COMPETENCIES FOR PUBLIC HEALTH NURSING PRACTICE INSTRUMENT (VERSION F: January, 2007)

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The purpose of this instrument is to describe and measure public health nursing competencies essential for improving population health. It was developed: to cover all aspects of population-based public health nursing practice; to reflect a range of skills needed to improve population health; and to be sensitive enough to document changes in skills over time. Because of the complexity of public health nursing practice, it is expected that nurses will be more competent in some areas and less competent in others.

Potential uses of this tool include guiding staff orientation, development and evaluation**;** structuring staff and student self-assessment; guiding workforce and organizational development; developing and revising job descriptions; providing a foundation for PHN curriculum development and student evaluation; informing others about the nature of PHN practice; and researching PHN education and practice.

The following descriptions help to clarify population-based Public Health Nursing (PHN) practice and were used in the Instrument's development.

A **public health issue** *is considered a strength or problem related to the health of the population.*

A **population** *is defined as persons who share one or more characteristics.*

A **community** *is a population where there is interaction among individuals.*

A **system** *is multiple related organizational entities.*

Population-based practice *is a professional activity that aims to improve population health through assessment, policy planning and development, and assurance. It focuses on the entire population; it is guided by the assessment of health status of the communities that comprise the population; it considers all determinants of health; it addresses all levels of prevention, and it utilizes interventions directed toward systems, communities and/or individuals and families within the population. The population-based process involves assessment, planning, intervention, and evaluation.*

> **Population-based practice with individuals and families** *is directed toward individuals, alone or as part of a family. Practice with individuals and families change the knowledge, attitudes, beliefs, skills, practices, and behaviors of individuals, singly or in families. Practice with individuals and families is population-based only if the individuals and families are members of a population where an identified PH issue is being addressed. Additionally practice with individuals and the families is population based only if it clearly contributes to improving the overall health status of the population.*
>
> **Population-based practice with communities** *is directed toward entire populations or communities within those populations. Practice with communities changes population health by changing community norms, attitudes, awareness, practices, and behaviors.*
>
> **Population-based practice with systems** *is directed toward systems that impact health (i.e .health, socioeconomic, judicial, political, educational, religious/faith community, commerce, and environmental systems). Practice with systems that impact the health of populations changes organizations, policies, laws, and structures.*

** An earlier version of this instrument was developed for the evaluation of the Minnesota Department of Health HRSA funded grant, Public Health Nursing Practice for the 21st Century.*

INSTRUCTIONS

As you consider the following activities, think of them in relationship to your present population-based practice as it is directed toward individuals and families, communities, and systems. Also assume that all population-based practice involves collaboration with partners. The specific activities range from those expected of a beginning PHN to those that might be expected of an expert PHN.

Circle the number below each description that best reflects your skill in population-based practice:
1. I would need to be taught the skills to accomplish this activity.
2. I do or could do this activity with assistance
3. I do or could do this activity.
4. I teach or could teach others to accomplish this activity.

COMPETENCIES FOR ASSESSMENT OF THE POPULATION

Identify Population(s).

Identify the population(s) for which I have a professional responsibility.
1 2 3 4

Identify Partners for the Population-based Process.

Identify individuals who can represent communities and systems (such as socioeconomic, educational, political, and legal) that influence the health of the population.
1 2 3 4

Identify key community and systems decision-makers whose participation in the population-based process is essential.
1 2 3 4

Engage and Re-engage Partners.

Establish a process for involving partner participation in the population-based process.
1 2 3 4

Work with partners to develop strategies to bring together partners reluctant to participate in the population-based process.
1 2 3 4
Share assessment, planning, implementation, and evaluation findings with identified partners.
1 2 3 4

Facilitate partner participation in the population-based process.
1 2 3 4

Encourage partners to allocate resources towards improving population health.
1 2 3 4

Describe the Individuals/Families, and Communities that Comprise the Population(s).

Describe the population's demographics, health, culture, history, health delivery systems, physical environment, and resources.
1 2 3 4
Describe the interrelationships of the population's demographics, health, culture, history, health delivery systems, physical environment, and resources.
1 2 3 4

Describe the Systems that Affect the Health of the Population(s) *(i.e., social, economic, educational, political, and legal systems).*

Assess the influences that each system has on the health of the population(s).
1 2 3 4

Identify organizations from systems that impact the health of the population(s).
1 2 3 4

Analyze Existing Data to Identify Population Health Indicators.

Identify health indicators such as risk factors, mortality, and morbidity of the population(s).
1 2 3 4

Calculate the percent of the population that have specific health indicators.
1 2 3 4

Determine expected rates of mortality, morbidity, and other events from the data gathered.
1 2 3 4

Consider limitations of available data in interpreting/applying meaning to information.
1 2 3 4

Interpret the meaning of the data.
1 2 3 4

Collaborate with partners to use data from various agencies.
1 2 3 4

Communicate with partners/populations about public health implications of the data.
1 2 3 4

Seek the population's perspective on the data.
1 2 3 4

Facilitate a process for achieving a shared perspective regarding the meaning of data.
1 2 3 4

Identify the need for statistical consultation.
1 2 3 4

Identify questions for the statistical consultant to answer.
1 2 3 4

Use statistical methods to compare populations.
1 2 3 4

Use the data gained from statistical consultation in the population-based planning process.
1 2 3 4

Rating Scale:
1. I would need to be taught the skills to accomplish this activity.
2. I do or could do this activity with assistance.
3. I do or could do this activity.
4. I teach or could teach others to accomplish this activity.

Analyze Existing Data to Identify Population Health Indicators. *(Cont.)*

Implement surveillance methods to monitor the health status of the population.
1 2 3 4

Throughout the Assessment Process, Determine the Need for and Collect Additional Data.

Develop protocol(s) for data collection.
1 2 3 4

Develop strategies to address current and future data needs.
1 2 3 4

Assure confidentiality of individual and family data.
1 2 3 4

Implement policies to protect the confidentiality of individual and family data.
1 2 3 4

Implement strategies to address current and future data needs.
1 2 3 4

Establish a system to monitor data quality.
1 2 3 4

Monitor the quality of the information.
1 2 3 4

Analyze Data to Determine Population(s) at Risk.

Identify risk factors that influence health of the population(s).
1 2 3 4

Identify strengths and resources that influence the health of the population(s).
1 2 3 4

Determine the relationships among risk factors, strengths and resources and the health of the population(s).
1 2 3 4

Determine how changing population characteristics may affect risk factors.
1 2 3 4

Identify populations with specific risk factors.
1 2 3 4

Rating Scale:
1. I would need to be taught the skills to accomplish this activity.
2. I do or could do this activity with assistance.
3. I do or could do this activity.
4. I teach or could teach others to accomplish this activity.

Determine Public Health Issues In the Population

Develop a list of public health (PH) issues based on the assessment data.
1 2 3 4

Determine the necessary partners for addressing the identified issues.
1 2 3 4

Clarify the nature and extent of each issue.
1 2 3 4

Determine the relationship between identified public health issues and population health.
1 2 3 4

COMPETENCIES FOR POPULATION-BASED PLANNING

Prioritize the Issues.

Determine the number of persons affected by specific issues.
1 2 3 4

For specific issues, consider the years of potential life lost.
1 2 3 4

Consider the number of persons at risk for each issue.
1 2 3 4

Analyze the issues based upon public concern/ opinion.
1 2 3 4

Rank the issues based upon the ability of public health to intervene.
1 2 3 4

Rank the issues based upon the ability of the partners to intervene.
1 2 3 4

Rank the issues based on the availability of resources to address the needs.
1 2 3 4

Rank the issues based on the magnitude of their severity (i.e., economics, morbidity, mortality, and quality of life) of each issue.
1 2 3 4

Facilitate a process to obtain input from key and representative community members to prioritize issues.
1 2 3 4

Rating Scale:

1. I would need to be taught the skills to accomplish this activity.
2. I do or could do this activity with assistance.
3. I do or could do this activity.
4. I teach or could teach others to accomplish this activity.

Identify Potential Interventions to Address Each Goal.

Identify PHN interventions that influence the achievement of each goal.

1 2 3 4

Use evidence-based information (e.g., research, literature, and expert opinion) to identify potential individual/family, community, and/or systems interventions.

1 2 3 4

Use evidence- based information to develop individual/family, community, and/or systems interventions for a specific issue.

1 2 3 4

Analyze each intervention to determine which ones have the greatest potential for contributing to goal achievement.

1 2 3 4

Facilitate decision-making concerning the role of each partner in potential interventions.

1 2 3 4

Select Interventions Directed at Individuals/Families, Communities, and/or Systems.

Select interventions with consideration for their acceptance by:

Individuals/families				***Communities***				***Systems***			
1	2	3	4	1	2	3	4	1	2	3	4

When selecting interventions, consider the strengths and weaknesses of:

Individuals/families				***Communities***				***Systems***			
1	2	3	4	1	2	3	4	1	2	3	4

Select interventions with a preference for primary prevention over secondary prevention over tertiary prevention.

Individual/family Interventions				***Community Interventions***				***System Interventions***			
1	2	3	4	1	2	3	4	1	2	3	4

Choose interventions with consideration for possible unintended consequences or harm.

Individual/family Interventions				***Community Interventions***				***System Interventions***			
1	2	3	4	1	2	3	4	1	2	3	4

Select interventions that maximize the benefits and minimize short and long term harm.

Individual/family Interventions				***Community Interventions***				***System Interventions***			
1	2	3	4	1	2	3	4	1	2	3	4

Select interventions that avoid unnecessary duplication of services/programs.

Individual/family Interventions				***Community Interventions***				***System Interventions***			
1	2	3	4	1	2	3	4	1	2	3	4

Select interventions based on available evidence/research.

Individual/family Interventions				***Community Interventions***				***System Interventions***			
1	2	3	4	1	2	3	4	1	2	3	4

Select Interventions Directed at Individuals/Families, Communities, and/or Systems. *(Cont.)*

Design interventions based on evidence/theory of the relationships between the interventions and the desired outcomes.

Individual/family Interventions				***Community Interventions***				***System Interventions***			
1	2	3	4	1	2	3	4	1	2	3	4

Use ethical principles when selecting interventions.

Individual/family Interventions				***Community Interventions***				***System Interventions***			
1	2	3	4	1	2	3	4	1	2	3	4

Select interventions that respect culture and ethnic beliefs.

Individual/family Interventions				***Community Interventions***				***System Interventions***			
1	2	3	4	1	2	3	4	1	2	3	4

Select interventions that are consistent with professional standards, the Nurse Practice Act, local, state, and national ordinances, and laws.

Individual/family Interventions				***Community Interventions***				***System Interventions***			
1	2	3	4	1	2	3	4	1	2	3	4

Compare interventions with consideration for their cost.

Individual/family Interventions				***Community Interventions***				***System Interventions***			
1	2	3	4	1	2	3	4	1	2	3	4

Address individual/family issues through:

Individual/family Interventions				***Community Interventions***				***System Interventions***			
1	2	3	4	1	2	3	4	1	2	3	4

Address community issues through:

Individual/family Interventions				***Community Interventions***				***System Interventions***			
1	2	3	4	1	2	3	4	1	2	3	4

Address systems issues through:

Individual/family Interventions				***Community Interventions***				***System Interventions***			
1	2	3	4	1	2	3	4	1	2	3	4

Plan the Sequencing and Frequency of the Interventions.

Plan the sequencing and frequency of the interventions considering resources and the complexity of each issue such as incidence, prevalence, and severity.

1 2 3 4

Plan the sequencing and frequency of the PHN interventions considering the expected outcomes of each intervention.

1 2 3 4

Plan the sequencing and frequency of the interventions considering which issues need to be resolved before the individual/family, community, and or/system's partners can focus on other issues.

1 2 3 4

Rating Scale:

1. I would need to be taught the skills to accomplish this activity.
2. I do or could do this activity with assistance.
3. I do or could do this activity.
4. I teach or could teach others to accomplish this activity.

Plan the Sequencing and Frequency of the Interventions (cont.).

Plan the sequencing and frequency of the interventions considering the motivation of the individual/family and or the political will of the community/system.
1 2 3 4

Plan the sequencing and frequency of the interventions considering the individual/family's functioning and/or the community and systems structure and function.
1 2 3 4

Plan interventions that are acceptable, affordable, accessible, and available to individuals/families and communities.
1 2 3 4

Establish a process to assure that the interventions are implemented.
1 2 3 4

Assure that interventions are implemented in a nonjudgmental and nondiscriminatory manner.
1 2 3 4

Determine Measurable and Meaningful Process and Health Status Outcome Indicators.

For each issue, select outcome indicators from state and national PH goals.
1 2 3 4

For each issue, select measurable and meaningful outcome indicators from evidence-based literature.
1 2 3 4

For each issue, design evaluation methods.
1 2 3 4

For each planned intervention, select measurable and meaningful process indicators from evidence-based literature.
1 2 3 4

For each planned intervention, develop measurable and meaningful process indicators.
1 2 3 4

For each planned intervention, design methods to measure process indicators guided by evidence-based literature.
1 2 3 4

Select outcome indicators that are consistent with priorities of the population(s) and decisionmakers.
1 2 3 4

Rating Scale:
1. I would need to be taught the skills to accomplish this activity.
2. I do or could do this activity with assistance.
3. I do or could do this activity.
4. I teach or could teach others to accomplish this activity.

Determine Evaluation Methods to Measure Each Process, and Health Outcome Indicator.

Select process and outcome measurement methods that evaluate each goal.
1 2 3 4

Select measurement methods that are the most efficient, accurate, reliable, and valid.
1 2 3 4

Develop a plan to collect and analyze evaluation data.
1 2 3 4

COMPETENCIES FOR IMPLEMENTING INTERVENTIONS

Implement the Selected Interventions for Each Issue According to the Plan.

Assure that the interventions are implemented in a manner consistent with current evidence/research.
1 2 3 4

Assure that the interventions are implemented according to the plan.
1 2 3 4

Obtain the necessary resources to implement the interventions at the needed frequency.
1 2 3 4

Implement Planned Interventions focusing on individual/family, community, and/or systems practice.

***** *For more information, see Keller, L.O., Strohschein, S., Lia-Hoagberg, B. & Schaffer, M. (1998). Population-Based Public Health Nursing Interventions: A model from practice. Public Health Nursing 15(3): 207-215.*

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).

Individual/family				*Community*				*Systems*			
1	2	3	4	1	2	3	4	1	2	3	4

Disease & 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).

Individual/family				*Community*				*Systems*			
1	2	3	4	1	2	3	4	1	2	3	4

Rating Scale:
1. I would need to be taught the skills to accomplish this activity.
2. I do or could do this activity with assistance.
3. I do or could do this activity.
4. I teach or could teach others to accomplish this activity.

Implement Planned Interventions focusing on individual/family, community, and/or systems practice. *(Cont.)*

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

Individual/family				*Community*				*Systems*			
1	2	3	4	1	2	3	4	1	2	3	4

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

Individual/family				*Community*				*Systems*			
1	2	3	4	1	2	3	4	1	2	3	4

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

Individual/family				*Community*				*Systems*			
1	2	3	4	1	2	3	4	1	2	3	4

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

Individual/family				*Community*				*Systems*			
1	2	3	4	1	2	3	4	1	2	3	4

Delegated functions (provides direct care 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).

Individual/family				*Community*				*Systems*			
1	2	3	4	1	2	3	4	1	2	3	4

Health teaching (communicates facts, ideas and skills that change knowledge, attitudes and practices).

Individual/family				*Community*				*Systems*			
1	2	3	4	1	2	3	4	1	2	3	4

Counseling (engages the community, system, and/or family/individual at an emotional level and establishes an interpersonal relationship intended to enhance capacity for self-care and coping).

Individual/family				*Community*				*Systems*			
1	2	3	4	1	2	3	4	1	2	3	4

Rating Scale:

1. I would need to be taught the skills to accomplish this activity.
2. I do or could do this activity with assistance.
3. I do or could do this activity.
4. I teach or could teach others to accomplish this activity.

Implement Planned Interventions focusing on individual/family, community, and/or systems practice. *(Cont.)*

Consultation (seeks data 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).

Individual/family				*Community*				*Systems*			
1	2	3	4	1	2	3	4	1	2	3	4

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).

Individual/family				*Community*				*Systems*			
1	2	3	4	1	2	3	4	1	2	3	4

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).

Individual/family				*Community*				*Systems*			
1	2	3	4	1	2	3	4	1	2	3	4

Community organizing (helps community groups to identify common problems or goals, mobilize resources, and develop and implement strategies for reaching collectively established goals).

Individual/family				*Community*				*Systems*			
1	2	3	4	1	2	3	4	1	2	3	4

Advocacy (pleads someone's cause or acts on someone's behalf, with a focus on developing the community, system, or individual/family's capacity to plead own cause or act on own behalf).

Individual/family				*Community*				*Systems*			
1	2	3	4	1	2	3	4	1	2	3	4

Social marketing (utilizes marketing principles and technologies for programs designed to influence the knowledge, attitudes, behaviors, and practices of the population-of-interest).

Individual/family				*Community*				*Systems*			
1	2	3	4	1	2	3	4	1	2	3	4

Rating Scale:

1. I would need to be taught the skills to accomplish this activity.
2. I do or could do this activity with assistance.
3. I do or could do this activity.
4. I teach or could teach others to accomplish this activity.

Implement Planned Interventions focusing on individual/family, community, and/or systems practice. *(Cont.)*

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).

Individual/family				*Community*				*Systems*			
1	2	3	4	1	2	3	4	1	2	3	4

Policy enforcement (compels others to comply with the laws, rules, regulations, ordinances and policies created in conjunction with policy development).

Individual/family				*Community*				*Systems*			
1	2	3	4	1	2	3	4	1	2	3	4

Modify Intervention Plan as Required.

Assess the response(s) to each intervention and compare them to the expected outcomes.

Individual/family response				*Community response*				*System response*			
1	2	3	4	1	2	3	4	1	2	3	4

Coordinate with representatives to jointly modify selected intervention(s) based upon the reassessment.

Individual/family representatives				*Community representatives*				*System representatives*			
1	2	3	4	1	2	3	4	1	2	3	4

Continue or modify each intervention according to reassessment findings and available resources of the community.

1 2 3 4

COMPETENCIES FOR EVALUATION OF PROCESS AND OUTCOMES

Collect Evaluation Information.

Collect and record individual/ family, community and/or system's evaluation data in a timely, efficient, and accurate manner.

1 2 3 4

Develop/adapt processes to regularly and systematically monitor the data collection process.

1 2 3 4

Analyze Collected Evaluation Information.

Use appropriate statistical processes to analyze collected information.

1 2 3 4

Interpret with partners the meaning of the analyzed information.

1 2 3 4

Rating Scale:

1. I would need to be taught the skills to accomplish this activity.
2. I do or could do this activity with assistance.
3. I do or could do this activity.
4. I teach or could teach others to accomplish this activity.

Analyze Collected Evaluation Information (cont.).

Compare evaluation results with the expected outcomes.
1 2 3 4

Identify populations (*individuals/families, communities, and or systems*) that achieved or did not achieve the process/ outcome indicator(s).
1 2 3 4

Describe the characteristics of the populations *(individual/family, community, and/or systems)* that achieved or did not achieve the outcome indicator(s).
1 2 3 4

Determine the difference between the populations *(individual/family, community, and/or systems)* that achieved or did not achieve the outcome indicator(s).
1 2 3 4

Examine the relationship between the process of each intervention (i.e. frequency and intensity) and outcomes.
1 2 3 4

Share Evaluation Results

Share the evaluation results with the individuals/ families communities and/or systems.
1 2 3 4

Obtain perceptions of individuals/families, communities, and/or systems of the need for changes in interventions and evaluation.
1 2 3 4

Plan for the reassessment of the health status of the population considering the responses of the individuals/ families/communities and or systems.
1 2 3 4

Reassess the health of the population based on evaluation findings and feedback.
1 2 3 4

Rating Scale:
1. I would need to be taught the skills to accomplish this activity.
2. I do or could do this activity with assistance.
3. I do or could do this activity.
4. I teach or could teach others to accomplish this activity.