

**Public Health
Nursing**

**Orientation
&**

**Practice Manual
2016**

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Foreword

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Foreword

The 2nd edition of the *Public Health Nursing Scope and Standards of Practice* asserts that public health nursing has significantly contributed to the health of our country's population for more than a century. The current cultural and political climate directly impacts public health nursing practice which is becoming more dynamic and increasingly complex. The Public Health Nursing Standardized Orientation and Practice Manual was developed in 2005 through the efforts of many State and Regional Public Health nurses to reflect the Scope and Standards of Public Health Nursing Practice. In order to meet the challenges of evolving practice standards, the manual has been revised through a collaborative effort between the Staff Training and Resource Team (STaRT) and the review and approval of the Nursing Leadership Team. The revised manual contains information pertinent to public health nursing management and practice, standardized training modules, and detailed orientation checklists. The manual now includes a Child Health section replacing all previous versions of the Child and Adolescent Health Manual.

The 2016 Public Health Nursing Orientation and Practice Manual is designed to be used in concert with Tennessee Department of Health policies, procedures and program guidelines. It is the standard for Public Health Nursing orientation and provides assistance to PHN's throughout the state as they strive to maintain practice principles and meet core competencies as defined by *Public Health Nursing Scope and Standards of Practice*.

Key Public Health Nursing Principles include:

- The client or unit of care is the population.
- The primary obligation is to achieve the greatest good for the greatest number of people or the population as a whole.
- Public health nurses collaborate with the client as an equal partner.
- Primary prevention is the priority in selecting appropriate activities.
- Public health nursing focuses on strategies that create healthy environmental, social and economic conditions in which populations may thrive.
- A public health nurse is obligated to actively identify and reach out to all who might benefit from a specific activity or service.
- Optimal use of available resources and creation of new evidence-based strategies is necessary to assure the best overall improvement in the health of the population.
- Collaboration with other professions, populations, organizations and to stakeholder groups is the most effective way to promote and protect the health of the people.

Special recognition is given to the following STaRT members for their hard work and dedication to this important project:

Gwen Blayde	Jenny Dudzinski	Katrina Hunnicutt
Ingrid Long	JoAnne Mullins	Mary Prince
Cathy Sandidge	DeSha Shaw	Brenda Thomas

SECTION I

OVERVIEW OF THE DEPARTMENT OF HEALTH

A. INTRODUCTION

The Tennessee Department of Health (TDH) works to protect, promote and improve the health and prosperity of people in Tennessee by facilitating access to high quality preventive and primary care services. Critical services are provided to the people of Tennessee in the areas of public health that are not accessible or available in the private sector.

Keeping people healthy by preventing problems that contribute to disease and injury is the overall emphasis of the TDH. It has become increasingly evident that the greatest causes of premature death and preventable illness are closely related to lifestyle. The Department promotes healthy lifestyles by providing education about these risks and increasing awareness as to the importance of individuals taking responsibility for their own health and safety, as well as that of their family.

TDH works to insure the quality of health care through the licensure and regulation of health professionals and health care facilities. The Department also plays a critical role in ensuring that personal health care services are available and accessible when, and where, people need them, despite economic and geographic barriers.

1. The Tennessee Department of Health

◆ **Mission:**

The mission of the Tennessee Department of Health is to protect, promote and improve the health and prosperity of people in Tennessee.

◆ **Vision:**

The vision of the Tennessee Department of Health is to be a recognized and trusted leader partnering and engaging to accelerate Tennessee to one of the nation's ten healthiest states.

◆ **Values:**

Teamwork – Passionate people innovating together

Integrity – Honesty and accountability in all that we do

Mutual Respect - Appreciation of one another's perspectives and our diversity

Excellence – Deliver superior quality services

Compassion - Demonstrate caring in daily operations and throughout public health crises

Servant Leadership – Combine humility with will to steward/serve the public's resources and trust

◆ **Core Functions:**

Assuring Services

Promote the development of services

Outreach and assist in accessing services

Push the system to provide needed services
Provide services

Assessment

Health status
Health resources
Health problems

Policy Development

Support individual and community efforts to protect, promote and improve health.

- ◆ **Primary Prevention**
 - Outreach and service in communities
 - Collaboration with communities
 - Being the voice for community health

- ◆ **Protection Through Policy and Regulation**
 - Prudent public policy
 - Quality and timely regulatory inspections

- ◆ **Customer Service**
 - Listening to customers and taking appropriate action
 - Patient education and marketing services
 - Improving processes and teamwork
 - Engaging stakeholders external to TDH

- ◆ **Workforce Excellence and Development**
 - Recruiting and retaining excellent staff
 - Ensuring competent workforce
 - Staff continuing education

2. **History of Public Health**

Recurring epidemics of cholera, yellow fever, and other frightening diseases were a powerful force in the development of what we know today as public health. Through the mid-1800s, Nashville, Knoxville, Memphis, and many smaller cities and towns experienced epidemics that threatened life, health, and economic disaster. As a result, efforts began to establish a State Board of Health and in 1874 Governor James D. Porter presented strong plea for legislation. The following paragraphs are quoted from this petition:

“We have called it preventive medicine because its benevolent object is to secure exemption from disease for a whole people, and as it is to be applied to an entire state, and cannot exist except under state laws, it has by common consent taken the name of State Medicine.

State Medicine does everything necessary to protect the health of communities and states: it investigates the air we breathe, the water we drink, the food we eat, the clothes we wear, the fuel we burn, the house we live in, the soil we cultivate, the habits and industries of life, the origin and nature of endemic and epidemic diseases, the method of their transmission, the means of their prevention and of their suppression whenever found. Its object is to discover the causes and to prevent the origination of disease, to prevent its spread, to circumvent it, to extinguish it, whether it be zymotic, contagious, or specific. In short, it is the function of State Medicine to protect the public health, which is the life of the nation.”

A bill was signed into law in 1877 to create such a board. For many years, the main activities of the board were combating epidemics, forming county boards of health, working on school sanitation, and maintaining vital records of births and deaths in the state.

In 1923, legislation was passed to create a Department of Public Health headed by a commissioner in the executive branch of State Government. Activities and responsibilities have evolved through the years as health needs and medical care has evolved. In 1983, law changed the Department’s name from the Department of Public Health to the Department of Health and Environment so as to more nearly reflect the broad functions of the Department. As part of an increased focus on environmental protection and conservation, the environmental programs were transferred to the newly established Department of Environment and Conservation in 1991. The Department of Health and Environment then became the Department of Health.

3. History of Public Health Nursing¹

The following article was written in recognition and celebration of one hundred years of public health nursing:

“The history of public health nursing is one of individuals doing what was within their power to do, making life better for others and proving that one person really can make a difference. These nursing pioneers set the stage for what was to become the complex mission of public health.

Public health nursing in this country began in 1893 with the vision of one woman, Lillian Wald, nurse and founder of the Henry Street (New York) Settlement, the first organized district-nursing agency. Through her relentless efforts, combined with political, organizational, and leadership abilities, people and resources were brought together to share a single philosophy – a spirit of caring, commitment to serve, and personal courage. Thus, the “public health nurse” was born, and so began a nationwide system of care.

¹ McIntyre, P.S., “One Hundred Years of Public Health Nursing” Journal of the Tennessee Medical Association, July 1993.

In Tennessee, nurses have played a vital role in public health since 1910. Although there are accounts of visiting nurses during the devastating Memphis yellow fever epidemic of 1879, the first official public health nurse was Elizabeth Simmons (Memphis City Health Department). A year later, the Nashville City Health department hired its first nurse who was charged by the mayor “to help the poor and sick, and to help prevent the high death rate among babies”, which was reported to be 300 for every 1,000 live births. For over 80 years, public health nurses throughout Tennessee have been doing just that.

Throughout the years, public health nurses have addressed a continuum of health care needs. Nursing, meaning to nourish and protect, gradually increased in scope from serving just the sick to guarding and enhancing the health of individuals and families. Traditionally, public health nurses have provided services to people of all walks of life and in a variety of settings. In the home, workplace, schools, street corners, and clinics, public health nurses can be found reaching out to care for the health of people in need.

In the last 100 years of service many battles on the disease front have been fought and won. Communicable diseases, which once presented a major threat to the consumer and a challenge for public health nurses have, for the most part, been eradicated or controlled. Maternal and infant mortality has been drastically reduced. Many improvements have been made with regards to safety in the workplace, and we are just beginning to recognize the importance of our environment with regards to health and disease.

However, just as some plagues are conquered, new ones emerge. As the next century dawns, we must address some difficult challenges. Public health is once again faced with the threat of a deadly communicable disease as HIV/AIDS proliferates, bringing with it a host of other health problems including a resurgence of tuberculosis. Teenage pregnancy and sexually transmitted diseases have reached epidemic proportions, and herpes and human papilloma virus (HPV), though not fatal, cause devastating long-term consequences for their sufferers. Low birth weight and infant mortality remain serious problems. Accidental death, homicide, suicide, and substance abuse are destroying our young people. Heart disease and cancer continue to be leading causes of death. Finally, much work remains if we are to preserve and improve the safety of the environment in which we live and work.

In today’s complex health care environment, nurses are committed to supporting an agenda for health care reform. As policy makers look for ways to assure quality, affordability, and accessibility in health care, public health nurses can bring their expertise and experience to an ever widening spectrum of health care concerns. The challenges of today and tomorrow are both similar and different from those of yesterday. But of one thing we may be certain: The vision that has guided public health nurses through 100 years of meeting the health care needs of the people will continue to serve us well – to preserve, protect, and enhance the health of the

citizens of this nation. Let us join together in assuring Tennesseans a healthier and happier place for this and future generations.”

Tennessee public health continues to face challenges today as it confronts the factors that contribute to morbidity and mortality including tobacco use, obesity, physical inactivity and substance abuse. These factors directly or indirectly impact the leading causes of death in Tennessee which have shifted from infectious diseases such as tuberculosis to chronic diseases like heart disease. As the challenges facing public health today have shifted, so too have the strategies to address these challenges. Public health must address today’s challenges by partnering with local, regional and state entities to promote health in all policies and in all communities addressing existing health inequities. Public health nurses are key players in addressing today’s public health challenges as they are trusted professionals within their communities and know firsthand the challenges faced by those living in them.

4. Philosophy of Public Health Nursing

The American Public Health Association defines public health nursing (PHN) as “the practice of promoting and protecting the health of populations using knowledge from nursing, social and public health science.” As integral members of the health care team, public health nurses, functioning within the framework of the agency, strive to accomplish the mission set forth by TDH.

Public health nursing has as its basic principle the worth and dignity of the individual patient, family, and community. PHNs believe individuals have the right to accept or reject care unless that decision places others in jeopardy. Nursing culture has always been one of care and cure with the central focus being strong, nonjudgmental advocacy for the patient. PHNs embrace the “Code of Ethics for Nurses” developed by the American Nurses Association which defines the responsibility of the nurse to the patient and to the community as a whole.

PHNs are committed to maintaining the identity as public health nurses and believe their services are critical components in the Department’s health care system. While the PHN role often requires independence and autonomy in practice, PHNs subscribe to the philosophy of interdependence that is necessary if health care services are to be successfully delivered effectively and efficiently.

If PHNs are to achieve the highest level of professional practice development and maintenance of competencies, representatives from local, regional, and central office should collaborate to develop methods to implement the standards developed by the American Nurses Association (*Scope and Standards of Practice: Public Health Nursing*, 2013). PHNs believe nurses are directly accountable for their actions. Validation of PHNs accountability is measured through:

- ◆ The use of the *ANA Standards of Practice for Public Health Nursing* that define quality practice
- ◆ The use of the *nursing process* that provides a conceptual framework for public health nursing
- ◆ The use of *nursing audits* that evaluate competencies outlined in the nursing standards
- ◆ The use of ongoing *self-evaluation* of PHN competencies

PHNs recognize the individual qualities that each nurse possesses which contributes to her/his unique skills and expertise. Nurse leaders must be able to identify the individual's outstanding characteristics and strive to provide opportunities for all nurses, as well as others with whom she/he works, to reach their highest potential.

PHNs must be qualified through formal education and experience in order to carry out their assigned responsibilities. Inservices, formal study programs, and continuing education must continually refurbish this basic knowledge. PHNs have the responsibility to participate in activities that will improve public health nursing practice through the testing of new ideas, creative thinking, and participating in research and/or study projects.

Public health must be futuristic. PHNs have a professional obligation to become knowledgeable, conversant and involved in the national health care reform. PHNs must maintain an awareness of the principles of traditional public health and strive to understand the ever-evolving health care system, and be alert to any barriers to health promotion and health maintenance. Tennessee PHNs must remain dedicated to the mission of the Tennessee Department of Health which is to protect, promote and improve the health and prosperity of people in Tennessee.

B. ADMINISTRATIVE STRUCTURE

1. Community Health Services (CHS)

Community Health Services provides direction, supervision, planning, communication, coordination, and fiscal support. It includes an array of programs and services that oversee the delivery of public health care to the people in Tennessee. Working through a network of regional offices, local health departments, and county clinic sites, CHS ensures that quality health care is delivered to those in need of services.

2. Office of Nursing

The Office of Nursing works collaboratively and cooperatively with all program areas at the central, regional, and local levels in order to provide a strong advocacy for public health nursing across the state. It is responsible to lead the development of public health nursing protocols, maintenance of the ANA Standards of Practice for Public Health Nursing, and development of nursing policies and procedures. The Office of Nursing maintains contracts with schools of nursing for student nurse orientation to public health. The Office of Nursing works closely with Nursing

Strike Teams and Emergency Preparedness to provide ongoing nurse training and support during emergency preparedness events. It ensures orientation and training of public health nurses and supports and enables them to provide effective and efficient care for people in Tennessee.

3. Local Health Services

All 95 counties in Tennessee have a local health department which is operated through a partnership between the state and county.

C. PUBLIC HEALTH SERVICES

The TDH provides a diverse set of services to protect, promote and improve the health and prosperity of people in Tennessee. Refer to TDH website for program specific details.

D. PLANNING FOR PUBLIC HEALTH SERVICES

1. Needs Assessment

◆ **Community Awareness:**

PHNs have been leaders in improving the quality of health care for people since the late 1800's. PHNs are an effective, vital force for promoting health and preventing illness. The PHN must understand and recognize the current status of the community's health needs/problems and health care systems. Major social, economic, and political developments influence community health programs. Nurses must be aware of the cultural diversity and socioeconomic factors that affect health care in their community.

◆ **Criteria Used to Assess Health Needs:**

An assessment of community health needs, by established and measurable criteria, will determine the need for services. The PHN may collaborate with other health department staff and community coalitions in making periodic community surveys/assessments.

Resources include TDH Office of Performance Management, local government planning office, Chamber of Commerce, library, vital records, morbidity/mortality statistics, community surveys, and household interviews. Community assessment provides valuable information about the county/community's strengths and weaknesses with regard to financial resources, pollution, substandard housing, crime, stress-induced illnesses, poor dietary patterns, and sense of responsibility for members. Assessment provides the basis for planning and intervention.

2. Service Delivery

The PHN is responsible and accountable to both the employer and the profession, as well as to the clients and their families when ensuring the provision of health services. The services may take place in the clinic, the client's home, or the

community setting. When planning care for individuals, families, and groups, the nurse will use available data and resources related to the social determinants of health.

◆ **Clinic Visit:**

The clinic setting has been found to be a cost-effective location for providing a wide variety of health services, health screening, and prevention services, as well as health promotion and maintenance services. PHNs, using the appropriate protocols and TDH program guidelines, provide services in the clinical setting. They function as providers of health care, teachers, counselors, case managers, and patient advocates – vital members of the health care team.

The nurse has the responsibility to evaluate the clinic for effectiveness and efficiency. The PHN should participate in initiatives to improve service delivery.

◆ **Home Visit:**

Although the roots of public health nursing are in-home visiting, it is now only one of a number of modalities for delivering community health services. A home visit provides the optimal setting for assessment of the child abuse situation, the young mother with a newborn, children with special needs, or patients with communicable disease. The home visit provides the PHN a picture of the family facilities, relationships, and coping abilities.

◆ **Community setting:**

PHNs collaborate with community partners to promote the health of individuals, families and communities through Primary Prevention Initiatives. PHNs participate and/or lead activities that facilitate community involvement through serving on community based committees and taskforces and providing PHN expertise to community partners.

E. POLICIES AFFECTING NURSING FUNCTION

A copy of the Tennessee Department of Health Community Health Services Policies and Procedures Manual is located in each health department. The manual can also be accessed on-line. It is the employees' responsibility to review all new and revised policies as they become available.

1. Personnel

It is expected that PHNs will be in compliance with all policies set forth by the Tennessee Department of Health. For a descriptive definition of policies, consult references, such as regional, local, or state policy manuals, Employee Handbook (metropolitan areas), or employee packets (rural counties).

Personnel policies, which are addressed in the CHS Policies and Procedures Manual, are discussed with each new employee in detail by the regional personnel office. New employees are also given a packet of material and information regarding benefits.

2. Expectation of Practice

The expectation of any nurse working for the Department of Health is that the nurse will follow Public Health Nursing Protocols and program guidelines. PHN Protocols cover the full scope of Public Health Nursing Services. It is expected that all Public Health Nurses will provide Family Planning Services to the full extent of their scope of practice according to PHN Protocol including the issuance of emergency contraception and providing confidential services to minors.

3. Fee Policy and Reimbursement for Services

Fee Collection:

Computerized fee schedules are applied for services provided by the TDH. Reimbursement and revenue generation in the local health department are important to maintain the ability to provide services. While nurses do not have direct responsibility for fee collection, it is necessary to understand the rationale for fee collection and to accurately document and code for services provided.

4. Policy for Correcting Charting Errors

The policy for correcting paper charting errors is as follows:

- ◆ Draw a line through the mistake
- ◆ Write CID (Correction in Documentation) immediately above the error
- ◆ Initial
- ◆ Date (if different from date of original entry)

An error on a growth chart should be corrected as follows:

- ◆ Make an “X” on the erroneous dot
- ◆ Draw a line from the dot to an area below or above the percentile curves
- ◆ Write CID
- ◆ Initial
- ◆ Date

Follow correction guidelines of electronic medical record.

5. Policy for the Administration of all Injectables Given in Health Department

Clinic Sites

Registered nurses and licensed practical nurses are allowed to administer injectables in clinic, including antibiotics, in the absence of a physician or nurse practitioner if the following conditions are met:

- ◆ The drug is administered according to the nurse’s current PHN protocol or per a

physician/APN medical order. If the order is written by a non-health department physician/APN, it must be written for a specific patient and approved by the public health supervising physician.

- ◆ The nurse is prepared to manage both anaphylaxis and other emergency reactions according to emergency protocol and procedures.
- ◆ There is at least one other employee in the building who can assist with emergency care as needed and has current CPR training.

This policy applies to all registered nurses and licensed practical nurses working in local health departments, regional offices, and the central office. The purpose of the policy is to prevent prolonged delay in providing necessary injectable therapy, including antibiotic therapy.

6. Policy for Receiving Telephone/ Verbal Orders

Only licensed nurses (RNs and LPNs) may receive and record telephone or verbal orders from a TDH physician or APN. In order to ensure accurate communication:

- ◆ The licensed nurse receiving the order must read back the order to the TDH physician/APN.
- ◆ The ordering TDH physician/APN will immediately verify that the read-back order is correct.
- ◆ The licensed nurse will document the order with read-back verification in the patient record. The abbreviation VORB (Verbal Order Read Back) may be used.
- ◆ The ordering TDH physician/APN will authenticate the order by written or electronic signature in the patient record no later than 1 month after the date of the telephone/ verbal order.

7. Policy Regarding Returned Drugs

RN's and LPN's are authorized to issue medications and related pharmaceutical supplies according to CHS policy 3.03b. To maintain compliance, PHNs must adhere to the Rules of the Tennessee Board of Pharmacy which prohibit receiving from any patient or other person the return of any portion of an order that has been taken from the premises. The US Food and Drug Administration supports this policy in the interest of public health (CPG Sec. 460.300 Return of Unused Prescription Drugs to Pharmacy Stock) as the return of unused drugs would be void of any assurance of the strength, quality, purity or identity of the articles.

<http://share.tn.gov/sos/rules/1140/1140-03.20151214.pdf>

[Compliance Policy Guides > CPG Sec. 460.300 Return of Unused Prescription Drugs to Pharmacy Stock](#)

8. Review of Medical Records

Rules and Regulations of the Tennessee Board of Nursing governing the utilization and supervision of services provided by the master's level nurse practitioner with prescription writing authority require that the supervising physician personally review a minimum of 20% of medical charts every 30 days.

The following is also recommended:

- A minimum of 20% of family planning charts completed by the PHN with GYN training be reviewed by either the Health Officer/Supervising Physician or the Nurse Practitioner
- A minimum of 20% of family planning charts completed by the RN-ES (Family Planning Nurse Practitioner) be reviewed by the Health Officer/Supervising Physician.

9. Professional Malpractice Insurance

State employees are granted immunity from liability for any actions within the scope of their employment. Please note that employees are not granted immunity for willful, malicious, or criminal acts or omissions or for acts or omissions done for personal gain. The Division of Claims Administration in the State of Tennessee's Treasury Department administers the malpractice coverage. The State of Tennessee will not provide malpractice coverage for any actions taken on behalf of another employer, such as when a nurse "moonlights" at a private hospital. Non-state employees should refer to the Human Resource department of their county employer regarding malpractice coverage.

10. Dress Code

PHNs are representatives of the health department in the community. The TDH's dress code allows nurses to wear "street" dress. It is expected that the nurses will bear in mind each day their roles as caregivers and as agency representatives. Each nurse has a personal responsibility to consider his or her appearance at work regardless of the setting. It should be noted that *the final interpretation of the dress code, as well as its enforcement, is the responsibility of the supervisor*. Questions are welcomed and should be directed to the supervisor.

Dress Code for Public Health Nurses, Advanced Practice Nurses, Licensed Practical Nurses and Nursing Assistants

◆ General Dress:

- All direct health providers and clerical personnel must wear name badges with the individual's name and professional identification clearly visible to ensure clients can readily identify providers. Name badges with photos are recommended.
- APNs delivering direct patient care must wear photo name badge with written name of the type of license held (Reference T.C.A. 63-1-109)

- **Scrubs** are considered uniform for clinic personnel. Acceptable scrubs should be clean and neat and have full length pants.
- **Street clothes** may be worn as an option to scrubs and must always be covered by an appropriate lab coat (either PPE or regular as defined below). Street clothes must be full length with no skin of the lower extremities exposed (such as capri pants).
- Professional attire must be worn whenever representing TDH in the community (ex. PPI) and will be at the discretion of the supervisor.
- **Any clothing deemed inappropriate to the work setting by the supervisor or manager will not be worn.**

◆ **Lab Coat Requirements:**

- Lab coats classified as **Personal Protective Equipment (PPE)** are furnished by the employer and must be worn when performing laboratory procedures.
 - PPE lab coats must be worn over uniform (whether scrubs or street clothes) whenever laboratory procedures are being performed (whether in clinic or a home visit).
 - PPE lab coat must be at least three-quarter length, long sleeves and buttoned.
 - Providers may wear PPE lab coats in the lab or clinic areas in addition to the time performing laboratory procedures; however, the PPE lab coat is to be removed when leaving the work area, going to lunch, etc. If not soiled or damaged, the PPE lab coat can be reused when lab or clinic activities resume.
 - PPE lab coat worn during a home visit is to be replaced upon return to clinic.
- **Regular Lab Coat** (may be white, a solid color, or appropriate print)
 - In the clinic setting, regular lab coats *may* be worn over scrubs, but **must** be worn over street clothes. Name badge with professional identification must be worn on the outside of the lab coat.
 - Regular lab coats must be worn over street clothes or over scrubs during home visits. A PPE lab coat is to be worn if laboratory procedures are performed during the home visit.
 - Regular lab coats worn during home visits are to be replaced with a clean lab coat prior to returning to clinic.

◆ **Other:**

- **Hose/socks** are always to be worn with street clothes or scrubs.
- Practical closed toe walking shoes that cover the entire foot are to be worn.
- Discretion and good taste should be exercised in **jewelry** and **hairstyle**. Long hair should be pulled back and off the shoulders.
- Visible piercings should be limited to the ears.

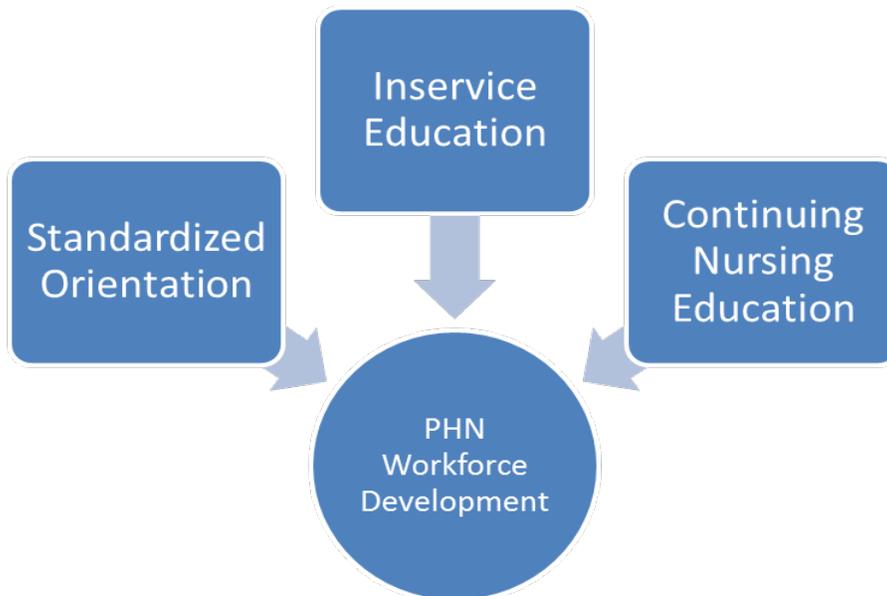
- Tattoos should not be visible.
- Artificial nails should not be worn. *Fingernails* should be kept clean and short. Caution and good judgment must be considered because of the potential for transmitting infection and causing trauma to self and/or others.

F. QUALITY IMPROVEMENT (QI)

The concept of Quality Improvement (QI) is being promoted today in all areas of healthcare. The goal of the TDH Office of Quality Improvement (OQI) is to improve population health and the overall quality of life for Tennesseans. The TDH OQI is committed to creating a system-wide culture of quality and to support continuing processes to benefit our patients. The efforts to achieve measurable improvement are ongoing and use defined processes, data analysis and benchmarks. For additional information, see current Quality Improvement Manual.

G. STAFF DEVELOPMENT

Workforce excellence and development activities will focus on enhancing the training, skills, and performance of public health nurses and will be based on the following framework:



The Staff Training and Resource Team (STaRT) consists of representatives from each region appointed by the Regional Nursing Director as staff development coordinators in their region. STaRT meets quarterly and as needed with the following objectives:

- Ensure standardized orientation for all new public health nursing staff establishing a strong foundation of PHN competencies. Orientation guidelines will be updated based on evidence based changes in practice and feedback from orientees.

- Ensure that all required in-service training material is relevant and current and nursing staff receives appropriate training.
- Provide continuing education to public health nurses based on a needs assessment which identifies a gap in knowledge, skills or practice.

SECTION II

NURSING PRACTICE & MANAGEMENT

A. DEFINITIONS

1. **Public Health Nurse (PHN)**

The PHN incorporates public health and nursing science in the delivery of care to individuals, families, and groups. When referenced in the Public Health Nursing Orientation and Practice Manual, PHN includes RN, LPN, and APN.

2. **Management**

Management provides the means of translating administrative philosophy, aims, and plans into reality by using available resources and by controlling group and individual behavior and activities. Management is also the art of “getting things done through other people”.

3. **Policy**

A policy is a principle or guideline that governs activities of an institution or organization. Employees are expected to know and to follow policy.

4. **Procedure**

A procedure provides a series (or steps) of related tasks that make up the chronological sequence and the established way of performing the work to be accomplished. A procedure focuses on task completion. The purpose of a procedure is how, not why.

5. **Standard**

A criterion measure of quality or value established by authority, custom, or general consent as a model or example. Agreed upon criteria are used to provide guidance in the operation of a health care, or other, facility to assure quality performance by the personnel. (For example, quality management standards, program standards).

6. **Core Competency**

Core Competency is the individual skills desirable for the delivery of Essential Public Health Services.

7. **Protocol**

A protocol is a written plan specifying the procedures to be followed in giving a particular examination, in conducting research, or in providing care for a particular condition. Protocols must be reviewed, revised as needed, and signatures completed on an annual basis.

8. **Program**

A public health program is an organized response designed to meet the assessed needs of individuals, families, groups, or communities by reducing or eliminating one or more health problem(s). Examples of specific programs provided by public health are family planning, immunizations, and Women, Infant and Children (WIC). Each program has administrative and/or programmatic policies procedures, and/or standards. An effort is made by central office personnel to consolidate these elements across program lines when at all possible.

Many public health patients receive the services of multiple programs; consequently, some policies, procedures, and standards are the same among programs. There are also policies, procedures, and standards which are unique for each program.

9. Guidelines

Guidelines are a defined set of directives that guide program activities (e.g., TB program, Women’s Health, WIC). Guidelines may be Federal, State, or program specific.

10. Job Class Specifications

Job class specifications describe in general the character of the duties, give examples and define the minimum qualifications with regard to education or experience. These criteria are used to select applicants for employment and for the reclassification of positions. (Job class specifications can be downloaded from the TN.GOV website).

11. Performance Management

The Performance Management Program is a systematic process used to define the standards of performance and expected work outcomes for all employees, provide ongoing performance feedback, offer the employee developmental opportunities, and document an objective and fact based performance. The purpose of the performance management program is to facilitate the creation and nurturing of a performance based culture where the individual employee’s performance is aligned with the agency and administration’s objectives and employees are appropriately rewarded for the results they achieve. Each covered employee shall have an individual performance plan (IPP) which details the defined performance standards and expected work outcomes. The IPP shall be specific, measurable, achievable, relevant to the strategic objective of the employee’s agency, and time sensitive (SMART).

B. SCOPE OF PRACTICE

1. Overview

The PHN practices according to:

- ◆ The legal scope of practice under the Tennessee Nurse Practice Act
- ◆ ANA Scope and Standards of Practice for Public Health Nursing
- ◆ Public health policies, procedures, and guidelines
- ◆ Public Health Nursing Protocols and/or specific TDH physician/APN orders for delegated medical functions
- ◆ Patient record documentation standards including use of SOAP format for narrative notes and approved abbreviations
- ◆ Quality Improvement Standards

2. Nurse Practice Act

All nurses practice under the Nurse Practice Act. Refer to the following:

“Professional Nursing” Defined TCA-63-7-101 and 63-7-103

“Practical Nursing” Defined TCA-63-7-108

3. Rules and Regulations

The Rules and Regulations of Registered Nurses 1000-1-.04(3) – as promulgated by the Tennessee Board of Nursing, explicitly state the nurse’s responsibility. Refer to the following reference materials

- ◆ Rules & Regulations of Registered Nurses
<https://www.ncsbn.org/1000-01.20111103.pdf>
- ◆ Rules & Regulations of Licensed Practical Nurses
<https://www.ncsbn.org/1000-02.20111103.pdf>
- ◆ Rules & Regulations of Advanced Practice Nurses and Certificates of Fitness to Prescribe
<http://share.tn.gov/sos/rules/1000/1000-04.20150622.pdf>

4. Good Samaritan Law

Refer to T.C.A., 63-6-218.

5. Protocol Requirements

According to Rules and Regulations of the Tennessee Board of Nursing, “RNs who manage the medical aspects of a patient’s care must have written medical protocols, jointly developed by the nurse and sponsoring physician(s). The detail of medical protocols will vary in relation to the complexity of the situations covered and the preparation of the nurse using them.”

The congruence of nursing, medicine, and administration in protocol development provides a support system for nurses in the delivery of quality health care. The following guidelines are provided:

- ◆ All licensed nursing personnel must practice under a signed protocol for delegated medical patient management. The nurse agrees to practice according to the protocol and validates that the protocol has been read by signing the signature page.
- ◆ Protocols must be reviewed, updated, and signed annually by the licensed nurse(s) practicing under the protocol, the Regional Medical Director, the Regional Nursing Director, the County Health Officer and the County Nursing Supervisor.

6. Advanced Practice Nurse (APN) Prescription Writing (See also Section III, D, Orientation Guidelines for Nursing Personnel)

Refer to TCA 63-7-123 Certified Nurse Practitioners, Nurse Practitioner Supervisory rules, 63-7-126 Advanced Practice Nurses.

Nurse practitioners apply to the Board of Nursing for a certificate to practice as an advanced practice nurse (APN) which, for those APNs with prescriptive authority, will include a certificate of fitness to enable them to write prescriptions.

Prescription issued by a nurse practitioner, under the supervision of a physician, shall be deemed that of the nurse practitioner and shall be written on a preprinted prescription pad bearing the name, address, and telephone number of the supervising physician and of the nurse practitioner. If the preprinted prescription pad contains the names of more than one (1) physician, the nurse practitioner shall indicate on the prescription which of those physicians is the primary supervising physician by placing a checkmark beside, or a circle around, the name of that physician.

7. Legal Issues

CHS policy requires the employee to directly contact the Office of General Counsel (OGC) upon receipt of a subpoena. Other legal questions should be directed to the local and regional management staff prior to contacting OGC.

8. Nursing Licensure

It is required that all licensed nursing staff will maintain a current license for the practice of nursing. This is the responsibility of each licensed nurse employed by the Tennessee Department of Health.

The Rules of the Tennessee Department of Human Resources Chapter 1120-10-.03 (9) state “failure to obtain or maintain a current license or certificate or other qualifications by law or rule as a condition of continued employment” is an example of a disciplinary offense.

Disciplinary action could lead to:

- ◆ A suspension of up to 5 days without pay or until license is renewed
- ◆ Dismissal if license is not renewed within the 5 days suspension time frame

The mission of the Department of Health Board of Nursing is to safeguard the health, safety and welfare of Tennesseans by requiring that all who practice nursing within this state are qualified and licensed to practice. Pursuant to the Board of Nursing Rules and Regulations 1000-1-.03, “the failure of any nurse to renew his/her license biennially or the failure to pay any fees required by law shall automatically forfeit the right of such nurse to practice nursing in this state.”

The Board of Nursing will send a renewal notification prior to the license expiration date. It is the responsibility of nursing professionals to ensure their licenses are renewed on time. License renewal may be completed online.

C. DOCUMENTATION

1. Introduction

Documentation of patient care in a medical record, including electronic medical record, is necessary to communicate accurate and complete information about the patient and the care provided. The Tennessee Nurse Practice Act defines documentation as “accurate recording of the facts.” Documentation is the objective recording of observations, findings, actions, and interactions, i.e., that which

you see, hear, feel and smell. Information is recorded according to established standards of practice.

2. **Principles of Documentation**¹

- ◆ Unique patient identification must be assured within and across paper-based and electronic healthcare documentation systems.
- ◆ Documentation systems must assure the security and confidentiality of patient information.
- ◆ Documentation must be accurate and consistent.
- ◆ Documentation must be clear, concise, and complete reflecting patient response and outcome related to nursing care received.
- ◆ Documentation must be timely and sequential.
- ◆ Documentation must be retrievable on a permanent basis in a nursing-specific manner.
- ◆ Documentation must be able to be audited.
- ◆ Documentation must meet existing standards such as those promulgated by state and federal regulatory agencies (to include HIPAA as enforced through the Department of Justice, the Centers for Medicare and Medicaid Services, and though accrediting organizations such as the Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance).
- ◆ Entries into the medical record (including orders) must be legible, complete, and authenticated and dated by the person responsible for ordering, providing, or evaluating the care provided.
- ◆ Abbreviations, acronyms, and symbols utilized in documentation must be standardized.
- ◆ The nurse must be familiar with organization policies and/or procedures related to documentation.

¹ Taken from Principles for Documentation, American Nurses Association, January 2003

3. **The Medical Record**

The medical record is a legal confidential document. The court system has recognized two types of ownership of medical records - the actual record remains the property of the health care agency but the information contained in the record is the property of the patient.

Refer to CHS policy section 5.0 – Records and Forms Management

4. **Documentation Guidelines**

- ◆ The provider has the responsibility to capture required data for tracking and billing purposes that accurately match the services provided.
- ◆ Services rendered must be coded on appropriate encounter form.
- ◆ Document all information directly into the patient's record immediately following the given care.
- ◆ Record facts, not opinions.
- ◆ Make all entries in chronological order. Never insert notes between lines or

leave space for someone to insert a note. If it should be necessary to record out of time sequence, the entry should be marked “late note”, dated and signed, and any unused spaces filled in with lines. Follow guidelines of electronic medical record for late entries as applicable.

- ◆ Correct all charting errors according to policy (See Section I, E, Policy for Correcting Charting Errors).
- ◆ Never obliterate entries or use “white out”.
- ◆ Write with blue or black ink unless record instructions or regional policy call for a notation to be made in red ink.
- ◆ Use only standard abbreviations approved by the Nursing Practice Committee (See PHN Protocol Manual) or region-specific approved abbreviations.
- ◆ Date and sign every entry according to specific medical record instructions.
- ◆ Use proper signature on medical record - first initial, last name, and provider status (e.g., J. Doe, R.N.); if initials are used (medical record, logs, equipment maintenance) full signature must be on file.
- ◆ Do not chart for anyone else or allow others to chart for you.
- ◆ Always record return visits, telephone conversations, and follow-up instructions.
- ◆ Telephone calls may be documented in patient’s record by indenting date (regional option) and a brief narrative note summarizing telephone call (SOAP format is not required).
- ◆ Documentation must be legible.
- ◆ Identify the informant when documenting subjective information.
- ◆ Document the full name of an interpreter when utilized. Document use of interpreter services per regional policy.
- ◆ Simplify documentation as much as possible.
- ◆ Use correct grammar and spelling.
- ◆ All laboratory data and measurements not provided by the primary provider are initialed by the individual completing the task.

5. **SOAP Format**

The nursing process is the framework a nurse should use in caring for a patient. The nurse should assess and identify patient needs, identify the problem, plan for the needed care, implement the care, and evaluate the outcome of the care.

To assure an orderly and coherent narrative of the nursing process, as well as to facilitate data retrieval, information in the patient record should be organized in a consistent pattern. The S.O.A.P. format is recommended, i.e., SUBJECTIVE, OBJECTIVE, ASSESSMENT, and PLAN for written documentation.

a. Subjective (S):

Subjective data is information about the patient, based on personal experience or the reporting of someone close to the patient. This includes the reason for visit and patient history, including pertinent physical, social, emotional, mental, spiritual, and economic information. Notations also include subjective feelings, symptoms, and perceptions reported by the patient. Descriptors for

subjective data include the following -

- Onset (time, date, type)
- Intensity
- Quality
- Location
- Radiation
- Number, length, and time of episodes
- Relieved by _____ or made worse by _____.
- Precipitating factors
- Associated with _____
- Overall course
- Effect of symptoms on daily life

b. Objective (O):

Objective data is describable, measurable, observable, and verifiable. Information is obtained through observation, examination, or other clinical findings. It is something that can be seen, heard, felt, smelled, quantified, etc. Examples include physical exam, lab test measures, blood pressure, etc. Descriptors for objective data include the following -

- Location
- Size
- Shape
- Color
- Temperature
- Moisture
- Consistency
- Presence or absence of swelling, movement, or weakness
- Associated pain with movement or touch

c. Assessment (A):

Assessment is an analysis or interpretation of the patient's status and need for help, based on subjective and objective data. It is a statement of conclusion – a nursing assessment or medical diagnosis based on protocol, a problem, and/or need. Documentation of nursing assessment reflects interpretation and evaluation of data, problems/needs of patient and/or family, and prognosis.

d. Plan (P):

This is a written plan of management for each patient problem using diagnostic, treatment, and education headings. The plan indicates intervention that will take place to alleviate or solve the problem. The plan must be related to the problems/needs and include a written action for each problem or need identified.

The plan may include the following -

- Treatment, care coordination, follow-up, referral, and/or management
- Patient and/or family counseling /education
- Request for additional information to accurately diagnose problem or need – example: request immunization record

6. Abbreviations

See PHN Protocol manual for the list of accepted standard abbreviations that can be used for documentation in the medical record. The use of abbreviations in standard program and laboratory manuals and PTBMIS are allowed. New requests for abbreviations to be added to the list should be submitted to the State Public Health Nurse Practice Committee for their review and approval.

If regional specific abbreviations are used, they must be approved by the regional medical director and/or regional nursing director and added as an addendum to the standard abbreviations in the state PHN Protocol Manual.

D. EMAIL ETIQUETTE

All email communication should follow the guidelines of email etiquette taken from Harbrace College Handbook, 13th edition, pages 616-617:

1. Is my tone appropriate for my audience and occasion? Have I refrained from using sarcasm or irony? If I have used humor, can I be sure that it will be understood?
2. Do I sound like the kind of person I want or need to be while at work? Am I signaling that I am competent and resourceful, helpful, and accommodating?
3. Is my content clear, concise, focused, and accurate? Have I made any statements or errors that would embarrass me if copies of this message were distributed elsewhere? Be aware that e-mail is not private. Not only may your recipient keep your message in a file, print it out, or forward it to someone else, but it may remain on the company's main computer.
4. Does my subject line describe the content of my message? Busy people use the subject line to identify messages they need to respond to immediately, those they can safely postpone for a few hours, and those they can postpone indefinitely.
5. If I need a response, have I established the kind of response I need and when I need it?
6. Have I sent copies to everyone who should receive one? To anyone who need not?
7. Am I respecting the privacy of others or am I forwarding a personal message without permission?
8. Have I respected copyright law by crediting any quotations, references, and sources?

E. CODING

An encounter is a summary of what happened to or for a patient receiving Health Department services. It tells the story details – who, what, where, when, why. Most of these details are recorded electronically using codes.

Provider code = who
Visit setting code = where
Date of service = when
Procedure code = what
Diagnosis code = why
Program Code = which program

1. **Types of Codes**

There are two basic types of codes for Procedures and Diagnoses:

- ◆ Valid, standard, universally recognized, HIPAA compliant codes
- ◆ Made-up codes

a. **Valid Codes:**

Valid codes are CPT, NDC, and ICD-10 codes. They can be found in books published by the AMA or on their websites. These codes are used to report medical services and procedures and have been designated by the Department of Health and Human Services as the national coding standard for physicians and other health care professional services and procedures under HIPAA.

- NDC Codes – identifies specific drugs
- ICD-10 Codes – identifies diagnosis
- CPT Codes – identifies procedure

b. **Made-Up Codes:**

“Made-up” codes have been created to capture specific information (not necessarily medical services) that is unique to public health or specific to a particular program area.

2. **Importance of Coding**

a. **Accuracy:**

The basic principle for accuracy is “code what you do, no more, no less”. It is important for the following reasons –

- ◆ It is the electronic record of what services a patient receives
- ◆ It is important for data collection
- ◆ Billing purposes
- ◆ Future funding may depend on the ability to document current levels of participation

b. **Consistency:**

Consistency means coding the same way each time the same type of service is provided and coding the same way in every region.

3. **Resources**

- TDH Billing and Codes Manual
- CPT codebook
- ICD10 codebook

4. **RVUs and Cost Allocation**

RBRVS (Resource-Based Relative Value System) is the method used for allocating pooled costs in the Health Department. This system uses RVUs (Relative Value Units), which are values placed on procedure codes based on time, effort, knowledge, and skill involved in providing a specific service, to allocate costs.

Relative Value Units (RVU) consists of the following three components:

- ◆ Work expense
- ◆ Practice expense
- ◆ Malpractice expense

Accurate and consistent coding across the state is important for this system to allocate costs correctly. Using encounter information RVUs are totaled by site and by programs within that site. Program percentages are then calculated using the total number of each program's RVUs divided by the total number of RVUs generated for that site.

Under coding services results in fewer RVUs, which in turn makes for a higher cost per RVU. When looking at productivity, under coding could make it appear that a site is overstaffed. This could result in it being decided that staff should be moved to a site where more staff is needed. Over coding services results in more RVUs and in a lower cost per RVU but could be considered fraud if services that are not provided have been coded. *The bottom line is to code what you do and the rest will take care of itself.*

Monitoring of the encounter coding information is done to detect errors such as, but not limited to, incorrect program codes, services being coded by the wrong discipline, codes with unusually high quantities. Reports are generated in central office using this information and are sent to regional management for follow up.

RVU reports showing a breakdown of costs, RVUs and direct program charges by site, program, region, and state are generated in central office and sent to the regions. These reports can be used as a management tool for administrators.

F. CLINICAL EXPERIENCES FOR NURSING STUDENTS

1. Purpose

To allow students enrolled in nursing programs to obtain their clinical experience at a regional or county health department in order to fulfill an academic requirement.

The role of the public health department:

- ◆ Provide role models for community/public health nursing practice
- ◆ Provide nursing experiences that will demonstrate the nursing process in public health.
- ◆ Provide clinical experiences that will demonstrate the multidisciplinary approach to health protection, promotion, and improvement
- ◆ Demonstrate the agency's programs and obligations in relation to the community's needs, interests, and resources
- ◆ Support the academic-Public Health partnership

2. Provisions or Conditions of Agreement

- ◆ There will be a signed Affiliation Agreement between the college or university and the State of Tennessee prior to assignment of clinical experience. Refer to school specific agreement.
- ◆ There should be advance planning and coordination between the school of nursing and TDH for student experiences to include when and where the students will participate, the number of students who will participate and what tasks will be performed by students.
- ◆ The school of nursing shall provide TDH a written list of the names of students who will participate in clinical experiences; this list should be provided in time for the agency to effectively plan for the students.
- ◆ The school of nursing must assume responsibility for malpractice and liability insurance.
- ◆ The school of nursing will inform students they are responsible for:
 - Being at their assigned stations at times scheduled
 - Adhering to any uniform or dress regulations required by the health department
 - Following applicable rules, regulations, policies and procedures of the health department
 - Signing a confidentiality agreement that protects client information

The health department may request that the school of nursing withdraw a student from the educational program based on the student's substandard or disruptive performance. The request must be accompanied by documentation.

- Any student found to be ill or contagious may be sent home at the health department's discretion.
- The confidentiality agreement will be retained by TDH for 3 years.

3. Guidelines

- ◆ Undergraduate students
 - Unaccompanied by instructor
 - Observe with PHN
 - If approved by the nursing supervisor, may assist health department staff with non-invasive tasks (ex. weight and height). Health department staff will maintain responsibility for client care and documentation.
 - Accompanied by instructor
 - If approved by the nursing supervisor and instructor, the student may perform tasks commensurate with the student's level of education and skill.
 - The student will document care in the medical record. The instructor and PHN responsible for the client's care will co-sign.

- ◆ Additional guidelines for undergraduate students with RN license (RN to BSN programs)
 - If approved by the nursing supervisor, an RN to BSN student may perform tasks commensurate with the student’s level of education and skill when accompanied by the PHN who will maintain responsibility for all aspects of client care.
 - The student will document care in the medical record. The PHN responsible for the client’s care will co-sign the student’s documentation. If the student is accompanied by an instructor, he/ she will also oversee care given and co-sign student documentation
- ◆ Graduate student with RN license
 - With approval by the supervising APN preceptor, a graduate student may perform tasks commensurate with the student’s level of education and skill.
 - The student will document care in the medical record. The APN responsible for the client’s care will co-sign.

G. NURSING COMMITTEES

1. Nursing Leadership Team (NLT)

The overall purpose of NLT is to provide nursing leadership for all nursing staff serving patients in regional and local health departments and local communities. NLT members analyze and deliberate nursing issues, provide nursing input into departmental programs and initiatives, share effective practices across regions, and serve as the decision making body for TDH public health nursing.

2. PHN Practice Committee

The Office of Nursing established the state Public Health Nursing (PHN) Practice Committee in November 1981. The overall purpose of this committee is to promote quality care by being alert to, addressing, and/or responding to matters relating to public health nursing practices.

3. Staff Training and Resource Team – STaRT

The Office of Nursing established the state Staff Training and Resource Team in March 2015. The overall purpose of this team is to ensure initial public health nursing orientation and ongoing professional development.

4. Other Committees

PHNs may be asked to serve on other state and regional committees.

H. EXIT INTERVIEW

Public health nursing staff that resign or transfer to another TDH position will complete the exit interview form.

- ◆ The form will be returned to the nursing supervisor.
- ◆ A copy of the exit interview form will be forwarded to the County Director

and the Regional Nursing Director.

- ◆ The nursing profile will be updated with the termination date/ reason.
- ◆ The updated profile and the exit interview will be forwarded to the Central Office of Nursing.

SECTION III

**ORIENTATION GUIDELINES
FOR
NURSING PERSONNEL**

A. Introduction

The purpose of public health orientation is to provide a mechanism for assisting the new public health employee in adjusting smoothly and progressively to a new/ changed work role and environment. The objective is for the orientee to be able to perform the functions of public health commensurate with his/her education and demonstrated competencies. The orientation program content is designed so that the public health employee is given the opportunity to become confident and competent at performing public health core functions and essential services in relationship to job expectations and Individual Performance Plan (IPP). The plan for orientation is recommended as a guide. Adjustments may be made based on the individual needs of the public health nursing personnel.

Each member of the public health nursing team contributes to the mission and vision of the Tennessee Department of Health. The following applies to all categories of public health nursing personnel:

- ◆ Function under written approved policies and protocols.
- ◆ Function within the limits of their specific education and experience and within the scope of the Nurse Practice Act, the IPP, and Departmental policy.
- ◆ Document all nursing activities on an official patient record (paper or electronic).

B. Public Health Nursing Personnel Orientation Standards

- ◆ Proactive On-Boarding will be initiated for all new public health nursing personnel to provide the tools, resources and knowledge needed to become a successful and productive employee. It is recommended that a “work buddy” in the local health department be assigned to serve as a resource and mentor.
- ◆ All new public health nursing personnel will complete a generalized orientation to public health nursing and public health programs. The recommended length of orientation is 4-8 weeks for licensed personnel and a minimum of 60 hours for non-licensed personnel.
- ◆ The following orientation tools will be utilized by the Staff Development Coordinator, Nurse Supervisor, assigned Preceptor, or other designee:
 - Public Health Nursing Orientation Checklist
 - Skills Orientation Checklist
 - WIC Orientation Checklist (Optional)
 - Orientation Communication Tool (Optional)
 - Public Health Nursing Evaluation of Orientee’s Performance
- ◆ All new public health nursing personnel will receive a brief introduction to public health, state policies, procedures, and benefits.
- ◆ A nursing profile form will be completed for all new public health nursing personnel. A copy of the profile form will be forwarded to the Central Office of Nursing. The nursing profile form will be updated upon transfer, promotion or termination.
- ◆ The assigned preceptor and local health department staff work with the orientee to provide guidance and support in implementing the orientation plan. Skills will be demonstrated and the orientee’s competent return demonstration will be documented

on the Skills Orientation Checklist. The employee may not have the opportunity to perform infrequent skills during the initial orientation period and must demonstrate competency prior to performing independently.

- ◆ All new public health personnel will receive an evaluation of their progress in orientation.
 - Orientation Communication Tool (optional)
 - Skills Orientation Checklist
 - Public Health Nursing Orientation Checklist
 - PHN pre and post-test for licensed personnel– 80% passing grade required for post-test
 - Public Health Nursing Evaluation of Orientee’s Performance

1. **ORIENTATION GUIDELINES FOR NURSING ASSISTANTS**

a. **Role**

The role of the nursing assistant(NA) is to extend nursing services by assisting public health providers in carrying out delegated nursing activities in clinics, and other health department settings.

b. **Policies**

- ◆ The NA works under the direction of a public health licensed provider.
- ◆ The NA shall have a minimum of 60 hours structured training within the first three months of employment.

c. **Functions**

Before performing skills independently, the NA must demonstrate competency. Refer to Skills Orientation Checklist.

d. **Evaluation**

A conference will be conducted by the nurse supervisor or designee at the end of the orientation period to discuss performance and to determine if additional orientation is needed.

2. **ORIENTATION GUIDELINES FOR LICENSED PRACTICAL NURSES**

a. **Role**

The role of the licensed practical nurse (LPN) is to contribute to the nursing assessment, participate in the development of the plan of care and contribute to the evaluation of the plan of care developed by the RN, APN or MD (refer to Tennessee Board of Nursing Position Statements, Feb 2012).

b. **Policies**

- ◆ The LPN practices within the scope of his/her license, education and demonstrated competencies under the PHN Protocol. The LPN functions under the direction of the higher level public health provider.

- ◆ The LPN recognizes and reports to the RN when assistance is needed to carry out nursing care.
- ◆ The LPN reports to the RN or higher level provider information regarding the patient's health status and documents reported information in the patient's record.
- ◆ The LPN shall have a minimum of 4 weeks structured training within the first three months of employment.

c. Functions

Before performing skills independently, the LPN must demonstrate competency. Refer to Skills Orientation Checklist.

The LPN scope of practice **does not** include:

- ◆ EPSDT/ well child physical exam
- ◆ WIC certification
- ◆ Oral health assessment
- ◆ Quickstart family planning service
- ◆ Treatment of anemia
- ◆ Counseling for tobacco cessation

The LPN scope of practice **does** include, but is not limited to:

- ◆ Assist with EPSDT under the direction of the higher level provider
- ◆ Fluoride varnish application
- ◆ Testing (including herpes culture) and treating STIs and issuance of Partner Delivered Therapy (PDT) according to PHN protocol
- ◆ Family planning resupply, emergency contraception, and Fertility Awareness Based method counseling according to PHN protocol
- ◆ Review immunization history and administer immunizations
- ◆ Treat lice, scabies, pinworms and ringworm per PHN protocol.
- ◆ Making referrals to the QuitLine

d. Evaluation

At the end of the orientation period, a conference will be conducted by the nurse supervisor or designee to discuss performance and to determine if additional orientation is needed.

3. ORIENTATION GUIDELINES FOR REGISTERED NURSES

a. Role

The registered nurse (RN) practices as a professional nurse according to the definition cited in T.C.A. 63-7-103: "Practice of professional nursing" means the performance for compensation of any act requiring substantial specialized judgment and skill based on knowledge of the natural, behavioral and nursing sciences and the humanities as the basis for application of the nursing process in wellness and illness care.

b. Policies

- ◆ RNs practice under PHN protocols that provide written guidelines that adequately describe the scope of nursing management to be performed by the public health nurse.
- ◆ The RN functions independently within the scope of professional nursing practice to collect data, provide screening assessments, identify patient problems, determine nursing diagnoses, plan interventions, and to provide teaching, counseling and referral for patients.
- ◆ The RN shall have a minimum of 4 weeks structured training within the first 3 months of employment.

c. Functions

The RN will demonstrate the Core Competencies at the Tier 1 level based on the Quad Council Competencies for Public Health Nurses and will practice according the Standards of Professional Public Health Practice (American Nurses Association (2013) *Public Health Nursing: Scope and Standards of Practice*):

Standard 1: Assessment

The public health nurse collects comprehensive data pertinent to the health status of populations

Standard 2: Population and Diagnosis

The public health nurse analyzes the assessment data to determine the diagnoses or issues

Standard 3: Outcomes identification

The public health nurse identifies expected outcomes for a plan specific to the population or the situation

Standard 4: Planning

The public health nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes

Standard 5: Implementation

The public health nurse implements the identified plan.

Standard 5A: Coordination of Care

The public health nurse coordinates care delivery.

Standard 5B: Health Teaching and Health Promotion

The public health nurse employs multiple strategies to promote health and a safe environment.

Standard 5C: Consultation

The public health nurse provides consultation to influence the identified plan, enhance the abilities of others and effect change.

Standard 5D: Prescriptive Authority – Not Applicable

Standard 5E: Regulatory Activities

The public health nurse participates in applications of public health laws, regulations and policies.

Standard 6: Evaluation

The public health nurse evaluates progress toward attainment of outcomes. Before performing skills independently, the RN must demonstrate competency. Refer to Skills Orientation Checklist.

d. Evaluation

At the end of the orientation period, a conference will be conducted by the nurse supervisor or designee to discuss performance and to determine if additional orientation is needed.

4. ORIENTATION GUIDELINES FOR ADVANCED PRACTICE NURSES

a. Role

- ◆ Under appropriate medical supervision, and in accordance with appropriate protocols and guidelines, the advanced practice nurse (APN) is uniquely prepared to administer primary health care and public health services.
- ◆ Scope of Practice – An APN (with prescriptive writing authority) is a registered nurse who has received a certificate to practice as an advanced practice nurse which includes a certificate of fitness from the Board of Nursing that allows the nurse practitioner to write and sign prescriptions and/or issue drugs pursuant to T.C.A. 63-7-123 and 63-7-126 (Rules of The Tennessee Department of Health, Bureau of Health Services Administration, Primary Health Care Advisory Board 1200-20-1-.01).

b. Policies

- ◆ Legislative Authority - APNs must work under a nursing license. If prescriptive authority is required, they must have an APN certificate/certificate of fitness, as delineated in the Law Regulating the Practice of Nursing In Tennessee and the Administrative Rules of the Tennessee Board of Nursing. They must also be supervised as stated in the Rules of Tennessee Board of Medical Examiners Division of Health Related Boards. It is the responsibility of the APN to have knowledge of current rules and regulations applicable to their practice. The following laws apply to advanced practice nurses:
 - “Practice of Professional Nursing” Defined T.C.A. 63-7-101, 63-67-103
 - Health Related Boards T.C.A. 63-1-132
 - Registered Nurse Licensure T.C.A. 63-7-105
 - Certified Nurse Practitioners T.C.A. 63-7-123
 - Advanced Practice Nurse T.C.A. 63-7-126
 - Authorized Services - Supervision T.C.A. 63-19-106
 - Restriction on Supervision - Physicians and Assistants T.C.A. 63-19-107
 - The Rules and Regulations of Registered Nurses 1000-4-01-.04
- ◆ Protocols - Advanced Practice Nurses practice under PHN protocols in addition to regionally approved clinical resources. PHN protocols and regional APN clinical resource list must be annually reviewed and signed.

- ◆ All APNs will be provided an orientation to public health and primary care services. The content and time frame of orientation will be determined by the Regional Nursing Director, Regional Primary Care Director, and Regional Medical Director.

c. Functions

The APN will demonstrate the Core Competencies at the minimum of the Tier 1 level based on the Quad Council Competencies for Public Health Nurses and will practice according the Standards of Professional Public Health Practice (American Nurses Association (2013) Public Health Nursing: Scope and Standards of Practice):

- ◆ Provide clinical services to those patients requiring treatment beyond the scope of public health nursing practice (i.e., within PHN Protocol)
- ◆ Maintain a complete and accurate record on each patient using appropriate documentation
- ◆ Serve as a resource to collaborate with public health nurses and other professional staff regarding health promotion and maintenance
- ◆ Consult with supervising physician about problems concerning patient management which are outside the APN's scope of practice
- ◆ Refer patients to appropriate resources

d. Evaluation

At the end of the orientation period, a conference will be conducted by the primary care director or designee to discuss performance and to determine if additional orientation is needed.

5. ORIENTATION GUIDELINES FOR PUBLIC HEALTH NURSING SUPERVISORS

a. Role

The public health nursing supervisor is responsible for the administration of and/or delegation of patient care in accordance with the Nurse Practice Act (T.C.A. 63-7-103) and performs supervisory duties as outlined in the Department of Personnel Class Specifications.

b. Policies

- ◆ The Regional Nursing Director is responsible for the orientation of the nursing supervisor and will plan an individualized orientation experience that includes:
 - A generalized orientation to PHN supervision (suggested minimum of 3 weeks at the discretion of the Regional Nursing Director at which time future orientation needs will be determined).

- Orientation with the Regional Nursing Director to observe and integrate leadership skills
 - A peer mentor will be designated for assistance and support
- ◆ The Nursing Supervisor Orientation Checklist will be utilized to coordinate a comprehensive orientation.

c. **Functions**

- ◆ The Nursing Supervisor will demonstrate the Core Competencies at the Tier 2 level based on the Quad Council Competencies for Public Health Nurses and will practice according the Standards of Professional Public Health Practice (American Nurses Association (2013) Public Health Nursing: Scope and Standards of Practice):
- ◆ The Nursing Supervisor is responsible for ensuring that all personnel under her supervision are in compliance with federal/state laws, and departmental rules/regulations, including job specifications. The Nursing Practice Standards and Legal Scope of Practice (as defined in T.C.A. 63-7-103 and the Tennessee Board of Nursing rules/regulations) will be followed as outlined in the Public Health Nursing Practice Section of this manual and the Community Health Services Policies and Procedures Manual. The Nursing Supervisor should create a climate of extraordinary customer service by her support and leadership in this process. The Nursing Supervisor is responsible for preparing improvement plans resulting from nursing deficiencies cited during quality improvement reviews.

d. **Evaluation**

A conference will be conducted by the Regional Nursing Director at the end of the orientation period to discuss performance and to determine if additional orientation is needed.

6. **ORIENTATION GUIDELINES FOR REGIONAL NURSING DIRECTOR**

a. **Role**

The Regional Nursing Director is in a key position in the regional structure of the Tennessee Department of Health. The many and varied roles and responsibilities of the regional director of nursing include:

- ◆ **Professional Nursing Guidance:**
 - Utilizes, updates and disseminates information on approved nursing protocols and standards
 - Interprets rules and regulations, special letters, departmental policies and program directives
 - Serves as consultant for all staff regarding activities in local health department
 - Collaborates with regional and local nursing supervisors, medical consultants, and health officers in planning nursing services
- ◆ **Coordination of Nursing with Other Disciplines:**

Works with county nursing supervisors, County Directors, district administrators, health officers, and program directors to ensure smooth integration of activities

◆ **Quality Improvement Activities:**

Supervises and promotes continuous quality improvement activities
Provides guidance and professional direction to the peer review process

◆ **Staff Development:**

Oversees the development of a complete orientation plan for all nursing staff
Plans and implements schedule of continuing education activities for all nursing staff
Serves as the primary regional liaison with schools of nursing
Monitors technical competencies of nursing staff

b. Policies

- ◆ The State Nursing Director is responsible for the orientation of the Regional Nursing Director and will collaborate with the Regional Director to plan an individualized orientation utilizing the Regional Nursing Director Checklist. The length of orientation will be determined by the State Nursing Director.

c. Functions

The Regional Nursing Director will demonstrate the Core Competencies at the Tier 3 level based on the Quad Council Competencies for Public Health Nurses and will practice according the Standards of Professional Public Health Practice (American Nurses Association (2013) Public Health Nursing: Scope and Standards of Practice).

d. Evaluation

A conference will be conducted by the State Nursing Director at the end of the orientation period to discuss performance and to determine if additional orientation is needed.

SECTION IV

PREVENTIVE CHILD AND ADOLESCENT HEALTH

A. INTRODUCTION

The American Academy of Pediatrics (AAP) has developed a comprehensive set of health supervision guidelines to direct well-child care. The intervals for preventive visits are determined by the Bright Futures guidelines. These intervals and guidelines are summarized in the AAP's current *Recommendations for Preventive Pediatric Health Care* (Periodicity Schedule) and include risk assessment with appropriate follow up as indicated (see Risk Assessment Questionnaire in appendices). The local health departments provide comprehensive and preventive child health exams for individuals under the age of 21.

- ◆ EARLY: early identification of concerns
- ◆ PERIODIC: checking children's health at periodic and age-appropriate intervals
- ◆ SCREENING: performing age-appropriate tests to identify potential concerns
- ◆ DIAGNOSIS: performing appropriate diagnostic tests when a risk is identified
- ◆ TREATMENT: referral for treatment of identified concerns

EPSDT screenings are available for children in DCS custody in all 95 counties. Refer to current *Tennessee Department of Health (TDH) and Department of Children Services (DCS) Information for EPSDT Screenings for Children in DCS Custody*.

The EPSDT/ well child examination performed by RNs is a screening exam. The RNs will utilize physical assessment knowledge and skills along with clinical judgement to refer abnormal findings to the primary care provider (PCP).

B. COMPONENTS

- ◆ Health history
- ◆ Sensory screening - vision and hearing
- ◆ Lab tests (age dependent)
- ◆ Development and/or behavior screening (age dependent)
- ◆ Immunizations
- ◆ Complete physical exam
- ◆ Anticipatory guidance

C. EXAM VISIT

1. **History** - obtain initial history and update at subsequent preventive exam visits

2. Sensory Screening

a. **Vision:**

- ◆ Risk assessment questionnaire should be performed from birth to 3 years of age and continued per periodicity schedule.
- ◆ Examiner should also note ability of the child to fix and follow objects. Refer for any subjective and/or objective concerns.
- ◆ Visual acuity measurement should begin at 3 years of age and continue per periodicity schedule.
- ◆ Allow children with glasses/contacts to test with corrective lenses.
- ◆ If a child's cognitive ability is questionable, let the child see the screening tool at a closer distance and identify the images before the exam.
- ◆ Typical choice of objective screen by age group:
 - 3 - 5 years of age: Picture test, tumbling E
 - 6+ years of age: Snellen letters or numbers
- ◆ Screen each eye separately (monocular vision) and then together (binocular vision).
- ◆ Screening distance should be 10 feet per AAP guidelines but may vary depending on the tool used.
- ◆ Refer any child who cannot be screened after 2 attempts (at the same visit), and any child in whom an abnormality is detected or suspected.
- ◆ Referral Criteria for Objective Screening:

Ages 3-5 years of age: Fewer than 4 of 6 correct on the 20 foot line with either eye

Ages 6 years and older: Fewer than 4 of 6 correct on the 15 foot line with either eye

- ◆ Vision Screener (ex. SureSight, Optec) may be used following manufacturer's instructions and guidelines for referral.

b. **Hearing:**

- ◆ Universal screening should be done at the birthing hospital.
 - If not done at birthing hospital, refer to PCP at no later than 1 month of age.
 - Comprehensive hearing exam should be repeated by 3 months of age by an audiologist for a failed newborn screening exam.
- ◆ Risk assessment questionnaire should be performed from birth to 4 years of age and continued per periodicity schedule.

- ◆ Objective hearing screening begins at 4 years of age, if a child is cooperative, and is continued per periodicity schedule.
 - ◆ Perform objective screening according to manufacturer’s instructions for specific equipment.
 - ◆ Referral Criteria
 - Refer any child for whom there is a subjective hearing concern
 - Refer any child who misses one, or more, of four sounds at either 20 or 25 decibels by audioscope/audiometer
 - RN also has the option of rescreening the child at a separate visit in 2-4 weeks
 - ERO-SCAN results are pass/ fail – refer failed screens
- c. Lab Tests:** – Age Dependent – Refer to AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) and Laboratory Policies and Procedures Manual and Bright Futures
- ◆ Hemoglobin – Refer to PHN Protocol and WIC Guidelines
 - ◆ Blood Lead Screening – Refer to PHN Protocol
 - ◆ Newborn Metabolic Screening – All infants born in Tennessee should have the newborn screening filter paper collected prior to leaving the hospital. Tests may need to be repeated for a number of reasons including being improperly collected, the infant having received a blood transfusion, the specimen being collected when the baby was less than 24 hours of age or when a possible disorder is indicated. Repeat testing may be done by the private physician or the county health department.
 - See TDH Division of Laboratory Services for collection instructions for repeat metabolic screening and hemoglobinopathy confirmation <http://tn.gov/assets/entities/health/attachments/Section4.pdf>
 - A Comprehensive Overview of Newborn Screening Video “Right from the Start” <http://tn.gov/health/article/MCH-nbs-reports>
 - Parent refusal form – PH-3686
 - ◆ TB testing – Refer to PHN protocol and Tuberculosis Elimination Program TB Manual
 - ◆ Cholesterol Screening – Refer to PHN protocol
 - ◆ STD Screening – Refer to PHN protocol
- d. Developmental/ Behavioral Screening** - Age Dependent – Refer to AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) and Bright Futures

Assessment Tool	Age to Administer	Periodicity Requirement Met
PEDS	0 through 4 years	<ul style="list-style-type: none"> Developmental Screening for 9, 18 and 30 months Psychosocial/ Behavioral Assessment required at every visit
M-CHAT- R/F	18 and 24 months *may be used between 16 through 30 months	<ul style="list-style-type: none"> Autism Screening
PSC -17 PH-3732	5 through 10 years *may be used for children 11-18 years when completed by parent/guardian	<ul style="list-style-type: none"> Psychosocial/ Behavioral Assessment required annually.
Y-PSC PH-3733	11 through 18 years *completed by adolescent, confirm literacy	<ul style="list-style-type: none"> Psychosocial/ Behavioral Assessment required annually. Depression Screening required annually beginning at age 11.
Adolescent Developmental/ Behavioral Questionnaire PH-3846	19 through 20 years	<ul style="list-style-type: none"> Psychosocial/ Behavioral Assessment required annually. Depression Screening required annually beginning at age 11.

e. Immunizations – Refer to PHN protocol for specific vaccines. To determine if a patient is in an ACIP recommended group is eligible for free federal vaccine, refer to the current Tennessee Immunization Program Policy on the use of federal vaccine. Federal law requires that health care staff provide a Vaccine Information Statement (VIS) prior to vaccine administration.

- ◆ <http://www.cdc.gov/vaccines/schedules/>
- ◆ <http://www.cdc.gov/vaccines/hcp/vis/current-vis.html>
- ◆ Epidemiology and Prevention of Vaccine-Preventable Diseases (Pink Book)

f. Physical Exam

- ◆ Growth Parameters
 1. Height/ Length
 - Infancy and early childhood (0-2 years)

- Measure lying down supine on a measuring frame
 - Remove the infant/ toddler's shoes
 - Align the head snugly and with assistance to the top of the frame, straighten the body and lower extremities, and bring the foot board to the bottom of the foot
 - Child (2 years of age and older)
 - Use a stadiometer or measuring bar
 - Remove the child's shoes
 - Measure the child standing with heels on the floor and back of feet touching the wall; the knees should be straight, scapula and occiput should be in contact with the wall, and head should be level
2. Weight
- Infancy and early childhood (0-2 years)
 - Weigh nude from birth to 12 months
 - Weigh with a clean diaper only from 12-24 months
 - Protect from harm (i.e. falls)
 - Distract to discourage excess movement
 - Child (2 years and older)
 - Measure child in minimal clothing or a gown
 - Remove the child's shoes
 - Weigh standing without assistance
 - May weigh parent, then parent and child together, if child is apprehensive and uncooperative despite reassurance as a last resort.
(parent + child) – parent's weight = child's weight)
3. Head Circumference
- Measure routinely until 24 months of age
 - Place measuring tape around the head, just above the eyebrows and around the head to the occipital prominence
 - Pull tape snugly to compress hair and soft tissue
4. Body Mass Index (BMI)
- Measure for children 2 years and older
 - Calculation based on weight and height
 - $\text{weight (lbs)} \div \text{height (in)} \div \text{height (in)} \times 703$
5. Interpreting the measurements
- Each curve is a representation of growth velocity for that age and parameter.
 - Children's measures over time should generally follow the percentile curves of the graph.

- Refer for overweight (BMI 85-94%), obesity (BMI ≥ 95) and underweight (BMI $< 5\%$) and consider a referral for any additional measures that are particularly high or low (for example, weight or length above the 95% or below the 5%).
- Head Circumference referral criteria:
 - At or above the 95th percentile or at or below the 5th percentile
 - An increased or decreased growth rate which varies 25 percentiles or more from a previous measure
- Any deviation from the norm may indicate a referral based on nursing clinical judgement.
- ◆ Blood Pressure - Refer to AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule), Bright Futures, and PHN Protocol.
- ◆ Complete unclothed (or suitably draped) physical assessment with referral as indicated.
- ◆ Oral health - Refer to AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule).

g. Anticipatory Guidance - Refer to AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule); Bright Futures.

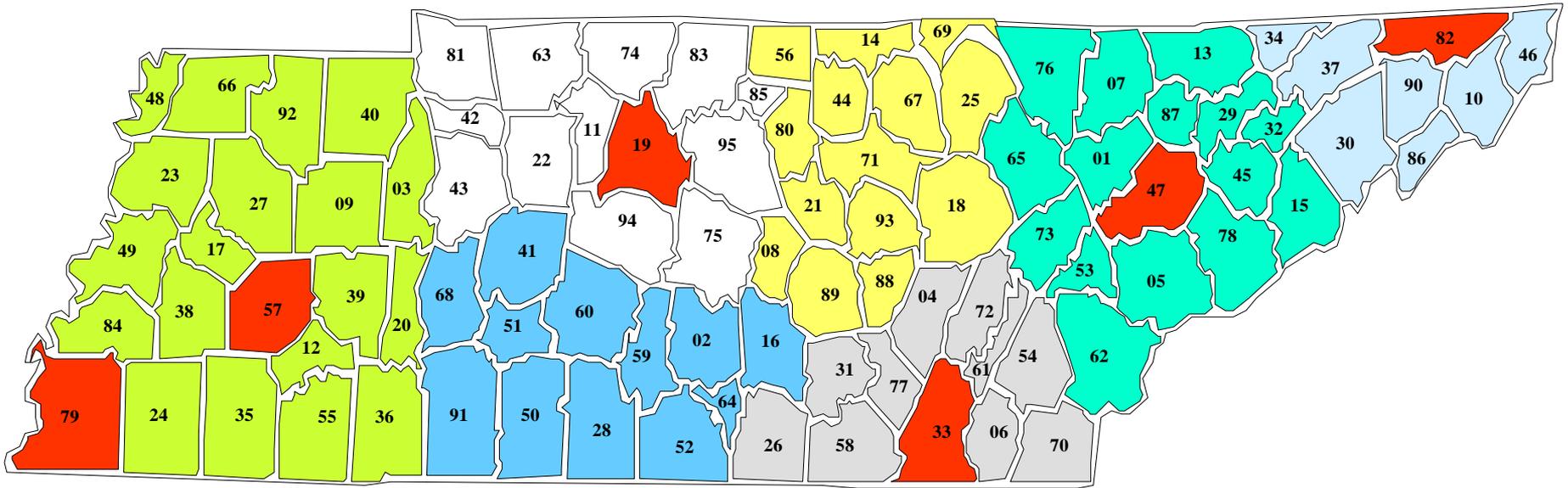
D. PCP LETTER

Following the well child/ EPSDT screening examination, the PCP should be informed of the results (normal or abnormal) via a letter as soon as possible (PH-3789). Abnormal findings needing further evaluation, diagnosis and treatment must be clearly indicated and details provided. Document that a letter was sent to the PCP.

E. CHILD ABUSE/ NEGLECT

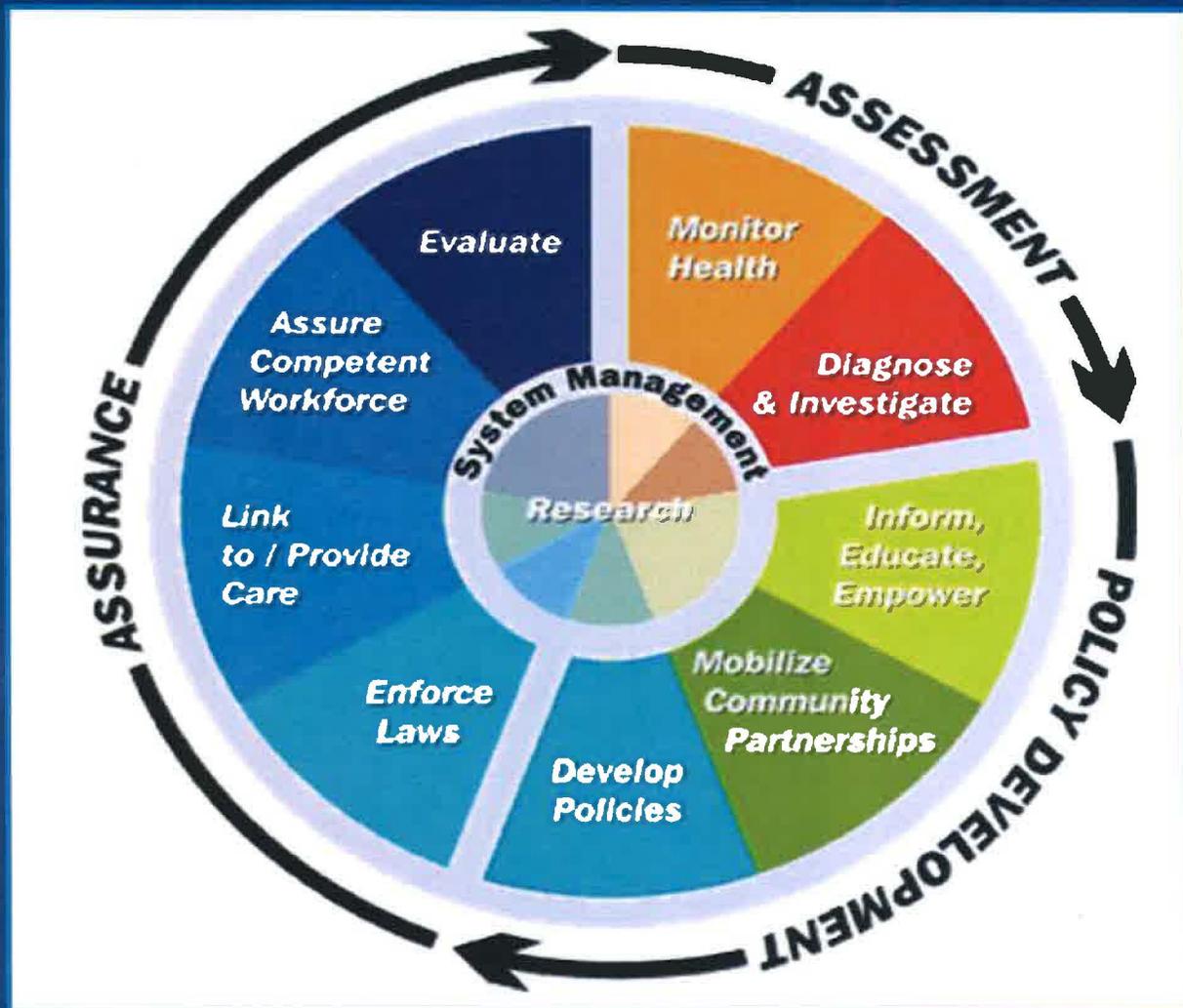
All cases of suspected child abuse/neglect or child sexual abuse shall be reported immediately to proper authorities. See CHS policy 3.6

APPENDIX A
General Information



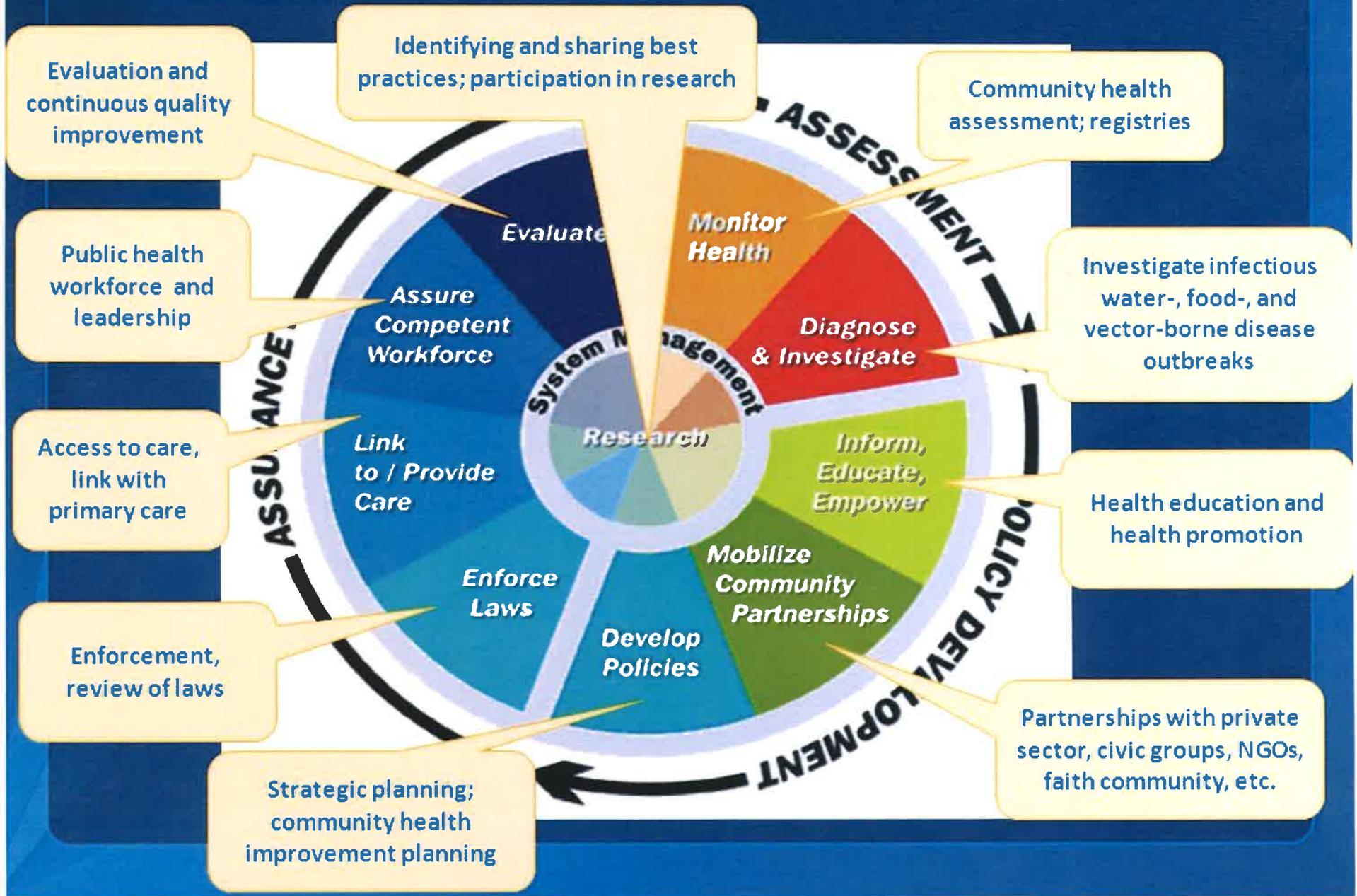
West		Mid Cumberland	South Central	Southeast	#	Upper Cumberland	East	North East					
#	County	#	County	#	County	#	County	#	County				
03	Benton	11	Cheatham	02	Bedford	04	Bledsoe	08	Cannon	01	Anderson	10	Carter
09	Carroll	22	Dickson	16	Coffee	06	Bradley	14	Clay	05	Blount	30	Greene
12	Chester	42	Houston	28	Giles	26	Franklin	18	Cumberland	07	Campbell	34	Hancock
17	Crockett	43	Humphreys	41	Hickman	31	Grundy	21	DeKalb	13	Claiborne	37	Hawkins
20	Decatur	63	Montgomery	50	Lawrence	54	McMinn	25	Fentress	15	Cocke	46	Johnson
23	Dyer	74	Robertson	51	Lewis	58	Marion	44	Jackson	29	Grainger	86	Unicoi
24	Fayette	75	Rutherford	52	Lincoln	61	Meigs	56	Macon	32	Hamblen	90	Washington
27	Gibson	81	Stewart	59	Marshall	70	Polk	67	Overton	45	Jefferson		
35	Hardeman	83	Sumner	60	Mauzy	72	Rhea	69	Pickett	53	Loudon		
36	Hardin	85	Trousdale	64	Moore	77	Sequatchie	71	Putnam	62	Monroe		
38	Haywood	94	Williamson	68	Perry			80	Smith	65	Morgan		
39	Henderson	95	Wilson	91	Wayne			88	Van Buren	73	Roane	19	Davidson
40	Henry							89	Warren	76	Scott	33	Hamilton
48	Lake							93	White	78	Sevier	47	Knox
49	Lauderdale									87	Union	57	Madison
55	McNairy											79	Shelby
66	Obion											82	Sullivan
84	Tipton												
92	Weakley												

Public Health Core Functions and 10 Essential Services

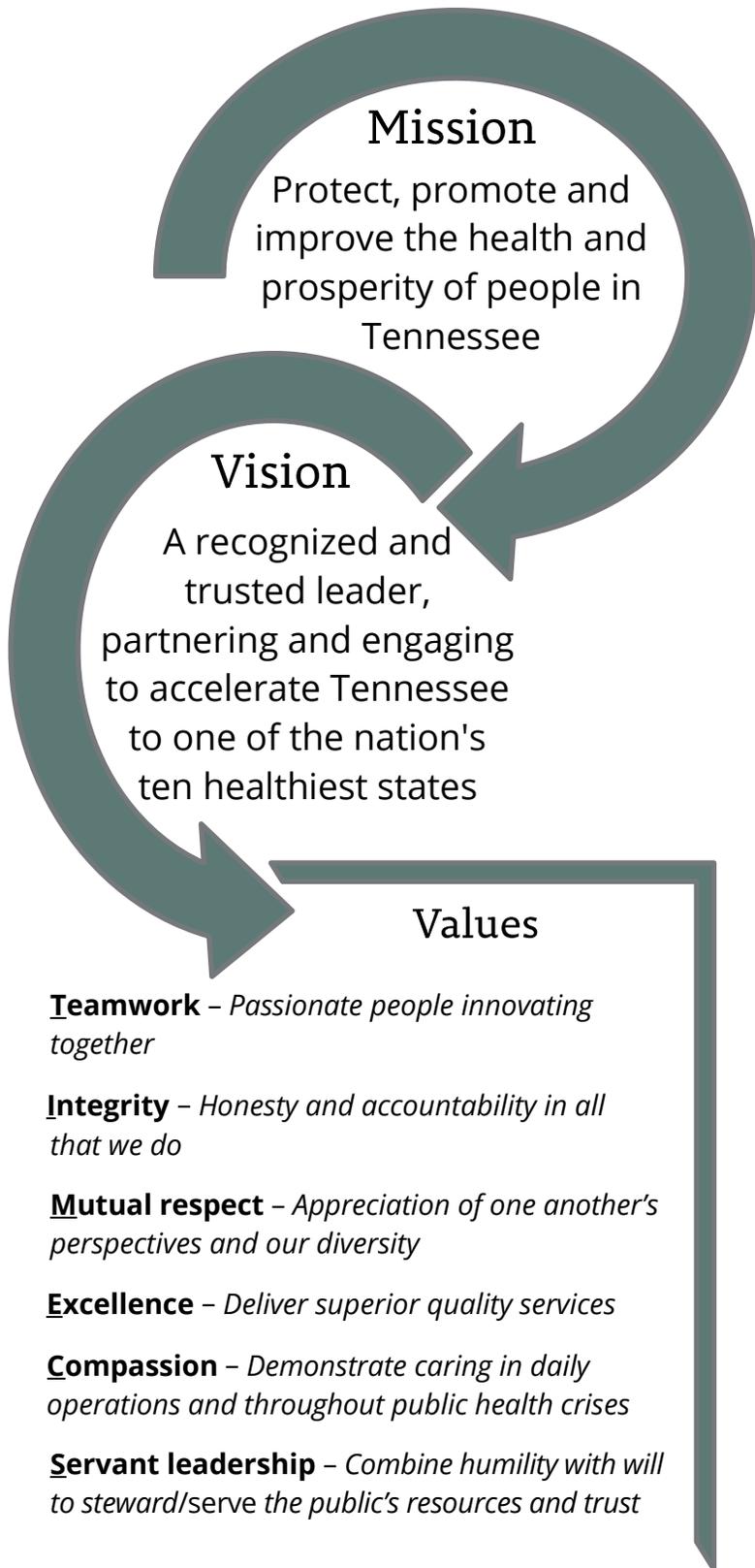


Source of Ten Essential Public Health Services: Core Public Health Functions Steering Committee, 1994

The Essential Public Health Services



Strategic Plan 2015-16



Competency 1: Health protection and promotion
GOAL: Leverage evidence-based strategies to conduct value-added outreach and service in communities
GOAL: Foster relationships and accelerate strategic collaboration with communities and other stakeholders
GOAL: Assess and measure community health improvement as the respected primary voice for the public's health
Competency 2: Protection through policy and regulation
GOAL: Promote responsible public policies that encourage healthy choices in all policies
GOAL: Provide effective regulatory oversight
GOAL: Initiate and foster strategic collaboration with public and private partners
Competency 3: Patient and customer focused service
GOAL: Receive and respond to customer needs and concerns courteously and in a timely manner
GOAL: Promote population health and market public health services
GOAL: Improve processes that foster teamwork to maximize customer satisfaction
Competence 4: Workforce excellence and development
GOAL: Recruit, retain, engage and recognize a competent and high performing workforce
GOAL: Sustain the workforce through mentoring and succession planning.
GOAL: Support continuing education and professional development
Competency 5: Leading with population, community and public health expertise
GOAL: Collect, analyze and share data to support health improvement in Tennessee communities
GOAL: Create or advise evidence-based interventions to support improvement interventions
GOAL: Continue engaging communities in assessment, planning, conducting and evaluating improvement efforts
Competency 6: Demonstrate adaptability in how TDH approaches public health challenges.

Leadership priorities to address Mission, Vision and Goals: Organizational culture change through continuous improvement; completion of transformative information infrastructure technology projects; and sustained focus on "Big Three Plus One" to accelerate progress.

Tennessee Big Three + 1

- Tobacco Use
- Obesity
- Physical Inactivity
- Substance Abuse

PHN PRACTICE COMMITTEE FACT SHEET

GOAL

To enhance the practice of nursing, ensure quality nursing care, promote nursing as a profession, and empower the nurse in decision making, service delivery, and community assessment/management

PURPOSE

To promote quality care by being alert to, addressing, and/or responding to matters relating to public health nursing practice

OBJECTIVES

- To develop an interested and involved COMMITTED GROUP of individual committee members
To evaluate PRACTICE ISSUES as identified in the workplace
- To evaluate POLICIES/procedures within scope of practice for compliance, clarification, application, legality, outcome
To provide LOCAL LEVEL INPUT for nursing practice
- To COMMUNICATE to the office of Nursing the needs and concerns of nurses in the field
To evaluate PROTOCOL, current standards, and orientation on an ongoing basis and update in a timely manner
To evaluate EDUCATIONAL NEEDS/requirements for nursing staff
- To act as a LIAISON between the local, regional and state level of nursing
- To foster an atmosphere of SHARING between regions for the purpose of problem solving, sharing ideas, and brainstorming
- To promote COLLABORATION between other programs/disciplines regarding decisions impacting nursing practice
- To promote awareness of current LEGISLATIVE ISSUES that might impact nursing practice
- To educate program staff on the PHN Practice COMMITTEE's structure and responsibilities
- To encourage the use of the PHN Practice Committee to REVIEW MATERIALS and provide input
To include a PHN practice meeting as part of ORIENTATION schedule for Nursing Directors and CO nursing staff

MEMBERSHIP

One public health nurse representing each of the rural regions and two of the metropolitan regions
One regional nursing director
One Advance Practice Nurse
One representative from the Office of Nursing
Officers include a chairperson and vice-chairperson
The Office of Nursing provides administrative support
Each member serves a term of three years and may serve one consecutive term by reappointment

RESPONSIBILITIES

Attends quarterly meetings in Nashville or Telephonically, or arranges appropriate representation
Participates in conference calls as scheduled
Brings regional public health nursing practice concerns to the committee for discussion
Reports back to the Regional Director of Nursing
Accepts assignments and participates in subcommittee work as requested

FUNCTIONS

Hear, review, and investigate public health nursing practice concerns
Review and make recommendations regarding program standards, guidelines, and policies affecting nursing practice
Recommend staff development activities
Hear program area concerns relating to nursing practice and work together toward problem resolution
Review and update Public Health Nursing Protocol
Study and research methods to improve nursing practice

Staff Training and Resource Team (STaRT)

FACT SHEET

“STaRT where you are - moving forward to excellence in public health nursing”

GOAL

Workforce excellence and development activities that focus on enhancing training, skills, and performance of public health nurses through Standardized Orientation, In-service Education, and Continuing Nursing Education.

PURPOSE

To ensure initial public health nursing orientation and ongoing professional development.

OBJECTIVES

- Ensure standardized orientation for all new public health nursing staff establishing a strong foundation of PHN competencies
- Update orientation guidelines based on evidence based changes in practice and feedback from orientees
- Ensure that in-service training material is relevant and current
- Provide continuing education to public health nurses based on a needs assessment which identifies a gap in knowledge, skills or practice
- Enhance the professional and work related skills and job satisfaction of nursing staff by providing relevant learning experiences that inform, motivate, and build confidence
- Ensure quality, consistency, and uniformity of TDH mandated trainings

MEMBERSHIP

Asst. State Public Health Nursing Dir.

Staff Development representative from each rural region

RESPONSIBILITIES

Attend quarterly scheduled meetings
Participate in conference calls as needed and/or scheduled
Accept assignments and provide training as requested
Bring regional nursing concerns/issues to STaRT for discussion
Communicate STaRT activities with Regional Nursing Director
Identify training opportunities
Serve as a staff development resource

FUNCTIONS

Review and update the PHN Orientation and Practice Manual as needed
Facilitate continuing education and training for nursing staff
Collaborate with program directors to facilitate mandatory annual inservice trainings for nursing staff
Act as a mentor, coach, or peer advisor to new and existing nursing staff in order to create and maintain a personal commitment to lifelong learning and professional development

ACRONYMS as they appear in Manual Section I through IV

ACRONYMS	DEFINITIONS
ACRONYMS	DEFINATION
AAP	American Academy of Pediatrics
ACIP	Advisory Committee on Immunization Practices
AMA	American Medical Association
ANA	American Nurses Association
APN	Advanced Practice Nurse
BMI	Body Mass Index
CDC	Centers of Disease
CHS	Community Health Services
CID	Correction in Documentation
CPR	Cardio Pulmonary Resuscitation
CPT	Current Procedural Terminology (Medical Services Codes Manual)
DCS	Department of Children Services
EPSDT	EARLY, PERIODIC, SCREENING, DIAGNOSIS, TREATMENT
ERO-SCAN®	Product name of device used to screen for hearing loss
GYN	Gynecological
HIPAA	Health Insurance Portability & Accountability Act
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HPV	Human Papilloma Virus
ICD-10	International Classification of Diseases, 10th Edition
IPP	Individual Performance Plan
LPN	Licensed Practical Nurse
M-CHAT-R/F	Modified Checklist for Autism in Toddlers, Revised with Follow-Up
MD	Medical Doctor
NA	Nursing Assistant
NDC	National Drug Code
NLT	Nursing Leadership Team
OQI	Office of Quality Improvement
PCP	Primary Care Provider
PEDS	Parents Evaluation of Developmental Status
PH	Public Health
PH-####	Public Health-form PH-3686 (Parent Refusal Form)
PHN	Public Health Nurse and/or Public Health Nursing
PPE	Personal Protective Equipment
PPI	Primary Prevention Initiatives
PSC-17	Pediatric Symptom Checklist (youth's point of view)
PTBMIS	Patient Tracking Billing Management Information System
QI	Quality Improvement
RBRVS	Resource-Based Relative Value System
RN	Registered Nurse
RN-ES	Registered Nurse-Expanded Skills
RVU	Relative Value Units
SOAP	Subjective, Objective, Assessment, Plan
STaRT	Staff Training and Resource Team
STD / STI	Sexual Transmitted Disease / Sexual Transmitted Infection

ACRONYMS as they appear in Manual Section I through IV

T.C.A.	Tennessee Codes Annotated
TB	Tuberculosis Mycobacterium
TDH	Tennessee Dept. of Health
VIS	Vaccine Information Statement
WIC	Women, Infant and Children
Y-PSC	Pediatric Symptom Checklist (caregiver's point of view)

APPENDIX B
PHN Competencies

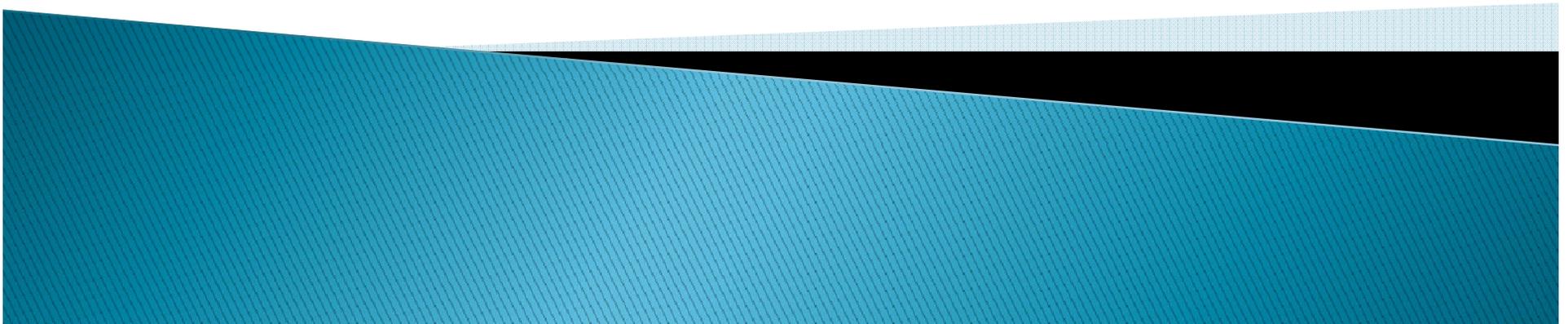
Quad Council Competencies for Public Health Nurses

Summer 2011

The Quad Council of Public Health Nursing Organizations is comprised of:

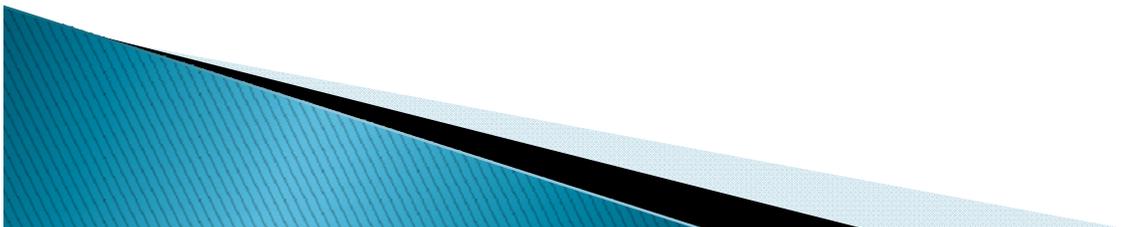
- The Association of Community Health Nurse Educators (ACHNE)
- The Association of State and Territorial Directors of Nursing (ASTDN)
- The American Public Health Association - Public Health Nursing Section (APHA)
- The American Nurses Association's Congress on Nursing Practice and Economics (ANA)

The Quad Council of Public Health Nursing Organizations was founded in the early 1980's to address priorities for public health nursing education, practice, leadership, and research, and as the voice for public health nursing.



Quad Council Competency Workgroup, 2009–2012

- ▶ Michelle Cravetz, MS, RN–BC
- ▶ Joyce Krothe, PhD, RN
- ▶ David Reyes, MN, MPH, RN
- ▶ Susan M. Swider, PhD, APHN–BC



Introduction

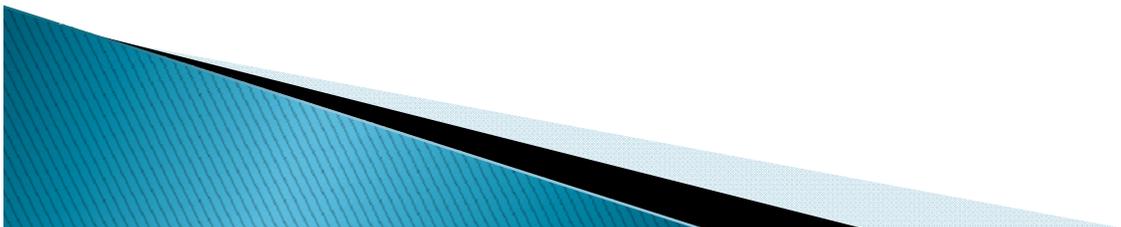
The Quad Council of Public Health Nursing Organizations is comprised of the Association of Community Health Nurse Educators (ACHNE), the Association of State and Territorial Directors of Nursing (ASTDN), the American Public Health Association Public Health Nursing Section (APHA) and the American Nurses Association's Congress on Nursing Practice and Economics (ANA). The Quad Council of Public Health Nursing Organizations was founded in the early 1980's to address priorities for public health nursing education, practice, leadership, and research, and as the voice for public health nursing.

Methods

In 2010, Quad Council undertook revision of the "Core Competencies for Public Health Nursing" (YR), in part because the Council on Linkages between Academia and Public Health Practice (CoL) revised its "Core Competencies for Public Health Professionals."

We have kept this Core Competencies for Public Health Nursing (CCPHN) document consistent with the "Definition of Public Health Nursing" adopted by the APHA's Public Health Nursing Section in 1996 and the Scope and Standards of Public Health Nursing (Quad Council, 1999). Therefore this CCPHN may be used at all levels and in a variety of practice settings. We planned competencies that could be useful for agencies/organizations employing PHNs, and educational institutions and other agencies engaged in educating PHNs. For example, this CCPHN could be used for initial PHN educational experience, orientation to a new agency, or meeting PHN continuing education needs.

In undertaking the revision process, Quad Council adopted the Council on Linkages (CoL) structure for competencies: eight recognized domains spanned by three tiers of practice. As we developed the CCPHN, we assumed that PHNs practice at the intersection of population-focused nursing care and public health practice. Proceeding from this assumption, we used the CoL document to determine how PHNs should demonstrate core competencies for public health professionals at all three levels: the basic or generalist level (Tier 1); the specialist or mid-level (Tier 2); and at the executive and/or multi-systems level (Tier 3).



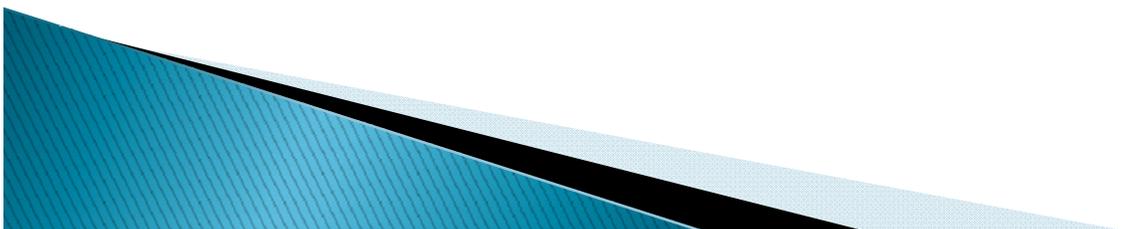
Further, we maintained each of the eight domains in the CoL document. Of course, some redundancy is inevitable, given the encompassing nature of public health and PHN practice. Competencies in some domains, such as Community Dimensions of Practice, reappear in virtually all domains.

Throughout the composition of this CCPHN, we solicited public feedback and carefully considered it. Feedback came from a broad array of PHNs in practice and academia, primarily members of the Quad Council member organizations. What resulted was a useful, organized list of knowledge, attitudes, behaviors, and skills that provide the floor for PHN practice at the three levels of service. The Quad Council gratefully acknowledges all those PHNs who invested their time in reviewing our drafts and commenting thoughtfully.

Levels of Practice

PHNs practice in diverse settings and environments. Thus these competencies represent the continuum of evolving PHN practice roles, responsibilities, and functions for which PHNs may have to account.

The baccalaureate degree in nursing (BSN) is the established educational preparation for entry level PHN practice (ACHNE, 2009; ANA, 2007; Quad Council, 2004). The BSN provides an essential framework of liberal arts and sciences education that serves as a foundation for PHN practice. From this framework, PHNs understand how social and ecological determinants affect the health of individuals, communities, and populations. BSN education prepares PHNs both didactically and clinically. As in the previous iteration of these competencies, the Quad Council reaffirmed that a PHN generalist has entry-level preparation at the baccalaureate level, reflected by Tier 1 competencies. True, in many areas of the US, nurses work in public health without the BSN. However, the Quad Council believes that those nurses may require a job description that reflects a differentiated level of practice and/or may require extensive orientation and education to successfully achieve generalist competencies in Tier 1.



Tier 1 Core Competencies apply to generalist public health nurses who carry out day-to-day functions in state and local public health organizations, including clinical, home visiting and population-based services, and who are not in management positions. Responsibilities of the PHN may include working directly with at-risk populations, carrying out health promotion programs at all levels of prevention, basic data collection and analysis, field work, program planning, outreach activities, programmatic support, and other organizational tasks. Although the CoL competencies and the Quad Council competencies are primarily focused at the population level, public health nurses must often apply these skills and competencies in the care of individuals, families, or groups. Therefore, Tier 1 competencies reflect this practice.

Tier 2 Core Competencies apply to PHNs with an array of program implementation, management and/or supervisory responsibilities, including responsibility for clinical services, home visiting, community-based and population-focused programs. For example, responsibilities may include: implementation and oversight of personal, clinical, family focused, and population-based health services; program and budget development; establishing and managing community relations; establishing timelines and work plans, and presenting recommendations on policy issues.

Tier 3 Core Competencies apply to PHNs at an executive/senior management level and leadership levels in public health organizations. In general, these competencies apply to PHNs who are responsible for oversight and administration of programs or operation of an organization, including setting the vision and strategy for an organization and its key structural units, e.g., a public health nursing division. Tier 3 professionals generally are placed at a higher level of positional authority within the agency/organization, and they bring similar or higher level knowledge, advanced education, and experience than their Tier 2 counterparts.

The following assumptions guided the Quad Council's work:

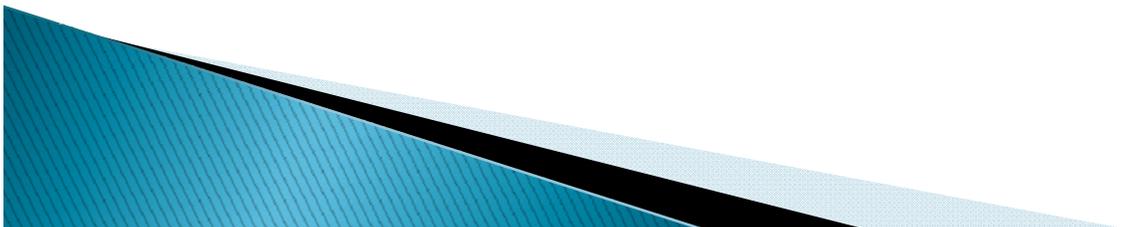
- ❖ While the CoL Competencies document was the basis for reformatting the competencies for Public Health Nursing, this document is designed to reflect the unique practice of PHNs, at the intersection of both public health and nursing practice.
- ❖ The Quad Council adopted the CoL definition of core competency: "The individual skills desirable for the delivery of Essential Public Health Services. "
- ❖ Public Health Nursing is defined as the practice of promoting and protecting the health of populations, using knowledge from nursing, social, and public health sciences. PHNs engage in population-focused practice, but can and do often apply the CoL concepts at the individual and family level.
- ❖ PHNs must first possess basic generalist nursing competencies common to all baccalaureate graduates. PHNs also accomplish all CoL competencies, but from the unique perspective of public health nursing.



- ❖ Competencies are written to be demonstrable and measurable. Tier 1 reflects PHN practice primarily directed at individuals, families, and groups in the community/public health setting; Tier 2 reflects PHN practice primarily with communities or populations; Tier 3 reflects organizational and systems level PHN leadership.
- ❖ The tiers are defined on a continuum, so PHN practice in each tier assumes mastery of the competencies of the previous tier.
- ❖ This CCPHN supports the scope and standards of practice for public health nursing. We used the **Public Health Nursing: Scope and Standards of Practice (ANA, 2007)** document as a reference to ensure continuity and consistency with those standards.
- ❖ Competencies are **not** intended to limit PHN practice. They reflect **minimum** competencies at each of the three tiers of practice within each domain.
- ❖ Conversely, the basic competencies do not necessarily reflect the practice of exceptional nurses in each tier. Job descriptions for PHNs may reflect components from each level, depending on agency size, needs, structure, leadership, and services.
- ❖ As noted in the CoL document, for workers within each competency, intended levels of mastery (and therefore learning objectives) will differ depending upon the workers' backgrounds, job duties, and years of experience.

Application to Practice

These competencies have relevance to all PHNs and the agencies that employ them. PHNs will benefit from using these competencies as a foundation for accountable PHN practice. Agencies will benefit from these competencies in designing job descriptions, orientation plans, and professional staff development options. Educators will find the competencies useful for designing curricula that reflect current practice needs, ensuring that their graduates have the knowledge and skills to perform the core functions and essential services of public health, and enabling those graduates to thrive in the public health workforce. Most importantly, the CCPHN provides the basis for public health nursing's efforts to meet the needs of the populations we serve, and to protect and promote the health of communities locally and globally.



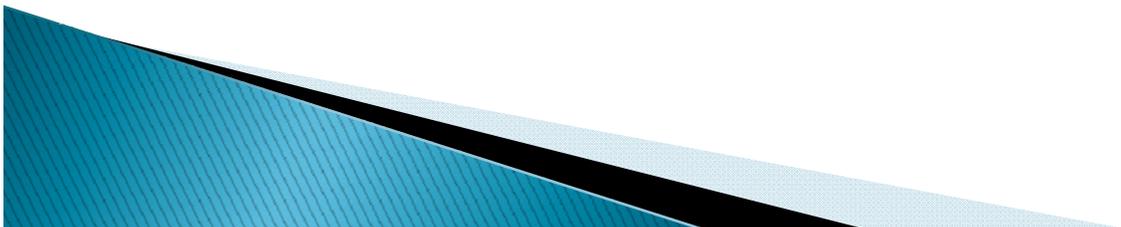
Quad Council of Public Health Nursing Organizations Core Competencies for Public Health Nurses

Based on the Council on Linkages – Core Competencies* for Public Health Professionals

***Core Competency:** The individual skills desirable for the delivery of Essential Public Health Services. Intended levels of mastery (and therefore learning objectives) for workers within each competency will differ depending upon workers' backgrounds, job duties, and years of experience.

Assumptions - The following assumptions supported the Quad Council work:

- ▶ Public Health Nursing is defined as the practice of promoting and protecting the health of populations, using knowledge from nursing, social and public health sciences. PHNs engage in population-focused practice, but can and do often apply the Council on Linkages concepts at the individual and family level.
- ▶ While the Council on Linkages Competencies document was the basis for reformatting the competencies for Public Health Nursing, this document is designed to reflect the unique practice of PHNs, the intersection of both public health and nursing.
- ▶ Competencies are written to be demonstrable and measurable. Tier 1 reflects PHN practice primarily directed at individuals, families, and groups in the community; Tier 2 reflects PHN practice primarily directed at communities or populations; Tier 3 reflects systems-level leadership demonstrated by PHNs.
- ▶ PHNs must first possess basic generalist nursing competencies. PHNs also accomplish Council on Linkages competencies, but from the unique perspective of public health nursing.
- ▶ The tiers are defined on a continuum, so PHN practice in each tier assumes the competencies of the previous tier.
- ▶ The Public Health Nursing Core Competencies support the scope and standard of practice for public health nursing. The **Public Health Nursing: Scope and Standards of Practice** document was used as a reference to ensure continuity and consistency with those standards.
- ▶ Competencies are not intended to limit PHN practice. They reflect **basic** competencies at each of the three tiers of practice within each domain. Competencies reflect the standards for PHN practice at each level, not necessarily the practice of exceptional nurses in each tier. Job descriptions for PHNs may reflect components from each level, depending on agency size, structure, leadership, and services.



Tier 1 Quad Council Public Health Nursing Competencies	Tier 2 Quad Council Public Health Nursing Competencies	Tier 3 Quad Council Public Health Nursing Competencies
<p>Tier 1 Core Competencies apply to generalist public health nurses who carry out day-to-day functions in state and local public health organizations, including clinical, home visiting and population-based services, and who are not in management positions. Responsibilities of the PHN may include working directly with at-risk populations, carrying out health promotion programs at all levels of prevention, basic data collection and analysis, field work, program planning, outreach activities, programmatic support, and other organizational tasks. Although the CoL competencies and the Quad Council competencies are primarily focused at the population level, public health nurses must often apply these skills and competencies in the care of individuals, families, or groups. Therefore, Tier 1 competencies reflect this practice.</p>	<p>Tier 2 Core Competencies apply to PHNs with an array of program implementation, management and/or supervisory responsibilities, including responsibility for clinical services, home visiting, community-based and population-focused programs. For example, responsibilities may include: implementation and oversight of personal, clinical, family focused, and population-based health services; program and budget development; establishing and managing community relations; establishing timelines and work plans, and presenting recommendations on policy issues.</p>	<p>Tier 3 Core Competencies apply to PHNs at an executive/senior, management level and leadership levels in public health organizations. In general, these competencies apply to PHNs who are responsible for oversight and administration of programs or operation of an organization, including setting the vision and strategy for an organization and its key structural units, e.g., a public health nursing division. Tier 3 professionals generally are placed at a higher level of positional authority within the agency/organization, and they bring similar or higher level knowledge, advanced education and experience than their Tier 2 counterparts.</p>

Click on the Domain Number below you wish to view.

[Domain 1: Analytic and Assessment skills](#)

[Domain 2: Policy Development/Program Planning Skills](#)

[Domain 3: Communications Skills](#)

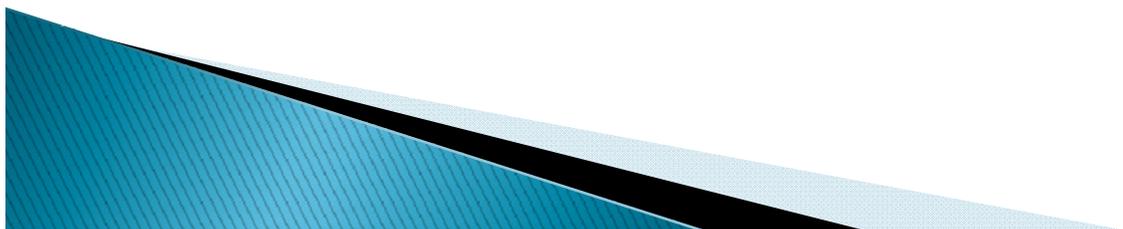
[Domain 4: Cultural Competencies Skills](#)

[Domain 5: Community Dimensions of Practice](#)

[Domain 6: Public Health Science Skills](#)

[Domain 7: Financial Planning and Management Skills](#)

[Domain 8: Leadership and Systems Thinking Skills](#)



Domain 1: Analytic and Assessment Skills

1. Identifies the determinants of health and illness of individuals and families, using multiple sources of data.	1. Assesses the health status of populations and their related determinants of health and illness. Partners with populations, health professionals, and other stakeholders to attach meaning to collected data.	1. Conducts comprehensive, in-depth system/organizational assessment as it relates to population health.
2. Uses epidemiologic data and the ecological perspective to identify health risks for a population. Identifies individual and family assets and needs, values and beliefs, resources and relevant environmental factors.	2. Develops Public Health Nursing diagnoses for individuals, families, communities and populations. Uses a synthesis of nursing, public health, and system science/theory when characterizing population-level health risks. Assures that assessments identify population assets and needs, values and beliefs, resources and relevant environmental factors. Derives population diagnoses and priorities based on assessment data, including input from populations.	2. Uses organizational and other theories to guide development of system wide approaches to reduce population-level health risks. Designs systems that identify population assets and needs, values and beliefs, resources and relevant environmental factors.
3. Identifies variables that measure health and public health conditions.	3. Utilizes a wide variety of relevant variables to measure health conditions for a community or population.	3. Utilizes a comprehensive set of relevant variables within and across systems to measure health conditions.
4. Uses valid and reliable methods and instruments for collecting qualitative and quantitative data from multiple sources. Develops a data collection plan using appropriate technology to collect data to inform the care of individuals, families, and groups.	4. Develops a data collection plan using models and principles of epidemiology, demography, and biostatistics, as well as social, behavioral, and natural sciences to collect quantitative and qualitative data on a community or population. Uses methods and instruments for collecting valid and reliable quantitative and qualitative data.	4. Develops systems that support the collection of valid and reliable quantitative and qualitative data on individuals, families, and populations.
5. Identifies sources of public health data and information. Collects, interprets and documents data in terms that are understandable to all who were involved in the process, including communities.	5. Uses multiple methods and sources when collecting and analyzing data for a comprehensive community/population assessment. Assures that assessments are documented and interpreted in terms that are understandable to all who were involved in process, including communities.	5. Designs systems that assure that assessments are documented and interpreted in terms that are understandable to all who are involved in the process, including individuals, communities, and populations. Designs data collection system that uses multiple methods and sources when collecting and analyzing data to ensure a comprehensive assessment process.
6. Uses valid and reliable data sources to make comparisons for assessment.	6. Critiques the validity, reliability, and comparability of data collected for communities/populations.	6. Designs systems to assure the validity, reliability, and comparability of data. Revises systems to assure optimal validity, reliability, and comparability of data.

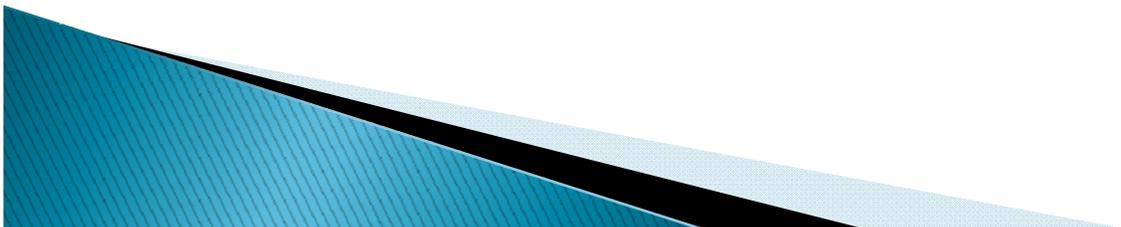
Domain 1: (Continued)

7. Identifies gaps and redundancies in data sources in a community assessment through work with individuals, families, and communities.	7. Identifies gaps and redundancies in data sources used in a comprehensive community/population assessment. Examines the effect of gaps in data on PH practice/program planning.	7. Identifies gaps and redundancies in sources of data used in a comprehensive organizational assessment. Strategizes with relevant others to address data gaps.
8. Applies ethical, legal, and policy guidelines and principles in the collection, maintenance, use, and dissemination of data and information.	8. Assures the application of ethical, legal, and policy principles in the collection, maintenance, use, and dissemination of data and information.	8. Ensures information disseminated is understandable to the community and stakeholders. Establishes systems that incorporate ethical, legal, and policy principles into the collection, maintenance, use, and dissemination of data and information.
9. Describes the public health nursing applications of quantitative and qualitative data.	9. Synthesizes qualitative and quantitative data during data analysis for a comprehensive community/population assessment. Uses various data collection methods and qualitative and quantitative data sources to conduct a comprehensive, community/population assessment.	9. Synthesizes qualitative and quantitative data during data analysis for a comprehensive organizational assessment. Uses multiple methods and qualitative and quantitative data sources for a comprehensive system/organizational assessment.
10. Collects quantitative and qualitative data that can be used in the community health assessment process. Assesses data collected as part of the community assessment process to make inferences about individuals, families, and groups.	10. Incorporates an ecological perspective when analyzing data from a comprehensive community/population assessment. Partners with groups, communities, populations, health professionals, and stakeholders to review and evaluate data collected.	10. Incorporates ecological perspective when analyzing data from a comprehensive, system/organizational assessment as it relates to population health.
11. Utilizes information technology to collect, analyze, store, and retrieve data related to public health nursing care of individuals, families, and groups.	11. Utilizes information technology effectively to collect, analyze, store, and retrieve data related to care of communities and populations.	11. Collaborates with others in the design of data collection processes and applications that facilitate the collection, use, storage, and retrieval of data.
12. Practices evidence-based Public Health Nursing to promote the health of individuals, families and groups.	12. Practices evidence-based Public Health Nursing to promote the health of communities and populations.	12. Practices evidence-based Public Health Nursing to create and/or modify systems of care. Utilizes data to address scientific, political, ethical, and social public health issues.
13. Uses available data and resources related to the social determinants of health when planning care for individuals, families, and groups.	13. Collects data related to social determinants of health and community resources to plan for community-oriented and population-level programs. Analyzes those data. Incorporates the results of those analyses into program planning.	13. Evaluates organization/system capacity to analyze the health status of the community/population effectively. Allocates organization/system resources to support the effective analysis of the health status of the community/population.



Domain 2: Policy Development/Program Planning Skills

1. Identifies policy issues relevant to the health of individuals, families, and groups. Describes the structure of the public health system and its impacts on individuals, families, and groups within a population.	1. Identifies valid and reliable data relevant to health policies targeted to communities and populations. Conducts and uses policy analysis to address specific public health issues.	1. Establishes methods to collect and analyze public health and public policy information.
2. Identifies the implications of policy options on public health programs and the potential impacts on individuals, families, and groups within a population.	2. Plans population-level interventions guided by relevant models and research findings.	2. Synthesizes complex policy options to plan public health services at the systems level.
3. Identifies outcomes of health policy relevant to PHN practice.	3. Conducts and uses policy analysis to address public health issues. Incorporates a wide range of policy options into the planning and delivery of health services and interventions to groups, communities, and populations.	3. Conducts and uses policy analysis to address specific public health and systems issues.
4. Collects information that will inform policy decisions. Describes the legislative policy development process. Identifies outcomes of current health policy relevant to PHN practice.	4. Plans population-level interventions guided by relevant theories, concepts, models, policies, and evidence. Uses planning models, epidemiology, and other analytical methods in evaluating population-level interventions. Critiques the evidence for population-level interventions. Conducts and uses policy analysis to address specific public health issues.	4. Conducts policy analysis to address specific public health and systems issues.
		5. Uses existing models and evidence to develop policies for public health systems within the framework of the organization's governing body.
	6. Selects an appropriate method of decision analysis for an issue relevant to an identified group, community, or population. Uses planning models, epidemiology, and other analytical methods in the development and implementation of population level interventions.	6. Develops a system of decision analysis using the strengths and appropriateness of various models and methods. Critiques health and public policy in order to address current and emerging public health problems and issues.

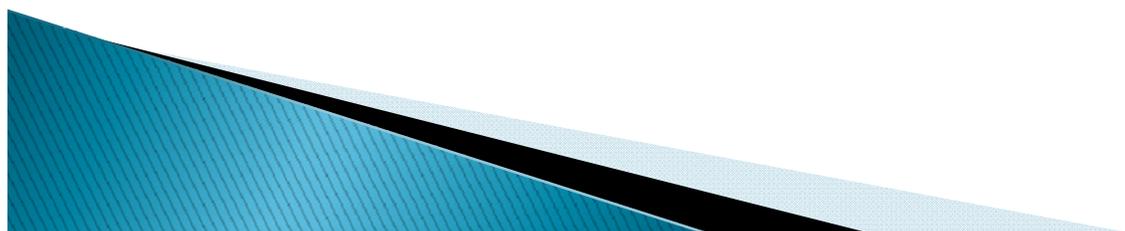


Domain 2: Policy Development/Program Planning Skills (Continued)

<p>7. Describes the structure of the public health system. Identifies public health laws and regulations relevant to PHN practice. Provides public health nursing services in a manner consistent with laws and regulations.</p>	<p>7. Manages the delivery of community/population-based health services. Evaluates and ensures compliance with public health laws and regulations.</p>	<p>7. Establishes public health programs and services that are consistent with laws and regulations.</p>
<p>8. Participates as a team member in developing organizational plans to implement programs and policies.</p>	<p>8. Develops plans to implement programs and organizational policies. Works as part of an interdisciplinary team to implement relevant policies into community/population level interventions.</p>	<p>8. Implements a system for monitoring the effectiveness and efficiency of policies and programs. Leads team to implement health policy in population health interventions and health systems operations.</p>
<p>9. Participates in teams to assure compliance with organizational policies.</p>	<p>9. Manages the implementation of organizational policies and programs for areas of responsibility.</p>	<p>9. Oversees the implementation of organizational policy throughout the organization.</p>
<p>10. Assists in the design of an evaluation plan for an individual-, family-, or community-focused program. Participates as a team member to evaluate programs to individuals, families, and groups for their effectiveness and quality.</p>	<p>10. Designs an evaluation plan that addresses multiple variables, includes both process and outcome measures, and uses multiple data collection methods. Conducts evaluation of care delivery to communities and populations served by the organization. Provides feedback on the organization's quality improvement program. Establishes methods to utilize technology to collect data to monitor and evaluate the quality and effectiveness of programs for communities and populations.</p>	<p>10. Oversees an evaluation of the program's overall effectiveness, quality, and sustainability. Designs systems-level quality initiatives and evaluation plans that foster program sustainability. Incorporates quality and cost measures into agency program evaluation. Serves as a resource on quality improvement and program evaluation. Promotes the development of systems to use technology in the evaluation of program quality and effectiveness.</p>
<p>11. Understands methods and practices used to identify and access public health information for individuals, families, and groups.</p>	<p>11. Identifies a variety of sources and methods to access public health information for a community or population. Utilizes technology to collect data to monitor and evaluate the quality and effectiveness of programs for populations.</p>	<p>11. Serves as a resource for others in the identification and use of public health informatics for communities and populations. Utilizes technology to collect data to monitor and evaluate the quality and effectiveness of programs and systems.</p>
<p>12. Understands that quality improvement is important to the practice of public health nursing. Participates in quality improvement teams. Describes various approaches used to improve public health processes and systems. Utilizes quality indicators and core measures to identify and address opportunities for improvement in the care of individuals, families, and groups.</p>	<p>12. Develops quality improvement indicators and core measures as part of the process to improve public health programs and services. Utilizes quality improvement indicators and core measures as part of the process to improve public health programs and services.</p>	<p>12. Implements organizational and system-wide strategies for continuous quality improvement and performance management.</p>

Domain 3: Communications Skills

1. Assesses the health literacy of the individuals, families, and groups served.	1. Assesses the health literacy of communities/populations served.	1. Ensures health literacy principles are integrated into all agency communication.
2. Communicates effectively in writing, orally, and electronically. Communicates in a culturally responsive and relevant manner. Communications are characterized by critical thinking.	2. Communicates effectively in writing, orally, and electronically. Communications are characterized by critical thinking and complex decision making.	2. Communicates effectively in writing, orally, and electronically. Communications are characterized by critical thinking and decision making at the systems level.
3. Solicits input from individuals, families and groups when planning and delivering health care.	3. Solicits input from community/population members and stakeholders when planning health care programs.	3. Solicits input from organizational partners and stakeholders when planning health care programs.
4. Utilizes a variety of methods to disseminate public health information to individuals, families, and groups within a population.	4. Utilizes a variety of methods to disseminate public health information tailored to communities/ populations	4. Utilizes systems level methods to widely disseminate public health information tailored to varying audiences.
5. Demonstrates presentation of targeted health information to multiple audiences at a local level, including to groups, peer professionals, and agency peers.	5. Demonstrates presentation of targeted health information and outcomes of Evidence Based Practice (EBP) to multiple audiences, including to community and professional groups.	5. Demonstrates presentation of targeted health information to multiple audiences, as well as to a variety of organizations. Mentors others in presentation/dissemination skills.
6. Communicates effectively with individuals, families, and groups and as a member of inter-professional team(s).	6. Communicates effectively with community groups, partners, and inter-professional teams.	6. Communicates effectively with systems leaders and key stakeholders. Communicates effectively as member or leader of inter-professional team, both internally and externally.
7. Articulates the role of public health nursing to internal and external audiences.	7. Articulates the role of public health within the overall health system to internal and external audiences.	7. Ensures system/organizational capacity to articulate the role of public health.



Domain 4: Cultural Competency Skills

1. Utilizes the social and ecological determinants of health to work effectively with diverse individuals, families, and groups.	1. Utilizes social and ecological determinants of health to develop culturally responsive interventions with communities and populations.	1. Ensures recognition and respect for diversity is integrated into the organizational culture. Recognizes the dynamic nature of a diverse workforce and the necessity for on-going responsiveness to the changing needs of diverse populations.
2. Uses concepts, knowledge, and evidence of the social determinants of health in the delivery of services to individuals, families, and groups. Utilizes information technology to understand the impact of the social determinants of health on individuals, families, and groups.	2. Uses epidemiological data, concepts, and other evidence to analyze the social determinants of health when developing and tailoring population-level health services. Applies multiple methods and sources of information technology to better understand the impact of the social determinants of health on communities and populations.	2. Develops systems level health programs using knowledge of social determinants of health. Facilitates the use of Community Based Participatory Research (CBPR) and other methods to evaluate effectiveness of strategies in reducing the impact of social determinants of health. Assures system access to technology that provides information on the cultural, social, and behavioral factors in determining the delivery of public health services.
3. Adapts public health nursing care to individuals, families, and groups based on cultural needs and differences.	3. Plans health services to meet the cultural needs of diverse communities and populations.	3. Plans for health services delivery at the systems level to address the needs of culturally diverse populations.
4. Explains factors contributing to cultural diversity.	4. Explains the interplay of multiple forces contributing to cultural diversity.	4. Explains the complexity and dynamic nature of the forces contributing to cultural diversity.
5. Articulates the benefits of a diverse public health workforce.	5. Serves as an advocate to build a diverse public health workforce.	5. Contributes to plans and actions that foster a diverse public health workforce.
6. Demonstrates culturally appropriate public health nursing practice with individuals, families, groups, and community members. Contributes to promoting culturally responsive work environment.	6. Uses evidence and awareness of cultural models to tailor interventions to diverse populations. Evaluates current population health programs for evidence of cultural tailoring. Evaluates staff development needs related to cultural competency.	6. Assures organizational/system adherence to standards, policies, and practices for cultural competency. Evaluates agency practices and policies for cultural competence.
	7. Uses evidence and cultural models to tailor program level interventions.	7. Uses evidence-based models to enhance the organization's cultural competence.

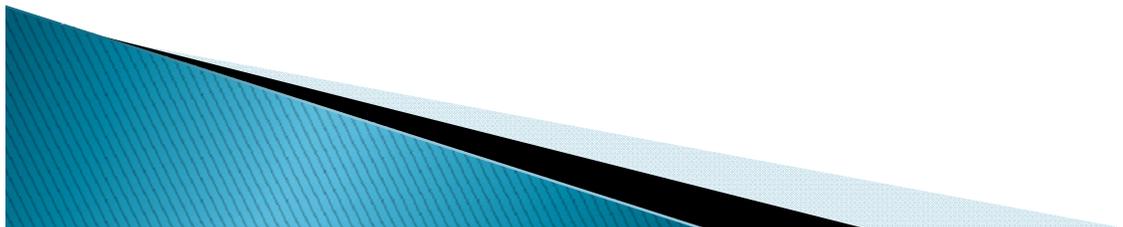
Domain 5: Community Dimensions of Practice Skills

1. Utilizes an ecological perspective in health assessment, planning, and interventions with individuals, families, and groups.	1. Utilizes an ecological perspective in health assessment, planning, and interventions with communities and populations.	1. Utilizes an ecological perspective to evaluate community linkages and relationships across agencies and systems.
2. Identifies research issues at a community level. Functions effectively as a member of a Community Based Participatory Research (CBPR) team.	2. Provides population health expertise for BPR teams.	2. Integrates CBPR approaches to support evidence-based practice within organizations and systems.
3. Identifies community partners for PHN practice with individuals, families and groups.	3. Identifies need for community involvement and partners to create community groups/coalitions.	3. Establishes organizational relationships, processes, and system improvements to enhance collaboration and cooperation among stakeholders in population-focused health policies.
4. Collaborates with community partners to promote the health of individuals and families within the population.	4. Identify mechanisms for enhancing collaboration among stakeholders in population-focused health interventions. Develops partnerships with key stakeholders and groups.	4. Establishes collaborative relationships and/or partnerships with key stakeholders, both internal and external. Evaluates the effectiveness of collaborative relationships and partnerships within organizations and systems. Seeks new partnerships to facilitate system-level goals.
5. Partners effectively with key stakeholders and groups in care delivery to individuals, families, groups.	5. Partners effectively with key stakeholders and groups in care delivery to communities/populations.	5. Partners effectively with key stakeholders and groups in development of population-focused health policies.
6. Participates effectively in activities that facilitate community involvement	6. Identifies areas for community involvement in agency programs and initiatives. Critiques the evidence on approaches to fostering community partnerships and involvement. Uses evidence-based guidelines and effective group processes to partner with community members and groups.	6. Implements mechanisms for ongoing and meaningful community involvement in population health issues. Demonstrates proficiency in the use of group processes that facilitate community involvement. Provides leadership in partnering with groups across systems. Functions as a resource in methods to foster community involvement.



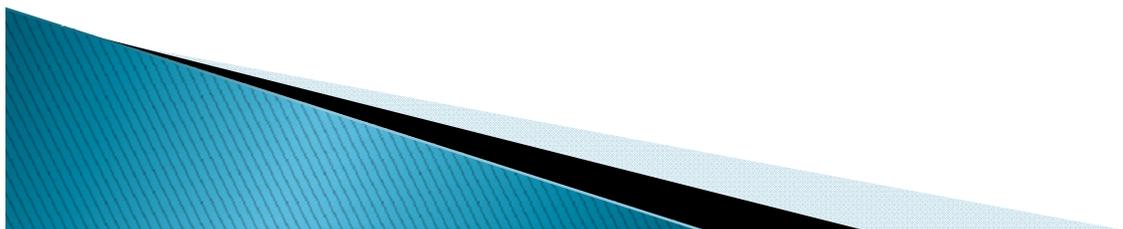
Domain 5: Community Dimensions of Practice Skills (Continued)

7. Describes to individuals, families, and groups the role of government and the private and non-profit sectors in the delivery of community health services.	7. Explains to community groups and partners the role of government and the private and non-profit sectors in the delivery of community health services.	7. Influences the role of government, the private sector, and non-profit sectors in the delivery of community health services.
8. Utilizes community assets and resources to promote health and to deliver care to individuals, families, and groups.	8. Utilizes community assets and resources to promote and to deliver care to communities/populations.	8. Utilizes community assets and resources in the agency and/or system health care programs. Implements strategies to seek resources for efforts to promote the health of populations.
9. Seeks input from individuals, families, and groups and incorporates it into plans of care.	9. Uses input from a variety of community/aggregate stakeholders in the development of public health programs and services.	9. Assures the comprehensive inclusion of input from the community served when developing policies and programs.
10. Supports public health policies, programs, and resources. Identifies opportunities for population-focused advocacy for individuals, families, and groups.	10. Advocates for public health policies, programs, and resources that better serve populations.	10. Advocates for national and global public health policies, programs, and resources that impact service population. Demonstrates leadership in advocacy efforts for public health priorities that improve population health and/or impact health care systems.
		11. Evaluates effectiveness of community engagement strategies on public health policies, programs, and resources.



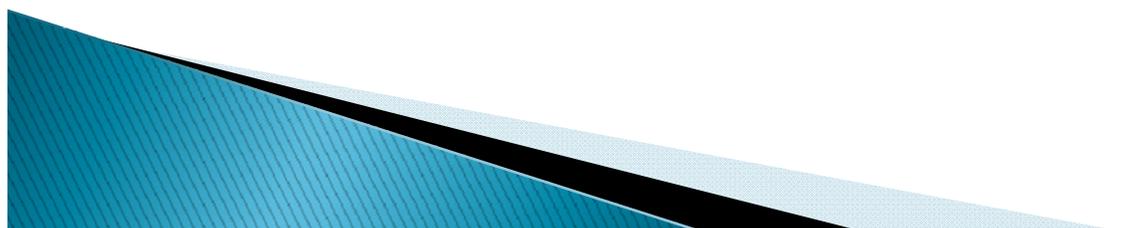
Domain 6: Public Health Sciences Skills

1. Incorporates public health and nursing science in the delivery of care to individuals, families, and groups.	1. Utilizes public health and nursing science in practice at population and community level.	1. Serves as an expert in utilizing public health and nursing science in the design of public health practice environments.
2. Describes the historical foundation of public health and public health nursing.	2. Describes the influence of sentinel events on current public health nursing practice.	2. Leads change in public health systems and practice that is informed by historical learning.
3. Describes how individual-, family-, and group-focused programs contribute to meeting the core public health functions and the 10 essential services.	3. Uses evidence-based practice to assure population level programs contribute to meeting core public health functions and the 10 essential services.	3. Uses epidemiology and other methods to appraise the organization's contribution to meeting the core public health functions and the 10 essential services.
4. Uses basic descriptive epidemiological methods when conducting a health assessment for individuals, families, and groups.	4. Uses descriptive and analytical methods, and public health sciences to design, implement, and evaluate interventions at community and population level.	4. Uses analytical methods when benchmarking practice and organizational outcomes.
5. Interprets research relevant to public health interventions for individuals, families, and groups.	5. Synthesizes research across disciplines related to public health concerns, and population-level interventions.	5. Collaborates with others to address gaps in evidence for preventing health threats at the population level. Evaluates and promotes organizational effectiveness in translating research into practice.
6. Accessing public health and other sources of information using informatics and other information technologies.	6. Identifies gaps in the scientific evidence related to public health issues, concerns, and population-level interventions.	6. Serves as an expert resource for others in the identification and use of public health informatics.
7. Identifies gaps in research evidence to guide public health nursing practice.	7. Identifies a wide variety of sources and methods to access public health information, e.g., GIS mapping. Identifies gaps and inconsistencies in research evidence for practice.	7. Strategizes with others to address limitations of research findings.
8. Complies with the requirements of patient confidentiality and human subject protection.	8. Incorporates the requirements of patient confidentiality, human subject protection, and research ethics into data collection and processing.	8. Serves as an expert in the design of data collection methods that incorporate the requirements of patient confidentiality, human subject protection, and research ethics.
9. Participates in research at the community level to build the scientific base of public health nursing.	9. Disseminates theory-guided and/or evidence-based practice outcomes in peer reviewed journals and national level meetings. Facilitates research projects within organization.	9. Develops new approaches to theory-guided and/or evidence-based practice in public health. Evaluates theory-guided and/or evidence-based practice in public health. Disseminates new evidence-based practices in public health.
		10. Establishes partnerships with academic and other organizations to expand the public health science base and disseminate research findings.



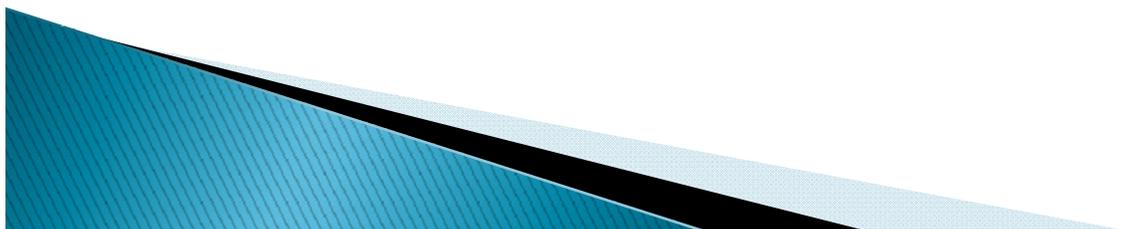
Domain 7: Financial Management and Planning Skills

1. Describes the interrelationships among local, state, tribal, and federal public health and health care systems.	1. Collaborates with relevant public and/or private systems for managing programs in public health.	1. Identifies potential funding sources and support to meet community and population health needs. Leverages relationships to form alliances across public and private health care systems that advance population health.
2. Describes the structure, function, and jurisdictional authority of the organizational units within federal, state, tribal, and local public health agencies.	2. Supervises the operations of health programs within federal, state, tribal, and local public health agencies.	2. Develops health programs within federal, state, tribal, and local public health agencies.
3. Adheres to the organization's policies and procedures, including emergency preparedness and response.	3. Develops partnerships with communities and agencies within the federal, state, tribal, and local levels of government that have authority over public health situations, such as emergency preparedness.	3. Provides leadership across agency partnerships within the federal, state, tribal, and local levels of government that have authority over public health situations or with specific issues, such as emergency events.
	4. Implements the judicial and operational procedures of the governing body and/or administrative unit designated with oversight of public health organizational operations.	4. Manages the implementation of the judicial and operational procedures of the governing body and/or administrative unit designated with oversight of public health organizational operations.
5. Provides data for inclusion in a programmatic budget.	5. Develops a programmatic budget.	5. Develops an organization-wide budget. Defends an organization-wide budget.
6. Describes the impact of budget constraints on the delivery of public health nursing care to individuals, families, and groups.	6. Manages care delivery to communities/populations within current and forecasted budget constraints.	6. Administers the delivery of agency services within current and forecasted budget constraints.
7. Provides input into budget priorities.	7. Develops strategies for determining budget priorities based on financial input from federal, state, tribal, and local sources.	7. Evaluates strategies for determining budget priorities. Recommends strategies for determining budget priorities.



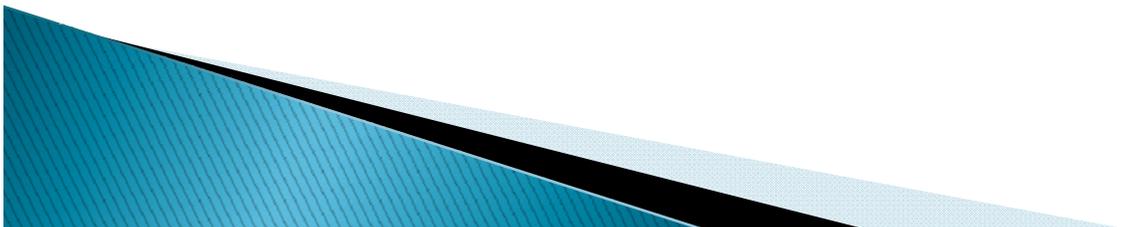
Domain 7: Financial Planning and Management Skills (Continued)

	8. Assesses the impact of organizational budget priorities on public health nursing programs and practice. Establishes organizational PHN resource priorities that assure effective public health nursing practice.	8. Assesses the impact of organizational budget priorities on public health systems and practice. Determines budgetary priorities for the organization.
9. Provides data to evaluate care and services for individuals, families, and groups. Contributes to the evaluation plan for a program targeting individuals, families, and/or groups.	9. Designs evaluation plans for population-focused programs. Implements evaluation plans for population-focused programs.	9. Evaluates program performance at the organizational/systems level for quality, effectiveness, efficiency, safety, and sustainability.
10. Adapts the delivery of public health nursing care to individuals, families, and groups based on reported evaluation results.	10. Leads revisions to population-focused programs based on formative and summative evaluation results.	10. Utilizes program evaluation data to improve organizational and system quality and performance.
11. Provides input into the fiscal and narrative components of proposals for funding from external sources.	11. Develops proposals for funding from external sources.	11. Approves proposals for submission to external funding sources.
12. Applies basic human relations and conflict management skills in interactions with peers and other health care team members.	12. Applies basic human relations and conflict management skills in interactions with direct reports, other professionals, and health care team members.	12. Applies basic human relations skills to the management of organizations, motivation of personnel, and resolution of conflicts. Establishes policies and procedures for basic human relation and conflict management throughout the system.
13. Utilizes public health informatics skills relative to the public health nursing care of individuals, families & groups.	13. Identifies opportunities to use health care technologies and informatics to improve public health program and business operations. Incorporates health care technology and informatics to improve public health program and business operations.	13. Leads processes to design and improve public health programs and business operations using informatics and health care technologies.



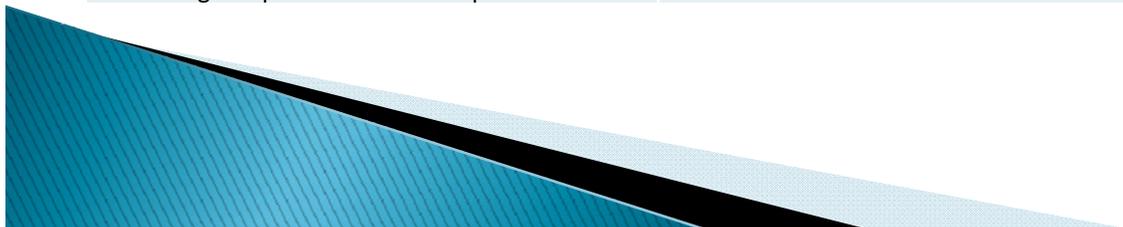
Domain 7: Financial Planning and Management Skills (Continued)

14. Provides input into contracts and other agreements for the provision of services.	14. Assists in the development of contracts and other agreements for the provision of services.	14. Approves contracts and other agreements for the provision of services.
15. Delivers public health nursing care within budgetary guidelines.	15. Describes how cost-effectiveness, cost-benefit, and cost-utility analyses affect programmatic prioritization and decision making. Employs cost-effectiveness, cost benefit, and cost-utility analyses for programmatic prioritization and decision making.	15. Utilizes cost-effectiveness, cost-benefit, and cost-utility analyses in decision making and prioritizing programs across organizations and systems.
		16. Utilizes data and information to improve organizational processes and performance.
	17. Participates in implementation and evaluation of performance management systems.	17. Establishes performance management systems across programs throughout the organization.



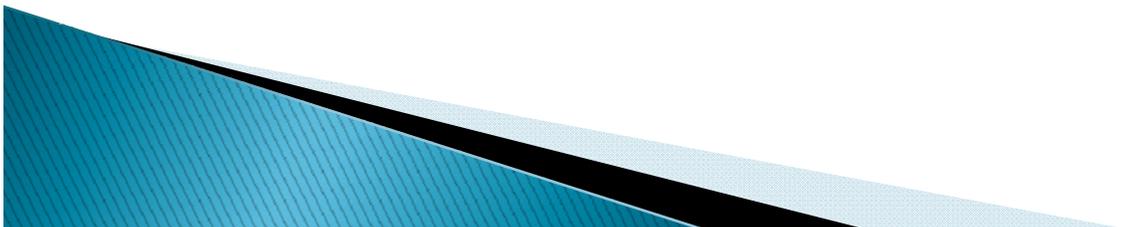
Domain 8: Leadership and Systems Thinking Skills

1. Incorporates ethical standards of practice as the basis of all interactions with organizations, communities, and individuals. Incorporates ethical standards into all aspects of public health nursing practice.	1. Addresses ethical issues related to the public health nursing care of communities/populations.	1. Incorporates ethical standards of practice as the basis of all interactions with organizations, communities, and individuals. Models accountability for ethical standards of public health practice as the basis of all interactions with organizations, communities, and individuals.
2. Applies systems theory to PHN practice with individuals, families, and groups.	2. Applies system theory to PHN practice with communities and populations.	2. Integrates systems thinking into public health practice. Evaluates new approaches to public health practice that integrate organizational and systems theories.
3. Participates with stakeholders to identify vision, values, and principles for community action.	3. Leads team and community partners in identifying vision, values, and principles for community action.	3. Partners with stakeholders to determine key values and a shared vision as guiding principles for community action. Integrates a shared vision, values, and principles for community action across the organization and the health care system.
4. Identifies internal and external factors affecting PHN practice and services.	4. Analyzes internal and external factors that may impact the delivery of essential public health services. Implements strategies to assure quality, collaboration, and coordination in delivery of PHN services.	4. Designs solutions that address internal and external problems that affect the delivery of essential public health services. Maintains systems that assure quality, collaboration, and coordination in the delivery of essential public health services.
5. Uses individual, team, and organizational learning opportunities for personal and professional development as a public health nurse.	5. Leads inter-professional team and organizational learning opportunities. Provides leadership in staff development.	5. Assures development of learning opportunities at the levels of individual, inter-professional team, and organization.
6. Acts as a mentor, coach, or peer advisor/reviewer for public health nursing staff. Maintains personal commitment to lifelong learning and professional development.	6. Implements opportunities to mentor, advise, coach, and develop peers, direct reports, and other members of the public health workforce.	6. Establishes mentoring, peer advising, coaching, and professional development systems for the public health workforce.



Domain 8: Leadership and Systems Thinking Skills (Continued)

<p>7. Participates in quality initiatives that identify opportunities for improvement. Provides data to measure, report, and improve organizational performance.</p>	<p>7. Uses evidence-based models to design and implement quality initiatives. Establishes indicators to monitor organizational performance.</p>	<p>7. Develops systems to measure, report, and improve quality of care and organizational performance. Maintains systems to measure, report, and improve quality of care and organizational performance.</p>
<p>8. Adapts the delivery of public health nursing care in consideration of changes in the public health system, and the larger social, political, and economic environment. Maintains knowledge of current public health laws and policies relevant to public health nursing practice.</p>	<p>8. Adapts program delivery to communities/populations in consideration of changes in the public health system, and the larger social, political, and economic environment. Assesses outcomes of current health policy relevant to public health and public health nursing practice.</p>	<p>8. Establishes organizational practices that reflect the changes in the public health system and the larger social, political, and economic environment.</p>
		<p>9. Effectively leads organizational and systems level change.</p>



PHN Competencies in the Health Department

Domain 1 Analytic and Assessment Skills	Public Health Nursing Examples
1.1 Identify the determinants of health and illness of individuals and families, using multiple sources of data	How & Why things happen to particular groups – behaviors....infants with smoking in home are at increased risk for ear infections. HIV risk Risk assessment tools used in clinic
1.2 Uses epidemiological data and the ecological perspective to identify health risk for a population. Identify individual and family assets & needs, values & beliefs, resources & relevant environmental factors.	Monitoring the status of an outbreak – Flu Zika Ebola
1.3 Identifies variables that measures health and public health conditions.	Community assessment Breastfeeding rates
1.4 Uses valid and reliable data sources to make comparisons for assessment.	Growth charts Lab values BP charts in PHN protocol
1.5 Identifies sources of public health data and information. Collects, interprets and documents data in terms that are understandable to all who were involved in the process, including communities.	TN.gov https://hit.health.tn.gov/home.aspx Drive your County Reports Encounter forms PTBMIS data
1.6 Uses valid and reliable methods and instruments for collecting qualitative and quantitative data from multiple sources.	Growth charts Assessment tools SureSight Snellen charts Audioscope
1.7 Identifies gaps and redundancies in a	Comparing reports – trends Evaluate data

PHN Competencies in the Health Department

community assessment through work with individuals, families and communities.	Identify needs of families/ groups that are not currently being met/ addressed
1.8 Applies ethical, legal, and policy guidelines & principles in the collection, maintenance, use, and dissemination of data and information.	HIPPA PHN Protocols CHS policies TDH policies
1.9 Describes the PHN applications of quantitative and qualitative data.	Risk assessment Tools Developmental screening tools History Milestone
1.10 Collects quantitative and qualitative data that can be used in community health assessment process. Assess data collected as part of the community assessment process to make inferences about individuals, families and groups.	Customer Surveys Outbreak Monitoring Immunization audits
1.11 Utilizes information technology to collect, analyze, store and retrieve data related to PHN care of individuals, families and groups.	Disease Monitoring Reportable diseases Patterns from reports PRISM STDMIS
1.12 Practice evidence-based PHN to promote the health of individuals, families and groups.	Home Visitation Program (referrals) TB screening
1.13 Uses available data and resources related to the social determinants of health when planning care for individuals, families and groups.	Community Resource List Disease Surveillance – example -1 school in county shut down due to high flu rates West Nile found in county
Domain 2: Policy	

PHN Competencies in the Health Department

Development/Program Planning Skills	
<p>2.1 Identify policy issues relevant to the health of individuals, families and groups.</p> <p>Describe the structure of the PH system and its impacts on individuals, families and groups within a population.</p>	<p>Newborn hearing screen Lead screening No smoking in public places Immunization requirements in schools and day cares</p> <p>Local health department services in every county in TN Community services Birth/Death Certificates</p>
<p>2.2 Identify the implications of policy options on PH programs and the potential impacts on individuals, families, and groups within a population.</p>	<p>Dependency on State and/or County funding to continue a program. Federal, VFC, 317 or State vaccine</p>
<p>2.3 Identifies outcomes of health policy relevant to PHN practice.</p>	<p>STI treatment- current CDC guidelines drive PHN protocols Fluoride Affordable Care Act Primary care and Safety Net services</p>
<p>2.4 Collects information that will inform policy decisions. Describes the legislative policy development process. Identifies outcomes of current health policy relevant to PHN practice.</p>	<p>] Child Fatality data NAS data informs legislation Smoking rates – Quitline and Breastfeeding hotline data Central Office TDH data informs sports concussion legislation</p>
<p>2.7 Describes the structure of PH system. Identifies PH laws and regulations relevant to PHN practice. Provides PHN services in a manner consistent with laws and regulations</p>	<p>RN licensure PHN Protocol HIPAA Reportable Diseases WIC</p>
<p>2.8 Participates as a team</p>	<p>PPI Staff Meeting</p>

PHN Competencies in the Health Department

member in developing organizational plans to implement programs and policies.	
2.9 Participate in teams to assure compliance with organizational policies.	Staff Meetings Peer Review Committee Opportunities such as Practice Committee
2.10 Assist in design of an evaluation plan for an individual, family, or community-focused program. Participates as a team member to evaluate programs to individuals, families and groups for their effectiveness and quality.	PPI – evaluation of projects Staff meetings PPT team meetings Customer Survey
2.11 Understand methods and practices used to identify and access public health information for individuals, families, and groups.	SMART Goals Immunization Audits Kids Central site TENNIIS Protocol Updates
2.12 Understands that quality improvement is important to the practice of PHN. Participates in QI teams. Describes various approaches used to improve PH processes and systems. Utilizes QI and core measures to identify and address opportunities for improvement in the care of individuals, families and groups.	Plan Do Study Act Cycles for Quality Improvement (?) QI results and plans of actions. LEAN principles Good Catch program
Domain 3: Communication Skills	
3.1 Assess the health literacy of the individuals, families and groups served.	ESL statistics determine required languages on posted signage and interpreter services. Reading level of materials

PHN Competencies in the Health Department

<p>3.2 Communicates effectively in writing, orally, and electronically. Communicates in a culturally responsive and relevant manner. Communications are characterized by critical thinking.</p>	<p>Complete/simple instructions and documentation for patients.</p> <p>Visual facts sheets-example Ebola handouts</p> <p>SOAP documentation</p>
<p>3.3 Solicits input from individuals, families and groups when planning and delivering health care.</p>	<p>Establishing plan of care i.e. reducing smoking by 1 cig per day Stages of Change</p>
<p>3.4 Utilizes a variety of methods to disseminate public health information to individuals, families and groups within a population.</p>	<p>Verbally reviews patient information pamphlets WIC online Kiosk TDH website refers patients to the CDC website</p> <p>Community flyers posted.</p>
<p>3.5 Demonstrates presentation of targeted health information to multiple audiences at a local level, including to groups, peer professionals, and agency peers.</p>	<p>Health Councils PPI Smoking Cessation Health Fairs</p> <p>Faith Based Groups</p>
<p>3.6 Communicates effectively with individuals, families and groups and as a member of interprofessional teams.</p>	<p>Disease management teams</p> <p>WIC Counseling (high risk) Training/ presentations Group classes</p>
<p>3.7 Articulates the role of PHN to internal and external audiences.</p>	<p>Orientation of nursing students to health department Speaking at job fairs Potential job applicants/ interview of job candidates</p>
<p>Domain 4: Cultural Competency Skills</p>	
<p>4.1 Utilizes the social and ecological determinants of health to work effectively with diverse individuals,</p>	<p>Target groups TB testing</p> <p>Monitoring for Ebola or Zika exposure</p>

PHN Competencies in the Health Department

families, and groups.	
<p>4.2 Uses concepts, knowledge, and evidence of the social determinants of health in the delivery of services to individuals, families, and groups.</p> <p>Utilizes information technology to understand the impact of the social determinants of health on individuals, families, and groups.</p>	<p>Stages of Change</p> <p>WIC risk status Family Planning history</p> <p>Risk assessments PTBMIS STD/HIV supplemental screens</p>
<p>4.3 Adapts public health nursing care to individuals, families, and groups based on cultural needs and differences.</p>	<p>Adjusting WIC packets to reflect cultural/religious practices</p>
<p>4.4 Explains factors contributing to cultural diversity.</p>	<p>Aware of the different cultures present in the community</p>
<p>4.5 Articulates the benefits of a diverse public health workforce.</p>	<p>Better equipped to meet the needs of a diverse population Develops rapport and uses strength of each staff member to produce the best outcomes.</p>
<p>4.6 Demonstrates culturally appropriate public health nursing practice with individuals, families, groups, and community members. Contributes to promoting culturally responsive work environment.</p>	<p>Cultural Competency Trainings – Knowing the community served</p> <p>Annual training on Respectful Workplace</p>
Domain 5: Community Dimensions of Practice Skills	
<p>5.1 Utilizes an ecological perspective in health assessment, planning, and</p>	<p>Ex. Community loses the only full service grocery store within 20 miles. Other store does not fill WIC vouchers.</p> <p>Population loses access to “healthier” food selections.</p>

PHN Competencies in the Health Department

interventions with individuals, families, and groups.	PPI project – Community Garden
5.2 Identifies research issues at a community level. Functions effectively as a member of a Community Based Participatory Research (CBPR) team.	Community Health Councils County assessments Grant funded initiatives such as tobacco
5.3 Identifies community partners for PHN practice with individuals, families and groups.	WIC Vendors List TBSCP providers Indigent care
5.4 Collaborates with community partners to promote the health of individuals and families within the population	County resource list PCP referrals Health Councils School flu clinics
5.5 Partners effectively with key stakeholders and groups in care delivery to individuals, families, groups.	PCP Referrals Pharmacies for special order formulas
5.6 Participates effectively in activities that facilitate community involvement.	Community Health Councils Community baby showers Health fairs PPI projects School based vaccines
5.7 Describe to individuals, families, and groups the role of government and the private non-profit sectors in the delivery of community health services.	ACA Insurance Komen B&C providers
5.8 Utilizes community assets and resources to promote health and to deliver care to individuals, families and groups	Community Resource List Encourage use of parks, bike trails and recreational facilities to increase physical activity

PHN Competencies in the Health Department

5.9 Seeks input from individuals, families and groups and incorporates it into plans of care	Stages of Change WIC Basic Nursing Process
5.10 Supports public health policies, programs, and resources. Identifies opportunities for population-focused advocacy for individuals, families, and groups.	WIC Services Family planning HUGS referrals Breastfeeding support activities
Domain 6 Public Health Sciences Skills	
6.1 Incorporates public health and nursing science in the delivery of care to individuals, families, and groups.	Quick Start – QFP Guidelines Nursing process 3 Step Counseling PHN Protocol CDC and ACIP recommendations
6.2 Describes the historical foundation of public health and public health nursing.	eradication of infectious disease (ex – smallpox and polio Clean Water & air Sanitation and hygiene
6.3 Describes how individual-, family-, and group-focused programs contribute to meeting the core public health functions and the 10 essential services.	CEDS report disease, monitor status and prevent epidemics Primary care – safety net – assurance of care for indigent population
6.4 Uses basic descriptive epidemiological methods when conducting a health assessment for individuals, families, and groups.	Example: Foodborne illness outbreak following a church social. Understand the populations involved, the disease cases reported. Identify Who, Where and When regarding disease in the county.
6.5 Interprets research relevant to public health interventions for individuals, families, and groups.	Participate in Practice Committee researching current guidance and practices to develop evidence based PHN protocol
6.6 Accessing public health	http://hit.state.tn.us/home.aspx County rankings reports

PHN Competencies in the Health Department

and other sources of information using informatics and other information technologies.	
6.7 Identifies gaps in research evidence to guide public health nursing practice.	High incidence and how PH can direct the response Zika outbreak Literature Review- not your current population
6.8 Complies with the requirements of patient confidentiality and human subject protection.	HIPAA TCA CHS policies
6.9 Participates in research at the community level to build the scientific base of public health nursing.	Participates in surveys such as the recent competency self assessment.
Domain 7 Provides data for inclusion in programmatic budget	
7.1 Describes the interrelationships among local, state, tribal, and federal public health and health care systems.	Federal programs – funding sources and related requirements Board of Health Emergency Preparedness – activation of nurse strike teams through TEMA request
7.2 Describes the structure, function, and jurisdictional authority of the organizational units within federal, state, tribal, and local public health agencies.	Emergency Preparedness ICS training Legislation process Rural & Metro TDH organization chart
7.3 Adheres to the organization’s policies and procedures, including emergency preparedness and response.	PHN protocol Initial and annual EP trainings Program guidelines
7.5 Provides data for inclusion in a programmatic budget.	Appropriate and accurate coding
7.6 Describes the impact of	Funding impacts services – state purchased immunization billing – which slides vs which are no-slide

PHN Competencies in the Health Department

budget constraints on the delivery of public health nursing care to individuals, families, and groups.	
7.7 Provides input into budget priorities.	Allocation of funds based on services provided – ex – WIC dollars to county Planning use of Tobacco Funds with nursing input
7.9 Provides data to evaluate care and services for individuals, families, and groups. Contributes to the evaluation plan for a program targeting individuals, families, and/or groups.	Appropriate coding Complete documentation Identifies clinic and community needs that allow for improved service delivery
7.10 Adapts the delivery of PHN care to individuals, families, and groups based on reported evaluation results	Targeted Testing Risk assessments
7.11 Provides input into the fiscal and narrative components of proposals for funding from external sources.	Tobacco Settlement Dollars Grant funds and related programs
7.12 Applies basic human relations and conflict management skills in interactions with peers and other health care team members.	Respectful Workforce Training Customer focused government
7.13 Utilizes public health informatics skills relative to the public health nursing care of individuals, families and groups.	Electronic Medical Record Reports generated from data source such as PTBMIS
7.14 Provides input into contracts and other agreements for the provision of services.	Contracted lab providers State lab courier provider
7.15	Appropriate Coding

PHN Competencies in the Health Department

Delivers PHN care within budgetary guidelines.	PHN Protocols –guides in what is distributed from clinical supplies Use of appropriate vaccines per qualifications – county purchased vs private pay vs TNCare
Domain 8: Leadership & Systems Thinking Skills	
8.1 Incorporates ethical standards of practice as the basis of all interactions with organizations, communities, and individuals. Incorporates ethical standards into all aspects of public health nursing practice.	Annual trainings Customer Service Practice within Scope
8.2 Applies systems theory to PHN practice with individuals, families, and groups.	PPI projects Multidisciplinary approach to needs to include nursing, medical, nutrition and environmental
8.3 Participates with stakeholders to identify vision, values, and principles for community action.	Community Health Councils Boards of Health Working with school nurses
8.4 Identifies internal and external factors affecting PHN practice and services.	Lack for dental resources for Adults Lack of mental health resources – Cost prohibitive. Example- county with no pediatric providers giving immunizations so the local health department may give all immunizations
8.5 Uses individual, team, and organizational learning opportunities for personal and professional development as a public health nurse.	Mentoring LifePath TRAIN.org
8.6 Acts as a mentor, coach, or peer advisor/reviewer for public health nursing staff. Maintains personal commitment to lifelong	Preceptors Continuing Education, etc. for nursing profile Orienting new public health employees Professional organization membership – APHN, TPHN nursing section, ANA

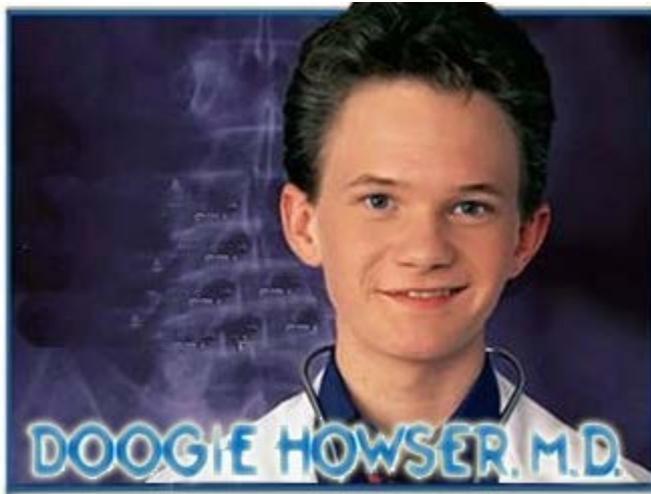
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learning and professional development.	
8.7 Participates in quality initiatives that identify opportunities for improvement. Provides data to measure, report and improve organizational performance.	Peer Review Improvement Plans QI Committees
8.8 Adapts the delivery of public health nursing care in consideration of changes in public health system, and the larger social, political, and economic environment. Maintains knowledge of current public health laws and policies relevant to public health nursing practice.	Monitor Zika and provide information Adheres to the most up to date protocols which reflect the current evidence based practice. Communicable disease regulations

APPENDIX C

Legal

Treatment of Minors



Presented by: Sarah Yusuf, Assistant General Counsel

Coming Up....

- I. Definitions of Minor/Emancipated Minor
- II. Duty to Report v. Duty to Treat
- III. Reporting Child Abuse/Sexual Abuse
- IV. Treating STDs in Minors
- V. Family Planning Services for Minors
- VI. All Other Services for Minors

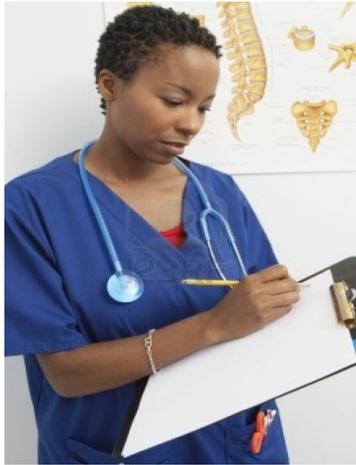
Definition of Minors

- Minor – anyone under age 18
- Exceptions:
 - Emancipated minors in Tennessee:
 - Minors independent of parental control and support
 - Two methods of emancipation:
 - Formal judicial proceeding
 - Marriage
 - Emancipated minors treated as adults for healthcare decision making purposes

Duty to Report vs. Duty to Treat

- Two separate and independent jobs
- Duty to report does not affect your duty to treat a minor





DUTY TO REPORT

Reporting Minors with STDs

- If a minor 13 years or younger is diagnosed, treated, or prescribed medication for an STD and if sexual abuse is suspected:
- The name, age, address, and STD treated shall be reported to DCS.
- T.C.A. § 37-1-403(f)

Mandatory Reporting of Child Abuse in Tennessee

- What situations should be reported?
 - Any time a child comes in for treatment and you reasonably suspect that the child has been physically, sexually, or mentally abused.
T.C.A. § 37-1-403(a), T.C.A. § 37-1-605, 45 C.F.R. § 164.512(c)

Child Abuse in Tennessee

- Child abuse
 - When a child has sustained or is in danger of sustaining a physical or mental injury caused by brutality, neglect or other actions by parent, relative, guardian or caretaker. T.C.A. § 37-1-102(b)
- Severe Child Abuse
 - Great bodily harm or death
 - Abuse likely to cause severe mental psychosis, severe neurotic disorder, severe depression, severe developmental delay or retardation, or severe impairment of the child's ability to function. T.C.A. § 37-1-102(b)

Child Sexual Abuse in Tennessee

- Types of sexual abuse that are reportable offenses regardless of age of minor:
 - Rape, sexual battery, criminal attempt to rape or sexually batter, sexual exploitation, incest. T. C.A. § 37-1-602
 - Any sexual contact by a parent, guardian, relative, caretaker, custodian, or resident of the child's home. T. C.A. § 37-1-602

Child Sexual Abuse – Age related offenses

Age of Victim	Perpetrator Characteristics	Offense	Statutory Authority
12 years and under	Does not matter; always report	Any inappropriate contact with a child 12 and under is child rape	T. C.A. § 39-13-522, T. C.A. § 39-13-531
13-14 years old	At least four years older than victim	Statutory Rape	T.C.A. § 39-13-506
15-17 years old	At lease five years older than victim	Statutory Rape	T.C.A. § 39-13-506

Reporting Child Abuse

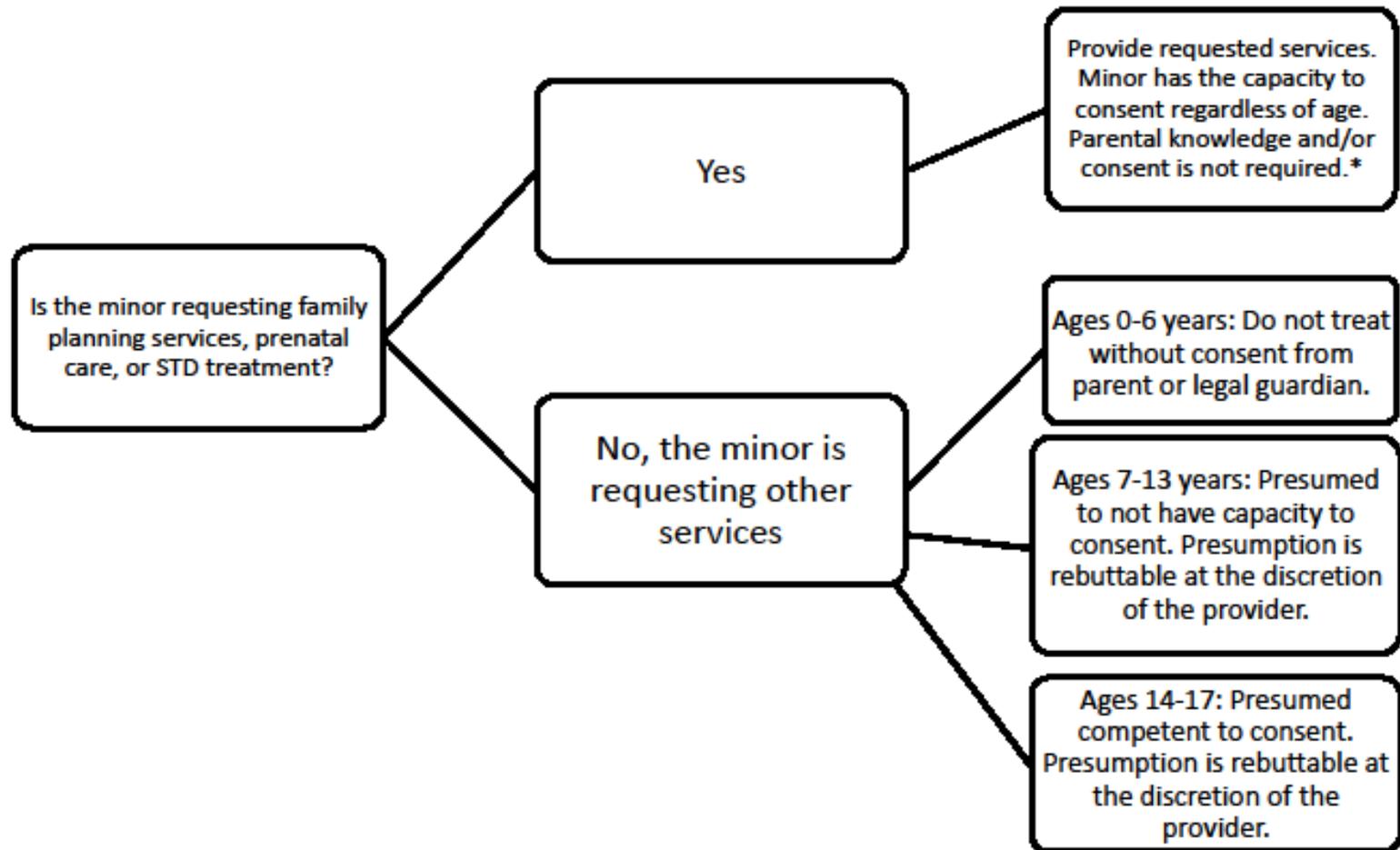
- 9-1-1 for life threatening situations
- All other situations may be reported to:
 - Judge having juvenile jurisdiction over child
 - DCS
 - Local sheriff
 - Chief law enforcement official of municipality where child resides
 - T.C.A. § 37-1-403, T.C.A. § 37-1-605(b)



DUTY TO TREAT

TREATMENT OF MINORS AT COUNTY HEALTH DEPARTMENTS

This document does not apply to emancipated minors. Emancipated minors are treated as adults.



***NOTE:** Legislation regarding the age of consent to engage in sexual activity or mandatory reporting requirements for statutory rape, child rape, child abuse, or sexual abuse should not be used as grounds to refuse the provision of family planning services, prenatal care, or STD treatment to minors. Such legislation is independent of treatment. Please refer to the memo issued by the Office of General Counsel for the Department of Health on February 21, 2013 for further information. This document is applicable only to services offered by Tennessee County Health Departments and does not cover drug and alcohol abuse treatment, emergency medical care, abortions, etc.

STD/Family Planning Services for Minors

- Tennessee law allows all minors regardless of age to consent to the following services without knowledge of legal guardian:
 - Treatment for sexually transmitted diseases or infections
 - Family planning and prenatal care services

STD Treatment for Minors

- T.C.A. § 68-10-104(c) states that no health officer or physician can be held civilly/criminally liable for providing STD treatment services to minors without parental consent
- Only exception is negligence



Family Planning Services

- Under Tennessee Law, contraceptive and prenatal services shall be provided to all minors regardless of age or knowledge of parents or legal guardians
- T.C.A. §§ 63-6-223, 68-34-104, 68-34-107



T. C. A. § 68-34-104

§ 68-34-104. Contraceptives; dissemination of information

Currentness

It is the policy and authority of this state that:

(1) All medically acceptable contraceptive procedures, supplies, and information shall be readily and practicably available to each and every person desirous of the same regardless of sex, race, age, income, number of children, marital status, citizenship or motive;

T. C. A. § 68-34-107

§ 68-34-107. Children and minors

Currentness

Contraceptive supplies and information may be furnished by physicians to any minor who is pregnant, a parent, or married, or who has the consent of the minor's parent or legal guardian, or who has been referred for such service by another physician, a clergy member, a family planning clinic, a school or institution of higher learning, or any agency or instrumentality of this state or any subdivision of the state, or who requests and is in need of birth control procedures, supplies or information.

Credits

1971 Pub.Acts, c. 400, § 1.

All other services – Mature Minor Doctrine

- In Tennessee the following presumptions apply:
 - Under 7: lacks capacity to consent; parental consent required for treatment
 - Ages 7-14: presumption of no capacity. Presumption is rebuttable at the discretion of provider
 - Ages 14-18: presumption of capacity unless proved otherwise. Presumption is rebuttable at the discretion of provider.

Factors to take into consideration

- Possession of a driver's license
- Possession of a vehicle
- Employment – part-time, full-time
- Caretaking responsibilities
- Whether they come alone or are accompanied by others
- Whether he or she seems to understand what constitutes treatment

Mature Minor Doctrine, Tennessee

An emancipated minor is someone under the age of 18 who is independent of parental control and support. Legally, an emancipated minor is treated the same as an adult and can make his own health care decisions. He can also appoint a health care agent or surrogate.

For a minor who is not emancipated, the underlying rule is that a physician must get parental (or guardian) consent before rendering medical treatment, except in cases of emergency. However, the legislature and the courts have carved out exceptions to this rule that allow a minor to consent to medical treatment under certain conditions.

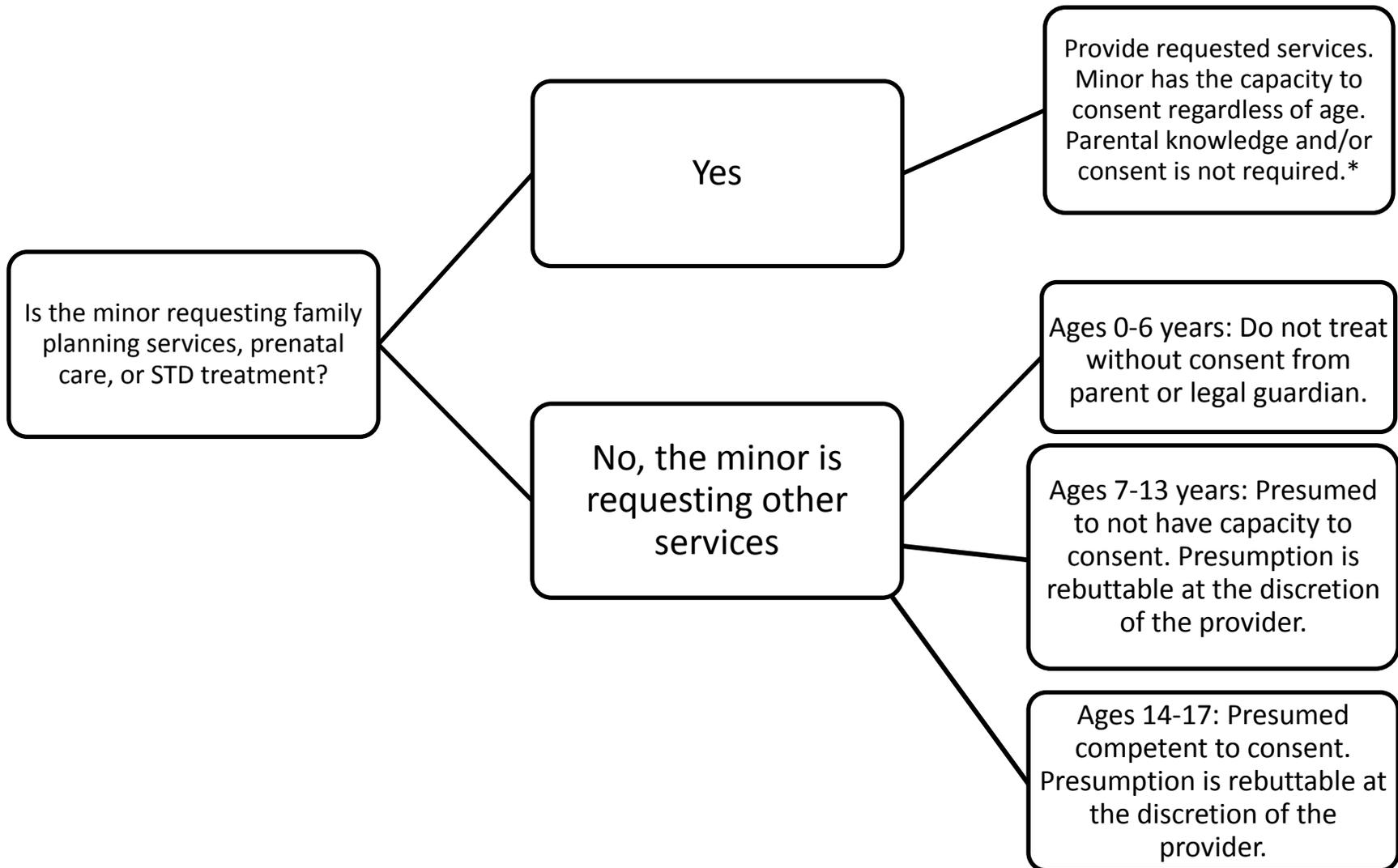
By statute in Tennessee, a physician can treat a minor without parental consent for certain health issues, such as drug abuse, venereal disease (STD/STI), contraception, and prenatal care. Also by statute, a physician may render emergency care to a minor without parental consent. After a reasonable effort has been made to contact a minor's parent or guardian, a physician may render emergency medical treatment to a minor without parental consent if the physician has a good faith belief that the emergency treatment is necessary to save the life of the minor or prevent further deterioration of the minor's condition. In Tennessee, an un-emancipated minor cannot obtain an abortion without parental consent or judicial bypass.

The courts in Tennessee have also adopted the "mature minor" doctrine that allows a physician to treat a mature minor without parental consent. In determining who is a "mature minor", Tennessee follows the "Rule of Sevens."

- Under the age of 7 there is no capacity, and the physician must have parental consent to treat (unless a statutory exception applies).
- Between the ages of 7 and 14, there is a rebuttable presumption that there is no capacity, and a physician generally should get parental consent before treating (unless a statutory exception applies).
- Between the ages of 14 and 18, there is a rebuttable presumption of capacity, and the physician may treat without parental consent unless the physician believes that the minor is not sufficiently mature to make his or her own health care decisions.

TREATMENT OF MINORS AT COUNTY HEALTH DEPARTMENTS

This document does not apply to emancipated minors. Emancipated minors are treated as adults.



***NOTE:** Legislation regarding the age of consent to engage in sexual activity or mandatory reporting requirements for statutory rape, child rape, child abuse, or sexual abuse should not be used as grounds to refuse the provision of family planning services, prenatal care, or STD treatment to minors. Such legislation is independent of treatment. Please refer to the memo issued by the Office of General Counsel for the Department of Health on February 21, 2013 for further information. **This document is applicable only to services offered by Tennessee County Health Departments and does not cover drug and alcohol abuse treatment, emergency medical care, abortions, etc.**



TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF GENERAL COUNSEL

JOHN DREYZEHNER, MD, MPH
COMMISSIONER

JANE YOUNG
GENERAL COUNSEL

TO: Dr. Jan BeVile, Medical Director for Community Health Services

FROM: Sarah Yusuf, Assistant General Counsel

DATE: February 21, 2013

RE: *Family Planning Services and Sexually Transmitted Disease Treatment for Minors*

QUESTION PRESENTED:

- 1) Does the Mature Minor Doctrine apply to the provision of family planning services and sexually transmitted disease (“STD”) treatment for minors?
- 2) Does legislation regarding the age of consent or mandatory reporting requirements prevent the Department of Health from providing family planning services and STD treatment to minors?

SHORT ANSWER:

- 1) No, the Mature Minor Doctrine does not apply to a minor’s ability to obtain family planning services and sexually transmitted disease treatment without parental knowledge or consent.
- 2) No, legislation regarding the age of consent or mandatory reporting requirements cannot be interpreted to prevent a minor from obtaining family planning services or STD treatment.

ANALYSIS:

I. The Mature Minor Doctrine in Tennessee

In 1987, the Tennessee Supreme Court adopted the Mature Minor Doctrine, which established parameters for a minor’s capacity to consent to medical treatment without parental knowledge or consent. *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987). The Mature Minor doctrine sets forth the following breakdown of a minor’s capacity to consent based on his or her age:

- (a) Under 7 years: the minor is presumed to have no capacity to consent;
- (b) Between 7-14 years: rebuttable presumption of no capacity to consent;
- (c) Between 14-18 years: rebuttable presumption of capacity to consent.

Id. at 749.

In establishing the Mature Minor Doctrine, the *Cardwell* Court recognized that the legislature had previously passed several statutes that permitted minors to consent to medical treatment regardless of age. The Court stated to the extent these statutes were in derogation of the common law, they should be “strictly construed and confined to their express terms.” *Id.* at 744 (quoting *Austin v. County of Shelby*, 640 S.W.2d 852, 854 (Tenn. Ct. App. 1982)). This means that these statutes can displace common law only to the extent required by the wording of the statute itself. *Houghton v. Aramark Educ. Res., Inc.*, 90 S.W.3d 676, 679 (Tenn. 2002).

T.C.A. §§ 68-10-104, 68-34-104, and 68-34-107 were all passed prior to the decision in *Cardwell*.¹ These statutes unambiguously permit minors of any age to consent to receive family planning services and treatment for STDs. Therefore, they fall under the category of statutes in derogation of the common law as contemplated by the *Cardwell* Court. This means that the Mature Minor Doctrine is not applicable to these statutes, and that these statutes should be applied in a manner consistent with their wording.

II. Family Planning Services:

T.C.A. § 68-34-104 states that “it is the policy and authority of this state that all medically acceptable contraceptive procedures, supplies, and information shall be readily and practicably available to each and every person desirous of the same regardless of . . . age.” T.C.A. § 68-34-107 states that “contraceptive supplies and information may be furnished by physicians to any minor . . . who requests and is in need of birth control procedures, supplies or information.” Even under narrow construction, it is clear that the wording of both statutes expressly permit minors of any age to obtain family planning services. This statute is a legislative exception to the Mature Minor Doctrine and should be given its full effect.

III. Sexually Transmitted Disease Treatment:

T.C.A. § 68-10-104(c) states that:

“Any state, district, county or municipal health officer or any physician may examine, diagnose and treat minors infected with STDs without the knowledge or consent of the parents of the minors, and shall incur no civil or criminal liability in connection with the examination, diagnosis or treatment, except for negligence.”

The statute places no age requirement on the minor’s ability to obtain treatment without parental knowledge or consent. The statute further shields health officers and physicians who provide STD treatment to minors from civil and criminal liability. This statute is also a legislative exception the Mature Minor Doctrine, and should be given its full effect.

IV. Reporting Requirements

Legislation regarding the age of consent to engage in sexual activity or mandatory reporting requirements for statutory rape, child rape, child abuse, or sexual abuse should not be used as

¹ T.C.A. § 68-10-104 was enacted in 1969; T.C.A. §§ 68-34-104 and 68-34-107 were both enacted in 1971 as part of the Family Planning Act of 1971.

grounds to refuse the provision of contraceptive supplies or STD treatment to minors. These types of legislation are intended to identify and prosecute the perpetrators of abuse and to protect the safety of the minor. These statutes cannot be interpreted to negate the minor's ability to obtain STD treatment or contraceptive supplies. To make such an interpretation would be wholly contradictive of existing law and in violation of T.C.A. §§ 68-10-104, 68-34-104, and 68-34-107.

APPENDIX D

Practice

How to Administer Intramuscular and Subcutaneous Vaccine Injections

Administration by the Intramuscular (IM) Route

Administer these vaccines via IM route

- Diphtheria-tetanus-pertussis (DTaP, Tdap)
- Diphtheria-tetanus (DT, Td)
- *Haemophilus influenzae* type b (Hib)
- Hepatitis A (HepA)
- Hepatitis B (HepB)
- Human papillomavirus (HPV)
- Inactivated influenza (IIV)
- Meningococcal serogroup B (MenB)
- Quadrivalent meningococcal conjugate (MenACWY [MCV4])
- Pneumococcal conjugate (PCV13)

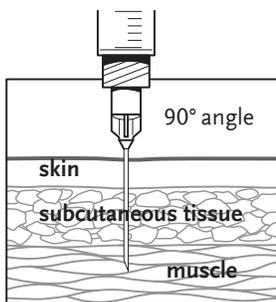
Administer inactivated polio (IPV) and pneumococcal polysaccharide (PPSV23) vaccines either IM or Subcut.

PATIENT AGE	INJECTION SITE	NEEDLE SIZE
Newborn (0–28 days)	Anterolateral thigh muscle	5/8"* (22–25 gauge)
Infant (1–12 months)	Anterolateral thigh muscle	1"* (22–25 gauge)
Toddler (1–2 years)	Anterolateral thigh muscle	1–1¼" (22–25 gauge)
	Alternate site: Deltoid muscle of arm if muscle mass is adequate	5/8–1"* (22–25 gauge)
Children (3–18 years)	Deltoid muscle (upper arm)	5/8–1"* (22–25 gauge)
	Alternate site: Anterolateral thigh muscle	1–1¼" (22–25 gauge)
Adults 19 years and older	Deltoid muscle (upper arm)	1–1½"*† (22–25 gauge)
	Alternate site: Anterolateral thigh muscle	1–1½" (22–25 gauge)

* A 5/8" needle usually is adequate for neonates (first 28 days of life), preterm infants, and children ages 1 through 18 years if the skin is stretched flat between the thumb and forefinger and the needle is inserted at a 90° angle to the skin.

† A 5/8" needle may be used in patients weighing less than 130 lbs (<60 kg) for IM injection in the deltoid muscle only if the skin is stretched tight, the sub-

cutaneous tissue is not bunched, and the injection is made at a 90° angle; a 1" needle is sufficient in patients weighing 130–152 lbs (60–70 kg); a 1–1½" needle is recommended in women weighing 153–200 lbs (70–90 kg) and men weighing 153–260 lbs (70–118 kg); a 1½" needle is recommended in women weighing more than 200 lbs (91 kg) or men weighing more than 260 lbs (118 kg).



Needle insertion

Use a needle long enough to reach deep into the muscle.

Insert needle at a 90° angle to the skin with a quick thrust.

(Before administering an injection of vaccine, it is not necessary to aspirate, i.e., to pull back on the syringe plunger after needle insertion.¶)

Multiple injections given in the same extremity should be separated by a minimum of 1", if possible.

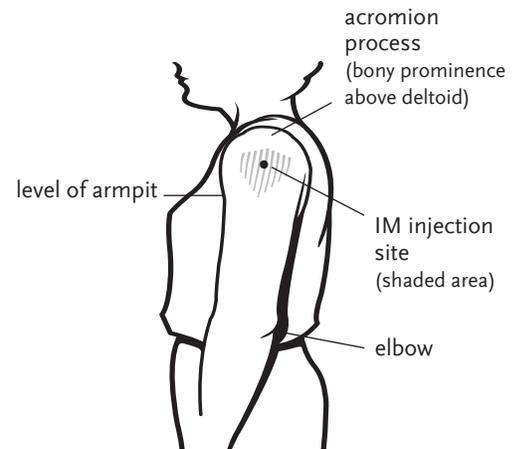
¶ CDC. "ACIP General Recommendations on Immunization" at www.immunize.org/acip

Intramuscular (IM) injection site for infants and toddlers



Insert needle at a 90° angle into the anterolateral thigh muscle.

Intramuscular (IM) injection site for children and adults



Give in the central and thickest portion of the deltoid muscle – above the level of the armpit and approximately 2–3 fingerbreadths (~2") below the acromion process. See the diagram. To avoid causing an injury, do not inject too high (near the acromion process) or too low.

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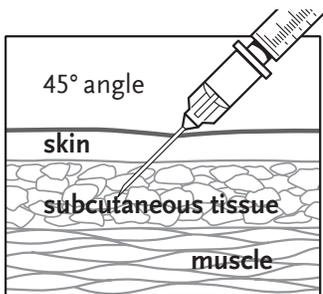
Administration by the Subcutaneous (Subcut) Route

Administer these vaccines via Subcut route

- Measles, mumps, and rubella (MMR)
- Meningococcal polysaccharide (MPSV4)
- Varicella (VAR)
- Zoster (shingles [ZOS])

Administer inactivated polio (IPV) and pneumococcal polysaccharide (PPSV23) vaccines either IM or Subcut.

PATIENT AGE	INJECTION SITE	NEEDLE SIZE
Birth to 12 months	Fatty tissue overlying the anterolateral thigh muscle	5/8" (23–25 gauge)
12 months and older	Fatty tissue overlying the anterolateral thigh muscle or fatty tissue over triceps	5/8" (23–25 gauge)



Needle insertion

Pinch up on subcutaneous tissue to prevent injection into muscle.

Insert needle at 45° angle to the skin.

(Before administering an injection of vaccine, it is not necessary to aspirate, i.e., to pull back on the syringe plunger after needle insertion.*)

Multiple injections given in the same extremity should be separated by a minimum of 1".

* CDC. "ACIP General Recommendations on Immunization" at www.immunize.org/acip

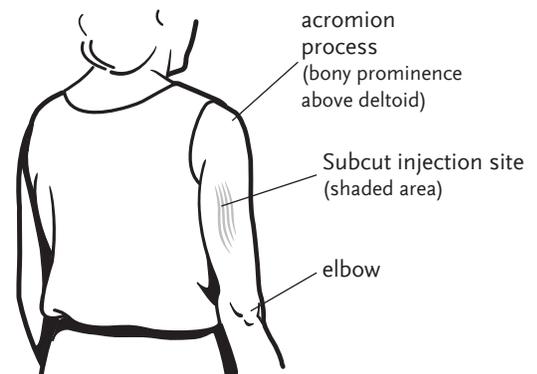
Subcutaneous (Subcut) injection site for infants



Subcut injection site (shaded area)

Insert needle at a 45° angle into fatty tissue of the anterolateral thigh. Make sure you pinch up on subcutaneous tissue to prevent injection into the muscle.

Subcutaneous (Subcut) injection site for children (after the 1st birthday) and adults

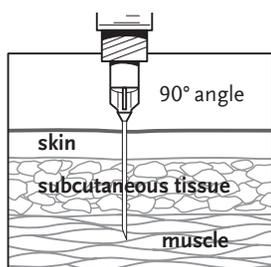


Insert needle at a 45° angle into the fatty tissue overlying the triceps muscle. Make sure you pinch up on the subcutaneous tissue to prevent injection into the muscle.

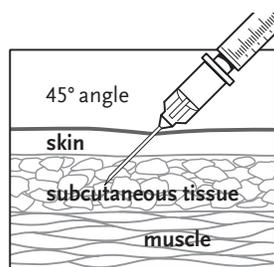
Administering Vaccines: Dose, Route, Site, and Needle Size

Vaccine	Dose	Route	Injection Site and Needle Size		
Diphtheria, Tetanus, Pertussis (DTaP, DT, Tdap, Td)	0.5 mL	IM	Subcutaneous (Subcut) injection Use a 23–25 gauge needle. Choose the injection site that is appropriate to the person's age and body mass.		
<i>Haemophilus influenzae</i> type b (Hib)	0.5 mL	IM	AGE	NEEDLE LENGTH	INJECTION SITE
Hepatitis A (HepA)	≤18 yrs: 0.5 mL ≥19 yrs: 1.0 mL	IM	Infants (1–12 mos)	5/8"	Fatty tissue over anterolateral thigh muscle
Hepatitis B (HepB) <i>Persons 11–15 yrs may be given Recombivax HB (Merck) 1.0 mL adult formulation on a 2-dose schedule.</i>	≤19 yrs: 0.5 mL ≥20 yrs: 1.0 mL	IM	Children 12 mos or older, adolescents, and adults	5/8"	Fatty tissue over anterolateral thigh muscle or fatty tissue over triceps
Human papillomavirus (HPV)	0.5 mL	IM	Intramuscular (IM) injection Use a 22–25 gauge needle. Choose the injection site and needle length that is appropriate to the person's age and body mass.		
Influenza, live attenuated (LAIV)	0.2 mL (0.1 mL in each nostril)	Intranasal spray	AGE	NEEDLE LENGTH	INJECTION SITE
Influenza, inactivated (IIV); recombinant (RIV), for ages 18 years and older	6–35 mos: 0.25 mL ≥3 yrs: 0.5 mL	IM	Newborns (1st 28 days)	5/8"	Anterolateral thigh muscle
Influenza (IIV) Fluzone Intradermal, for ages 18 through 64 years	0.1 mL	ID	Infants (1–12 mos)	1"	Anterolateral thigh muscle
Measles, Mumps, Rubella (MMR)	0.5 mL	Subcut	Toddlers (1–2 years)	1–1¼"	Anterolateral thigh muscle
Meningococcal conjugate (MCV4 [MenACWY])	0.5 mL	IM		5/8–1"	Deltoid muscle of arm
Meningococcal serogroup B (MenB)	0.5 mL	IM	Children and teens (3–18 years)	5/8–1"* 1–1¼"	Deltoid muscle of arm Anterolateral thigh muscle
Meningococcal polysaccharide (MPSV)	0.5 mL	Subcut	Adults 19 years or older		
Pneumococcal conjugate (PCV)	0.5 mL	IM	Female or male <130 lbs	5/8–1"*	Deltoid muscle of arm
Pneumococcal polysaccharide (PPSV)	0.5 mL	IM or Subcut	Female or male 130–152 lbs	1"	Deltoid muscle of arm
Polio, inactivated (IPV)	0.5 mL	IM or Subcut	Female 153–200 lbs Male 130–260 lbs	1–1½"	Deltoid muscle of arm
Rotavirus (RV)	Rotarix: 1.0 mL Rotateq: 2.0 mL	Oral	Female 200+ lbs Male 260+ lbs	1½"	Deltoid muscle of arm
Varicella (Var)	0.5 mL	Subcut	* A 5/8" needle may be used for patients weighing less than 130 lbs (<60 kg) for IM injection in the deltoid muscle only if the skin stretched tight, the subcutaneous tissue is not bunched, and the injection is made at a 90-degree angle.		
Zoster (Zos)	0.65 mL	Subcut	NOTE: Always refer to the package insert included with each biologic for complete vaccine administration information. CDC's Advisory Committee on Immunization Practices (ACIP) recommendations for the particular vaccine should be reviewed as well. Access the ACIP recommendations at www.immunize.org/acip .		
Combination Vaccines					
DTaP-HepB-IPV (Pediarix) DTaP-IPV/Hib (Pentacel) DTaP-IPV (Kinrix; Quadracel) Hib-HepB (Comvax) Hib-MenCY (MenHibrix)	0.5 mL	IM			
MMRV (ProQuad)	≤12 yrs: 0.5 mL	Subcut			
HepA-HepB (Twinrix)	≥18 yrs: 1.0 mL	IM			

Intramuscular (IM) injection



Subcutaneous (Subcut) injection



Intradermal (ID) administration of Fluzone ID vaccine



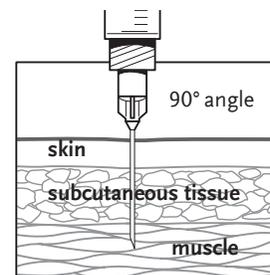
Intranasal (NAS) administration of Flumist (LAIV) vaccine



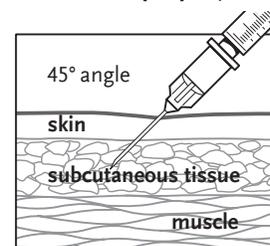
Administering Vaccines to Adults: Dose, Route, Site, and Needle Size

VACCINE	DOSE	ROUTE
Hepatitis A (HepA)	≤18 yrs: 0.5 mL ≥19 yrs: 1.0 mL	IM
Hepatitis B (HepB)	≤19 yrs: 0.5 mL ≥20 yrs: 1.0 mL	IM
HepA-HepB (Twinrix)	≥18 yrs: 1.0 mL	IM
Human papillomavirus (HPV)	0.5 mL	IM
Influenza, live attenuated (LAIV)	0.2 mL (0.1 mL into each nostril)	Intranasal spray
Influenza, inactivated (IIV) and recombinant (RIV)	0.5 mL	IM
Influenza (IIV) Fluzone Intradermal, for ages 18 through 64 years	0.1 mL	Intradermal
Measles, Mumps, Rubella (MMR)	0.5 mL	SC
Meningococcal conjugate (MCV)	0.5 mL	IM
Meningococcal polysaccharide (MPSV)	0.5 mL	SC
Pneumococcal conjugate (PCV)	0.5 mL	IM
Pneumococcal polysaccharide (PPSV)	0.5 mL	IM or SC
Tetanus, Diphtheria (Td) with Pertussis (Tdap)	0.5 mL	IM
Varicella (VAR)	0.5 mL	SC
Zoster (Zos)	0.65 mL	SC

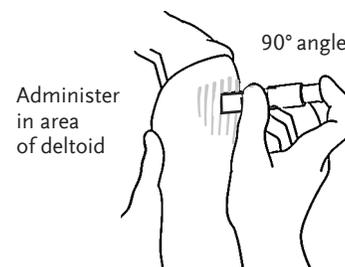
Intramuscular (IM) injection



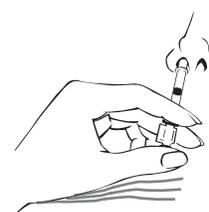
Subcutaneous (SC) injection



Intradermal (ID) administration of Fluzone ID vaccine



Intranasal (IN) administration of Flumist (LAIV) vaccine



NOTE: Always refer to the package insert included with each biologic for complete vaccine administration information. CDC's Advisory Committee on Immunization Practices (ACIP) recommendations for the particular vaccine should be reviewed as well. Access the ACIP recommendations at www.immunize.org/acip.

Injection Site and Needle Size

Subcutaneous (SC) injection – Use a 23–25 gauge, 5/8", needle. Inject in fatty tissue over triceps.		
Intramuscular (IM) injection – Use a 22–25 gauge needle. Inject in deltoid muscle of arm. Choose the needle length as indicated below:		
Gender/Weight	Needle Length	
Male or female less than 130 lbs	5/8" *–1"	* A 5/8" needle may be used for patients weighing less than 130 lbs (<60 kg) for IM injection in the deltoid muscle only if the subcutaneous tissue is not bunched and the injection is made at a 90-degree angle.
Female 130–200 lbs	1–1 1/2"	
Male 130–260 lbs	1–1 1/2"	
Female 200+ lbs	1 1/2"	
Male 260+ lbs	1 1/2"	

EXECUTIVE DECISION MEMO

October 20, 2014

TO: David Reagan MD, Chief Medical Officer

**FROM: Jan BeVille MD, Clinical Health Services Medical Director
Calita Richards, PharmD, MPH, State Pharmacy Director
Jane Young JD, General Counsel**

Created in consultation with Janet Ridley, RN, Ami Mitchell, Tonya Stephens, DPh, Karen Hartley, DPh, Shavetta Conner, MD, Leslie Humphreys, Michelle X. Ramsey, RN

SUBJECT: Clinic nurse labeling of oral contraceptives according to Public Chapter 0585

ACTION REQUESTED: **Request for Approval**
 Request for discussion or further review
 For your information
 Other (please specify)

STATEMENT OF ISSUE:

Potential under Public Chapter 0585 for oral contraceptives (OCs) to be shipped directly from the wholesaler/purchasing source to the Health Department clinics, and to be labeled in the clinic by registered and licensed practical nurses (“nurses”) for issuing to patients.

PRIMARY RECOMMENDATION:

It is acceptable for nurses in Health Department clinics to apply a standardized label provided by the Regional Pharmacy to OCs, adhering to established procedures incorporated into the medical protocol jointly developed by the supervising physician and nurse, with oversight of a State or Regional pharmacist.

I. SUMMARY OF FACTS/BACKGROUND:

Currently, in some Regions, OCs are shipped to the local Health Department clinics from the wholesaler as packaged by the manufacturer. Included on the product packaging is the name and strength of the medication. In those Regions, the package is labeled by the local Health Department clinic nurse and issued to the patient. Labels are provided by the Regional Pharmacy. In some sites of these Regions, multiple packets of unlabeled OCs are placed in a bag, and the bag is labeled by the nurse and issued to the patient. In other sites, a compact that holds an OC packet is labeled and placed in a bag, along with unlabeled multiple packets, and issued to the patient.

In other Regions, the Regional Pharmacy receives the OCs and each packet is labeled by the pharmacy technician or Regional pharmacy director. All labeling by the pharmacy technician is checked by the pharmacy director. After labeling, the product is supplied to the clinic.

II. SYNOPSIS OF SIGNIFICANT/RELATED ISSUES:

Some nurses may show reluctant in labeling OCs due to confidence/comfort level and perceived need for additional time to accurately complete this process. The potential for errors in accurate labeling is unknown.

Rather than scanning a barcode that has been placed on an OC packet by the Regional pharmacy, the process will require the pharmacy to provide reference cards/sheets to each site for scanning the appropriate barcode of the OC being issued. Error rates will continue to be monitored for any increase potentially due to this process. If error rates increase and are found to be due this process, there may be changes made to the process.

III. CRITERIA FOR DECISION MAKING:

Legal standards under current statutes were reviewed, including the relevant practice acts for nurses and pharmacists. Issues of safety and expediency in serving patients were also reviewed.

Nursing staff will receive training on policy and procedure changes and will demonstrate skills competence prior to performing new tasks.

IV. STAKEHOLDER INVOLVEMENT:

Medical, Nursing, and Pharmacy State and Regional leadership, and Legal were included in discussions.

V. DISSENTING OPINIONS REGARDING RECOMMENDED OPTIONS:

No dissenting opinions were provided. Division of Health Licensure and Regulation attorney was included in the discussion.

VI. EFFECT OF RECOMMENDED OPTION ON EXISTING PROGRAMS:

It will be necessary to train current nursing staff who will be involved in the labeling process. Newly hired nurses will have orientation of this process added to standard public health nurse orientation. There should not be any impact on the clinic drug room space, as quantities of medication shipped to the clinic will not be altered by this process. With the shift of labeling OCs responsibility from the Regional Pharmacy to nurses, there will be a slight increase in time needed for a nurse to issue medications to a patient in sites that currently apply labels with all information pre-printed. There will be a reduction in nursing staff time for sites that currently write in patient name, provider name, date and administration instructions on the medication label.

VII. LEGAL OR LEGISLATIVE CONSIDERATIONS:

Current law: Public Chapter 585 repealed prior provisions of Tenn. Code Ann. § 63-10-205 and states that "[t]he department of health shall develop procedures and protocols for inventory controls, accountability, repackaging, security, storage and issuance of drugs by state and local health departments. The commissioner shall appoint a state or regional pharmacist to oversee these activities." Pharmacy rules and nursing laws have been reviewed with respect to labeling of medications.

Oral contraceptive labels applied in the clinics must include:

- Name, address, and telephone number of practice site;
- Name of prescriber; when issuing to patients with a deferred examination, the responsible physician's name will be added.
- Name of patient;
- Directions for use;
- Date medical or prescription order originally issued, and/or refill date;

VIII. BUDGET OR FINANCIAL CONSIDERATIONS:

Medication wholesaler ships without charge to the initial address provided. There would be no change if medications were to be shipped directly to individual local Health Department clinics. The expense of shipping OCs via FedEx from a Regional Pharmacy to a local Health Department clinic is borne by the State. The proposed change in policy would eliminate this FedEx expense.

IX. IMPLEMENTATION:

Community Health Services policy, Department of Health Pharmaceutical Management 3.03.b, will be amended to include the process of labeling OCs in the Health Department clinics. A procedure will be developed for this process, to include a standard label with appropriate information. Training for adherence to the policy will be provided to current staff. The procedure will be added to the Public Health Nursing (PHN) orientation. An addendum will be added to the current PHN protocol that is signed by each nurse.

APPENDIX E

Orientation Checklists

Public Health Nursing Orientation Checklist

Name of Orientee

County

AREA OF ORIENTATION	Employee Initials	Completed By: Initials	Completion Date	PHN Competencies Tier 1
Facility Orientation				
Tour of Facility/Meet Staff				
Location of work station/breaks and lunch schedule				
Review safety procedures, codes, drills, emergency plans				7.3
Location of emergency equipment including crash cart, AED, PPE, O2 tank, spill kit, fire extinguishers, medications, panic button if available				7.3
Review organizational charts, region map, contact information				7.1, 7.3
Paperwork - Sign/Complete				All 1.8
*PH 3131 (6 in 1)				1.8
*TennCare Impartiality Statement				1.8
*Computer Access Security Agreement				1.8
*Individual Performance Plan - review probationary period, interim review, annual evaluation, disciplinary action				
*State of Tennessee Code of Conduct				
*Social Media Policy				1.12, 6.1
*Acceptable Use Policy				7.3
PHN Protocol - LPN, RN, APN				1.8
Exposure Control Plan				1.8
Nursing Profile Data Sheet				
Apply for NPI - LPN, RN, APN				
IT systems access request form				
Personnel - Review/Complete				
Attendance and Leave				
Return to Work Policy 16-2 State EE only				
Travel Claims				
Time Reporting				
Email Etiquette				3.2
Dress Code				
No Smoking				
Cell Phone Policy				
Orientation plan and schedule				
Incident/Accident Reporting				
Benefits Information - meet with HR				
Photo ID/Name Badge - Request & Issue				
Copy of Nursing License/Certifications - LPN, RN, APN				2.7
Copy of CPR Card				
Malpractice Insurance Coverage - LPN, RN, APN				

AREA OF ORIENTATION	Employee Initials	Completed By: Initials	Completion Date	PHN Competencies Tier 1
School Located Vaccine Clinics/Off-site Clinics				5.4, 5.6
Voluntary Newborn Surrender – CHS 3.11				2.1
Request WIC eLearning & WIC Works - see WIC checklist				
Occupational Health				
TB Risk Assessment/Screening/Testing				
Medical Questionnaire and Fit Testing				
Immunization/Immunity Status - Hep B, Varicella, MMR, Tdap				
Training				
Lab Training				
Specimen Shipping and Handling				
Title 6				8.1
WIC Civil Rights				8.1
Child Abuse				8.1
Human Trafficking				8.1
Customer Service				
Respectful Workplace				7.12
HIPAA				6.8
Emergency Preparedness				7.3
ICS 100,200 -NIMS 700				7.3
Introduction to Mental Health Preparedness				7.3
Suicide Prevention				3.3
OSHA and BBP				6.1
Workplace Violence				7.12
<i>Run, Hide, Fight</i> Video				
New Employee Orientation - Program Orientation				
<i>You Call the Shots</i> and/or <i>Epidemiology and Prevention of Vaccine-Preventable Diseases</i> - Modules Online				6.1, 6.3
Pediatric Nursing Physical Assessment				4.3
Patient Tracking				7.13
PTBMIS				
Oral Health Assessment - RNs				2.3
Autism/MCHAT - RNs				1.9
Community Health Services Intranet Website				
Stool Collection Training (video-optional)				
Retinal Screening (as applicable)				
Coding				7.5
Documentation				3.2
Good Catch				
Baby and Me Tobacco Free				2.8; 2.9; 2.10; 3.2; 3.4; 3.6; 4.1; 4.2; 4.3; 4.6; 5.5
Primary Prevention Initiatives (PPI)				1.3; 1.6; 1.13; 2.4; 2.8; 2.9; 2.10; 3.1; 3.2; 3.4; 3.5; 5.1; 5.5; 5.6; 8.7

AREA OF ORIENTATION	Employee Initials	Completed By: Initials	Completion Date	PHN Competencies Tier 1
Locate and Review Manuals & Resources				
Public Health Nursing Orientation & Practice Manual				1.8
Public Health Nursing Protocol Manual				1.12, 6.1
Policies and Procedures Manual (CHS, HSA)				1.8
TDH Billing and Codes Manual				7.1, 7.5
Quality Improvement Manual				2.12, 8.7
Directory of Laboratory Services				
Lab Policies and Procedures Manual				1.9
Infection Control Manual - Exposure Control Plan				1.12
Hazard Communication Plan - Safety Data Sheets				
Respiratory Protection Plan				
TB Elimination Manual				1.10, 1.12
TBCSP Manual				
Family Planning Guidelines				6.1
TennCare Presumptive Eligibility Desk Guide				
Primary Care Services Guidelines				
WIC Manual				1.2
BRIGHT FUTURES Guidelines for Health Supervision of Infants, Children, and Adolescents				
Epidemiology and Prevention of Vaccine-Preventable Diseases ("Pink Book")				2.2
International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)				
Current Procedural Terminology (CPT) Codes				
PHN Training Modules				All 6.1; 6.3; 6.6; 6.8
Introduction to PH Nursing Module				1.1; 1.3; 4.1; 4.1; 5.3; 5.4; 5.5; 5.6; 8.3
CEDEP Nursing Module				1.11; 6.4; 8.8
Child Health Module				
FP/Women's Health Module				4.2
Primary Care Services Module				
Immunization Module				
WIC Module				2.7; 3.6; 4.2; 4.3; 5.3; 5.9; 5.10;

* Time sensitive per region.

Employee's Signature, Title & Date

Completed by: Signature, Title & Date

Skills Orientation Checklist - RN, LPN, NA

Name of Orientee

County

Skills	Demonstration by Preceptor: Date & Initial	Competent Return Demonstration by Orientee: Preceptor to Date & Initial	Orientee: Initial	Supervisor/Designee Competency Check Off: Date & Initial	Tier 1*
Patient Measurements: RN, LPN, NA					All 1.4
Blood Pressure: Adult					
Blood Pressure: Child					
Temp, Pulse, Respiration					
Weight: Infant Scale					
Weight: Standing Scale					
Height: Recumbent					
Height: Standing					
Head Circumference					
Growth Chart - manual					
Growth Chart - electronic					
Growth Chart - premature					
Calculate BMI					
Hearing: Audioscope/Audiometer/ ERO-SCAN					
Vision: Snellen Chart/Vision Screener Red/Green Color Chart					
Laboratory: RN, LPN, NA					All 1.4
Hemoglobin					
Pregnancy Test					
Venipuncture- see lab manual for procedure guidelines					
Urinalysis (Dipstick)					
Urine Genprobe					
Lab Specimen Handling/Packaging/ Shipping					
Control Tests & Documentation					
IGRA/QFT					
Collection/Incubation/Shipping					
Lab Order Entry					
Reference Lab Requisitions					
Hemocult/Stool					
Capillary Blood Glucose					
Lead: Capillary Collection					
Newborn Screening					6.1
Sickle Cell Screening/Collection					6.1

Skills	Demonstration by Preceptor: Date & Initial	Competent Return Demonstration by Orientee: Preceptor to Date & Initial	Orientee: Initial	Supervisor/Designee Competency Check Off: Date & Initial	Tier 1*
Patient Exam/Clinic Room/Equipment: RN, LPN, NA					
Prepare/Clean/Stock Clinic Room					
Check for Expired Supplies					
Prepare for Exam					
Assist with Exam					
Vaccine Storage and Handling					
Temp Monitoring: Refrigerator/Freezer					
Temp Monitoring: Incubator					
Sensaphone: Review					
Emergency Kit/Crash Cart/AED					
Spill Kit					
Autoclave operation - spore testing					
Primary Care: RN, LPN, NA					
EKG					
Patient Assistance Program (PAP)					
O2 Saturation					
Rapid Strep					
Laboratory: RN, LPN (NAs stop here. RNs & LPNs continue)					
Oral Genprobe					
Rectal Genprobe					
Vaginal/Cervical/Endocervical Genprobe					
Male Urethral Genprobe					
Herpes Culture					
Sputum Collection					
Nasopharyngeal swab					
Medication Administration: RN, LPN					
"5 Rs"					
IM Vaccine Injection: Adult					
IM Vaccine Injection: Child					
IM Vaccine Injection: Infant					
IM Injection: Other (Depo, Ceftriaxone, Bicillin, Kenalog, etc.)					
Subcutaneous Vaccine Injection: Adult					
Subcutaneous Vaccine Injection: Child					
Reconstitute meds/vaccines					
Oral Vaccine Administration					
Intranasal Vaccine Administration					

Skills	Demonstration by Preceptor: Date & Initial	Competent Return Demonstration by Orientee: Preceptor to Date & Initial	Orientee: Initial	Supervisor/Designee Competency Check Off: Date & Initial	Tier 1*
Medication Administration: RN, LPN					
Nebulizer Treatment					
Label Medications - CHS policy 3.03b					
Issue Medications Electronically					
Issue Medications with Instructions - Provide Education					
Patient Screening: RN, LPN					All 3.1 & 3.6
Health History (PH-3566)					3.3
TB Risk Assessment Tool					1.2 & 3.3
Tuberculin Skin Test Placement					
Tuberculin Skin Test Reading					1.2
Patient Visits: RN, LPN					All 3.1, 3.6, 4.3 & 6.1
STI Screening					
STI Case, Contact, S/S					
Direct Observed Therapy (TB DOT)					
TBI Medication Refill					
Pregnancy Test (Positive)					
Pregnancy Test (Negative)					
Pregnancy Presumptive TennCare					
TBCSP enrollment					
TBCSP Presumptive TennCare					
Combined Hormonal Contraception					
Progestin-Only Injectable Contraception					
Emergency Contraception Pills (ECP)					
Fluoride Varnish Application					
Problem Visit					
Primary Care: RN, LPN					
Glucometer/DM Teaching					
Patient Screening: RN (LPNs stop here. RNs continue)					
Risk Assessment Questionnaire					3.3
PEDS Score Form					
PSC-17 (PH-3732)					
Y-PSC (PH-3733)					

Skills	Demonstration by Preceptor: Date & Initial	Competent Return Demonstration by Orientee: Preceptor to Date & Initial	Orientee: Initial	Supervisor/Designee Competency Check Off: Date & Initial	Tier 1*
Adolescent Developmental/Behavioral Questionnaire (PH-3846)					
MCHAT-R/F					
Patient Visits: RN					
Family Planning Quick Start					
Physical Exam: Infant					
Physical Exam: Child					
Physical Exam: Adolescent					
Anticipatory Guidance					4.1, 5.9 & 7.1
Oral Health Assessment					
WIC - see WIC checklist					

* PHN Competency Domain

Employee's Signature, Title & Date

Preceptors' Signature, Title & Date

Supervisor's Signature, Title & Date

Nursing Supervisor Orientation Checklist

Name of Orientee

County

AREA OF ORIENTATION	Employee Initials	Regional Nursing Director/Designee Initials	Completion Date
Nursing Management			
Organizational Structure - local, regional, state			
Nursing Leadership Role and Mentoring/Coaching			
Employees - State/County/DGA			
Annual Performance Cycle - Individual performance plan, interim review, probationary, annual			
Disciplinary Action and Documentation			
Employee Assistance Program			
Appointment Profiles/Open Access			
Staffing and Scheduling			
Clinic Flow			
Standardized Orientation for New Public Health Nursing Staff			
Schedule trainings as needed			
Schedule meetings and updates as needed			
Dress Code Compliance			
Email Etiquette			
Good Catch			
Chart review			
Productivity (RVUs)			
Patient Tracking			
Monitor reports as required by region with action as needed (examples: Overdue Lab; Pap smear billing, Error reports; Tracking)			
Weekly monitoring of lab quality control logs			
Inventory Management - supplies			
Child Abuse Reporting and Recordkeeping			
Incident/Accident Reporting			
Drug Room Management - inventory and ordering			
Emergency Equipment Maintenance including crash cart, AED, PPE, O2 tank, spill kit, fire extinguishers, medications, panic button if available			
Vaccine Management - TENNIIIs, VOMS, storage and handling, data logger, Sensaphone			
Subpoenas			
Legal Issues			
Legal Role of the TDH Public Health Employee (Document)			

AREA OF ORIENTATION	Employee Initials	Regional Nursing Director/Designee Initials	Completion Date
Schools of Nursing Affiliation Agreement and Student Placement			
School Located Vaccine Clinics/Off-site Clinics			
Response to Media Requests - CHS 6.6			
Voluntary Newborn Surrender - CHS 3.11			
Primary Prevention Initiatives			
Job Application and Hiring Process			
Child Fatality Review Team			
Nurse Strike Team			
SAVE Act CHS 7.25			
LEAN projects			
Baldrige			
Emergency Preparedness/TnHAN			
Maintenance of Required Records/Licensure			
Nursing license verification			
Basic Life Support (CPR)			
Annual Requirements: Title 6; HIPAA; Child Abuse Reporting; Human Trafficking; BBP; OSHA; Hazard Communication/SDS; Fit testing; TB screening; WIC Civil Rights training			
Clinical Laboratory Improvement Amendment (CLIA) Certificates			
Lab Training Certificates			
Lab Shipping and Packaging Training			
Preventive Maintenance of Equipment (following equipment manual's instruction)			
Personnel Policies			
Attendance & Leave (including comp time)			
Family Medical Leave Act			
Employee Injured on the Job - CHS 3.4			
Travel (County and State)			
Affirmative Action/EEO			
No Smoking			
Dress Code			
Cell Phone			
Inclement Weather			
Social Media			
State of TN Code of Conduct			
Personnel Files - CHS 3.9			
Occupational Health			
TB Risk Assessment/Screening/Testing			
Medical Questionnaire and Fit Testing			
Immunization/Immunity Status - Hep B, Varicella, MMR, Tdap			
Flu Declination			
Post Exposure Prophylaxis			

AREA OF ORIENTATION	Employee Initials	Regional Nursing Director/Designee Initials	Completion Date
Training			
Edison (leave, travel, time approval)			
Navigating Practices and Policies for Supervisors and Managers (Edison)			
Proactive On-Boarding (Edison)			
HIPAA Privacy Training (Edison)			
Performance Management (Edison)			
SMART training			
SMARTer training			
Respectful Workplace for Managers			
Interviewing Practices for Management			
ICS 800			
ICS 300			
Manuals & Resources - Update and Communicate Changes			
Public Health Nursing Orientation & Practice Manual			
Public Health Nursing Protocol Manual			
Policies and Procedures Manual (CHS, HSA)			
TDH Billing and Codes Manual			
Quality Improvement Manual			
Directory of Laboratory Services			
Lab Policies and Procedures Manual			
Infection Control Manual - Exposure Control Plan			
Hazard Communication Plan - Safety Data Sheets			
Respiratory Protection Plan			
TB Elimination Manual			
TBCSP Manual			
Family Planning Clinical Guidelines			
TennCare Presumptive Eligibility Desk Guide			
Primary Care Services Guidelines			
HUGS Program Guidelines			
CSS Manual			
WIC Manual			
Safety Procedures, Codes, Drills and Emergency Plans			
Review of Programs and Services			
Family Health and Wellness			
Communicable and Environmental Disease and Emergency Preparedness			
Laboratory Services			
Primary Care			
Community Development - TennCare Kids; Health Promotion; Workplace Wellness			
Dental Services			
Quality Improvement - Improvement Plans			
Fiscal Services - billing			
Environmental Services			

AREA OF ORIENTATION	Employee Initials	Regional Nursing Director/Designee Initials	Completion Date
Local Discipline Introductions			
Public Health Office Supervisor (PHOS)			
Nutritionist			
Environmentalist			
Home Visiting Programs (CSS, HUGS, CHAD, Welcome Baby)			
Health Educator			
Breastfeeding Peer Counselor			
Disease Intervention Specialist (DIS), Public Health Representatives, CEDS/CDC Nurse			
Local clinic staff			
Local Director Conference			
Roles/Relationships			
Budget Process (Preparation, Local Direct, Purchasing)			
Internal Audit			
County Health Assessment			
Health Council			
Board of Health			
Coordinated School Health			
County Government Personnel			
Community Leaders as appropriate			
Office Management/Other:			
Services			
TennCare Presumptive Eligibility			
Paternity			
Records Management (Central Filing, Release of Medical & Immunization Information) - CHS 5.1			
Confidentiality: Access to Records (Personnel, Patient, Guardian) - CHS 5.2			
Record Retention/Destruction - CHS 5.3			
PTBMIS			
Appointment System/Open Access			
Vital Records - CHS 5.5			

Employee's Signature & Date

Regional Nursing Director's Signature & Date

Regional Nursing Director Orientation Checklist

Name of Orientee

Region

AREA OF ORIENTATION	Employee Initials	Supervisor/ Designee Initials	Completion Date
Nursing Management			
Organizational Structure - local, regional, state			
Central Office Contacts			
Setting Regional Priorities			
Regional Director			
Nursing Supervisor Communication			
Nursing Supervisor Meetings			
Team Building			
Program Updates			
PHN Protocol Maintenance			
Practice Committee			
Staff Training and Resource Team (STaRT)			
Nursing Leadership Team			
Quarterly Meetings			
Monthly Conference Calls			
Other Statewide Committee Participation			
Primary Prevention Initiatives (PPI)			
County Health Assessments			
Lean Project Management			
Baldrige			
Nursing Issues			
Roles and Relationships			
Job Description for Nursing Director			
Job Description for Other Nursing Employees			
Job Application and Hiring Process			
Annual Performance Cycle - Individual performance plan, interim review, probationary, annual			
Nursing Profiles			
Exit Interviews			
Tennessee Board of Nursing Rules & Regulations			
Employee Health - Immunizations; TB risk; Post-Exposure Prophylaxis			
New Employee Orientation			
Required Training			
Required Inservices			
Lab Training - scheduling			
Physical Assessment Course - scheduling			

AREA OF ORIENTATION	Employee Initials	Supervisor/ Designee Initials	Completion Date
Safety Procedures, Codes, Drills and Emergency Plans			
Legal Role of the Public Health Employee Document			
OSHA Guidelines			
Red Book - Report of the Committee on Infectious Diseases - American Academy of Pediatrics			
Pink Book - Epidemiology and Prevention of Vaccine Preventable Diseases			
Vaccine Tool Kit			
TDH Vaccine Temp Monitoring and Excursion Guidelines			
Bright Futures			
ICD 10			
CPT			
Training to be Scheduled			
Performance Management			
Computer Training (as appropriate/ available)			
Regional/ Central Program Conferences			
Communicable Environmental Disease Emergency Preparedness - CEDEP - (TB, STD, HIV, Hep B, Surveillance, Outbreak Investigation)			
Family Health and Wellness			
Children's Special Services			
Nutrition, WIC, Breastfeeding			
Primary Care			
Emergency Preparedness			
Community Development			
Quality Improvement/ Improvement Plans			
Staff Development			
Pharmacy			
Dental			
Environmental -			
Regional Discipline Conferences			
Regional Health Officer			
Administrative Support Director			
Systems Administrator/IT			

AREA OF ORIENTATION	Employee Initials	Supervisor/ Designee Initials	Completion Date
CEDEP Director (Comm/ Environmental Disease and Emerg. Prep.)			
Family Health and Wellness Director			
QI Director			
Assessment & Planning Coordinator			
Purchasing/ Supplies			
Office Management/Other:			
Records Management (Central Filing, Release of Medical & Immunization Information) - CHS 5.1			
Confidentiality: Access to Records (Personnel, Patient, Guardian) - CHS 5.2			
Record Retention/Destruction - CHS 5.3			
PTBMIS			
RVU/ Coding			
Patient Tracking			
Lab Control Logs			
Reference and State Lab			
Pharmacy Inventory and Maintenance			
Vaccine Inventory and Maintenance			
Community Introductions			
Regional Board of Health Members			
Community Health Councils			
Physicians as appropriate			
Hospitals - Director of Nursing			
Department of Human Services and Dept. of Children's Services			
Community Leaders			
Schools of Nursing - Deans and Instructors			
Department of Mental Health			
American Red Cross			
Local School System			

Employee's Signature & Date

Supervisor's Signature & Date

NURSING DISCIPLINE - APN Individual Procedure Checklist

Name of orientee _____

County _____

Evaluation time period _____

Self Rating: how well prepared the APN orientee feels capable of functioning in the following areas – proficient or non-proficient

Observation/Check-off for non-proficient: APN orientee demonstrated competency in specified task

PROCEDURE	DATE	SELF RATING	DATE	OBSERVATION/ CHECK OFF (AS RECOMMENDED)*
<i>Patient Screening:</i>				
Blood Pressure				
Temp, Pulse & Respiration				
Weight				
BMI compute and plot				
Height: Standing				
<i>Vision Screening:</i>				
Snellen Chart				
Red/Green Color Chart				
Hearing screening: Audioscope				
Developmental Screening forms				
EKG				
<i>Laboratory:</i>				
Capillary stick & collection (for Hgb, glucose,PT.INR)				
Urinalysis/microalbumin (dipstick)				
Pregnancy Test				
Hemocult/stool				
Venipuncture				
Genprobe collection (endocervical, oral, rectal)				
Throat culture/RSS				
<i>Medication Administration:</i>				
5 R's				
Intradermal injection				
Intramuscular injection				
Subcutaneous injection				
Fluoride Varnish Application				

*Observation/check-off will be based on APN's self rating

Orientee

Preceptor

Base Supervisor

Date

WIC Orientation Checklist

Name of Orientee

County

AREA OF ORIENTATION	Employee Initials	Completed By: Initials	Completion Date
Register for:			
PTBMIS access number			
Auto Growth Chart access number and password			
WIC E-learning			
An account on WIC Works-Learning Online-will set own password (http://wicworks.nal.usda.gov/wic-learning-online)			
Read/Review			
WIC Manual			
WIC record sheets and questionnaires			
WIC food lists			
TN WIC Program Formulary			
VENA Skills Checklist			
Food packages with status			
Certification Codes			
WIC Code Sheet 1 - Food Package and Voucher Codes			
WIC Code Sheet 2 - Formula Codes			
Encounter - complete front & back			
Approved WIC abbreviations			
PTBMIS - DWICQ			
Transfer documentation/VOC data			
Procedures for Lost, Stolen, Destroyed FI/CVV			
Farmers Market			
Formula Inventory - electronic logs			
SMART Goals			
Stages of Change			
Therapeutic Formulas - coding, documentation			
Regional Process for Therapeutics			
Low Risk vs. High Risk			
WIC Online Education			
Nutrition Education Topics (age appropriate feeding practices, food safety, etc.)			
Approved handouts & locations in clinic			
Locate and Review Forms			
WIC Health Care Provider Communication Tool			
WIC Program Referral Form PH-3151			
WIC Medical Request for Formula/Foods, Request for Alternate Contract Formula PH-4234			
Request for WIC Therapeutic Products and Supplemental Foods PH-4077			

AREA OF ORIENTATION	Employee Initials	Completed By: Initials	Completion Date
WIC Qualifying Conditions for Issuing Therapeutic Formula or Nutritionals			
Therapeutic Formula Assessment Tool			
WIC Complementary Foods Order Form			
WIC Breast Pump Release Form PH-3817			
WIC Formula Log and BF Aids Signature Labels			
Complete E-Learning Modules			
Civil Rights			
Food Allergy			
Certification			
Food Packages			
Complete E-Learning Skills Checklists			
Food Package Infant			
Food Package Child			
Food Package Woman			
Therapeutic Food Package			
WIC Works Learning Online (http://wicworks.nal.usda.gov/wic-learning-online)			
WIC 101			
Interpersonal Communication: Listening Skills			
WIC Baby Behavior Basics			
Feeding Infants: Nourishing Attitudes and Techniques			
Value Enhanced Nutrition Assessment (VENA)			
Communicating with Participants			
WIC Breastfeeding Basics			
Breastfeeding			
Grow & Glow Modules 1-6			
Grow & Glow Modules 7-10			
Role & Identity of CPAs and BF Support Staff (RN, RD, Nutrition Educator, BFPC, DBE)			
Approved BF handouts & BF resources			
Status differences, changes, documentation			
Locate BF Education tools and discuss reasons/methods for use (dolls, breast models, etc)			
Locate BF Aids & Breast Pumps - discuss proper use, eligibility and process for issuing			
Documentation & Coding for BF Aids and Breast Pump Issuance			

AREA OF ORIENTATION	Employee Initials	Completed By: Initials	Completion Date
Electronic Inventory of BF Aids and Breast Pumps			
Page 2 of prenatal and postpartum record			
Skills with appropriate counseling, documentation & coding as indicated			
Prenatal Certification			
Postpartum Certification			
Breastfeeding Certification			
Infant Certification			
Child Certification			
Mid-certification			
Nutrition Education Visit			
AGC entry			
Graphing measures of a premature infant			
Issuing BF Aids			
Issuing a Loaner Pump			
Issuing a Manual Pump			
Using Electronic Inventory (formula, pumps, aids)			
Tailoring a food package			
Issuing Therapeutics			
Other			
Follow WIC participant thru HD visit (check-in to check-out)			
Complete VENA skills checklist			

Employee's Signature & Date

Signature, Title & Date

Signature, Title & Date

Signature, Title & Date

INSTRUCTIONS FOR ORIENTATION CHECKLISTS

1. **Public Health Nursing Orientation Checklist** – includes items to be completed at the employee's base site as well as items which may be completed at the Regional Office and preceptor site. This checklist should be used for all new nursing employees (APN, RN, LPN, NA). The goal for completion of this checklist is by the end of the employee's orientation period. Some training may not be available during the orientation period, but should be completed by the end of the probationary period.

Column 1 "*Employee Initials*" - the employee initials when the task is completed.

Column 2 "*Completed By: Initials*" and Column 3 "*Completion Date*" - the local or regional employee who provides the information or works with the new employee to complete the task initials and dates.

Column 4 "*PHN Competencies Tier 1*" – requires no response or input. These designate the PHN competency from the document "Quad Council Competencies for Public Health Nurses" that corresponds to completion of the task.

The last page of the checklist includes signature lines for the new employee as well as anyone who may have initialed the checklist.

Although not required to sign off on every item, responsibility for ensuring completion lies with the employee's immediate supervisor.

2. **Skills Orientation Checklist – RN, LPN, NA** – includes skills to be demonstrated to the new nursing employee who then must competently perform those skills in the presence of the preceptor or other designated RN. The goal for completion of the checklist is by the end of the employee's probationary period. It is recognized that some skills are performed infrequently and the employee may not be checked off during this time period.

Column 1 "*Demonstration by Preceptor: Initial & Date*" - record the date of initial demonstration of a skill by the preceptor or designated RN and the initials of the nurse who provided the demonstration of the skill.

Column 2 "*Competent Return Demonstration by Orientee: Preceptor to Date & Initial*" - record the date the employee **competently** performs the skill in the presence of the preceptor or other designated RN. (Please note that competent performance of the skill is the criteria for this date; in some cases this may be the 1st time the skill is performed and in other cases the skill may be performed multiple times before the new nurse is determined competent to perform the skill alone).

Column 3 *“Orienteer Initial”* - the new nurse will initial when signed off as competent.

Column 4 *“Supervisor/Designee Competency Check Off: Date & Initial”* - is an optional check off. Once orientation is complete and the new nurse returns to his or her base assignment, the local nursing supervisor or designee may choose to observe and sign off on any or all skills listed. This last skills competency check off may be a local or regional decision.

Column 5 *“PHN Competencies Tier 1”* – requires no response or input. These designate the PHN competency from the document *“Quad Council Competencies for Public Health Nurses”* that corresponds to completion of the task.

The last page of the checklist includes signature lines for the new employee, anyone who may have initialed the checklist, and the new employee’s supervisor.

Although not required to sign off on every item, responsibility for ensuring completion lies with the employee’s immediate supervisor.

3. **WIC Orientation Checklist** – includes skills/information/training for the new nurse who will be working with WIC patients and may function as a Competent Professional Authority (CPA). The provision of this orientation component is determined by each region and may be by staff development, a local nurse preceptor, Regional Nutrition Director, local nutrition employee or other designee.

Each column of this checklist is self-explanatory.

The last page of the checklist includes signature lines for the new employee as well as anyone who may have initialed the checklist.

Although not required to sign off on every item, responsibility for ensuring completion lies with the employee’s immediate supervisor.

4. **Nursing Discipline – APN Individual Procedure Checklist** – the new APN rates his or her skills as proficient or non- proficient. Any skill rated as non-proficient requires observation and check off by the preceptor or designee. The goal for completion of this checklist is by the end of the employee’s orientation period.

Columns 1 & 2 *“Date and Self Rating”* are completed by the new APN.

Columns 3 & 4 *“Date and Observation/Check off (as recommended)”* -completed by preceptor or designee who teaches and observes APN competently perform any task rated non-proficient by on the self- rating.

This form includes signature lines for the new employee, the preceptor or designee, and the base supervisor.

Although not required to sign off on every item, responsibility for ensuring completion lies with the employee's immediate supervisor.

5. ***Nursing Supervisor Orientation Checklist*** – is completed by the Regional Nursing Director or designee. The goal for completion of this checklist is by the end of the employee's orientation period.

Each column of this checklist is self-explanatory.

The last page of the checklist includes signature lines for the new employee and the Regional Nursing Director. Additional signatures may be added for items completed by the Regional Nursing Director designee(s).

Although not required to sign off on every item, responsibility for ensuring completion lies with the employee's immediate supervisor.

6. ***Regional Nursing Director Orientation Checklist*** – is completed by the State Nursing Director or designee. The goal for completion of this checklist is by the end of the employee's orientation period.

Each column of this checklist is self-explanatory.

The last page of the checklist includes signature lines for the employee and the employee's supervisor. Additional signatures may be added for items completed by the supervisor's designee(s).

Although not required to sign off on every item, responsibility for ensuring completion lies with the employee's immediate supervisor.

All checklists are to be maintained in employee files per Regional Policy.

Regional decisions may be made to ADD items to the checklists, however items should not be removed from checklists. If items are not applicable in a region please designate "N/A".

ADDITIONAL FORMS

Public Health Nursing Evaluation of Orientee's Performance

Orientation Communication Tool (optional)

Nursing Profile Data Form

09/14

First Name		Last Name		Middle	
Birth Year	Home Phone ()	()		Work Phone	()
RACE Circle only one number					
1 White		2 Black		3 Hispanic	
4 Native American		5 Asian		6 Black & Hispanic	
7 Other Hispanic		9 All Other		0 Unknown	
Official Work Station you must enter county even if located in region					
County Number _____ (see other side of this page)					
Region: Circle only one Number:					
1 East 1 (Northeast)		6 Middle 6 (South Central)		11 Knox	
2 East 2 (East)		7 West 7 (North West)		12 Hamilton	
3 Central 3 (South East)		8 West 8 (South West)		13 Madison	
4 Central 4 (Upper Cumberland)		9 Shelby		14 Sullivan	
5 Middle 5 (Mid-Cumberland)		10 Davidson		20 Central Office	
BASE - Usually where mail is received - Circle one number					
1 County		3 Central Office			
2 Region					
Personnel - Circle one Class Number					
0 None		4 LPN-2		8 RN-3	
12 NC-1		16 "DIR RN"		20 OTHER	
1 NA-1		5 LPN-3		9 RN-4	
13 CON-1		17 PROG-1		21 FEDERAL	
2 NA-2		6 RN-1		10 RN-5	
14 CON-2		18 PROG-2		22 RN-ES	
3 LPN-1		7 RN- 2		11 NP-1	
15 "ASST DIR"		19 PROG-3			
Basic Nursing Education Number - Circle One Number					
0 NONE		2 ASSOCIATE		4 BSN	
6 OTHER		1 LPN		3 DIPLOMA	
5 MSN					
Other Formal Education Number - Circle One Number					
0 NONE		3 BSN OTHER		6 MS OTHER	
1 CERTIFICATE PROG.		4 MPA		7 MPH	
2 MSN		5 MBA		8 PHD	
Are You Certified? YES or NO					
Circle Certifying Body:					
1 ANA		3 NAACOG		5 ANCC	
2 ACNM		4 NAPNAP		6 OTHER	
Circle Area of Certification					
1 FNP		5 COMMUNITY NURSING		9 SCHOOL HEALTH NURS	
13 PSYCH/ MH NURSING		2 FP		6 PEDIATRIC NURSING	
10 NURSE MIDWIFERY		3 OB/GYN		7 PERINATAL NURSING	
11 NURSING ADMIN		4 GENERAL NURSING		8 HOME HEALTH NURSING	
12 NURSING ADMIN ADV					
Circle One Letter: You Are Certified to Write Rx's?				YES NO	
Circle One Number: Employment Status					
1 FULL		2 PART		3 SHARED	
4 CONTRACT					
Employer Number - Circle One:					
1 STATE		3 CITY		5 FEDERAL	
7 UNKNOWN		2 COUNTY		4 CONTRACT	
6 OTHER					
Hire Date ____/____/____ (mm/dd/yy)		Orientation Date ____/____/____		Orientation completion date ____/____/____	
Circle One - Is This A Termination? Y N Exit Interview Date ____/____/____					
DATE OF TERMINATION:			REASON FOR TERMINATION:		

Codes

1	ANDERSON	55	MCNAIRY
2	BEDFORD	56	MACON
3	BENTON	57	MADISON
4	BLEDSON	58	MARION
5	BLOUNT	59	MARSHALL
6	BRADLEY	60	MAURY
7	CAMPBELL	61	MEIGS
8	CANNON	62	MONROE
9	CARROLL	63	MONTGOMERY
10	CARTER	64	MOORE
11	CHEATHAM	65	MORGAN
12	CHESTER	66	OBION
13	CLAIBORNE	67	OVERTON
14	CLAY	68	PERRY
15	COCKE	69	PICKETT
16	COFFEE	70	POLK
17	CROCKETT	71	PUTNAM
18	CUMBERLAND	72	RHEA
19	DAVIDSON	73	ROANE
20	DECATUR	74	ROBERTSON
21	DEKALB	75	RUTHERFORD
22	DICKSON	76	SCOTT
23	DYER	77	SEQUATCHIE
24	FAYETTE	78	SEVIER
25	FENTRESS	79	SHELBY
26	FRANKLIN	80	SMITH
27	GIBSON	81	STEWART
28	GILES	82	SULLIVAN
29	GRAINGER	83	SUMNER
30	GREENE	84	TIPTON
31	GRUNDY	85	TROUSDALE
32	HAMBLEN	86	UNICOI
33	HAMILTON	87	UNION
34	HANCOCK	88	"VAN BUREN"
35	HARDEMAN	89	WARREN
36	HARDIN	90	WASHINGTON
37	HAWKINS	91	WAYNE
38	HAYWOOD	92	WEAKLEY
39	HENDERSON	93	WHITE
40	HENRY	94	WILLIAMSON
41	HICKMAN	95	WILSON
42	HOUSTON		
43	HUMPHREYS		
44	JACKSON		
45	JEFFERSON		
46	JOHNSON		
47	KNOX		
48	LAKE		
49	LAUDERDALE		
50	LAWRENCE		
51	LEWIS		
52	LINCOLN		
53	LOUDON		
54	MCMINN		

TERMINATION CODES:

1. TO RETIRE	13. DISABILITY RETIRE
2. NO NEED TO WORK	14. HEALTH REASON
3. BETTER SALARY	15. JOB CHANGE
4. TOO MUCH PAPERWORK	16. JOB DISATISFACT
5. GO BACK TO SCHOOL	17. UNKNOWN
6. GET BETTER SUPERVISOR	
7. MOVING OUT OF AREA	
8. NONE OF YOUR BUSINESS	
9. TO STAY HOME	
10. LAY OFF	
11. DEATH	
12. DISMISSAL	

APPENDIX F

Orientation Modules and Resources

Introduction to Public Health Nursing Module

(Adapt to Discipline: NA, LPN, RN, APN)

Regional and Local Health Department Orientation

Objectives:

- Discuss the Mission, Vision, Values and Core Functions of TDH
- Discuss the history, philosophy and legal aspects of public health nursing
- Identify Public Health Programs and Services
- Explain the role and scope of practice for public health nursing personnel including PHN competencies
- Describe the relationship between the local health department and the Community Health Council, county health assessment, and county/ regional drive report

References/ Resources

- Quad Council Competencies for Public Health Nurses
- Public Health Nursing: Scope and Standards of Practice 2nd Edition (2013)
- Tennessee Codes Annotated
- TN.GOV
- Tennessee Board of Nursing Rules and Regulations
- Tennessee Nurse Practice Act
- Public Health Nursing Orientation and Practice Manual
- Drive Your County to the Top Ten <http://www.tn.gov/health/topic/specialreports>

Family Planning/ Women's Health Module

(Adapt to Discipline: NA, LPN, RN, APN)

Objectives:

- Identify family planning and women's health program services
- Understand TN Breast and Cervical Program Services
- Demonstrate competency in providing family planning services according to PHN protocol and Family Planning Clinical Guidelines (Title X)
- Complete Skills Checklist related to module

Topics:

- PHN FP protocols
- FP Guidelines
- BCS Manual
- Components of FP/ WH/ BCS visits
- Natural Family Planning
- Presumptive Eligibility
- Coding
- Documentation
- Services for minors – legal aspects
- Referrals
- Tracking
- Summary Chart of U. S. Medical Eligibility Criteria for Contraceptive Use

Resources/ Resources

PHN Orientation Manual

Laboratory Policy and Procedure Manual

PHN Protocol

QI Manual

TBCSP Manual

Contraceptive Technology Web site

Office of Population Affairs

<http://www.hhs.gov/opa/reproductive-health/>

Title X of the Public Health Service Act

UpToDate

Presumptive Eligibility Desk Guide

A Pocket Guide to Managing Contraception

Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs – MMWR April 25. 2014

Child Health Module

(Adapt to Discipline: NA, LPN, RN, APN)

Objectives:

- State and perform components of EPSDT/ child health/ school examinations
- Identify Family Health and Wellness programs and make appropriate referrals
- Explain and utilize Bright Futures Recommendations for Preventive Pediatric Health Care
- Discuss the process for Newborn Screening and Sickle Cell/ Hemoglobinopathy
- Review current TDH/ DCS Agreement for EPSDT
- Review additional child health services – ex. pediculosis, anemia, thrush
- Identify target populations for oral health assessment/ fluoride varnish application
- Complete Skills Checklist related to module

Topics:

- 7 components of EPSDT/ child health examinations
- Sports physicals – region specific
- Coding
- Documentation
- PCP letter for physical exams
- Referrals
- TDH/ DCS Agreement
- CSS/ HUGS/CHAD

Resources:

PHN Orientation Manual

PHN Protocol

QI Manual

Web sites:

Newborn Screening <http://www.tn.gov/health/article/MCH-nbs-providers>

Lead Program <http://www.tn.gov/health/topic/MCH-lead>

CDC Learn the Signs. Act Early. <http://www.cdc.gov/ncbddd/actearly/>

<http://tnap.org/pdf/coding/2015%20EPSDT%20Manual%2007-15-15.pdf>

<https://www.kidcentraltn.com/>

<https://brightfutures.aap.org/materials-and-tools/PerfPrevServ/Pages/default.aspx> (click cancel if windows security pop up box appears, website will then open)

Red Book

Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents

PHN Orientation & Practice Manual

August 2016

Communicable and Environmental Disease and Emergency Preparedness Module

(Adapt to Discipline: NA, LPN, RN, APN)

Objectives:

- Discuss STI/ HIV guidelines for screening, treatment, education and contact investigation.
- Discuss TB guidelines for screening, treatment, education and contact investigation.
- Identify appropriate actions for communicable disease outbreaks.
- Understand the role of the PHN in Emergency Preparedness.

Topics:

- Reportable diseases – process of notification
- Sexually transmitted infections
- HIV – legal aspects, Ryan White Program
- TB
- Documentation
- Coding
- Legal Issues
- Perinatal Hep. B
- DOT/ Respiratory Protection
- TB skin test vs IGRA
- Partner Delivered Therapy
- Emergency Preparedness – TnHAN, Strike Team, PODS, Sheltering

Resources:

PHN Orientation & Practice Manual

PHN Protocol

QI Manual

Respiratory Protection Plan

Red Book

APHN Position Paper

http://www.achne.org/files/public/APHN_RoleOfPHNinDisasterPRR_FINALJan14.pdf

Current Sexually Transmitted Disease (STD) Treatment Guidelines

TB Guidelines

<http://www.cdc.gov/std/life-stages-populations/adolescents-YoungAdults.htm>

Primary Care Module

(Adapt to Discipline: NA, LPN, RN, APN)

Objectives:

- Discuss the role of the PHN in the primary care clinic
- Identify primary care sites within the region
- Understand eligibility criteria for primary care clinic.

Topics:

- Patient Assistance Programs (PAP)
- Regional afterhours call plan
- Clinic flow and roles of staff members
- Issuing medication
- Case management and tracking
- Referral procedures
- Coding
- Documentation
- Laboratory services – contracted labs, billing appropriate account, requisitions,

Resources:

PHN Orientation & Practice Manual

PHN Protocol

QI Manual

Primary Care Guidelines

Ferri's Clinical Advisor

Up-To-Date

ICD-10 International Classification of Diseases, 10th Edition

Needymeds.org

Immunizations Module

(Adapt to Discipline: NA, LPN, RN, APN)

Objectives:

- Understand the current adult and child immunization schedule including the catch up schedules
- Discuss vaccine preventable diseases
- Demonstrate ability to assess immunization status, determine needs and administering per PHN protocol

Topics:

- Promoting vaccination – talking with parents
- Adverse reactions – VAERS
- Appropriate administration techniques
- TennIIS
- Vaccine funding and eligibility – VFC, 317 and State purchase
- Coding
- Documentation
- Pt post exposure prophylaxis
- Minimum intervals for vaccines
- School/ Daycare requirements/ certificates
- Vaccine Information Statement (VIS)

Resources:

PHN Orientation & Practice Manual

PHN Protocol

<http://www.immunize.org/>

Epidemiology of Vaccine Preventable Diseases (Pink Book)

1-800 CDC INFO (1-800 -232-4636)

Advisory Committee on Immunization Practices

CDC.gov <http://www.cdc.gov/vaccines/ed/courses.html>

<http://eziz.org/>

WIC Module

(Adapt to Discipline: NA, LPN, RN, APN)

Objectives:

- Discuss the role of the CPA (Competent Professional Authority) – RN, RD, Nutrition Educator
- Understand certification process and nutrition education requirements
- Identify eligible WIC participants
- Understand breastfeeding promotion and education
- Utilize WIC Training Plan for RNs Checklist

Topics:

- Value Enhanced Nutrition Assessment
- Certified Lactation Counselor
- Designated Breastfeeding Expert
- Breastfeeding peer counselor
- Coding
- Documentation

Resources:

PHN Orientation & Practice Manual
PHN Protocol
WIC Manual
WIC E-Learning
WIC Works
Glow & Grow Modules

Required Annual Training

- Title VI
- HIPAA
- Family Planning Annual Training including:
 - Child Abuse Reporting
 - Human Trafficking
 - Cultural Competency
- Hazardous Communication
- OSHA Bloodborne Pathogens
- WIC Civil Rights Training

Required Bi-Annual Training

- BLS for Healthcare Providers
- Lab Packaging and Shipping Category B

HELPFUL WEBSITES

Edison – https://sso.edison.tn.gov/psp/paprd/EMPLOYEE/EMPL/h/?tab=PAPP_GUEST

Outlook (email) – type mail.tn.gov in browser address bar or <https://mail.tn.gov/owa/>

TN Health alert network - <https://tnhan.tn.gov>

Dept of Health intranet – <https://intranet.health.tn.gov/intranet/>

CDC home page - www.cdc.gov

CDC immunization home page - www.cdc.gov/vaccines

State of TN home page - www.tn.gov

Tennessee Dept of Health home page – <https://www.tn.gov/health>

Immunization Action Coalition - www.immunize.org

<http://hsaintranet.health.tn.gov/Login.asp> - to access online PHN Protocol manual, CHS policy manual, WIC, Home visiting manuals

<http://eziz.org/eziz-training/>

<http://www.cdc.gov/vaccines/ed/youcalltheshots.html>

https://www.surveymonkey.com/r/stool_collection

<https://nppes.cms.hhs.gov/NPPES/Welcome.do> - to apply for NPI number

<https://www.dhs.wisconsin.gov/wicpro/training/grow-and-glow.htm> - WIC Grow and Glow Training

<http://www.surveygizmo.com/s3/2878958/Run-Hide-Fight-Training>

<http://www.cdc.gov/tb/>

APPENDIX G

Evaluation Tools

Orientation Communication Tool

Date: 34T

Orientee Name and Position:

Training Site:

Strengths:

Areas of Improvement:

Action Plan:

Person(s) responsible for follow up:

Orientee

Staff Development

Preceptor

Nursing Supervisor

Follow-up of action plan

Date: 34T

Comment:

**PUBLIC HEALTH NURSING
EVALUATION OF ORIENTEE'S PERFORMANCE**

This form is to be used when evaluating the orientee's performance at the end of orientation. Both the orientee and the preceptor may write comments.

Rating Scale: **3 – Satisfactory**
 2 – Needs Improvement
 1 – Unsatisfactory
 N/A – Not Applicable

NAME OF ORIENTEE	COUNTY	ORIENTATION TIME PERIOD
PHN CORE COMPETENCIES	RATING	COMMENTS
Analytic & Assessment Skills		
Identifies Public Health programs and services		
Identifies individual/family health needs		
Describes Family Health and Wellness programs and makes appropriate referrals		
Utilizes technical skills for collecting and analyzing data		
Identifies appropriate actions for communicable disease outbreaks		
Assesses eligibility criteria for primary care clinic		
Identifies current adult and child immunization needs		
Assesses eligibility criteria for WIC participants		
Development/Program Planning Skills		
Demonstrates ability to set goals		
Demonstrates ability to contract on mutually agreed upon goals with client		
Revises plan when indicated		
Communication Skills		
Utilizes therapeutic communication		
Provides appropriate education both written and verbal		
Demonstrates counseling skills		
Documents accurately, promptly, completely, and legibly		
Uses approved abbreviations		
Utilizes SOAP format		
Utilizes interpreting services appropriately when indicated		
Maintains constructive communication with coworkers and supervisors		
Maintains confidentiality		
Cultural Competency Skills		
Accepts individual differences		
Adapts care based on cultural needs and differences		

Public Health Nursing Evaluation of Orientee's Performance (Continued)

Community Dimensions of Practice Skills		
Identifies community partners and understands appropriate referrals		
Recognizes TDH/DCS agreement for EPSDT		
Understands Primary Prevention Initiatives		
Identifies target populations for community based referrals		
Public Health Sciences Skills		
Understands the history, philosophy, and legal aspects of Public Health Nursing		
Recognizes the Mission, Vision, Values, and Core Functions of TDH		
Financial and Management Skills		
Demonstrates appropriate coding		
Understands vaccine funding and eligibility		
Adheres to PHN protocol		
Identifies appropriate laboratory services		
Leadership and System Thinking Skills		
Demonstrates effective utilization of work time		
Demonstrates adaptability and flexibility		
Demonstrates promptness and reliability		
Seeks learning opportunities		
Demonstrates professional behavior/actions		
Adheres to dress code		
Collaborates effectively with multidisciplinary team		

ADDITIONAL COMMENTS:

Submit to Base Supervisor after completion

Orientee

Preceptor

Supervisor

Date

NURSING ASSISTANT Evaluation of Orientee's Performance

This form is to be used when evaluating the orientee's performance. Both the orientee and the evaluator may write comments. When indicated, the plan of action and plan for follow-up is to be included.

NAME OF ORIENTEE	COUNTY	ORIENTATION TIME PERIOD		
NURSING CARE/SERVICE	SATIS.	NEEDS IMPROV.	COMMENTS	
Performs tasks as assigned under direct nursing supervision:				
Teaching				
Technical skills				
Documentation				
Prompt recording on appropriate records				
Accurate, factual, complete, legible, applicable info.				
Working relationships with individuals, health care providers, groups, organizations & Agencies within the Community:				
Accepts Individual Differences				
Observes Confidentiality				
Maintains Constructive Communication				
Collaborates Effectively				
Recognizes Individual Rights				

QUALITIES CONTRIBUTING TO EFFECTIVENESS	SATIS.	NEEDS IMPROV.	COMMENTS	
Communication Skills				
Participation as a Team Member Within Agency				
Concern for Overall Objectives of Agency				
Willingness to Accept and Share Responsibility				
Initiative				
Adaptability and Flexibility				
Promptness and Attendance				
Maximum Utilization of Work Time				
Reliability				
Adherence to Dress Code				

ADDITIONAL COMMENTS:

APPENDIX H

Screening Tools

PEDS RESPONSE FORM

Provider _____

Child's Name _____ Parent's Name _____

Child's Birthday _____ Child's Age _____ Today's Date _____

Please list any concerns about your child's learning, development, and behavior.

Do you have any concerns about how your child talks and makes speech sounds?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child understands what you say?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her hands and fingers to do things?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her arms and legs?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child behaves?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child gets along with others?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning to do things for himself/herself?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning preschool or school skills?

Circle one: No Yes A little COMMENTS:

Please list any other concerns.

Child's Name _____

Birthdate _____

Specific Decisions

PEDS INTERPRETATION FORM

Path A: Two or more predictive concerns?

Yes?

Two or more concerns about self-help, social, school, or receptive language skills?

Yes?

Refer for audiological and speech-language testing. Use professional judgment to decide if referrals are also needed for social work, occupational/physical therapy, mental health services, etc.

4-5 mos _____

6-11 mos _____

No?

Refer for intellectual and educational evaluations. Use professional judgment to decide if speech-language, audiological, or other evaluations are also needed.

12-14 mos _____

15-17 mos _____

Path B: One predictive concern?

Yes?

Health concerns only?

Screen for health/sensory problems, consider second-stage developmental screen.

If screen is passed, counsel in areas of concern and watch vigilantly.

18-23 mos _____

2 yrs _____

Administer second-stage developmental screen.

If screen is failed, refer for testing in area(s) of difficulty.

3 yrs _____

Path C: Nonpredictive concerns?

Yes?

Counsel in areas of difficulty and follow up in several weeks.

If unsuccessful, screen for emotional/behavioral problems and refer as indicated. Otherwise refer for parent training, behavioral intervention, etc. If concerns still exist at age 4 1/2 and older, refer for mental health services.

4-4 1/2 yrs _____

Path D: Parental difficulties communicating?

Yes?

Foreign language a barrier?

Use a second screen that directly elicits children's skills or refer for screening elsewhere.

4 1/2-6 yrs _____

No?

Use foreign language versions, send PEDS home in preparation for a second visit; seek a translator, or refer for screening elsewhere.

6-7 yrs _____

Path E: No concerns?

Yes?

Elicit concerns at next checkpoint.

No?

Use PEDS between checkpoints (e.g. sick- or return-visit).

7-8 yrs _____



STATE OF TENNESSEE
DEPARTMENT OF HEALTH

Pediatric Symptom Checklist 17 (PSC-17)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:	Never	Sometimes	Often
<input checked="" type="checkbox"/> Fidgety, unable to sit still	0	1	2
<input type="checkbox"/> Feels sad, unhappy	0	1	2
<input checked="" type="checkbox"/> Daydreams too much	0	1	2
<input checked="" type="checkbox"/> Refuses to share	0	1	2
<input checked="" type="checkbox"/> Does not understand other people's feelings	0	1	2
<input type="checkbox"/> Feels hopeless	0	1	2
<input checked="" type="checkbox"/> Has trouble concentrating	0	1	2
<input checked="" type="checkbox"/> Fights with other children	0	1	2
<input type="checkbox"/> Is down on him or herself	0	1	2
<input checked="" type="checkbox"/> Blames others for his or her troubles	0	1	2
<input type="checkbox"/> Seems to be having less fun	0	1	2
<input checked="" type="checkbox"/> Does not listen to rules	0	1	2
<input checked="" type="checkbox"/> Acts as if driven by a motor	0	1	2
<input checked="" type="checkbox"/> Teases others	0	1	2
<input type="checkbox"/> Worries a lot	0	1	2
<input checked="" type="checkbox"/> Takes things that do not belong to him or her	0	1	2
<input checked="" type="checkbox"/> Distracted easily	0	1	2

OFFICE USE ONLY

Total _____ Total _____ Total _____ + + _____

©1988, M. Jellinek & J.M. Murphy, Massachusetts General Hospital
17-item version created by W. Gardner & K. Kelleher



STATE OF TENNESSEE
DEPARTMENT OF HEALTH

Pediatric Symptom Checklist 17 Scoring

Instructions for Scoring

The *Pediatric Symptom Checklist-17* (PSC-17) is a psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible.

The PSC-17 consists of 17 items that are rated as “Never,” “Sometimes,” or “Often” present. A value of 0 is assigned to “Never,” 1 to “Sometimes,” and 2 to “Often”. The total score is calculated by adding together the score for each of the 17 items. Items that are left blank are simply ignored (i.e., score equals 0). If four or more items are left blank, the questionnaire is considered invalid.

A PSC-17 consists of 15 or higher suggests the presence of significant behavioral or emotional problems.

To determine what kinds of mental health problems are present, determine the 3 factor scores on the PSC:

The PSC-17 Internalizing Subscale (Cutoff 5 or more items):

1. Feels sad, unhappy
2. Feels hopeless
3. Is down on self
4. Worries a lot
5. Seems to be having less fun

The PSC-17 Attention Subscale (Cutoff 7 or more items):

6. Fidgety, unable to sit still
7. Daydreams too much
8. Distracted easily
9. Has trouble concentrating
10. Acts as if driven by a motor

The PSC-17 Externalizing Subscale (Cutoff 7 or more items):

11. Fights with other children
12. Does not listen to rules
13. Does not understand other people’s feelings
14. Teases others
15. Blames others for his/her troubles
16. Refuses to share
17. Takes things that do not belong to him/her

Tennessee Department of Health
Adolescent Developmental/Behavioral Questionnaire (19 to 21 years old)

1. What do you do for fun? Is it easy or hard for you to make friends?

2. Do you feel you'll be successful and achieve what you would like to do?

3. How do you feel about the way you look? About your weight? Do you exercise?

4. Are you going to school? Are you working? How many hours a week? How are things going at school/work?

5. Do you smoke cigarettes, chew tobacco, drink alcohol, or take drugs? How often?

6. Do you own a gun? Have you ever witnessed violence? Has anyone ever tried to harm you?

7. Have you begun having sexual intercourse? Do you use a kind of birth control? Condoms? Have you ever been pregnant?

8. How are you and your parents dealing with you living away from home or preparing to do so?



**Tennessee Department of Health
Pediatric Symptom Checklist - Youth Report (Y-PSC)**

Please mark under the heading that best fits you:

	Never	Sometimes	Often
1. Complain of aches or pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Spend more time alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Tire easily, little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Fidgety, unable to sit still.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have trouble with teacher	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Less interested in school.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Act as if driven by motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Daydream too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Distract easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are afraid of new situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Feel sad, unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Are irritable, angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Feel hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Have trouble concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Less interested in friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Fight with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Absent from school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. School grades dropping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Down on yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Visit doctor with doctor finding nothing wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Have trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Worry a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Want to be with parent more than before	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Feel that you are bad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Take unnecessary risks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Get hurt frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Seem to be having less fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Act younger than children your age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Do not listen to rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Do not show feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Do not understand other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Tease others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Blame others for your troubles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Take things that do not belong to you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Refuse to share	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pediatric Symptom Checklist

INSTRUCTIONS FOR SCORING

The Pediatric Symptom Checklist is a psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. Included here are two versions, the parent-completed version (PSC) and the youth self-report (Y-PSC). The Y-PSC can be administered to adolescents ages 11 and up.

The PSC consists of 35 items that are rated as “Never,” “Sometimes,” or “Often” present and scored 0, 1, and 2, respectively. The total score is calculated by adding together the score for each of the 35 items. For children and adolescents ages 6 through 16, a cutoff score of 28 or higher indicates psychological impairment. For children ages 4 and 5, the PSC cutoff score is 24 or higher (Little et al., 1994; Pagano et al., 1996). The cutoff score for the Y-PSC is 30 or higher. Items that are left blank are simply ignored (i.e., score equals 0). If four or more items are left blank, the questionnaire is considered invalid.

HOW TO INTERPRET THE PSC OR Y-PSC

A positive score on the PSC or Y-PSC suggests the need for further evaluation by a qualified health (e.g., M.D., R.N.) or mental health (e.g., Ph.D., L.I.C.S.W.) professional. Both false positives and false negatives occur, and only an experienced health professional should interpret a positive PSC or Y-PSC score as anything other than a suggestion that further evaluation may be helpful. Data from past studies using the PSC and Y-PSC indicate that two out of three children and adolescents who screen positive on the PSC or Y-PSC will be correctly identified as having moderate to serious impairment in psychosocial functioning. The one child or adolescent “incorrectly” identified usually has at least mild impairment, although a small percentage of children and adolescents turn out to have very little or no impairment (e.g., an adequately functioning child or adolescent of an overly anxious parent). Data on PSC and Y-PSC negative screens indicate 95 percent accuracy, which, although statistically adequate, still means that 1 out of 20 children and adolescents rated as functioning adequately may actually be impaired. The inevitability of both false-positive and false-negative screens underscores the importance of experienced clinical judgment in interpreting PSC scores. Therefore, it is especially important for parents or other laypeople who administer the form to consult with a licensed professional if their child receives a PSC or Y-PSC positive score.

For more information, visit the Web site: <http://psc.partners.org>.

REFERENCES

- Jellinek MS, Murphy JM, Little M, et al. 1999. Use of the Pediatric Symptom Checklist (PSC) to screen for psychosocial problems in pediatric primary care: A national feasibility study. *Archives of Pediatric and Adolescent Medicine* 153(3):254–260.
- Jellinek MS, Murphy JM, Robinson J, et al. 1988. Pediatric Symptom Checklist: Screening school-age children for psychosocial dysfunction. *Journal of Pediatrics* 112(2):201–209. Web site: <http://psc.partners.org>.
- Little M, Murphy JM, Jellinek MS, et al. 1994. Screening 4- and 5-year-old children for psychosocial dysfunction: A preliminary study with the Pediatric Symptom Checklist. *Journal of Developmental and Behavioral Pediatrics* 15:191–197.
- Pagano M, Murphy JM, Pedersen M, et al. 1996. Screening for psychosocial problems in 4–5 year olds during routine EPSDT examinations: Validity and reliability in a Mexican-American sample. *Clinical Pediatrics* 35(3):139–146.

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

		Never	Sometimes	Often
1. Complains of aches and pains	1	_____	_____	_____
2. Spends more time alone	2	_____	_____	_____
3. Tires easily, has little energy	3	_____	_____	_____
4. Fidgety, unable to sit still	4	_____	_____	_____
5. Has trouble with teacher	5	_____	_____	_____
6. Less interested in school	6	_____	_____	_____
7. Acts as if driven by a motor	7	_____	_____	_____
8. Daydreams too much	8	_____	_____	_____
9. Distracted easily	9	_____	_____	_____
10. Is afraid of new situations	10	_____	_____	_____
11. Feels sad, unhappy	11	_____	_____	_____
12. Is irritable, angry	12	_____	_____	_____
13. Feels hopeless	13	_____	_____	_____
14. Has trouble concentrating	14	_____	_____	_____
15. Less interested in friends	15	_____	_____	_____
16. Fights with other children	16	_____	_____	_____
17. Absent from school	17	_____	_____	_____
18. School grades dropping	18	_____	_____	_____
19. Is down on him or herself	19	_____	_____	_____
20. Visits the doctor with doctor finding nothing wrong	20	_____	_____	_____
21. Has trouble sleeping	21	_____	_____	_____
22. Worries a lot	22	_____	_____	_____
23. Wants to be with you more than before	23	_____	_____	_____
24. Feels he or she is bad	24	_____	_____	_____
25. Takes unnecessary risks	25	_____	_____	_____
26. Gets hurt frequently	26	_____	_____	_____
27. Seems to be having less fun	27	_____	_____	_____
28. Acts younger than children his or her age	28	_____	_____	_____
29. Does not listen to rules	29	_____	_____	_____
30. Does not show feelings	30	_____	_____	_____
31. Does not understand other people's feelings	31	_____	_____	_____
32. Teases others	32	_____	_____	_____
33. Blames others for his or her troubles	33	_____	_____	_____
34. Takes things that do not belong to him or her	34	_____	_____	_____
35. Refuses to share	35	_____	_____	_____

Total score _____

Does your child have any emotional or behavioral problems for which she or he needs help? () N () Y

Are there any services that you would like your child to receive for these problems? () N () Y

If yes, what services? _____

Pediatric Symptom Checklist—Youth Report (Y-PSC)

Please mark under the heading that best fits you:

		Never	Sometimes	Often
1. Complain of aches or pains	1	_____	_____	_____
2. Spend more time alone	2	_____	_____	_____
3. Tire easily, little energy	3	_____	_____	_____
4. Fidgety, unable to sit still	4	_____	_____	_____
5. Have trouble with teacher	5	_____	_____	_____
6. Less interested in school	6	_____	_____	_____
7. Act as if driven by motor	7	_____	_____	_____
8. Daydream too much	8	_____	_____	_____
9. Distract easily	9	_____	_____	_____
10. Are afraid of new situations	10	_____	_____	_____
11. Feel sad, unhappy	11	_____	_____	_____
12. Are irritable, angry	12	_____	_____	_____
13. Feel hopeless	13	_____	_____	_____
14. Have trouble concentrating	14	_____	_____	_____
15. Less interested in friends	15	_____	_____	_____
16. Fight with other children	16	_____	_____	_____
17. Absent from school	17	_____	_____	_____
18. School grades dropping	18	_____	_____	_____
19. Down on yourself	19	_____	_____	_____
20. Visit doctor with doctor finding nothing wrong	20	_____	_____	_____
21. Have trouble sleeping	21	_____	_____	_____
22. Worry a lot	22	_____	_____	_____
23. Want to be with parent more than before	23	_____	_____	_____
24. Feel that you are bad	24	_____	_____	_____
25. Take unnecessary risks	25	_____	_____	_____
26. Get hurt frequently	26	_____	_____	_____
27. Seem to be having less fun	27	_____	_____	_____
28. Act younger than children your age	28	_____	_____	_____
29. Do not listen to rules	29	_____	_____	_____
30. Do not show feelings	30	_____	_____	_____
31. Do not understand other people's feelings	31	_____	_____	_____
32. Tease others	32	_____	_____	_____
33. Blame others for your troubles	33	_____	_____	_____
34. Take things that do not belong to you	34	_____	_____	_____
35. Refuse to share	35	_____	_____	_____

Modified Checklist for Autism in Toddlers, Revised with Follow-Up
(M-CHAT-R/F)TM

Acknowledgement: We thank Joaquin Fuentes, M.D. for his work in developing the flow chart format used in this document.

For more information, please see www.mchatscreen.com
or contact Diana Robins at DianaLRobins@gmail.com

Permissions for Use of the M-CHAT-R/F™

The Modified Checklist for Autism in Toddlers, Revised with Follow-Up (M-CHAT-R/F; Robins, Fein, & Barton, 2009) is a 2-stage parent-report screening tool to assess risk for Autism Spectrum Disorder (ASD). The M-CHAT-R/F is available for free download for clinical, research, and educational purposes. Download of the M-CHAT-R/F and related material is authorized from www.mchatscreen.com.

The M-CHAT-R/F is a copyrighted instrument, and use of the M-CHAT-R/F must follow these guidelines:

- (1) Reprints/reproductions of the M-CHAT-R must include the copyright at the bottom (© 2009 Robins, Fein, & Barton). No modifications can be made to items, instructions, or item order without permission from the authors.
- (2) The M-CHAT-R must be used in its entirety. Evidence indicates that any subsets of items do not demonstrate adequate psychometric properties.
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- (4) If you are part of a medical practice, and you want to incorporate the first stage M-CHAT-R questions into your own practice's electronic medical record (EMR), you are welcome to do so. However, if you ever want to distribute your EMR page outside of your practice, please contact Diana Robins to request a licensing agreement.

Instructions for Use

The M-CHAT-R can be administered and scored as part of a well-child care visit, and also can be used by specialists or other professionals to assess risk for ASD. The primary goal of the M-CHAT-R is to maximize sensitivity, meaning to detect as many cases of ASD as possible. Therefore, there is a high false positive rate, meaning that not all children who score at risk will be diagnosed with ASD. To address this, we have developed the Follow-Up questions (M-CHAT-R/F). Users should be aware that even with the Follow-Up, a significant number of the children who screen positive on the M-CHAT-R will not be diagnosed with ASD; however, these children are at high risk for other developmental disorders or delays, and therefore, evaluation is warranted for any child who screens positive. The M-CHAT-R can be scored in less than two minutes. Scoring instructions can be downloaded from <http://www.mchatscreen.com>. Associated documents will be available for download as well.

Scoring Algorithm

For all items except 2, 5, and 12, the response "NO" indicates ASD risk; for items 2, 5, and 12, "YES" indicates ASD risk. The following algorithm maximizes psychometric properties of the M-CHAT-R:

- LOW-RISK:** Total Score is 0-2; if child is younger than 24 months, screen again after second birthday. No further action required unless surveillance indicates risk for ASD.
- MEDIUM-RISK:** Total Score is 3-7; Administer the Follow-Up (second stage of M-CHAT-R/F) to get additional information about at-risk responses. If M-CHAT-R/F score remains at 2 or higher, the child has screened positive. Action required: refer child for diagnostic evaluation and eligibility evaluation for early intervention. If score on Follow-Up is 0-1, child has screened negative. No further action required unless surveillance indicates risk for ASD. Child should be rescreened at future well-child visits.
- HIGH-RISK:** Total Score is 8-20; It is acceptable to bypass the Follow-Up and refer immediately for diagnostic evaluation and eligibility evaluation for early intervention.

M-CHAT-R™

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

- | | | |
|--|-----|----|
| 1. If you point at something across the room, does your child look at it?
(FOR EXAMPLE , if you point at a toy or an animal, does your child look at the toy or animal?) | Yes | No |
| 2. Have you ever wondered if your child might be deaf? | Yes | No |
| 3. Does your child play pretend or make-believe? (FOR EXAMPLE , pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?) | Yes | No |
| 4. Does your child like climbing on things? (FOR EXAMPLE , furniture, playground equipment, or stairs) | Yes | No |
| 5. Does your child make <u>unusual</u> finger movements near his or her eyes?
(FOR EXAMPLE , does your child wiggle his or her fingers close to his or her eyes?) | Yes | No |
| 6. Does your child point with one finger to ask for something or to get help?
(FOR EXAMPLE , pointing to a snack or toy that is out of reach) | Yes | No |
| 7. Does your child point with one finger to show you something interesting?
(FOR EXAMPLE , pointing to an airplane in the sky or a big truck in the road) | Yes | No |
| 8. Is your child interested in other children? (FOR EXAMPLE , does your child watch other children, smile at them, or go to them?) | Yes | No |
| 9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (FOR EXAMPLE , showing you a flower, a stuffed animal, or a toy truck) | Yes | No |
| 10. Does your child respond when you call his or her name? (FOR EXAMPLE , does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?) | Yes | No |
| 11. When you smile at your child, does he or she smile back at you? | Yes | No |
| 12. Does your child get upset by everyday noises? (FOR EXAMPLE , does your child scream or cry to noise such as a vacuum cleaner or loud music?) | Yes | No |
| 13. Does your child walk? | Yes | No |
| 14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her? | Yes | No |
| 15. Does your child try to copy what you do? (FOR EXAMPLE , wave bye-bye, clap, or make a funny noise when you do) | Yes | No |
| 16. If you turn your head to look at something, does your child look around to see what you are looking at? | Yes | No |
| 17. Does your child try to get you to watch him or her? (FOR EXAMPLE , does your child look at you for praise, or say “look” or “watch me”?) | Yes | No |
| 18. Does your child understand when you tell him or her to do something?
(FOR EXAMPLE , if you don’t point, can your child understand “put the book on the chair” or “bring me the blanket”?) | Yes | No |
| 19. If something new happens, does your child look at your face to see how you feel about it?
(FOR EXAMPLE , if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?) | Yes | No |
| 20. Does your child like movement activities?
(FOR EXAMPLE , being swung or bounced on your knee) | Yes | No |

M-CHAT-R Follow-Up (M-CHAT-R/F)TM

Permissions for Use

The Modified Checklist for Autism in Toddlers, Revised, with Follow-Up (M-CHAT-R/F; Robins, Fein, & Barton, 2009) is designed to accompany the M-CHAT-R. The M-CHAT-R/F may be downloaded from www.mchatscreen.com.

The M-CHAT-R/F is a copyrighted instrument, and use of this instrument is limited by the authors and copyright holders. The M-CHAT-R and M-CHAT-R/F may be used for clinical, research, and educational purposes. Although we are making the tool available free of charge for these uses, this is copyrighted material and it is not open source. Anyone interested in using the M-CHAT-R/F in any commercial or electronic products must contact Diana L. Robins at DianaLRobins@gmail.com to request permission.

Instructions for Use

The M-CHAT-R/F is designed to be used with the M-CHAT-R; the M-CHAT-R is valid for screening toddlers between 16 and 30 months of age, to assess risk for autism spectrum disorder (ASD). Users should be aware that even with the Follow-Up, a significant number of the children who fail the M-CHAT-R will not be diagnosed with ASD; however, these children are at risk for other developmental disorders or delays, and therefore, follow-up is warranted for any child who screens positive.

Once a parent has completed the M-CHAT-R, score the instrument according to the instructions. If the child screens positive, select the Follow-Up items based on which items the child failed on the M-CHAT-R; only those items that were originally failed need to be administered for a complete interview.

Each page of the interview corresponds to one item from the M-CHAT-R. Follow the flowchart format, asking questions until a PASS or FAIL is scored. Please note that parents may report "maybe" in response to questions during the interview. When a parent reports "maybe," ask whether most often the answer is "yes" or "no" and continue the interview according to that response. In places where there is room to report an "other" response, the interviewer must use his/her judgment to determine whether it is a passing response or not.

Score the responses to each item on the M-CHAT-R/F Scoring Sheet (which contains the same items as the M-CHAT-R, but Yes/No has been replaced by Pass/Fail). The interview is considered to be a screen positive if the child fails any two items on the Follow-Up. If a child screens positive on the M-CHAT-R/F, it is strongly recommended that the child is referred for early intervention and diagnostic testing as soon as possible. Please note that if the healthcare provider or parent has concerns about ASDs, children should be referred for evaluation regardless of the score on the M-CHAT-R or M-CHAT-R/F.

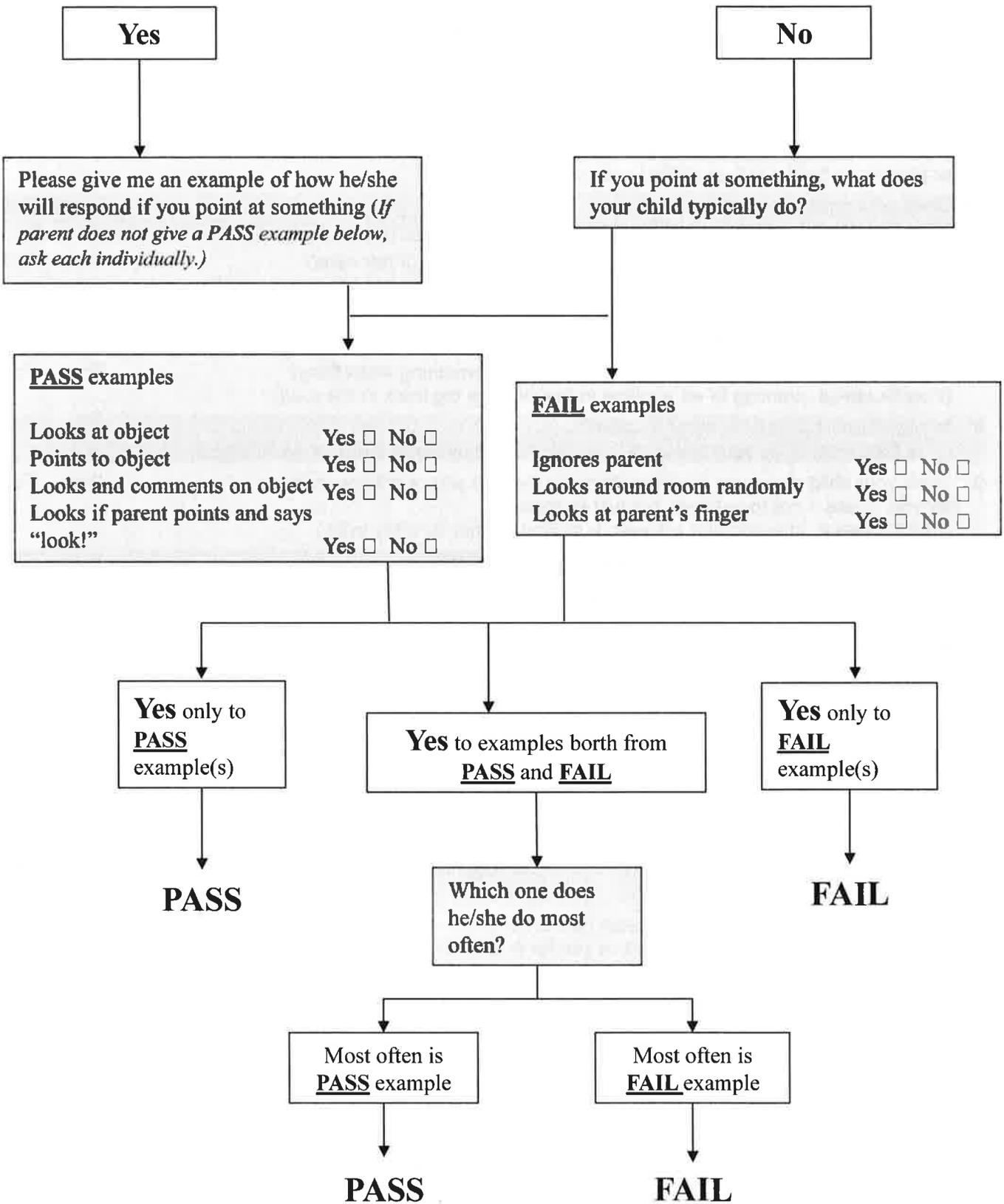
M-CHAT-R Follow-Up™ Scoring Sheet

Please note: Yes/No has been replaced with Pass/Fail

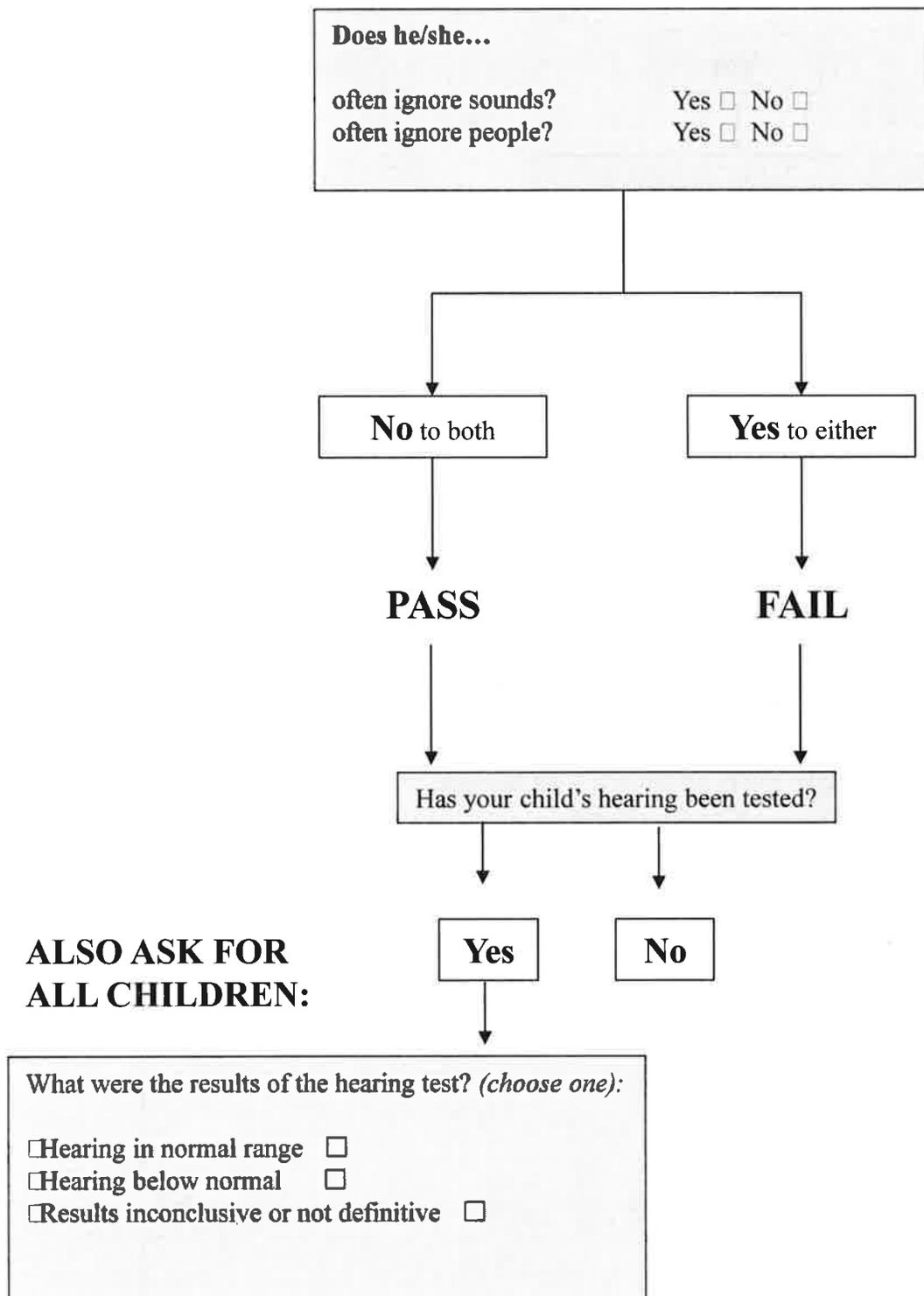
1. If you point at something across the room, does your child look at it? (FOR EXAMPLE , if you point at a toy or an animal, does your child look at the toy or animal?)	Pass	Fail
2. Have you ever wondered if your child might be deaf?	Pass	Fail
3. Does your child play pretend or make-believe? (FOR EXAMPLE , pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal)	Pass	Fail
4. Does your child like climbing on things? (FOR EXAMPLE , furniture, playground equipment, or stairs)	Pass	Fail
5. Does your child make <u>unusual</u> finger movements near his or her eyes? (FOR EXAMPLE , does your child wiggle his or her fingers close to his or her eyes?)	Pass	Fail
6. Does your child point with one finger to ask for something or to get help? (FOR EXAMPLE , pointing to a snack or toy that is out of reach)	Pass	Fail
7. Does your child point with one finger to show you something interesting? (FOR EXAMPLE , pointing to an airplane in the sky or a big truck in the road)	Pass	Fail
8. Is your child interested in other children? (FOR EXAMPLE , does your child watch other children, smile at them, or go to them?)	Pass	Fail
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (FOR EXAMPLE , showing you a flower, a stuffed animal, or a toy truck)	Pass	Fail
10. Does your child respond when you call his or her name? (FOR EXAMPLE , does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Pass	Fail
11. When you smile at your child, does he or she smile back at you?	Pass	Fail
12. Does your child get upset by everyday noises? (FOR EXAMPLE , a vacuum cleaner or loud music)	Pass	Fail
13. Does your child walk?	Pass	Fail
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Pass	Fail
15. Does your child try to copy what you do? (FOR EXAMPLE , wave bye-bye, clap, or make a funny noise when you do)	Pass	Fail
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Pass	Fail
17. Does your child try to get you to watch him or her? (FOR EXAMPLE , does your child look at you for praise, or say “look” or “watch me”)	Pass	Fail
18. Does your child understand when you tell him or her to do something? (FOR EXAMPLE , if you don’t point, can your child understand “put the book on the chair” or “bring me the blanket”)	Pass	Fail
19. If something new happens, does your child look at your face to see how you feel about it? (FOR EXAMPLE , if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Pass	Fail
20. Does your child like movement activities? (FOR EXAMPLE , being swung or bounced on your knee)	Pass	Fail

Total Score: _____

1. If you point at something across the room, does _____ look at it?



2. You reported that you have wondered if you child is deaf. What led you to wonder that?



ALSO ASK FOR ALL CHILDREN:

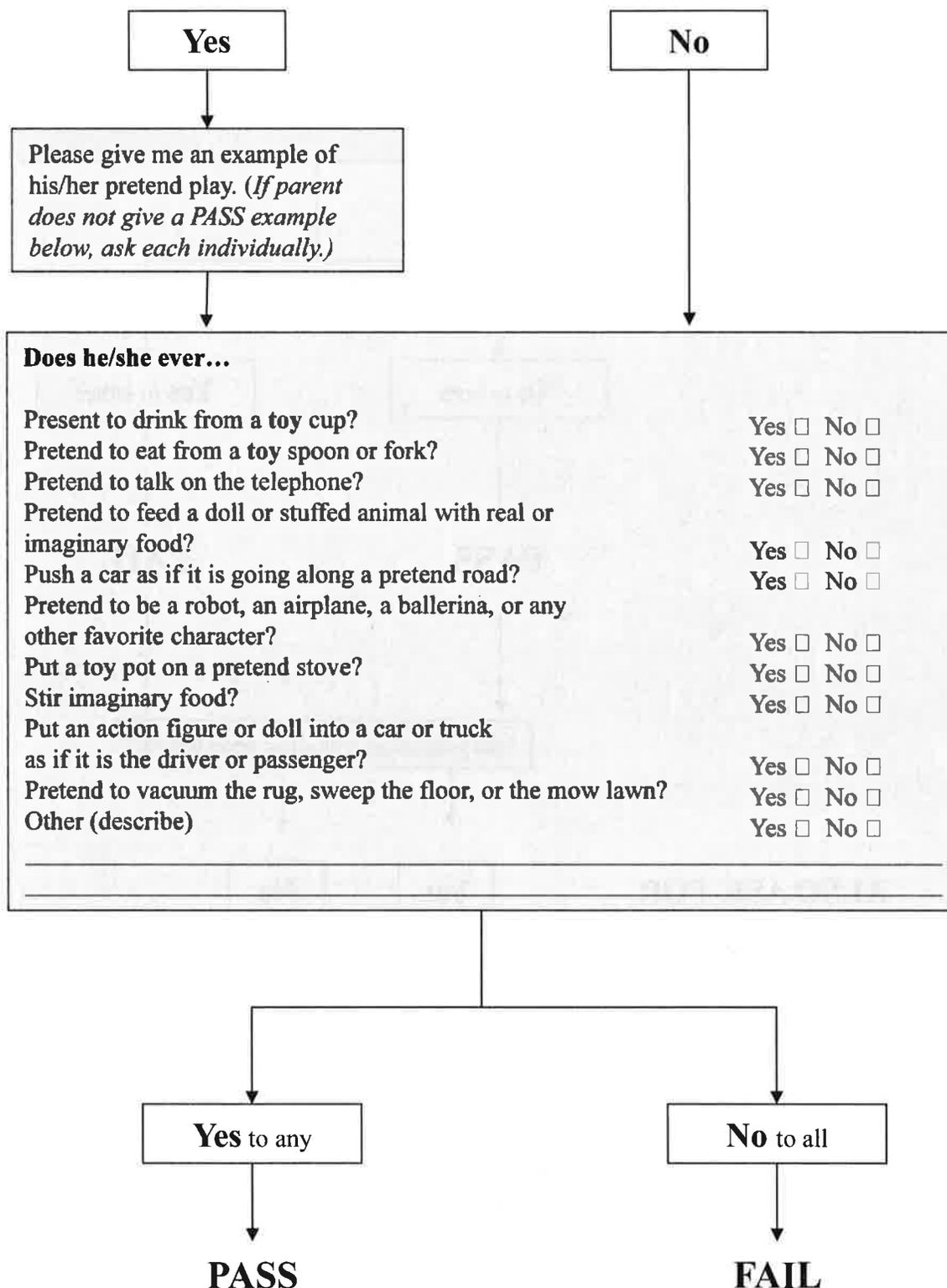
What were the results of the hearing test? (choose one):

Hearing in normal range

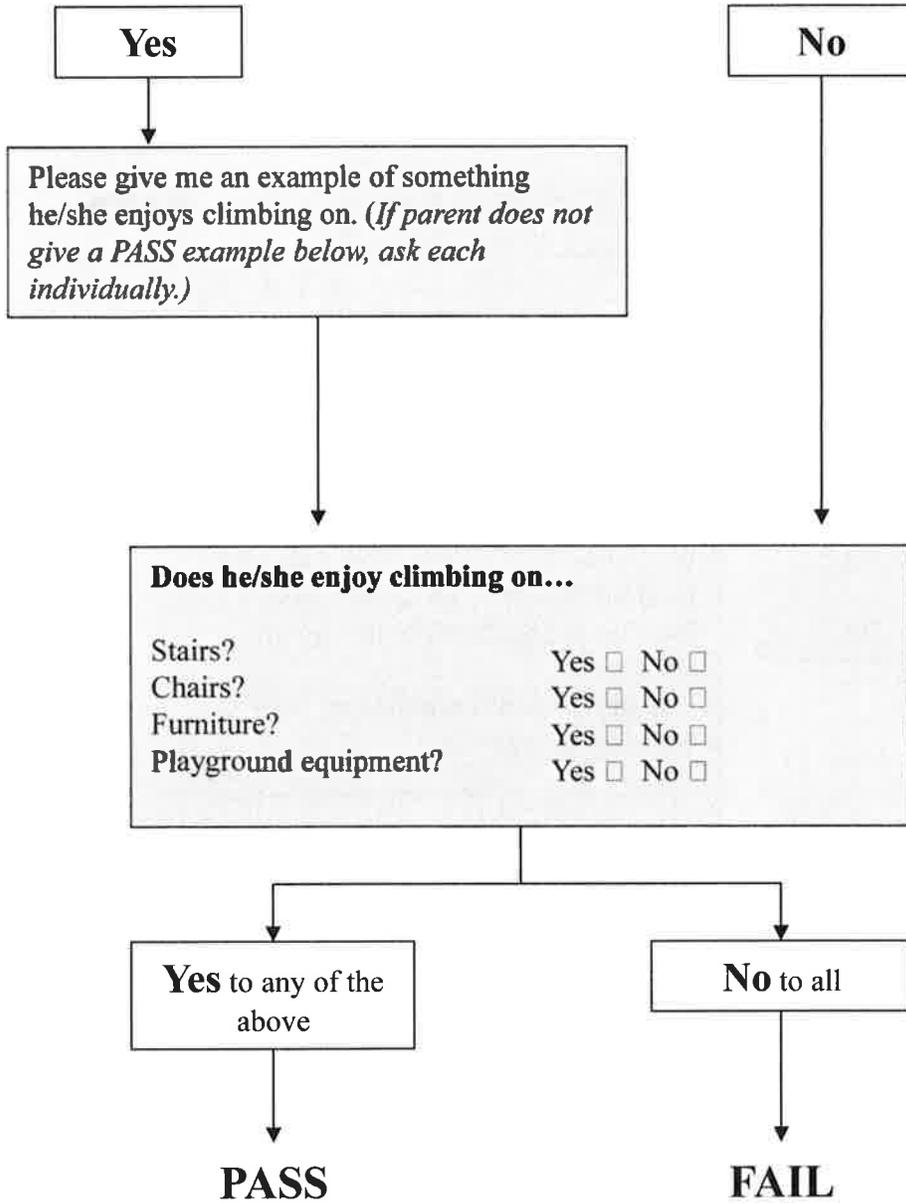
Hearing below normal

Results inconclusive or not definitive

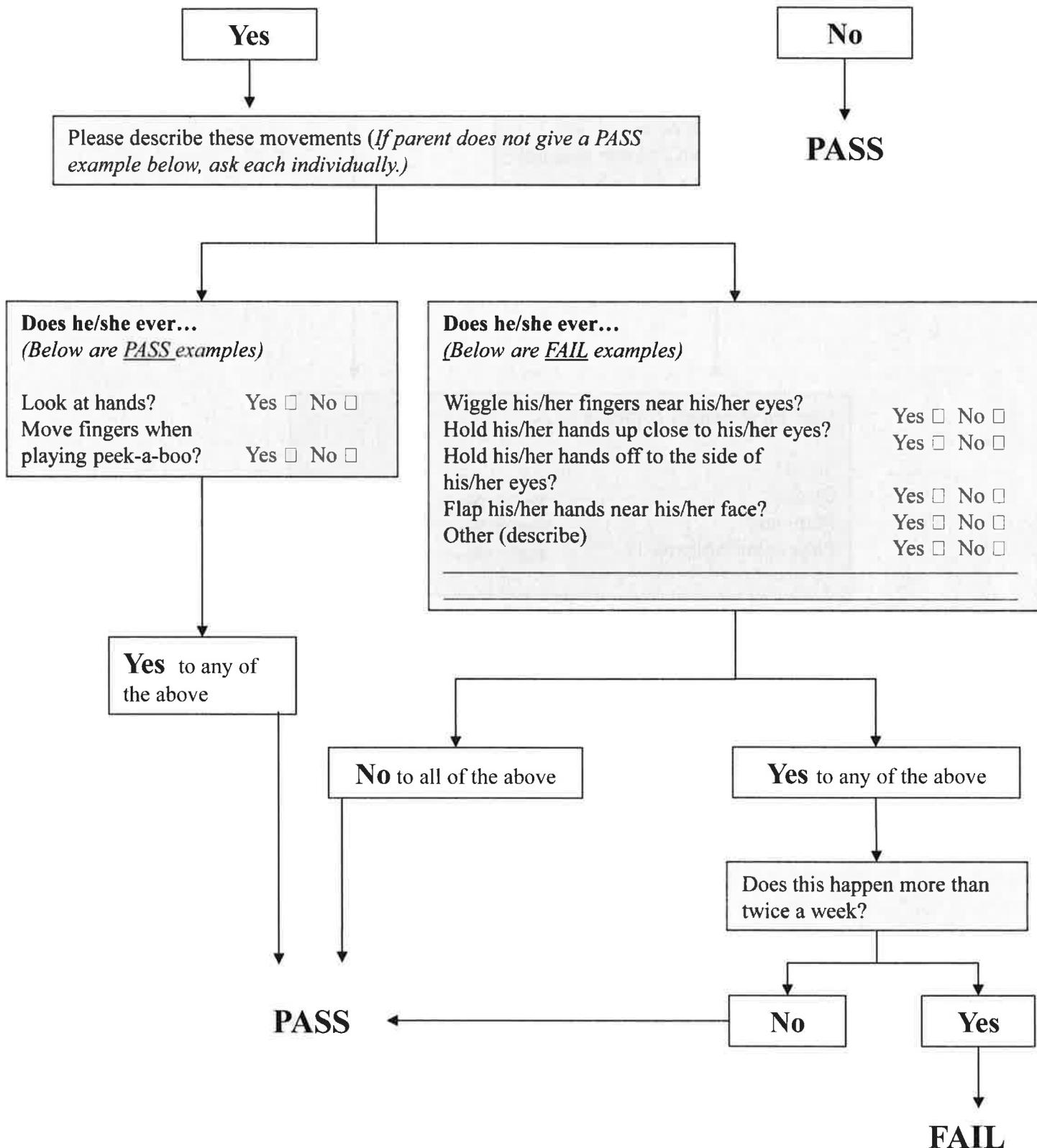
3. Does _____ play pretend or make-believe



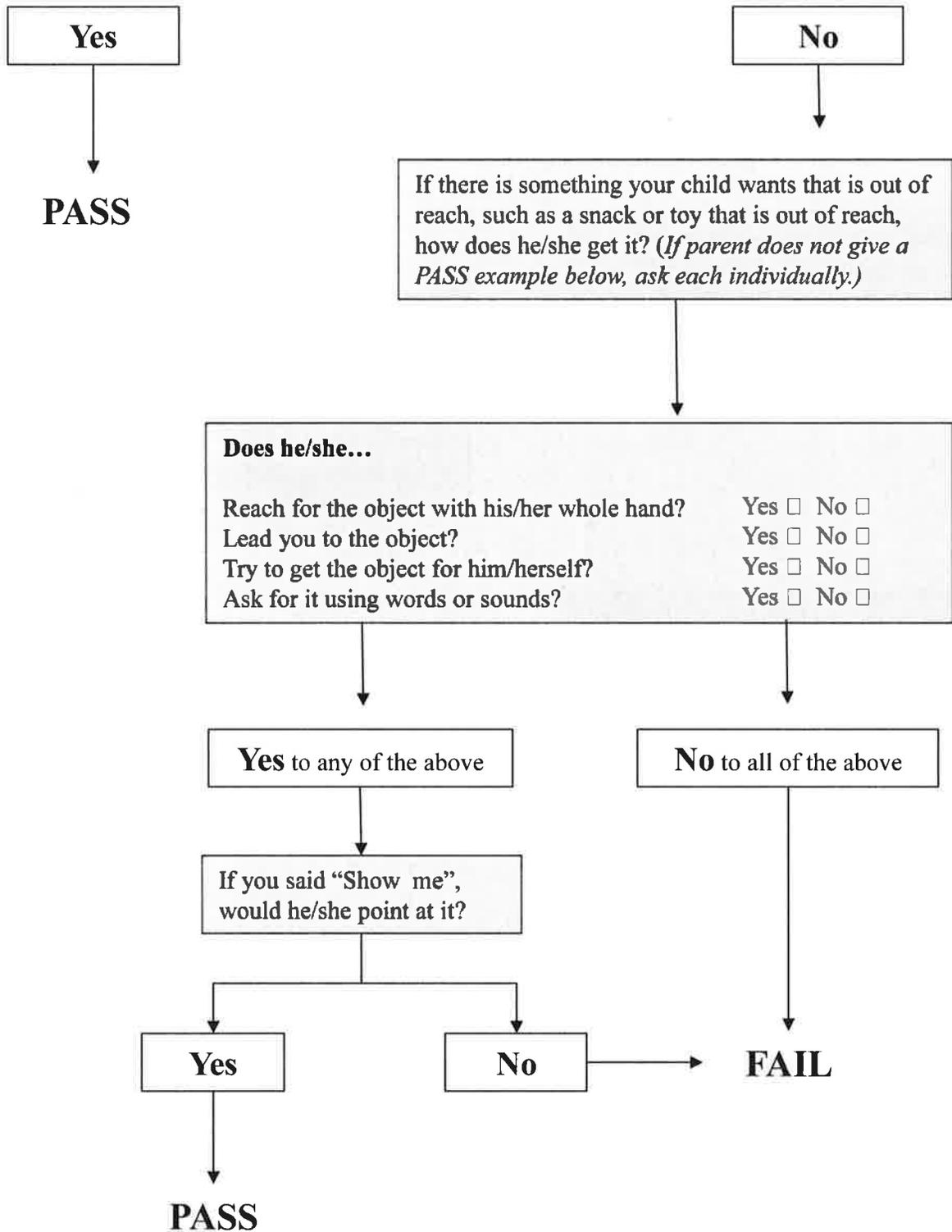
4. Does _____ like climbing on things?



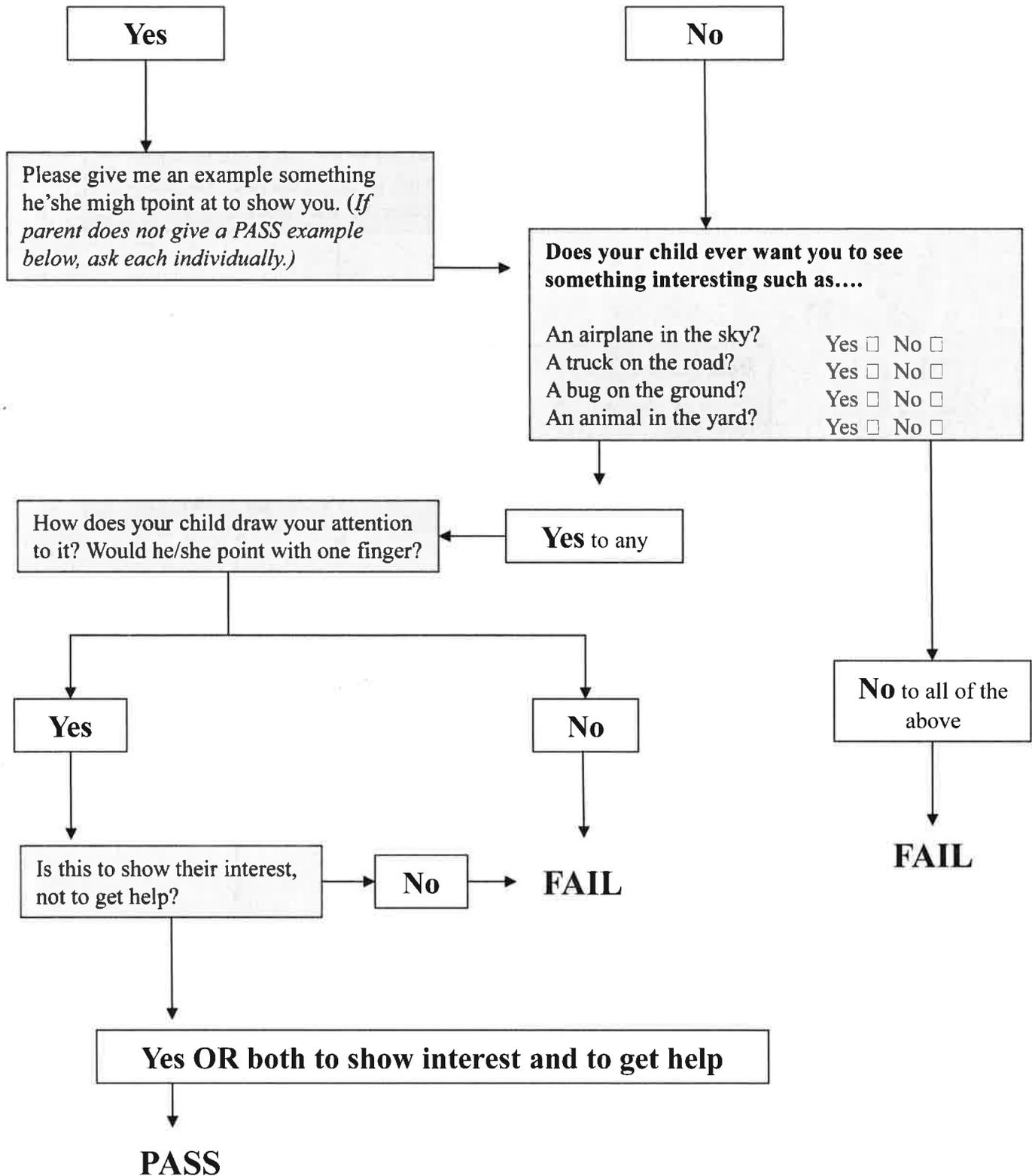
5. Does _____ make unusual finger movements near his/her eyes?



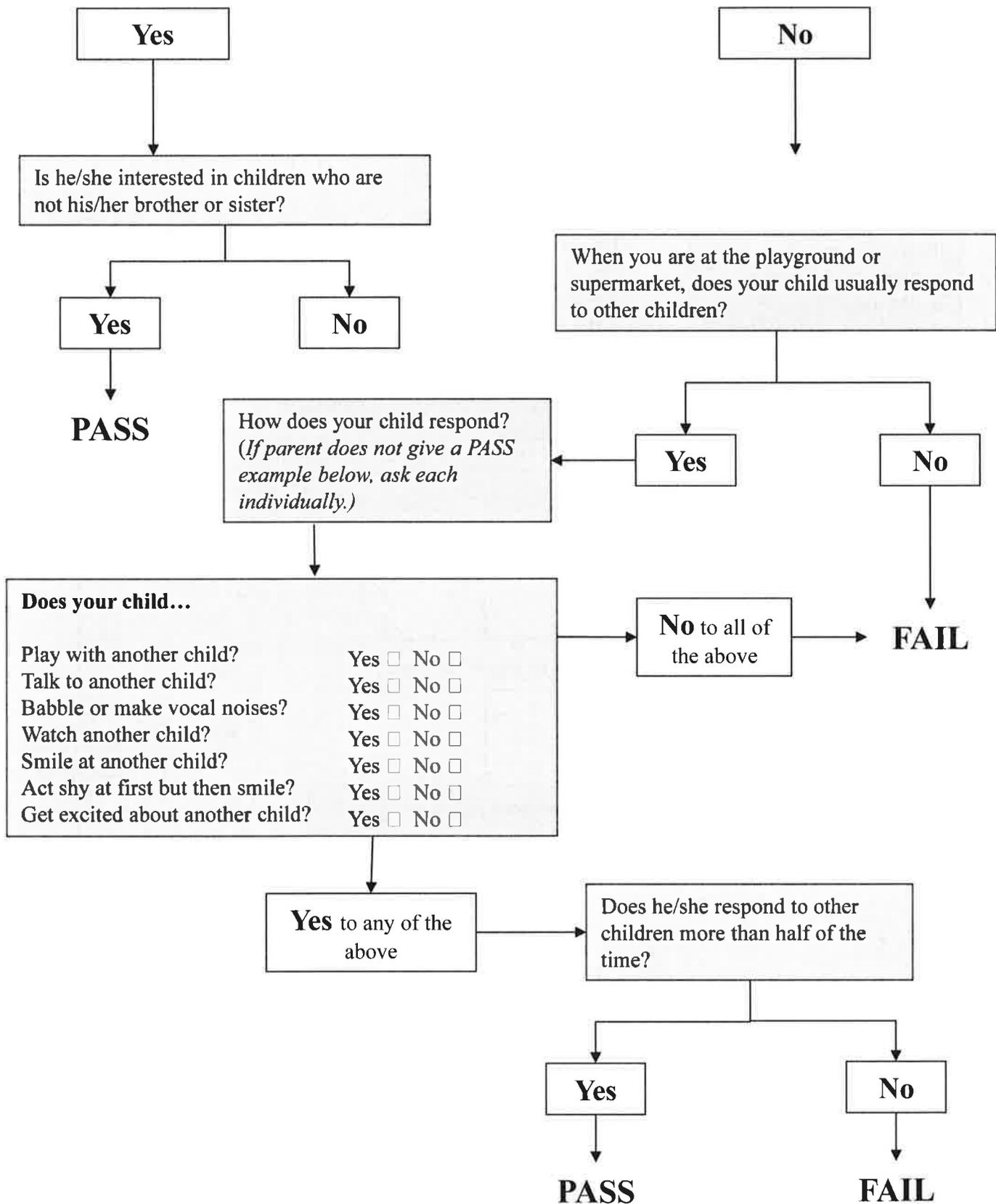
6. Does your child point with one finger to ask for something or to get help?



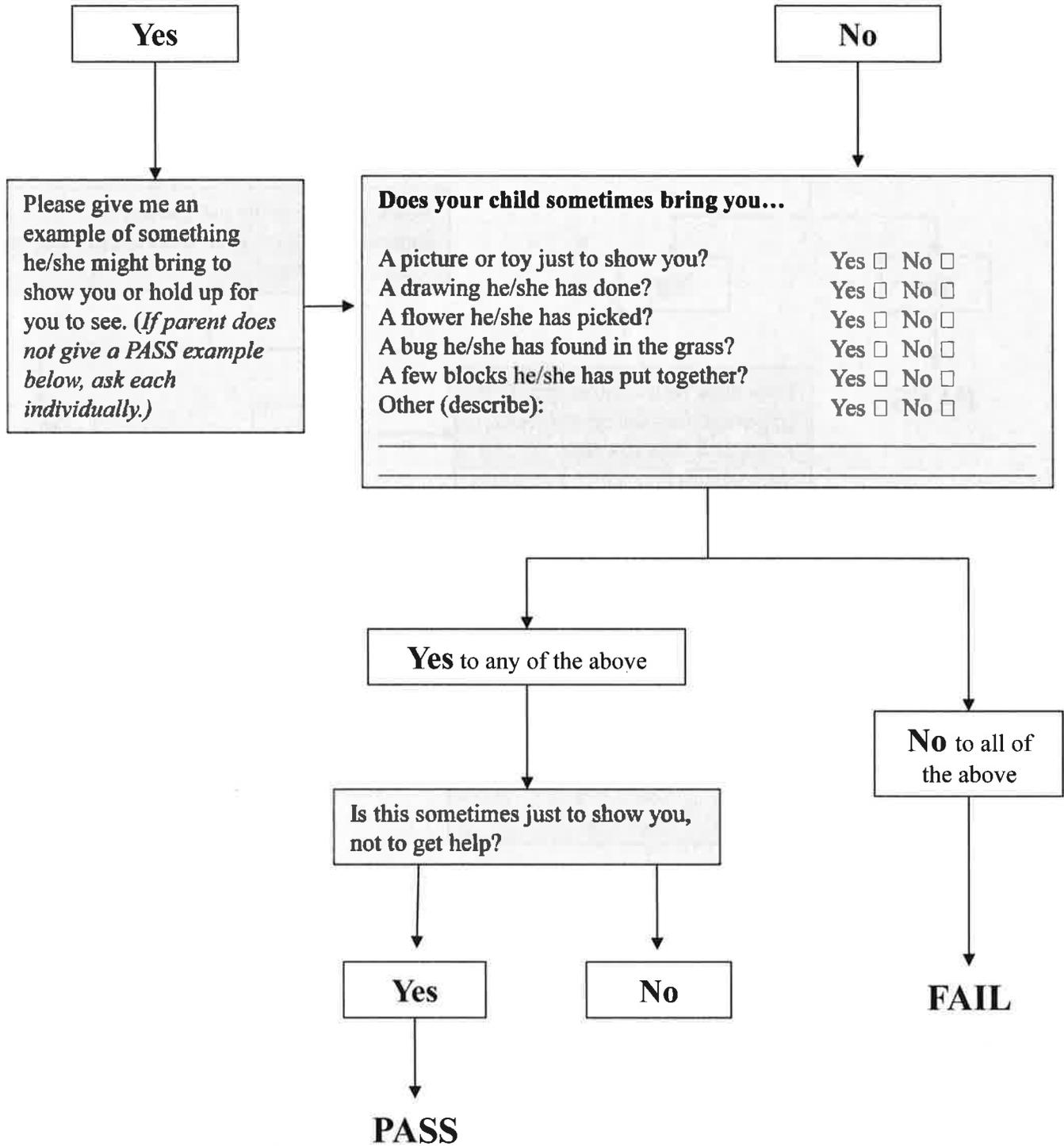
7. * If the interviewer just asked #6, begin here: We just talked about pointing to *ask* for something, ASK ALL → Does your child point with one finger just to show you something interesting?



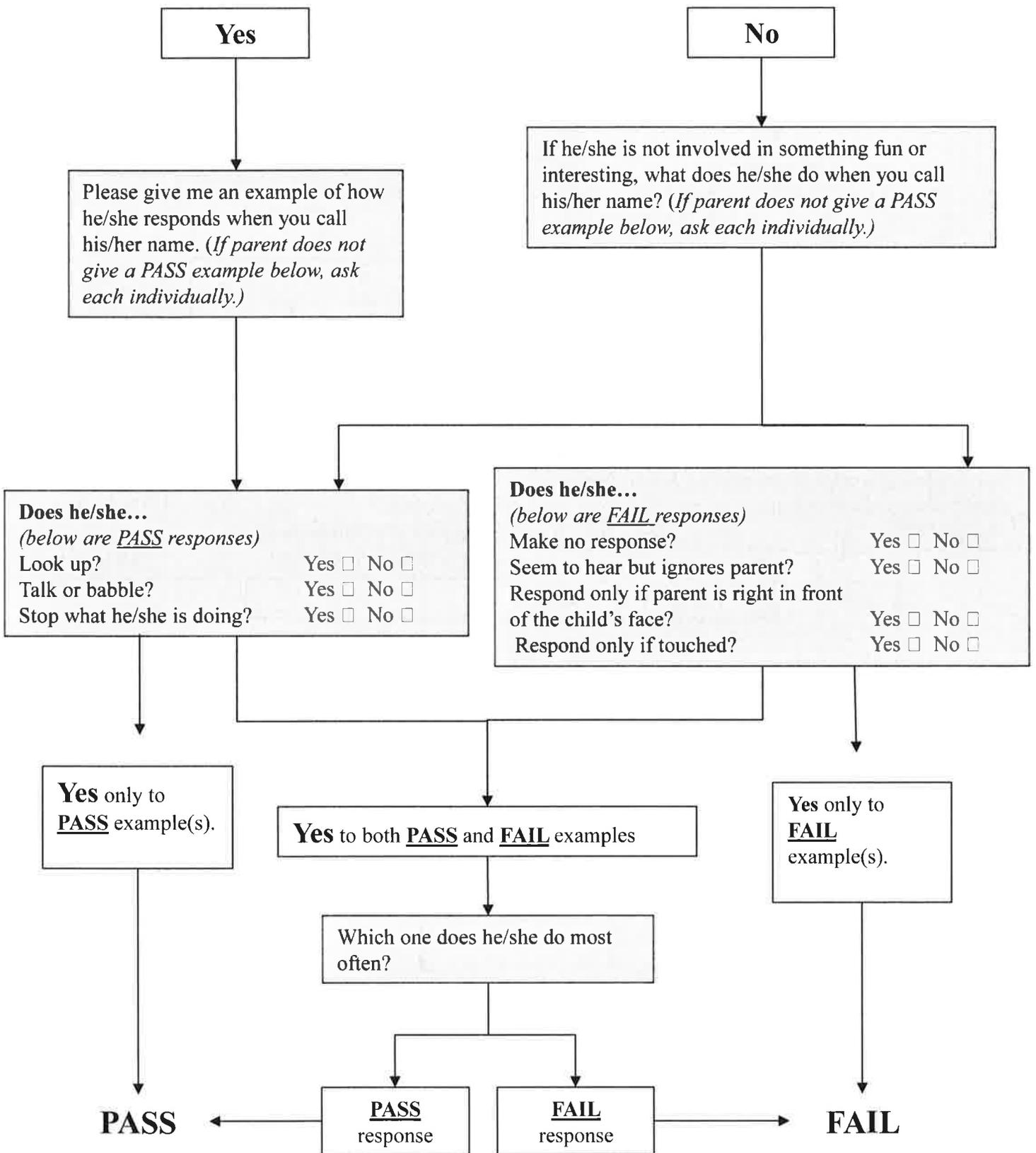
8. Is _____ interested in other children?



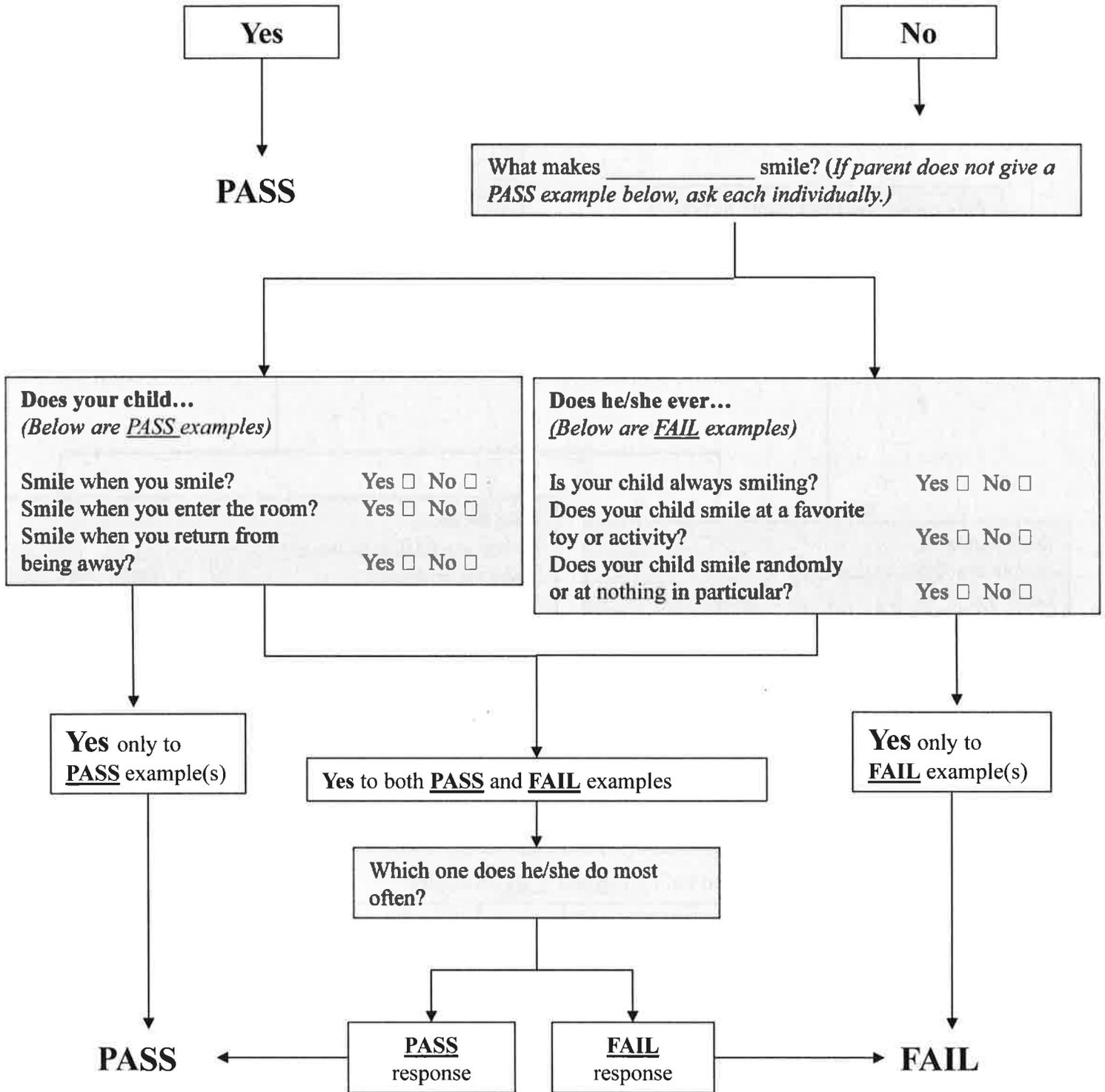
9. Does _____ show you things by bringing them to you or holding them up for you to see? Not just to get help, but to share?



10. Does _____ respond when you call his/her name?



11. When you smile at _____, does he/she smile back at you?



12. Does _____ get upset by everyday noises?

Yes

No

Does your child have a negative reaction to the sound of...

A washing machine?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Babies crying?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Vacuum cleaner?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hairdryer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Traffic?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Babies squealing or screeching?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Loud music?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Telephone/ doorbell ringing?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Noisy places such as a supermarket or restaurant?	<input type="checkbox"/>
Other (describe):	Yes <input type="checkbox"/> No <input type="checkbox"/>

PASS

Yes to two or more

How does your child react those noises? (If parent does not give a PASS example below, ask each individually.)

Does your child...
(Below are PASS responses)

Calmly cover his/her ears?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Tell you that he/she does not like the noise?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Does your child...
(Below are FAIL responses)

Scream?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cry?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cover his/her ears while upset?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Yes only to PASS example(s)

Yes to both PASS and FAIL

Yes only to FAIL example(s)

Which one does he/she do most often?

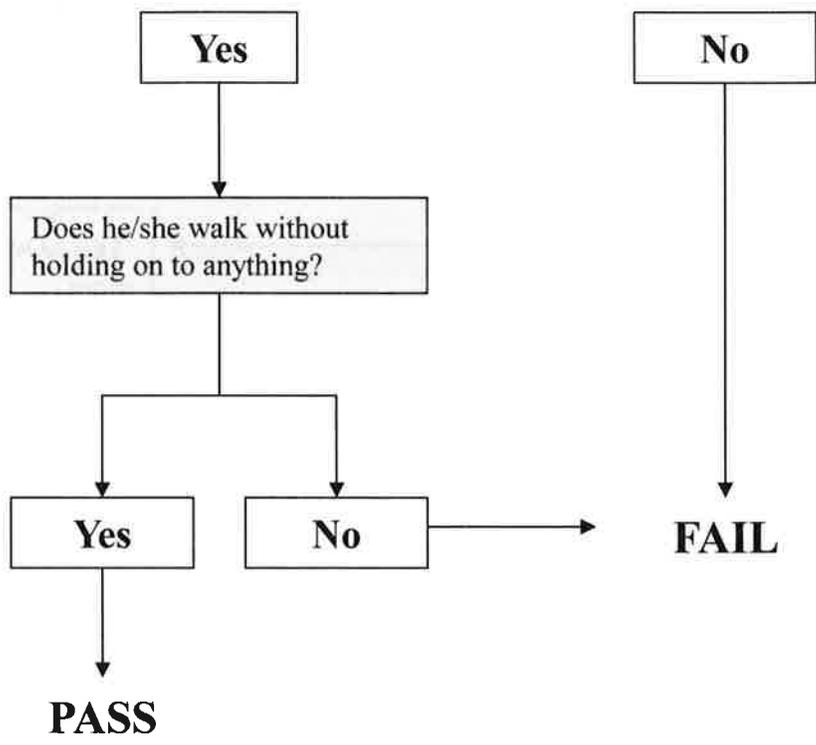
PASS response

FAIL response

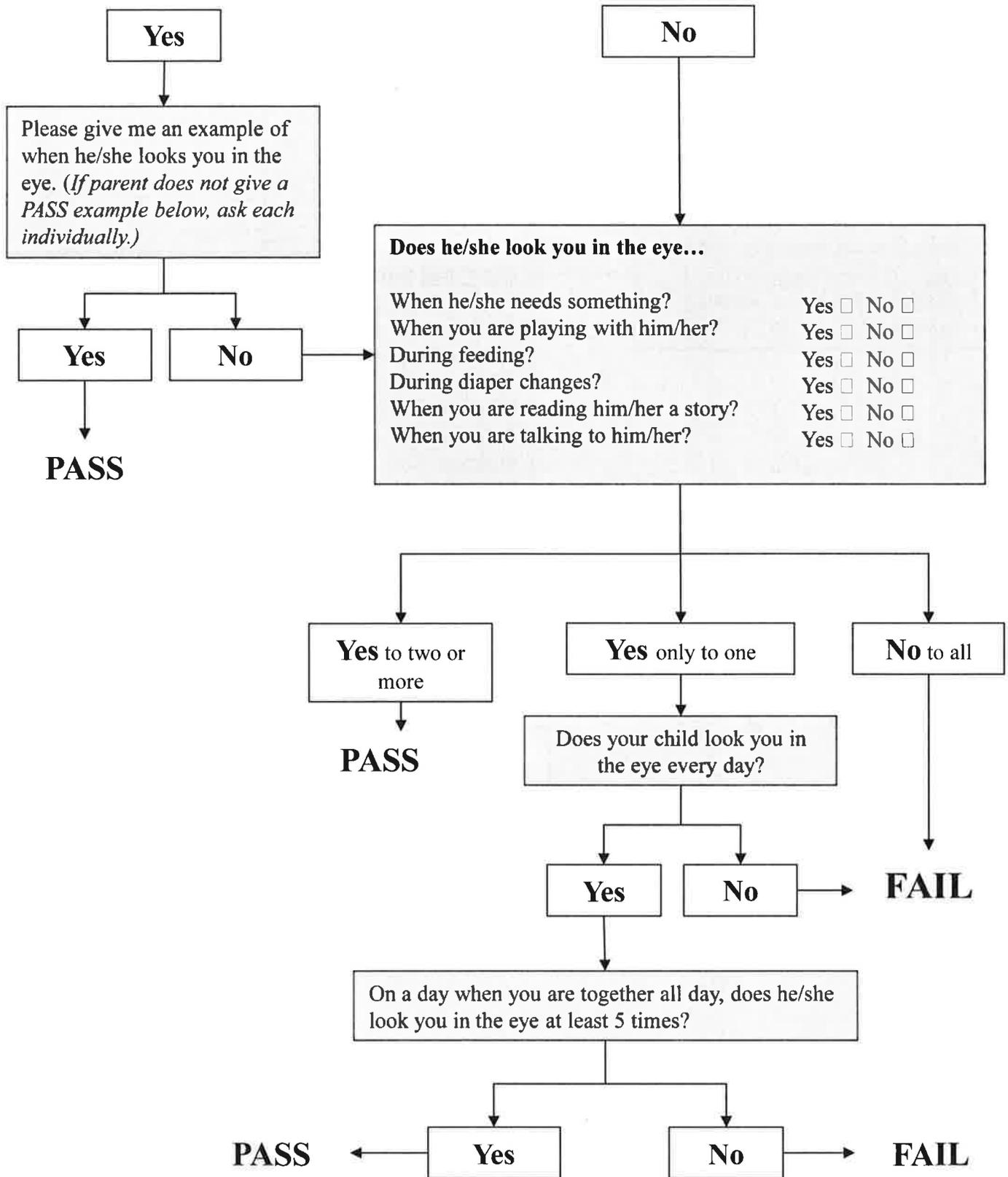
PASS

FAIL

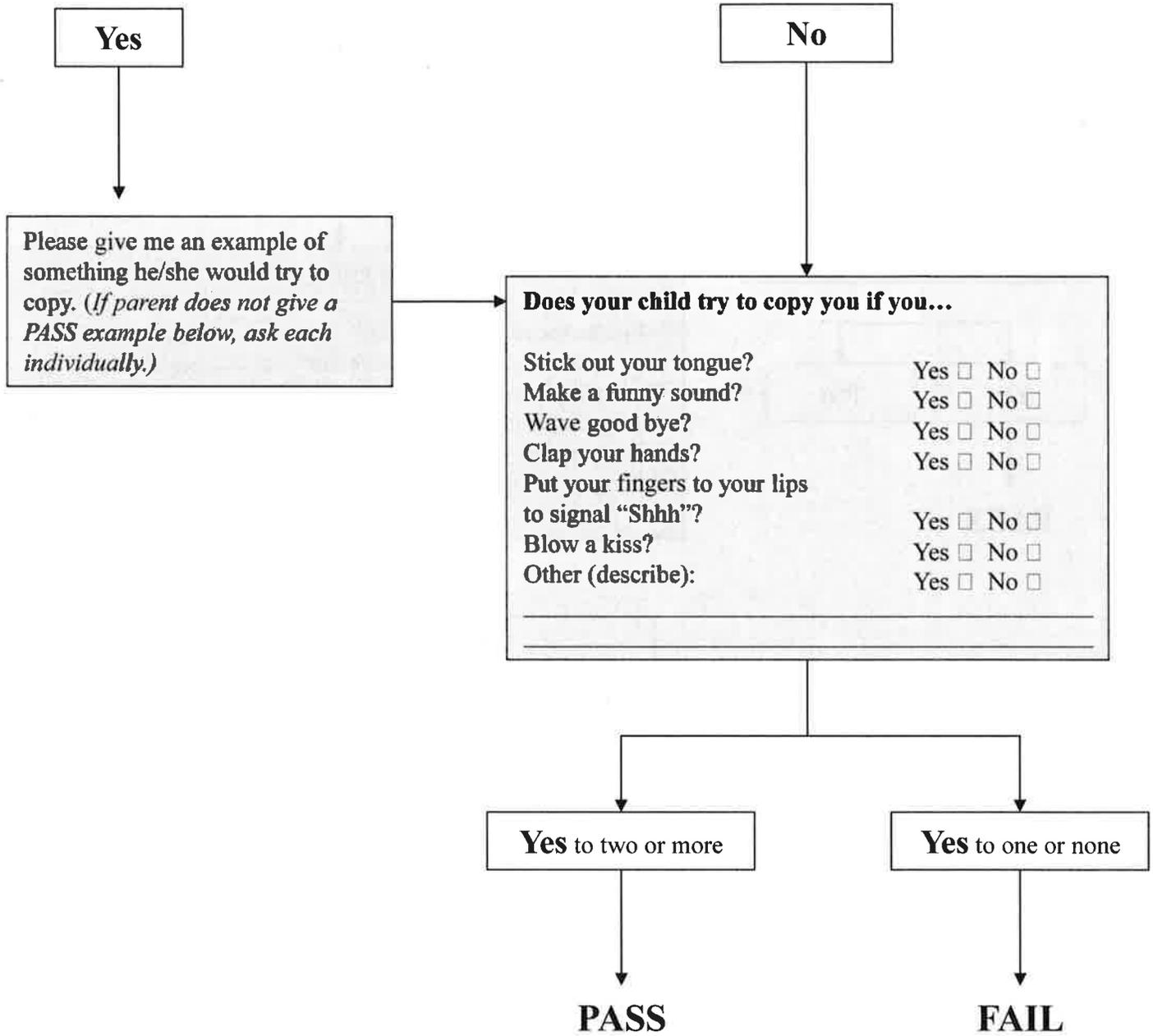
13. Does _____ walk?



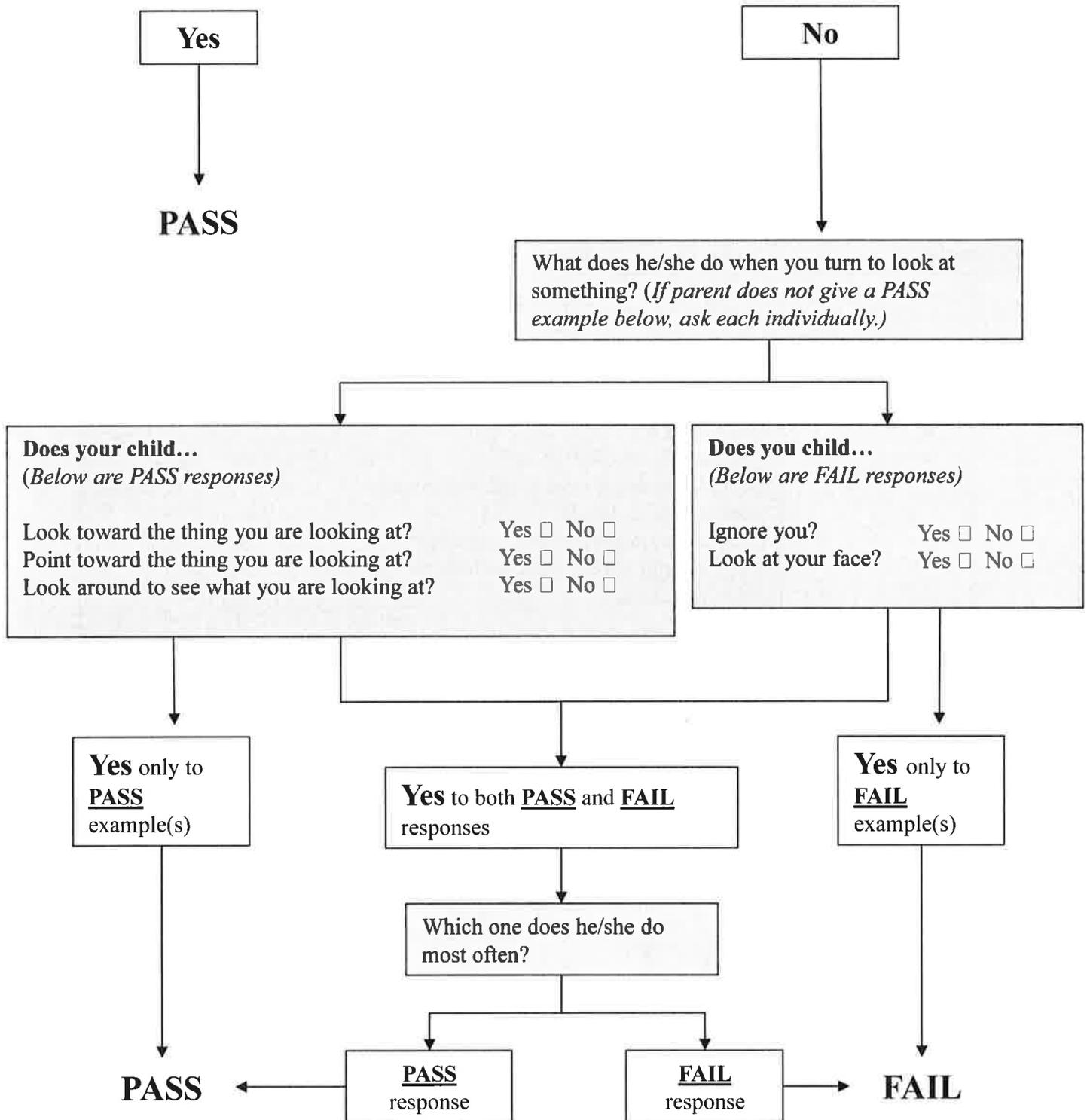
14. Does _____ look you in the eye when you are talking to him/her, playing with him/her, or changing him/her?



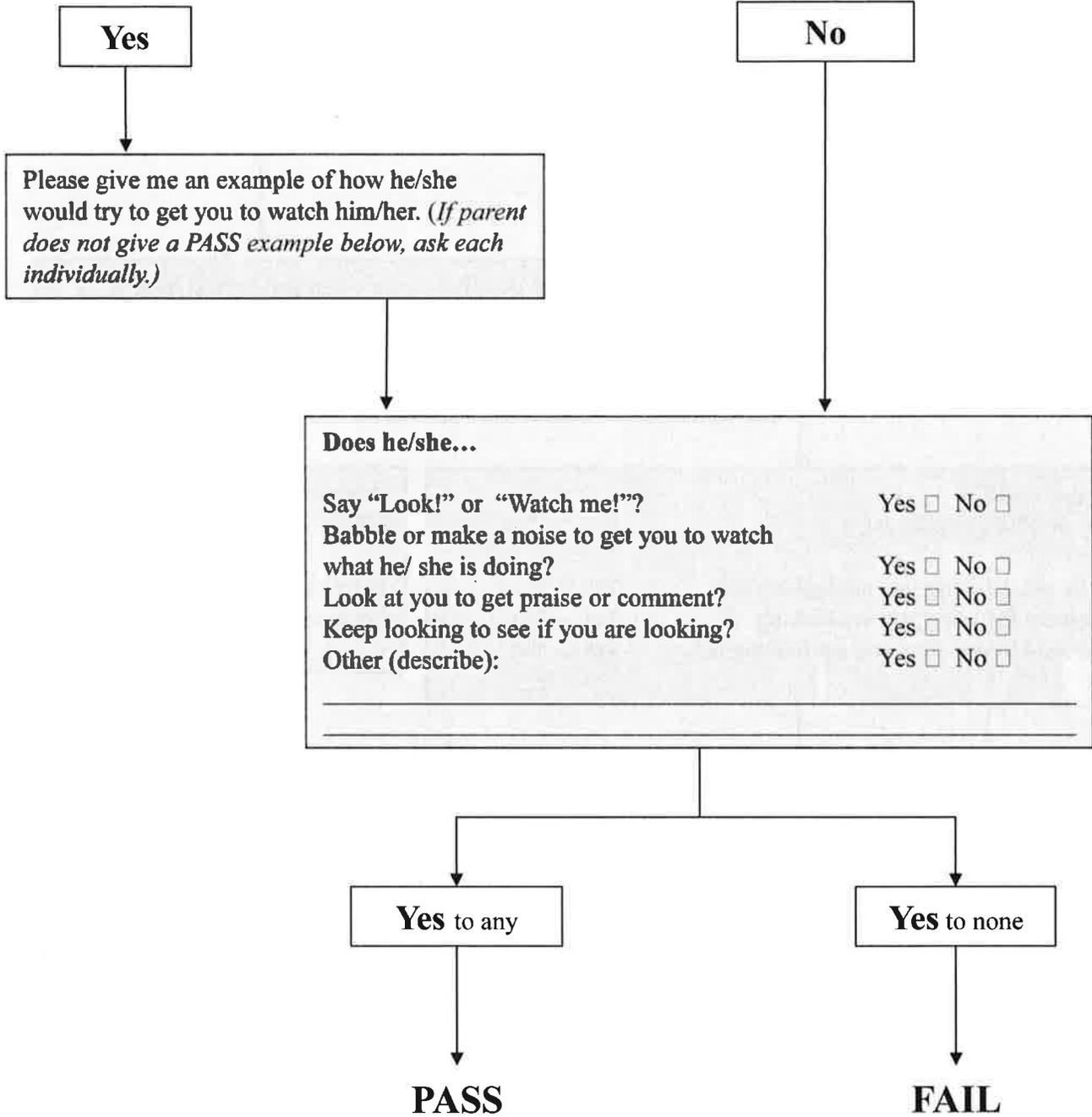
15. Does _____ try to copy what you do?



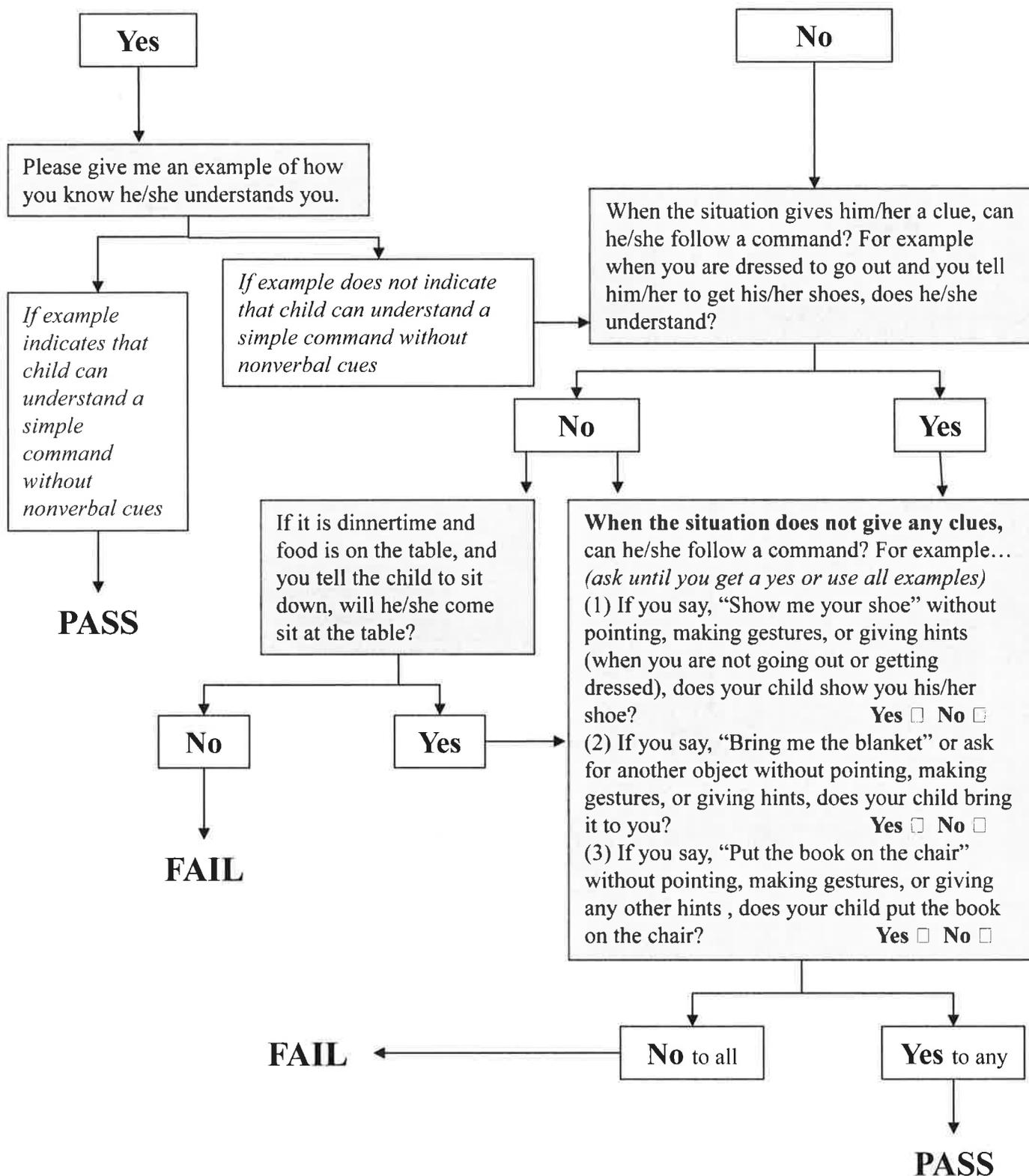
16. If you turn your head to look at something, does _____ look around to see what you are looking at?



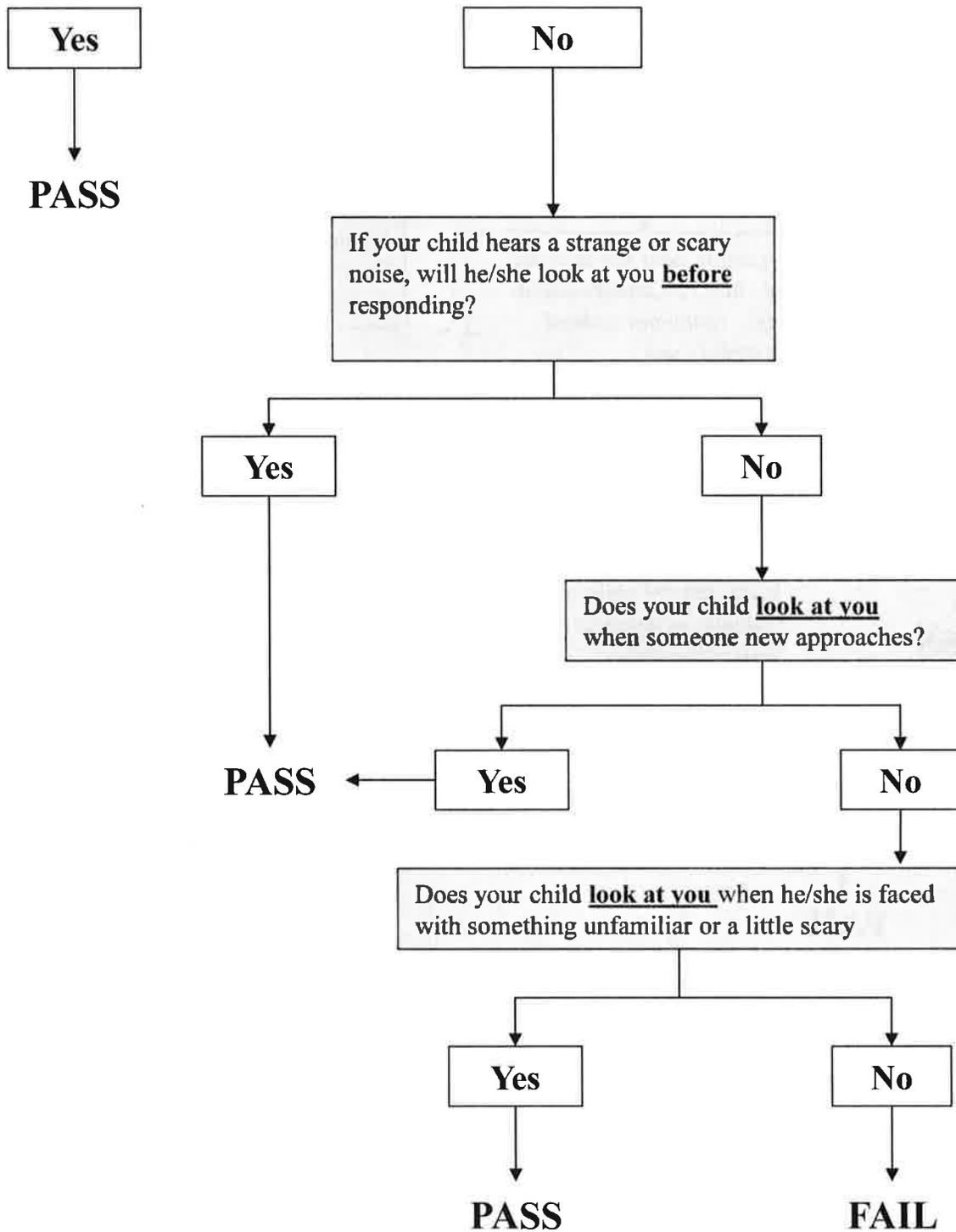
17. Does _____ try to get you to watch him/her?



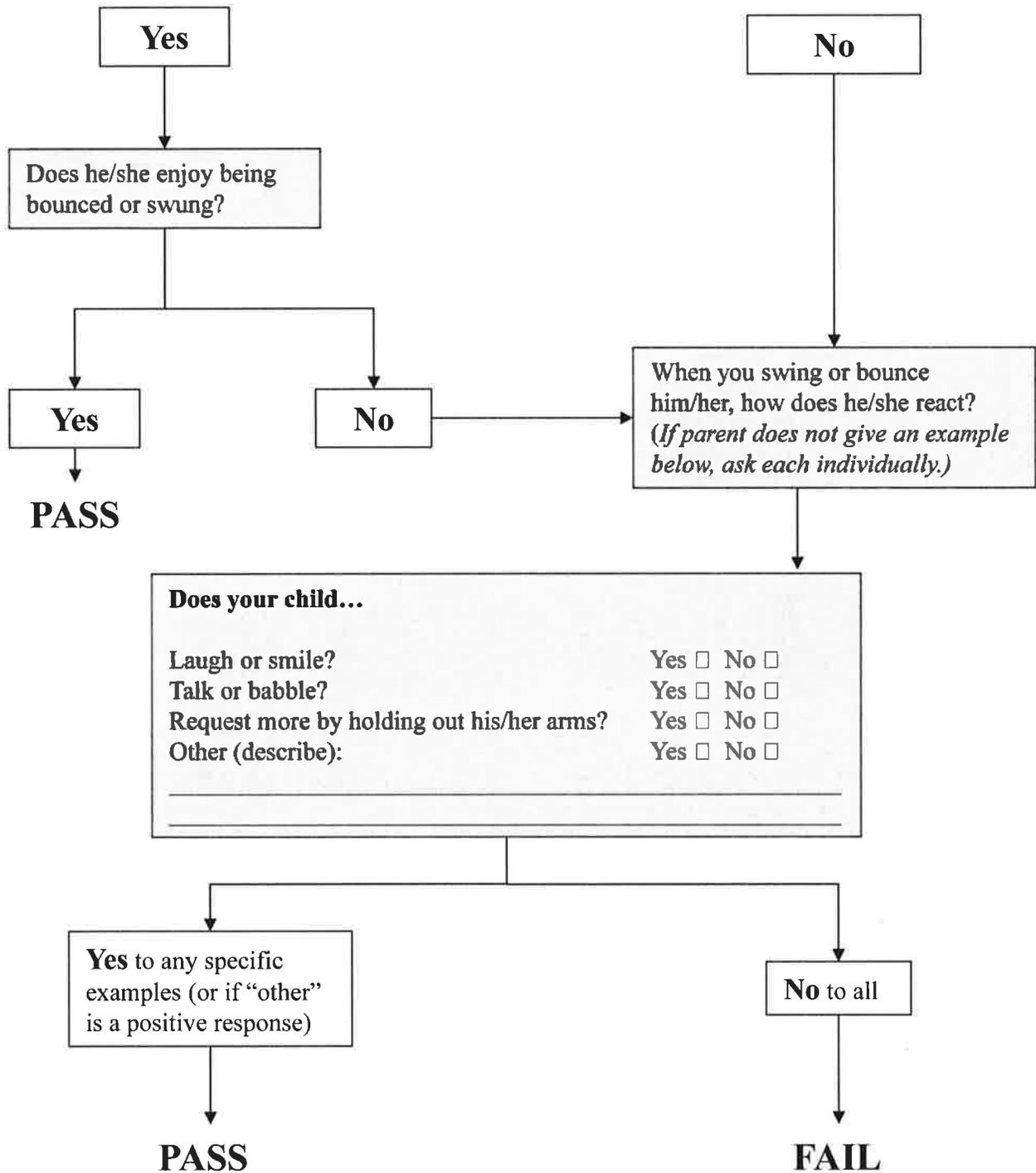
18. Does _____ understand when you tell him/her to do something?



19. If something new happens, does _____ look at your face to see how you feel about it?



20. Does _____ like movement activities?



RISK ASSESSMENT QUESTIONNAIRE

LEAD RISK ASSESSMENT (For ages 6 months to 72 months)

1.*	Does your child live in, or regularly visit, a house built before 1950? (day care center, baby sitter's home, relative's home.)	Y	N
2.*	Does your child live in, or regularly visit, a house built before 1978 that has recent, ongoing, or planned renovations or remodeling (within the past 6 months)?	Y	N
3.*	Does your child have a brother, sister, or playmate that has, or did have, lead poisoning?	Y	N
4.	Does your child frequently come in contact with an adult who works with lead (construction, welding, pottery, etc.)?	Y	N
5.	Does your home contain any plastic or vinyl mini blinds made before July 1996?	Y	N
6.	Have you ever been told that your child has low iron?	Y	N
7.	Have you seen your child eating paint chips, crayons, soil, or dirt?	Y	N
8.	Does your child live near, or visit with someone who lives near, a lead smelter, battery recycling plant, or other industry that could release lead?	Y	N
9.	Do you give your child any home or folk remedies that may contain lead (such as moonshine, Azarcon, Greta, Paylooh)?	Y	N
10.	Does your child live within 80 feet (or one block) of areas with a constant flow of traffic, such as busy intersections and streets, highways and interstates? (The soil near heavily used streets and roads may contain lead as a result of past use of lead in gasoline; automobile exhaust from past leaded gasoline contributes to both air and soil lead pollution.)	Y	N
11.	Does your home's plumbing have lead pipes or copper pipes with lead solder joints?	Y	N
12.	Does your family use pottery ware or lead crystal for cooking, eating, or drinking?	Y	N

*Mandatory questions, other 9 questions are optional based on professional judgement

CHOLESTEROL RISK ASSESSMENT (For ages 2 years and older)

1.	Do the child's parents or grandparents have a history of heart disease, heart attack, or stroke before age 55?	Y	N
2.	Do either of the child's parents have high cholesterol (over 240), or are they taking medication for high cholesterol?	Y	N

TUBERCULOSIS RISK ASSESSMENT

1.	Are you or your child in close contact with a person with TB (tuberculosis)?	Y	N
2.	Are you or your child foreign born (especially Asian, African, Latin American), a refugee, or a migrant?	Y	N
3.	Have you, your child, or any household member traveled to a country where TB is common (e.g., Africa, Asia, Latin America, Eastern Europe, Russia, Caribbean) in the last 12 months?	Y	N
4.	Do you or your child have a medical condition, or treatment of a medical condition, which interferes with your ability to fight infection?	Y	N
5.	Do you or your child have HIV infection or is he/she considered at risk for HIV infection?	Y	N
6.	Are you or your child exposed to any of the following: HIV infected persons, homeless individuals, residents of nursing homes, institutionalized adolescents or adults, users of street drugs, incarcerated adolescents or adults, or migrant farm workers?	Y	N

IMMUNIZATION RISK ASSESSMENT (For All children who are to receive an immunization)

1.	Does your child or any household member have a medical condition, or treatment of a medical condition, which interferes with his/her ability to fight infection?	Y	N
2.	Does your child have a moderate or severe illness, with or without fever?	Y	N
8.	Is your child allergic to any of the vaccine components?	Y	N
3.	Has your child ever had a fever of 105° or greater within 48 hours following an immunization?	Y	N
4.	Has your child ever had a convulsion after receiving an immunization?	Y	N
5.	Has your child ever had limpness (collapse/shock like state) within 48 hours of receiving an immunization?	Y	N
7.	Has your child ever had a crying session that wouldn't stop (lasting more than 3 hours) within 48 hours of receiving an immunization?	Y	N
8.	Other:	Y	N

DEVELOPMENTAL ASSESSMENT

Ages 0 through 59 months: use “*Parents’ Evaluation of Developmental Status*” (PEDS).

Ages 5 through 18 years: use “*Pediatric Symptom Checklist*” (PSC-17). (For scoring instructions, refer to Pediatric Symptom Checklist 17 Scoring)

Ages 11 through 18: may use the “*Pediatric Symptom Checklist, Youth Version*” (PSC-Y); a total score of 30 or higher indicates high risk status and need for referred.

Ages 19 to 21 years: use “*Adolescent Developmental/Behavioral Questionnaire*”

HEARING RISK ASSESSMENT

Birth-5 Months			
1.	Did your newborn have a hearing test while in the hospital?	Y	N
2.	(If yes to #1) Did your baby receive a non-passing screening result in one or both ears?	Y	N
3.	Are you worried about your baby's hearing?	Y	N
4.	Does a loud sound wake your baby?	Y	N
5.	Does your baby turn his/her head to an interesting sound?	Y	N
6-14 Months			
1.	Are you worried about your baby's hearing?	Y	N
2.	Does a loud sound wake your baby?	Y	N
3.	Does your baby turn his/her head to an interesting sound?	Y	N
15-35 Months			
1.	Are you worried about your baby's hearing?	Y	N
2.	Has your child had any ear infections, drainage, or a bad odor from his/her ears?	Y	N
3.	Can your child identify familiar objects, “car”, “dog”, “mama”, “dada”?	Y	N
36 Months			
1.	Are you worried about your child's hearing?	Y	N
2.	Has your child had lots of ear infections?	Y	N
3.	Does your child pull, tug, or rub his/her ears?	Y	N
4.	Are you worried about your child's speech?	Y	N
4-17 Years			
1.	Are you worried about your child's hearing?	Y	N
2.	Has your child had lots of ear infections?	Y	N
3.	Are you worried about your child' speech and language development? (For instance, do people outside the family have trouble understanding your child?)	Y	N
4.	Do you have to continually repeat what you say?	Y	N
5.	Has your child received hearing screening in school or with a medical provider?	Y	N
6.	Does your child have developmental delays or is he/she in special education? Does your child have a problem with behavior or grades at childcare or school?	Y	N

VISION RISK ASSESSMENT

1.	Does anyone in your immediate family (child's mom, dad, brothers, sisters) have a history of eye problems or of wearing glasses as a young child?	Y	N
2.	Do you have any concerns about your child's eyes or vision?	Y	N
3.	Does your child seem to see well?	Y	N
4.	Does your child hold objects unusually close to his/her face when trying to focus?	Y	N
5.	Do your child's eyes ever seem to cross?	Y	N
6.	Is your child experiencing problems with school that you think are related to vision problems and/or has the school told you they suspect a vision problem?	Y	N

SEXUAL ACTIVITY RISK ASSESSMENT (For ages 11 years and older; questions to be asked of the child/adolescent)

1.*	Do you have a boyfriend/girlfriend?	Y	N
2.*	Do you date? (If yes, what do you usually do on a date?)	Y	N
3.*	Has anyone ever touched you in a way you did not like?	Y	N
4.	Have you ever had sex?	Y	N
5.	Are you sexually active now?	Y	N

*Mandatory questions, other questions optional based on professional judgement.