clients' interests and preferences
    b. Public health cannot move their products nearer the demand as readily
    c. Behavioral change through SM requires the commitment to a sustained promotional effort which public health can rarely afford
    d. Buying air time may erode the availability of PSA's over time

Future

1. Development of "development communication," or greater concern with interpersonal, group, and mediated communication, particularly with communities, is needed
2. Increased emphasis (and training) on communication for health educators must exist
3. Increased emphasis must be placed on public relations in public health (in the sense of media outreach, special events, in-house communication, and community education)
4. Evolution of a broader, more comprehensive perspective that includes policy, economic and social circumstances, personal altitudes, political and religious allegiances, societal norms and the entrenched interests of business, institutions, and certain professional groups is required
5. Increasing work must be undergone in the area of health promotion (here defined as a "broader version of health education).

Review=41%

Research Reports

Wright, Naylor, et al. (1997, October). Using cultural knowledge in health promotion: breastfeeding among the Navajo. *Health Education and Behavior, 24*(5), pp. 625-639.

A three-pronged intervention to increase breastfeeding on a Navajo reservation during the early 1990s is described and analyzed. On the community level, community empowerment techniques were implemented to create a more supportive collective opinion of breastfeeding; included were related radio spots, an infant T-shirt, billboards, and a slide tape show. On the systems level, provider education was used to change knowledge and skills regarding breastfeeding within the provider group. The individual intervention level (referred to as the "micro-change" level) included written and videotaped educational materials teaching breast feeding for use immediately post-partum, plus promotional materials for use prenatally. In addition, a native bilingual "foster grandmother" visited the maternity ward daily to talk with new mothers about her own breastfeeding experiences and how well her grown children were now doing. A new mothers' support group was also attempted, but abandoned after encountering unspecified difficulties.

Social marketing techniques were employed at all levels to create increased acceptance by incorporating cultural knowledge into promotional activities. Initially, ethnographic interviews were done to explore how infant feeding practices were related to daily life and to family and kinship and how they were influenced by traditional beliefs and other sources. This information was then incorporated into the promotional designs by reframing current understanding with the revised.

Qualitative= 76%

Jernigan, D., & Wright, P. Medica advocacy: Lessons learned from community experiences. *J. Public Health Policy, 17*(3), 306-330.

Media advocacy, or the strategic use of mass media and community organizing as a resource for advancing a social or public policy initiative" (p. 330), is derived from the following:

1. Media relations provide basic principles of how to identify and approach media
2. Social marketing provides insight into defining and targeting audiences and messages
3. "Guerrilla media," or the use of small amounts of hard-hitting advertising, bring attention to an issue and/or exert pressure on individual decision-makers

4. Community organizing influences media by showing widespread public support
5. Political campaign media controls what media covers and shapes how it covers it.

Through case studies focusing on the "4 P's" of marketing (i.e., product, promotion, place, and price) the authors demonstrate the following:

1. Media advocacy is most successful when linked to a strong community-organizing base and a long-term strategic vision. Broader coalitions open the way to bigger policy gains
2. Attracting media attention is rarely sufficient to achieve permanent change
3. Permanent change requires changing policy
4. Clarity about long-term goals, and development and communication of a media strategy, frame, and symbols that reflect those goals, are crucial to success
5. Media advocacy is cumulative–successful campaigns set up further efforts
6. The campaign's spokespeople define it in the public eye. In particular, young people and "authentic voices" often frame and add power to the story being told
7. Training and designating spokespeople keep the campaign's message clear
8. Making news–holding events, releasing research, or in some other way doing something "newsworthy"–will generally draw media attention
9. Advocates have power in relation to the media, in particular, the power to offer or withhold story ideas and information
10. Television requires visuals that tell the story in and of themselves
11. Understanding the different audiences served by different media outlets enables campaigns to target key constituencies. No media outlet or contact should be overlooked
12. It is necessary to practice good media relations, including maintaining relationships, being accurate, using every contact, and always having a spokesperson available
13. The media have their own agenda–advocates need to understand what motivates the media, and how their motivation differs from those of advocates
14. Controversy draws media attention
15. Media advocacy is often controversial and, as a result, is not for everyone or every situation
16. Controversy over the accuracy of advocates' facts should be avoided
17. Sensational tactics can attract media attention, but, alone, seldom achieve policy change
18. Opponents of policy change may try to encourage controversy, in order to divide, or sow the appearance of division, among coalitions for better health policies
19. Computer-based electronic communications systems and other emerging technologies can help in planning and sharing information
20. Different groups or individuals can play different roles in media advocacy, depending on the personal or institutional abilities and constraints
21. Research, both scientific studies and community-based data collection and documentation, is needed and helpful
22. Funding for ongoing organizing is critical and often scarce

"Media advocacy is about media, but more fundamentally, about advocacy, working to change public policies" (p. 327).

Qualitative=73.5%

de la Cuesta, C. (1994). Marketing: A process in health visiting. *J. Advanced Nursing, 19,* 347-353.
The author reports on a grounded theory study investigating how health visitors (in England) introduce their services to prospective clients and analyzing it using a marketing framework.
Results showed:
1. Health visitors openly viewed their work as sales, most typically in enrolling clients for services that they had not requested (e.g., mandatory home visits to all children under five years of age) and in situations of persuading individuals and families to adopt or change life styles.
2. Tactics used to make home visiting services acceptable, relevant, and accessible to clients:
   a. promoting the service to make it familiar, acceptable, and desirable (first encounter was critical)
      - •raising awareness: determining the client's wants or needs and then describing the services available to meet them
      - •personal presentation style exhibited by the health visitor was critical (personality and appearance)
      - •displaying or demonstrating available services
   b. adjusting delivery of the service to increase accessibility and reduce barriers
      - •bargaining a way, that is, allowing the client to choose the time, day of visit, etc.
      - •exhibiting timing and opportunism
      - •pacing
   c. tailoring the product
      - •making the "cost" attractive (both in terms of psychological cost to the client, as well as any monetary issues)
      - •arranging the agenda to "meet the client where they're at"
      - •negotiating and compromising: establishing goals that are attainable, rather than optimum
      - •performing "fringe work," or going beyond the usual and customary nature of the work, to accommodate the special needs of particular clients.

Qualitative=62.5%

Golden, L., & Johnson, K. (1991). Information acquisition and behavioral change: A social marketing application. *Health Marketing Quarterly, 8*(3/4), 23-60.
The article describes an application of market analysis and segmentation in a social margin campaign focused on AIDS prevention. Variables, including the core health beliefs element of the Health Belief Model, personal knowledge, personality and involvement, and demographic variables, were tested in a randomized telephone survey of residents of a southwestern state. The core health beliefs were important for all the health information variables tested. The authors conclude that "marketers need to first begin their strategy development with an understanding of how target market individuals perceive themselves in relationship to the disease" (p. 51). Specifically, they found that if an individual perceived themselves as severely at risk, acquisition of new information might be impeded. It is important, then, to use tactics that are consistent with the realities of the target individual.
Quantitative/Non-experimental=49%

Gries, Black, & Coster. (1995). Recruitment to a university alcohol program: Evaluation of social marketing theory and stepped approach model. *Prev. Medicine, 24,* 348-356.
Social marketing theory was tested in designing a marketing campaign to abate apathy among students and generate interest in alcohol reduction in a college dorm system. The intervention tested used the stepped approach model, which increases the intensity of an intervention presented in a series preceded by an aggressive social marketing campaign. Three dorms matched for demographics were used: one (test) was the source of

focus groups and in-depth interviews used to develop the marketing strategy; the second served as the control, receiving the invitation to participate through traditional methods; the invitations for the third (treatment) were based on social marketing principles of the 4 P's (i.e., price, place, product, and promotion). An attendance rate of 3-5 percent was considered successful (a rate similar to the rate considered successful in sales marketing). Attendance was much higher in the treatment dorm. Other factors found to be significant included focusing on altruistic motivations to assist another drinker, factual information about the effects of alcohol, personal benefit of abstinence, and attendance incentives (i.e., food, prizes).
Quantitative/Experimental= 44%

Expert Opinion

Gray, B. (1994). Health communicators as agents of social change. *AMWA Journal, 9*(1), 11-14.
Reporting information alone is insufficient to change health behaviors; "the processing of new information is impeded by disinterest; disagreement, personal altitudes, beliefs and faults and perceived social norms" (p. 11). Three "tools" are used to overcome these impediments:
Persuasion
In marketing regular commodities, producers determine what products consumers want then try to satisfy those wants. Ideally, persuasion is not needed, as the product should sell itself. Selling health behavioral change with social marketing is more difficult, since the "products" (i.e., attitudes or behaviors) are invisible to the customer and often unpopular. Commodity marketers use advertising (i.e., "the nonpersonal communication of persuasive information") to persuade but traditional verbal methods do not work well in conveying mood or attitude. Social marketers use, instead, image advertising, which visually puts the viewer in a scene that conveys the desired mood or attitude–the "primacy of image over fact." In addition, when verbal and nonverbal cues conflict, the nonverbal ones are the most compelling (p. 12).
Positioning
When more than an image of health needs to be conveyed, the message is positioned, meaning the benefits of the "product" are sold. "Benefits" are constructed to appeal to a hierarchy of human needs from physiological, safety, and social, to personal needs. The trick is to "position" the health attitude or behavior in ways that are meaningful to the consumer and will prompt action.
Segmentation
Researching the group for which change is desired (i.e., the "target-adopter" population) for characteristics that can be used to break the group down into subsections for specific marketing. Factors such as family, SES, and culture are frequent criteria applied.
Expert Opinion=71%

Manoff, R. (1997). Getting your message out with social marketing. *Am J Trop Med Hyg, 57*(3), 260-265.
This is a print of an address on social marketing given by Manoff at a l996 professional meeting. He offers numerous examples of how social marketing techniques are used to provide necessary information to control or prevent various tropical diseases in developing countries. In social marketing, the trick is to design messages by using a two-way process in which communication with people is used to ascertain how to communicate to them. It uses "feed-forward rather than feed-back, to listen to and learn from people in advance, not to replace feedback but to minimize feedback-shock–the belated discovery of preventable error" (p. 261). The "problem" often is found, after further probing via social marketing, to be only a symptom of the real problem that needs to be addressed.
Expert Opinion= 65%

Walsh, D., Rudd, R., et al. (1993, Summer). Social marketing for public health. *Health Affairs*, 104-119.

The authors provide an overview of the evolution and uses of social marketing in the early 1990s through a review of textbooks, conference proceedings, application of the concept in five different areas of disease prevention and health promotion, and interviews with 30 key informants in the field. They catagorize their findings based on the three phases of process elements associated with the discipline:

Phase One: Research and Planning

- •persistence and a long timeframe are essential; 10 years waiting for results is not unusual
- •segmentation of the audience is a critical task and needs to include psychographic variables (i.e., lifestyle and personality factors), as well as traditional demographics.

Phase Two: Strategy Design

- •incentive is used for motivation of all participants
- •teaching consumer skills supports behavioral change
- •malleable products are crucial for consumer satisfaction; "products" that support a set of health– promoting goals are essential and learned through close dialogue between health experts and the targeted consumer.

Phase Three: Implementation and Evaluation

- •program success requires leadership support
- •community participation builds local awareness and ownership
- •integration of feedback improves program effectiveness.

The authors conclude that three "powerful tensions remain unresolved":

1. Theory versus practice

practitioners view the intuitive approach as superior to the theoretical, although development of the latter is advancing

2. "Research to know versus research to show" debate
   - •Should resources be targeted toward formative or summative research?
3. Clash of market versus social values
   - •commercial marketer is satisfied with a 1-2 percent shift in a large market, whereas health promotion objectives generally seek behavioral shifts of 20-30 percent
   - •commercial marketers usually do not collect baseline data, preferring to use the funding instead for formative research and product design
   - •commercial marketing selects the easy targets, while social interventions often seek out the hard-to-reach bottom 11 percent of the population so lacking in resources that commercial marketers would never consider them
   - •for many, use of marketing orientation in public health seems fundamentally at odds with the core values of public health
   - •social marketing emphasizes individual change strategies and deflects attention from the social and physical environment
   - •marketing reflects commercial values and interest and is, therefore, part of the problem.

Future Issues
1. Determining where social marketing can have its largest effect
2. Paying closer attention to cultural appropriateness and boundaries between persuasion and manipulation.
Expert Opinion=57%

Samuel, S. (1993, Jan-Feb). Project LEAN–Lessons learned from a national social marketing campaign. *Public Health Reports, 108*(1), 45-53.
The author reports on the achievements of the project begun in 1987 and funded by a private foundation to reduce dietary fat consumption to 30 percent of total calories in American diets. A national campaign was implemented to promote these dietary changes among persons, reinforce the changes through organizations, and facilitate the change in settings where people make food choices. Important lessons learned were:
1. Advertising and public health professionals must be more aware of their differing approaches to the development of messages
2. Well-placed publicity, not public service advertising, may be the most appropriate and effective communications strategy for national campaigns
3. Media monitoring and tracking must be built into the program
4. National campaign strategies and material have important benefits for state or community programs
5. Building a network of state and local programs strengthens and sustains the campaign
6. Selection of credible campaign spokespersons strengthens the message
7. Partnership with other organizations is an essential ingredient for success.
8. Collaboration with the private sector expands the campaign.
Expert Opinion=55%

Blair, J.E. (1995, October). Social marketing: Consumer focused health promotion. *AAOHN Journal, 43*(10), 527-531.
Blair, an occupational health nurse, describes application of social marketing principles as a means of increasing participation in employee wellness programs. Marketing begins with a study of consumer needs and wants. Next the 4 P's of marketing are applied, conceiving of employee wellness as a product at three levels: core (the benefit gained), tangible (the actual gain), and augmented (tied to long-term adherence to the chosen behavior). The author concludes that, to be successful, social marketing: 1) provides a theoretical basis to increase awareness of preventable health conditions and participation in wellness programs; 2) has a philosophy that underscores the necessity to be aware of, and responsible to, the consumer's perception of needs; 3) is distinguished by its emphasis on "non-gamble" and of products such as disease, attitudes, and lifestyle changes; 4) has a marketing mix that is a social marketing strategy intertwining elements of product (price, place and promotion) to satisfy the needs and wants of consumers.
Expert Opinion=52%

Woodruff, K. (1996, August). Alcohol advertising and violence against women: A media advocacy case study. *Health Education Quarterly, 23*(3), 330-345.
The author describes a community organizing and media advocacy campaign in California in the early 1990s to pressure the alcohol industry to change the sexist ways in which women are portrayed in their advertising and promotion. More than 80 groups came together to petition the industry's three major trade associations to amend their advertising code to include items addressing their concerns. The wine industry group agreed, but the beer and distilled spirits groups refused. The campaign then turned to media advocacy, focusing on the key

elements described by Wallack et al.: assure community consensus; focus on public health; set the agenda; gain access; and reframe the debate. Lessons learned regarding media advocacy include starting where the journalists are; developing professional relationships with journalists; building coalitions based on commitment, not convenience; agreeing in advance on an appropriate level of confrontation; planning several ways to keep the issue on the media agenda; not being seduced by the spotlight; remembering media advocacy is only one method. Expert Opinion=46%

Stubblefield, C. (1997). Persuasive communication: Marketing health promotion. *Nursing Outlook, 45,* 173-177.

The author suggests that "effective health education depends on selecting the most appropriate theory and related interventions" and that "integrating marketing principles into health promotion efforts" would increase effectiveness in relation to promoting lifestyle changes (p. 173). She describes the message-learning approach to persuasive communication. Factors include:

1. Source: who is delivering the message
   - •credibility
   - •perceived power
   - •intent to persuade
2. Message: what is being suggested
   - •*fear*: the message provides a strong argument that the recipient will suffer negative consequences if the recommendations are not accepted, and the message provides strong assurance that adoption of the recommendation will eliminate the negative consequence
   - •*cognitive dissonance*: creating a message that is in conflict with beliefs promotes consideration of those beliefs and the potential to change them
   - •*concrete, vivid information versus abstract*: personal stories are remembered
   - •*negative versus positive appeals for health behavior change*: the value of an option will seem greater when framed in terms of potential losses from not acting on the option, rather than in terms of potential gains for action on it; negative consequences are more likely to prompt health promotion-related actions

Stubblefield speaks to the ethical concerns raised by some that persuasive communication is manipulation and, therefore, inappropriate to use in health education. She suggests that health professionals first ask the following questions before launching such approaches:

1. What are we selling?
2. Who are we selling it to?
3. How are we selling it?
4. Whose side are we on?

Expert Opinion=44%

Maibach, E., Shenker, A., & Singer, S. (1997). Consensus conference on the future of social marketing. *J. of Health Communication, 2,* 301-303.

The field of social marketing was started in 1971; this conference was held to review the first 25 years and look ahead; data was collected via a pre-conference Delphi process and reported at the meeting. Based on the results, a modified model was designed, featuring the following 10 elements:

1. Social marketing programs are designed to respond to the audience's needs, wants, and perceptions
2. The objective of social marketing programs is to promote appropriate behavioral change among audience members

3. Research is used to segment and profile target audiences and to identify appropriate distribution and promotion channels
4. Formative research is used to develop and test concepts and executions
5. Strategies are developed and implemented specifically to meet the perceived needs of the target audiences
6. Ideally, products are delivered through distribution channels identified in audience research
7. Programs are promoted through media and organizational channels identified in audience research
8. There is meaningful tracking of program implementation through process evaluation
9. Audience response is documented through the impact of routine evaluation
10. Evaluation data are used to modify and improve the program.

Barriers to consistent and optimal application of the model:
1. Inadequately trained workforce
2. Limited financial resources
3. Lack of support from senior management
4. Lack of collaboration among organizations with complementary goals.

Expert Opinion=32.5%

Montazeri, A. (1997). Social marketing: A tool not a solution. *J. Roy Soc Health, 117*(2), 115-118.

The author discusses the strengths and limitations of social marketing and concludes that
1. Social marketing has value if it is used as a tool for effective communication of health-related messages and not as an end in itself
2. Social marketing should be used in a proper balance with public health-oriented approaches.

Expert Opinion=25%

Texts and Monographs

Andreasen, A. (1994, Spring). Social marketing: Its definition and domain. *J. Public Policy and Marketing, 13*(1), 108-114.

In this article, the author reviews the historical evolution of social marketing and suggests a revised, more precise definition be adopted so that it "not be held responsible for failures for which it should not be held accountable" (p. 108).

Kotler and Zaltman's 1971 definition (the first formal definition):

"Social marketing is the design, implementation, and control of programs calculated to influence the acceptability of social ideas and involving considerations of product planning, pricing, communication, distribution, and marketing research."

Problems with it:

- has a confusing name
- is unclear whether private-sector marketing can do social marketing
- limits social marketing to ideas, whereas it also involved attitudes and behaviors

Proposed:

"Social marketing is the adaptation of commercial marketing technologies to programs designated to influence the voluntary behavior of target audiences to improve their personal welfare and that of the society of which they are a part."

Better because it
keeps social marketers focused on the outcomes they are best suited to influence
keeps the discipline of social marketing distinguishable from its academic "competitors"
keeps social marketing programs out of areas in which their likelihood of failure is high
Key Elements
1. If commercial marketing's "bottom line" is production of sales, social marketing's should be "influencing behavior"
2. Social marketing is applied to a program, not only a campaign, and therefore, needs to continue across time
3. Social marketing is focused on behavioral change and should not be diverted for other purposes as that would be an "enormous waste"; it is not communication, it is not education, it is not propaganda
4. Social marketing programs influence behavior; they do not always change it
5. Social marketing seeks to influence voluntary behavior
6. Social marketing seeks to benefit target consumers and/or the society as a whole, not the marketer.

Proposes three criteria be met in order to be considered social marketing:
1. Applies commercial marketing technology
2. Has as its bottom line the influencing of voluntary behavior
3. Seeks primarily to benefit individual/families or the broad society and not the marketing organization itself

Offers Eight Characteristics of Excellence in Social Marketing
1. Program managers understand the target audiences' needs, wants, perceptions, and present behavioral patterns before acting
2. Program managers segment target markets, where politically feasible, and devise budgets and strategies specifically adapted to the characteristics of each defined segment
3. All major elements of strategy and tactics are pretested with members of the target audience
4. Program managers conceive of the decision process by which target consumers commit to and understand a six-step target behavior (p. 112)
5. The program explicitly recognizes that it faces direct or indirect competition for the target consumer's behavioral choices.
6. Strategies designed to effect behavioral change always comprise all four elements of the "4 P's" marketing mix.

Andreasen, A. (1995). ***Marketing social change: Changing behavior to promote health, social development, and the environment*** **(pp. 1-32). San Francisco: Jossey-Bass.**
Defines social marketing as:

> "Social marketing is the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of program designed to influence the voluntary behavior of target audiences in order to improve their person welfare and that of their society" (p. 7).

Key Points:
1. The ultimate objective of social marketing is to benefit targeted individuals or society and not the marketer
2. The basic means of achieving improved welfare is through influencing behavior, in most cases bringing about a behavioral change
3. The target audience has the primary role in the social marketing process.

Why Social Marketing Works Better Than...

1. The Education Approach, which assumes that individuals will do the right thing if only they understand why they need to do it and how to do it. The author critiques the Health Belief Model to demonstrate what does not work with the education approach:
    a. Does not focus on behavior, but, rather, assumes that if one can change beliefs, behavioral change will follow
    b. Ignores the effects of social pressure
    c. Does not acknowledge that delivering facts to change beliefs may have a "boomerang" effect and actually provide negative results
2. The Persuasion Approach, which assumes that action takes place only if people are sufficiently motivated. This requires the consumer to adopt the persuader's view of the world (which may or may not fit for the consumer)
3. The Behavioral Modification Approach, which assumes that people do what they do because they learn the techniques and are rewarded for it. However, this is very costly, because it has to be carried out at the individual level
4. The Social Influence Approach, which assumes that changing community norms and collective behavior is the most cost-effective way to reach and change individuals and families. However, it is only effective when the following conditions are met:
    a. Social issues and norms are well understood and accepted
    b. The pressures to conform are extremely strong
    c. The behavior is understood as socially important and visible.

<u>Key Features of Social Marketing</u>

1. Consumer behavior is the bottom line
    Learning facts is only important if it leads to a desired behavioral outcome
    because behavioral change is a long-term effort, smaller steps need developing
2. Programs must be cost effective, which makes trade-offs, ignoring certain markets, seeking cooperative alliances, etc., part of the activity
3. All strategies begin with the customer
    Recognize that customers only take action when they believe that it is in their interest;
    begin with an understanding of the target audience's needs and wants, their values, their perceptions
4. Interventions involve the "4 P's":
    Product: it proposes the right kind of behavioral offering
    Price: perceived benefits outweigh the costs to the customer
    Place: behaviors must be easy to do
    Promotion: it employs the kind of promotional technique most appealing to the audience
5. Market research is essential to designing, pretesting, and evaluating intervention programs.

Since customers control outcomes, it is critical to know "where they are coming from"

6. Markets are carefully segmented, recognizing that customizing approaches to special populations is effective
7. Competition is always recognized, in that, for every choice a customer makes, there are competing interests that must be considered.

Text=80%

Siegel, M., & Doner, L. (1998). *Marketing public health: Strategies to promote social change* (pp. 29-65). Gaithersburg, MD: Aspen Publishers.

Chapter 2: A Challenge for the Public Health Practitioner

Public health, by its very nature, is in the business of marketing, since achieving health, whether individual or societal, requires an exchange–the key requirement of marketing. The authors conclude, therefore, that the "primary challenge of the public health practitioner is to market social change" (p. 31). The change is in three specific areas: lifestyle choices (individual level); changes in social and economic conditions (community level); and changes in social policy (systems level).

This presents an unique marketing challenge for three reasons:

1. *Unfavorable state of individual and societal demand for social change*

   In commercial marketing, there are eight states of the demand level for a product which require different marketing techniques: full, overfull, faltering, irregular, and latent

   In social marketing, there are three demand levels: negative demand (most public health products), no demand, or unwholesome demand.

   - Negative demand: the public dislikes the product, does not want it, and is not willing to pay for it regardless of the benefits (e.g., reducing intake of fatty fast foods)
   - No demand: the public is simply uninterested in the product (e.g., job training for the homeless)
   - Unwholesome demand: the choices are deemed undesirable and unhealthy by public health practitioners, but are in high demand by the public (e.g., tobacco, drugs)

2. *Hostile environment in which social change must be marketed*

   Social marketers often face competition from counter-marketing forces, making the effort even harder. One source is active, such as campaigns by tobacco companies promoting smoking, while public health is trying to reduce use. The other source is passive and embedded in the social environment via ingrained social norms.

3. *Limited training in the skills necessary to market social change*

   - Inadequate emphasis on advocacy in public health practice, which is often confused with lobbying
   - Limited expertise in advocacy among the current public health workforce
   - Inadequate training in advocacy for public health students and practitioners

Chapter 3: An Opportunity for the Public Health Practitioner

Marketing Individual Health Behavior Change

Studies show that it is not really health itself that people value, but the freedom, independence, autonomy, and control over their lives that it affords. Therefore, the most compelling "product" a public health professional can "sell" is not health, but all the things that come with health. It also is important to keep in mind that if people maintain certain behaviors (such as smoking), they usually have a good reason for doing so–rational or not. "The key is to redefine the public health product and its benefits in a way that appeals to the most compelling core values of the target audience....The public health practitioner must first find out what the consumer wants and then redefine, repackage, reposition, and reframe the product in such a way that it satisfies an existing demand among the target audience" (p. 48-49).

1. Finding Out What the Consumer Wants

"Before public health practitioners can design programs that will be successful in changing individual behavior, they must attempt to get under the skin of their target audience and to explore core values...and how they related to the audience's perceptions of health, disease, behaviors, behavior change, and the experience of illness" (p. 50).

2. Redefining the Public Health Product

Remember that customers only take action when they believe that it is in their interests:

"Public health practitioners must learn to redefine the public health product so as to offer a promise that appeals to people's core values" (p. 52).

3. Repacking, Repositioning, and Reframing the Public Health Product

The process includes the search for appropriate metaphors, symbols, words and phrases, visual images, and themes" (p. 53). In reframing public health products, practitioners must recognize that the most deeply ingrained core value (i.e., freedom) has two meanings: the freedom from something, as well as the freedom to do something.

Components of these include:

1. Defining the product
2. Determining the promise of the benefit that the product should offer
3. Developing an image for the product that is consistent with the promise
4. Providing support for the promise.

Marketing Public Health Programs and Policies

The process here is similar to marketing behavioral change to individuals, except that the target audience is not the individual, but the public in general and policy-makers in particular. However, the needs and wants of policy-makers regarding health and a healthy society are different from those of the individual:

"Public health practitioners must begin to sell something other than health itself, or health behavior change itself, if they are ever to be effective in addressing the chronic disease epidemic.

PFirst they must begin to sell freedom, independence, control, identify, and rebellion. In other words, they have to redefine their product so that it offers benefits that will fulfill a clearly identified need or desire among their target audience.

PSecond, they must package the product, position it, and frame it in a way that appeals to their audience's core values. This means that it must place and promote the product in a way that will demonstrate to their audience how the practice will fulfill their desire or needs....The practitioner must define the product so that it

Soffers a benefit desired by the target audience,

Soffers a promise for how the product will satisfy important needs and desires of the target audience,

Spresents a visual image of the product that reinforces the audience's core values **S**provides support or documentation that the product will indeed deliver the promised benefit

Each of these components of the market strategy must work together to reinforce the most important and compelling core values of the target audience."

Text=74%

Manoff, R. (1985). ***Social marketing: A new imperative for public health*** **(pp. 106-117). New York: Praeger.**

A stepwise process for developing a social marketing plan is provided:

Strategy Development

1. Define the problem and set the objectives
2. Identify the target audience
3. Define the proposed behavioral change
4. Identify the resistance points
5. Assess media availability
6. Design the product, i.e., the strategic response to the product
7. Choose distribution systems
8. Conduct research about the primary audience

Strategy Formulation

9. Determine messages or the principle point needing to be conveyed
10. Target audiences and segments
11. Determine media
12. Delineate the product (i.e., consumer target groups, physical characteristics, consumer benefits(s), name, pricing, packaging, promotion strategy, and distribution channels
13. Conduct research on tracking methods for evaluation
14. Integrate with other ongoing activities

Strategy Implementation

15. Prepare prototype materials
16. Test materials
17. Prepare final
18. Inaugurate
19. Determine resource requirements

Strategy Assessment

20. Conduct process evaluation
21. Conduct summative evaluation
22. Determine resource requirements.

Text=56.5%

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Public Health Interventions

Applications for Public Health Nursing Practice

Policy Development & Enforcement

Public Health Nursing Practice for the 21st Century
March 2001

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INTERVENTION: POLICY DEVELOPMENT AND ENFORCEMENT

Interventions **are activities taken by PHNs on behalf of communities and the individuals and families living in them.**

Assumptions about all PHN Interventions...

- They are population-based; that is, they:
  - **S**are focused on an entire population
  - **S**are guided by an assessment of community health
  - **S**consider broad determinants of health
  - **S**consider all levels of prevention
  - **S**consider all levels of practice
- The public health nursing process applies at all levels of practice.

Definition

Policy development places health issues on decision-makers' agendas, acquires a plan of resolution, and determines needed resources. Policy development results in laws, rules and regulations, ordinances, and policies. Policy enforcement compels others to comply with the laws, rules, regulations, ordinances, and policies created in conjunction with policy development.

Examples at All Practice Levels

Population-of-interest: *Entire community*
Problem: *Housing hygiene*

Community Example:

Public health periodically receives calls from concerned citizens regarding isolated elderly living in questionable housing conditions. The public health nursing agency views such reports as a reflection of a community norm that is, in effect, an informal policy. Every call is responded to with the belief that each call deserves an assessment, despite the possibility of a crank call. This practice, in turn, encourages continuing community involvement.

Systems Example:

As part of the response to a specific housing hygiene report (see individual example) a PHN meets with the county attorney, the sanitarian, law enforcement officer, and social worker. While they acknowledged that there was a problem, their conclusion was that the situation was not a public health nuisance. After a year of repeated contacts, the client agreed to move into a small apartment. Two weeks later the garage burned due to spontaneous combustion. The fire chief notified the PHN that he would not allow his men to enter the house again due to unknown hazards in the debris. Further investigation finally resulted in an abatement order. After this situation, the PHN met with the county attorney to propose a land use ordinance that would declare a property a public health nuisance if it presented a threat to the health of emergency personnel.

Individual/Family Example:

A PHN received several referrals from concerned citizens regarding the safety of an 80-year-old woman living by herself in her childhood home. The PHN's assessment revealed a farm site littered with old cans, garbage, clothes, vehicles, and a double car garage stuffed full of clothing. The lady was dressed in many layers of clothing. Eighteen cats lived with her in a house with floors covered with twelve inches of cans, clothes, cat feces, and other debris. The house had no running water and the only source of heat was a lamp next to a bed heaped with clothing. The entrance door was permanently ajar due to debris, resulting in skunks living in the basement. The client stated that she could not tolerate the entrance door being closed because cats die and their spirits could not leave if the door was closed. Despite the PHN's efforts, the client refused to accept any assistance to clean up her house. The PHN initiated a vulnerable adult evaluation (as required under law) that resulted in a "not sufficiently vulnerable" finding. Though repeated contacts, the PHN was able to establish a relationship with the woman and successfully initiated a referral to a physician and local home care provider. However, her living conditions were unchanged.

Relationships to Other Interventions

Policy development and enforcement relates to a variety of other interventions. Since its intent is to bring health issues to the attention of decision-makers for the purpose of changing laws, rules, regulations, ordinances, and policies, it is frequently paired with other interventions operating predominantly at the community or systems practice levels, such as **collaboration, coalition building,** and, especially, **community organizing.** The system's level of health teaching, **provider education,** often follows policy development and precedes, or is implemented in conjunction with, policy enforcement. **Advocacy** is a frequent co-intervention at this level. In contagious disease outbreaks, policy development and enforcement is frequently paired with **surveillance, disease and health event investigation, screening, outreach, case-finding, referral and follow-up, and case management.** At the individual/family level, policy development is often paired with **health teaching, counseling, consultation, case management, and advocacy.**

BASIC STEPS for Policy Development and Enforcement[67]

Working alone or with others, PHNs…

1. Identify problems experienced by the target population for which a policy solution would be appropriate; *reframe the problem* into a policy issue by asking: What could or should be done about this issue?

- establish the policy agenda
- consider the values held by decision-makers and stakeholders engaged in the policy development
- develop and analyze options for resolution
- identify the policy-making body with jurisdiction over the issue
- identify other individuals and groups who might also be interested in working toward resolution of the issue.

2. *Formulate* the policy

- present the issue and options for resolution to policymakers
- establish objectives
- draft the policy language
- identify stakeholders and other interest groups and invite their participation, often through hearings (where appropriate) or written comments.

3. *Adopt* the policy language

- add budget and funding requests
- carry out hearings or other means of soliciting input from stakeholders.

4. *Implement* and monitor the policy

- develop rules and guidelines necessary for a functioning program, including conditions requiring enforcement
- disseminate rules and guidelines to those impacted by the policy or otherwise needing to know
- determine how the policy will be monitored and who will monitor it
- monitor policy implementation.

5. *Enforce* components of the policy where compelling compliance has been authorized

- encourage compliances first through education about the policy and its rationale
- negotiate conditions of compliance as allowed in the policy
- assure due process
- institute methods to force compliance as allowed in the policy if conditions are not met.

[67] Adapted from J. E. Anderson's model, as presented in Barbara Hanley's chapter (1993) in Mason, Talbott, & Leavitt (Eds.). *Policy and politics for nurses: Action and change in the workplace, government, organizations, and community* (2nd ed.) (pp. 75-79). Philadelphia: WB Saunders.

6. ***Evaluate* the policy for effectiveness**
   Based on data and other feedback regarding intended and unintended consequences of policy implementation, modify the policy by repeating the basic steps.

Notes from Abby

Patricia Smart, writing in Milstead's *Health Policy and Politics: A Nurse's Guide*, notes there are five basic categories of "tools" or methods to be used when designing policy:

- *Authority Tools*: those (such as regulations, rules, or mandates) used to guide the behavior of agents and officials at lower levels
- *Incentive Tools*: tangible payoffs (positive and negative) promoting action without encouragement or coercion.
- *Capacity Tools*: information, training, education, and resources enabling individuals, groups, or agencies to make decisions or carry out activities.
- *Symbolic Tools (such as logos)*: those appealing to individual's, groups', or agencies' systems of beliefs and values.
- *Learning Tools*: those used when it is unclear what would motivate the target population into action.

Milstead, J. (Ed.). (1999). Gaithersburg, MD: Aspen Publications, p. 159.

Application to Practice...
Much of the literature written for nurses on policy development focuses on influencing federal-level policy. However, in the work world of the typical PHN, it is much more common to deal with policy at the local level. The basic steps and best practices presented for policy development can be adapted in most circumstances.

Notice, the basic steps describe *policy* development, not *political* involvement. It is true that some degree of "politicking" (in the sense of using influence or otherwise attempting to persuade decision-makers) is inherent in the process of setting the policy agenda. Authority boards with whom PHNs work will often have established rules of conduct (often unwritten) about how much and what kinds of influence (i.e., "politicking") is allowable from their staffs. Similarly, most boards will have established rules of conduct regarding staff involvement in partisan politics; the PHN is wise to be aware of these.

BEST PRACTICES for Policy Development and Enforcement

Best practices are recommendations promoting excellence in implementing this intervention. When PHNs consider the following statements, the likelihood of their success is enhanced. The best practices come from a panel of expert public health nursing educators and practitioners who blended evidence from the literature with their practical expertise. These best practices are not presented in any ranking or particular order; each may not apply to every implementation of the intervention.

1. UNDERSTANDS THAT ALL PUBLIC HEALTH NURSING IS POLITICAL.
Best Evidence: Aroskar; Cohen; Evers in Farrunt and Ever

Public health nurses need to understand (and believe) that their involvement in policy development and enforcement is a social mandate grounded in public health nursing's ethic of caring and commitment to social change and social justice.

As Aroskar states, "As nurses we have opportunities to raise [ethical] questions in any number of arenas in policy review mechanisms, in proactive policy development or revision of existing policies, both in our own institutions and in the wider community" (p. 270). She offers Warwick and Kelman's discussion of the areas of policy where ethical issues should be raised before decisions are made, noting they include:

- the choice of policy goals that maximize certain values and minimize others
- the definition of the target population and their involvement
- the means chosen to implement the policy (these have the potential to range from coercive to voluntary)
- a consideration of the direct and indirect consequences of a proposed policy.

Cohen and Mason provide a continuum of the developmental stages through which nurses progress in their political activism:

- *buy-in level*: reactive response to a perceived personal professional threat or a "wake-up call," with a focus on nursing issues
- *self-interest level*: reactive to nursing issues, but from a "what's in it for me" perspective
- *political sophistication level*: proactive on nursing and other health issues
- *leading the way level*: proactive on leadership and agenda-setting for a broad range of health and social policy issues.

Hall-Long provides an interesting review of nursing's involvement on the political scene[68] and concludes with a rouser or "call to action" to encourage nurses' involvement in the policy arena: "Following the lead of our political pioneers risk-taking behavior, contemporary nurses need to face the political challenges of the 21st century to guarantee representation around the public policy-making tables. Once around those tables, political voices and power will be welded to the nursing profession and to the consumers they represent" (p. 28).

[68] Hall-Long, B. A. (1995, January/February). Nursing's past, present, and future political experiences. *N&HC: Perspective on Community, 16*(1), 24-28.

2. USES SCIENCE-BASED EVIDENCE TO INFLUENCE POLICY DEVELOPMENT AND ENFORCEMENT.

Best Evidence: Badovinec; Conn; Hanley; Spradley and Allender; Swanson and Nies; Milstead

Science-based evidence used for policy development should be comprehensive and succinct and should include an analysis of financial impact.

Most of the textbook authors reviewed adapted their models of policy development from J.W. Kingdon.[69] Kingdon suggests that three "streams" have to come together at the right "window of opportunity" in order for public issues to be addressed through policy.

The three streams are:

1. The Problem Stream
   This stream is marked by indicators (such as economic or health indicators) of a problem, by a sudden crisis, or by feedback that a program is not working as intended.

2. The Policy Stream:
   Ideas for policy change come from everywhere. It does not matter where or from whom the idea comes. What matters is what made it take hold and grow. To "stay," a policy idea must meet the following five criteria:
   - Technical feasibility
   - Value to the community
   - Tolerable cost
   - Anticipated public agreement
   - Reasonable chance elected officials will be receptive to it.

3. The Political Stream:
   This stream includes public mood, pressure group campaigns, election results, composition of the decision-making board, and changes in top management.

The fourth variable is the probability that the "streams" will converge at the right "window of opportunity," or time. Agendas are affected more by the problem and political streams. The policy stream is affected more by which criteria (feasability, value, cost, public agreement, or officials' receptiveness) is strongest at that moment. "Windows" open for developing or changing policy, because of changes in the political stream or because new problems capture officials' attention.

[69] Kingdon, in turn, based his model on previous work by Cohen, March, and Olsen's "garbage can" model which describes the policy process as "series of options floating around seeking a problem" (Hanley, p. 74). See: Cohen, M., March, J., & Olsen, J. (1972, March). A garbage can model of organizational change. *Administrative Quarterly Review, 17,* 1-25; Kingdon, J. W. (1995). *Agendas, alternatives, and public policies.* New York: Harper Collins College Publishers.

Public health nursing significantly impacts policy development in the problem "stream." Data that support the existence of problems and their consequences on health have huge importance there. Although PHNs gather and interpret epidemiological data, they often fail to use the data to support policy development.

Conn and Amer point out that data do not speak for themselves. Their suggestions for presenting results to policy-makers are good advice for any data presentation:

- do not bore policy-makers with the details of how data is collected and interpreted
- present only the major points, using the most dramatic statistics
- use anecdotal evidence (that is, stories) to personalize the meaning of the results; the more they can reflect real situations from a policy-maker's own constituency, the greater their impact (p. 270).

3. INCLUDES PARTICIPATION OF THOSE CONSTITUENCIES POTENTIALLY AFFECTED BY THE POLICY.

Best Evidence: Badovinec; Evers in Farrunt and Evers; Hanley; Spradley and Allender; Swanson and Nies; Milstead; Longest

Good policy is made better when those affected are involved. Across authors, however, a range of opinion exists about when and how to involve constituents[70] (that is, members of a group sharing common characteristics, such as all persons living in the same voting district).

Longest, for instance, acknowledges that while constituents need to be engaged in the process to reduce their resistance to change, they often come to the discussion with unalterable "mindsets."
He categorizes the four prevailing mindsets on this issue as:

- **True Romantics**
  those who choose to ignore the concept of economic limits
- **Pseudo Romantics**
  those who understand economic limits, but choose to think that someone else in the future will figure out the details
- **Truly Self-Serving**
  those so intent on ensuring that their own interests are served, that other issues become secondary
- **Procrastinators**
  those who understand economic limits, but choose to delay action, usually due to the potential for political repercussions.

On the other end of the continuum are those invested in "community empowerment" concepts, where the members of the community themselves are the policy-makers. (See the **advocacy** intervention for further discussion of empowerment.)

[70] The entire March 2000 issue of the *Journal of Public Health Management Practice* is devoted to developing a constituency for public health. For a description of one state's approach (with nine recommendations to developing county commissioners as one of those constituencies), see Lind, P. & Finley, D. (2000, March). County commissioners as a key constituency for public health. *J. Public Health Management Practice*, *6*(2), 30-38.

4. DEVELOPS SKILL NECESSARY FOR POLICY DEVELOPMENT AND ENFORCEMENT.
Best Evidence: panel recommendation based on practice expertise

The Expert Panel recognized that the inherent potential for conflicting viewpoints in policy development requires PHNs to have expert communication skills, particularly in the areas of conflict management, negotiation, and mediation. Those PHNs involved in ***policy enforcement*** must have these skills.

5. BUILDS PERSONAL AND PROFESSIONAL SUPPORT SYSTEMS.
Best Evidence: panel recommendation based on practice expertise

Public Health Nurses need to develop both personal and professional support systems to deal with the ethical dilemmas and role conflict occasionally encountered in policy development and enforcement.[71] Whenever possible, a PHN should seek a mentor as part of this support system. The more PHNs take on the role of **advocating** for policy development and becoming politically active, the more likely they will need a strong support system.

6. UNDERSTANDS THE LIMITATIONS OF POLICY DEVELOPMENT AND ENFORCEMENT.
Best Evidence: Longest; Milstead

The PHN should strictly adhere to the policy implementation plan. Marlene Wilken, writing in Milstead's textbook, describes the multiple areas where policy implementation can go awry:

Tractability, or the degree of difficulty encountered in the management and control of implementation. It includes such things as whether or not the agency charged with administering the policy has access to:

- technology required to enact and enforce the policy
- staff who possess the necessary competencies
- resources sufficient to deliver the program enacting the policy
- composition of the target group whose behavior is to change
- management competencies equal to the complexity of the change created by the policy.

Structure, or the extent to which the implementing agency can structure or organize the process of policy enactment:

- clear objectives
- causal links established between the interventions and the desired change
- sufficient jurisdiction and authority to make things happen.

[71] Readers of these best practices interested in further enhancing their skill set in this area could benefit from reading *Negotiating at an Uneven Table: A Practical Approach to Working with Difference and Diversity* (1996) by Phyllis Beck Kritek, professor of nursing and chair of the Department of Mental Health and Management, University of Texas/Schools of Nursing.

Nonstatutory variables, or environmental factors:

- socioeconomic conditions
- public support
- prevailing attitudes of staff
- resources of constituency groups
- commitment and leadership skill of the implementing officials.

Independent variables, or

- extent to which the organization or agency charged with enacting the policy may choose to undermine the intent of the policy by inserting regulatory program elements they are unable to put into the policy itself
- pressure from rival agencies
- public acceptance of the program.

7. UTILIZES BOTH INFORMAL AND FORMAL POLITICAL PROCESSES.

Best Evidence: Badovinec; Cohen; Conn and Amer; Kingdon as found in Longest and Milstead; Furlong in Milstead

If PHNs are to be effective in policy development, they must be very familiar with both the formal and informal ways in which policy work is done. Formal ways include knowing the legislative process at both the state and federal levels of government. They also include knowing how any organization or group sets its policy. This is usually explained in a constitution or set of bylaws established by the group. The most difficult step, however, in advancing the issue to be addressed, is to get decision-makers' agendas. This requires engaging them in the issue, a largely informal process based on interpersonal relationships. Overall, policy development is largely an informal process requiring patience, presence, and timing.

Presence means to be visible or known as associated with a policy issue. The more PHNs can establish a visual association between themselves and an issue, the more likely policy-makers will remember who they are or, at least, what they stand for. At times, borrowing a well-known person, such as a sports figure or movie star, to serve as the issue's "spokesperson" can create the needed "presence" for the issue. Every issue needs a champion or a cheerleader–an advocate–to keep it alive and capture the interest of others.

Timing means knowing when to push forward with an issue and when to hang back. As those authors who reference Kingdon and his three policy "streams" note, success is all in the timing. The "window of opportunity," as Kingdon calls it, will only be open to a policy suggestion when all the political conditions are in the right place.

Furlong presents a case study of the ten-year process it took to create the National Institute for Nursing Research within the National Institutes of Health. Although largely a story of what happens when both poor timing and competing champions exist, it is instructive, nevertheless. Policy-makers are not patient with groups or organizations who present opposing or even differing views of the same policy issue; they generally just want to know who is for a policy and who is against it. They also need to hear and see the issues brought forward by someone the constituents support as their spokesperson who is also articulate and accustomed to public debate.

Notes from Abby

Trevor Hancock, writing in Farrunt and Evers' *Healthy Public Policy at the Local Level* (1990), suggests that public policy that promotes health will reflect the following principles:

- A long-term view
- Political commitment
- Processes and structures that allow different sectors to work together (for example, coalitions, collaboratives, councils, task forces, etc.)
- Public support
- Community-driven process
- Multifaceted strategies
- Credibility and expertise on the parts of both the initiator and spokesperson
- Win/win solutions
- A new organizational culture to maintain it (p. 9)

Hancock also notes that "health may be a useful metaphor for addressing issues such as social injustice and environmental deterioration."

BEST EVIDENCE for Policy Development and Enforcement

Each item was first reviewed for research quality and integrity by graduate students in public health nursing. It was then critiqued for its application to practice by at least two members of a panel of practice and academic experts. The nature of the material and a score expressed as a percentage is included at the end of each annotated citation. The percentage is the average of scores assessed by the experts who reviewed it. It reflects the strength of the item's contribution to practice in the opinion of the experts.

Review Articles

none

Research Reports

Coburn, A. (1998, January/February). The role of health services research in developing state health policy. *Health Affairs, 17*(1), 129-151.

Funded by a grant from the Robert Wood Johnson Foundation, Coburn visited universities involved in state health policy in five states (Maryland, Minnesota, North Carolina, Washington, and Wisconsin) and developed case studies regarding the appropriate role of the university in the often highly political state environment. Findings include:

- **P**Regarding state policy-makers:
  - **S**state policy-makers are becoming increasingly sophisticated consumers of complex research and policy analysis, which drives demand for university research
  - **S**demand for policy analysis and technical assistance is increasing, often accomplished through contracts with outside sources, especially in states downsizing their own staffs
- **P**From the university perspective, Coburn found that doing state-level work does not have the status many academicians feel they need and that it often requires more work than state agencies are willing or able to pay for. In addition, many university promotion criteria devalue state-level work as compared to other accomplishments.

He notes that a "tension exits between the need to maintain a strong link to policymakers and agencies and the need to remain sufficiently independent so as not to be (or be perceived as) agents of the government. His recommendations for improving the links include:

- **P**developing a formal technical assistance program to assist other states in developing effective partnership programs
- **P**soliciting funding from foundations and other funders to finance such partnerships
- **P**developing academic training programs in state health policy analysis.

Qualitative=30.5%

Expert Opinion

Rains, J., & Hahn, E. (1995, April). Policy research: Lessons from the field. *Public Health Nursing, 12*(2), 72-77.

The authors describe an application of research methods to generate data useful to policy decisions within a 48-hour period. A diversion program for those charged with alcohol and/or marijuana possession was evaluated to determine the relationship (if any) between successful completion of the program and subsequent charges. The authors found that successful completion of the program reduced the number who reoffended within the first 12

months, but resulted in no difference after that. These findings led to further re-evaluation. Final recommendations included incorporating screening for ATOD use in the program, referral to therapy for treatment where indicated (as opposed to information-giving only), and extended follow-up. The authors also discuss important "contextual issues," such as the differences in philosophies between the criminal justice and public health nursing disciplines. They conclude, "In each policy development situation the nurse can adopt the most appropriate research role, whether it be academic and neutral, as in the 'objective technician' role, or more political, as in the 'issue or client advocate' role" (p. 76).
Expert Opinion=79%

Badovinac, K. (1997, October). Policy advocacy for public health practitioners: Workshop on policy change. *Public Health Nursing, 14*(5), 280-285.
The author reports on workshops attended by more than 1,000 public and community health practitioners in Ontario from fall 1995 through spring 1997. The workshop series was entirely funded by the Health Promotion Branch of the Ontario Ministry of Health. The intent was to provide information and skills to better equip public health practitioners with the means of initiating policy change.
The basic workshop was three hours in length and utilized small-group activities to cover the following topics:

- **P**identifying and analyzing problems with information-gathering techniques
- **P**identifying key stakeholders for a given issue
- **P**understanding the process by which bylaws are enacted
- **P**accessing and persuading decision-makers
- **P**general information on advocacy and lobbying strategy.

The advanced workshop was six hours long and covered the following topics:

- **P**learning/problem-solving styles to identify strengths in collaborative work, such as coalition building
- **P**problem analysis from the perspective of ideological orientations vis à vis downstream/midstream/upstream thinking
- **P**trends in macroscopic issues (e.g., economics, public sentiment, etc.) and their relationship to coalition development
- **P**personal leadership style analysis
- **P**effective framing of policy issues around an environmental, social justice perspective; exercises included experience with critical analysis and argument rebuttal
- **P**tactical planning models (top-down, bottom-up, random events)

A survey of randomly selected workshop participants three months after completing the workshops was positive toward both the skills learned and their practical application.
Expert Opinion=77%

Conn, V., & Armer, J. (1996, November/December). Meta-analysis and public policy: Opportunity for nursing impact. *Nursing Outlook, 44*(6), 267-271.
The authors suggest that nursing, and especially public health nursing, could do more to influence public policy through the use of meta-analysis. Meta-analysis, a means of quantitatively summarizing the pooled results of multiple previously conducted primary studies, has the following strengths:

- **P**summarizes numerous primary studies
- **P**may find ample effects in small sample sizes

Phas the potential to find consistency amid apparent inconsistences

Pexamines multiple outcomes

Pexamines program effectiveness in both process and outcomes

Drawbacks include insufficient numbers of primary cases that consider the variable of interest or of primary studies with adequate rigor to be included.

In using meta-analysis results with policy-makers, the authors suggest

Pnot boring them with the process details

Pincluding only the major points and only a few numbers when presenting verbal testimony

Pusing anecdotal evidence (i.e., stories) to humanize the meaning of the results

Expert Opinion=76%

Aroskar, M. (1987, Nov/Dec). The interface of ethics and politics in nursing: Can we do ethics effectively in the real world without doing politics? *Nursing Outlook, 35*(6), 268-272.

> Ethics is a discipline within the broader domain of philosophy. It is the systematic study of what our conduct and actions *ought* to be with regard to ourselves, other human beings, and the environment, the justification of what is right or good, the study of what our lives and relationships *ought* to be–not necessarily what they are. Ethics in nursing, an area of applied ethics, is using the insights gained from systematic study and reflection to achieve more ethical decision making in practice and policy development. Ethics in nursing also includes consideration of the environments in which client care occurs and of the integrity of individual practitioners of nursing and of the profession collectively....Ethical situations in patient/client care and in related policy making are often characterized by relationships in which there are questions about what *should* be done....To promote decision making that takes explicit account of ethics, the political/power dimension must also be taken into account (p. 268).

Aroskar asserts that nursing must take the necessary leap to incorporate community values into its ethical structure, which has historically focused only on individual ethics: "Balancing pursuit of the good of the individual with that of the common good requires sensitivity to both ethical and political dimensions in using ethical reasoning and moral imagination in the arenas of health care" (p. 269). She says that the interface between politics and ethics happens at three levels: that of the nurse/client/physician political triad; the public policy-making arena; and institutional/organizational activity. It is nursing's job to anticipate the ethical issues related to proposed policy and influence the policy before it is set. Ethical principles that hold for the individual may not for communities as a whole; therefore, the notion of what constitutes justice will inevitably include "tension between individual autonomy, the health, safety, and welfare of all (i.e., the common good) and our local, national, and global interconnectedness and interdependence" (p. 272). Aroskar suggests that ethical principles shape nursing's perspective on policy decisions and, in order to affect policy, nursing is inevitably involved in political thought and action; she concludes by inferring that political action is necessary to meet nursing's social mandate (p. 272).

Expert Opinion=73%

Ryder, D. (1996). The analysis of policy: Understanding the process of policy development. *Addiction, 91*(9), 1265-1270.

The author describes an eight-stage model of the policy development process, using substance use prevention in Australia as the basis for his examples:

Agenda Setting Government decides what action is (or is not) required on a particular issue; essentially this is a political issue which may or may not be based on scientific evidence

Issue Filtration Government decides the means by which options for action will be generated; this may include contracting with consultants, holding public meetings, relying on internal staff, etc.

Issue Definition Problems, options, and opportunities that government needs to consider are clarified; filtration and definition stages are iterative

Forecasting Government considers the probable consequences, should a given policy be adopted; this includes costs and economic impact

Options Analysis Government reviews the various options that will achieve the desired goals and selects the most appropriate; forecasting and analysis stages are iterative

Objective Setting Government sets objectives to measure the effectiveness of the policy chosen

Monitoring Consequences of the chosen policy are monitored against its objectives; unintended consequences may also be monitored

Maintenance/ succession/ termination Government decides to continue with the policy (maintenance), replace it with an alternative policy (succession), or discontinue it (termination)

The author concludes by providing recommendations to researchers regarding positioning their findings for greatest policy impact: 1) form alliances with others holding similar aims; 2) provide evidence that can be used as "ammunition" which also promotes allies' causes; 3) choose the "battle" which plays to the research findings' greatest strength and the opposition's weakest.
Expert Opinion=58%

Cohen, S., Mason, D. et al. (1996, Nov/Dec). Stages of nursing's political development: Where we've been and where we ought to go. *Nursing Outlook, 44*(6), 259-266.

The authors present developmental stages of nurses' political interest and characteristics in the areas of action, language, coalition building, and policy shapers. In terms of action, the following descriptors apply:

Stage 1 (buy-in): reactive, with a focus on nursing issues

Stage 2 (self-interests): reactive to nursing issues

Stage 3 (political sophistication): proactive on nursing and other health issues

Stage 4 (leading the way): proactive on leadership and agenda-setting for a broad range of health and social policy issues

The authors call for more of nursing to move into Stage 4 development so that "the public will benefit from nursing's expertise and the advocacy that nursing can provide on behalf of the public" (p. 263). To get there, the following recommendations are set:

- Build coalitions, constituencies, and collaborations around health and social issues
- Develop leadership capacity: current leaders must seek out those with potential and provide mentoring
- Integrate health policy development into core curricula and not treat it as an "add on"
- Develop public media expertise: publish in non-nursing journals and the popular press; create a presence in mass media
- Increase sophistication in policy analysis, policy research, and nursing research with policy implications.

Expert Opinion=57.5%

Davis, C., Oakley, D., & Sochalsi, J. (1997). Leadership for expanding nursing influence on health policy. In B. Spradley & J. Allender (Eds.), ***Readings in community health nursing*** **(pp. 570-579). Philadelphia: Lippincott-Raven.**

[Note: previously published (1982, January) in *JONA, 12*(1), 15-21.]

The authors contend that for nurses to be effective in working at "aggregate" levels (i.e., community or systems levels) "nurses [must] increase their political expertise and their activity in the political arena" (p. 570). Successful political action requires that nurses assume leadership roles (meaning the capacity to establish and maintain reciprocal relationships with the group for which they are providing leadership) and the capacity for action in the following three areas:

1. Obtain and maintain current and accurate information on policies affecting the issue or problem through the use of
   - Formal channels (e.g., memberships, networks in formal organizations)
   - Informal channels (e.g., informal contact with other leaders)

   The information received needs to be considered in the context of those providing the information.
2. Build a support base by disseminating the information to recruit support as well as to inform.
3. Provide direction through offering a concise plan, with specific activities, for workers at all levels; minimize the potential for internal strife by keeping the group focused on common goals, rather than on satisfying personal needs.

"Tips" for effectiveness in a variety of political actions are provided:

1. Have a seven-item checklist for organizing and directing a political action group:
   a. Organize a steering committee
   b. Develop a briefing sheet for information supporters
   c. Include a list of activities that all supporters can do
   d. Assemble phone lists of all other key leaders
   e. Use the telephone for making contacts when time is limited or to reinforce material sent in the mail
   f. Identify one central phone as the "headquarters" or reference point
   g. Hold frequent steering committee meetings since "coordination is the unequivocal basis for success" (p. 573).
2. Have a clear concise statement of what you want ready (rather than just a description of the problem or issue), when working with decision-makers.
3. Have a checklist for an effective interaction with a decision-maker (p. 574):
   a. Know the person's interests, past voting patterns, connections
   b. Make an appointment; if necessary, first develop a relationship with any aides important to the issue or problem
   c. Offer a briefing sheet (no more than two pages) to all with a "need to know"; include information regarding whom to call for additional information
   d. Include a list of organizations or people known to the decision-maker who support your position
   e. State arguments in terms the decision-maker uses and values (e.g., cost-savings); seek mutual goals where possible; do not appeal merely to ego
   f. Follow up with a letter of thanks; continue to provide relevant information
4. Seek to develop long-term political involvement locally
   a. Convene a local interest group of nurses around a common issue or concern
   b. Strive to develop a broad-based coalition

c. Identify resource needs (e.g., postage) and other material costs (e.g., people time, prestige, etc.)
d. Choose a neutral meeting site
e. Convey a sense of personal commitment in the invitation through such gestures as hand writing invitations, rather than using labels
f. Plan a comfortable meeting atmosphere, organized and professional. (Note: Keep food at a minimum; too much distracts from the importance of the meeting.)
g. Work cooperatively
h. Maintain contacts.

Expert Opinion=51%

Jossens, R. (1997, July/August). Strategies for development of contemporary nursing policy. *J. Professional Nursing, 13*(4), 222-227.

Jossen sends a call to the nursing profession to use this time of change and uncertainty in the health care arena to redefine and name nursing's course for the future. Specifically, she proposes:

1. Maintaining clarity of definition, direction, and objectives between nursing groups.

Jossen especially calls for consistency in nursing around the differentiation of primary health care (as defined in the Alma Alta declaration of 1978) and primary care (the 1965 revision of the medical model).

2. Reassessing "community-based care" as the defining focus of future nursing practice.

Jossen fears this is too open to interpretation to serve as a central force to define nursing in the future. She notes it is far too often practiced as bringing the medical model into a community setting, without addressing healthy communities. It also serves to segregate hospitals as other than community, which is wrongly conceived. She suggests substituting other phrases and proposes "community integrated."

3. Involving representatives of nursing's full constituency in professional policy decisions.

Jossen believes that "community-based" disenfranchises large groups of nurses whose education and practice is hospital focused and that its continued use will only further divide the profession. Instead, she proposes nurses be purposefully engaged in the process of policy change.

4. Using the input of nursing alliance organizing, including organizations that represent ADNs.

Jossen notes that "major nursing policy positions should use and reflect the organized diversity of professional nursing alliances" (p. 225).

5. Supporting documentation, research, and demonstration projects concerning the impact of health care reform strategies on individual, family, and community health.

Jossen encourages nursing research to focus on client outcomes related to the changing system in order to better prepare for articulating nursing's role.

6. Using collaborations with health disciplines seeking similar objectives.

Jossen suggests the further liaison between public health and nursing, whose models "share many characteristics in common" (p. 226).

7. Exploring innovative methods of including practicing nurses in changing educational philosophies.

Jossen urges going forward in ways that do not "retroactively redefine a nurse's preparation or practice" (p. 22).

8. Continuing to reanalyze and modify strategies, as necessary, in the ongoing work toward policy changes and health care reform.

Jossen argues for continuing discussion about nursing and health care futures.

Expert Opinion=45%

Texts and Monographs

Swanson, J., & Nies, M. (1997). *Community health nursing: Promoting the health of aggregates* (pp. 194-213). Philadelphia: WB Saunders.

"Policy deals with values. It treats the 'should' of a situation....Policy articulates the guiding principles of collective endeavors, establishes direction, and sets goals. It influences and, in turn, is influenced by politics. Through the policy process, policy directives may become realized or obstructed at any step along the way" (p. 199). "The premises supporting the goals of health policy should be equitable distribution of services and the assurance that the appropriate care is given to the right people, at the right time, and at a reasonable cost" (p. 199). "[Policy] evolves slowly and incrementally as an accumulation of many small decisions. It also changes slowly because changes in the social beliefs and values that underlie established policy develop within the context of actual service delivery. More often, once a direct health care service is offered, especially an official, tax-funded service, it is difficult to discontinue it" (p. 200).

Steps in the policy process (adapted from Spradley, 1985) include:

1. Formulation: defining the problem and "getting it on the agenda";
   includes policy analysis, or the identification of those who benefit and those who lose as a result of a policy
2. Adoption: committing resources (e.g., through legislation, ordinances, etc.)
3. Implementation (regulatory plan): establishing and carrying out a plan of action (e.g., promulgating rules, procedures, and protocols)
4. Evaluation: comparing the actual effects of the policy with its desired effects; also, comparing the policy's actual effects with its anticipated effects

The authors go on to provide a thorough overview of the government's authority for the protections of the public's health, safeguards provided by the balance of powers within government, the legislative process (how a bill becomes a law), and nurses' participation in the political process.
Text=74%

Hanley, B. (1993). Policy development and analysis. In Mason, Talbott, & Leavitt (Eds.), *Policy and politics for nurses: Action and change in the workplace, government, organizations and community* (2nd ed.) (pp. 71-87). Philadelphia: WB Saunders.

Kingdon's and Anderson's models for policy process are reviewed. (Note: See the Longest and Milstead abstracts for discussion of the Kingdon model.)

Anderson's Sequential Model

Stage 1: Policy Agenda: there are three levels of policy agendas (discussion, action, and decision), but the development process for each is the same:

1. Identify a policy problem (i.e., a situation that produces needs or dissatisfaction for which relief is sought); development of issues papers is a common method.
2. Refine the problem into a policy issue (i.e., a problem with societal ramifications of concern to a number of people and on which there are conflicting opinions for resolution).
3. Consider the values held by the stakeholders as they determine the amount of political interest the issue will generate

4. Frame the issue as a question: What could or should be done about this issue?
5. Develop and analyze options for resolution.
6. Identify the policy-making body with jurisdiction over the issue.
7. Identify other individuals and groups who might also be interested in working toward resolution.

Stage 2: Policy Formulation: policy-makers determine the type of policy options to be developed and set objectives. This is a technical phase where legislative or regulatory language is drafted. It is often carried out through hearings in which special interest groups, among others, participate.
Stage 3: Policy Adoption: the decision is made to adopt a policy, allowing it to go forward to develop related budget and funding requests; hearings are frequently used at this point to gain testimony from interested groups
Stage 4: Policy Implementation: the administrative agency charged with implementing the policy develops rules and guidelines necessary for a functioning program; once drafted, there is usually a period of time for public response; drafting rules and regulations provides the administering agency an opportunity to insert related agenda items, which may not have made it into the legislation or which may undermine legislative intent
Stage 5: Policy Evaluation: feedback regarding intended and unintended consequences of the implementation are collected. Once established, policies are rarely terminated, but may be modified.
Text=70%

Milstead, J. (1999). (Ed.). ***Health policy and politics: A nurse's guide.*** **Gaithersburg, MD: Aspen Publications.**

Chapter 2: Agenda Setting (written by E. A. Furlong)

The author focuses on the historical process of establishing the National Institute of Nursing Research within the National Institutes of Health as a case study exemplifying several models of agenda setting. Kingdon's model for political agenda setting, Schneider and Ingram's model for social construction of target populations, policy design, and the contextual dimension to policy initiation, development, implementation, and redesign are featured:

PKingdon's Model: establishing an issue as an agenda item is related to

SProblem Streams: these are marked by systematic indicators of a problem, a sudden crisis, or feedback that a program is not working as intended

SPolicy Streams: ideas for policy change come from everywhere; the key is not where or whom the idea comes from, but what makes it take hold and grow; the presence of a "policy community" (i.e., a group interested in seeing it progress and willing to put resources to it); to "stay," a policy idea must meet the following five criteria:

Technical feasibility
Value acceptability
Tolerable cost
Anticipated public agreement
Reasonable chance elected officials will be receptive to it

SPolitical Streams: these include public mood, pressure group campaigns, election results, composition of Congress, changes in the administration

SProbability that the Streams will converge at the right window of opportunity: agendas are affected more by problems and political systems, whereas alternatives are affected more by the policy stream; "windows" open because of changes in the political stream or because new problems capture officials' attention.

A second model for understanding this policy process is Bobrow and Dryzek's model for studying the political "context" in which policy ideas are kept alive and moving. The contextual dimensions include:

- **P**complexity and uncertainty of the decision-system environment
- **P**feedback potential
- **P**control of design by an actor or group of actors
- **P**stability of the policy's actors over time
- **P**motivation of the audience to action.

Scheider and Ingram's Model focuses specifically on the "social construction of the target population," or those groups affected by the policy. They state that, by knowing how elected officials perceive the target population, policy can be better designed. That model includes two traits:

an awareness of the shared traits that make a particular group socially meaningful
specification of values, symbols, and images that one associates with a target population

Text=55%

Chapter 5: Policy Design (written by Patricia Smart)

"Policies that address social problems in the United States usually are formulated by a combination of legislators and aides, the executive branch, courts, and special interest groups. In addition, professional experts are often asked to serve as panel members or consultants or to serve on committees that provide input to policy-makers" (p. 148).

Policy design is a "process that can occur at both the policy formulation and the policy implementation phases or as a blueprint approach that shapes policy" (p. 154). Five "tools" are generally used by government to design policy:

- **P**Authority Tools: used to guide behavior of agents and officials at lower levels; examples include laws, regulations, and mandates
- **P**Incentive Tools: providing tangible payoffs (positive and negative) to take action without encouragement or coercion
- **P**Capacity Tools: providing information, training, education, and resources to enable individuals, groups, or agencies to make decisions or carry out activities
- **P**Symbolic and Hortatory Tools: appealing to individual's, groups', or agencies' systems of beliefs and values
- **P**Learning Tools: used when the basis upon which the target population might be moved to take problem-solving action is unknown or uncertain

"Fire alarms" are signals built into a policy that alert policy-makers that the design, implementation, or evaluation phase is in danger of failing.

"Fuzzy or crisp charges" are words describing the degree of clarity of objectives and directors or implementation in a mandate or law; "fuzzy" leaves more room for interpretation. The author then compares how policy was developed regarding reducing infant mortality in South Carolina and the Netherlands using Schneider and Ingram's Model (pp. 162-182).

Text=59%

Chapter 6: Policy Implementation (written by Marlene Wilken)

Policy implementation is a dynamic process involving directed change that results in the accomplishment of the policy goals; the single most important factor in successful policy implementation is availability of sufficient resources to carry it out.

Implementation usually goes through several stages:

- Passage of the basic statute
- Policy decisions of the implementing agency
- Compliance of target groups with those policy decisions
- Actual impact, both intended and unintended
- Revisions to the basic statutes

Each stage is vulnerable to change from one or more of the following variables:

- Tractability, or the degree of difficulty encountered in the problem's management and control
  - accessibility of the technology required
  - diversity of the proscribed behavior
  - size and composition of the target group whose behavior is to change
  - complexity of the behavioral change expected
- Structure, or to what extent the implementing agency can structure or organize the process of policy implementation
  - clear objectives required
  - causal links between the government interventions and the attainment of program objectives must be understood
  - official responsibility for implementing the policy or program must have jurisdiction over a sufficient number of critical linkages so the objective can be obtained
- Nonstatutory Variables, or environmental factors:
  - socioeconomic conditions
  - public support
  - attitudes
  - resources of constituency groups
  - commitment and leadership skill of the implementing officials
- Independent Variables, or
  - the organization or agency charged with carrying out the policy mandate; administrative agencies frequently use the regulatory process to include program elements they are unable to put into legislation
  - competency of the personnel involved
  - pressure from rival agencies
  - public's acceptance
- Flawed basic design.

Factors related to successful implementation: control is at the heart of success

- The program is based on sound theory relating changes in target group behavior to achievement of the desired end-state (i.e., objectives)
- The statue or basic policy decision contains unambiguous policy directives and structures the implementation process so as to maximize the likelihood that target groups will perform as desired
- The key players in implementing agencies use adequate managerial and political skills, while being dedicated to statutory ends

- Organized constituency groups and elected or appointed officials maintain active support throughout the implementation process
- The ranking of statutory objectives remains stable over time, so as to manage conflict in the environment that could undermine the statute.

Text=69%

Farrunt, W., & Evers, A. (1990). *Healthy public policy at the local level.* Boulder, CO: Westview Press.

Chapter 1: Developing Healthy Public Policy at the Local Level (written by Trevor Hancock)

Principles of Healthy Public Policy:

1. A long-term view
2. Political commitment
3. Intersectoral processes and structures: A way for many sectors in the community to work together
4. Public support
5. Community-driven process
6. Multifaceted strategies
7. The initiator and activist must be credible and have expertise
8. Win/win solutions
9. New organizational culture to maintain it
10. "Health may be a useful metaphor for addressing issues such as social injustice and environmental deterioration" (p. 9).

"One of the major problems we can anticipate in developing health policy at the local level is lack of congruence between national and local policy concern; this will be particularly keenly exacerbated when there is a party political difference between the local administration and the regional or national administration" (p. 10).

Text=46.5%

Longest, B. (1998). *Health policy making in the United States* (2nd ed.). Chicago: Health Administration Press.

Chpt 1: Health and Health Policy–Definitions and Background

Longest suggests that at all levels of health policy, the values held by the majority culture will be reflected. For the U.S., at least at the turn of the century, those values include:

- individual autonomy
- self-determination
- personal privacy
- commitment to justice for all members of society (Longest notes this is widely held, but not universal)
- faith in the potential of technological; rescue
- long-standing desire to prolong life, regardless of cost (Longest notes there are signs this may be changing) (pp. 1-30).

Public policy = "authoritative decisions that are made in the legislative, executive, or judicial branches of government, intended to direct or influence the actions, behaviors, or decisions of others"; *authoritative* = "decisions made within the three branches of government (at any level) that are within the legitimate purview of those who make the decisions"

Health policy = when public policies pertain to health or influence the pursuit of health; they generally affect or influence groups or classes of individuals or types or categories of services

Private-sector health policy = authoritative decisions made by private health companies (i.e., product lines, pricing decisions, etc., made by managed care organizations) and their trade organizations (i.e., JCAHO or National Committee for Quality Assurance).
Longest acknowledges that private and public health policy decisions impact upon each other, but notes that this book focuses only on the public side.

Forms of health policies:

Laws: this is true regardless of the level of government at which they are made
Rules/Regulations: these are established to guide the implementation of laws and have the force of law
Operational Decisions: protocols and procedures made at the level of the governmental agency charged with implementing the rules/regulations which spell out how they will be implemented
Judicial Decisions: decisions made by the courts regarding whether an authoritative decision is in keeping with the intent of the rule or law to which it is related; the courts can overrule authoritative decisions made by the other branches of government; they affect policies even though they do not make them
Macro Policies: policies made at the very top levels of government that have an impact on all other levels, e.g., whether to have national health service

Categories of Health Policies (Note: These reflect areas where the government intercedes because the market economy, left on its own, has "failed to achieve desired public objectives"):

P Policies: those designed to provide net benefits to some distinct group or class of individuals or organizations at the expense of others to ensure that public objectives are met
(e.g., government subsidies provided to rural hospitals, medical schools, etc.)
PRegulatory Policies: directive approaches government takes to ensure that public objectives are met
SMarket-entry Restrictions: licensure, certificate-of-need programs
SPrice Regulation: establishment of reimbursement rates
SQuality Controls: FDA
SMarket-Preserving Regulations: rules of conduct established for market participants such as anti-trust laws
SSocial Regulation: rules to ensure socially desirable outcomes such as OSHA, blood-borne pathogen regulations, etc.

Assumption about the relationship between health policy and health: "Policies...impact on health through an intervention variable, health determinants. Health determinants, in turn, directly impact on health" (p. 12).

PHealth policies and the environment: designed to guard against poor health outcomes associated with physical, chemical, and biologic exposures and also with factors related to poor health in socio-cultural and economic environments
PHealth policies and human behavior and genetics: designed to intervene with lifestyle choices and genetic pre-determinations that promote ill-health; minimum government intervention here due to conflict with societal values toward personal autonomy
PHealth policies and health services: policies that affect availability and access to services
SMoney: projected expenditures for health in 2000 is 52 percent from private, 36 percent from federal, 12 percent from state and local; the trend is for decreasing private share and dramatically increasing federal shares

SWorkforce: in 1998, 11 percent of nonagricultural workers in the U.S. were in health-related fields; the trend shows health care workers as the fastest growing component with the federal government controlling the supply through subsidies for education and training
STechnology: availability tends to drive demand, which results in greater expenditures
SHealthcare System: government promotes systems changes through financial manipulations, such as the Hill-Burton Act, which expanded rural hospitals, and institution of employer-paid health insurance post-WWII; there have been three phases of change in the system:

Phase I: 1960s and before, with multiple independent, fragmented service providers
Phase II: 1970s to current, with dramatic vertical and horizontal integration reducing fragmentation
Phase III: the future, with fully integrated systems, but fewer of them; this will mostly be driven by the dominance of managed care

Because of the "powerful link" between health policy and health outcomes, Longest argues that "politically competent people [who] know how to participate efficiently in the actual drafting of legislative proposals or in providing testimony at the hearing in which legislation is developed" are critical.

Chapter 2: The Context and Process of Public Policymaking (Summary, pp.60-61)
The process is highly complex, interactive, and cyclical, incorporating the following phases: formulation, implementation, and modification. It is a process among human beings and, as such, is subject to the use of power and influence between the demanders of health policy (i.e., health and consumer organizations and interest groups) and its suppliers (i.e., elected and appointed members of government, plus the civil servants who staff them). The process is not only cyclical, but redundant, resulting in no real beginning or end to the process.

Chapter 3: Policy Formulation: Agenda Setting (Summary, pp. 90-92)
Agenda setting is the "confluence of problems, possible solutions to the problems, and political circumstances that permit certain problem/possible solution combinations to progress along to the point of legislation development."

Chapter 4: Policy Formulation: Development of Legislation (Summary, pp. 120-121)
The process through which the "solution possibilities" constructed through agenda setting are converted into law by following a prescribed legislative protocol.

Chapter 5: Policy Implementation (Summary, pp. 166-167)
Rule making is the process through which the enacted laws are given the steps necessary to guide their implementation; where authorized to do so, the administering agency may also promulgate regulation. The actual management of the operational activities associated with implementation usually is the "domain of the appointees and civil servants who staff the executive branch of government." Operational success is dependent on the clarity of the policy itself, the characteristics and attributes of the agencies charged with implementation responsibilities, and the capabilities of the senior-level managers of these agencies.

Chapter 6: Policy Making Outcomes and Consequences (Summary, pp. 203-204)
Those affected by the policies, whether positively or negatively, share two concerns: anticipating the impact and influencing the formulation and implementation stages of policy development. These groups and organizations may pool their resources to effect greater power and focus on the development process.

Chapter 7: Policy Modification (Summary, pp. 239-240)

This involves feeding back policy consequences and related actions into the policy formulation process. Most U.S. health policies result from the modification of prior policies. There are continuing opportunities to stimulate modifications at all levels. It is this built-in flexibility to respond to changes over time that allows the process to function.

Chapter 8: The Future of American Health Policy

Determinants of health are defined as "physical, sociocultural, and economic environments in which people live; their behaviors and genetics; and the type, quality, and timing of he heath service their receive" (p. 244). Public health policy can affect all of these and, therefore, is a powerful contributor to the overall health status of Americans. The areas of critical influence on future health policy include:

- **P**Objectives of Health Policy: Longest says in the long run the objectives will most impact future policy, but at this point they "exist for numerous and divers specific health policies, but not of the overall set of policies" (p. 247). To get to that point "will require extraordinarily broad thinking...made even more difficult in regard to health policy by the splintering effect of the diversity of individuals, organizations, and interest groups who seek to influence policymakers' thinking and actions" (p. 248). He predicts that truly successful broad health policy must impact on all determinants of health, not just health services.
- **P**The Political Marketplace: uncertainty will continue to add "fluidity" to the policy-making process
- **P**Limitations of Public Policy in a Market Economy: the inability of health policy to produce desired outcomes will increasingly give way to the power of markets as a means toward this end
- **P**Growing Role and Importance of Health Policymaking at the State Level: states' traditional roles– 1) financing or paying for health services for several categories of people, 2) ensuring the public's health, 3) regulating health-related professionals and organizations, plus 4) experimenting with comprehensive health reform strategies–will continue.
- **P**Looming Economic Limits of the Pursuit of Health: at some point we will reach the limit of what we as a society are willing to pay for health, and hard decisions will have to be made; how these decisions will be made will depend on which of the four mindsets prevails at the time:
  - **S**True Romantics, the group who choose to ignore the concept of economic limits
  - **S**Pseudo Romantics, the group who understands economic limits, but choose to think that someone else in the future will figure out the details
  - **S**Truly Self-Serving, those so intent on ensuring their own interests are served that other issues become secondary
  - **S**Procrastinators, those who understand economic limits and choose to act, but not now, usually due to potential for political repercussions

Challenges:

1. Current policies do not provide for long-term funding of existing health programs.
2. The emergence of new, threatening contagious diseases and the return of older, now drug-resistant diseases.
3. The growing burden of chronic diseases, especially as populations age.

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Kickbusch, I., Draper, R., & O'Neill, M. (1990). Healthy public policy: A strategy to implement the health for all philosophy at various governmental levels. In A. Evers, W. Farrunt, & A. Tigan (Eds.), *Healthy public policy at the local level*. (pp. 1-6). Boulder, CO: Westview Press.

These authors propose that to impact significantly on health, governments must move away from "the excessive emphasis on curative medicine and behavioral approaches to disease prevention that have characterized health policy development in the industrialized world since the 1950s" (p. 1). They acknowledge this is "not a new idea but an old one reborn," and they credit Nancy Milio's seminal book, *Promoting Health Through Public Policy*, and Trevor Hancock's essays on "beyond health care" (both, early 1980s) as "central to this process" (p. 3).

They propose, instead, that governments focus on creating environments in which people can be healthy by continuing in the spirit of the "Health for All" movement established by the World Health Assembly in 1977, the strategies stemming from the Declaration of Alma Ata the following year, and, the convening of the First International Conference on Health Promotion in November 1986, which resulted in the Ottawa Charter for Health Promotion. This conference was co-sponsored by the WHO, The Canadian Ministry for Health and Welfare, and the CPHA. The Ottawa Charter identifies five overlapping and interactive means of action: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services. A second international conference was held in Adelaide, Australia in 1988 which focused specifically on the practical implications of building healthy public policy. Case studies were presented focusing on a set of policy priorities: 1) women's health, 2) food and nutrition, 3) tobacco and alcohol, and 4) creation of biologically, chemically, and physically supportive environments" (p. 2). The place to start these policy changes, according to the authors, is at the local level since "politicians at this level are more closely in touch with their electors and respond more clearly to their concerns" (p. 4).

The following challenges are foreseen in formulating such policy:

1. Politicians and the public must engage in a dialogue that will redefine health expectations in terms of environmental change and not in terms of better and more technological medical care.
2. Public service managers will have to learn the skill of lateral management and recognize achievements in terms of cooperative action rather than the expression of hierarchical control and power.
3. Compartmentalized approaches to work and reliance on experts only should not be acceptable any more in the field of healthy public policy.
4. Public health authorities will have to relearn the skills of advocacy, mediating and negotiating that were the very substance of public health when it began during the 19th century.
5. [The academic community] must move away from its narrow focus on health care and go into the complexities of analyzing the impacts of health for political decision-making in other sectors....For this a much broader and more interdisciplinary approach to work is needed... (p. 4).

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Public Health Interventions

Applications for Public Health Nursing Practice

Appendix

Public Health Nursing Practice for the 21st Century
March 2001

For Further Information please contact:
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Minnesota Department of Health
Division of Community Health Services
Public Health Nursing Section

CORNERSTONES OF PUBLIC HEALTH NURSING

PUBLIC HEALTH NURSING IS THE SYNTHESIS OF THE ART AND SCIENCE OF:

PUBLIC HEALTH	*AND*	NURSING
Population-Based		**Relationship-Based**
Grounded in Social Justice		**Grounded in an Ethic of Caring**
Relies on the Science of Epidemiology		**Holistic**
Focus on Health Promotion and Prevention		**Sensitivity to Diversity**
Long-term Commitment to the Community		**Independent Practice**

Public health nursing practice is *population based*, that is, based on a process that determines the health status of the community, identifies populations at risk, and determines the priority health problems of the community; and plans, implements, and evaluates public health strategies accordingly at community, systems, or family/individual levels. The selection of these strategies are *based in the science of epidemiology*.

Public health nurses' commitment to the communities, families, and individuals they serve emanates from a combination of the passion underlying their *social justice beliefs* that all persons, regardless of circumstances, are entitled equally to a basic quality of life, their *ethic of caring and compassion*, and *their sensitivity to and respect for the worth of all people, especially those persons who are vulnerable.*

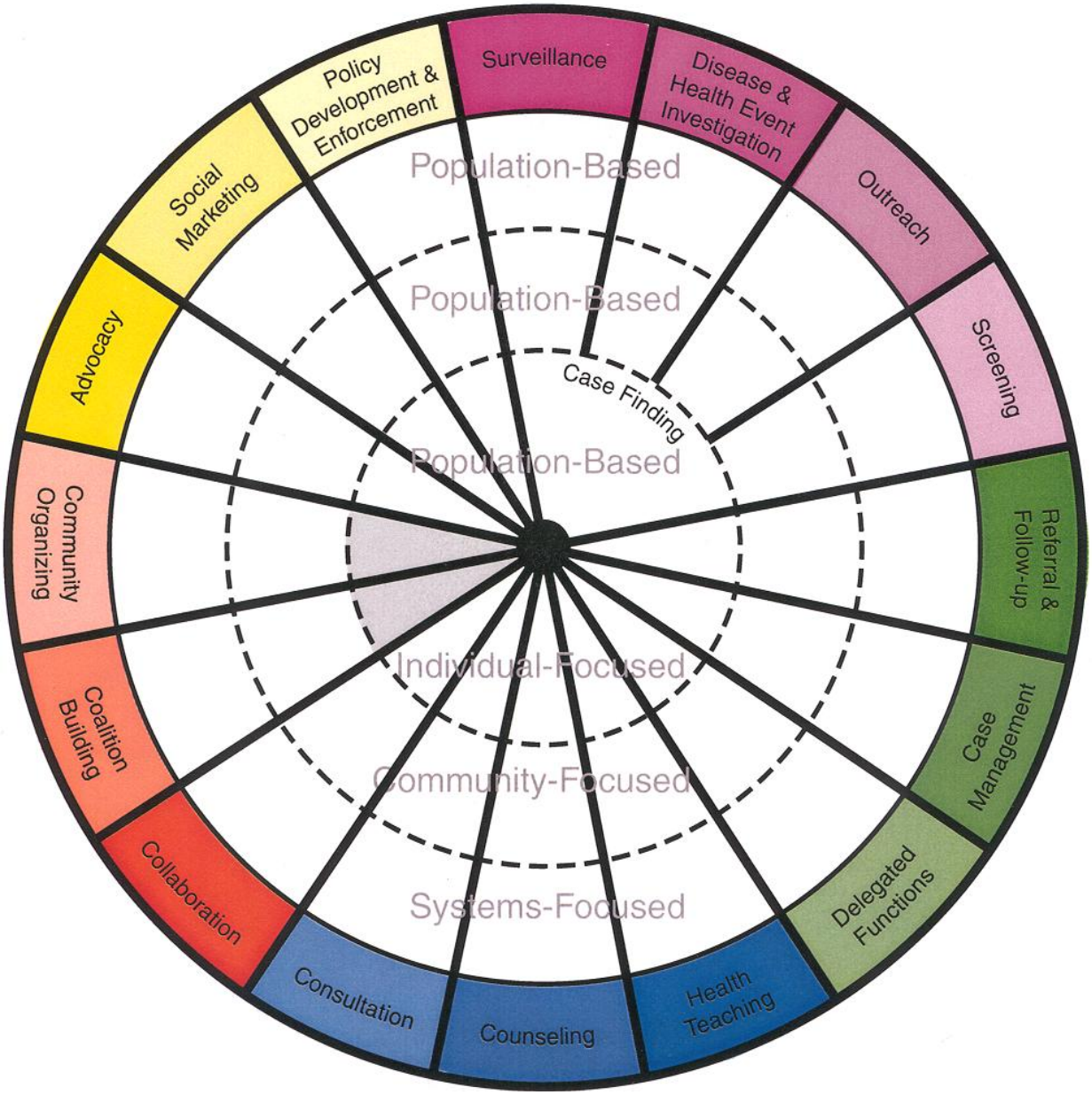
Public health nursing practice is *relationship-based*, that is, all public health nursing interventions are provided in the context of a relationship. The relationships that public health nurses establish with the communities, families, individuals, and systems they serve are grounded in personal integrity, honesty, consistency, and trustworthiness.

Public health nursing is *committed long term to promoting and maintaining health and preventing illness, injury, and disability*. The interventions that public health nurses utilize for health promotion and prevention *encompass a holistic approach that includes the inter-relationship of mind, body, spirit as well as the dynamic relationships between people and their physical and social environments.*

Public health nurses use their extensive knowledge of the community to *organize community resources to collaboratively* meet the health needs of community, families, and individuals. As do all public health professionals, public health nurses can and will work alone if others are unable or choose not to work on an issue. Most public health nursing interventions are *independent nursing functions* as outlined in the Nurse Practice Act.

Minnesota Department of Health, Section of Public Health Nursing, June 1999

Public Health Interventions



March 2001

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

Literature Search and Analysis of Evidence
in Support of Public Health Interventions
Public Health Nursing Practice for the 21st Century

The original interventions set was developed from the practice experience of over 200 PHNs practicing in Minnesota in 1994.[1] It was based entirely on the wisdom gained through the practice experiences of those involved. At the time, resources for a thorough search of supporting public health nursing literature were not available. The Minnesota Department of Health's 1998-2001 HRSA grant, "Public Health Nursing Practice for the 21st Century," allowed this work to go forward, resulting in the development of basic steps and best practices for the 17 population-based public health nursing interventions identified in the Public Health Interventions (PHI) Model. To accomplish this, a rigorous search of literature relevant to the interventions was conducted, and then analyzed by an expert panel of public health nursing practitioners and educators. Using a consensus process, they crafted a set of recommendations for basic steps for implementing each intervention, as well as how to implement them with excellence. The entire search and consensus process was carried out in a series of phases.

Phase One: Establishing the knowledge baseline

To estimate the knowledge base regarding the interventions, the 51 accredited baccalaureate nursing preparatory programs in the five states participating in the grant (Iowa, Minnesota, North Dakota, South Dakota, and Wisconsin) were sent a letter inquiring about the texts used in their community health/public health nursing curriculum. This was based on the assumption that the majority of PHNs currently employed in local public health agencies in the five states most likely would not have traveled beyond the five state region to receive their basic education. Seventeen programs (33 percent) returned the survey. The texts most frequently reported were (in descending order):

- Stanhope and Lancaster (1996) *Community Health Nursing: Promoting the Health of Aggregates, Families and Communities*
- Swanson and Nies (1997) *Community Health Nursing: Promoting the Health of Aggregates*
- Clemen-Stone, McGuire, Eigsti (1998) *Comprehensive Community Health Nursing: Family, Aggregate and Community Practice*
- Spradley and Allender (1996) *Community Health Nursing: Concepts and Practice*
- Smith and Mauer (1995) *Community Health Nursing: Theory and Practice*
- Stolte (1998) *Wellness: Nursing Diagnosis for Health Promotion*

These texts were reviewed for their content regarding any of the 17 interventions. In addition, any materials referenced in their development were obtained.

Phase Two: Design and Implementation of a search strategy

Minnesota Department of Health library staff collaborated in development of the search strategy development and implementation. Two approaches were used:

A. Each of the interventions was separately searched as a key term independently and again in combination with "public health nursing," "nursing," and "public health" in the following data bases: CINAHL, Medline, HealthStar, Dissertation Abstracts, PsychINFO, and Sociofile. An initial yield of approximately 900 titles resulted.

B. A retrospective 10-year-review of the following journals was completed searching under the same strategy: *American Journal of Public Health, Public Health Nursing, Nursing Outlook,* and *Journal of Community Health Nursing.*

The results of the journal retrospective review and the search by interventions were compared for frequency of similar items. Those, in turn, were compared with the references associated with the public health nursing texts. The resulting 665 articles, papers, dissertations, conference proceedings, etc., provided the core of the initial set of readings to be reviewed.

Phase Three: Review of the identified literature for rigor and acceptability

Students enrolled in graduate nursing programs in the five participating states[2] were recruited to review the literature for methodologic quality. Each reviewer was required to have successfully completed the research course requirements for their respective graduate programs. A tool for assessing methodologic quality[3] was distributed and inter-rater reliability achieved using audio-conferencing. From October, 1998 through April, 1999 the students reviewed 665 articles, monographs, dissertations, proceedings, textbook chapters, books, etc. Those with a quality rating of 70 percent or better constituted the pool of materials considered for their application to public health practice. The distribution was:

Surveillance: 13	Health Teaching: 15	Advocacy: 16
Disease Investigation: 1	Provider Education: 12	Social Marketing: 18
Outreach/Case-Finding: 11	Counseling: 7	Policy Development: 22
Screening: 12	Consultation: 5	
Referral and Follow-up: 11	Collaboration: 21	
Case Management: 13	Coalition Building: 12	
Delegated Functions*	Community Organizing: 12	

Phase Four: Review for practice application

These 201 articles were next reviewed by public health nursing practice experts and educators for their potential to advance practice.

A. Review criteria were established by the grant's advisory committee.

B. A review tool incorporating the criteria[4] was developed and field tested by an expert practitioner and educator not involved in the project.

C. The grant's advisory committee generated an initial list of practice experts and educators to serve on the expert panel; this list was supplemented with names submitted by PHN consultants employed by the state health departments of the participating states. The number recruited from each state was proportional to the number of nurses practicing in public health in that state. A panel of 42 was eventually recruited.[5] Orientation and inter-rater reliability was achieved using audio-conferencing with groups of five. From April through May, 1999 each piece of material was read and rated for practice application by two panelists; where panelists' rating were in wide disagreement, the item was read by a third expert. Each expert read and rated approximately 30 items. The results were entered into a data base.

*The material on delegation as it pertains to nursing was developed mainly from related material available at the National Council of State Boards of Nursing website and other material referenced there.

Phase Five: Consensus development

Recommendations for implementing each intervention with excellence, based on the findings in the literature, were developed through a consensus process adapted from that used by the federal Council on Health Care Technology and work by Saint and Lawson.[6]

A. A two-day meeting was held in Minneapolis in June, 1999. On day one, panel members met with their fellow intervention group readers to discuss and debate the merits of the materials

read. The meeting was facilitated by a non-panelist with preparation in consensus development. For each piece of material, the panelists who read that piece presented their rating and rationale and led brief discussion regarding its application to practice. At the end of the day, each group generated an intervention definition and a list of practice recommendations. On day two, all panelists met together. Each intervention group presented their recommendations and lead discussion. At the end of each presentation, the whole group indicated the extent of their agreement through a voting process.[7]

B. The results of the consensus were incorporated into the intervention definitions and recommendations. In July, 1999 the revised set was distributed to the panelists for their review, comment, and second consensus vote, using a mailed survey process.

Phase Six: Testing

The results of the second consensus vote were considered in developing the first draft of "Public Health Interventions: Applications for Public Health Nursing Practice." After each round of testing, suggestions and comments were incorporated into successive drafts. However, the organization of the interventions' content remained the same: definition with examples from each practice level (i.e., community, systems, individual/family); basic steps to implement the intervention; "best practices" to consider in implementing each intervention with excellence; abstracts of the evidence from which the best practices were drawn; and "Abby Notes" with additional information and insights drawn from both the literature and practice.

A. Round One: Participants and preceptors field testing the population-based public health nursing continuing education curriculum from October, 1999 through May, 2000 provided comment regarding the utility of the draft.

B. Round Two: Those comments were incorporated into development of the second draft of interventions document which was distributed as part of the 9th Annual Public Health Nursing Practice Workshop, "Getting Behind the Wheel," held in St. Paul, June 8-9, 2000, and sponsored by the Minnesota Department of Health/Section of Public Health Nursing. This same draft was offered to the original panel of experts for their review and comment in July-August, 2000; approximately half of the original group responded.

C. Round Three: A second panel of expert reviewers were recruited, this time from a national pool, to critique the second draft. 14 public health nursing practice experts and 14 educators participated.

Results from both Round Three testing and comments from the original set of expert panelists were considered in preparation of the final document, "Public Health Interventions: Applications for Public Health Nursing Practice."

1. A structured exercise during a workshop repeated around the state by the MDH/Section of Public Health Nursing in 1994 was used to collect the data. It was later analyzed by an expert panel consisting of public health nursing consultants employed by the Minnesota Department of Health. [Note: For further discussion, see Keller, Strohschein, Lia-Hoagberg, & Schaffer. (1998, June). Population-based Public Health Nursing Interventions: A Model from Practice, *Public Health Nursing, 15*(3), 207-215.]

2. Members of the grant's advisory committee served as liaison between the grant staff and the graduate programs. The students who participated in this phase were: Mary Jo Chippendale, University of Minnesota; Jennifer Deschaine, Bethel College (St. Paul); Kathy Lammers, Minnesota State University at Winona; Deborah Meade, Augsburg College (Minneapolis); Jackie Meyer, University of Iowa; Dolores Severtson, University of Wisconsin-Madison; Victoria Von Sadovszky, University of Wisconsin-Madison.

3. *Tools for Analyzing Evidence in Support of Public Health Nursing Practice*, 3rd Ed. (1999, February). Minnesota Department of Health/Division of Community Health Services. [Note: This set of analysis tools and the processes for their use was patterned after that utilized by the federal Agency for Health Care Policy and Research in their development of practice guidelines.]

4. For additional information regarding the tool, contact Sue Strohschein at 320//650-1078.

5. The panel members are listed in the Acknowledgments.

6. Committee of the Institute of Medicine's Council on Health Care Technology. (1990). *Consensus Development at the NIH: Improving the Program*. Washington, DC: National Academy Press; Saint, S., & Lawson, J. R. (1994). *Rules for Reaching Consensus: A Modern Approach to Decision Making.* San Diego: Pfeiffer and Co.

7. The group was asked to indicate their preference for the following categories of agreement: agree without qualification; agree but with qualification; have reservations but can live with it; and can't live with it–needs changing. Reservations, suggestions, comments, etc. were recorded.

For more information about this process contact:
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