



Public Health Nursing

Leadership Guide and Resource Manual

2005

The Massachusetts Association of Public Health Nurses

Preface

(written Spring 2002)

The Massachusetts Association of Public Health Nurses (MAPHN) is pleased to introduce the new *Public Health Nursing Leadership Guide and Resource Manual*. Over 6 years ago, a small group of public health nurses met with the previous Commissioner of Public Health, David Mulligan, to ask for Massachusetts Department of Public Health (MDPH) support for public health nursing. MAPHN requested assistance and funding for a yearly public health nursing conference and help with developing and publishing an orientation manual.

Our committee believed that a guidebook could help to standardize public health nursing care and practice throughout the state. When completed, the guidebook would be a reference for veteran public health nurses, an orientation manual for new nurses, and a guide that schools of nursing could use to show nursing students the practical application of public health nursing.

Planning and preparing the guidebook was an overwhelming, time-consuming task that required the commitment of dedicated public health nurses and MDPH staff. As is stated in the acknowledgements, the contribution of each member, whether as writer, editor, or reviewer was invaluable. We thank all who gave countless hours and boundless energy to the project.

MAPHN wishes to thank current Commissioner of Public Health Dr. Howard Koh, Associate Commissioner Deborah Klein Walker, and Assistant Commissioner Kathleen Atkinson who encouraged and supported the production of this guidebook from the beginning. Their support of public health nurses in the Commonwealth has enabled MAPHN to enact the vision and mission of public health nursing.

MAPHN also wishes to thank Ruth Brophy for assisting us with formatting and Vicki Soler and Kate McAdams for the patience and effort they applied toward successful completion of this guidebook.

MAPHN is pleased to report that, since that first meeting with the MDPH, the following changes have occurred, which strengthen public health nursing in Massachusetts:

- The first statewide organization for public health nurses, MAPHN was incorporated in 1998.
- MAPHN is hosting the 6th annual public health nursing conference in June, in collaboration with the MDPH and the Massachusetts Public Health Association (MPH).
- MAPHN has worked with the MDPH to enhance local public health infrastructure to include a stronger public health nursing presence and voice.
- Public health nurses sit on various state and local health advisory committees.
- MAPHN is currently printing the second copy of the local directory of statewide public health nurses.

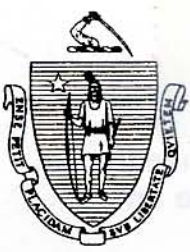
- The major public health organizations collaborate routinely and effectively through the Local Coalition of Health, which represents the following organizations: Massachusetts Association of Public Health Nurses (MAPHN), Massachusetts Health Officers Association (MHOA), Massachusetts Environmental Health Association (MEHA), Massachusetts Public Health Association, and Massachusetts Association Health Board (MAHB).

In closing, MAPHN asks public health nurses to use this guidebook along with the many other valuable resource tools already produced by the state, to strengthen and expand their practice. During the coming year, MAPHN will develop a process for distributing the guidebook to new public health nurses as they begin their practice in Massachusetts and welcomes any comments or suggestions.

Sandy Collins RN BSN
Immediate Past President
MAPHN

Kaydee Schmidt RN MS, MPH
President
MAPHN

Spring 2002



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

JANE SWIFT
GOVERNOR

ROBERT P. GITTENS
SECRETARY

HOWARD K. KOH, MD, MPH
COMMISSIONER

June, 2002

Kaydee Schmidt, RN, MS, MPH, President
Sandy Collins, RN, BSN, Immediate Past President
The Massachusetts Association of Public Health Nurses

Dear President Schmidt and (Past) President Collins:

Congratulations to you and the membership of the Massachusetts Association of Public Health Nurses on the publication of the first edition of the ***Public Health Nursing Leadership Guide and Resource Manual!***

This guidebook is the result of your tireless efforts over the past several years to ensure that public health nurses - in particular those who serve the 351 cities and towns across the Commonwealth - have ready access to information and resources that will aid them in their practice on a daily basis.

In addition to providing an overview of the astoundingly broad range of fields of practice embodied in public health nursing on the local level, the Guidebook also serves as a wonderful introduction to the proud history and important role of public health nursing in the Commonwealth.

During my tenure as Commissioner of Public Health I have gained an enormous appreciation for the work of public health nurses. Particularly noteworthy has been the Association's leadership on behalf of local public health nurses on the Massachusetts Local Health Coordinating Council and the planning group for the Massachusetts Institute for Local Public Health.

Thank you so much for your efforts on behalf of public health nursing, especially your wonderful work on this manual and your leadership and many contributions to the improvement of the public's health across the Commonwealth.

Sincerely,

A handwritten signature in black ink that reads "Howard K. Koh" with a stylized flourish at the end.

Howard K. Koh, MD, MPH
Commissioner

Purpose

The *Public Health Nursing Leadership Guide and Resource Manual* has multiple purposes. It is a compendium of information for the content areas needed for safe practice. It provides a framework for public health nursing practice by presenting current practice standards and competencies.

This document is meant to serve as a:

- Manual for orienting newly hired public health nurses
- Resource manual for public health nurses well established in their practice
- Reference text for nurse educators
- Guide for Boards of Health to understand the many roles and responsibilities of public health nurses
- Model of standards of practice

The purpose of this document is to improve the health of all residents of the Commonwealth through strengthening the leadership role of public health nurses. The *Public Health Nursing Leadership Guide and Resource Manual* is meant to be a dynamic document initially offered as a hard copy while it is formatted to be available and updated electronically. It must be a dynamic document in order to embody the tradition of public health nursing which is to continually adapt and change it's focus and objectives as the public health system is forged and changed. The forces of change may be biological, with emerging pathogens; new interventions based on research, financial or system changes that effect access to care.

The nurses in public health nursing continually assess the needs and resources available to communities, groups and individuals. They organize and work with diverse entities and systems in order to promote, assure and strengthen health and well being of communities; always striving to achieve a higher standard of health for the population. The purpose of this document is to support and guide public health nurses in their day-to-day work as well as their vision for future work as practitioners of population-focused nursing. The independent nature of public health nursing has long required such a mechanism as this document to provide ready access to pertinent information.

Table of Contents

Part I – Chapters

Chapter One - What is Public Health?

Chapter Two - The Nurse's Role in Public Health

Chapter Three - Legal Matters

Chapter Four - Scope and Standards of Care for Public Health Nursing Practice

Chapter Five - Public Health Practice Interventions and Competencies

Part II – Professional Practice Modules

1. Atmosphere and Indoor Air Quality
2. Biohazardous Waste Disposal
3. Blood Lead Screening, Education and Prevention
4. Blood Pressure Screening Clinics
5. Breast and Cervical Cancer Screening Public Health Initiatives
6. Burial Permits
7. Camp Inspections
8. Cholesterol (Lipid) Profile Screening
9. Community Health Network Area (CHNA) Participation
10. Communicable Disease Investigation
11. Community Resources and Referrals
12. Dental Screening
13. Diabetes Screening Clinics
14. Hepatitis A Vaccine
15. HMO Senior Plan Reimbursement Program
16. Home Visits for General Health Supervision
17. Immunization Clinics
18. Influenza Pandemic Planning
19. International Travel Immunizations
20. Latex Allergy in Practice Setting
21. Medicare Reimbursement for Influenza and Pneumococcal Vaccines
22. Rabies Animal Clinics
23. Rabies Prevention in Humans
24. School Health Services to Private Schools
25. Smoking Cessation- Assessment and Referral
26. Tetanus – Diphtheria Vaccine (Td)
27. Tuberculosis Nursing Case Management
28. Tuberculosis (TB) Testing
29. Universal Precautions
30. Vaccine Management

Part III – Appendices

A. Rulings, Schedules and Forms

1. Advisory Ruling 9804- Administration of Immunizing Agents
2. Biohazard Disposition Schedule
3. Board of Health Record Retention Schedule
4. Patient Eligibility Screening Form (VFC)
5. Summary of Reportable Diseases
6. Nursing Clinical Assessment Form
7. Social Service Client Referral Form

B. Massachusetts Department of Public Health, Massachusetts Immunization Program, Model Standing Orders

1. General Protocols for Standing Orders
2. Needlestick Injury
3. Emergency Treatment
4. Model Screening Tools
5. Model Standing Orders

C. Massachusetts Department of Public Health

1. Organizational Structure
2. Bureaus, Divisions, Programs, Hospitals, Regional Offices

Contributors

Managing Editor

Vicki Soler, RN, M.Ed.
Massachusetts Department of Public Health

Format

Ruth Brophy, RN, M.Ed.
Reading Board of Health

Program Committee

Sandy Collins, RN, BSN – Committee Chair
Westford Board of Health

Kathleen Atkinson
Massachusetts Department of Public
Health

Judy Baggs, RN, BSN
Burlington Board of Health

Ruth Brophy, RN, M.Ed.
Reading Board of Health

Mary Doerr, RN
Weymouth Board of Health (retired)

Gail Douglas, RN, MPH
Boston University School of Public
Health

Jane Fiore, RN, BSN, PNP, CHO
Reading Board of Health

Ann Fitzgerald, RN, BSN
Wilmington Board of Health

Kathy Hursen, RN, MS
Massachusetts Department of Public
Health

Sheryl Knutsen, RN, MSN
Gloucester Board of Health

Mary Mulready, RN
Braintree Board of Health

Marie-Eileen Onieal RN, MMHS,
RNC, PNP, FAANP
Massachusetts Department of Public
Health

Andrea Penney, RN, BSN
Home Health Care of Newburyport

Kaydee Schmidt, RN, MS, MPH
Boston Public Health Commission

Vicki Soler, RN, M.ED
Massachusetts Department of Public
Health

Joyce Sullivan, RN, BSN
Hull Board of Health

Charlotte Stepanian, RNC, BS
Merrimack Board of Health

Mary Whitney, RNC, BA
Milton Board of Health

Writers

Judy Baggs, RN, BSN
Burlington Board of Health

Ruth Brophy, RN, M.Ed
Reading Board of Health

Sandy Collins, RN, BSN
Westford Board of Health

Mary Doerr, RN
Weymouth Board of Health (retired)

Gail Douglas, RN, MPH
Boston University School of Public
Health

Jane Fiore, RN, BSN, PNP, CHO
Reading Board of Health

Ann Fitzgerald, RN, BSN
Wilmington Board of Health

Judy Fitzsimmons, RN
Cohasset Board of Health

Kathleen Hursen, RN, MS
Massachusetts Department of Public
Health

Stacy Lane, RN, BSN
Norwood Board of Health

Donna Lazorik, RN, MS
Massachusetts Department of Public
Health

Mary Mulready, RN
Braintree Board of Health

Andrea Penny, RN, BSN
Newburyport Board of Health

Kaydee Schmidt, RN, MS, MPH
Boston Public Health Commission

Vicki Soler, RN, M.Ed
Massachusetts Department of Public
Health

Charlotte Stepanian, RNC, BSN
Merrimack Board of Health

Joyce Sullivan, RN, BSN
Hull Board of Health

Mary Whitney, RNC, BA
Milton Board of Health

Reviewers

Kathleen Atkinson
Massachusetts Department of Public
Health

Alfred DeMaria, Jr., MD
Massachusetts Department of Public
Health

Sally Cheney, MA
Massachusetts Department of Public
Health

Sharon Lefebvre, RN, BSN
Tewksbury Hospital

Anne Sheetz, RN, MPH, CNA
Massachusetts Department of Public
Health

Vicki Soler, RN, M.Ed
Massachusetts Department of Public
Health

We'd like to acknowledge the many departments within the Massachusetts Department of Public Health and the MAPHN Southeast and Northeast chapter members who assisted us with the review process. We apologize for omissions that may have occurred.

Part I: Chapters

Chapter One

What is Public Health ?

Chapter Two

The Nurse's Role in Public Health

Chapter Three

Legal Matters

Chapter Four

Scope and Standards of Care for Public Health Nursing Practice

Chapter Five

Public Health Practice Interventions and Competencies

CHAPTER ONE

WHAT IS PUBLIC HEALTH

I. Introduction

Public health is the systematic approach to preserve, protect, and improve the health of entire populations through the prevention and control of communicable disease, injury and disability prevention, promotion of health status improvement for all, and universal access to preventative services. Public health systems are charged with preventing epidemics and the spread of disease, protecting the public against environmental hazards, disaster response and community recovery, assuring access to quality health care services, and promoting healthy behaviors. These efforts are challenged by the re-emergence of previously controlled diseases and the emergence of new diseases, new and re-emerging social problems, and the changing definition of health and health status. (Massachusetts Guidebook for Local Boards of Health, 1997).

Public health systems intersect at national, state and local levels. National initiatives such as *Healthy People 2000* and *Healthy People 2010* with specific health related goals and objectives help to set the stage for state and local governing boards. Public health systems use data collection and measurable outcomes to help target areas to improve the health and health status of populations. State and local agencies utilize systems to collect and assess data, project and measure outcomes, and assure access to preventative services for their residents. (Healthy People 2010, 1998).

II. The goals of public health

Many of the goals of public health might be considered altruistic, but it is the social good of the many while preserving the integrity of the individual that actually form its foundation. Included in the desired goals and outcomes are healthy people in healthy communities and the preservation and protection of the health of entire populations. It is essential to promote health status for all populations while increasing the span of healthy life and reducing health disparities among the population at-large.

III. Population-based concepts of public health

According to a report presented by the Commission on the Future of Public Health in the Commonwealth of Massachusetts (Massachusetts Public Health Association, 1997), "Public health authorities are generally viewed as responsible for communities and their residents. Private providers and health plans are seen as caring specifically for the patients who have chosen their services." Herein lies the historic separation of public and private providers of health care.

The concept of epidemiology is defined as the study of the distribution of various states of health within the population and the study of the causal relationship of biological, environmental, lifestyle and systems factors associated with those states of health. The purview of public health authorities, private providers, and health plans are unquestionably intertwined. Epidemiology is the basic science common to all public health professionals necessary in the search for the causal relationships in health and illness and for the prevention and control of illness and the promotion of health.

This search may be accomplished through the use of one of the following investigative models used to organize data (Clark, 1994, pp. 108-114):

1. *Triad Model* investigates the relationship between the host, the environment, and the agent.
2. *Web of Causation Model* creates an understanding of the causal relationship between multiple direct and indirect factors.
3. *Dever's Epidemiological Model* examines the interplay of four basic elemental causative factors:
 - human biological factors including genetics, maturation, immunity and physiological factors
 - environmental factors effecting physical, psychological and social elements
 - health care system factors of availability, accessibility and utilization
 - life style factors of employment, consumption and leisure

It is through these epidemiological models the prevention model of practice has evolved over time. Identifying the root causative factors has allowed public health professionals to more effectively prevent illness, injury, and disability. Health promotion and disease prevention has a positive impact on the health status of the population served. Equally important is the ultimate cost effectiveness for preventing illness, injury and disability.

The 1997 Massachusetts Public Health Association (MPHA) report further states: "Public health agencies endeavor, first and foremost, to extend and improve the lives of specific demographic groups or whole communities and all their members. Such communities are usually defined in demographic or geographic terms. They may consist of an age cohort or gender cohort, racial, ethnic or linguistic group, state, county, city, town or some grouping of these areas."

IV. Public Health in Massachusetts

Public health practice in the Commonwealth of Massachusetts is unique to that found elsewhere in the United States. Generally, the home for public health is at the county and state health department level. In Massachusetts, each of the 351 cities and towns in the Commonwealth maintain and administer their own local health departments. These departments or boards of health may be comprised of either elected or appointed membership, generally serving limited terms of office. The

membership of the boards is derived from civic-minded community members, who have varied knowledge of health and sanitation regulations or public health needs prior to their election or appointment. This results in a rapid turnover of board members with agencies in a frequent state of flux and struggling to properly address the community's public health needs.

Each city or town has its own identifiable programmatic health needs or at-risk populations to be served through specific services rendered. However, each of the 351 cities and towns has *mandated services* that must be delivered irrespective of *Home Rule* provisions. Please refer to Chapter 3 in this manual for more complete information pertaining to the Massachusetts General Laws relevant to these topics.

Immunization and communicable disease investigation and case management are two of the prime mandates that generally involve public health nursing. This service is usually provided by a public health nurse employed by the department or board or through a contractual agreement with a nursing service. Many small towns have neither of these alternatives in place causing an unfortunate dilemma for the community and the individual in need of skilled services.

With the philosophical shift of public health practice from a reactive delivery of care to a proactive preventative methodology, communities are actively assessing their public health needs. Economically, most communities cannot afford a full-service health department. Hence, partnerships and collaborative agreements are being developed with local civic groups and neighboring communities to share in the provision and support of services on a regional basis. Public health nursing professionals use networking and the sharing of knowledge as an enhancement to their practice.

V. Core Functions

The rebuilding of public health infrastructure following the infamous 1988 Institutes of Medicine (IOM) report caused public health to rethink its position in the delivery of health care. Conley (2000) stated that public health had two choices. The first was to continue as "static government agencies caught in the maze of categorical funding and relegated to serving populations who have no other source of medical care." The second was to move into the 21st century as significant leaders in the health care industry by returning to basics by providing population-based services and effectively collaborating with private providers in the community and community-based managed care organizations.

It would appear that the latter option was chosen for the future of public health. The mission of public health is to protect and promote health, and prevent disease and injury. In order to accomplish this mission, public health agencies are required, according to Conley (2000), to balance the three core functions essential to the maintenance of population-based services: **assessment, policy development and assurance.**

First: Public health agencies work in collaboration with their communities to **assess** their strengths and weakness and determine their health status. Priorities are established based on assessed data. Community resources must be sufficient to adequately address the problems identified.

Second: The agencies must use the data gathered through the assessment to **develop** health **policy** and recommend initiatives to carry out the policies.

Finally: The public health agencies must **assure** that necessary, high quality effective services are available. This includes responsibility for working with private providers to assure quality care is being delivered and that identified health outcomes are being met. Public health, in addition, has the responsibility to assure that all individuals in the community can access care (Conley, 2000).

VI. Essential Public Health Services

In 1995, the Centers for Disease Control and Prevention (CDC) in collaboration with an extensive group of health care organizations promulgated a detailed list of ten essential services that more explicitly defined the role of public health. These services must be accomplished in order to implement the core functions (Conley, 2000).

1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure a competent public health and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

VII. Healthy People 2000 & Healthy People 2010

Through *Healthy People 2000*, the Surgeon General presented *National Health Promotion and Disease Prevention Objectives* in 1990 as a national strategy for producing a significant improvement in the health of the American people. The three goals of the program were designed to increase the span of healthy life, reduce health disparities, and achieve access to preventative services for everyone. A total of 319 objectives were organized into 22 priority areas. Additional information

pertaining to *Healthy People 2000* is available on the Internet at <http://www.health.gov/healthypeople>.

Healthy People 2010 with 28 focus areas was presented for review in 1998. Two overarching goals were identified:

- to help individuals of all ages increase life expectancy
- improve their quality of life and to eliminate health disparities among different segments of the population

Among the new *Healthy People 2010* objectives, #14 specifically addressed public health infrastructure and its ability to deliver essential public health services that protect and improve the health of a community. Since public health infrastructure is difficult to visualize, five components necessary to support delivery of services are being assessed:

- a skilled workforce (competencies, training, and continuing or distance education)
- integrated electronic information systems (data)
- effective public health organizations
- resources
- research

This concept is a *work-in-progress*. Public health nurses have both the opportunity and the privilege to make this objective achievable.

VIII. Massachusetts Department of Public Health (MDPH)

The Massachusetts Department of Public Health (MDPH) administrative headquarters is located at 250 Washington Street, Boston, MA 02108 with the State Laboratory Institute residing at 305 South Street, Jamaica Plain, MA 02130. The Department's Goal is *Helping People Lead Healthy Lives in Healthy Communities*.

The Department's mission statement is:

- We believe in the power of prevention.
- We work to help all people reach their full potential for health.
- We ensure that the people of the Commonwealth receive quality health care and live in a safe and healthy environment.
- We build partnerships to maximize access to affordable, high quality health care.
- We are especially dedicated to the health concerns of those most in need.
- We empower our communities to help themselves.
- We protect, preserve, and improve the health of all the Commonwealth's residents.

A Commissioner, assisted by Deputy Commissioners manages the Department. There are nine Bureaus with multiple divisions and programs:

- Bureau of Health Statistics, Research, and Evaluation
- Bureau of Health Quality Management
- Bureau of Substance Abuse Services
- HIV/AIDS Bureau
- Bureau of Family and Community Health
- Bureau of Environmental Health Assessment
- Bureau of Communicable Disease Control
- Bureau of Laboratory Sciences
- Bureau of Hospitals

MDPH bureaus contain many programs located at various offices across the state. Brief descriptions of the bureaus, divisions, programs, and locations are included in the appendix.

Visit <http://www.state.ma.us/dph> for more in depth information pertaining to the many divisions within these individual bureaus.

Complementing the organizational structure across the state are regional Prevention Centers that provide organization-building, public information, multimedia library materials, as well as leadership training at the local, regional and state level. Visit <http://www.state.ma.us/dph/mpc> for further information and location of your regional Prevention Center. Six Regional Health Offices are situated across the Commonwealth and serve as distribution centers for vaccines and home for epidemiological resources for the region. Location and access numbers are available at: <http://www.state.ma.us/dph/phone.htm>.

The local link to MDPH is accomplished through two channels. One has historic roots and the other is nearing a decade of existence. The local health history for Massachusetts began in 1799 with Paul Revere as chairman of the first Board of Health in Boston. Since that time, people from all walks of life by virtue of election or appointment have been given the legal authority to set policies and make regulations that protect the public and environmental health. Visiting the website of the Massachusetts Association of Health Boards at <http://www.mahb.org> will provide an overview of the complexity of local responsibilities.

The Community Health Network Area (CHNA), is comprised of twenty-seven areas across the state. Their mission, as a local coalition of public, non-profit, and private sectors working together, is to build healthier communities in Massachusetts through

community-based prevention, planning and health promotion. Visit the CHNA website at <http://www.state.ma.us/dph/chna.htm> .

A schematic visualization of the structure of the Massachusetts Department of Public Health can be obtained at <http://www.state.ma.us/dph/orgchart.gif>. This will provide a clearer correlation of the accountability and chain of command for the previously identified bureaus.

References

Clark, M. (1994). *Nursing in the community* (2nd Ed.). Stanford, CT: Appleton & Lange, 108-114.

Conley, E. (2000). *Core public health functions: A call to action*. Alameda county Public Health Department.

Healthy People 2010 (1998). Available: [On-line]
<http://www.health.gov/healthypeople/>.

Massachusetts Association of Health Boards. Massachusetts Department of Public Health (1997). *The Massachusetts guidebook for local boards of health*
BOH Manual (1997).

Massachusetts Public Health Association (1997). *The future of public health in Massachusetts*. Report by the commission on the future of public health in the Commonwealth of Massachusetts.

Resources

Massachusetts Department of Public Health
250 Washington Street
Boston, MA 02108
<http://www.state.ma.us/dph>

State Laboratory Institute
305 South Street
Jamaica Plain, MA 02130

CHAPTER TWO

THE NURSE'S ROLE IN PUBLIC HEALTH

I. Introduction

A. History of Public Health Nursing

Public health nursing's historical roots evolved from the district nursing concept first developed during the mid 1800s in England. Following the traditions of the *Enlightenment* period of the 18th century, district nursing provided nursing care to the sick poor and helped the poor by providing them with information and channels in the community that enabled them to improve their health status (Swanson & Albrecht, 1993, pp. 30-31). Florence Nightingale directly aided in the success of district nursing by training these first "health nurses."

District and home nursing first emerged in the United States in 1877 when the Women's Board of the New York City Mission sent a graduate nurse into the home to provide care for the sick. Nursing associations later called visiting nurse associations began in Buffalo in 1885 and in Boston and Philadelphia in 1886. In Chapter 2 of Swanson and Albrecht, a chronology of events pertaining to the 1893 establishment of a district nursing service by Lillian D. Wald and her nursing school classmate, Mary Brewster can be found. This service on the Lower East Side of New York City was known as the House on Henry Street or later, the Henry Street Settlement House. Public health nursing history is rich with many references and texts highlighting the contributions of Lillian Wald to the practice of *public health nursing*. Wales (1941, p. 11), provided Wald's description of the term, *public health nursing*, as an "*organic relationship with a neighborhood that constitutes the starting point for universal service to the region.... utilizing as well as implemented by, all agencies and groups of whatever creed....working for social betterment, private as well as municipal....motivated by a vital sense of interrelation with all these forces.* For that reason, they considered themselves *public health nurses*."

Wald published an account of her experiences that led to the founding of the Henry Street Settlement House and the social reforms that ensued in 1915 under the title, *The House on Henry Street*. (This book was reprinted in 1971). In 1902, one of the Henry Street nurses was loaned to the New York City Health Department by Wald to work in the schools as part of an experiment in school nursing. This trial soon led to its widespread adoption of school nurses by Boards of Health or Boards of Education (Swanson & Albrecht, p. 33).

In 1907, Alabama became the first state to legally approve the employment of public health nurses by local boards of health. In 1910, the Department of Nursing and Health began at the Teachers College of Columbia University with field placement at

the Henry Street Settlement. In 1912, the National Organization of Public Health Nursing was formed with Lillian Wald as its first president. A year later, the Los Angeles Department of Health formed the first Bureau of Public Health Nursing. The first public health nurse for the U. S. Public Health Service was also appointed in 1913 (Swanson & Albrecht, 1993, pp. 33-34).

Swanson & Albrecht cite an excerpt from Dreher's (1984) ethnohistorical study of public health nursing in rural New England at the turn of the century. While its purpose was to examine the cost-benefit ratios of population-based public health nursing practice as opposed to a private agency, it is remarkably accurate in describing the health promotion and disease prevention activities that we continue to provide in similar fashion a century later. Just as Lillian Wald brought social justice to the neediest of the needy more than one hundred years ago, we today are also in a position to deliver health and hope to the current underserved population among us.

B. History of Public Health Nursing in Massachusetts

Boston was among the early pioneers in developing district nursing associations. The first was called The Instructive District Nursing Association and recognized teaching as an objective of the district nurse as well as home care. In addition to Boston, Waltham, Brockton, Newton, Needham, and Worcester all had visiting nurse associations that addressed and met the needs of poor sick children and those infected with disease. Teaching the family was a major element in the public health nurse's role.

In 1912, in-service education was developed and advanced under the joint management of Simmons College and Harvard University. As public health nursing practice expanded, it became evident that the skills and knowledge base required a multiple disciplinary approach. By the 1950s as universities began to develop baccalaureate degree level nursing programs, public health nursing practice was added to the curriculum.

In 1975, the Bureau of Public Health Nursing was eliminated. This resulted in many nurses being transferred to other units within the state health department. The advent of managed care in the 1980s drastically altered the health care delivery and reimbursement system. Public Health nurses were called upon once again to fill in the voids in health care.

The public health infrastructure continues to be rebuilt following the 1988 Institute of Medicine's critical report of the public health system. Public health nursing has assumed its seat at the political table on behalf of the populations it serves. In 1998 independent regional public health nursing groups across the state joined together to form the Massachusetts Association of Public Health Nurses. This is the only incorporated organization for public health nurses in the Commonwealth. One of the goals of the organization is to promote public health nursing practice in accordance with accepted national standards.

II. Functions of Public Health Nursing

C. Disease Prevention

The goal of public health nursing is to keep the community healthy using the core functions of **assessment**, **policy development**, and **assurance**. Population-based interventions emphasize prevention. Throughout this document, the nursing process (**assessment**, **problem identification**, **diagnosis**, **planning**, **implementation**, and **evaluation**) underlies and is applied to each intervention.

Prevention is acknowledged to save lives and improve the quality of life. Priority is given to primary health prevention and protection. Its goal is to prevent a disease from occurring through “*protection from actual and potential health threats.*” More formally stated, primary prevention is:

“The empowerment of individuals, families, and communities to achieve and maintain their maximum health and functioning through promotion of health enhancing behaviors and the reduction of biological, economic, social and environmental risk factors which contribute to the incidence of illness, health problems, and disability” (MDPH, 1994 p.11).

Examples of primary prevention by a public health nurse include:

- conducting adult and childhood immunization clinics
- programs on smoking risks
- pre-natal nutrition education and counseling
- stress reduction programs
- elderly safety and fall prevention in the home (Refer to Professional Practice Modules)

Examples of Massachusetts Department of Public Health (MDPH) Primary Prevention efforts include:

- Tobacco Initiative
- Food Stamp Program
- WIC (Women, Infants, and Children) Nutrition Program
- Chronic Disease Prevention Program

Secondary health prevention is defined as, “*early detection and intervention to promote the health and well being of those who are the most at risk of illness, or are beginning to experience health related problems and disability*” (MDPH, 1994). Its goal is to cure disease in the early stages, or to slow its progression. This also includes reduction of risk factors.

Examples are most commonly in the form of screenings and can include:

- Lipid Profile Testing to detect risk factors for Coronary Artery Disease
- PAP (Papanicolou) testing for Cervical Cancer
- Mantoux testing for Tuberculosis

- Phenylalanine testing in infants for PKU (Phenylketonuria)

Case finding is a component of screening. An element of secondary prevention is to identify the unmet health needs of the uninsured and underinsured population. Public health nurses collaborate with health service providers in the community and may form partnerships with a local health care organization to establish free care for this population.

Examples of MDPH Secondary Prevention include:

- Programs for children with AIDS (Acquired Immunodeficiency Syndrome)
- Early intervention for infants and children with special needs
- School health
- Refugee health
- Lead poisoning detection and treatment

Tertiary health prevention, the treatment, care and rehabilitation to prevent further progression of disease, is defined as an *"intervention to promote the maximum health of those experiencing illness or injury, designed to limit the onset of disability and secondary condition resulting from the initial health problem"* (MDPH, 1994).

Examples of public health nursing tertiary interventions include:

- home visits to the chronically ill
- referrals of individuals and families to support groups for specific therapies and interventions, i.e. physical therapy for a stroke patient to preserve muscle tone, restore motion and prevent contractures
- special services to individuals with residual organ damage
- infants with poor fetal outcome resulting from pregnancy induced hypertension (PIH)

Examples of DPH tertiary prevention include:

- Tobacco Initiative sponsored smoking cessation programs
- Early Intervention programs

D. Disease Investigation/Reporting/Case Management

The Communicable Disease Control Bureau's Epidemiology and Immunization Division has published a comprehensive manual on the surveillance and reporting. The manual details the disease reporting process. For public health nurses the communicable disease process begins when the confirmed report of a "dangerous" disease is received. Diseases defined as "dangerous" are specified by regulation. The MDPH publishes the *Summary of Reportable Diseases and Isolation and Quarantine, 1999*. The confirmed report may come from a :

- licensed clinical laboratory
- medical provider (MD)
- hospital emergency room
- hospital infection control department

Using the MDPH Division of Epidemiology and Immunization Case Reporting forms (see appendices), the public health nurse begins to take action. Using the appropriate disease reporting investigation form, the nurse obtains information pertaining to:

- disease history
- determination of etiology and/or source of infection
- identification of case contacts
- appropriate treatment
- individual and/or group education
- case follow-up

In the case of a **disease outbreak**, i.e., Pertussis outbreak, the public health nurse collaborates with:

- MDPH regional epidemiologist
- medical providers
- school nurses
- parents
- administrators
- day-care providers
- potential case contacts to control the outbreak

Disease investigations and reports should be completed within 24 hours. All information is confidential. Records are retained for 30 years.

In **food-borne illness** investigations, the public health nurse receives confirmed reports from:

- licensed medical laboratories
- MDPH State Laboratory

These reports require investigation within 24 hours and are reported to the MDPH Surveillance and Epidemiology Unit. If a food-borne illness is traced to a local food establishment, the local health department works with the facility, and excludes workers who are determined to be disease carriers.

This is a public health opportunity to educate:

- the client or facility and family on the disease process
- the steps necessary to prevent further spread of infection, especially in group settings such as day-care centers, schools or prisons

Sexually transmitted diseases (STD) are not reported to the boards of health. They are reported directly to the STD Division of the MDPH by licensed medical laboratories or medical providers. These reportable disease include:

- HIV/AIDS
- Gonorrhea
- Syphilis

HIV/AIDS cases are also reported to the MDPH AIDS Bureau for tracking purposes. Partners and contacts of persons testing positive may access anonymous test sites across the state. The MDPH AIDS Surveillance program publishes the AIDSLETTER that reports data on HIV in the state. Partner and contacts of persons testing positive may access anonymous test sites across the state. Information on HIV/AIDS services and programs is available through the AIDS Bureau at 250 Washington St., Boston.

Hepatitis B and **Hepatitis C** are reported to the local Board of Health in the community where the individual resides. There has been a significant decline in the number of confirmed Hepatitis B cases statewide. In part, this can be attributed to the collaboration between school nurses and public health nurses working together to improve the immunization rates among school age children. Immunization for hepatitis B is required for entry to daycare and schools in the Commonwealth.

Tuberculosis is reportable directly to the MDPH Division of TB Control. At the local level, the public health nurse provides Mantoux testing and interpretation, distributes Purified Protein Derivative (PPD) to community providers when secondary testing is necessary, and generally provides case management locally for identified patients. At the regional level, Tuberculosis Surveillance Areas (TSAs) have assigned free care clinics where follow-up care and medication may be provided. Multicultural outreach workers and interpreters are available upon request through the MDPH Division of TB Control.

Lead poisoning prevention and investigation, with the testing component now incorporated into pediatric medical practices for children 0-5 years of age, can again become a function of the public health nurse in underserved areas. The protocol and guidelines for the Childhood Lead Prevention Program (CLPP) direct the process. In the event of an elevated lead level test, CLPP regional teams will provide case management. (Lead testing is required for school entry in the Commonwealth.) See professional practice module for blood lead screening.

Nationally, the Centers for Disease Control (CDC) in Atlanta, GA maintain new and emerging pathogen data, as well as track and follow large outbreaks. The *Morbidity and Mortality Weekly Reports* (MMWR) are published by the CDC and provide current disease updates and travel advisories. Visit the CDC website at <http://cdc.gov> to access a wealth of information pertaining to the public's health.

E. Health Promotion/Protection

Continuing with the premise of applying **core function** and **nursing process** to all our public health nursing practice, several existing mechanisms are available to facilitate *assessment* and *policy development*. Nurses have presumed skills in the assessment of an individual. There are a number of assessment tools available to conduct a community survey. Carl Helvie's (1998), *Energy Theory for Community Assessment* format, is readily applied to information accessible by the public health nurse. More formal tools such as *Assessment Protocol for Excellence in Public*

Health (APEX) from the CDC or *Planned Approach to Public Health* (PATCH), a joint product of the CDC and National Association of County and City Health Officers (NACCHO) are commonly used by local health agencies.

Data sources within the Commonwealth's agencies and departments can be accessed electronically or by direct contact in most instances. To obtain a wealth of information about your particular community, visit the Commonwealth Communities website at <http://www.state.ma.us/cc/>. The Department of Public Health can be visited at <http://www.magnet.state.ma.us> for further information pertaining to the following databases:

- Cancer Registry: Number of cancer deaths in the local community
- Children's Medical Security Program: Number of enrolled children under the age of 19
- Early Intervention: Number of disabled children receiving assistance
- Environmental Health: Number of hazardous waste sites
- First Link: Number of newborn and families receiving home visits
- Health Care Quality: Number of hospital admissions for heart conditions, diabetes, and asthma
- Healthy Start: Number of uninsured mothers receiving pre-natal care
- MassChip: Secure site for obtaining health statistics
- Maternal-Child Health: Number of low birth weight infants, infants born with birth defects, and infants born to mothers that smoke
- Women, Infants & Children (WIC): Number receiving food vouchers

Additional broad-based compendiums of information are available from the Department of Medical Assistance and the Department of Social Services regarding families receiving aid for dependent children, food stamps, and medical assistance. The Department of Education can offer documentation for the number of students receiving free school lunches. These state resources can be combined with local social service providers to develop a snapshot of the at-risk and needy in the community.

It becomes more difficult to assess the mental health needs within a community. Problems often are hidden until precipitated by a crisis. Initial *assessment* of a mental health problem could indicate the inability of your locality to provide necessary treatment. A public health nurse may be required as part of *policy development* to build collaborative relationships within your region to eliminate this shortcoming.

Public health is not limited solely to a disease process and its prevention. The public's health is complex with a composite array of environmental, lifestyle and behavioral factors that contribute to the equation. Pollution of air quality, chemical exposure, hazardous waste, second-hand smoke and the increased incidence of skin cancer now compound prior clean water and sanitation concerns. Personal safety should be addressed through seatbelt enforcement and education, bicycle safety and helmet use in the schools, knowledgeable medication use, lifestyle

changes, and through stress reduction and negotiation as a mechanism to reduce the impact of violence. (See Chapter 3 for mandated reporting criteria & professional practice modules for health promotion activities.)

III. Collaboration/Coalition Building

A. Establishing Partnerships

A majority of public health nurses in the Commonwealth practice independently and must rely heavily upon the collaborations and coalitions that they create or those already established in the community. Without these structures in place, meeting the needs of the individual, families or the community is difficult. As problems are identified and prioritized, interventions must have the potential for success.

Collaboration and coalition building can lead to the establishment of a partnership of organizations and professionals combining resources and skills to achieve a shared vision. This vision might be the elimination of disparities that limit access to care for the uninsured and/or underinsured, the underserved, and the financially and physically disabled populations. This shared vision might be designed to strengthen and mobilize a community health promotion campaign through education and advocacy. Other possibilities that could be explored in this manner are endless as populations have continually evolving health and social needs that require collective resolutions.

The following is a list of suggested collaborations and/or coalitions that could become viable partners for the public health nurse:

1. Contact local hospitals and/or Health Maintenance Organizations (HMOs) to become a member of their Community Benefit Planning Committees.
2. Join an existing, or start a “professional providers network” or “professional advisory committee” with public and private health care providers, agencies, and organizations to maintain a current and comprehensive network.
3. Establish or become a member of committees addressing community assessment and planning of health care, using municipal departments and other disciplines.
4. Become a board member of public and/or private service agencies.
5. Establish working relationships with local accredited hospitals and educational institutions that provide teaching, training and research for students in degree granting or advanced practice programs including resident physicians and fellows in post-graduate training. Offer the agency as a field site for training.
6. Become an active member of professional organizations and take advantage of networking opportunities.
7. Attend local Community Health Network Area (CHNA) monthly meetings on a regular basis.

Any or all of these activities and partnerships will contribute to the assurance that there is an opportunity for healthy people to reside in your community.

IV. Advocating for Individuals/Populations

Swanson & Albrecht (1993, pp.192-193) provide a clear statement of the indispensable role of nursing. As advocates, nurses are seen as the professional whose knowledge, skill, and concern are used to promote society's well being through a disciplined process of change. They are the interpreters of the health care system for the public. Since public health nursing is so profoundly affected by governmental funding, public health nurses must know how to actively participate in the political process. To be effective, public health nurses should have or be willing to acquire a sound knowledge of community, state, and national governmental organization and function. They must know how to interact with the system and how to actively influence the creation of health care legislation and health care policy. The lives of two of our historic nursing leaders, Florence Nightingale and Lillian Wald, clearly show that their interaction with the political systems can bring about disciplined change for the betterment of needy populations and the health of all.

V. Utilizing Technology

Electronic resources have been mentioned repeatedly in the above sections as readily available information sources. Unfortunately, many small and rural communities have yet to acquire the necessary equipment. For this segment of our profession, we urge you to persevere and seek out the resources necessary through grant application and local initiatives.

Database information has become crucial for validation purposes throughout health care. While many of these demands are related to fiscal accountability, this same data provides the foundation for community assessment needs. Real-time record keeping is already in place in our communities with home care agency staff personnel using hand-held computers. Systems that allow public health practitioners the same advantages have been available for several years. Reference to technology as a tool for life-long learning is addressed in the following section. Several websites and a recent text are listed in the resources that can offer you unlimited medical and health references. Visit the local public library for assistance in securing publications or accessing the Internet if not available through the workplace or personal computer system.

VI. Professional Development

In keeping with the trend of lifelong learning, public health nurses must continually remain abreast of advances in both his/her professional and personal life. With the shift into the information age, public health nurses, can no longer remain complacent with simply being proficient in *hands-on* nursing skills. They must also have both the

skill and the ability to readily access current evidence-based knowledge and information through the internet.

Computer skills have become an essential component in public health nursing practice as a tool for compiling necessary data to preserve patient's records and validating job performance for the municipality. Using a global perspective, the information age has created a new nursing specialty, Nursing Informatics which is certified by the American Nurses Credentialing Center (ANCC) at the graduate level. Professional practice standards for nursing informatics have been published by the American Nurses Association as nursing data moves forward to create new nursing information for the enhancement of nursing knowledge.

Public health nursing in its independent venue of practice has the potential to benefit greatly from this ready access to knowledge and networking capability. The isolation that once limited lifelong adult learning prospects for the public health workforce has been eliminated. Adult learning is focusing on transporting the learning environment to where the learners live. With this concept and the urgent need for current information in order to practice safely, public health practitioners are but a mouse-click away from continuing education material and documents that enrich both the individual and the community.

The 1999 *Scope and Standards of Public Health Nursing Practice* published by the American Nurses Association in conjunction with the Quad Council of Public Health Nursing Organizations promulgated distinct recommendations for the educational requirements. Baccalaureate preparation is deemed necessary for entry into practice when the health of the public is the goal. Master's level nurses are seen developing and evaluating programs and policy directed toward health promotion and disease prevention for at-risk populations (ANA, 1999). This challenges the highly dedicated public health nursing workforce towards professional development through life-long learning opportunities.

It is through continued learning that public health nursing professionals have become strong advocates for their communities. They must be able to speak for those without a voice and bring about change in policy and behavioral actions and beliefs. Public health nurses have become visible through their many contributions to professional journals and organizations.

Nurses remain the most trusted and believable members of the health care team in the public's view according to recent public opinion polls. It behooves public health nursing practitioners to capitalize on this trust as they interact with their communities. They *are* the experts in the battle to promote *Healthy People Living In Healthy Communities* throughout the Commonwealth of Massachusetts.

References

- American Nurses Association (1999). *Scope and standards of public health nursing practice*. Washington, DC, American Nurses Association.
- Dreher, M. (1984). District nursing: The cost benefits of a population-based practice. *American journal of public health* (74), 1107-1111.
- Helvie, C. (1998). *Advanced practice nursing in the community*. Thousand Oaks, CA. Sage Publications, 435-444.
- Massachusetts Department of Public Health (1994). *Blueprint for prevention: A framework for maximizing health*. Boston, MA. (Vol. 1) 11.
- Swanson, J. & Albrecht, M. (1993). *Community health nursing: Promoting the health of aggregates*. Philadelphia, PA, W. B. Saunders Company, 30-34, 192-193.
- Wales, M. (1941). *The public health nurse in action*. New York, NY. Macmillan, 11.

Resources

- American Nurses Association. Available (on-line) <http://www.nursingworld.org>
- American Medical Informatics Association, Nursing Informatics Working Group
<http://www.AMIA-NIWG.org>
- Massachusetts Association of Public Health Nurses <http://www.maphn.org>
- National Library of Medicine. Available (on-line) <http://www.nlm.nih.gov/>
- Sigma Theta Tau, Nursing Honor Society. Available (on-line)
<http://www.nursingsociety.org>
- Thede, L. (2003). *Informatics and nursing: Opportunities and challenges*. Philadelphia, PA, Lippincott-Williams and Wilkins.
- Thede, L. (1999). *Computers in nursing: Bridge to the future*. Philadelphia, PA Lippincott-Williams and Wilkins.
- Wald, L. (1971). *The house on Henry street*. New York, NY. Dover Publications, Inc., (reprint of House on Henry Street, New York, Henry Holt & Company, 1915).

CHAPTER THREE

LEGAL MATTERS

This chapter provides only an overview of issues of the law that are relevant to public health nurses and to your practice. It is not meant to be exhaustive but rather to provide a starting point of inquiry. Should you have questions about your legal public health nursing role and level of accountability, it is critical that you call the Board of Registration in Nursing or the Massachusetts Department of Public Health for assistance. As a professional, it is imperative to know what you do not know and then to frame the questions. If there are situations beyond your capability, your expertise, or your education, it is your obligation to protect the public by referring the issue to someone who might assist you and your community.

I. Introduction

Public health nurses are licensed under the Board of Registration of Nursing in the Commonwealth of Massachusetts. As licensees they are individually responsible and accountable for their practice. The board recognizes that taking care of patients is a complex process requiring not only the safest possible systems but also competent individuals following safe standards of care within those systems (McCarthy, 2000). Public health nursing is population-focused, community-oriented nursing practice and may include caring for individual members of that population. Because licensure is not venue specific, nursing practice in public health bridges many areas of health and social service care. It is therefore important that licensed nurses who work in public health understand the complexities, the inter-relationships and the context of their nursing practice.

With that in mind, this chapter will discuss the roots of the law as it pertains to the public's health as well as the many connections that must be made to integrate the nurse's role within this context. This chapter will describe basic principles of the law, and its role in protecting the public's health. It will lay the foundation for Standards of Care describe a level of care or performance common to the profession. (The basic standard is defined by what a prudent public health nurse would do in a like or similar situation). Chapter four is a compilation of those discrete standards by which the public health nurse is evaluated and held to, and models for performance expectations for the position of municipal or public health nurse for a city or town.

To understand the law as it relates to the public's health, it is important to understand some basic concepts about our legal system and how it operates. There are four primary forms of law: statutes, constitutions, regulations and judicial opinions. Statutes are law passed by legislatures at any level of government. There are federal statutes, state statutes, and the equivalent of statutes passed by city and county governments that may be called ordinances or municipal laws. Statutes are codified, arranged according to subject matter, in sets of volumes or codes that are

periodically updated to reflect recent changes. Constitutions are also laws and are the written legal documents establishing the government. The United States Constitution defines the various powers of the federal government and the function of its branches. By virtue of the ninth and tenth Amendments, there are certain authorities left to the States such as regulation of professions and the local public health. In addition to statutes and constitutions, there are regulations that are also laws. Regulations are authorized by statutes and implemented under statutory law. State Legislatures delegate authority to administrative agencies such as the Massachusetts Department of Public Health where such regulations are proposed, hearings held for debate and then enacted.

There are also three branches of the government that are related to the law: legislative, executive and the judicial. The legislative branch usually makes law, the executive enforces the law and the judicial branch interprets the law. The executive branch at the state level, in its expansion, creates the administrative agencies such as the MA Department of Public Health. This is where most public health regulatory laws that are authorized by statute are established.

The function of law is to define and enforce legal rights. First, for there to be a legal right there must be a specific law that recognizes that right. There is a relationship between two parties that confers benefits on at least one and creates a duty or responsibility on the other (Wing, 1999). **Hence the balance that public health must hold: to protect an individual's freedoms and rights but not at the expense of the health of society.**

II. Source and Scope of legal authority

To accomplish the goals of public health in the community, it is imperative that public health nurses understand the sources of authority. There are three primary sources of authority: federal, state, local.

A. The Federal Government

The powers of the federal government are limited to those functions explicitly delegated by the Constitution of the United States inclusive of its amendments. All other powers are reserved for the states or the people. Although health and safety matters have been considered properly regulated by the state and local governments, federal regulatory action is derived from the power to regulate inter-state commerce and to levy taxes. The Federal impact is powerful in the administrative law and regulations that follow. Occupational Health and Safety Administration (OSHA), employment laws, anti-discrimination statutes, Americans with Disabilities (ADA) implementation, and other mandates such as Centers for Disease Control (CDC) advisories have impact on program development and enforcement at the state and local levels.

B. The State Government

State governments have broad powers. These include powers to prescribe, within the limits of the state and federal constitutions, reasonable regulations necessary to preserve the public health, safety, and welfare. These powers, commonly referred to as *police powers*, are derived from the nature of state government. Two basic purposes that must be held in balance are to protect the rights of a given individual and to protect the health of society at large. The primary role of government is to protect the health of society, even at the expense of an individual's freedom. State agencies derive virtually all of their powers from laws enacted by the state legislature and approved by the Governor (MAHB & MDPH, 1997). Local governments derive most (but not all) of their authority from such state laws. (MGL is the abbreviation for Massachusetts General Laws, c. denotes the chapter of the General Law, § denotes section of the General Laws.)

C. Local Authority

Local public health departments derive their authority primarily through explicit and specific delegation of power from the state legislature. Local regulations must be consistent with state law. Local regulations **may be more** stringent than existing state mandates, **but in no case may they be inconsistent with state regulations**. The local regulations must be "reasonable" solutions to the problems they address and reasonably related. It is the "reasonableness" that is tested in court (MAHB & MDPH). Since 1986 there is an amendment to the Massachusetts Constitution called the "**Home Rule Amendment**". This amendment provides that local governments have the power, through their own ordinances and bylaws and without specific authorization from the state, to regulate in areas that the state's law does not prohibit them from regulating. Cities and towns may promulgate general ordinances and bylaws related to health matters that will be enforceable by the local Board of Health or other public board or official. These local ordinances and regulations are not enforceable if they conflict with applicable federal or state law or if they are unconstitutional or are not reasonably related to legitimate local government interest (MAHB & MDPH).

To enforce health regulations created by the local board or the city or town, local boards are sometimes granted the power to make inspections and examinations to issue, revoke or suspend licenses or permits. Local Boards are directly responsible for the enforcement of the regulations they create or the standards of state or federal Codes. Certain state statutes provide for *coordinate powers* of the Department of Public Health with local boards of health (e.g. M.G.L. c 111§7 concerning the investigation of contagious or infectious diseases), or *concurrent responsibility and authority* [e.g. M.G.L. c. 111 §198 concerning enforcement of lead poisoning prevention and control statutes (MAHB & MDPH)].

III. Standard of Care for Public Health Nurses

The standard of care for a licensed nurse practicing in a public health venue is determined by what a reasonably prudent licensed nurse would do in the same or similar situation. The position or job description is but one local standard and must be congruent with the practice expectations as outlined in the Board of Registration of Nursing. That being said, it is up to licensed nurses to know what the standards of his/her practice are regarding public health and public health nursing practice. All applicable nursing statutes, regulations, and community/public health regulations that another prudent licensed public health nurse would know and follow become the standard. The Massachusetts Board of Registration in Nursing enforces the rules and regulations promulgated by the Board and they are not venue specific. Since the nurse is granted a privilege through licensure, (of providing health care), the actions, or omissions are judged against an array of evidence offered as the standard of care. But whatever the standard that is applied, if the nurse falls below that standard, acts in contrast with the standard or fails to act within that duty relationship and harm or injury has been caused, the nurse may be liable. As a rule, a nurse should comply with the standard of care recognized for the professional level at which the nurse practices.

IV. Common Principles of the Law

Informed Consent

The doctrine of informed consent, is that **before** a patient is asked to consent to any treatment or procedure that has risks, alternatives, or low success rates, the patient must be provided with certain information. This information must be information that the patient deems as relevant to assist him/her to make a decision and includes at least the following, which must be presented in a manner and in the language the patient can understand.

1. A description of the recommended treatment or procedure.
2. A description of the risks and benefits of the recommended procedure, with special emphasis on risks of death or serious injury.
3. A description of the alternatives, including other treatments or procedures.
4. The likely results of no treatment.
5. The probability of success.
6. The major problems in recuperation and the time period during which the patient will not be able to resume normal activities (Annas, 1989).

Confidentiality and privilege

Patient information belongs to the patient. In 1996 the Health Insurance Portability and Accountability Act (HIPAA) mandated regulations to be created that govern privacy, security and administrative standards for health care information. In December 2000, US Health and Human Services(HHS) enhanced the HIPAA by including privacy of all information, oral, electronic and written. This also covers

access to information ensuring that the patient must be able to see and get copies of the records, and request amendments. It ensures that health information is not used for non-health purposes, and that disclosures of information must be limited to the minimum necessary for the purpose of the disclosure. Health information that is stored, computerized, sent by fax machine, and in individual records must be safeguarded to the highest level, and consent from the patient must be provided in order to share it. Visit <http://cms.hhs.gov/hipaa>, <http://hhs.gov/ocr/hipaa>, or <http://www.cdc.gov/privacyrule> for current information guiding public health practice. Massachusetts has legislated confidentiality of information pertaining to HIV and the HLTV-III test. Chapter 111, section 70F requires written informed consent to release results of HIV testing. A communication is privileged if the person to whom the information is given is forbidden by law from disclosing it in a court proceeding without the consent of the person providing it. This testimonial privilege is a legal rule of evidence, belonging to the patient, not to the professional (Annas). Registered nurses in Massachusetts do not have privilege, except psychiatric nurse clinical specialists who practice in the expanded role.

Defining an emergency

“Prudent Layperson Standard”-“**Emergency Medical Condition**” is defined in MGL Chapter 176, section 5a.: a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of a member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

V. Liability for Negligence

The Massachusetts Tort Claims Act (M.G.L. c.258) makes public employees liable for the negligent acts or omissions of public employees and immunizes those employees from personal liability for negligence. *Public employee* is broadly defined in the act to include officers and employees of any public employer. *Public employer* includes any county, city, town, public health district or joint district or regional health board established pursuant to the provisions of M.G.L. c. 111 §§ 27A or 27B.

A public employee is immune from personal liability for discretionary decision-making as long as he/she acts in good faith and without malice or corruption. The courts have defined a discretionary function as one characterized by a high degree of discretion and judgement invoked in weighing alternatives and making choices with respect to public policy and planning (MAHB & MDPH, 1997).

This immunity does not apply to the nursing license as the Board regulates nursing practice and is not venue specific. Nursing practice is the purview of the

Massachusetts Board of Registration in Nursing and meeting and/or not meeting the Rules and Regulations for Licensed Nurses is under their domain. Failure to meet the standard of care as defined by these licensure standards could be reason for license revocation.

The public employee remains personally liable for civil rights violations, intentional torts such as assault and battery, false imprisonment, intentional infliction of emotional distress, libel, slander, misrepresentation, deceit, invasion of privacy.

In **Massachusetts General Law 112, section 12C** there is also immunity for a physician or a nurse providing an immunization or other public health program. It states: "No physician or nurse administering immunization or other protective programs under public health programs shall be liable in a civil suit for damages as a result of any act or omission on his/her part in carrying out his/her duties.

VI. Federal Law of Interest

A. United States Constitution

1st Amendment: Freedom of speech and press

Congress shall make no law respecting an establishment or religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people to peaceably assemble, and to petition the government for a redress of grievances.

4th Amendment: Freedom and protection from unreasonable search and seizure

The right of the people to be secure in their persons, houses, papers, and the effects against unreasonable searches and seizures, shall not be violated, and no warrants shall issue, but upon probable cause, supported by oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.

14th Amendment: Equal protection and access to the law, due process rights including notice

In part : No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

B. Civil Rights Act of 1964

Discrimination against any individual with respect to hiring, discharge, compensation, terms, conditions or privileges of employment because of such

individual's race, color, religion, gender, or national origin is prohibited by the Civil Rights Act of 1964. The Act also forbids employers to limit, segregate, or classify employees in any way that would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his or her status as an individual because of such individual's race, color, religion, gender, or national origin.

As amended, the act includes the Pregnancy Discrimination Act, which prohibits discharge because of pregnancy, childbirth, or related medical conditions and requires employers to provide maternity benefits under their insurance programs if other disabilities are covered. The act also prohibits sexual harassment.

C. Occupational Safety and Health Act of 1970

Federal standards for a safe and healthful working environment were established by the Occupational Safety and Health Act of 1970. The act also prohibits the discharge of employees if they refuse to work in an unsafe workplace or otherwise exercise their rights under the act.

D. Equal employment Opportunity Act of 1972

This act ensures that state and local governments, government agencies, and political subdivisions and departments offer equal employment opportunities to all people.

E. Rehabilitation Act of 1973

Section 503 of this act prohibits job discrimination on the basis of disability and requires affirmative action to employ and advance employment individuals with disabilities who, with reasonable accommodation, can perform essential functions of the job.

F. American with Disabilities Act of 1990 (ADA)

This act provides for equal opportunity for people with disabilities in employment, public accommodations, and transportation. The act prohibits discrimination in hiring and promotion of qualified persons with disabilities, and requires that employers provide reasonable accommodation such as job restructuring and equipment modification unless such provisions impose undue hardship.

G. Drug Free Workplace Act of 1988

This law applies to employers who have a contract of \$25,000 or more with the federal government. It requires publication of a statement to employees prohibiting controlled substances in the workplace. Employers covered by the law must also

establish a drug-free awareness program, publish the statement, and make other efforts to maintain a drug-free workplace.

H. Occupational Exposure to Bloodborne Pathogens: Final Rule Department of Labor, OSHA 29 CFR 1910.1030

This regulation outlines the definitions, rules and practices regarding all occupational exposures to blood and other potentially infectious material.

I. The Needlestick Safety and Prevention Act, Public Law 106-430 of 11/6/2000

This law amends the OSHA bloodborne pathogens standard to require all health care facilities/organizations to use needle systems and sharps with engineered protections such as retractable needles, keep a sharps injury log, adequately train direct health care workers on the use of needleless technologies and systems with engineered sharps protections.

J. Federal Public Law 87-301

This law re: resident aliens newly arrived in the United States, with diagnosed or suspected TB must be identified and all appropriate forms must be completed and the implementation of disease control protocols instituted.

VII. State Laws

A. Mandatory Reporting

In Massachusetts, there are four categories of family violence in which mandatory reporting rules apply: abuse of children, abuse of elders, and abuse of disabled people, and people who have been stabbed, shot, or burned more than 5% of the body.

Abuse and Neglect of Children

M.G.L. c.119 §51A mandates certain categories of professionals who come in contact with children to report suspected abuse or neglect to the Massachusetts Department of Social Services (DDS). Mandated reporters include such individuals as physicians, medical interns, hospital personnel, medical examiners, psychologists, emergency medical technicians, dentists, nurses, chiropractors, podiatrists, public or private school teachers, educational administrators, guidance or family counselors, probation officers, social workers, foster parents, fire fighters, police officers as well as administrators of child centers and licensed family day care providers and all their employees.

A mandated reporter must file a written report within 48 hours to the MA Department of Social Services after an immediate oral communication to the DSS if he/she has reasonable cause to believe that: A child under the age of 18 years old is:

- suffering from physical or emotional injury resulting from abuse inflicted upon him which causes harm or substantial risk of harm to the health or welfare, including sexual abuse;
- suffering from neglect, including malnutrition; or
- physically dependent upon an addictive drug at birth.

Any such person so required to make such oral and written reports and who fails to do so shall be punished by a fine of not more than one thousand dollars. No person making such report shall be liable in any civil or criminal action by reason of such report if it was made in good faith.

One needs to have a reasonable belief or suspicion that abuse is occurring. One does not need to have direct knowledge.

In order to make a report, telephone the Department of Social Services area office serving the child's hometown and ask for the protective screening unit. On weekends or after hours you can call the DSS Child-at-Risk Hotline at 1-800-792-5200.

Elder Abuse

In general, elder abuse or mistreatment is defined as an act of commission or omission that results in harm or threatened harm to the health and welfare of an adult 60 years of age or older. The parameters of abuse include: physical abuse, physical neglect, psychological abuse, psychological neglect, and the violation of personal rights.

In summary, **Massachusetts General Law, c. 19A §14 mandates:** When providers have reasonable cause to believe that an elder, who is 60 years or older, has suffered or is suffering from:

- Abuse: injury caused by someone's physical, sexual or emotional conduct; or
- Financial Exploitation: substantial financial loss to the elder caused by someone's actions or failure to act;
- Neglect: a caretaker's refusal or failure to provide one or more of the basic necessities of life; or
- From a combination of these acts.

In the above, providers must make a verbal report to the Executive Office of Elder Affairs at the Elder Abuse Hotline 1-800-922-2275 and file a written report within 48 hours of their oral report. The law protects professionals who file a report from civil and criminal liability. Failure to report may result in a criminal fine up to \$1000.

Abuse of Disabled

In general, a disability may mean any physical, mental, or emotional impairment which affects a person's ability to learn, hear, see, walk, work, or take care of himself/herself. Disabilities can include, but are not limited to: mental retardation, autism, cerebral palsy, blindness, deafness, AIDS, mental illness, learning disabilities, serious illness, alcohol or drug addiction.

Massachusetts law M.G.L. c. 19C §1, defines a disabled person as “a person between the ages of 18 and 59, inclusive, who is mentally retarded or otherwise mentally or physically disabled and as a result of the disability is wholly or partially dependent upon others to meet daily living needs.”

A verbal report of such information may be made to the Disabled Persons Protection Commission (DPPC) by calling the **24 hour Hotline at 1-800-426-9009**. If the disabled person is in an institution/ or receiving home health or nursing home services, the report must be made to the DPH at 1-800-462-5540. Mandated reporters and others are immune from civil or criminal liability for a report made in good faith.

Report of treatment of wounds, burns and other injuries

“Every physician attending or treating a case of bullet wound, gunshot wound, powder burn or any other injury arising from or caused by the discharge of a gun, pistol, BB gun, or other air rifle or firearm, or examining or treating a person with a burn injury affecting five per cent or more of the surface area of his body or whenever any such case is treated in a hospital, sanitarium or other institution, the superintendent or other person in charge shall report such case to the state fire marshal and to the police in the community where the burn occurred. **M.G.L. 112, § 12A**”

The burn hotline is 1-800-475-3443

Emergency Treatment of Minors and Emancipation

M.G.L. Chapter 112 §12F states that no physician, dentist or hospital shall be held liable for damages for failure to obtain consent of a parent, legal guardian, or other person having custody or control of a minor child, or of the spouse of a patient, to emergency examination and treatment, including blood transfusions, when delay in treatment will endanger the life, limb, or mental well-being of the patient.

Any minor may give consent to his medical or dental care at the time such care is sought if (i) he is married, widowed, divorced; or (ii) he is the parent of a child, in which case he may also give consent to medical or dental care of the child; or (iii) he is a member of any of the armed forces; or (iv) she is pregnant or believes herself to be pregnant; or (v) he is living separate and apart from his parent or legal guardian,

and managing his own financial affairs; or (vi) he reasonably believes himself to be suffering from or to have come in contact with any disease defined as dangerous to the public health pursuant to section six of chapter one hundred and eleven; provided, however, that such minor may only consent to care which relates to the diagnosis or treatment of such disease.

Whistle Blower Protection

Chapter 149 of the MGL, section 186a provides for Whistle Blower protection for health care providers. The Attorney General will enforce the provisions that provide for protection against retaliatory action if the health care provider reasonably believes that a risk exists, and that written notice has been filed with the health facility or organization, and there has been a reasonable opportunity to correct the activity, policy or practice.

Communicable Disease Reporting and Case Investigation: Relevant Statutes and Regulations

MGL c. 111, §. 112; 105 CMR 300.110 Report cases of dangerous diseases to DPH within 24 hours. **105 CMR 300.130** Clusters or outbreaks must be reported immediately.

MGL c. 111, §§. 6,7,18, and 111 CMR 300.100 re: receiving of reports of diseases dangerous to the public health and requiring interpretation and evaluation of clinical data. Reports must be sent to other jurisdictions where an infected individual may reside, where disease was contracted and where the patient is known to have exposed another person to the disease.

MGL c. 111, §. 7 must consult with DPH regarding prevention of dangerous disease.

MGL c. 111, §§. 6,95; CMR 300.200 re: enforcement of isolation and quarantine. Requires clinical interpretation and correct information transmitted to a variety of institutions and public facilities.

MGL c. 140, §. 145A re: referring exposed individuals for anti-rabies vaccine and treatment and on occasion to administer post-exposure prophylaxis.

105 CMR 300.120 requires sending reports to the DPH regarding reports of food poisonings.

MGL c. 111, §. 181 provides the means for vaccinations, without charge, if such vaccinations are required by the Board.

Tuberculosis

MGL c. 111, §. 81A re: investigation of each reported case or suspect case of TB to determine source and possible spread of infection to others, to identify contacts, and screen selected groups by using and interpreting Mantoux skin test.

MGL c. 111, §. 94A, 105 CMR 360.000 re: assisting in the identification, transporting, and hospitalization of patients eligible for admission to the hospital designated by the DPH for TB treatment.

105 CMR 365.000 Re: ensuring the prompt diagnostic and follow-up examinations of patients and suspected TB cases and the uninterrupted treatment of patients with diagnosed TB.

105 CMR 365.000 re: collaborating with hospitals and other care facilities in the discharge planning for patients with confirmed or suspected TB.

105 CMR 365.000 re: providing appropriate case management and nursing services under medical orders for administration of injectable anti-tuberculosis drugs or supervised chemotherapy apart from a TB clinic. These services must be provided until the patient has completed therapy.

MGL c. 111, §§. 94A through 94C re: Compulsory hospitalization of uncooperative TB patients after exhausting all reasonable attempts to influence the patient to accept treatment or isolation.

Federal Public Law 87-301 re: resident aliens newly arrived in the United States, with diagnosed or suspected TB must be identified and all appropriate forms must be completed and the implementation of disease control protocols instituted.

VIII. Practice Issues

Using Volunteers

Volunteers must be supervised. As the Board of Registration states, the licensed nurse is accountable **for the outcome of any delegation.** An assessment must take place of the activity to be performed, the needs of the patient or population and the experience, education, and credentialing of the nurse to perform the specified activity. If the action requires a specific level of experience and skill, then the person performing the activity must be assessed as having the prerequisite skill, and education to perform it. Volunteers performing professional nursing assessments and functions should be licensed individuals.

Needlestick Injury Prevention:

MGL Chapter 111 section 53D provides for Massachusetts DPH to promulgate rules and regulations requiring the use at all acute, and non-acute hospitals of only such

devices which minimize the risk of injury to health care workers from needlesticks and sharps.

References

Annas George A. (1989). The rights of patients, *ACLU Handbook*, Humana Press, Totowa, New Jersey.

Center for Disease Control and Prevention. Retrieved on July 18, 2004 from <http://www.cdc.gov/privacyrule>.

Center for Medicare and Medicaid Services. Retrieved on July 18, 2004 form <http://www.cms.hhs.gov/hipaa>.

Massachusetts Association of Health Boards/Massachusetts Department of Public Health (1997). *Guidebook for Massachusetts boards of health*. Boston MA.

McCarthy, M. (2000, March27). *A nursing license*. *Boston Globe*

Wing, K.R. (1999). *The law and the public's health*. (5th ed.), Chicago, IL: Health Administration Press.

Resources

DeMaria, Alfred MD. Assistant Commissioner of Massachusetts Department of Public Health, Director of Communicable Disease.

Findlaw.com/casecode/constitution

Myers, Donald. (1998). *1999 US master human resources guide*, CCH INC., Chicago, IL.

CHAPTER FOUR

SCOPE and STANDARDS of PRACTICE

for

PUBLIC HEALTH NURSING

I. ORGANIZATIONAL OVERVIEW OF PUBLIC HEALTH NURSING

The Quad Council of Public Health Nursing Organizations represents public health nursing's national structural component. This group is comprised of:

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

Each has contributed to the establishment of tenets, processes, and standards of care and performance for public health nursing practice at individual/family, population (aggregates & subgroups), and community-wide levels. The 1999 document, *Scope and Standards of Public Health Nursing Practice*, which can be found in Chapter Four of the 2002 first edition of the *MAPHN Guidebook & Resources Manual*, was replaced in 2007 following a multi-year Quad Council project. The new 2007 *Public Health Nursing: Scope and Standards of Practice* includes the 1986 edition of the *Standards of Community Health Nursing Practice* and the 1999 *Scope and Standards of Public Health Nursing Practice* into a twenty-first century document for Public Health Nursing Practice. The 2007 *Scope and Standards* are summarized in Sections II and III below.

II. PUBLIC HEALTH NURSING PRINCIPLES

In 1996, APHA--Public Health Nursing Section defined public health nursing as the practice of promoting health of populations using knowledge from nursing, social, and public health sciences. This statement identified systematic process, role, activities, and educational preparation for public health nurses. Since that time, the Quad Council of Public Health Nursing Organizations have individually and collectively worked to establish a clear voice and definition for the role of public health nursing.

Public health nursing distinguishes itself from other nursing specialties by adhering to all eight (8) of the following principles:

1. The client or unit of care is the population.
2. The primary obligation is to achieve the greatest good for the greatest number of people or the population as a whole.
3. The processes used by public health nurses include working with the client as an equal partner.
4. Primary prevention is the priority in selecting appropriate activities.

5. Public health nursing focuses on strategies that create healthy environmental, social, and economic conditions in which populations may thrive.
6. A public health nurse is obligated to actively identify and reach out to all who might benefit from a specific activity or service.
7. Optimal use of available resources to assure the best overall improvement in the health of the population is a key element of the practice.
8. Collaboration with a variety of other professions, populations, organizations, and other stakeholder groups is the most effective way to promote and protect the health of the people (ANA, 2007, pp. 7-9).

III. STANDARDS OF PUBLIC HEALTH NURSING PRACTICE

In 2004, the American Nurses Association (ANA) released *Nursing: Scope & Standards of Practice* as the first document incorporating the levels of generalist and advanced practice into the criteria for each standard of practice and professional performance. It was also the first time that all nursing practice is described as “fundamentally independent practice” (ANA, 2004, p.10). This document provided the foundation and structure for all revision of nursing specialty practice guidance in the immediate future.

Nursing process: *assessment, diagnosis, outcomes identification, planning, implementation and evaluation* form the traditional standards of practice across all nursing and its specialty areas. The diagnosis and implementation standards will reflect specialty specific wording and subsets. All 16 standards of the 2007 *Public Health Nursing: Scope & Standards of Practice* contain measurement criteria for both the public health nurse and the advanced practice public health nurse. Please refer to the reference page for direction to access the complete document (ANA, 2007).

STANDARDS of PRACTICE

Standard 1: Assessment

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

Standard 2: Population Diagnosis and Priorities

The public health nurse analyses the assessment data to determine the population diagnoses and priorities.

Standard 3: Outcomes Identification

The public health nurse identifies expected outcomes for a plan that is based on population diagnoses and priorities.

Standard 4: Planning

The public health nurse develops a plan that reflects best practices by identifying strategies, action plans, and alternatives to attain expected outcomes.

Standard 5: Implementation

The public health nurse implements the identified plan by partnering with others.

Standard 5A: Coordination

The public health nurse coordinates programs, services, and other activities to implement the identified plan.

Standard 5B: Health Education and Health Promotion

The public health nurse employs multiple strategies to promote health, prevent disease, and assure a safe environment for populations.

Standard 5C: Consultation

The public health nurse provides consultation to various community groups and officials to facilitate the implementation of programs and services.

Standard 5D: Regulatory Activities

The public health nurse identifies, interprets, and implements public health laws, regulations, and policies.

Standard 6: Evaluation

The public health nurse evaluates the health status of the population.

IV. STANDARDS of PROFESSIONAL PERFORMANCE

The standards of professional performance terminology are consistent across the nursing discipline with specialty specific definitions. The measurement criteria for public health nurses and advanced practice public health nurses continues below:

STANDARDS of PROFESSIONAL PERFORMANCE**Standard 7: Quality of Practice**

The public health nurse systematically enhances the quality and effectiveness of nursing practice.

Standard 8: Education

The public health nurse attains knowledge and competency that reflects current nursing and public health practice.

Standard 9: Professional Practice Evaluation

The public health nurse evaluates one's own nursing practice in relation to professional practice standards and guideline, relevant statutes, rules, and regulations.

Standard 10: Collegiality and Professional Relationships

The public health nurse establishes collegial partnerships while interacting with representatives of the population, organizations, and health and human services professionals, and contributes to the professional development of peers, students, colleagues, and others.

Standard 11: Collaboration

The public health nurse collaborates with representatives of the population, organizations, and health and human service professionals in providing for and promoting the health of the population.

Standard 12: Ethics

The public health nurse integrates ethical provisions in all areas of practice.

Standard 13: Research

The public health nurse integrates research findings into practice.

Standard 14: Resource Utilization

The public health nurse considers factors related to safety, effectiveness, cost, and impact on practice and on the population in the planning and delivery of nursing and public health programs, policies, and services.

Standard 15: Leadership

The public health nurse provides leadership in nursing and public health.

Standard 16: Advocacy

The public health nurse advocates to protect the health, safety, and rights of the population (ANA, 2007, pp.15-40).

V. CERTIFICATION

The American Nurse Credentialing Center (ANCC) offers Public/Community Health Nursing Clinical Specialist certification for advanced degree nurses. There is currently no baccalaureate level certification for public/community health nursing with the ANCC. However, with the emerging *patient safety* concerns for provider competency, credentialing/certification of public health nursing practitioners is being discussed within the Commonwealth by the Massachusetts Association of Public Health Nurses (MAPHN) and other public health organizations. Current credentialing information may be accessed at the American Nurses Credentialing Center, 8515 Georgia Avenue, Suite 400, Silver Springs, MD 20910-3402 or <http://www.nursecredentialing.org>.

VI. NATIONAL MODELS

In 1997, the Association of State and Territorial Directors of Nursing (ASTDN) formatted a public health nursing practice model. The three-ringed elliptical diagram represents the delivery of essential public health services. The *Art & Science of Nursing Practice* is in the center surrounded by the three core functions of public health; assessment, policy development and assurance. The ten essential services are in the outer ring. That same year, the Minnesota Department of Health unveiled an evidence-based model of *Public Health Interventions* for practice at the individual/family, community and systems level. This model now has national acceptance in both academia and practice. These *Interventions* provide the substance for the following chapter: **Public Health Nursing Practice Interventions & Competencies**.

In April of 2003, the Quad Council of Public Health Nursing Organizations finalized many years of work with the Centers for Disease Control (CDC) and the Council on Linkages between Academia and Public Health (COL). A series of eight domains and core competency statements for public health professionals are applied to an expected level of performances and application for public health nurses. A complete analysis of the expectations for baccalaureate-prepared nurses (generalists) and master's-prepared (specialists) can be accessed at the <http://astdn.org> library button. These competencies, also addressed in Chapter Five, are intended to be a guide for agencies employing public health nurses and for academic settings to facilitate education and life-long learning. The above ASTDN address provides numerous other public health nursing documents and publications.

The need to connect academia more closely to practice has brought the Association of Community Health Nursing Educators (ACHNE) together with the Association of State and Territorial Director of Nursing (ASTDN) on a regular basis at the national level. The emerging doctorate in nursing practice programs with specialization in public health nursing clinical and leadership tracks is viewed as the mechanism that can achieve that connection as well as prepare clinically proficient educators in the field of public health nursing. More information can be explored at <http://www.achne.org>.

This overview is intended to provide a basic understanding of the professional expectations and infrastructure that guide this specialty practice. May it inspire professional growth for your personal knowledge base and the fulfillment of your contributions to the populations that you serve.

REFERENCES

American Nurses Association (ANA), (2007). *Public health nursing: Scope & standards of practice*. Silver Springs, MD: Nursesbooks.org.

American Nurses Association (ANA), (2004). *Nursing: Scope & standards of practice*. Silver Springs, MD: Nursesbooks.org.

American Nurse Credentialing Center (ANCC). Retrieved August 25, 2007 from <http://nursecredentialing.org> .

Association of Community Health Nursing Educators (ACHNE). Retrieved August 25, 2007 from <http://www.achne.org>.

Association of State and Territorial Directors of Nursing (ASTDN). Retrieved August 25, 2007 from <http://www.astdn.org>.

RESOURCES

American Nurse Association (ANA). Visit <http://www.nursingworld.org>.

American Public Health Association (APHA). Visit <http://www.apha.org>
Click on Sections & SPIGS to access the Public Health Nursing Section

Minnesota Department of Health, (2001). *Public health interventions: Applications for public health nursing practice*. Retrieved August 25, 2007 from <http://www.health.state.mn.us/divs/cfh/ophp/resources/db.html>.

CHAPTER FIVE

PUBLIC HEALTH PRACTICE INTERVENTIONS AND COMPETENCIES

I. Introduction

Public health nurse consultants at the Section of Public Health Nursing of the Minnesota Department of Health constructed a set of seventeen interventions common to public health nursing wherever it is practiced. The model began as a set of examples of public health nursing practice collected in 1994 from over 200 experienced public health nurses. A panel of practice experts from the section identified the common themes within those examples and the initial set of interventions was created, depicted as spokes on a wheel. Hundreds of copies of the interventions were distributed within the state and throughout the nation. Reports from public health nurses using the interventions suggested the framework could be quickly adopted to both teach and enrich practice.

The initial interventions framework was practice-based. In July 1998 the Section began intensive work to determine the evidence underlying the interventions. With the award of a grant from the federal Division of Nursing, current public health nursing, nursing, public health and related literature were explored to identify the theory, research, and expert opinion supporting and enhancing the interventions. The model withstood the challenge of rigorous examination with only a few changes to the original set of 17 interventions. This final intervention model is commonly referred to as *the wheel*.

This intervention model synthesizes the art and science of nursing and the art of science of public health. This intervention model represents the joint efforts of academic leaders and public health nurses in practice. Efforts that encompass the arenas of nursing, public health, academia and practice have been envisioned, however rarely do they have the broad applicability of the framework of this *wheel* intervention model. The work of the Section of Public Health Nursing of the Minnesota Department of Health through the sponsorship of the federal Division of Nursing enables Massachusetts' public health nurses to take a major leap forward in describing, affirming and developing their public health nursing practice.

It has been challenging for public health nurses to present their work to others in public health and to the general citizenry. Much of what a colleague or citizen may understand of public health nursing is based on one or two observations or experiences with public health nurses. This intervention model outlines and describes the total expanse of public health nursing. The *wheel* intervention model developed from public health nursing practice is also applicable to the roles and practice of other public health professionals. Learning to inventory and

describe public health nursing practice using this intervention model with the levels of individual, community and systems provides public health nurses the context to present, describe and substantiate their practice to a variety of audiences.

II. Practice Assumptions of Public Health Nursing

1. Public health nursing is a specialized nursing practice that combines the art and science of nursing with the art and science of public health and requires licensure as a registered professional nurse.
2. Public health nursing is grounded in:
 - a belief in social justice
 - an ethic of caring
 - the promotion and maintenance of health and optimal functioning
 - the prevention of illness, injury and disability
 - a long-term commitment to the community
 - respect and knowledge of cultural, racial and ethnic diversity
 - systems theory that acknowledges the dynamic relationship between the individual, the community and society
 - holistic care, which acknowledges the inter-relationship of mind, body and spirit within the context of the individual's life.
3. Public health nursing practice is population-based. Population-based public health nursing services are interventions aimed at health promotion and disease prevention that improve a community's health outcomes.
4. The public health core functions of assessment, policy development, and assurance are fulfilled through activities and interventions based on community need. The core public health functions overlay all public health nursing interventions. Each of the interventions has an assessment, policy development and assurance component.
5. The public health core functions of assessment, problem identification, planning, implementation and evaluation underlay each of the interventions; and are applied at the individual, community or system level.
6. Interventions are actions implemented by public health nurses on behalf of individuals, families, and/or communities. Interventions can occur in any setting. They are based on;
 - theoretical and scientific knowledge,
 - clinical skills, judgment and experience and the
 - interrelation between interventions and desired outcomes.

7. The health of populations is most effectively promoted and protected through interdisciplinary and inter-organizational collaborations and partnerships.

III. Intervention Model

A. Definition

All public health nurses use a core set of interventions to accomplish their goals.

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

B. Scope of Practice

This framework, or the intervention model, defines the scope of public health nursing practice by type of intervention and level of intervention (systems, community, individual/family) rather than by the more traditional *site* of service. The intervention model describes the scope of practice across settings.

While these interventions are applicable to other public health disciplines and not exclusive to public health nursing; public health nurses do operate within a context that makes them unique as a specialty practice of nursing. There are 17 interventions that together describe the scope of the practice of public health nurses.

The 17 interventions can be grouped into categories.

- Surveillance, Disease and Health Investigation, Outreach, Screening and Case-finding
 - Referral and Follow-up, Case Management and Delegated Functions
 - Health Teaching, Counseling and Consultation
 - Collaboration, Coalition Building and Community Organizing
 - Advocacy, Social Marketing and Policy Development
1. **Surveillance** describes and monitors health events through ongoing and systematic collection, analysis, and interpretation of health data for the purpose of planning, implementing, and evaluating public health interventions (Morbidity and Mortality Weekly Report, MMWR 1988, May 6).
 2. **Disease and other health event investigation** systematically gathers and analyzes data regarding threats to the health of populations, ascertains the

source of the threat, identifies cases and others at risk, and determines control measures.

3. **Outreach** locates populations-of-interest or populations-at-risk and provides information about the nature of the concern, what can be done about it, and how services can be obtained.
4. **Screening** identifies individuals with unrecognized health risk factors or asymptomatic disease conditions in populations.
5. **Case-finding** locates individuals and families with identified risk factors and connects them with resources.
6. **Referral and follow-up** assists individuals, families, groups, organizations, and/or communities to identify and access necessary resources to prevent or resolve problems or concerns.
7. **Case management** optimizes self-care capabilities of individuals and families and the capacity of systems and communities to coordinate and provide services.
8. **Delegated functions** are direct care tasks a registered professional nurse carries out under the authority of a health care practitioner as allowed by law. Delegated functions also include any direct care tasks a registered professional nurse entrusts to other appropriate personnel to perform.
9. **Health teaching** communicates facts, ideas and skills that change knowledge, attitudes, values, beliefs, behaviors, and practices of individuals, families, systems, and/or communities.
10. **Counseling** establishes an interpersonal relationship with a community, a system, family or individual intended to increase or enhance their capacity for self-care and coping. Counseling engages the community, a system, family or individual at an emotional level.
11. **Consultation** seeks information and generates optional solutions to perceived problems or issues through interactive problem-solving with a community, system, family or individual. The community, system, family or individual selects and acts on the option best meeting the circumstances.
12. **Collaboration** commits two or more persons or organizations to achieve a common goal through enhancing the capacity of one or more of the members to promote and protect health [adapted from Henneman, Lee, and Cohn "Collaboration: A concept analysis" in *Journal of Advanced Nursing* Vol. 21 1995: 103-109]

13. **Coalition building** promotes and develops alliances among organizations or constituencies for a common purpose. It builds linkages, solves problems, and/or enhances local leadership to address health concerns.
14. **Community organizing** helps community groups to identify common problems or goals, mobilize resources, and develop and implement strategies for reaching the goals they collectively set (Minkler & Wallerstein, 1997, pp.31-52).
15. **Advocacy** pleads someone's cause or acts on someone's behalf, with a focus on developing the community, system, individual or family's capacity to plead their own cause or act on their own behalf.
16. **Social marketing** utilizes commercial marketing principles and technologies for programs designed to influence the knowledge, attitudes, values, beliefs, behaviors, and practices of the population-of-interest.
17. **Policy development** places health issues on decision-makers' agendas, acquires a plan of resolution, and determines needed resources. Policy development results in laws, rules and regulation, ordinances, and policies. Policy enforcement compels other to comply with the laws, rules, regulations, ordinances and policies created in conjunction with policy development.

B. Population-based practice

All public health nursing interventions are population-based.

Examples of populations include:

- all families of newborn infants
- all older adults at risk for falls
- everyone who drinks well water
- all children at risk for vaccine-preventable disease
- all adolescents at risk for suicide

Population-based practice meets four criteria:

1. **Interventions are based in community need**, which is determined through a community health assessment process. A population model of practice analyzes indicators of health status (risks, problems, assets) within populations, establishes priorities, and implements and evaluates public health programs and strategies.

The importance of community assessment cannot be emphasized enough. All public health programs are based in the needs of the community. As communities change, so do community needs. This is

why the core function of assessment is so important. Public health nurses need to assess the health status of communities on an ongoing basis so that public health programs respond appropriately to new and emerging problems and concerns.

2. **Interventions focus on the entire population at risk** or ultimately affected by the condition. This means focusing on everyone actually or potentially affected by a health concern or who share a similar characteristic. Public health nursing interventions are not limited to only those who seek service or who are poor or otherwise vulnerable. Public health planning always begins by determining everyone who is or could be at risk, including those who are unaware, unwilling, or unable to participate in public health strategies. For example, public health nurses' responsibility is to assure that all children are immunized against vaccine-preventable disease, but with limited resources, public health efforts may target those known to be at particular risk for not being immunized.
3. **Interventions focus on the broad determinants of health.** A population-based approach examines all factors, which determine health rather than just personal health risks or disease. It focuses on the entire range of factors, which determine health rather than just risks, and clinical factors related to particular diseases. These factors include income and social support, networks, education, neighborhood safety and violence issues, physical environment, genetic endowment, personal health practices and coping skills, cultural customs and values, and community capacity to support families and economic growth.
4. **Interventions are prevention focused** with a preference for primary prevention. All public health nursing interventions have a preventive component. Prevention is a unique concept in public health. While a general definition is to stop something from arising in the first place public health believes that prevention may occur at any point – before a problem occurs, when a problem is developing or even after a condition has occurred. Not every problem is preventable, but every problem does have preventable components.

Public health interventions can be implemented at multiple-practice levels.

A population-based approach considers intervening at all possible levels of practice. Interventions may be directed at the entire population within a community, the systems that affect the health of those populations, and/or the individuals and families within those populations known to be at risk.

Community - focused practice changes community norms, attitudes, awareness, practices and behaviors of the population-of-interest.

Systems – focused practice changes organizations, policies, laws, and power structures of the systems that affect health.

Individual/family – focused practice changes knowledge, attitudes, beliefs, values, practices, and behaviors of individuals, alone or as part of a family, class or group. Individuals receive services because they are identified as belonging to a population-at-risk.

The practice level depends on; community need, goals, objectives, resources, and strategy effectiveness. Interventions at each of these levels of practice contribute to the overall goal of improving population health status. Public health professionals determine the most appropriate level(s) of practice based on community need and the availability of effective strategies and resources. No one level of practice is more important than another, in fact, most public health problems are addressed at all three levels, often simultaneously. This is an extremely important concept for public health nursing since productivity often only measures individual-focused home visits or clinical services leaving much of public health nursing practice inadequately described and consequently difficult to account for and evaluate.

IV. Competencies

Nurses have competencies that they have developed through education and experience in the practice of nursing. They usually have specific in depth knowledge and skill developed from serving a specific group based on age, disease, state of health or other factors. Nurses are also educated to develop specific leadership competencies utilized in their role as staff nurse through roles in management and administration. In addition, nurses practicing in public health need to develop competencies for the broad area of public health practice.

Public health nursing practice requires skills and knowledge derived from both experience and education in nursing and public health. It is the public health nurse's individual responsibility to master these skills and acquire knowledge to ensure competency in carrying out the interventions. Following are a set of competencies prepared for review by a national project for all public health professionals. These competencies are relevant to interventions at all levels and are listed here so that public health nurses can categorize and inventory their skills and then select educational and experiential opportunities to further develop and achieve excellence in practice. Skill levels assigned to the competencies are aware, knowledgeable and proficient.

Analytic/Assessment Skills

1. Defines a problem
2. Determines appropriate uses and limitations of both quantitative and qualitative data
3. Selects and defines variables relevant to defined public health problems
4. Identifies relevant and appropriate data and information sources
5. Evaluates the integrity and comparability of data and identifies gaps in data sources
6. Applies ethical principles to the collection, maintenance, use, and dissemination of data and information
7. Partners with communities to attach meaning to quantitative & qualitative data
8. Makes relevant inferences from quantitative and qualitative data
9. Obtains and interprets information regarding risks and benefits to the community
10. Applies data collection processes, information technology applications and computer systems storage/retrieval strategies
11. Recognizes how the data illuminates ethical, political, scientific, economic, and overall public health issues

Policy Development/Program Planning Skills

1. Collects, summarizes, and interprets information relevant to an issue
2. States policy options and writes clear and concise policy statements
3. Identifies, interprets, and implements public health laws, regulations, and policies related to specific programs
4. Articulates the health, fiscal, administrative, legal, social, and political implications of each policy option
5. States the feasibility and expected outcomes of each policy option

6. Utilizes current techniques in decision analysis and health planning
7. Decides on the appropriate course of action
8. Develops a plan to implement policy, including goals, outcome and process objectives, and implementation steps
9. Translates policy into organizational plans, structures, and programs
10. Prepares and implements emergency response plans
11. Develops mechanisms to monitor and evaluate programs for their effectiveness and quality

Communication Skills

1. Communicates effectively both in writing and orally, or in other ways
2. Solicits input from individuals and organizations
3. Advocates for public health programs and resources
4. Leads and participates in groups to address specific issues
5. Uses the media, advanced technologies, and community networks to communicate information
6. Effectively presents accurate demographic, statistical, programmatic, and scientific information for professional and lay audiences

Attitudes

Listens to others in an unbiased manner, respects points of view of others, and promotes the expression of diverse opinions and perspectives

Cultural Competency Skills

1. Utilizes appropriate methods for interacting sensitively, effectively, and professionally with persons from diverse cultural, socioeconomic, educational, racial, ethnic and professional backgrounds, and persons of all ages and lifestyle preferences
2. Identifies the role of cultural, social, and behavioral factors in determining the delivery of public health services
3. Develops and adapts approaches to problems that take into account cultural differences

Attitudes

1. Understands the dynamic forces contributing to cultural diversity
2. Understands the importance of a diverse public health workforce

Community Dimensions of Practice Skills

1. Establishes and maintains linkages with key stakeholders
2. Utilizes leadership, team building, negotiation, and conflict resolution skills to build community partnerships
3. Collaborates with community partners to promote the health of the population
4. Identifies how public and private organizations operate within a community
5. Accomplishes effective community engagements
6. Identifies community assets and available resources
7. Develops, implements, and evaluates a community public health assessment
8. Describes the role of government in the delivery of community health services

Basic Public Health Sciences Skills

1. Identifies the individual's and organization's responsibilities within the context of the Essential Public Health Services and core functions
2. Defines, assesses, and understands the health status of populations, determinants of health and illness, factors contributing to health promotion and disease prevention, and factors influencing the use of health services
3. Understands the historical development, structure, and interaction of public health and health care systems
4. Identifies and applies basic research methods used in public health
5. Applies the basic public health sciences including behavioral and social sciences, biostatistics, epidemiology, environmental public health, and prevention of chronic and infectious diseases and injuries

6. Identifies and retrieves current relevant scientific evidence
7. Identifies the limitations of research and the importance of observations and interrelationships

Attitudes

Develops a lifelong commitment to rigorous critical thinking

Financial Planning and Management Skills

1. Develops and presents a budget
2. Manages programs within budget constraints
3. Applies budget processes
4. Develops strategies for determining budget priorities
5. Monitors program performance
6. Prepares proposals for funding from external sources
7. Applies basic human relations skills to the management of organizations, motivation of personnel, and resolution of conflicts
8. Manages information systems for collection, retrieval, and use of data for decision-making
9. Negotiates and develops contracts and other documents for the provision of population-based services
10. Conducts cost-effectiveness, cost-benefit, and cost-utility analyses

Leadership and Systems Thinking Skills

1. Creates a culture of ethical standards within organizations and communities
2. Helps create key values and shared vision and uses these principles to guide action
3. Identifies internal and external issues that may impact delivery of essential public health services (i.e., strategic planning)
4. Facilitates collaboration with internal and external groups to ensure participation of key stakeholders
5. Promotes team and organizational learning

6. Contributes to development, implementation, and monitoring of organizational performance standards
7. Uses the legal and political system to effect change
8. Applies theory of organizational structures to professional practice

The above core competencies can be viewed and downloaded from the Council on Linkages Between Academia and Public Health Practice web page www.phf.org/competencies.htm. The competencies were released April 11, 2001 and revision is anticipated for April 2004. The core competencies can be viewed by domains and by domains with skill level of front line staff, senior level staff and supervisory and management staff. The core competencies are also categorized on the Council's web site by the 10 essential services.

V. Conclusion

The scope of public health nursing presented here and the competencies needed to ensure quality practice are an on-going project of life long learning for all public health nurses in the state. The *wheel* framework and intervention model can teach and enhance public health nursing practice as demonstrated in other states across the country and is the framework for building and ensuring the standard of practice of public health nurses in Massachusetts.

REFERENCES

- Guidelines for evaluating surveillance systems.(1988, May 6). *MMWR*, 37(S-5), 1A.
- Henneman , Lee & Cohen. (1995). Collaboration: A concept analysis. *Journal of Advanced Nursing* Vol. 21.
- Minkler, M. & Wallerstein, N. (1997). Improving health through community organization and community building: A health education perspective. *Community Organizing and Community Building for Health*. New Brunswick, NJ: Rutgers University Press.
- Minnesota Department of Health, Public Health Nursing Section. *Public Health Interventions – Applications for Public Health Nursing Practice*. St. Paul.
- Minnesota Department of Health, Section of Public Health Nursing. *Public Health Interventions – Examples from Public Health Nursing*. St. Paul.

RESOURCES

Public Health Foundation: Council on Linkages Between Academia and Public Health Practice <http://www.phf.org/competencies.htm>

Minnesota Department of Health, Division of Community Health Services, Public Health Nursing Section
<http://www.health.state.mn.us/divs/chs/phn/interventions.html>

CHAPTER SIX

BIOTERRORISM and EMERGENCY PREPAREDNESS

I. Introduction

At the time the first edition of this guidebook was being written, the primary long range planning issues for public health nursing in Massachusetts focused on preparing for an anticipated Flu Pandemic. However, the tragic events of September 11, 2001 dramatically changed the landscape for the practice and delivery of public health across the United States. This country had suddenly become the target of both human and biological attack for which we were ill prepared to combat or resist.

Systematic planning for response to natural disasters (storms, floods and fire) has evolved during the last quarter century that has recognized the role of health professionals in the management of disasters (Landesman, 2001). With the application of epidemiological methods in the evaluation of responses to disasters during this period of time, a body of knowledge has been accumulated that allows more affective management to be achieved. This ultimately lessens the adverse human impact by improving preparedness and response.

This preparedness process has created a new vocabulary and new partners for public health along with the need for coalition building and understanding across disciplines that historically have functioned in isolation. We are assimilating and sharing each other's knowledge and culture as a collaborative response structure is built in each community of the Commonwealth. Nationally, guidelines for local health capacity and competency have been developed collectively by the Centers for Disease Control and Prevention (CDC) and several schools of public health and public health organizations. These guidelines are currently in varying stages of implementation.

II. Local Capacity

An integral component of emergency response is the ability of the local health infrastructure to respond to public health threat and emergencies. In 2002, an inventory tool was developed to assess and fund six of seven Focus Areas. These areas have been labeled as follows:

- Focus Area A: Preparedness Planning and Readiness Assessment
- Focus Area B: Surveillance and Epidemiologic Capacity
- Focus Area C: Laboratory Capacity-Biologic Agents
- Focus Area D: Laboratory Capacity-Chemical Agents (not funded)

- Focus Area E: Health Alert Network/Communications and Information Technology
- Focus Area F: Risk Communication and Health Information Dissemination
- Focus Area G: Education and Training

Additional broad-based topics included in this capacity assessment for local health departments are more familiar to most practitioners and are more regional or national in their scope. The National Pharmaceutical Stockpile Preparedness and the Smallpox Vaccination Preparedness comprise the appendices to this public health inventory assessment tool, which was peer-reviewed in its initial format and has been amended to be more user-friendly. This document can be viewed and retrieved from the Public Health Practice Program Office website: <http://www.phppo.cdc.gov/od/inventory.docs/local> .

III. Competencies

The term, competencies, has been addressed from several perspectives in the two preceding chapters. However, in this chapter you will consider the role of the public health nurse in the grand scheme of competencies for all public health workers in relation to emergency preparedness. Columbia University School of Nursing Center for Health Policy and the CDC, jointly prepared the document, *Bioterrorism & Emergency Readiness: Competencies for All Public Health Workers* that identifies nine core competencies for all public health workers.

- **Core Competency 1.** Describe the public health role in a range of emergencies that might arise.
- **Core Competency 2.** Describe the chain of command in emergency response.
- **Core Competency 3.** Identify and locate emergency response plan.
- **Core Competency 4.** Describe his/her functional role(s) in emergency response and demonstrate his/her role(s) in regular drills.
- **Core Competency 5.** Demonstrate correct use of all communication equipment used for emergency communication.
- **Core Competency 6.** Describe communication roles(s) in emergency response:
 - Within the agency using established communication systems
 - With the media
 - With the general public
 - Personal (with family, neighbors)
- **Core Competency 7.** Identify limits to own knowledge/skill/authority and identify key system resources for referring matters that exceed these limits.
- **Core Competency 8.** Recognize unusual events that might indicate an emergency and describe appropriate action.
- **Core Competency 9.** Apply creative problem solving and flexible thinking to unusual challenges within his/her functional responsibilities and evaluate effectiveness of all actions taken. www.nursing.hs.columbia.edu/

- This document, completed in November of 2002, provides additional position or job specific emergency preparedness competencies that are related to the public health worker's role in their agency or department. These roles are defined as:
 - **Public Health Leaders/Administrators**
 - **Public Health Professionals** (Communicable Disease, Clinical, Environmental Health, Public Health Laboratory, Information, Medical Examiner/Coroner, and other professional staff [i.e. educators, legal and financial officers]), and
 - **Public Health Technical and Support Staff.**

Each discipline has specific skills related to the Core Competencies that are applicable to preparedness and planning, response and mitigation, and recovery and evaluation. It is noted in the introduction of this document that;

“Competencies cannot replace the specific description of any job, nor the specific emergency plan for any public health organization” but “can, if mastered, assure that the individual public health worker will be able to perform in emergency circumstances” www.nursing.hs.columbia.edu/.

It must also be noted that in the Commonwealth of Massachusetts, because of our Home Rule mandate, public health nurses function in several of the above categories and roles within their respective communities. This may require the attainment of skills and development of a leadership role beyond the traditional realm of public health nursing. However, in the practice of population-focused nursing, Bioterrorism and Emergency Preparedness are factors that impact populations and must become part of our knowledge base and practice.

IV. Incident Command

The Incident Command System (ICS) evolved in the 1970s following a disastrous series of forest fires in California. It is now the benchmark for the management of multiple jurisdictions, agencies, and authorities (Landesman, 2001, pg. 36). The consistent organizational structure of the ICS has five major components; command, planning, operations, logistics, and finance/administration. There are never more than five subgroups accountable or reporting directly to a component of the system. ICS expands and contracts according to the scope of the event.

The Incident Commander is the first person on the scene of an event until relieved by a superior or a person more skilled relative to the specific event. Public health has not been part of this pre-existing management structure that has been well practiced and rehearsed. Public health must now find their “fit” in ICS. Landesman (pp. 36- 40) explores the diagrammatic structure and features of ICS. Critical to ICS success is the use of a standardized vocabulary for all personnel, equipment, and communication and not revert to agency or discipline specific terminology.

V. Risk Communication

Focus Area F of the Public Health Preparedness and Response Inventory discussed under the heading of Local Capacity` is a critical issue in the dissemination of health information to the public in both emergency and non-emergent situations. Communication must be provided through coordinated and knowledgeable sources and by a designated spokesperson. Health departments are provided with constructive guidelines for assessing their capacities and ability to respond to emergency or crisis events in the Inventory that can be retrieved at <http://www.phppo.cdc.gov/od/inventory/docs/Local>.

Since this assessment tool is designed to explore capacity of an agency or health department, available equipment and practices are the focus for identifying assets and needs. Past history has unfortunately clearly illustrated the impact of being ill prepared to deliver essential health information in a timely and consistent manner. The design of the Focus Areas is intentionally inter-related and promotes and encourages linkage with other Focus Areas to achieve population communications during critical events. The 2004 Guidelines for Focus Area F can be retrieved and viewed at a <http://www.bt.cdc.gov/planningguidance> link.

REFERENCES

- Centers for Disease Control and Prevention. Bioterrorism & emergency preparedness website. Retrieved August 27, 2004 from <http://www.bt.cdc.gov/planning/continuingguidance/pdf/> .
- Columbia University School of Nursing Center for Health Policy, (2002). *Bioterrorism & emergency readiness: Competencies for all public health workers*. Retrieved July 18, 2004 from <http://www.nursing.hs.columbia.edu/>
- Landesman, L., (2001). *Public health management of disasters: The practice guide*. Washington, DC: American Public Health Association.
- Public Health Practice Program Office. Local capacity inventory. Retrieved August 21, 2004 from <http://www.phppo.cdc.gov/od/inventory.docs/local/>

Part II: Professional Practice Modules*

* Federal, state, and local law, policy, and procedure, as well as clinical standards of care and practice, are subject to change and legal interpretation. Therefore, the practice modules contained in this section provide general guidance, and may not necessarily reflect current law, policy, procedure, or standard of practice. For verification, interpretation, and updating of information contained in these modules, please consult the appropriate federal, state, or local authority.

Atmosphere and Indoor Air Quality Control

Purpose: To prevent and control environmental contamination by particulate matter, hydrocarbons, oxides of nitrogen, heavy metals and ground-level ozone. To respond to indoor ventilation issues to control airborne contaminants. To reduce the incidence of asthma, chronic obstructive pulmonary disease (COPD), lung cancer and other respiratory disease.

Population: All town residents and occupants (e.g. workers, school pupils, prison inmates) as determined.

Legal Considerations:

1. Federal /State Law or Local Regulations? (Y)
e.g. M.G.L. c. 111, §. 31, 31 C, 122 and
142A – 142M
310 CMR 7.00
2. Physician order(s)? (N)
3. Informed consent? (N)

Equipment Materials:

1. Incident log
2. Occupant interview Form
3. Camera and film
4. Building floor plans
5. Inventory logs / chemical storage
6. Nitrous oxide (NO) and oxygen (O₂) meter

Planning:

1. Complaint received by BOH.
2. Coordinate with Environmental officer for data collection and inspection.
3. Utilize the **Bureau of Environmental Health Assessment** (617) 624-5757 re: Indoor air quality in school, town and other public access buildings.
4. Consult with Department of Environmental Protection for outdoor particulate/odor.
1-800-462-0444 information
Central Region (508) 792-7650
Metropolitan Boston – Northeast Region (978) 661-7600
Southeast Region (508) 946-2700
Western Region (413) 784-1100

Financial Considerations:

1. Equipment cost
2. Staff cost

3. If issue presents in town-owned building , a private engineering firm may be needed

Procedure:

1. Have individuals involved in complaint complete incident log.
2. Complete occupant interview and medical complaint log.
3. Gather statistics for numbers of asthmatic episodes, headaches, nausea, absenteeism etc.
4. Document results.
5. Collaborate with Health Director to develop and send letters of corrective action.

Evaluation:

1. Assess whether corrective actions have been taken.
2. Assess disappearance / improvement of original complaints of symptoms by employees/ staff/ students, once corrective actions have been taken.

Health Promotion / Disease Prevention Intervention(s):

1. Provide educational materials regarding indoor air quality.
2. Educate facility management on importance of documentation of complaints and use of incident logs.
3. Encourage smoke free facilities.

References:

American Lung Association-Homes and Schools 1-800-Lung-USA.

EPA & CDC June 1998 Action Plan. (1998,June). *Building air quality: A guide for building owners and facility managers.*

Fact Sheets: NACCHO iaqinfo@aol.com - Buildings.

Massachusetts Association of Health Boards and Massachusetts Department of Public Health. (1997). *Guidebook for Massachusetts Boards of Health.* Boston, MA.

National Association of County & City Health Officials. (1996). *Indoor air quality reference.* Washington, D.C.

Miller, Norma L. Ed.D. (June 1999). *The healthy school handbook: Conquering the sick building syndrome and other environmental hazards in and around your school.*

General Indoor Air

Building Officials & Code Administrators International Inc. (1993). *The BOCA national mechanical code. 8th ed.* Club Hills, IL.

Feeney, M. (2000). Indoor air quality and the functions of fresh air supplies and exhaust vents in schools, Part III. *Ph Professional*, 13(3),8.

<http://www.state.ma.us/dph/beha/>

Feeney, M. (1999). Indoor air quality and the function of fresh air supplies and exhaust vents in schools, Part II. *Ph Professional*, 12(2),4.

<http://www.state.ma.us/dph/beha/>

Feeney, M. (1999). Indoor air quality and the function of fresh air supplies and exhaust vents in schools, Part I. *Mass Health*, 2(1),5.

<http://www.state.ma.us/dph/beha/>

Microbial/ Mold Concerns

American Conference of Governmental Industrial Hygienists, ACGIH. (1989). *Guidelines for the assessment of bio-aerosols in the indoor environment*. Cincinnati, OH.

US Environmental Protection Agency (EPA), Environmental Criteria and Assessment Office, Office of Health and Environmental Assessment, Research. (1992). *Indoor biological pollutants* (ECAO-R-0315). Triangle Park, NC.

US EPA Office of Air and Radiation, Indoor Air website

<http://www.epa.gov/mold/index.html>

Guidelines for Occupied Buildings under Renovation

Sheet Metal and Air Conditioning Contractors' National Association, Inc., SMNACNA. (1995). *IAQ guidelines for buildings under construction*, 1st ed. Chantilly, VA.

Chemical Storage

Feeney, M. (1998). Chemical storage in schools and impact on indoor air quality.

MassHealth, 11:3, pp5-6. <http://www.state.ma.us/dph/beha/>

Biohazardous Waste Disposal

Purpose: To limit on-the-job exposure to blood and other potentially infectious material. Regulations imposed by local, state and federal agencies dictate that infectious waste must be segregated, packaged and disposed of in a specific manner to limit on-the job exposure to blood and other potentially infectious materials.

Population: All Board of Health employees, agents, or volunteers who are at risk of exposure to bloodborne pathogens or other potentially infectious materials.

Legal Considerations:

1. Federal/State Law or Local Reg.? (Y)
e.g. M.G.L. c. 111. §127A
105 CMR 480.00
DPH 29CFR 1910.1030
Local policies
2. Physicians order(s)? (N)
3. Informed consent? (N)

Equipment:

1. Personal protective equipment that may include but is not limited to:
 - a. disposable gloves (including non-latex)
 - b. face shields
 - c. disposable gowns
 - d. disposable shoe covers
2. Biohazard disposal bags (red)
3. Biohazard disposal containers
4. Biohazard disposal approved sharps containers
5. Biohazard signs and symbols to denote work areas
6. Biohazardous material spill kits
7. Viricidal agent(s)

Planning:

1. A written protocol for handling biohazardous waste at the main facility and satellite facilities that may include but is not limited to:
 - a. types of containers and name of company that supplies them:
 1. red bags marked with biohazard symbol- 3ml. or equivalent
 2. rigid containers to store red bags
 3. rigid, puncture resistant and leak resistant containers for sharps
 - b. storage of waste: the packaging of solid waste and sharps, how long it can be stored, and under what conditions and where it is to be stored:
 1. waste storage areas must be limited to authorized personnel
 2. all access doors must be marked with biohazard symbol

3. autoclaved infectious wastes, including sharps, must be placed into a biohazard box for disposal
4. a determination of maximum length of time for storage (ex. No more than 35 days)
- c. sharps containers and infectious waste concerns:
 1. must be disposed into red bags and the red bags placed in rigid containers
 2. all full containers must be taped closed before removal and autoclaved infectious waste should not be placed in regular trash
 3. infectious waste must be maintained in a non-putrescent state using freezing or refrigeration if necessary
- d. name and telephone number, and contract of waste management company that collects the waste and schedule for pick up
2. A written protocol for tracking disposal of biohazardous waste that may include but is not limited to: bill of manifest storage, authorized signatory for bill, date and number of containers disposed
3. A written hand-washing protocol
4. A written protocol for handling spills that may include but is not limited to:
 - a. name, manufacturer, and re-order information on product used in the spill kit
 - b. name, application instructions and expiration date(s) of the viricidal agent used in clean-up
 - c. specific instructions for clean up and decontamination process
 - d. documentation of spill and clean up
5. A written protocol for annual training and documentation of training on bloodborne pathogens
6. A written protocol for annual training and documentation of training on disposal of biohazardous waste both at the main facility and at any satellite facilities
7. A written protocol for management of occupational exposure to blood, blood products that may include but is not limited to: Immediate first aid measures, occupational medicine referral information, documentation of hepatitis B vaccine status, follow up procedures to the exposure, and post-exposure documentation procedures

Financial Considerations:

Cost of the following:

- a. solid waste disposal supplies: labels, bags, boxes, sharps containers, viricidal agents
- b. personal protective equipment
- c. annual bloodborne pathogen training
- d. annual biohazardous waste disposal training
- e. hepatitis B vaccine
- f. work related post-exposure referral and treatment
- g. contract with biohazardous waste removal company

Procedure:

1. Provide clearly marked appropriate containers in work areas where exposure to blood or other potentially infectious material may occur.
2. Advocate for the most up to date syringe technology.
3. Provide both latex and non-latex gloves.
4. Post hand-washing reminders prominently.
5. Use appropriate technique when disposing of sharps.
6. Use appropriate personal protective equipment at all times.

Nursing Considerations:

It is important to note that in Massachusetts the Federal government is responsible for enforcement of the Occupational Safety and Health Act (OSHA). OSHA does not cover the following:

- Self-employed persons
- Farms at which only immediate members of the farmer's family are employed
- Working conditions regulated by other federal agencies under other federal statutes (this category includes most employment in mining, nuclear energy and nuclear weapons manufacture, and many segments of the transportation industries)
- State and local government employees (unless the State has assumed the responsibility for development and enforcement of occupational safety and health standards)

There is mandatory reporting to MDPH of select occupational health conditions.

Three agencies of state government have responsibility for issues related to biohazardous waste:

The Department of Public Health
The Department of Labor and Workforce Development
The Department of Environmental Protection

Documentation/Record keeping:

1. Document (as per protocol) all work related exposures.
2. Document (as per protocol) all training(s) related to biohazardous waste disposal.
3. Documentation is to be maintained for the legal retention period as specified in the Massachusetts General Laws (MGL) and the Code of Massachusetts Regulations (CMR). The retention schedule is included as an appendix. Refer to the relevant statutory code or regulation for detailed information on what must be included in each record.

Evaluation:

1. Review incident reports
2. Periodic review of written biohazard protocols to assure compliance

Health Promotion/Disease Prevention Intervention(s):

Obtain and disseminate information on bloodborne pathogens and prevention of exposure to all employees.

References:

Massachusetts Association of Health Boards and Massachusetts Department of Public Health. (1997). *Guidebook for Massachusetts Boards of Health*. Boston, MA. <http://www.dol.gov/dol/asp/public/programs/handbook/main.htm>

U.S. Department of Labor, OSHA Program

Resources:

National Institute for Occupational Safety and Health (NIOSH)
New England Field Office
PO Box 87040
South Dartmouth, MA 02748-0701
(508) 997-6126
(800) 356-4674
<http://www.cdc.gov/niosh/homepage.html>

OSHA Occupational Safety
http://www.osha-slc.gov/SLTC/nursinghome_ecat/bbp/bbp.html

SBA REGION I --BOSTON, MA
Employment Standards Administration-
Office of Federal Contract Compliance Programs (ESA-OFCCP)
JFK Federal Building, Room E-235
Boston, MA 02203
(617) 565-2055

Blood Lead Screening, Education and Prevention

Purpose: To screen young children for elevated levels, educate families to prevent long term disabilities and to prevent children from becoming elevated.

Population: Children under six years of age are at risk for lead poisoning. Mandatory screening is required for all children in Massachusetts yearly through age three. There is additional screening required for children living in high-risk communities that are four years old. The Childhood Lead Poisoning Prevention Program (CLPPP) has a list of high-risk communities that is available on CLPPP's web site and can be requested from the program. Special consideration is given in the regulation to children who maybe at high-risk for other reasons and the criteria is listed in the screening regulation.

Legal Considerations:

1. Mandated Federal/State Law or Local Reg.? (Y)
e.g. M.G.L. c. 111. §. 189A-199B
Massachusetts Regulations for Lead Poisoning
Prevention and Control, 105 CMR 4360.00 and
M.G.L. c. 111. §. 127A to 127K
2. Physicians order(s)? (N)
3. Informed consent? (Y)

Equipment Needed:

1. Heparinized tube with purple top
2. Sterile lancet
3. Sterile gauze sponge
4. Disposable gloves –check for latex allergy
5. Alcohol wipes
6. Band-Aids
7. Mailer approved for biohazard transport
8. Sharps container
9. Biohazardous waste container

Heparinized tubes can be obtained through either the commercial lab doing the testing or *free* through the Childhood Lead Screening Program of the State Laboratory Institute. Mailers and requisition forms also available for *free* through CLPPP.

Planning:

1. Notify parent or guardian of the requirement that all children entering kindergarten must have proof of one lead screening when registering the child for kindergarten.

2. Media outreach: newspaper articles, public service announcements on radio and television

Financial Considerations:

1. Testing is performed at the Childhood Lead Screening Laboratory of the State Laboratory Institute.
2. Tell clients that the state will bill clients with insurance for testing leads. There is no fee for testing children with no health insurance, when the provider indicates family hardship under comment section, on the form submitted with the sample.
3. Commercial laboratories will charge a fee for testing.

Procedure:

1. Suggest that the child be accompanied by parent or guardian.
2. Have parent/guardian prepare child for fingerstick discomfort.
3. Explain procedure briefly.
4. Have supplies ready and labeled.
5. Grasp child's hand firmly in gloved hand.
6. Wash finger.
7. Pierce finger quickly and obtain sample in pipette tube.
8. Cap the tube, then shake the tube.
9. Apply Band-Aid to finger.
10. Dispose of lancet and sponge in biohazard container.
11. Put specimen and appropriate requisition in the mailer.

Nursing Considerations:

1. For lead blood level results greater than or equal to 10 mcg/dl, refer the child to the Childhood Lead Poisoning Prevention Program (CLPPP).
2. After nursing assessment, if the family lives in an older home, or there is a history of exposure to lead paint, recommend parent or guardian call the Childhood Lead Poisoning Prevention Program for a parental request form. Inspections are done free of charge.
3. Inform parents, that all siblings who are under six years old must be screened for lead poisoning.

Documentation/Record Keeping:

1. Parental signature is required for procedure.
2. The appropriate requisition form must be completed to accompany sample.
3. A copy of the lab results is kept in the Board of Health record and a copy is sent to the parents and primary care provider.

Evaluation:

1. Review the kindergarten records for compliance with the mandatory screening regulations.

2. Note trends in elevations.

Health Promotion/Disease Prevention Intervention(s):

1. Obtain latest brochures and literature from the CLPPP.
2. Display educational materials in library and local agency.

References:

Childhood Lead Poisoning Program (CLPPP)
56 Roland Street, Suite 100
Boston, MA 02129
(617) 284-8400
(800) 532-9571

Lead Screening Laboratory at the State Laboratory Institute.
305 South Street, Jamaica Plain, MA 02131
(617) 983-6665
<http://www.state.ma.us/dph/bls/envilab.htm>

Free sampling supplies (including finger stick tube, requisition forms and mailers) for public health facilities, free testing if the child is uninsured, and information on submission of samples is available through the Childhood Lead Screening laboratory at the State Laboratory Institute.

Resources:

Centers for Disease Control (CDC)
National Center for Environmental Health
Lead Poisoning Prevention Branch
Division of Environmental Hazards and Health Effects
National Center for Environmental Health
1600 Clifton Road, Mailstop E25
Atlanta, GA 30333
(404) 639-2510
FAX: (404) 639-2570
<http://www.cdc.gov/nceh/lead/lead.htm>

MDPH Regional Health Offices

Blood Pressure Screening Clinics

Purpose: To provide accessible monitoring of health risks to a community. To provide health education, health promotion, and screening as necessary in accordance with accepted standards of care.

Population: Community

Legal Considerations:

1. Federal/State Law or Local Reg.? (N)
2. Physicians order(s)? (N)
3. Informed consent? (N)

Equipment Needed:

1. Blood pressure cuffs: Adult standard, wide and pediatric
2. Stethoscope for each practitioner
3. File cards (for individual records) and a file box for storage
4. Develop computer program for data

Planning:

1. Assess population on the basis of need and frequency.
2. Assess number of clinics currently being offered in community by other agencies to avoid duplication.
3. Consider target population: schedule daylight hours for elders and after work or weekends for young and mature adults.
4. Identify handicapped accessible sites in community for clinics and negotiate time slot availability for holding clinics.
5. Promote clinics through local daily and weekly news media.
6. Post notice of clinics in church and organizational bulletins.
7. Collaborate with area nursing programs to offer student learning experience.

Financial Considerations:

1. Determine if budgetary allotment is sufficient to fund time expended and/or
2. Develop collaborative relationship with population-focused collegiate nursing program that could provide these services as a clinical practicum for the students.

Procedure:

1. Educate individual re: desirable parameters for blood pressure
2. Assess medication, diet, activity, and cognitive levels
3. Have patient sit for five minutes before taking blood pressure.
4. Take blood pressure in both arms. Take two readings if elevation noted.

5. Refer to health care provider if poorly controlled blood pressure is evident.
6. Provide follow-up monitoring and support as needed for compliance.
7. Triage for emergent or evolving medical conditions presented at clinic setting.

Nursing Considerations:

Encourage return visits on a regular basis for monitoring, education and health promotion.

Documentation/Record Keeping:

1. Provide individual with a personal record in addition to maintaining clinic record if possible.
2. Record interventions according to a recognized nursing minimum data set by either using or developing a pen and paper or computer generated program.

Evaluation:

1. Quantify data in relation to regional, state, and national norms for detecting cardiovascular risks through blood pressure monitoring.
2. Assess utilization according to time and site specifics and consider expansion/reduction/relocation/time changes of clinics.
3. Determine if program screened and referred high risk/at risk populations appropriately.

Health Promotion/Disease Prevention Intervention(s):

1. Establish relationship with area medical providers to develop referral mechanism to accept/receive community members in need of service.
2. Identify other registered nurses in community available to assist at public clinics if needed.
3. Prepare articles addressing cardiovascular risks for publication in area newspapers circulated in the community.
4. Avail yourself to community groups as a speaker to address health risks and offer strategies for risk reduction.

References:

American Heart Association

www.americanheart.org

National Heart, Lung, and Blood Institute, National Institute for Health

www.nhlbi.gov/health/index

Resources:

Massachusetts Regional Centers for Healthy Communities

Breast and Cervical Cancer Screening Public Health Initiatives (Women's Health Network)

Purpose: Early detection of breast and cervical cancer to reduce the incidence of morbidity and mortality.

Population: All eligible town residents and occupants as determined by the guidelines set forth by the Department of Public Health.

Legal Considerations:

1. Federal/State Law or Local Reg.? (N)
2. Physicians order(s)? (N)
3. Informed consent? (Y)

Equipment Needed:

1. List of sites offering the screening in the surrounding geographical area.
2. Schedule of screening sessions for the sites.
3. List of participating providers for follow-up.

Planning:

1. Consult with the American Cancer Society and/or the Department of Public Health on current initiatives.
2. Consult with local providers on schedules and promotional activities for the WHN screenings.
3. If there are no local providers, gather a committee to evaluate the possibility of local sponsorship.

Financial Considerations:

- A. There are eligibility requirements to participate in the WHN program.
 1. To be eligible for services, women must:
 - a. live in Massachusetts
 - b. have a household income less than 250% of the Federal Poverty Level
 - c. have no other insurance that covers the services
 - d. be between ages 40-64 or
 - e. be under age 40 *and*
 1. have a personal or family history* of breast or ovarian cancer
 2. have received therapeutic radiation to the chest
 3. be referred by a clinician to rule out cancer
 4. be age 18-39 and have never had a Pap test or have not had a Pap test for five years
 - f. be over age 64 *and*
 1. be ineligible for Medicare

2. be unable to pay for Medicare Part B
2. Men are also eligible if they meet the above eligibility guidelines and are referred by a clinician to rule out breast cancer.

*Family history refers to immediate family members, such as mother, sister, daughter

B. Covered Services: The Women's Health Network covers the following services:

1. mammograms
2. clinical breast exams
3. pap tests
4. pelvic exams
5. diagnostic services for breast and cervical cancer including, if needed, radiology, biopsy, pathology, anesthesia, and ambulatory surgical center fees
6. screening* for hypertension, cholesterol, and diabetes
7. healthy lifestyle counseling*

*Only available at certain locations.

Procedure:

1. The Women's Health Network of DPH contracts with approximately 40 local health centers, hospitals, and community-based agencies to provide WHN services at over 90 locations throughout the state.
2. Refer eligible women to accessible locations.
3. Assist with scheduling screening appointment as needed.

Nursing Considerations:

1. Follow-up with client about screening appointment.
2. Link client to primary care provider/medical home.
3. Link WHN screening site with primary care provider/medical home.

Documentation/Record keeping:

1. Documentation consists of name of client, date of referral, name of agency referred to, reason for referral, date of appointment, name of person scheduling the appointment.
2. Documentation is to be maintained for the legal retention period as specified in the Massachusetts General Laws (MGL) and the Code of Massachusetts Regulations (CMR). The retention schedule is included as an appendix. Refer to the relevant statutory code or regulation for detailed information on what must be included in each record.
3. All other facilities, e.g., doctor offices, BOH, VNAs, nursing homes, etc must retain documentation for a period of 10 years following the end of the calendar year in which the documentation occurred.

Evaluation:

1. Keep data on how many eligible women were referred for screening from the community.
2. Compare data to numbers of women eligible for screening.
3. Keep data on numbers of women screened.

Health Promotion/Disease Prevention Intervention(s):

1. Schedule educational opportunities to promote breast and cervical cancer information.
2. Schedule Self-Breast Examination training.
3. Distribute educational materials on breast and cervical cancer.
4. Distribute information on breast and cervical cancer screening programs in the area.

References:

Massachusetts Women's Health Network, Bureau of Family and Community Health, Division of Community Health Promotion, MDPH.
<http://www.state.ma.us/dph/whn/whn.htm>

Resources:

Toll free information line for help finding an enrollment site or to get more information, 1-877-414-4447 (TTY 617-624-5992).

Cancer Information:

American Cancer Society (ACS) (www.cancer.org)
Information on all cancers and local ACS chapters

Boston Public Health Commission (www.tiac.net/users/bdph)
Information on the Commission, including Boston City's Cancer Crusade (also available in Spanish)

National Breast Cancer Coalition (www.natlbcc.org)
A national grassroots advocacy group responsible for increasing breast cancer funding to 900 million and dedicated to fighting breast cancer

National Breast and Cervical Cancer Early Detection Program Centers for Disease Control and Prevention (www.cdc.gov/cancer/nbccedp/index.htm)
Information on the national program and Massachusetts data

National Cervical Cancer Coalition (www.nccc-online.org)
Cervical cancer information

Burial Permits

Purpose: To issue valid burial permits and sign death certificates.

Population: All residents and occupants (e.g. workers, school pupils, prison inmates) who expire within the town/city.

Legal Considerations:

1. Federal/State Law or Local Reg.? (Y)
e.g. M.G.L. c. 114. §. 45, 46, 47
M.G.L. c. 17. §. 4
2. Physicians order(s)? (N)
3. Physicians signature? (Y)
3. Informed consent ? (N)

Materials Needed:

1. Death certificate signed by the physician.
2. A registered nurse pronouncement form. A registered nurse employed by a nursing home, hospice program, visiting nurse association, or home health agency, may, in many circumstances, make a nurse pronouncement of death. This enables the funeral director (or other authorized person) to remove the remains from the place of death. Such a pronouncement is not sufficient for obtaining a permit. A death certificate must be obtained. If a nurse pronouncement form has been completed, it must be so noted on the death certificate.
3. Burial permit logbook.

Planning:

1. The board of health (BOH), or if no board of health exists in a community, the city or town clerk will serve as, or designate the burial agent.
2. Arrangements for the issuance of permits must be available seven days a week.
3. Designations of burial agents for the board of health issuance of permits (particularly off-hours issuance) must be official and in writing.
4. The designation of burial agents by the board of health to issue burial permits places the same responsibilities on the designee as a BOH employee, including responsibilities for examining, acceptance and signing of death certificates.

Financial Considerations:

1. Off hours coverage for issuing permits by burial agents
2. Fee determined by the town/city for the burial permits

Procedure:

1. Receive the death certificate from the funeral director or other authorized person in a timely manner. The death certificate must be issued before burial occurs.
2. Examine the certificate for completeness and accuracy of information. The information includes:
 - a. full name
 - b. age
 - c. last known residence
 - d. sex
 - e. race
 - f. date of death
 - g. place of death; if at sea , name of vessel
 - h. names of his or her parents
 - i. current or previous marriage
 - j. name of spouse
 - k. information on circumstances
 - l. cause of death
 - m.immediate disposition
3. The certificate is considered to be prima facie evidence of the fact of death and as such can be introduced in a court of law as evidence when a question about the death arises.
4. The certificate must be prepared with black ink only.
5. The certificate must not contain cross-outs, or corrections made with white-out.
6. Bodies brought into a town for burial from outside the Commonwealth must be accompanied by a removal permit issued under the laws of the state from which it was taken.
 - a. bodies not accompanied by a removal permit may not be buried until the BOH issues a burial permit
 - b. this permit will not be issued until a certified copy of the death certificate has been given to the board
 - c. the board retains custody of this certificate
7. Fetal deaths (stillbirths) have special requirements:
 - a. if the gestational age was at least 20 weeks or the fetus weighed 350 grams, the death is reportable to the Department of Public Health (DPH)
 - b. if the gestational age is less than 20 weeks or the fetus weighed less than 350 grams, the hospital or certifying physician/medical examiner must provide a letter on the hospital or physician stationery to the funeral director or other authorized person, stating the facts of the case and the information required for the issuance of the permit

- c. the funeral director or another authorized person is provided a photocopy of the report of fetal death to obtain the permit
- d. the board maintains a copy of the Report of Fetal Death for thirty days
- e. the Report of Fetal Death is not forwarded to the city or town clerk for registration. The disposition or removal permit is issued in the normal manner

Nursing Considerations:

Technical assistance is available at DPH, through the State Registry of Vital Records and Statistics. The Registry develops, prints and distributes the permits to the Boards of Health. In cases where substantial questions about the acceptability of a death certificate exists, DPH will make the final determination.

Documentation/Record keeping:

- 1. The burial agent must sign the certificate and transmit it to the town clerk for registration.
- 2. If the death certificate is accompanied by a nursing pronouncement, the pronouncement must accompany the certificate to the town clerk.
- 3. An affidavit must be filed with the BOH by the undertaker or any person authorized to make a burial or disposition if the deceased was a veteran. The affidavit must contain the following information:
 - a. complete name of the deceased
 - b. date and place of birth
 - c. date and place of death
 - d. cause of death
 - e. summary of his/her service record
 - f. detailed statement of the location of the burial or other disposition of his/her body
- 4. The affidavit is sent by the board of health, to the town's grave officer.
- 5. Make a copy of out of state removal permit (see procedure # 6 above) and return original to town of origin.
- 6. Maintain a copy of the Report of Fetal Death (see Procedure # 7 above) for thirty days.

Evaluation:

N/A

Health Promotion/Disease Prevention Intervention(s):

N/A

References:

Massachusetts Association of Health Boards and Massachusetts Department of Public Health. (1997). *Guidebook for Massachusetts Boards of Health* (Chapter 21, Cemeteries and Disposition, pp. 1-5). Boston MA.

Resources:

Commonwealth of Massachusetts, Registry of Vital Statistics

150 Mount Vernon Street, 1st Floor

Dorchester, MA 02125-3105

Main Telephone: (617) 740-2600

<http://www.state.ma.us/dph/hstat.htm>

Camp Inspection

Purpose: To prevent disease transmission, injuries and death. To assure the drinking water is safe, the waste water is disposed of properly, poor drainage is corrected and screened doors and windows are in good repair. To ensure that all campers and staff are immunized according to current requirements.

Population: All town residents and occupants (e.g. workers, campers, school pupils) as determined. All international campers and staff.

Legal Considerations:

1. Federal/State Law or Local Reg.? (Y)
e.g. State Sanitary Code (Chapter IV) 105 CMR 430.00
M.G.L. c. 111. §. 127A
M.G.L. c. 140. §. 32A-E
Applicable Policies of the Department of Public Health
2. Physicians order(s)? (Y)
For all medications
3. Informed consent? (Y)
For all medications

Equipment/Materials Needed:

1. Copy of the most current regulations
2. Copies of relevant documents
 - a. Sample Daily Log for Medication Administration
 - b. Storage and Administration of Medication policies
 - c. Health Record requirements
 - d. Injury Report requirements
 - e. Required Immunizations information for both campers and staff

Planning:

1. Identify camps (expanded definition) in the town/city
2. Contact camp director and set up time for inspection
3. Initial contact with camp director is in the early spring
4. Purpose of contact with camp director:
 - a. to assure director is familiar with state regulations
 - b. to assure director is aware of changes in regulations/requirements
 - c. to permit inspection in a timely manner
 - d. to assure deficiencies will be corrected before camp opens
5. Collaborate with other Board of Health (BOH) agents, i.e. sanitarian, health agent or code enforcement officer to perform inspections as a team. The sanitarian/health agent, for example, might be responsible for inspecting minimum standards for subsurface sewage disposal systems, bathing beaches, and swimming pools.

Financial Considerations:

Inspection fees are set by the individual city/town.

Nursing Considerations:

1. Review immunization records of all adult counselors and campers to assure compliance with immunization / physical exam requirements.
2. Offer immunizations to counselors needing boosters.

Documentation/Record keeping:

Utilize DPH inspection form.

Health Promotion/Disease Prevention Intervention(s):

1. Educate camp director/staff as to reporting of communicable diseases, e.g. pertussis.
2. Ensure camp director is aware of child abuse/neglect policies and procedures.

References:

Massachusetts Association of Health Boards and Massachusetts Department of Public Health. (1997). *Guidebook for Massachusetts Boards of Health*. Boston, MA.

Massachusetts Immunization Program, Massachusetts Department of Public Health. (February, 2001). *Childhood immunization guidelines*. Boston, MA.

Massachusetts Immunization Program, Massachusetts Department of Public Health. (July 2000). *Supplied vaccines and eligibility*. Boston, MA.

National Immunization Program, Centers for Disease Control and Prevention. (2000). *Epidemiology and prevention of vaccine-preventable diseases*, 6th ed. Atlanta, GA.

Resources:

Camp Regulations, Massachusetts Department of Public Health.

<http://www.state.ma.us/dph/dcs/campre.pdf>

Centers for Disease Control and Prevention:

1-800-232-2522 or <http://www.cdc.gov/> or

<http://www.cdc.gov/nip/publications/VIS/default.htm>

Massachusetts Department of Public Health, Division of Epidemiology and Immunization:

305 South Street, Jamaica Plain, MA 02130 1-617-983-6800 or 1-888-658-2850

<http://www.magnet.state.ma.us/dph/cdc/epiimm2.htm>

Massachusetts Department of Public Health, Division of Community Sanitation

305 South Street, Jamaica Plain, MA 02130 617-983-6761 Fax 617-983-6770

Cholesterol (Lipid) Profile Screening

Purpose: To provide the opportunity to check for potential coronary artery disease indicators as part of health promotion and chronic disease prevention activities.

Population: All town residents and occupants as determined.

Legal Considerations:

1. Federal/State Law or Local Reg.? (N)
2. Physicians order(s)? (N)
3. Informed consent? (Y)

Equipment/Materials:

1. Cholestech LDX Analyzer (or other screening tool)
2. Appropriate calibration equipment for screening tool
3. Instruction manual for screening tool used
4. Equipment needed for testing as indicated by the cholesterol analyzer
 - a. sterile microtainer (for fingerstick)
 - b. pipette tube (for blood collection)
5. Alcohol swabs
6. Band-Aids
7. Disposable gloves—including non-latex
8. Sharps container
9. Biohazardous waste receptacles
10. OSHA recommended cleaning solution(s) for cleaning work area
11. Tables and chairs for both registration and work area

Planning:

1. Review or conduct community needs assessment to support rationale for activity in collaboration with other community groups.
2. Work with the regional Prevention Center(s) to collect data.
3. Review or write protocol for policy and procedure on how, when and where to refer clients with results requiring referral.
4. Identify community resources for referral for follow-up for clients with no medical home.
5. Review registration paperwork.
6. Review screening questionnaire.
7. Three months before screening:
 - a. arrange to obtain cholesterol screening equipment
 - b. make sure testing equipment used is either Clinical Laboratory Improvement Amendments (CLIA) exempt or a CLIA permit has been obtained
 - c. notify community partners of screening dates

- d. determine maximum number of screenings per session
- e. reserve space for clinic

One month before screening:

- a. media campaign: local newspaper(s), radio, cable TV channel(s), posters, fliers, bulletins in local churches, senior bulletins, mosques, synagogues
- b. identify paid or volunteer staff

Day of Screening:

- a. perform quality control testing per manufacturer's instructions
- b. set up space to include emergency treatment area for adverse reactions
- c. review routine procedures and emergency procedures with staff
- d. review operating procedures for screening tool
- e. review master lists of registrants

Financial Considerations:

- 1. Equipment costs—screening equipment, other equipment as listed above
- 2. Staffing costs—professional, clerical
- 3. Media campaign
- 4. Space rental
- 5. Cost to provide service and need to charge a fee
- 6. Consider possibility of revolving account to offset cost of supplies/staff

Procedure:

- 1. Have client fill out the registration paperwork.
- 2. Review risk assessment.
- 3. Perform test following manufacturers' recommendations.
- 4. Perform test consistent with ATP III Guidelines.

Nursing Considerations:

- 1. For clients with health insurance: refer to primary care provider/medical home for follow-up indicated as per protocol.
- 2. For clients without health insurance: refer to appropriate community health agency for follow-up per protocol.
- 3. Telephone/visit clients referred for follow up to ascertain compliance with referral.
- 4. Document results and referrals on clients referred.

Documentation/Record keeping:

- 1. Documentation consists of name of patient, date of screening, and site of screening.
- 2. Documentation is to be maintained for the legal retention period as specified in the Massachusetts General Laws (MGL) and the Code of Massachusetts Regulations (CMR.) The retention schedule is included as

- an appendix. Refer to the relevant statutory code or regulation for detailed information on what must be included in each record.
3. All other facilities, i.e., doctor offices, boards of health, VNAs, nursing homes, etc must retain documentation for a period of 10 years following the end of the calendar year in which the documentation occurred (NCVIA 1986).
 4. An additional requirement applies to all categories of providers. If a notice of a claim or lawsuit has been made, other types of approved documentation pertaining to the matter must be retained until a final disposition of the claim or litigation has been made.

Evaluation:

1. Utilization of clinic by residents
2. Assessment that at risk populations were served
3. Determination if fees charged were adequate

Health Promotion/Disease Prevention Intervention(s):

1. Provide educational materials on nutrition, healthy lifestyles, smoking cessation etc.
2. Offer to co-sponsor presentations on nutrition and health in collaboration with other agencies.

References:

American Heart Association (AHA), [http:// www.americanheart.org](http://www.americanheart.org)

Massachusetts Association of Health Boards and Massachusetts Department of Public Health. (1997). *Guidebook for Massachusetts Boards of Health*. Boston, MA.

National Cholesterol Education Program (NCEP), <http://www.nhlbi.nih.gov/chd/>

National Heart, Lung and Blood Institute, (NHLB), www.nhlb.nih.gov

Resources:

Centers for Disease Control and Prevention, Public Health Practice Program Office, Division of Laboratory Systems
<http://www.phppo.cdc.gov/dls/clia/waived.as>

Massachusetts Department of Public Health, Chronic Disease Surveillance Program.
<http://www.state.ma.us/dph/cdsp.htm>

Massachusetts Department of Public Health, Division of Community Health Promotion, Health Promotion, Nutrition, and Chronic Disease Prevention Program.
<http://www.state.ma.us/dph/helpro.htm>
Massachusetts Department of Public Health, Regional Prevention Centers

<http://www.state.ma.us/dph/mpc/prevctr.htm>

For questions on CLIA requirements:

Massachusetts Department Of Public Health, Clinical Laboratory Program, State
Lab Institute,
305 South Street, Rm 224
Jamaica Plain, Ma 02130
(617) 983-6739 FAX: (617) 983-6740
Contact: Doris DeGraves

Resources:

Cholesterol Screening tools exempted from CLIA regulations

ActiMed Laboratories ENA.C.T Total
Cholesterol Test (PDU) 04802
12/2/1998

ActiMed Laboratories ENA.C.T Total
Cholesterol Test 04573
12/19/1997

Boehringer Mannheim Accu-Chek
InstantPlus Cholesterol 07776
5/20/1996

ChemTrak AccuMeter 10165
3/17/1995

Cholestech L.D.X. 10170
1/23/1996

Johnson & Johnson ADVANCED CARE
Cholesterol Test 31014
3/24/1995

Lifestream Technologies Cholesterol Monitor 37146
2/24/1999

Polymer Technology Systems MTM
BioScanner 1000 (for OTC use) 49196
8/199/1999

Roche Diagnostics Accu-Chek
InstantPlus Cholesterol 55321
5/7/1999

Additional Reference

National Education Program
ATP III At-A-Glance: Quick Desk Reference

Table of Contents

- Step 1: Determine lipoprotein profile after 9- to 12-hour fast
- Step 2: Identify presence of clinical atherosclerotic disease that confers high risk for coronary heart disease (CHD) events (CHD equivalent)
- Step 3: Determine presence of major risk factors (other than LDL)
- Step 4: If 2+ risk factors (other than LDL) are present without CHD or CHD risk equivalent assess 1 year (short term) CHD risk
- Step 5: Determine risk category
- Step 6: Initiate therapeutic lifestyle changes (TLC) if LDL is above goal
- Step 7: Consider Adding drug therapy if LDL exceeds levels shown in Step 5 table
- Step 8: Identify metabolic syndrome and treat, if present, after 3 months of TLC
- Step 9: Treat elevated triglycerides

Full text available on line at;

<http://www.nhlbi.nih.gov/guidelines/cholesterol/atglance.htm>

Community Health Network Area (CHNA) Participation

Purpose: A Community Health Network (CHNA) is a local coalition of public and private sector organizations working together to build healthier communities in Massachusetts through community-based prevention, planning and health promotion. The Massachusetts Department of Public Health established the Community Health Network Area (CHNA) effort in 1992. Today, this initiative involves all 351 towns and cities through 27 Community Health Networks. The initiative is designed to identify local and regional health priorities, design community-based prevention plans, and track success in achieving healthier communities.

Population: All town residents and occupants (e.g. workers, school pupils, prison inmates) as determined.

Legal Considerations:

1. Federal/State Law or Local Reg.? (N)
2. Physicians order(s)? (N)
3. Informed consent? (N)
4. All DPH contractors are required to participate.

Planning:

1. Identify community providers, organizations and residents who should be represented.
2. Assess community needs, which could be addressed on a regional basis, to bring back to CHNA meetings for discussion.
3. Keep suggestions for initiatives broad so as to be inclusive for all communities as possible. (e.g. substance abuse vs IV drug use)

Financial Considerations:

Staff time to attend CHNA meetings (typically one per month). Assuming a leadership position in a CHNA (e.g. member of a steering committee or task force participant) will require an additional meeting per month.

Nursing Considerations:

1. Nursing perspective enriches the collaborative efforts of the CHNA and enhances project planning.
2. Nursing knowledge can help to identify, define and plan the community focused public health interventions.

Documentation/Record Keeping:

Document attendance of staff at CHNA meetings.

Evaluation:

1. Assess effectiveness and appropriateness of CHNA initiatives for your community.
2. Assess networking opportunities with local healthcare providers and other municipal services.

Health Promotion/Disease Prevention Intervention(s):

1. Bring community health and wellness concerns to the larger regional audience.
2. Bring back information on resources, “best practices”, and community activities from the region to local health coalition.
3. Build partnerships that enhance local health initiatives.

References:

Massachusetts Association of Health Boards and Massachusetts Department of Public Health. (1997). *Guidelines for Massachusetts Boards of Health*. Boston, MA.

Massachusetts Department of Public Health, Office of Healthy Communities
250 Washington Street, Boston, MA, Second floor
617-624-5270 Fax 617-624-5246
<http://www.state.ma.us/dph/chna.htm>

Resources:

Website: www.healthycommunities.org
Coalition for healthier cities and communities

Website: www.preventioncenters.org
Regional Prevention Centers support community prevention and health promotion efforts. Call your regional Prevention Center for more information on prevention, regional health events, local trainings or visit their resource library.

Website: <http://ctb.lsi.ukans.edu/>
Community Tool Box. Tools for program evaluation and community building

Website: www.communityinitiatives.com
Community Initiatives. Dedicated to building healthy and sustainable communities

Communicable Disease Investigation

Purpose: To receive and process reports of communicable disease and undertake appropriate follow-up measures, including notifying the Bureau of Communicable Disease Control of any disease dangerous to the public health.

Population: All town residents and occupants

Legal Considerations:

1. State Law and State Regulation? (Y)
e.g. M.G.L. c. 111. §. 6 and 7
105 CMR 300.000
2. Physicians order(s)? (N)
3. Informed consent? (N)

Materials Needed:

1. Appropriate case report forms from the DPH Bureau of Communicable Disease Control
2. Communicable Disease Record Book (see resources)
3. A copy of the DPH manual *Guide to Surveillance and Reporting*, describes the reporting process in detail
4. System for notifying contacts of person diagnosed with a reportable disease(s)
5. A copy of the *Report on Infectious Diseases* (Red Book)
6. A copy of the *Control of Communicable Diseases Manual*

Planning:

1. Establish and maintain relationship(s) with local primary care providers, clinics, and hospitals.
2. Establish and maintain relationships with local school health professionals.
3. Establish and maintain relationships with other board of health professionals both locally and in surrounding communities.
4. Establish and maintain relationships with the regional epidemiologists, located at the State Laboratory Institute, and nurses from the Bureau of Communicable Disease Control.

Financial Considerations:

Staff

Procedure:

1. Keep timely and accurate records of all communicable disease reports in the *Communicable Disease Record Book* from Hobbs and Warren, Inc.

2. Prompt follow-up of all communicable disease reports is necessary as delays in responding may lead to unnecessary spread of disease.
3. Coordinate investigations with the epidemiologists and nurses from the DPH Bureau of Communicable Disease Control. Clusters of reports can indicate breakdowns in control measures.
4. Reports should be conducted via the telephone or in writing.
5. Keep all records pertaining to communicable disease investigations in a secure and confidential manner.
6. Remind providers to report sexually transmitted diseases directly to the Sexually Transmitted Disease (STD) Division, Communicable Disease Control Bureau, DPH.
7. Remind providers to report TB cases directly to the Tuberculosis Prevention and Control Program, Communicable Disease Control Bureau, DPH. (see section Control, Prevention and Elimination of Tuberculosis)

Nursing Considerations:

Be able to identify the conditions that promote outbreaks: natural disasters (floods, earthquakes), man-made social problems (crowding, poverty, malnutrition), inadequate immunization levels, lack of personal hygiene, carelessness in food handling, contamination of water supplies, and failure to control insects, rodents or other animals capable of transmitting disease.

1. Ability to identify the basic characteristics of the reportable communicable diseases i.e.
 - a. basic description of the disease—symptoms, effects
 - b. occurrence (locations)
 - c. infectious agent
 - d. reservoir (e.g. humans, certain animals, soil, etc)
 - e. mode of transmission
 - f. incubation period
 - g. susceptibility and resistance
 - h. control of patients, contacts, and immediate environment
 - i. methods of control
 - j. epidemic measures
 - k. international measures
 - l. prevention methods
2. The public health nurse (phn)duties also include
 - a. identifying the source of contagion
 - b. establishing control measures
 - c. follow-up with contacts of infected patients
 - d. instructing patients on prevention and control
 - e. instructing family members and other relevant people regarding prevention and control
 - f. making necessary referrals to providers
 - g. writing necessary reports

- h. referring waterborne, food processing, handling or storage issues or septic system issues to a qualified sanitarian to investigate and take the necessary action

Documentation/Record keeping:

1. Use appropriate report forms.
2. Reports should be sent to:
 - a. town where patient resides
 - b. town where patient is known to have contracted the disease
 - c. town(s) where the patient is known to have exposed any person(s) to the disease
 - d. DPH
3. Reports should contain:
 - a. name and location of infected persons
 - b. disease
 - c. name of person reporting
 - d. date of report
 - e. other information required by DPH (M.G.L. C 111 s 113)
4. Records should be kept of all communication, including telephone communication with patients, families and contacts including:
 - a. date of call
 - b. time of call
 - c. name of the respondent
 - d. nature of the communication
5. Reports are to be kept in a confidential and secure manner.
6. Notification is to be sent to DPH within 24 hours of any case “dangerous to the public health.”
7. Written reports should be sent in envelopes marked “confidential” and “to addressee only.”
8. When reporting information that is potentially identifying to DPH or other boards of health, affirm that the connection is made to the properly designated agency and receive assurance that the responder is authorized to accept the information to be discussed.
9. The Bureau of Communicable Disease Control has adopted policies concerning release of patient data for Bureau staff. Please refer to the *Guide to Surveillance and Reporting* for details of these policies.
10. Documentation is to be maintained for the legal retention period as specified in the Massachusetts General Laws (MGL) and the Code of Massachusetts Regulations (CMR.) The retention schedule is included as an appendix. Refer to the relevant statutory code or regulation for detailed information on what must be included in each record.
11. All other facilities, e.g., doctor offices, boards of health, VNAs, nursing homes, etc must retain documentation for a period of 10 years following the end of the calendar year in which the documentation occurred (NCVIA 1986).

Evaluation:

Assess reporting process both internally and externally with health care providers to ensure prompt notification and timely investigation.

Health Promotion/Disease Prevention Intervention(s):

1. Education through media outlets in the event of community outbreak of disease.
2. Prevention efforts to prevent foodborne illness outbreaks through ongoing inspection of restaurants.
3. Educational opportunities for individuals affected by communicable disease by sharing Public Health Fact Sheets.
4. Follow preventive measures associated with each disease.

References:

- American Academy of Pediatrics. (2000). *2000 Red Book: Report of the committee on infectious diseases (25th ed)*. Elk Grove Village, IL.
- American Public Health Association. (2001). *Control of communicable diseases manual (17th ed.)* Edited by James Chin, MD, MPH. Washington, D.C.
- Massachusetts Association of Health Boards and Massachusetts Department of Public Health. (1997). *Guide for Massachusetts Boards of Health*. Boston, MA.
- Massachusetts Department of Public Health. (1997). *Foodborne illness investigation and control manual*. Boston, MA.
- Massachusetts Department of Public Health. (2001). *Guide to surveillance and reporting*. Boston, MA.
- Massachusetts Department of Public Health. (1995). *The comprehensive school health manual*. Boston, MA.
- Massachusetts Department of Public Health. (1995). *Health and safety in child care*. Boston, MA.
- Massachusetts Health Officers Association. (1995). *Reference manual for food protection programs*. Boston, MA. MHOA-508-8203.
- National Immunization Program, Centers for Disease Control and Prevention. (2000). *Epidemiology and prevention of vaccine-preventable diseases (6th ed)*. Atlanta, GA.

Resources:

Centers for Disease Control:

1-800-232-2522 or <http://www.cdc.gov/> or
<http://www.cdc.gov/nip/publications/VIS/default.htm>

Communicable Disease Record Book

Hobbs and Warren, Inc.

PO Box 63

Boston MA 02101-0063

617-542-7947 or 7948

Massachusetts Department of Public Health, Bureau of Communicable Disease
Control:

1-617-983-6800 or 1-888-658-2850

<http://www.magnet.state.ma.us/dph/cdc/epiimm2.htm>

Community Resources and Referrals

Purpose: To prevent delay in seeking medical care or aid due to lack of funds or knowledge. Residents may gain access to affordable medical, dental and social services. Residents will have a directory/library of resources in a central location.

Population: Community residents who are uninsured or underinsured.

Legal Considerations:

1. Federal/State Law or Local Reg.? (N)
2. Physicians Order(s) Necessary? (N)
3. Informed Consent? (N)

Equipment/Materials:

N/A

Planning:

1. Gather information from:
 - a. town departments, schools
 - b. local health facilities
 - c. mental health agencies
 - d. legal services
 - e. elder services
 - f. homecare agencies
 - g. community faith organizations
 - h. local charities, i.e. Salvation Army
 - i. multi-service agencies serving the community
 - j. Council on Aging
 - k. local food pantry
 - l. federal, state and local government agencies such as:
 1. Department of Public Health
 2. Department of Mental Health
 3. Department of Social Services
 4. Department of Transitional Assistance
 5. Department of Medical Assistance
 - a. MassHealth
 - b. Children's Medical Security Plan
 - m. community health centers—offer a wide variety of medical, dental and mental health services
2. Develop a resource directory specific to community.

Financial Considerations:

1. Cost of booklet or publication

2. Assistance from the town library, schools, service clubs i.e. Kiwanis, Lions, and Rotary to help defray cost of booklet

Procedure:

1. Set up a committee or identify available resources within the community.
2. Identify basic needs such as fuel, food, clothing, affordable housing, legal aid, access to specific agencies.
3. Identify need for protective services such as the Department of Social Services, Elder Protective Services, Domestic Violence Shelters.
4. Assess client's financial status if applying for fuel, food, and/or clothing assistance.
5. Requests for assistance/referral are handled with respect for privacy of the individual.

Nursing Process:

1. Public Health nurses collaborate with various community groups:
 - a. school nurses
 - b. council on aging
 - c. healthcare providers/agencies
 - d. mental health providers/agencies
 - e. local home-care agencies
 - f. local charities
 - g. local church organizations
 - h. food pantries
 - i. multi-service agencies handle various concerns including: fuel programs, utility, housing, insurance, legal issues, special needs problems of children, teens, disabled adults or elders
2. If required, an assessment form is completed either in person or over the telephone. It is important to note the referral source when claiming verification of need. In some cases proof of residency may be necessary. A sample is provided in the appendix.
 - a. refer to appropriate source with telephone number and contact person
 - b. document any paperwork such as signed voucher, outstanding bills etc.
 - c. contact agency for referral as needed

Documentation/Record Keeping:

1. Complete assessment form
2. Maintain record of transaction in files for future reference
3. Keep all information confidential

Evaluation:

1. Review records on an ongoing basis, note trend for increase or decrease in requests for assistance.

2. Assess collaboration with local social service agencies and their utilization of nursing services.
3. Assess response of referral agencies/providers to clients.

Health Promotion/Disease Prevention Intervention(s):

1. Refer clients for assistance before crisis happens.
2. Encourage clients to utilize programs and to advocate on their behalf.

Resources The websites and information contained here are intended to help begin the search.

Healthfinder: a guide to health information
www.healthfinder.gov

The Commonwealth of Massachusetts website: provides information on state agencies.

<http://www.mass.gov/portal/index.jsp> general info and links to other state agencies

<http://www.state.ma.us/dph/> Department of Public Health

<http://www.state.ma.us/dhcd/default.htm> Department of Housing and Community Development

<http://www.qualitychildcare.org/> Office of Childcare Services

<http://www.state.ma.us/dss/> Department of Social Services

<http://www.state.ma.us/dma/> Division of Medical Assistance

<http://www.state.ma.us/dta/> Department of Transitional Assistance

<http://www.state.ma.us/sec/cis/ciscig/guide.htm> Citizen's Guide to State Services

<http://www.state.ma.us/dmh/> Department of Mental Health

<http://www.lawlib.state.ma.us/referral.htm> Legal Aid

<http://www.800ageinfo.com/> Resources for Massachusetts Elders

<http://massleague.org/> Massachusetts League of Community Health Centers

<http://suicidehotlines.com/massachusetts.html> Crisis Hotlines/Suicide prevention

<http://www.state.ma.us/dph/bfch/vpis/vpp.htm> Violence Prevention and Intervention Services

<http://www.state.ma.us/dph/sapss/sites.htm> Rape Crisis Centers

<http://www.crossnet.org/where/chapts.html#ma> American Red Cross Websites

<http://www.bostonredcross.org/> American Red Cross of Massachusetts Bay

Ball, George. (1999). *Human resources yellow pages*. Boston, MA.

Other Programs:

AHEC NETWORKS

Community Action Centers

Good Neighbor Energy Fund: Clothing, furniture, shelter

Salvation Army

<http://www.SalvationArmy-USAEast.org>

Social Security Administration: Social Security Programs

<http://www.ssa.gov/>

Dental Screening

Purpose: To assure access to dental care for all school children and to promote oral health.

Population: All school pupils, as determined.

Legal Considerations:

1. Federal/State Law or Local Reg.? (N)
2. Physicians order(s)? (N)
3. Informed consent? (Y)
Parent/guardian signature required

Equipment Needed:

1. Dental chair
2. Light
3. Fluoride paste and rinse
4. Tongue depressors
5. Autoclave bags
6. Dental instruments (sufficient for number of children to be screened)
This can include but is not limited to:
 - a. sickle scalers
 - b. curet scalers
 - c. explorers
 - d. mirrors
 - e. prophyl angles
 - f. prophyl cups
 - g. portable hand piece
7. 2x2 gauze pads
8. Gloves—latex and non-latex
9. Bibs
10. Antiseptic
11. Toothbrushes (sufficient for number of children to be screened)

Planning:

1. Clinics may be organized to meet community needs.
2. Review or conduct a needs assessment in collaboration with other community agencies and organization on the numbers of children in need of access to dental care. i.e. school health staff, community health centers, private practitioners, hospitals, or other organizations.
3. Join or develop a planning committee for community Oral Health initiatives. The tasks of the committee could include:
 - a. designing a screening program for targeted grades or schools
 - b. creating a referral system for follow-up care to community dentists

- c. identifying community professionals who will support and participate at the screenings
 - d. linking eligible children to health insurance networks and medical homes
 - e. identifying sources for dental equipment needed for screenings
 - f. identify target population(s)
 - g. identifying sources for free toothbrushes to give out (pharmaceutical companies, dental supply houses can be sources)
 - h. identifying small grants to help underwrite costs. Some sources may include the Department of Public Health Division of Oral Health, Delta Dental Insurance, other insurance carriers
4. The committee should include:
 - a. community dentists
 - b. community dental hygienists
 - c. school nurses
 - d. superintendent of schools
 - e. school principals
 - f. volunteer parents from the school Parent/Teacher group
 5. Work with school nurses early in the school year (August, September) to help schedule and identify space and resources for the dental clinic(s).
 6. Identify professional staff—paid and volunteer for the clinic.
 7. Design permission slips. Recommendations for information on permission slip may include but are not limited to:
 - a. child's name
 - b. date of birth
 - c. parent/guardian name
 - d. address
 - e. telephone numbers—both day and evening
 - f. name of current dentist
 - g. date of last visit to dentist
 - h. major health history
 - i. history of latex allergy
 8. Media campaign: local newspaper(s), radio, cable TV channel(s), posters, fliers, letter to Parent/teacher organization.
 9. Three months prior to clinic date:
 - a. identify and reserve space for clinic
 - b. order (or identify source of) dental equipment
 - c. send consent forms to the school to be sent out to the parent/guardians Establish return date for forms.
 - d. notify community media of event and provide copy for articles as indicated
 - e. notify Parent-Teacher organization of upcoming clinic(s)
 - f. recruit professional staff
 10. One month prior to clinic date:
 - a. begin to create master list of people to be screened

- b. review returned permission forms

Financial Considerations:

1. Staffing for clinic(s)—paid or volunteer, professional and clerical
2. Equipment as outlined
3. Media campaign: community newspapers, radio, local cable channels, fliers, posters

Procedure:

Day of clinic:

- a. set up space to include emergency treatment area for adverse reactions. review routine procedures and emergency procedures with staff
- b. review master lists of registrants
- c. prescreen registrants for precautions and contraindications to receiving screening
- d. prescreen for allergies to latex
- e. record dental screening results and recommendations
- f. send copies of the results to the parent/guardian along with referral information

Nursing Considerations:

1. Follow up with school nurse on tracking referral for treatment progress.
2. Follow up with referral dentist for appointments scheduled and kept.
3. Follow up with family on referral for assistance with health insurance.

Documentation/Record keeping:

1. Documentation consists of name of patient, date of screening, site of screening. It must be noted that parental consent is on file.
2. Documentation is to be maintained for the legal retention period as specified in the Massachusetts General Laws (MGL) and the Code of Massachusetts Regulations (CMR). The retention schedule is included as an appendix. Refer to the relevant statutory code or regulation for detailed information on what must be included in each record.
3. All other facilities, e.g., doctor offices, BOH, VNAs, nursing homes, etc must retain documentation for a period of 10 years following the end of the calendar year in which the documentation occurred (NCVIA 1986).

Evaluation:

1. How many of the children screened were referred for follow-up?
2. How many of the children screened did not identify a primary dentist?

Health Promotion/Disease Prevention Intervention(s):

1. Educate residents about oral health by providing material of effective programs that prevent or control dental disease.
2. Provide linguistically and culturally appropriate information.

3. In non-fluoridated communities, support implementation of other preventive programs for schools that may include:
 - a. fluoride rinse programs
 - b. sealant programs
 - c. work with local organizations and recreational programs that sponsor or promote contact sports to encourage the use of mouthguards to prevent dental injury

References:

Massachusetts Association of Health Boards and Massachusetts Department of Public Health. (1997). *Guidebook for Massachusetts Boards of Health*. Boston MA.

Massachusetts Department of Public Health, Division of Oral Health
<http://www.state.ma.us/dph/oral.htm>

Resources:

Dentistry for All: a program of the MDS
Patients on a fixed or low income may be eligible to participate in Dentistry for All. This program is designed for low-income individuals and families who have too high an income to qualify for MassHealth (state Medicaid assistance). Eligibility is based on certification of need from a social service agency plus completion of a financial need form. Individuals and families with dental insurance are not eligible.

Massachusetts Dental Society (MDS)
www.massdental.org

Massachusetts League of Community Health Centers (CHC): many CHC's offer dental services on an income adjusted sliding fee scale.
1-800-475-8455.
massleague@massleague.org

Rent –A- Dent Contract hygienists
1-978-957-6201

Request a brochure and an application by writing to the Massachusetts Dental Society, 2 Willow Street #200, Southborough, MA 01745-1027.

Diabetes Screening Clinic

Purpose: To provide the opportunity to check for potential diabetes indicators as a part of health promotion/chronic disease prevention activities.

Population: Town residents and occupants (i.e. employees, school pupils, prison inmates, organizations.)

Legal Considerations:

1. Federal/State Law or Local Reg.? (N)
2. Physicians order(s)? (N)
3. Informed consent? (Y)

Equipment/Materials Needed:

1. Tables and chairs for both registration and work area
2. Glucometer(s) and instruction manual
3. Calibration equipment for glucometer for each screening
4. Equipment needed for testing as indicated by the glucometer:
 - a. test strips
 - b. control test solutions for glucometers (for quality assurance)
 - c. spare batteries
 - d. lancets, autolets and or platforms (as needed)
5. Alcohol swabs
6. 2X2 unsterile gauze pads
7. Band-Aids
8. Disposable gloves—including non-latex
9. Sharps container
10. Biohazardous waste receptacles
11. OSHA recommended cleaning solution(s) for cleaning work area
12. Test result forms and patient education materials
13. Hard candies, sweetened juice or other “quick fix” items for potential hypoglycemic reaction

Planning:

1. Conduct or review community needs assessment to support rationale for activity in collaboration with other community groups (i.e. school health staff, community health centers, private practitioners, hospitals, and other organizations.)
2. Work with the regional prevention center(s) to collect data.
3. Review or write protocol for policy and procedure on how, when and where to refer clients with results requiring referral using DPH guidelines. Note whether the test is random or fasting.

4. Identify community resources for referral for follow-up for clients with no primary care provider/medical home. Refer immediately if in undesirable range.
5. Review or write registration paperwork.
6. Review or write screening questionnaire.
7. Three months prior to screening date:
 - a. arrange for screening equipment
 - b. make sure testing equipment used is either CLIA (Clinical Laboratory Improvement Amendments) exempt or a CLIA permit has been obtained
 - c. notify community partners and providers of screening date
 - d. determine maximum number of screenings per session
 - e. reserve space for clinic
8. One month before screening:
 - a. media campaign: local newspaper(s), radio, cable TV channel(s), posters, fliers, bulletins in local churches, mosques, and synagogues
 - b. identify paid or volunteer staff
9. Day of screening:
set up space and review routine procedures and emergency procedures with staff

Financial Considerations:

1. Equipment costs—screening equipment, other equipment as listed above
2. Staffing costs—professional, clerical
3. Media campaign
4. Space rental

Procedure:

1. Have client fill out the registration paperwork.
2. Review risk assessment.
3. Perform test following manufacturer's recommendations.

Nursing Considerations:

1. For clients with health insurance: refer to primary care provider/medical home for follow-up as indicated.
2. For clients without health insurance: refer to appropriate community health agency for follow-up.
3. Telephone/visit clients referred to ascertain compliance with referral.
4. Document results and referrals of clients.

Documentation/Record keeping:

1. Documentation consists of name of patient, date of screening, and site of screening.

2. Documentation is to be maintained for the legal retention period as specified in the Massachusetts General Laws (MGL) and the Code of Massachusetts Regulations (CMR.) Retention schedule is included as an appendix. Refer to the relevant statutory code or regulation for detailed information on what must be included in each record.
3. All other facilities, e.g., doctor's office, BOH, VNA, nursing home, etc must retain documentation for a period of 10 years following the end of the calendar year in which the documentation occurred (NCVIA 1986).
4. An additional requirement applies to all categories of providers. If a notice of a claim or lawsuit has been made, other types of approved documentation pertaining to the matter must be retained until a final disposition of the claim or litigation has been made.

Evaluation:

1. Assess efficacy of clinics to identify and screen at risk individuals
2. Utilization review

Health Promotion/Disease Prevention Intervention(s):

1. Provide educational materials on nutrition, healthy lifestyles, smoking cessation, etc.
2. Offer to co-sponsor presentations on nutrition and health in collaboration with other agencies.

References:

American Diabetes Association <http://www.diabetes.org/>

Massachusetts Association of Health Boards and Massachusetts Department of Public Health. (1997). *Guidebook for Massachusetts Boards of Health*. Boston MA.

Resources:

Massachusetts Department of Public Health, Bureau of Family and Community Health, Division of Community Health Promotion, Diabetes Control Program.
<http://www.state.ma.us/dph>

Massachusetts Department of Public Health, Chronic Disease Surveillance Program .<http://www.state.ma.us/dph/cdsp.htm>

Massachusetts Department of Public Health, Regional Prevention Centers
<http://www.state.ma.us/dph/mpc/prevctr.htm>
see appendix for regional telephone numbers

For questions on CLIA requirements:

Centers for Disease Control and Prevention (CDC), Public Health Practice Program Office (PHPPO)

Massachusetts Department Of Public Health, Clinical Laboratory Program, State
Lab Institute, 305 South Street, Rm. 224
Jamaica Plain, Ma 02130 Division of Laboratory Systems
(617) 983-6739 FAX: (617) 983-6740
<http://www.phppo.cdc.gov/dls/clia/waived.asp>

Hepatitis A Vaccine

Purpose: To protect persons from infection; to reduce disease incidence by preventing transmission; and to ultimately eliminate transmission.

Population: Persons 2 years of age and older traveling or working in countries with high rates of hepatitis A, persons who live in communities that have prolonged outbreaks of hepatitis A, men who have sex with men, persons who use street drugs, persons with chronic liver disease, persons who receive clotting factor concentrates. For the complete list see the Massachusetts Immunization Program (MIP) document *Supplied Vaccines and Patient Eligibility*.

Since November 2003, reports of cases of hepatitis A in Massachusetts have increased significantly. In September 2004, MDPH recommended that those who serve the homeless or drug using populations, such as homeless shelters, drug treatment programs, community health centers, and transitional programs for recently released inmates, encourage clients to get vaccinated for hepatitis A, and if possible, set up vaccination clinics to help them do so, MDPH will supply the vaccine for the clinics and provide technical assistance

Legal Considerations:

1. Federal/State Law or Local Reg.? (Y)
e.g. M.G.L. c. 111. §.181-183
102 CMR 7.07 and CMR 220.00
2. Physicians order(s)? (Y)
Nurses may administer vaccines when protocols or “standing orders” are signed by a physician. Sample standing orders are available through the Massachusetts Immunization Program (MIP). See the *Board of Registration in Nursing Advisory Ruling 9804* included in appendix.
3. Informed consent? (Y)
Vaccine Information Statements (VIS) must be given to each recipient (or parent/legal guardian) at the time of administration of each vaccine. The opportunity to ask questions and receive informed answers must be provided prior to administration. See *Guidelines for Compliance with Federal Vaccine Administration Requirements*.
4. Board(s) of Health must have written protocols consistent with the US Department of Health and Human Service publication *Standards for Pediatric Immunization Practices, 1996*. Also see the MIP document *General Protocols for Standing Orders* included in appendix.

Equipment Needed:

1. *General Protocols for Standing Orders* document
2. Intramuscular (IM) needle
3. Havrix or VAQTA vaccine

Planning:

Review or conduct needs assessment. Results may include hepatitis A initiatives and/or immunization clinics in response to disease outbreaks.

Financial Considerations:

1. The vaccine is available to Boards of Health for children and high-risk adults seen at public provider sites.
2. See the current MIP document *Supplied Vaccines and Patient Eligibility* for the complete list.
3. Vaccine can be purchased privately for residents not eligible or at high-risk.

Procedure: see *General Protocols for Standing Orders*.

1. Give hepatitis A vaccine 1 ml intramuscularly (IM) in the deltoid muscle of the adult using at least a 1-1/2 inch needle.
2. Hepatitis A vaccine is given in a series of 2 doses.
3. See the current MIP schedule for number of doses and scheduling.
4. See model standing orders for hepatitis A vaccine

Nursing Considerations:

Post vaccination testing is not indicated because of the high rate of vaccine response among adults and children.

Documentation/Record Keeping:

1. Documentation consists of:
 - a. Name and address of the health care provider administering the vaccine.
 - b. Name of patient, age or date of birth, date of injection, site and route of injection, name of vaccine, dosage, lot number and expiration date. It must be noted that the Vaccine Information Statements were given, and the publication date of the VIS.
2. Report any adverse reaction to the Vaccine Adverse Event Reporting System (VAERS.) The Vaccine Adverse Event Reporting System is a cooperative program for vaccine safety of the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA.) VAERS is a post-marketing safety surveillance program, collecting information about adverse events and possible side effects that occur after the administration of US licensed vaccines.
3. Provide documentation to recipient.
4. Documentation is to be maintained for the legal retention period as specified in the Massachusetts General Laws (MGL) and the Code of Massachusetts Regulations (CMR.) The retention schedule is included

as an appendix. Refer to the relevant statutory code or regulation for detailed information on what must be included in each record.

5. An additional requirement applies to all categories of providers. If a notice of a claim or lawsuit has been made, the VIS, Provider Enrollment Form and other types of approved documentation pertaining to the matter must be retained until a final disposition of the claim or litigation has been made. (*Guidelines for Compliance with Federal Vaccine Administration Requirements*, revised, May 1999.)

Evaluation:

1. Review data collection
2. Compliance with series of vaccinations

Health Promotion/Disease Prevention Intervention(s):

1. Distribution of educational materials –schools, libraries, high/risk employees,
2. Media campaign: articles/notices in community newspapers and newsletters, and cable TV.

References:

Advisory Committee on Immunization Practices ACIP. (August 25, 1998). *Hepatitis A vaccine information statement*.

Department of Health and Human Services. (January, 2000). *Epidemiology and prevention of vaccine- preventable diseases 6th ed.*

Massachusetts Association of Health Boards and Massachusetts Department of Public Health. (1997). *Guidebook for Massachusetts Boards of Health*. Boston MA.

Massachusetts Immunization Program Documents:

- *Adult Immunization Guidelines*, March, 2001
- *Childhood Immunization Guidelines*, February, 2001
- *Emergency Treatment Model Standing Order*, February, 2001
- *General Protocols for Standing Orders*, February, 2001
- *Guidelines for Compliance with Federal Administration Requirements*, November, 2000
- *Hepatitis A Vaccine Guidelines*, February, 1999
- *Pediatric Hepatitis A Vaccine Guidelines*, October, 1997
- *Supplied Vaccines and Eligibility*, July, 2000

U.S. Department of Health and Human Services. (1990 February). *Protection against viral hepatitis. Recommendations of the immunization practices advisory committee on immunization practices (ACIP) Vol. 39*. Atlanta, GA.

Resources:

American Liver Foundation
1-800-456-4837
<http://www.liverfoundation.org>

Centers for Disease Control:
1-800-232-2522 or <http://www.cdc.gov/> or
<http://www.cdc.gov/nip/publications/VIS/default.htm>

Immunization Action Coalition
<http://www.immunize.org>

Johns Hopkins University Institute for Vaccine Safety
<http://www.vaccinesafety.edu>

Massachusetts Department of Public Health, Division of Epidemiology and Immunization:
1-617-983-6800 or 1-888-658-2850
<http://www.magnet.state.ma.us/dph/cdc/epiimm2.htm>

Additional Resources:

Massachusetts Department of Public Health Immunization Program
Pediatric Hepatitis A Vaccine Guidelines
Pediatric Hepatitis A Order Form

HMO Senior Plan Reimbursement Project

Purpose: To reimburse community agencies for providing flu and pneumococcal immunizations to members of Medicare HMO Senior Health Plans.

Population: Individuals enrolled in a Medicare Senior Health Maintenance Organization (HMO) Plan

Legal Considerations:

1. Federal/State Law or Local Reg.? (N)
2. Physicians order(s)? (N)
3. Informed consent? (Y)

Materials Needed:

1. Letter of intent submitted to Massachusetts Peer Review Organization (MassPRO)
2. Attend a Workshop offered by MassPRO
3. Use and submit Health Plan Influenza and/or Vaccine Administration Forms
4. Use and submit Health Plan Influenza/ Pneumonia Cover Sheets

Planning:

To participate in the HMO Senior Plan Reimbursement Project, contact MassPRO and submit the letter of intent by August. In order to participate, the agency must be a Medicare roster biller and attend a two-hour project workshop.

Financial Considerations:

It is recommended that a revolving account be set up so that money reimbursed to your agency can be utilized for immunization services.

Procedure:

1. Influenza:
 - a. Community agencies will submit copies of the Influenza Adult immunization Record Form to the appropriate plans for all members of the plan that the agency immunized.
 - b. The Adult Immunization Record must be accompanied by an Influenza Cover Sheet, and must be submitted to each HMO only once.
 - c. The HMOs agree to accept the submitted claims for reimbursement of the cost of administration of the vaccine at the established Medicare rate.
2. Pneumococcal:
 - a. Community agencies will submit copies of the Pneumococcal Adult Immunization Record Form to the appropriate plans for all members of the plan that the agency immunized.

- b. The Adult Immunization Record must be accompanied by a Pneumococcal Cover Sheet, and must be submitted only once.
- c. The HMOs agree to accept the submitted claims for reimbursement of the cost of administration of the vaccine at the established Medicare rate.

Nursing Interventions:

If your patient belongs to a Medicare Senior Plan, National Heritage Insurance Company (NHIC) Medicare Part B will not reimburse you.

Documentation/Record Keeping:

1. Keep a record of the immunization administered to the patient.
2. Keep copies of all forms submitted.

Evaluation:

Monitor the amount of money reimbursed to your agency.

Health Promotion/Disease Prevention Intervention(s):

N/A

References:

MassPRO: Massachusetts Peer Review Organization

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

MassPRO was founded as a wholly owned subsidiary of the Massachusetts Medical Society in March 1986. MassPRO is a not-for-profit organization governed by a Board of Directors comprised of physicians, health care administrators, researchers and consumers.

MassPRO is responsible for evaluating and improving the quality of care provided to Medicare beneficiaries in Massachusetts hospitals, Medicare-participating health maintenance organizations (HMOs), Medicare-certified skilled nursing facilities (SNFs), and home health agencies.

Resources:

Sheryl Knutsen MSN, RN,CS

Adult Immunization Coordinator

MassPRO

235 Wyman Street

Waltham, MA 02451-1231

Phone: 781-419-2749

Email: sknutsen@maqio.sdps.org

Home Visits for General Health Supervision

Purpose: To provide health care to homebound residents, elders in need, disabled persons, maternal and child health, and individuals at risk for abuse or neglect. To ensure access to care at home, regardless of ability to pay.

Population: Homebound and those residents in need of health supervision.

Legal Considerations:

1. Federal/State Law or Local Reg.? (local)
2. Physicians order(s)?
Only if visit requires medication administration (Y)
or clinical procedure
3. Informed consent ? (Y)
Written care plan
4. Health Care Proxy and Do Not Resuscitate (Y)
Documentation (DNR)?

Equipment Needed:

1. Durable bag with space for records
2. Blood pressure cuff, pediatric and adult regular and large (calibrate every year)
3. Stethoscope
4. Measuring tape
5. Digital thermometer
6. Tape, sponges, alcohol wipes and Band-Aids
7. Glucometer, lancets and sticks
8. Sterile syringes
9. Sharps container attached to bag, not in bag (per OSHA)
10. Non latex disposable gloves
11. Biohazardous waste bag
12. Separate cold container for Flu/Pneumonia/PPD/vaccine
13. Portable scale (for elders at risk of nutritional deficit)
14. I.D. card with emergency numbers (nurse's information)
15. Client record with current MD orders and medication list
16. Nursing clinical assessment form (see Appendix)

Planning:

1. Maintain client card file
2. Notify client of next visit
3. Maintain list of homebound in need of immunizations each year
4. Number of visits is determined by policies of the agency
5. Referral evaluation if within the scope of practice or sent to another agency
6. Review or write protocols for policy and procedures for maternal, child, and elder visits including development of assessment forms

7. Review or establish policy for transmittal of information to primary care providers
8. Review or obtain necessary standing orders

Financial Considerations:

1. Cost of equipment
2. Cost of auto maintenance
3. Cost of nursing and clerical time
4. Cost of vaccine administration, reimbursement from Medicare, if applicable
5. Grants from Massachusetts Department of Public Health, Office for Elder Affairs

Procedure:

1. Contact client and family to set up appointment time and date
2. Initial assessment visit completed
3. Plan of care is established with client and family
4. Establish frequency of visits
5. Referrals made to other care agencies, MD orders completed
6. At next visit leave written care plan and business card with nurses number and emergency contacts
7. Record data in permanent record, making entries on timely basis

Nursing Considerations:

1. Contact primary care provider (PCP), other agencies when change of health status occurs
2. Case conference with other providers as needed
3. Review PCP orders and keep current when changes occur
3. Notify client and family, PCP, and other providers when discharged

Documentation/Record Keeping:

1. Maintain permanent client record with notes, orders, flow sheets, current medications, and plan of care.
2. Record all phone calls, referrals and correspondence related to client.
3. Maintain current Health Care Proxy and current DNR order in case of terminal illness.

Evaluation:

Continue to analyze process and effectiveness of case management. Evaluate services rendered and make necessary changes if indicated.

Health Promotion/Disease Prevention Intervention(s):

Teach family and client safety measures in home and the use of devices such as Lifeline, walker and canes.

References:

American Nurses Association. (1999). *Scope and standards of public health nursing practice*.

Commonwealth of Massachusetts, Board of Registration in Nursing. (1994). *Current Nurse Practice Act M.G.L. 1999*.

Guidebook for Local Boards of Health, Chapter 24, 1981

Massachusetts Association of Health Boards and Massachusetts Department of Public Health. (1997). *Guidebook for Massachusetts Boards of Health*. Boston MA,

Springhouse Books Corporation. (1994). *Mastering documentation*.

Resources:

Local Council on Aging

Local Hospitals-Lifeline

Local/ Regional Services Providers

Massachusetts Department of Public Health

Immunization Clinics

Purpose: To promote or provide for the routine immunization of children and adults to prevent death and disability due to the occurrence of vaccine preventable diseases.

Population: All town residents and occupants (i.e., workers, school pupils and prison inmates) as determined.

Legal Considerations:

1. Federal/State Law or Local Reg.? (Y)
e.g. M.G.L. c. 111. §. 181-183
102 CMR 7.07 and CMR 220.00
2. Physicians order(s)? (Y)
Nurses may administer vaccines when protocols or “standing orders” are signed by a physician. Sample standing orders are available through the Massachusetts Immunization Program. See the *Board of Registration in Nursing Advisory Ruling 9804* included in Appendix.
3. Informed consent? (Y)
Vaccine Information Statements (VISs) must be given to each recipient (or parent/legal guardian) at the time administration of each vaccine. The opportunity to ask questions and receive informed answers must be provided prior to administration. See *Guidelines for Compliance with Federal Vaccine Administration Requirements*. Use the most current VIS. Publication dates are printed on the lower corner of the back page, note the English and foreign language dates vary.
4. Protocols
 - a. Board(s) of Health (BOH) must have written protocols consistent with the US Department of Health and Human Service publication *Standards for Pediatric Immunization Practices, 1996* (or most current version.) See the Massachusetts Immunization Program document *Guidelines for Compliance with Federal Vaccine Administration Requirements* available on line at <http://www.state.ma.us/dph/cdc/vaxcomp.htm> or through the regional office. See also *General Protocols for Standing Orders* available on the website or through the Massachusetts Immunization Program (MIP.)
 - b. Special considerations must be addressed for school-based clinics (see School-based Clinics professional practice module.)
 - c. Parent/legal guardian except in school-based clinics, which follow special consent protocols, must accompany minors.

Equipment/Materials: see *General Protocols for Standing Orders*.

1. Emergency equipment: CPR mask, blood pressure cuff and stethoscope, Benadryl elixir/tablets, epinephrine, syringes, anaphylactic protocol and CPR protocol. See the MIP document *Emergency Treatment Model Standing Orders*.
2. Vaccine(s)
3. Insulated container(s) for vaccine transport and storage
4. Hand washing equipment or hand-sanitizer
5. Gloves (disposable, single use, non-latex recommended)
6. Syringes (appropriate gauge and needle length)
7. Alcohol swabs
8. Gauze
9. Band-Aids
10. Paper tablecloths or similar product to provide clean area for preparation and administration of vaccine
11. Biohazard needle disposal containers
12. Standing orders and appropriate protocols
13. Current Vaccine Information Statements (VISs)
14. Current Vaccine Administration Record forms, School Hepatitis B Consent Forms/Screening Forms
15. Tables, chairs, trash cans
16. Access to a telephone in case of emergency
17. For school-based clinics and other large clinics where past vaccine history is important, a master list to determine eligibility for the next dose is needed.
18. For large flu clinics, a system to keep order is needed: examples include: giving each recipient a number on an index card; using markers and paper for signage; directing recipients to the next station; a system to collect fees and make change (if applicable) and recording information for Medicare reimbursement.
19. Current immunization guideline(s) e.g., *General Protocols for Standing Orders* available on the website or through MIP
20. Immunization Card or Blue Book
21. Form letter to provider re: vaccines received
22. Incident Report forms
23. Vaccine Adverse Event Reporting System (VAERS) forms

Planning:

1. Immunization clinics are an excellent opportunity for collaboration and media exposure.
2. Review or conduct needs assessment in collaboration with other pertinent community agencies.
3. Three months prior to clinic date:
 - a. identify and reserve space for clinic
 - b. order vaccine(s) from regional office
 - c. order supplies

- d. recruit nursing staff (must have current registration) and volunteers
 - e. plan media campaign
 - f. see module on school-based clinics regarding specific planning needs
- 4. One month prior to clinic date:
 - a. if appropriate, begin to create master list of people to be vaccinated
 - b. plan and conduct inservice training for nursing staff and volunteers
 - c. implement media campaign
 - d. check inventory of vaccine(s), supplies, and appropriate forms
 - e. call custodian of building, arrange for tables, chairs, trash cans and parking
 - f. notify traffic enforcement, police and local EMT services for large clinics
- 5. Day of clinic:
 - a. set up space to include emergency treatment area for adverse reactions
 - b. review routine and emergency procedures with staff
 - c. post signage for each area

Financial Considerations:

- 1. All required vaccines for children through age 18 years are available at no cost through the Massachusetts Immunization Program (MIP.)
- 2. All vaccines required for adults considered at high risk, according to immunization guidelines published by the MIP, are available at no cost. Complete information on all vaccines provided by the Department of Public Health (DPH) is available in the publication *Massachusetts Immunization Program, Supplied vaccines and Eligibility*, July 2000, available at the regional offices and on the DPH web site.
- 3. The BOH must be currently enrolled in the MIP vaccine program to receive state-supplied vaccine.
- 4. The cost of auxiliary supplies
- 5. The cost of mailings to parents for school based clinics
- 6. Media campaign: articles and notices in the form of community or public service announcements (PSA's) can be given to local and community newspapers and newsletters. Usually these announcements are published at no charge. Check with the individual newspapers and newsletters for requirements and deadlines. Some BsOH plan an advertising budget to promote BOH activities.
- 7. Staffing
 - a. may need to hire temporary staff for large clinics and during flu season
 - b. volunteers work well as greeters, crowd control and clerical staff
 - c. consider retired nurses

Procedure: See General Protocols for Standing Orders (MIP document)

A. General Immunization Clinics

1. May be by appointment or walk-in
2. Patients should provide past immunization records for review.
3. Screen for eligibility. Eligibility is based on age, vaccination status and the presence of a medical condition that puts them at high risk.
4. Screen for contraindications. At the minimum, obtain information regarding vaccines previously received, pre-existing health conditions, allergies and adverse events that occurred after previous vaccinations. Physical exam and vital signs (i.e., temperature, blood pressure, respiration, and pulse) are not necessary before administration of vaccine unless indicated. Assessment of the patient's physical condition can be based exclusively on information elicited from the patient, parent or guardian and on the provider's observation of the patient's condition. Anyone for whom vaccine is deferred should be referred to his/her primary care provider for evaluation and confirmation of contraindication.
5. Provide patient, parent/guardian with adequate information regarding the risks and benefits of a vaccine, and answer any questions. Current VISs (available in many languages) must be given to the patient or parent/guardian for each dose of vaccine administered. The copies of the most up to date VISs are available at the MIP regional offices and on line at <http://www.cdc.gov/nip/publications/VIS/default.htm> .
6. Hands should be washed or hand sanitizer used before each new patient is immunized.
7. Gloves are not required when administering vaccines unless the health care provider has open lesions or could come in contact with potentially infectious body fluid.
8. If gloves are worn, they must be changed between each recipient and hands washed or sanitized before re-gloving. The use of latex free gloves is advised.
9. Always review vaccine package insert prior to administration of any vaccine.
10. Administer the vaccine according to protocol. The protocol and standing orders should address correct dosage, via correct route and site, and the correct needle length. Changing needles between drawing up the vaccine and injecting it is not necessary, unless indicated in the package insert. After use, the needles should not be recapped, bent or broken. Used needles and syringes should be discarded in specially labeled biohazard containers. The most effective sharps injury prevention technology should be used. Different vaccines should not be mixed in the same syringe unless specifically licensed and labeled for such use.
11. Whenever possible, patients should be observed for allergic reaction for 15-20 minutes after receiving immunizations. Facilities and personnel should be available to treat immediate hypersensitivity

reactions. Reactions are reported to VAERS using the incident report form.

12. Record immunization in both the patient immunization record for the facility and give documentation to the patient using the Blue Book or a card.
13. Use the immunization visit to screen for other unmet health needs and referral to the primary care provider (PCP.) For families or individuals without health insurance, referral to the nearest community health center will provide access to health care and access to information on programs such as the Children's Medical Security Plan and MassHealth. (See Community Resources and Referrals Module.)

B. Additional Considerations for School-based Clinics- See *General Protocols for Standing Orders* (MIP document)

1. Population receiving the vaccine is usually predetermined prior to the clinic using master lists from the school and parental consent forms.
2. The MIP has published legal considerations specific to school-based clinics involving minors. The most current version of the *Guidelines for Compliance with Federal Vaccine Administration Requirements* is available from the MIP at the DPH regional offices and on line at <http://www.state.ma.us/dph/cdc/vaxcomp.htm> . These guidelines provide information on the federal requirements relating to consent for school-based immunization clinics, including the use of a Single Signature Consent Form for an entire series. For example, the three-dose hepatitis B vaccine is administered on three different dates. The MIP publishes a manual on hepatitis B immunization in school settings. The manual, available from the MIP or at the DPH regional offices, addresses issues such as the need to send the VIS home prior to each dose, the need to establish procedures for responding to questions from parents/guardians by telephone or mail, the use of the Withdrawal of Permission Form, pre-screening for contraindications, etc.
3. In addition to routine supplies, incentives could include colorful Band-Aids, juice and cookies and the use of "squeeze/stress" balls for the children during administration of the vaccine.
4. Use of a portable screen to provide privacy during the administration of the vaccine(s).
5. Planning with the school staff is imperative for the success of the clinics. It is important to coordinate with the school nurse, school administration, the custodian and the parent-teacher organizations to choose the best date and time for the school and students to avoid conflicts with exams, field trips, the prom, etc. Educate the school staff about the clinic. Obtain labels for the mailing list from the school and determine who will send the letters out . Design the cover letter with the principal/headmaster and school nurse and determine the deadline date to return the consent forms. Allow at least one month for mailings to the parents and return of the consent forms.

6. Recommendations for drawing up vaccine prior to clinic and transportation and storage at the site:
 - a. Two issues must be considered when drawing up vaccine in preparation for school-based or large community clinics: viability of the vaccine and ability to identify the vaccine in the syringes. Label and store the vaccine according to the manufacturer's recommendations.
 - b. Environmental conditions such as heat and light can affect the viability of the vaccines and vaccines vary as to their stability. In order to ensure the viability of the vaccine, it should be drawn up as close to the time of administration as possible and never more than 8 hours before administration. Varicella vaccine can be drawn up only 30 minutes prior to administration.
 - c. Only the number of syringes needed for the clinic should be drawn up. Any vaccine not used within 8 hours (30 minutes for Varicella vaccine) should be discarded.
 - d. Once the vaccine is drawn up it should be stored in a refrigerator or in containers with cold packs.
 - e. There are specific instructions regarding MMR and varicella vaccine. MMR not used within 8 hours of being reconstituted must be discarded. Cold (refrigerated) diluent must be used to reconstitute MMR that will not be used immediately. Vials and syringes containing MMR vaccine should be protected from light at all times. Varicella vaccine cannot be drawn up prior to clinics.
 - f. In order to avoid medication errors, syringes with different vaccines should be stored in separate or divided containers or trays. Each container should be clearly labeled with the type of vaccine, the date and time it was drawn up, the lot number and the initials of the person who drew it up.

C. Large Community Clinics—Additional Considerations

1. These types of clinics are usually an annual, seasonal event offering influenza, pneumococcal, and/or tetanus/diphtheria vaccines.
2. Eligibility for state supplied influenza may vary from year to year. The MIP publishes recommendations on how to prioritize vaccine distribution each year.
3. State supplied influenza vaccine is ordered once a year, usually in late spring/early summer. It is important to adhere to ordering deadlines.
4. Flu vaccine delivery is usually targeted for sometime in the fall. Delivery of flu vaccine from the manufacturer to the Massachusetts Immunization Program is based on estimates. The vaccine unit of the MIP dispenses vaccine as soon as it is received. Recommendations for the scheduling of flu clinics come from the Centers for Disease Control and Prevention (CDC) and are distributed to the BOH by the MIP.

5. Identify priority populations as recommended by the CDC in collaboration with local community groups and agencies.
6. Identify and communicate as needed with other locations in the area that are offering flu clinics such as grocery stores and pharmacies.
7. Hold the clinics in locations that will be easily accessible to high-risk patients such as senior housing developments, long term care facilities, etc.
8. Follow the guidelines for drawing up vaccine in advance as described in School Based Clinics, Section B, Number 6.
9. When offering multiple vaccinations, it is useful to use a color coding system for all forms i.e., pink or green for Td, white for influenza, blue for pneumococcal.
10. When administering multiple vaccines, injection sites should be spaced 2 inches apart. Care should be taken as administering five vaccines at the same time is more prone to cause soreness as a common reaction in the non-dominant arm.
11. To prevent medication errors, use a separate clinic area for administering pneumococcal and Td vaccines. Nurses must screen at each station for past vaccination history.

D. Homebound Patients—Special Considerations

Nurses may want to implement communication with the PCP to review and sign a standing order for the patient, since many homebound patients have a complicated medical history. This is particularly important for the administration of pneumococcal vaccine.

E. Foreign Travel (See International Travel Module)

Nursing Considerations:

Arrange for any accommodations necessary to ensure confidentiality and privacy. Plan for interpreter services for non-English speaking patients, as well as reasonable accommodations for the disabled.

Documentation/Record Keeping: see *General Protocols for Standing Orders*

1. Documentation consists of:
 - a. Name and address of the health provider administering the vaccine
 - b. Name of patient, age or date of birth, date of injection, site and route of injection, name of vaccine, dosage, lot number and expiration date. It must be noted that the Vaccine Information Statements, were given, the date given, and the publication date of the VIS given and that parental consent is on file.
2. Documentation is to be maintained for the legal retention period as specified in the Massachusetts General Laws (MGL) and the Code of Massachusetts Regulations (CMR.) The retention schedule is included

as an appendix. Refer to the relevant statutory code or regulation for detailed information on what must be included in each record.

3. All other facilities, e.g., doctors office, BOH, VNA, nursing home etc must retain documentation for a period of 10 years following the end of the calendar year in which the documentation occurred (NCVIA 1986).
4. An additional requirement applies to all categories of providers. If a notice of a claim or lawsuit has been made, the VIS, Provider Enrollment Form and other types of approved documentation pertaining to the matter must be retained until a final disposition of the claim or litigation has been made. (Guidelines for Compliance with Federal Vaccine Administration Requirements, revised, May 1999.)
5. Report any adverse reaction to the Vaccine Adverse Event Reporting System (VAERS.) The Vaccine Adverse Event Reporting System is a cooperative program for vaccine safety of the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA.) VAERS is a post-marketing safety surveillance program, collecting information about adverse events (possible side effects) that occur after the administration of US licensed vaccines. VAERS telephone number is 1-800-822-7967.

Evaluation:

1. Collect the data needed to evaluate the objectives for the clinic. Data should include:
 - a. number of people receiving vaccinations and in which locations
 - b. ages of people receiving vaccinations
 - c. insurance status of people receiving vaccinations
 - d. anything else significant to the program, such as, number of individuals completing a series and or adverse reactions.
2. Analyze data in relation to objectives.
3. Determine how effective the vaccine program was in reaching the specific population; also how many people in the specific group were not reached.
4. Present the data and conclusions in the form of a report to appropriate supervisors and committees with recommendations on how to improve the effort in the future. Be sure to report the costs of the effort in relationship to the cost of possible illness or disability that did not occur because of the primary prevention immunization effort.
5. Survey clinic participants to gather their input and satisfaction level with the program.
6. Incorporate survey of immunization needs and services in any community-wide assessments.

Health Promotion/Disease Prevention Intervention(s):

1. The immunization process presents numerous opportunities for health promotion. For example, the importance of basic hand washing for the

prevention of illness, can be incorporated into the process of immunizations.

2. Availability of pamphlets for distribution, posters for display, incorporation of health messages in outreach efforts, need to be considered when planning for the specific needs of the population served
3. The identification of a primary source of medical care, the verification of payment source, and actual access to medical care are basic health promotion inquiries that should be documented and addressed with each person receiving a vaccine. (Patient eligibility form included in appendix.)

References:

Advisory Committee on Immunization Practices (ACIP). *MMWR 1994:43 (No. RR-1): 1-38.*

CDC Adult Immunization Programs in Nontraditional Settings. Quality Standards and Guidance for Program Evaluation: A Report of the National Vaccine Advisory Committee. *MMWR 2000:49 (No. RR-1): 1-13.*

CDC Use of Standing Orders to Increase Adult Vaccination Rates: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR 2000: 49 (No. RR-1): 21-27.*

Department of Health and Human Services. (2000, January). *Epidemiology and prevention of vaccine preventable diseases 6th edition.* Atlanta, GA.

Massachusetts Association of Health Boards and Massachusetts Department of Public Health. (1997) *Guidebook for Massachusetts Boards of Health.* Boston, MA.

Massachusetts Immunization Program Documents:

- *Adult Immunization Guidelines*
- *Childhood Immunization Guidelines*
- *Emergency Treatment Model Standing Order*
- *Flu Model Standing Order, July, 2001*
- *General Protocols for Standing Orders*
- *Guidelines for Compliance with Federal Administration Requirements*
- *Pneumococcal (PPV23) Model Standing Order*
- *Supplied Vaccines and Eligibility*
- *Tetanus/Diphtheria Model Standing Order*

Resources:

Centers for Disease Control and Prevention:

1-800-232-2522 or <http://www.cdc.gov/nip> and
<http://www.cdc.gov/nip/publications/VIS/default.htm>

Immunization Action Coalition:

<http://www.immunize.org>

Johns Hopkins University Institute for Vaccine Safety

<http://www.vaccinesafety.edu>

Massachusetts Department of Public Health, Division of Epidemiology and Immunization:

1-617-983-6800 or 1-888-658-2850

<http://www.magnet.state.ma.us/dph/cdc/epiimm2.htm>

Additional Resources:

Guidelines for Compliance with Federal Vaccine Administration Requirements

Massachusetts Department of Public Health – Immunization Program

Immunization Guidelines and Schedules

<http://www.gov/dph/topics/immunization.htm>

Revised Standards for Immunization Practices Childhood, Adolescent and Adult

National Immunization Program

<http://www.cdc.gov/nip/recs/rev-immz-stds.htm>

National Vaccine Injury Compensation Program Vaccine Injury Table

US Department Health and Human Services Health Resources and Services Administration

<http://www.hrsa.gov/osp/vicp/table.htm>

Massachusetts Department of Public Health – Immunization Program

Vaccine Management

[Http://www.gov/dph/topics/immunizations.htm](http://www.gov/dph/topics/immunizations.htm)

MIP Supplied Vaccine and Patient Eligibility Criteria

Massachusetts Department of Public Health

Immunization Program

Vaccine Management

<http://www.gov/dph/topics/immunizations.htm>

Up-to-Date Vaccine Information Sheets

<http://www.cdc.gov/nipvistable.htm>

Influenza Pandemic Planning

Purpose: An influenza pandemic occurs when a novel and highly contagious strain of the influenza virus emerges, affecting the world's population. Historically, influenza pandemics occur every 10-30 years. It has been more than 30 years since the last pandemic. Many experts consider influenza pandemics to be inevitable, but no one knows when the next one will occur.

Population: Entire community

Legal Considerations:

1. Federal/State Law or Local Reg.? (N)
2. Physicians order(s)? (N)
3. Informed consent? (N)

Materials:

1. Local Comprehensive Emergency Plan (CEMP)
2. Influenza Pandemic Emergency Plan MA Town, Massachusetts (IPEP)
3. Pandemic Influenza-A Planning Guide for State and Local Officials:
Version 2.1-CDC

Planning:

Planning for the next influenza pandemic now will not only facilitate an effective response if the time comes, but also provide tangible benefits in the interim. Contingency planning for an event on the horizon is frequently difficult to justify, particularly in the face of limited resources and other urgent problems and priorities. However, an influenza pandemic presents challenges unlike those of any other public health emergency or community disaster.

1. There may be very little warning. Most experts believe that we will have between one and six months from the time that a novel influenza strain is identified to the time that outbreaks begin to occur in the U.S.
2. Outbreaks are expected to occur simultaneously throughout much of the U.S., preventing shifts in human and material resources that are normally possible during other natural disasters. The effect of influenza on individual communities will be relatively prolonged-lasting weeks to months.
3. The impact of the next pandemic could have a devastating effect on the health and well being of the American public. We estimate that in Massachusetts alone up to 4 million persons will be affected.
4. Effective preventative and therapeutic measures-including vaccines and antiviral agents-will be in short supply, as may some antibiotics to treat secondary infections.
5. Existing medical facilities may be quickly overwhelmed, requiring the use of nontraditional medical settings, e.g. hotels, schools, etc.

6. Health-care workers and other first responders will likely be at even higher risk of exposure and illness than the general population, further impeding the care of victims.
7. Widespread illness in the community will also increase the likelihood of sudden and potential significant shortages of personnel in other sectors who provide critical community services: military personnel, police, firemen, utility workers, and transportation workers, just to name a few.

Financial Considerations:

Contingency planning for an event on the horizon is frequently difficult to justify, particularly in the face of limited resources and other urgent priorities. However, an influenza pandemic presents challenges unlike those of any other public health emergency or community disaster.

Procedure:

1. Collaborate with local emergency planning and public safety agencies.
 - a. Share information on the Flu-Pandemic with your Emergency Management Director. Form a small workgroup comprised of representatives from EMS, fire, police, school nurses and administration , businesses, health department and Emergency Management, hospitals and ER personnel.
 - b. Check information in your town's CEMP to make sure it's current.
 - c. Consider public health measures to curtail the spread of influenza during a pandemic. (school closings, cancellation of sport and music events)
 - d. Speak with Funeral Directors to establish maximum capacity of mortuary services in the event of mass casualties.
 - e. Determine health care facilities backup overflow areas if needed.
2. Plan for vaccine storage and administration.
 - a. Have large refrigeration units available, including generated backup storage.
 - b. May need local police protection to ensure vaccine security.
 - c. Develop a list of possible health care professionals that could help administer immunizations.
 - d. Plan for possible distribution of antiviral medication.
3. Increase influenza and pneumococcal vaccine coverage now.

Educate the public through media regarding the importance of getting influenza and pneumococcal immunizations now before the pandemic.

Nursing Considerations:

1. Pre-pandemic planning will forge new and better communications between the public health and emergency response sectors. It can also clarify the role of each partner, identify gaps in the ability to respond, and ensure that existing legal authorities are adequate to implement the plan when the time comes.
2. Immunizing people at risk for pneumococcal disease now will protect them now, and during the next influenza pandemic. (Pneumococcal disease is one of the most common complications of influenza.)
3. Local City/Town government should either develop or maintain a community influenza response plan. Assessing and improving infrastructure now will assist in addressing the major elements of pandemic preparedness. These improvements can have immediate and lasting benefits, and can also mitigate the effect of the next pandemic.

Documentation/Record Keeping:

The MA Town, Massachusetts Influenza Pandemic Emergency Plan (IPEP) has been developed to provide the framework and methodology to efficiently respond to an influenza pandemic within your city or town. This plan can minimize morbidity and mortality, and maintain health care and other essential community services during periods of high absenteeism due to illness. The Plan has been specifically designed to serve as an Annex to the Comprehensive Emergency Management Plan (CEMP) and supplements that document.

Evaluation:

Meet regularly with local emergency planning and public safety agencies and update the CEMP annually.

Health Promotion/Disease Prevention Interventions(s):

Educate the public about the importance of getting an annual flu shot. Identify and immunize those at risk for pneumococcal infection.

References:

Centers for Disease Control and Prevention. Influenza Pandemic Emergency Plan MA Town, Massachusetts (IPEP). *Pandemic Influenza-A planning guide for state and local officials: Version 2.1.*
www.cdc.gov/phn/pandemic/pandemicflu.htm

Resources:

Division of Epidemiology and Immunization
Massachusetts Department of Public Health
617-983-6800 www.state.ma.us/dph

Local Emergency Planning Committee

Local Comprehensive Emergency Plan (CEMP)

Update: Preparing for the Next Influenza Pandemic, a CDC satellite broadcast, is available on video at www.cdc.gov/phtn/pandemic/pandemicflu.htm

Training and information about emergency planning and response is available from the Massachusetts Emergency Management Agency at 508-820-2028 or www.state.ma.us/mema

Additional Resources:

Template for Local Infectious Disease Planning and Response
<http://www.mass.gov/dph/topics/bioterrorism/dep.doc>

Influenza Pandemic Planning
<http://www.mass.gov/dph/cdc/epii/flu/pandemic.htm>

International Travel Immunizations

Purpose: To provide appropriate information to international travelers and immunizations as indicated.

Population: International travelers.

Legal Considerations:

1. Federal/State Law or local Reg.? (Y)
e.g. M.G.L. c. 111. §.181-183
102 CMR 7.07 and CMR 220.00
2. Physicians order(s)? (Y)
Nurses may administer vaccines when protocols or “standing orders” are signed by a physician. Sample standing orders are available through the Massachusetts Immunization Program (MIP). See the *Board of Registration in Nursing Advisory Ruling 9804* included in Appendix.
3. Informed consent? (Y)
Vaccine Information Sheet (VIS's) must be given to each recipient (or parent/legal guardian) at the time administration of each vaccine. The opportunity to ask questions and receive informed answers must be provided prior to administration. See *Guidelines for Compliance with Federal Vaccine Administration Requirements*.

Equipment Needed:

1. Emergency equipment: CPR mask, blood pressure cuff and stethoscope, Benadryl elixir/tablets, epinephrine and syringes, anaphylactic protocol and CPR protocol. See the MIP document *Emergency Treatment Model Standing Orders*.
2. Vaccine(s)
3. Hand washing equipment or hand-sanitizer
4. Gloves (disposable, single use, non-latex recommended)
5. Syringes (appropriate gauge and needle length)
6. Alcohol swabs
7. Gauze
8. Band-Aids
9. Paper tablecloths or similar product to provide clean area for preparation and administration of vaccine
10. Biohazard needle disposal containers
11. Standing orders and appropriate protocols

12. Current Vaccine Information Statements (VISs)
13. Current Vaccine Administration Record forms
14. Access to a telephone in case of emergency
15. Current immunization guideline(s) Adult Immunization Card or Blue Book
16. Incident report forms
17. VAERS forms

Planning:

1. Prescreen registrants for precautions and contraindications and previous adverse reactions to receiving vaccine(s). Precautions and contraindications for receiving immunizations are found in the *Epidemiology and Prevention of Vaccine Preventable Diseases*, 6th edition, January, 2000, or the MIP model standing orders, or the package insert.
2. Prescreen for allergies to latex.
3. Record immunization in the both patient immunization record for the facility and immunization record form (Blue Book) personal patient record.

Financial Considerations:

Vaccines provided by the Mass. Immunization Program. Administration charge, if local policy.

Procedure:

Give immunizations per vaccine protocol.

Nursing Considerations:

1. Review client's itinerary.
2. Identify disease prevalence.
3. Determine client's risk.
4. Review immunization history.
5. Administer immunizations recommended/needed.
6. Assess re; prophylactic anti-malarial medication and Typhoid Vaccine
7. Yellow Fever Vaccine administered only in state designated sites. Call MDPH, Division Of Epidemiology for a current list. Refer client.
8. Provide validated (stamped) international vaccination certificate.
9. Provide printed travel information and advice re: prophylaxis, disease prevention and avoidance of risk factors.

Note: All immunizations provided by the MDPH Immunization Program except Yellow Fever, Typhoid, Malaria and Rabies vaccines.

Documentation/Record Keeping: see *General Protocols for Standing Orders*.

1. Documentation consists of:
 - a. name and address of the health provider administering the vaccine
 - b. name of patient, age or date of birth, date of injection, site and route of injection, name of vaccine, dosage, lot number and expiration date. It must be noted that the Vaccine Information Statements, were given, the date given, and the publication date of the VIS given and that parental consent is on file.
2. Documentation is to be maintained for the legal retention period as specified in the Massachusetts General Laws (MGL) and the Code of Massachusetts Regulations (CMR.) The retention schedule is included as an appendix. Refer to the relevant statutory code or regulation for detailed information on what must be included in each record.
3. All other facilities, e.g., doctor's office, BOH, VNA, nursing home, etc. must retain documentation for a period of 10 years following the end of the calendar year in which the documentation occurred (NCVIA 1986).
4. An additional requirement applies to all categories of providers. If a notice of a claim or lawsuit has been made, the VIS, Provider Enrollment Form and other types of approved documentation pertaining to the matter must be retained until a final disposition of the claim or litigation has been made. (Guidelines for Compliance with Federal Vaccine Administration Requirements, revised, May 1999.)
5. Report any adverse reaction to the Vaccine Adverse Event Reporting System (VAERS.) The Vaccine Adverse Event Reporting System is a cooperative program for vaccine safety of the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA.) VAERS is a post-marketing safety surveillance program, collecting information about adverse events (possible side effects) that occur after the administration of US licensed vaccines. VAERS telephone number is 1-800-822-7967.

Evaluation:

N/A

Health Promotion/ Disease Prevention Intervention:

Utilize opportunity to educate patient on disease prevention.

References:

Centers for Disease Control and Prevention. Superintendent of Documents, US Government Printing Office. *Health information for international travel*. Washington, D.C.

Health Information for International Travel. CDC Yellow Book 2005-2006. Phyllis E Kozarsky MD, Paul Arguin MD, Ava Navin. Centers for Disease Control and Prevention.

(to purchase Traveler's Health: Yellow Book visit <http://cdc.gov/travel>)

Resources:

Centers for Disease Control and Prevention

<http://www.cdc.gov/travel/destinat.htm>

International Society of Travel Medicine

<http://www.istm.org> (list of travel clinics, by country, state and city)

Latex Allergy in Practice Setting

Purpose: To educate individual(s) and/or community about issues related to latex allergies and items of potential exposure i.e. exam gloves, dental dams, stethoscopes, syringe stoppers, etc.

Population: All town residents and occupants (e.g. workers, school pupils, prison inmates) as determined.

Legal Considerations:

1. Federal/State Law or Local Reg.? (N)
2. Physicians order(s)? (N)
3. Informed consent ? (N)

Materials:

Educational materials on latex allergies and relevant equipment

Planning:

1. Identify target populations
2. Conduct educational needs assessment
3. Design and/or obtain presentation and educational materials
4. Schedule presentations
5. Prepare evaluation tool

Financial Considerations:

1. Cost of educational materials and equipment
2. Cost of marketing and media campaign
3. Cost of replacing equipment containing latex
4. Cost of emergency supplies that can include but are not limited to: EPI-Pens, antihistamines

Procedure:

1. Inventory the site for latex containing products.
2. Provide information about latex allergy symptoms: i.e.: skin rash, itch, hives, itchy eyes, nasal stuffiness, sneezing, coughing, wheezing, asthma, chemical sensitivity, IgE antibody reaction, collapse, shock, and anaphylaxis.
3. Provide information about possible cross sensitivities to bananas, kiwi fruit, and pineapple.
4. Refer people reporting symptoms as described above to their medical home or primary health care facility promptly.
5. Provide information on the use of medic-alert bracelets for people reporting severe allergic reaction.
6. Post "THIS IS NOT A LATEX FREE CLINIC" sign at all clinics.

Nursing Considerations:

Follow up with person reporting symptoms per nursing protocol.

Documentation/Record keeping:

1. Documentation on educational activities is to be maintained per nursing protocol.
2. Documentation on referrals to medical home or primary care provider is to be maintained per nursing protocol.

Evaluation:

1. Provide formal evaluation forms to each attendant for each educational activity.
2. Samples of evaluation forms are available in the appendix.

Health Promotion/Disease Prevention Intervention(s):

1. Develop presentations/workshops for identified latex glove users i.e. health care, restaurant, school cafeteria, daycare providers etc.
2. Provide resource materials and information on latex allergy.
3. Ensure that latex information is included in allergy protocols in schools and worksites.

References:

National Institute for Occupational Safety and Health (NIOSH). (June 1997).
Preventing allergic reactions to natural rubber latex in the workplace.

Resources:

Massachusetts Department of Public Health, Occupational Health Surveillance Program: 617-624-5632 or <http://www.state.ma.us/dph/ohsp/ohsp.htm>
National Institute for Occupational Safety and Health (NIOSH),
www.cdc.gov/niosh/homepage

Medicare Reimbursement for Influenza and Pneumococcal Vaccines (PPV)

Purpose: To reimburse agencies for some of the expenses incurred when hosting community based influenza and pneumonia clinics.

Population: Senior citizens enrolled in Medicare (except Medicare Risk HMO)

Legal Considerations:

1. Federal/State Law or Local Reg.? (N)
2. Physicians order(s)? (N)
3. Informed consent? (Y)

Materials Needed:

1. HCFA-855, Provider/Supplier Enrollment Application
2. Adult Vaccine Administration Record
3. Influenza Virus Vaccine and Pneumonia Rosters
4. HCFA-1500 Claim Form for Pneumococcal/Influenza Vaccine

Planning:

To initiate Medicare reimbursement for Influenza and PPV administration if you do not have a Medicare provider identification number, call National Heritage Insurance Companies (NHIC) Medicare Certification Unit at 1-781-741-3400 to obtain the HCFA-855 Provider Enrollment form.

Financial Considerations:

It is recommended that a revolving account be set up so that the money reimbursed to your agency can be utilized for immunization services.

Procedure: Intervention/Referral/Case Management

Coverage of vaccine administration is available only under Medicare Part B using roster billing. To qualify for roster billing, public health clinics must immunize at least five beneficiaries on the same day. Public health clinics qualified to use the simplified billing process may use a pre-printed HCFA-1500 Claim Form containing standardized information. This claim form serves as a cover document for the roster sheets. The standardized roster sheet holds the names and information of 10 beneficiaries. Five roster sheets may be attached to each claim form. Send completed HCFA-1500 claim forms and attached roster to:

NHIC
PO BOX 1000
Hingham, MA 02044

Nursing Process:

Medicare coverage of PPV no longer requires a physicians order or supervision. If the patient belongs to a Medicare HMO, NHIC will not reimburse.

Other Considerations:

1. Separate claim forms and roster must be submitted for influenza and PPV claims.
2. Medicare does not require a physician to be present but, standing orders are required for both influenza and PPV administration.
3. A stamped "signature on file" is acceptable on a roster claim to qualify as an actual signature providing that the provider has a signed authorization on file to bill Medicare.

Documentation/Record Keeping:

1. Keep record of vaccination of patient.
2. Keep copies of all forms submitted for reimbursement.

Evaluation:

Monitor the amount of money reimbursed to your agency

References:

Medicare B Bulletin

Resources:

Medicare Customer Service
Claims Inquiries: 781-741-5225

Provider Services
Policy and Billing: 781-741-3400

Telephone Appeal/Review
Claim Correction: 781-740-3700

Rabies Animal Clinics

Purpose: To prevent and control the incidence of animal rabies in the community.

Population: All cats, dogs and ferrets in the Commonwealth.

Legal Considerations:

1. Federal/State Law or Local Reg.? (Y)
Chapter 140, Section 145B M.G.L. and
105 CMR 330 for dogs and cats and
321 CMR 2.07 of Mass. Division of
Fisheries and Wildlife
2. Physicians order(s)? Veterinarian directed
3. Informed consent? (N)

Equipment/Materials:

1. Open, accessible site (school or public parking lot, or fire station on weekend day) to hold clinic for vaccinating cats and dogs and ferrets.
2. Table(s) and chair(s) for clerical work such as completing vaccination certificates and issuing collar tags.
3. Veterinarian provides vaccine, syringes, and hazardous waste disposal equipment.

Planning:

1. Coordinate clinic with annual re-licensing of dogs and cats by the City/Town Clerk and any statewide initiatives.
2. Assure that a professional veterinarian is available to conduct the clinic.
3. Review or conduct a needs assessment in collaboration with other community agencies and organizations on the numbers of animals in need of access to rabies vaccine i.e., private veterinarians, pet stores, local breeders, animal rescue or other organizations. Consult State Veterinarian.
4. Explore potential for public/private jointly sponsored clinics.

Financial Considerations:

Vaccinations for dogs, cats and ferrets are supported by fee for service to the vendor.

Procedure:

Collaborate with the Animal Control Officer and City/Town Clerk for record keeping.

Nursing Considerations:

Provide the City/Town Clerk with the listing of vaccinated animals.

Documentation/Record Keeping:

1. Ensure preservation of animal's vaccination record for three years.
2. Permanent records are retained by the City/Town Clerk and vaccinating veterinarian.

Evaluation:

1. Collect data on the numbers of animals vaccinated.
2. Collect data on the number of residents using the clinic.
3. Evaluate data collected.

Health Promotion/Disease Prevention Intervention(s):

1. Establish or participate in community advisory group to promote awareness of health risks related to rabies exposure.
2. Ongoing interdisciplinary education of health risks from occupational rabies exposure to animal handlers, sanitarians, health inspectors, and summer camps operators and staff.
3. Encourage dissemination of rabies information at clinic.

References:

Massachusetts Department of Public Health. (1998). *Massachusetts immunization of dogs, cats and ferrets*. Boston, MA.
www.state.ma.us/dph/cdc/rabdcf

Resources:

Centers For Disease Control and Prevention
<http://www.cdc.gov/ncidod/dvrd/rabies/>
www.cdc.gov
1-800-232-2522

Massachusetts Department of Public Health
Communicable Disease Control Bureau
Division of Epidemiology and Immunization
305 South Street, Jamaica Plain, MA 02131
617-983-6800

Rabies Prevention in Humans

Purpose: To prevent pre and post exposure to rabies to the at-risk and general population.

Population:

1. Post-exposure: All town residents and occupants (e.g. workers, school pupils, prison inmates) as determined.
2. Pre-exposure:
 - a. animal control officials (includes dog officers, animal control officers, animal inspectors, and any others involved in animal control work)
 - b. public safety officers whose primary responsibility is animal control
 - c. dairy and livestock inspectors
 - d. livestock and slaughterhouse workers
 - e. taxidermists
 - f. trappers
 - g. veterinarians and veterinary and animal shelter workers
 - h. wildlife workers, including wildlife rehabilitators
 - i. students in veterinary, livestock, and animal technician programs requiring direct animal contact
 - j. researchers using wild species of mammals, particularly if wild-caught
 - k. rabies research lab workers
 - l. rabies biologics production workers
 - m. travelers visiting areas where rabies is enzootic and immediate access to appropriate medical care including biologics is limited
 - n. all others whose occupations bring them into close or constant contact with wild and/or domestic mammals.

Legal Considerations:

1. Federal/State Law or Local Reg.? (Y)
e.g. M.G.L. c. 111. §. 3,6,7,109,110,111,and 112
105 CMR 300.00, 300.100, 300.200, 300.300
2. Physicians order(s)? (Y)
Nurses may administer vaccines when protocols or "standing orders" are signed by a physician. sample standing orders are available through the Massachusetts Immunization Program. See the Board of Registration in Nursing Advisory Ruling 9804.
3. Informed consent? (Y)
Parental/guardian written consent required for minors.

Equipment needed:

These vaccines are only available through the manufacturer or their distributor. They are not available through Massachusetts Immunization Program.

Pre-exposure:

1. Vaccines(s): Human Diploid Cell Vaccine (HDCV) available through Connaught (1-800-VACCINE)
2. Rabies Vaccine Adsorbed (RVA) available through BioPort Corporation (517)-335-8120
3. Purified chick embryo cell vaccine (PCEC) is available through Cliron Corporation (800) CHIRON8

Post-exposure:

1. Vaccine(s): Human Diploid Cell Vaccine (HDCV) is available through Connaught (1-800-VACCINE)
2. HRIG, given in conjunction with HDCV or Rabies Vaccine Adsorbed (RVA) available through BioPort Corporation (517)-335-8120
3. Current immunization guideline(s): The recommendations at the time of publication are found in *Human Rabies Prevention-1999*, Recommendations of the Advisory Committee on Immunization Practices (ACIP.)
4. Biohazard disposal containers—waste and sharps
5. Disposable Syringes
6. Disposable gloves—including non-latex
7. Vaccine administration record form
8. Alcohol swabs
9. Gauze
10. Band-Aids
11. Blood pressure cuff
12. Emergency equipment as outlined in standing order(s) or protocol(s)

Planning:

1. Collaboration with Animal Control Officer, community veterinarians, camp directors, and other interested community members on promoting community education and awareness of the importance of preventing human exposure to rabies.
2. Identify at-risk animal handlers in the community susceptible to exposure to rabies.
3. Review or conduct needs assessment for incidence of rabies in the community.
4. Plan community-wide education campaign on prevention of rabies in humans. Such planning can include but is not limited to:
 - a. vaccination of all pet cats, dogs, and ferrets against rabies

- b. teaching the community not to touch, pick up, or feed wild or stray animals of any kind.
 - c. teaching children to avoid wildlife and strays
 - d. avoiding sick or strangely acting animals
 - e. what to do if they are bitten or scratched by any animal
 - f. what to do if their pet is bitten or scratched by any animal
- 5. Increase vigilance for presence of bats during summer camp inspections.
- 6. Promote vaccinations of all domestic animals (cats, dogs and ferrets) in the community.
- 7. Identify community healthcare providers (clinics, emergency rooms, and private offices) who administer post-exposure prophylaxis.

Financial Considerations:

- 1. Cost of vaccine—"the Board of Health shall furnish post-exposure prophylaxis free of charge to any uninsured resident who has been or may have been exposed to rabies. M.G.L. c.140 145A."
- 2. Training for personnel to perform summer camp inspections.
- 3. Need assessment costs related to identifying at-risk population(s).
- 4. Media campaign: community newspapers, fliers, school bulletins, houses of worship, community groups.

Procedure:

Pre-exposure:

- 1. Refer at-risk person to community provider.

Post-exposure:

- 1. Advise person calling to report an animal bite/scratch/wound/exposure to wash the wound immediately with soap and water for a minimum of 10 minutes, then call their primary health care provider as quickly as possible.
- 2. Gather information from the caller:
 - a. name of person making the report
 - b. name of person (people) with potential exposure
 - c. age(s)
 - d. address(s)
 - e. telephone number(s)—day and evening
 - f. type of animal
 - g. type(s) of exposure: bite, scratch, saliva in open wound
 - h. location of animal
 - i. date of exposure
 - j. where exposure took place
- 3. Notify the Animal Control Officer or equivalent position.
- 4. Complete rabies exposure form for the Department of Public Health.
- 5. Collaborate with Animal Control Office when identifying resident requiring post-exposure prophylaxis.

6. Refer person to medical home or administer vaccine(s) as per protocol(s).

Nursing Considerations:

1. Evaluate the exposure following the guidelines in the CDC publication *Human Rabies Prevention-1999*, Recommendations of the Advisory Committee on Immunization Practices (ACIP), pp 7-11.
2. Consult with the epidemiologist-on-call from the Epidemiology and Immunization Division for any questions.
 - a. Toll free number: 1-888-658-2850
 - b. Boston number: 617-983-6800
 - c. Evening and weekend (emergencies) 617-983-6200
3. Follow up with Animal Control Officer about whereabouts of the animal and status of submission of the specimen.
4. Testing results from the submitted specimen are usually available within 24 hours. The state Lab will notify the Board of Health of positive results and the individual(s) exposed to rabies. The Lab will also notify the Division of Epidemiology and Immunization, of the Communicable Disease Bureau of DPH, which in turn notifies the individual medical provider(s) and veterinarians(s).
5. Follow up with the medical provider of the person with potential rabies exposure to inform about:
 - a. Location and status of suspect animal
 - b. Results of rabies test of animal (if specimen was obtained and sent)
 - c. Vaccine recommendations, or other medical treatment the provider has initiated
6. Follow up with person with potential rabies exposure for:
 - a. Compliance with recommendation to see primary provider
 - b. Compliance of completing all recommended medical interventions
 - c. Information on recommendations for other family members with potential exposure (if applicable)
7. Follow up with Inspection Services regarding bat infestations at summer camps or other buildings (if applicable).
8. Follow up with animal control if the animal has not been quarantined or euthanized.

Documentation/Record keeping:

1. Maintain records of all reports of potential exposure to rabies.
2. Complete appropriate rabies report form and forward to the Epidemiology and Immunization Division, Communicable Disease Control Bureau, DPH.
3. Maintain health records of all persons receiving pre and post-exposure prophylaxis at the BOH.

4. Note that the Vaccine Information Sheets were given and that consent is on file. This information shall include the site of the injection, name of vaccine, dosage, lot number, expiration date and date of VIS.
5. Maintain documentation for the legal retention period as specified in the Massachusetts General Laws (MGL) and the Code of Massachusetts Regulations (CMR.) The retention schedule is included as an appendix. Refer to the relevant statutory code or regulation for detailed information on what must be included in each record.
6. Retain documentation for all other facilities, e.g., doctor offices, BOH, VNAs, nursing homes, etc for a period of 10 years following the end of the calendar year in which the documentation occurred (NCVIA 1986).
7. Note that an additional requirement applies to all categories of providers. If a notice of a claim or lawsuit has been made, the VIS, Provider Enrollment Form and other types of approved documentation pertaining to the matter must be retained until a final disposition of the claim or litigation has been made. (Guidelines for Compliance with Federal Vaccine Administration Requirements, revised, May 1999).
8. Record incidences of bats in summer camps or other buildings in the community.

Evaluation:

1. Effectiveness of pre and post exposure prophylaxis education for at risk populations to include numbers of animal handlers completing pre-exposure prophylaxis and the numbers of people completing recommended post-exposure prophylaxis.
2. Effectiveness of education campaign.

Health Promotion/Disease Prevention Intervention(s):

1. Contact at-risk animal handlers in community. Educate to the benefits of pre-exposure prophylaxis.
2. Educate community on health risks associated with avoiding animal bites and providing appropriate first aid and medical supervision when bites occur.
3. Promote annual rabies vaccination clinics.
4. Promote appointment of animal control officer position for the city or town.
5. Participate in or establish a community based advisory group dedicated to raising awareness of health risks related to rabies exposure.
6. Promote interdisciplinary training of sanitarians, health inspectors, summer camp operators, pest control professionals and public health nurses on risks of exposure to rabies.

References:

Massachusetts Association of Health Boards and Massachusetts Department of Public Health. (1997). Guidebook for Massachusetts Boards of Health. *Animal and insect control*, 19, 1-19. Boston MA.

Massachusetts Department of Public Health. (1997, May). *Prevention of rabies in humans*. Boston, MA.

United States Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control and Prevention. (1999). *MMWR* (48/No. RR-1). *Rabies pre-exposure prophylaxis guide, and rabies pre-exposure prophylaxis schedule*. Atlanta, GA.

Resources:

Centers for Disease Control:

1-800-232-2522 or <http://www.cdc.gov/> or

<http://www.cdc.gov/ncidod/dvrd/rabies/>

Massachusetts Department of Public Health, Division of Epidemiology and Immunization:

1-617-983-6800 or 1-888-658-2850

<http://www.magnet.state.ma.us/dph/cdc/epiimm2.htm>

<http://www.state.ma.us/dph/cdc/rabbat.htm>

School Health Services to Private Schools

Purpose: To ensure compliance with the Department of Public Health mandates in private schools **when services are provided by the Board of Health.**

Population: Private school children within the community grades K-12.

Legal Considerations:

- | | |
|-------------------------------------|-----|
| 1. Federal/State Law or Local Reg.? | (Y) |
| 2. Physicians order(s)? | (Y) |
| 3. Informed consent? | |
| Immunization clinics | (Y) |
| Scoliosis screenings | (Y) |
| Medication Administration | (Y) |

Equipment Needed: see *Comprehensive School Health Manual* for a complete listing.

1. Audiometer
2. Vision tester
3. Snellen chart

Planning:

1. Acquire class lists
2. Gather documentation of immunizations of all new students
3. Plan calendar with principals for screening dates

Financial Considerations:

If the local community, through the public school system has an Enhanced School Health Service Grant, collaborate with the public schools in providing services to private school students.

Procedure:

1. Maintain health record for each student.
2. Prepare medication administration schedule and plan consistent with 105 CMR 210, *Regulations Governing Administration in Public and Private Schools*.
3. Prepare list of special needs of student for the teachers and principals; discuss these issues with teachers. **Do not publicize list.**
4. Organize vision, hearing and scoliosis schedule.

Nursing Considerations:

Follow up on all referrals sent home for failed screenings.

Documentation/Record Keeping:

Establish and maintain Massachusetts Health Record for each student.

Evaluation:

Periodic assessment of screening clinics to identify students as most risk.

Health Promotion/Disease Prevention Intervention(s):

1. On-going health education and promotion
2. Health counseling to students and staff
3. Provide medically prescribed interventions consistent with physician's orders, parental consent and the Nurse Practice Act.

References:

Massachusetts Department of Public Health. (1995). *The comprehensive school health manual*. Boston, MA. Available at the State House Bookstore, Boston, MA. 617-727-2834.

Resources:

Department of Public Health
Bureau of Family and Community Health
School Health Unit
<http://www.state.ma.us/dph/shu.htm>

Smoking Cessation- Assessment and Referral

Purpose: To initiate the process of smoking cessation and make an appropriate referral that moves the client along the continuum toward quitting.

Population: Individuals who smoke

Legal Considerations:

1. Federal/State Law or Local Reg.? (N)
2. Physicians order(s)? (N)
3. Informed consent? (N)

Materials:

1. Brochures from the American Cancer Society (ACS), American Lung Association (ALA), and/or the Massachusetts Tobacco Education Clearinghouse (MTEC).
2. Resource phone numbers:
 - a. Smoker's Quitline: Telephone counseling: (800) TRYTOSTOP
 - b. Smokers Quitline: 24 hour motivational message: (800) 9-Get-A-TIP.
 - c. Portuguese & Espanol: (800) 833-5256 or
 - d. TTY (800) 833-1477
3. Web Site www.TRYTOSTOP.org (features Quit Wizard, self-directed quitting tool; articles from cessation experts, "success stories", electronic cards, frequently asked questions, links to valuable tobacco treatment resources.)
4. Tobacco Treatment is provided by certified Tobacco Treatment Specialists: A listing of local Tobacco Treatment Services can be obtained by calling (800) -TRYTOSTOP.

Planning:

Available approaches to help an individual in *"their planning"*:

1. Self-help manuals and minimal clinical interventions: Although self-help manuals (i.e. Lung Association or ACS manuals) have had only modest success at helping smokers quit, when used in conjunction with behavioral interventions, particularly proactive telephone counseling or group behavioral counseling, their success will be enhanced. Hypnosis has a low degree of success unless it is done in combination with a behavior modification class.
2. Individual Counseling: Focused counseling that offers personalized support for an individual in a more structured setting. (Nicotine Replacement Therapy can be an option at reduced rates.)
3. Group Counseling: Behavior modification groups offer support from many participants who are setting the same goals.
4. Pharmacologic interventions: Nicotine Replacement Therapy (NRT): "Abundant evidence confirms that nicotine gum and the nicotine patch

are effective aids to smoking cessation. The efficacy of nicotine gum may depend on the amount of accompanying behavioral counseling. The nicotine patch appears to exert an effect independent of behavioral support, but success doubles when used in conjunction with behavioral therapy. Bupropion or Zyban is the first non-nicotine pharmacotherapy for smoking cessation to be studied in large-scale clinical trials. Results suggest it is an effective aid to smoking cessation. In addition, bupropion has been demonstrated to be safe when used in conjunction with nicotine replacement therapy.” (Surgeon General’s Report, 2000).

5. Working with smokers with medical conditions: While smoking is the cause of the development and/or enhancement of many medical conditions such as coronary artery disease (CAD), chronic obstructive pulmonary lung disease (COPD), peptic ulcer disease and diabetes mellitus, pharmacologic treatment can become complicated. Patients should work closely with their physicians in monitoring their nicotine replacement and progress.

Financial Considerations:

1. Cost of brochures (very often the first 100 are free of charge.)
2. Counseling and/or nicotine replacement can often be offered at reduced cost through the tobacco control program for those who have financial limitations.

Procedure:

1. Intake and Assessment:

- a. Conduct an initial screening in order to triage the client to the most appropriate intervention. Questions to ask include:
 1. Who actually requested the information (individual or family member)?
 2. What type of help is the person actually seeking?
 3. When did the individual start smoking and how many cigarettes, cigars, or pipes are they currently smoking?
 4. Has the person tried to quit smoking before?
 5. How long were they able to stop smoking with previous attempts?
 6. When was the most recent attempt?
 7. What support systems were used?
 8. Did the choice of system fit the need at the time?
 9. Did they use NRT?
 10. How did they use NRT?
 11. What was learned from previous attempts to stop smoking?
 12. What has changed since the last attempt to stop smoking?
- b. Conduct an assessment in a manner which establishes realistic expectations for the client but also promotes a sense of “hope.”
- c. Explore the causes of relapse:

Finding out what was learned from these attempts will allow the client to build on personal experiences.

- d. Utilize the information to promote self-efficacy. (enhanced confidence)
- e. Explain to the individual that frequent quit attempts before succeeding is the norm, not the exception.
- f. Use this opportunity to reinforce that **quitting is a process**.

2. Making the Referral

- a. Who actually initiated the call or requested information? (the client or someone else)
- b. What type of help is the person actually seeking? (self help information, telephone counseling assistance, individual counseling, group counseling)
- c. Have referral resources readily available.

Nursing Considerations:

- 1. **All clients seen during the day concerning any health issue should be routinely asked if they smoke.**
- 2. Even if an individual is not ready to quit at that time, it increases their level of awareness around their habit and for many, moves them closer to cessation.

Documentation/Record Keeping:

Date of initial contact, pertinent details of assessment and results of referral.

Evaluation:

Did the individual initiate contact with referral suggestion?

Health Promotion/Disease Prevention Intervention (s)

Smoking is the leading preventable cause of death and disability in the United States. Diseases and conditions now known to be caused and/or aggravated by tobacco include heart disease, atherosclerotic peripheral vascular disease, laryngeal cancer, oral cancer, esophageal cancer, chronic obstructive pulmonary disease, peptic ulcer disease and complications of pregnancy (intrauterine growth retardation, premature delivery, antepartum hemorrhage and low birthweight.) Tobacco usage significantly compounds the negative health effects of diabetes mellitus.

References:

Center for Disease Control and Prevention, U.S. Department of Health and Human Services, Office of Smoking and Health. (2000). *Reducing tobacco use: A report of the Surgeon General, 13-14*. Atlanta, GA.

University of Massachusetts Medical School, Center for Tobacco Prevention and Control. (1999). *Massachusetts tobacco treatment specialist training manual, 4-6*. Worcester, MA.

Resources:

Massachusetts Tobacco Control Program
Massachusetts Department of Public Health
250 Washington Street
Boston, MA. 02108 (617) 624-5900

Massachusetts Public Information and Smoker's Resource Center
1-(800) TRYTOSTOP

American Cancer Society
1 (800) 227-2345

American Lung Association
1 (800) 586-4872 (Boston Office)

Nicotine Anonymous
1 (415) 750-0328
www.nicotine-anonymous.org

Tetanus-diphtheria Vaccine (Td)

Purpose: To prevent tetanus-diphtheria.

Population: Td is indicated for primary vaccination for persons 7 years of age and older and for booster doses for everyone who has completed a primary series with DTP, DTaP, Pediarix, DT or Td. Adults should be offered boosters in conjunction with their annual influenza vaccination at age 50, 60 and 70, or by a more recent recommendation at age 60 and 75.

Legal Considerations:

1. Federal/State Law or Local Reg.? (Y)
2. Physicians order(s)? (Y)
Nurses may administer vaccines when protocols or “standing orders” are signed by a physician. Sample standing orders are available through the Massachusetts Immunization Program. See the *Board of Registration in Nursing Advisory Ruling 9804* included in Appendix.
3. Informed consent? (Y)
Vaccine Information Statements (VISs) must be given to each recipient (or parent/legal guardian) at the time administration of each vaccine. See *Guidelines for Compliance with Federal Vaccine Administration Requirements*.
4. Board(s) of Health must have written protocols consistent with the US Department of Health and Human Service publication *Standards for Pediatric Immunization Practices, 1996*. See the Massachusetts Immunization Program document *Guidelines for Compliance with Federal Vaccine Administration Requirements* available on line at <http://www.state.ma.us/dph/cdc/vaxcomp.htm> or through the regional office. See also *General Protocols for Standing Orders* available on the website or through the Massachusetts Immunization Program (MIP.)

Equipment Needed: see also *Guidelines for Compliance with Federal Vaccine Administration Requirements*.

1. Emergency equipment (CPR mask, BP cuff and stethoscope, Benadryl elixir/tablets, epinephrine and syringes, anaphylactic protocol and CPR protocol)
2. Vaccine

3. Insulated coolers/containers for vaccine transport and storage until used
4. Hand washing equipment/hand sanitizer
5. Gloves (disposable, single use, non-latex recommended)
6. Syringes (appropriate gauge and needle length)
7. Alcohol wipes
8. Gauze
9. Band-Aids
10. Provide clean area for administration of vaccine
11. Biohazard needle disposal containers
12. Standing orders and appropriate protocols
13. Current VIS (Vaccine Information Statements)
14. Vaccine Administration Records/Consent Forms
15. Tables, chairs and trash cans
16. Access to telephone in case of emergency
17. For school-based clinics and other large clinics where past vaccine history is important, a master list to determine eligibility for next dose is needed.
18. Immunizations booklets or cards to give to recipients
19. VAERS forms

Planning:

Community-wide clinics can be advertised locally in newspapers, senior newsletters and on cable television or coordination with schools for school based clinics.

Financial Considerations:

The MIP provides tetanus-diphtheria vaccine for all persons age 7 and older.

Procedure: see *General Protocols for Standing Orders*.

1. See the recommendations from the MIP for dosages and scheduling.
2. See package insert.
3. See MIP model standing orders.

Nursing Considerations: see *General Protocols for Standing Orders*.

1. The nurse is responsible for knowing the most up-to-date recommended immunizations schedules and dosages.
2. Know the exceptions to the legal requirements that include:
 - a. A certificate from a physician stating the child's physical health would be endangered by receiving the immunization. The certificate must be submitted at the beginning of each school year.
 - b. A written statement from the parent or guardian declaring that vaccinations or immunizations "conflict with his/her sincere religious beliefs."

3. Screen for opportunity to provide other immunization(s) that might be indicated. Examples may include but are not limited to MMR, hep B, etc.
3. Link recipient to primary care provider/medical home. If immunization was part of a series, sending reminder letters for next dose one month prior to date of clinic.
4. Documentation consists of:
 - a. name and address of health provider administering vaccine
 - b. name, age or date of birth, date of injection, site and route of injection, name of vaccine, dosage, lot number and expiration date (It must be noted that the Vaccine Information Statements were given.)
5. Report any adverse reaction to the Vaccine Adverse Event Reporting System (VAERS.) The Vaccine Adverse Event Reporting System is a cooperative program for vaccine safety of the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA.) VAERS is a post-marketing safety surveillance program, collecting information about adverse events (possible side effects) that occur after the administration of US licensed vaccines. The VAERS telephone number is 1-800-822-7967.
6. Provide documentation to recipient.
7. Documentation is to be maintained for their legal retention period as specified in the Massachusetts General Laws (MGL) and the Code of Massachusetts Regulations (CMR.) The disposition schedule is included as an appendix. Refer to the relevant statutory code or regulation for detailed information on what must be included in each record.
8. An additional requirement applies to all categories of providers. If a notice of a claim or lawsuit has been made the VIS, Provider Enrollment Form and other types of approved documentation pertaining to the matter must be retained until a final disposition of the claim or litigation has been made. (Guidelines for Compliance with Federal Vaccine Administration Requirements, revised, May 1999.)

Evaluation:

1. Review data collection
2. Compliance with booster recommendation

Health Promotion/Disease Prevention Intervention(s):

1. Distribution of educational materials to schools, libraries, and high-risk employees
2. Media campaign: articles/notices in community newspapers and newsletters, cable TV

References:

Advisory Committee on Immunization Practices. (1994, June 10). *Tetanus-diphtheria fact sheet*.

Resources:

CDC:Immunization Practices Advisory Committee ACIP. (1991, August 18). *Diphtheria, tetanus, and pertussis recommendations for vaccine use and other preventive measures* (40) No. RR-10.

Centers for Disease Control and Prevention (CDC)
1-800-232-2522 or <http://www.cdc.gov/> or
<http://www.cdc.gov/nip/publications/VIS/default.htm>

Department of Health and Human Services. (2000, January).
Epidemiology and prevention of vaccine preventable diseases 6th edition.
Atlanta, GA..

Massachusetts Association of Health Boards and Massachusetts Department of Public Health. (1997). *Guidebook for Massachusetts Boards of Health*. Boston, MA.

Massachusetts Department of Public Health, Division of Epidemiology and Immunization:
1-617-983-6800 or 1-888-658-2850
<http://www.magnet.state.ma.us/dph/cdc/epiimm2.htm>
<http://www.cdc.gov/nip/publications/VIS/default.htm>

Massachusetts Immunization Program Documents:

- *Adult Immunization Guidelines*, February, 2001
- *Childhood Immunization Guidelines*, February, 2001,
- *Emergency Treatment Model Standing Order*, February, 2001
- *General Protocols for Standing Orders*, February, 2001
- *Guidelines for Compliance with Federal Administration Requirements*, November, 2000
- *Supplied Vaccines and Eligibility*, July, 2001,
- *Tetanus/Diphtheria Model Standing Order*, February, 2001

Tuberculosis Nursing Case Management

Purpose: To implement and coordinate medical, nursing, outreach and social service systems which ensure that persons with suspected /confirmed TB start and complete appropriate and effective treatment.

Population: Any resident who is reported to the local health department with a diagnosis of suspected or confirmed TB.

Legal Considerations:

1. Federal/State Law or Local Reg.? (Y)
2. Physician's order(s)?
 - a. Case Management (N)
 - b. Contact Investigation (N)
 - c. Treatment (Y)
3. Informed consent? (N)

Materials Needed:

See TB testing module.

Planning:

Coordinate with MDPH TB program.

Financial Considerations:

1. Nursing case management is provided to all patients, including those under the care of private health care providers.
2. Statewide clinic services are offered free to all patients.

Procedure:

1. A suspected/confirmed case is reported to the Division of Tuberculosis Prevention and Control. The Division notifies the local health department within 24 hours.
2. Consult with the Tuberculosis Surveillance Area (TSA) nurse for your region.
3. Contact patient within 3 working days to begin initial case assessment and contact investigation. Assess the patient's infectiousness and the potential for transmission.
4. Develop discharge plan in collaboration with the TSA nurse, discharge planner, and health care provider.
5. Coordinate with TSA nurse to ensure that necessary specimens are obtained for laboratory analysis.
6. Conduct a contact investigation on infectious patients. Determine the limits of the contact investigation, based on:
 - a. Infectiousness of case

- b. Duration of exposure
- c. Environmental characteristics
- d. Susceptibility of contacts
- 7. Identify close contacts and administer a tuberculin skin test within 7 days, using the Mantoux technique.
- 8. Extend the contact investigation based on results of initial testing.

Nursing Considerations:

- 1. Follow protocols established by Division of TB Prevention and Control and develop plan according to individual needs.
- 2. Ensure patient is on an appropriate treatment regimen.
- 3. Assess need for directly observed therapy (DOT.)
- 4. Determine factors that are potential barriers to adherence to therapy.
- 5. Complete TB history form and send to TSA nurse.
- 6. Assess need for incentives or enablers.
- 7. Assess need for outreach educator to assist with adherence to treatment.
- 8. Identify and categorize contacts according to their risk for latent infection.

Documentation and Record Keeping:

- 1. Maintain all reports from TB clinics and health care providers in health department files.
- 2. Maintain case history report and document all communication with patient.
- 3. Update and change nursing care plan as needed.
- 4. Submit reports as required for tracking patient care and contacts.

Evaluations:

- 1. Assess patient adherence and response to treatment monthly.
- 2. Determine if treatment plan is effective and ensure that barriers to adherence are removed.
- 3. If patient is non-adherent with treatment, consult with your TSA nurse to discuss the need for more restrictive measures, including compulsory hospitalization.

Health Promotion/ Disease Prevention Intervention(s):

- 1. Educate patient and family about the spread/prevention of TB.
- 2. Educate patient on medications prescribed, including side effects.
- 3. Educate patient and family regarding consequences of incomplete or inadequate treatment.
- 4. Explain the consequences if patient is unwilling to accept the course of treatment.
- 5. Explain health care system to patient and family.

References:

Department of Public Health
Division of Tuberculosis Prevention and Control
Bureau of Communicable Disease Control
State Laboratory Institute
305 South Street
Jamaica Plain, MA 02130
1-(617) 983-6970
Fax - (617) 983-6990

Resources:

Regional-based TSA nurses:

- | | |
|--|---------------------------|
| 1. Central Western | (800) 445-1255 |
| 2. Metro West | (781) 774-6739 |
| 3. Northeast: | (978) 851-7261, Ext. 4048 |
| 4. Boston: Boston Public Health Commission | (617) 534-5611 |
| 5. Southeast, Cape & Islands: | (508) 977-3703 |
| 6. Metro Northeast | (781) 851-7261, Ext 4050 |

Regional state-funded TB Clinics (call for list) (617) 983-6970

TB Medical Consultant (617) 983-6979

TB Treatment Unit-Lemuel Shattuck Hospital (617) 971-3443

Community Educational Resources (617) 983-6974

Outreach Educators /Interpreters (617) 983-6970

24 hour reporting

1-888-MASSMTB

1-888-627-7682

Tuberculosis (TB) Testing

Purpose: To identify residents at risk for Tuberculosis

Population: The following individuals are at high risk for TB infection:

- Contacts of active TB cases
- Individuals born in countries of high TB prevalence
- Individuals with or at risk for HIV infection
- Individuals who work or live in potentially high risk congregate settings
- Individuals with a history of substance abuse in the past year
- Healthcare workers involved in high risk procedures such as respiratory therapy, bronchoscopy or autopsy
- Mycobacteriology laboratory workers
- Migrant/seasonal workers
- Individuals who have lived or traveled continuously outside the US within the past five years to countries with a high incidence of TB

Legal Considerations:

1. Mandated Federal/State Law or Local Reg. (N)
2. Physicians Order(s) Necessary (N)
3. Informed Consent (Y)

Equipment Needed:

1. Tuberculin syringe 25 3/8 or 26 1/2 guage
2. 5 tuberculin Units (TU) purified protein derivative (PPD)
3. Interpretive millimeter (mm) ruler

Planning:

For large screenings consult with regional Tuberculosis Surveillance Area (TSA) nurse.

Financial Considerations:

1. Cost of materials used.
2. The state-supplied 5 TU PPD is provided free through the regional vaccine depot to the BOH if utilized for residents considered at risk.
3. State-funded TB clinics are available across the state for referral for clinical evaluation and treatment. Services are provided without charge.

Procedure:

1. Obtain previous tuberculosis skin test (TST) history.
2. Inform the patient of the reason for the test.
3. e the TST if appropriate.

4. Inject 0.1 ml of 5 TU PPD intradermally into the dorsal surface of the forearm needle bevel faces up.
5. Form a tense, white wheal, 6-10 mm in diameter.
6. Read the TST 48-72 hours after planting.
7. Measure the TST across transverse diameter of forearm using mm ruler.
8. Record reading in mm of induration.
9. Cards are available from the TB Division to document the testing results.

Nursing Considerations:

1. Assess individuals for risk factors for TB infection (as listed under "Populations") or symptoms of TB disease. Individuals without symptoms or risk factors are at low-risk and do not need a TST. Testing individuals without risk factors, for employment purposes only, is contraindicated.
2. Interpret reactions according to the following guidelines:
 - a. > 5 mm is considered Positive for:
 - Human Immunodeficiency Virus (HIV) positive persons or persons at risk for HIV
 - Recent contacts* of TB case patients
 - Fibrotic changes on chest radiograph consistent with prior TB
 - Patients with organ transplants and other immunosuppressed patients (receiving the equivalent of > 15 mg/d of prednisone for 1 month or more)

*Recent contacts are individuals who have shared air for a prolonged period with someone who has infectious TB.

- b. >10 mm is considered positive for:
 - Recent immigrant (i.e. within the last 5 years) from high prevalence countries
 - Injecting drug users
 - Residents and employees of the following high-risk congregate settings: prisons and jails, nursing homes and other long term care facilities for the elderly, hospitals and other health-care facilities, residential facilities for patients with AIDS, and homeless shelters
 - Mycobacteria laboratory personnel
 - Persons with the following clinical conditions that place them at high risk: silicosis, diabetes mellitus, chronic renal failure, some hematologic disorders (e.g. leukemias and lymphomas), other specific malignancies (e.g., carcinoma of the head, or neck and lungs), weight loss of > 10% of ideal body weight, gastrectomy, jejunioileal bypass
 - Children younger than 4 years of age or infants, children and adolescents exposed to adults at high-risk

- c. >15 mm is considered positive for:
 - persons with no risk factors for TB.
- 3. If the TST is negative and the individual is asymptomatic, no further follow-up is required.
- 4. If the TST is positive, refer for clinical evaluation and chest radiograph.
- 5. State-funded TB clinics are available across the state for referral for clinical evaluation and treatment.

Documentation/Record Keeping:

Both the Board of Health / health care provider who administers the test, as well as the individual, keeps a record of the result. Cards for documentation are available from the Division.

Evaluation:

Assess data to identify high-risk populations tested, referrals made, evaluations completed, results, and to determine community trends.

Health Promotion/Disease Prevention Intervention(s):

Obtain and distribute informational materials provided by the MDPH Division of Tuberculosis Prevention and Control to educate and raise awareness of the reasons for TST and follow-up.

References:

Bureau of Communicable Disease Control,
Division of Tuberculosis Prevention and Control
305 South Street
Jamaica Plain, MA 02131
(617) 983-6970

Detailed information on TB testing is available through the MDPH Division of Tuberculosis Prevention and Control at the State Laboratory Institute, 305 South Street, Jamaica Plain, MA 02130. Telephone (617) 983-6970 or on line at <http://www.mass.gov/dph/cdc/tb>

<http://www.mass.gov/dph/cdc/tb> Classifications of TB skin test reactions

<http://www.mass.gov/dph/cdc/tb> TB two step testing

RESOURCES:

Regional-based TSA nurses:

- | | |
|--|---------------------------|
| 1. Central Western | (800) 445-1255 |
| 2. Metro West | (781) 774-6739 |
| 3. Northeast: | (978) 851-7261, Ext. 4048 |
| 4. Boston: Boston Public Health Commission | (617) 534-5611 |
| 5. Southeast, Cape & Islands: | (508) 977-3703 |
| 6. Metro Northeast | (781) 851-7261, Ext 4050 |

Regional state-funded TB Clinics (call for list)	(617) 983-6970
--	----------------

TB Medical Consultant	(617) 983-6979
-----------------------	----------------

TB Treatment Unit-Lemuel Shattuck Hospital	(617) 971-3443
--	----------------

Community Educational Resources	(617) 983-6974
---------------------------------	----------------

Outreach Educators /Interpreters	(617) 983-6970
----------------------------------	----------------

24 hour reporting
1-888-MASSMTB
1-888-627-7682

Universal Precautions

Purpose: To prevent exposure to bloodborne pathogens.

Population: Anyone who is exposed to blood, blood products or other potentially infectious materials which includes, but is not limited to, all health settings, clinics, schools, home visits and day care centers.

Legal Considerations:

- A. Federal/State Law or Local Reg.? (Y)
Part 1910.1030 of Title 29 of the Code of Federal Regulations (29CFR 1910.1030) for all private sector employers with one or more employees, as well as federal civilian employers.
- B. Physicians order(s)? (N)
- C). Informed consent? (N)

Equipment needed:

1. Personal protective equipment can include but is not limited to:
 - a. disposable gloves
 - b. masks
 - c. face shields
 - d. gowns
 - e. lab coats
 - f. shoe covers
 - g. eye protection.
2. Personal protective equipment is considered appropriate only if it does not permit blood or other potentially infectious materials to pass through or reach employee's and/or client's work clothes, street clothes, undergarments, skin, eyes, mouth or other mucus membranes under normal conditions of use and for the duration of time which the protective equipment will be used. (Occupational Exposure to Bloodborne Pathogens, OSHA 3127, 1996 revised, U.S. Department of Labor, Occupational Safety and Health Administration, p.6.)

Planning:

1. Each agency to have a written exposure control plan that includes at a minimum:
 - a. exposure determination
 - b. the procedures for evaluating the circumstances surrounding an exposure incident
 - c. the schedule and method for implementing sections of the standard covering the methods of compliance, hepatitis B

vaccination and post-exposure follow-up, communication of hazard to employees and recordkeeping (Occupational Exposure to Bloodborne Pathogens, OSHA 3127, 1996 revised, U.S. Department of Labor, Occupational Safety and Health Administration, p. 2.)

2. Educational training modules developed for ongoing staff training on universal precautions, post exposure plan, spill clean up and biohazardous waste disposal.
3. Each agency to have a written policy for offering hepatitis B vaccine to persons at risk for exposure to bloodborne pathogens or other potentially infectious materials.
4. Each agency to have written spill clean-up plan in place.
5. Each agency to have written policy on biohazardous waste disposal.

Financial Considerations:

1. Purchase of personal protective equipment
2. Purchase of hepatitis B vaccine
3. Training costs for staff
4. Biohazardous waste management
5. Safety educational materials
6. Spill kits
7. Appropriate cleaning materials for decontamination

Procedure:

1. Agency to provide personal protective equipment for employees.
2. Agency to provide annual training on Universal Precautions and Occupational Exposure to Bloodborne Pathogens.
3. Agency to provide written policies and procedures on all aspects of occupational exposure to all employees whose job identifies them at risk.

Nursing Considerations:

Review or write all policies/procedures related to all aspects of occupational exposure to all employees whose job identifies them at risk.

Documentation/Record keeping:

1. Employers must preserve and maintain accurate records for each employee of occupational exposure in accordance with OSHA's rule governing access to employee exposure and medical records, Title 29 *Code of Federal Regulations*, Part 1910.20.
2. Medical records must include the following information:
 - a. employee name
 - b. social security number
 - c. hepatitis B vaccination status (including dates and any medical records related to the employee's ability to receive vaccinations)
 - d. results of examinations

- e. medical testing and post-exposure evaluation
 - f. follow-up procedures
 - g. health care professional's written opinion
 - h. a copy of information provided to health care professional.
 - i. medical records must be kept confidential and maintained for at least the duration of employment plus 30 years
3. Accurate training records must be kept for three years and include the following: training dates, content/summary of training, names and qualifications of trainers and names and job titles of employees.

(Occupational Exposure to Bloodborne Pathogens, OSHA 3127, 1996 revised, U.S. Department of Labor, Occupational Safety and Health Administration, p.12.)

References:

U.S. Department of Labor, Occupational Safety and Health Administration (OSHA). (1996). *Occupational exposure to bloodborne pathogens, revised, 3127.*

Resources:

Massachusetts Department of Labor and Workforce Development, Division of Occupational Safety at: <http://www.state.ma.us/dos/>

Massachusetts Department of Labor and Workforce Development, Division of Occupational Safety, On-Site Consultation Program at:
<http://www.state.ma.us/dos/Consult/Consult.htm>

U.S. Department of Labor, Occupational Safety and Health Administration at:
www.osha.gov

Additional Resources

Occupational Safety & Health Administration, US Department of Labor

OSHA's Bloodborne Pathogens Standards
<http://www.osha.gov/SLTC/bloodbornepathogens/standards.html>

NeedleStick Safety and Prevention - Frequently Asked Questions
<http://www.osha-slc.gov/needlesticks/needlefaq.html>

Vaccine Management

Purpose: To maintain an established biologic (vaccine) distribution station.

Population: All eligible Providers.

Legal Considerations:

1. Federal/State Law or Local Reg.? (Y)
e.g. M.G.L. c. 111 s.s. 181-183
M.G.L. c. 111 and 92-116
2. Physicians order(s)? (Y)
3. Informed consent? (N)

Vaccine may be dispensed in accordance with Section 317 of the Public Health Service Act, federal vaccine contract terms, the specification of the National Childhood Vaccine Injury Act, NCVIA , of 1986 (Section 2125, of the Public Health Service Act), the Vaccine for Children Program, VFC, (Section 1928 of the Social Security Act), and the Massachusetts Immunization Program (MIP.)

Equipment/Materials:

1. Full size refrigerator and freezer. Check the product information for temperature maintenance of varicella vaccine
2. Scientific thermometers for both refrigerator and freezer
3. Insulated container for vaccine transport from Regional Depot
4. Cold packs for insulated container
5. Locked storage area
6. Established backup storage plan in the event of mechanical or power failure.
7. Temperature recording log
8. Vaccine order forms
9. Vaccine usage forms
10. Vaccine Information Statements (VISs) for all vaccine doses distributed

Planning:

1. All Providers must enroll in the Vaccines For Children Program or MIP Program annually. Check with Immunization Program Regional Office for annual enrollment dates.
2. The Physician-in-Charge is responsible for signing the enrollment form.
3. Vaccines are distributed only to Providers registered with the MIP by completing the Provider Enrollment Form.
4. Up to date lists of registered providers can be obtained from the MIP.

Financial Considerations:

1. Cost of equipment:
 - a. refrigerator
 - b. scientific thermometers
 - c. separate freezer (if necessary)
 - d. insulated carrying container(s)

Procedure:

1. Transporting Vaccine:
 - a. Use an insulated container with cold packs.
 - b. Do not place vaccine in direct contact with cold packs-vaccines are not meant to be frozen.
 - c. Include thermometer in the insulated container; check temperature when opened.
 - d. Keep the container in the passenger area of the car, not the trunk.
 - e. Do not leave vaccines in a parked car as there is too much possibility of temperature variations that can affect the vaccine efficacy.
2. Storage:
 - a. Order vaccine monthly.
 - b. Keep no more than two months supply on hand.
 - c. Document completely vaccine(s) received from the MIP: type, lot number, manufacturer expiration date, and quantity.
 - d. It is very important to store all vaccines according to the most up to date guidelines, as mishandling vaccines can impact efficacy.
 - e. Vaccines are stored and handled according to manufacturer's specifications and the guidelines established by the MIP.
 - f. All vaccines with the exception of varicella must be stored refrigerated at 2° to 8° degrees C (35°-46° F.)
 - g. Varicella vaccine must be stored frozen $\leq -15^{\circ}$ degrees C ($\leq 5^{\circ}$ F.)
 - h. Vaccines should **never** be stored on the doors of the refrigerator or the freezer.
 - i. Check and record refrigerator and freezer temperatures twice daily.
 - j. Store cold packs in freezer compartment.
 - k. Stack vaccines neatly, with space in between to allow for accessibility and air circulation.
 - l. Rotate vaccine stock using the vaccine with the shortest expiration date first.
3. Distribution:
 - a. Document completely vaccine(s) distributed to Provider: type, lot number, manufacturer expiration date, and quantity.
 - b. Verify provider enrollment in the MIP vaccine program.
 - c. Verify provider understanding of safe transport the vaccine.

- d. Review vaccine usage and vaccine order forms for accuracy and completeness.
- e. Distribute vaccine on a replacement basis. Replenish what was documented as used.
- f. Encourage vaccine accountability from provider including: doses administered, doses wasted and doses lost .
- g. Distribute a Vaccine Information Statements (VIS) for each dose of each vaccine distributed.

Nursing Considerations:

- 1. Follow up with providers on proper storage and handling of vaccine.
- 2. Provide education on:
 - a. proper storage and handling
 - b. evaluation of vaccine usage (wasted, lost, unaccounted for doses) and education

Documentation/Record Keeping:

- 1. Record all distribution using the MIP vaccine usage and MUP vaccine order forms.
- 2. Ensure provider is enrolled in the VFC and/or MIP vaccine program.
- 3. Account for all expired or contaminated vaccines on the vaccine order form.
- 4. Record retention: clinics and hospitals must retain documentation for 30 years at the discharge or final treatment of the patient. (105 CMR140.302C, 105 CMR: 130.370A, MGL c. 111 s 70.)
- 5. All other facilities, e.g. doctor's offices, BOH, VNA, nursing home etc. must retain documentation for a period of ten years following the end of the calendar year in which the documentation occurred (NCVIA 1986).
- 6. An additional requirement applies to all categories of providers. If a notice of a claim or lawsuit has been made, the VIS, Provider Enrollment form and other types of approved documentation pertaining to the matter must be retained until a final disposition has been made. (Guidelines for Compliance with Federal Vaccine Administration Requirements, revised, November, 2000.)

Evaluation:

- 1. All vaccines accounted for both at the depot and from providers.
- 2. All vaccines distributed with proper VIS for each dose both at depot and at provider sites.
- 3. All vaccines stored at proper temperature(s) both at depot and at provider sites.

Health Promotion/Disease Prevention Interventions:

1. Post MIP/ACIP information about vaccine storage on/near refrigerator/freezer.
2. Distribute vaccine storage information to providers.
3. Maintain criteria for refrigerator/freezer.

References:

Massachusetts Association of Health Boards and Massachusetts Department of Public Health. (1997). *Guidebook for Massachusetts Boards of Health* chap. 23. Boston MA.

Massachusetts Immunization Program Documents:

- *Massachusetts Immunization Program Supplied Vaccine and Patient Eligibility*, July, 2000.
- *Guidelines for Compliance with Federal Vaccine Administration Requirements*, revised, November, 2000).

<http://www.state.ma.us/dph/cdc/vaxcomp.htm>

Resources:

Division of Epidemiology and Immunization Overview

<http://www.state.ma.us/dph/cdc/epiimm2.htm>

Guidelines for Compliance with Federal Vaccine Administration Requirements

<http://www.state.ma.us/dph/cdc/vaxcomp.htm>

Massachusetts Department of Public Health, Division of Epidemiology and Immunization.

Standards For Pediatric Practice <http://www.state.ma.us/dph/cdc/spip.htm>

Supplied Vaccines and Patient Eligibility

<http://www.state.ma.us/dph/cdc/mipcri.pdf>

Appendix A

Advisory Ruling 9804 - Administration of Immunizing Agents

<http://www.mass.gov/dpl/boards/rn/advrul/rulimnz.htm>

Biohazard Disposition Schedule

<http://www.mass.gov/dph/dcs/105CMR480.pdf>

Board of Health Record Retention Schedule

<http://www.mass.gov/dph/clp/record.htm>

Summary of Reportable Disease

<http://www.mass.gov/dph/cdc/epii/reportable/reportable.htm>

Patient Eligibility Screening Form (VFC)

http://www.mass.gov/dph/cdc/epii/imm/guidelines_sched/vfc_eligi_form.doc

Nursing Clinical Assessment Form

Social Service Client Referral Form

Appendix B:

Massachusetts Department of Public Health Massachusetts Immunization Program Model Standing Orders

General Protocols for Standing Orders

<http://www.mass.gov/dph/cdc/mso/proto.pdf>

Needlestick Injury

<http://www.mass.gov/dph/bhqm/needle.htm>

Emergency Treatment

<http://www.mass.gov/dph/cdc/mso/etreat/pdf>

Model Screening Tools

<http://www.mass.gov/dph/cdc/epi/imm/imm.htm#mso>

- [Adult Immunization Screening Tool](#) (HTML) | [PDF 88k](#)
- [Human Immune Globulin Information Sheet](#) (PDF 63k) | [MS Word](#)
- [Hepatitis A Postexposure Prophylaxis IG Screening Tool](#) (PDF 116k) | [MS Word](#)
- [Hepatitis A Postexposure Prophylaxis IG Self Screening Tool](#) (PDF 65k) | [MS Word](#)
- [Hepatitis A Screening Tool](#) (PDF 63k) | [Word](#)
- [Screening Questionnaire Inactivated Influenza Vaccination \(IAC 8/05\)](#) (HTML) | [PDF 42k](#)
- [Screening Questionnaire for Live, Attenuated Intranasal Influenza Vaccination \(IAC 8/05\)](#) (HTML) | [PDF 44k](#)

Model Standing Orders

<http://www.mass.gov/dph/cdc/epii/imm/imm.htm#mso>

- [Diphtheria/Tetanus Toxoids, Acellular Pertussis Vaccine](#) (PDF 118k) | [Word](#)
- [Emergency Treatment](#) (PDF 18k)
- [General Protocols for Standing Orders](#) (PDF 200k) | [MS Word](#)
- [Hepatitis A Vaccine, Inactivated](#) (PDF 21k)
- [Hepatitis B Vaccine](#) (PDF 145k) | [Word](#)
- [Haemophilus b Conjugate Vaccine \(Hib\)](#) (PDF 130) | [MS Word](#)
- [Immune Globulin \(Human\) USP](#) (PDF 23k)
- [Immune Globulin \(Human\) USP For Hepatitis A Postexposure Prophylaxis](#) (PDF 110k)
- [Inactivated Poliomyelitis Vaccine \(IPV\)](#) (PDF 110k) | [MS Word](#)
- [Influenza Vaccine](#) (PDF 134k) | [Word](#)
- [Live Attenuated Influenza Vaccine \(LAIV\)](#) (PDF 119k) | [MS Word](#)
- [Measles, Mumps and Rubella \(MMR\)](#) (PDF 133k) | [MS Word](#)
- [Meningococcal Polysaccharide Vaccine](#) (PDF 107k) | [Word](#)
(Groups A, C, Y and W-135 Combined)
- [Pneumococcal Conjugate Vaccine 7-Valent \(PCV7\)](#) (PDF 112k) | [MS Word](#)
- [Pneumococcal Polysaccharide Vaccine 23-Valent \(PPV23\)](#) (PDF 124k) | [MS Word](#)
- [Tetanus and Diphtheria Toxoids \(Td\) and \(DT\)](#) (PDF 115k) | [MS Word](#)
- [Varicella Vaccine](#) (PDF 136k) | [Word](#)

Appendix C:

Massachusetts Department of Public Health

1. Organizational Structure

<http://www.mass.gov/dph/comm/orgchart.htm>

2. Bureaus, Divisions, Programs, Hospitals, Regional Offices

Alphabetical List of Bureaus and Programs

<http://www.mass.gov/dph/dphorg2.htm>

Directory Phone

<http://www.mass.gov/dph/about/phone.htm#1>

Directory Addresses

<http://www.mass.gov/dph/about/phone.htm#2>

Helplines

<http://www.mass.gov/dph/about/dphelp.htm>