

POPULATION HEALTH and ITS INTEGRATION INTO ADVANCED NURSING PRACTICE

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Foreword

THIS textbook, *Population Health and Its Integration into Advanced Nursing Practice*, is a welcome and timely addition to the nursing literature. As advanced practice nurses, we have an opportunity for a more significant and far-reaching impact on healthcare by understanding the array of determinants that impact health and by intervening to utilize comprehensive and upstream strategies and solutions. The focus on population health, as offered by this textbook, supports this level of thinking. With a concentration in advanced nursing care, population health strives toward better health outcomes for the group. Population healthcare hinges on the belief that individuals will benefit when the focus is on improving communal healthcare. The contributors to this textbook have provided readers with information on population health, its fit with advanced practice nursing care, obtaining and using data to drive health, specific population foci across the lifespan, illustrative case studies, policy considerations, education, and social media strategies as sources of health advocacy. This is a one of a kind resource that will pave the way for advanced practice nurses and other healthcare providers to see greater possibilities of practice in advancing the health of all.

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Preface

POPULATION HEALTH is a topic that is central to healthcare in current times. As the world continues to shrink, care for many becomes prevention- and intervention-focused. It is important to determine how influences within population health impact healthcare for all and how to identify and analyze specific populations. It is also necessary to explain the supports and practices used by advanced practice nurses to enhance population health delivery.

Because of these two distinct needs, the present text is divided into three parts. The first part provides a global review of population health, which includes access to data and application of population health in advanced practice, and then addresses the various roles of the educator, nurse executive, and policy advocate, as these evolve in response to population health and healthcare. The specific variables that healthcare providers need to understand and make an impact in population health (PH) are explained in Chapter 1 and throughout this textbook. In the second part, population health issues that affect vulnerable groups today, such as children, the elderly, the military, substance abusers, the chronically ill, and the obese, are described as major contributing (PH) issues. Disease etiology, cultural influences, and strategies for understanding and addressing such groups are included in this section. The third part takes a deeper look at compassion fatigue and burnout, the use of coaching, social marketing, and other techniques that can foster better care delivery in special populations.

As we begin, it is important we identify what population health is.

Most healthcare leaders agree that population health is directed toward the health outcomes of a specific group of individuals—a subpopulation with specific needs. Defined by Kindig and Stoddart (2003), population health is “the health outcomes of a group of individuals, including distribution of such outcomes within the group” (p. 382). The term may also apply to the total number of residents in a geographic location (Jacobson & Teutsch, 2012; Noble & Casalino, 2013). It can denote classes of individuals with specific health problems and can be defined in terms of health status indicators influenced by a plethora of individual and environmental factors (Dunns & Hayes, 1999).

Population health is addressed best from a holistic perspective, in which it is considered in the context of healthcare in its entirety and for everyone. We are aware that the influence of one aspect of a person’s life may impact all others, and the same can apply to groups. Therefore, preventative care for all and care management for those with chronic illnesses are part of this perspective. When both are done, the entire population becomes healthier.

To offer prevention or intervention services, one must understand the factors that influence health. The practitioner must realize both the health dynamics for a given population and the effects of healthcare on everyone within it. Otherwise, practitioners will be left treating symptoms and miss the big picture due to small practices.

Thus, systematic variances in patterns within and between populations need to be investigated, and policies and practices need to address these as a means to improve the overall health and well-being of vulnerable populations (Dunn & Hayes, 1999). Identifying possibilities for interdisciplinary collaboration among nurses, physicians, social workers, the public health system, other healthcare professionals, and supportive economists and demographers can clarify the population health agenda (Noble & Casalino, 2013).

We can no longer work in silos and must collectively put the patient population at the center of our consideration, as we determine how best to address the health dynamic presently confronting our profession. Therefore, this book explores major health concerns from both a theoretical and case-study perspective. Vignettes are interspersed throughout the chapters, so that the reader can consider how specific dynamics come into play within practice. Information is fine on its own; however, it is only through applying knowledge to practice that evidence can make a difference in overall health. Knowing what to do—and when and where to do it—are goals for this text.

Because the healthcare professional is key to the success of population health, support for practitioners is offered. Understanding how to educate and market to populations is critical. Ready access to screens for various conditions, such as substance use disorders and the impact of trauma, is necessary for quality care. Becoming an advocate and having a voice in the scope and role of a practice as it relates to population health are critical to keep all nurses up to speed. Therefore, chapters on these topics, as well as how to use coaching to support health changes, are included.

With many texts on population health available, why should you choose this book? *Population Health and Its Integration into Advanced Nursing Practice* is a textbook that not only looks at the overall dynamics of population health, but also focuses on how this knowledge can be used in practice. To make this easier for readers, a tool kit with key information and resources is provided for each chapter. Discussion questions that focus on application and synthesis are included, which will allow instructors and students to address topics at a graduate level.

Detailed case studies are appended at the end of each chapter. As we are all aware, healthcare is not cut and dried. We nurses cannot claim a given group has issues because of X, and if Y is done, all will be well. Rather, as advanced practitioners and potential policy influencers, we must grasp the complexities of every case we encounter and address such in hypothetical and actual interventions.

For students, applying the information in this volume to real-life situations should support and reinforce their learning and career development. For those already in practice, this text is designed to increase understanding of the highly specific, often economic and cultural, influences on patients and clients in diverse communities. Being able to recognize the social dynamics allows for better comprehension, more effective intervention, and superior outcomes.

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Section 1

Population Health Overview and Engagement Opportunities for Population Health

Population Health Introduction

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Population Health Overview

THE Institute for Healthcare Improvement (IHI) is a nonprofit organization focused on motivating and building the will for change, partnering with patients and healthcare professionals to test new models of care, and ensuring the broadest adoption of best practices and effective innovations (IHI, 2017a). “It is IHI’s belief that new designs must be developed to simultaneously pursue three dimensions, which we call the *Triple Aim*: Improving the patient experience of care (including quality and satisfaction); Improving the health of populations; and Reducing the per capita cost of healthcare” (IHI-Triple Aim, 2017b, para. 1). The Triple Aim incorporates a critical shift in point of view. The concept of treating the health of a population is a systemic approach to identifying and meeting the health needs of a large collective of people.

Defining Population Health

Population Health is a complex concept and a struggle for many; whether a provider or a consumer, population health can mean many different things. To start, one must understand what a population is or how we define a *population* in healthcare. According to *The Merriam-Webster Dictionary*, a population is “1 a: the whole number of people or inhabitants in a country or region; b : the total of individuals occupying an area or making up a whole; c: the total of particles at a particular

energy level—used especially of atoms in a laser; 2: the act or process of populating, 3 a: a body of persons or individuals having a quality or characteristic in common; b (1): the organisms inhabiting a particular locality; (2): a group of interbreeding organisms that represents the level of organization at which speciation begins; and 4: a group of individual persons, objects, or items from which samples are taken for statistical measurement” (Merriam-Webster, 2017). We often think of a population as defined by a group at large. Depending on the patient’s or people’s view, we can define based on a location, specific characteristics or experiences, or other traits. For example, a nurse practitioner will think of the patients he or she serves in the practice as his/her population. As a provider, he or she will consider the characteristics of the population served to look at assessments, developing treatment plans and plans of care, and ultimately the impact on the health of the population. Note: It is important to understand that throughout this book, the terms patients, clients, and customers are used synonymously and interchangeably.

A population can be a group of people in a community or geographical region. For example, an acute care facility will look at their market share and seek engagement of the providers (e.g., physicians, advanced practice nurses [APNs]) to promote wellness with prevention in clinics and offices. The goal is to reduce progress of precursors for chronic disease, comorbidities, and illnesses. The impact to the acute care facility is a reduction in admissions, length of stay, readmissions, and mortality.

The specialist will view his or her patient population based on a body system or category of diseases he or she treats. The cardiologist will see his or her population through the patients served with such diagnoses as heart failure, acute myocardial infarction, or endocarditis. The cardiologist and cardiac APN can expand care for population health to include multiple preventative programs, such as wellness clinics focusing on weight management, blood pressure control, healthy nutritional intake with cholesterol management, exercise programs with cardio, and more. The specialist will seek to increase preventative measures and compliance for outcome improvements of health and wellness.

Population health is defined with various terms and terminology depending on the setting and groups of patients served. For example, in the acute care setting, the concept of population health can be described as improving the continuum of care with patient (client) medical report sharing and breaking down silos of episodic care to improve the medical management of patients. Improvement of medical management

could be measured as less frequent emergency department visits, a reduction in readmissions, an increase of the medial home model, and improved compliance with medical plans of care.

“Probably the most influential contribution to the development of the population health approach is Evans, Barer, and Marmor’s *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations*, which grew out of the work of the Population Health Program of the Canadian Institute for Advanced Research” (Kindig & Stoddart, 2003, p. 380). This work strengthens the concept that population health is a focus for larger groups of people (called determinants) concentrating on health (wellness) and preventing disease conditions, and it takes on the new concept of personal ownership in one’s (the patient’s/client’s) health and wellness. APNs must engage patients in active participation and personal ownership of their physical, mental, and psychosocial wellbeing. This includes an understanding of the value of preventive and wellness activities as a driver for population health successes. Simply, the APN who engages her patients within her population she serves to improve compliance with basic principles of weight management, exercise program participation, and dietary controls of fats and sodium, with a net improvement (reduction) in obesity, hypertension, and hyperlipidemia will contribute to the advances in population health.

Case Vignette

You are working as a cardiac APN within a large practice, and you want to start a new population health program to invite not only the practice patients, but also the community at large. You speak with the administrative team and share your ideas of twice a week offering a walk in the local park, monthly before the walk leading a meditation exercise with a brief class on stress management and related topics, and twice a year holding a large community screening program for blood pressure, cardiac assessment (monitoring heart sounds), cholesterol testing, health education sessions, and more.

- What would be the information you share with administration to justify and present your case, with the return on investment, to get your project approved?
- What will be the benefits you share for developing such a population health program?

Food for Thought

As you read this book, we want you to challenge yourself to look beyond your everyday practice and ask, “How can I make a broader difference?” “Can I change, enhance, and improve my practice to make a broader impact focusing on population health?” You want to make an impact that will focus on the Triple Aim in Healthcare, decreasing cost, and improving quality for more people, the greater good, and make a difference. This supports APNs taking the lead in a more proactive manner with a focus on preventative care and improved coordination of care. As an APN, what can be done to engage the patients in their personal ownership for health and wellness? In any practice setting, the APN can make greatest impact in prevention and progression of disease.

Triple Aim

In the simplest design, Berwick, Nolan, and Whittington (2008) describe the Triple Aim in three components: better health for the population, better care and experience for individuals/patients, and lower cost of healthcare (per capita cost). Figure 1.1 demonstrates the IHI Triple Aim illustration. “The concept is a straightforward way to tackle improvement opportunities for maximum impact: look for opportunities that provide a balance among the health of the populations cared for, the

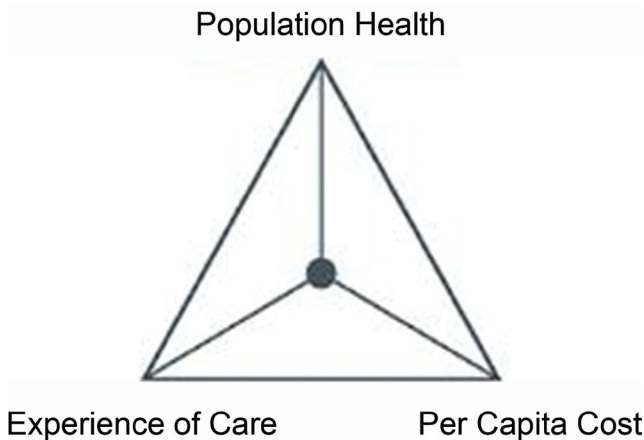


FIGURE 1.1. IHI Triple Aim.

Public Domain: www.ihl.org/Engage/Initiatives/TripleAim/pages/default.aspx

experience of patients or members, and the overall cost of healthcare” (IHI, 2017, para. 2, <http://www.ihl.org/engage/initiatives/TripleAim/Pages/default.aspx>).

The Triple Aim is not a revelation; we know and understand the cost of healthcare has been on the rise without a net positive impact on quality. Knight (2015) shares maneuvering through a broken system as many countries try to be the best in healthcare. Yet, the data show many deaths per year from hospital acquired conditions, medical errors, and illnesses that are mismanaged. Errors occur not only in acute care, but also in primary care, rehabilitation, and longterm care and in each component across the continuum of care and in every setting. According to Mangat (2015), to make an impact, providers of healthcare must focus on five elements: drive toward cost efficiency, value-based reimbursement, population health management, cost and quality data transparency, and advances in technology.

Application of Triple Aim in Practice

Case Vignette

Do you challenge yourself each day to drive cost efficiency and improve costs and quality? Are you asking about resource allocation and resource use? What is the maximum impact when we prescribe a new medication or a test for a patient? There have been times before noon, I have reflected, and I realize I have seen six patients for whom I prescribed the same treatment plans, and I question why their past treatment plans (medications as an example) were not effective. But I become robotic, chart my notes, and go on to treat the next patients as an advanced care provider. Hence, I start to challenge myself to attempt to understand population health and how I can make a broader impact on the care delivery to/for the patients I serve. The population I treat. Population Health Management is building a culture of wellness and prevention (Mangat, 2015). So, I challenge myself, and I challenge you. How can we embed population health management into our practice each day? Learning about population health, we need to change the focus from the few (approximately 5% of the population) who are sick to the larger portion of the population (20%) who are in good health with chronic illnesses and are likely to become ill later (Hegwer, 2016). As we change this focus, we can transition to health promotion and improve population health. Van Dyke (2016) shared that “population health is creating a sense of urgency . . . timing is vital to consider when

rethinking about the pace of transformation” (p. 23). Population health embraces the overall health of larger groups of people, the allocation of resources, targeting maximum impacts, and improving the population’s view of health.

According to Berwick *et al.* (2017), “Preconditions for this include the enrollment of an identified population, a commitment to universality for its members, and the existence of an organization (an *integrator*) that accepts responsibility for all three aims for that population. The integrator’s role includes at least five components: partnership with individuals and families, redesign of primary care, population health management, financial management, and macro system integration” (p. 759). So back to the question, do we challenge ourselves as advance care practitioners to commit to universality and to accept responsibility for the population we serve? Integrated with accepting the responsibility, are we adding value (quality of care and experience) while reducing cost?

Knight (2015) acknowledges a “systematic approach to care process improvement is necessary to reduce errors and save lives” (p. 4). The future must be grounded in lean process improvements, a changing focus on a value-based versus volume-based structure of fee for service, and improving the transition of care across the continuum. Lean production, also known as the Toyota Production System or justintime production, is an assembly line methodology developed originally for Toyota and the manufacturing of automobiles. Lean production principles are also referred to as lean management or lean thinking. Lean principles of manufacturing have been applied to healthcare and the principles of standardizing workflow processes to reduce the eight wastes in healthcare are essential to reduce errors. The wastes are often remembered using the mnemonic DOWNTIME (**d**efects, **o**verproduction, **w**aiting, **n**ot engaging all, **t**ransportation, **i**nventory, **m**otion, and **e**xtra processing). Improving these processes will enhance the Triple Aim by reducing cost and increasing quality outcomes for populations of people.

Case Vignette

Betty Brown, a 40-year-old African American female, has not been to the doctor since she had her fourth child 6 years ago. She is 20 pounds overweight and cannot lose the weight since her last baby. She acknowledges she could lose some weight, but feels comfortable and does not stress about her appearance. Her only complaint is occasional

headaches, which she associates with stress at work. Her work has a Live Well program; when Betty went to *check her numbers* to meet a portion of the programs financial reimbursement for teammates, the advanced practice nurse (APN) shared a concern that her blood pressure was elevated 156/90.

You are the APN—what steps will you take with Ms. Brown? How is the treatment of Ms. Brown an application of the principles of Population Health?

Expanding our Partners

After healthcare focused on the acute episodes of care, rather than developing the health of a population, we created a system in which value was measured by incidents of treatment instead of value reflecting the health of the community served. The cost of healthcare in the United States (U.S.) is disproportionately high. The transition to population health comprises thinking outside the box and expanding our stakeholders and partners to serve a broader community, including the healthy, with preventative measures, screening, and wellness strategies (for example, nutrition and exercise). Additionally, with population health, the goal is to address the bulk of the population who are progressing toward health conditions of chronic illnesses and disease. For example, patients with conditions such as mild hypertension (HTN), *slight* overweight, and lipidemia may state they are in good health, yet they may have silent warning signs for health complications in the future years that will escalate healthcare costs and lead to higher demands of acute care treatment.

Care of complex patients utilizing the principles of the Triple Aim will include affiliating and connecting with a large variety of partners (for example, retail stores and pharmacies, to support access to medications at lower costs, church support groups to enhance compliance to treatment plans). “Not addressing poverty, illiteracy, alcohol, and drug abuse, or even maladaptive cultural beliefs and behaviors that affect healthy behaviors and overall health status will leave the system short of accomplishing all three elements of the triple aim” (Knight, 2015, p.7). For example, engaging the patient in church support groups can help get to the root of many population health issues such as the cultural and socioeconomic barriers to health. These elements are not beyond the scope of an advanced care practitioner; rather they are essential if we are to improve care delivery and quality outcomes.

Case Vignette

John Smith, a 54-year-old man, lost his job as manager of a retail store six months ago and has been unable to find another job. He needs to work, because he is supporting two children in college and has a mortgage. He has been suffering from depression and, four months ago, started drinking excessively to cope with everything. He finds himself having beer and cocktails before noon each day and drinking until his head hits the pillow. He no longer has the energy to look for a job or go on interviews, and there is tension at home. He is withdrawn, and the only conversations with his wife and children are with anger, argumentation, and disruption to the household functioning.

- As the APN caring for John, what would your treatment plan be? What community services would you refer him to?
- Are there any measures you could take to impact the broader community related to alcoholism versus caring for one individual, such as John in this case?

Population Health Management

The top three investment areas for population health management include the workforce, information technology, and network development (Advisory Board, 2016). Incorporating these three investments can be complex for care management, transition of care, and telehealth pilot programs being developed and implemented. In the past, the focus of healthcare was on acute care, and today we see various roles and opportunities that expand beyond the hospital to provide care, improving access and care delivery. This means that the workforce has different training and insight into expanded roles of value and purpose with a direct impact on population health. For example, in the Charlotte, North Carolina, market, there was a job posting for a Community Outreach Partner, a registered nurse. A potential candidate for this position would be working with schools, churches, nonprofit organizations (such as Classroom Central and Salvation Army), the YMCA, and other organizations to build relationships for health promotion. Looking at the health assessment of the population in the Charlotte area, multiple opportunities exist due to the high percentage of schools with free-lunch and high incidences of diabetes, stroke, and cardiac diseases. The same organization with the Community Outreach position posted has a computer application that is free for anyone to download. It provides health

messages and links to clinical experts and access to information related to multiple disease processes and wellness. An individual can be on Medicaid for the children and Welfare, but he or she often has a cell phone. Using a cell phone to send reminders and alerts for health promotion may be the only opportunity to deliver a message to a population prior to seeing them in an acute care setting. When one focuses on population health, innovation and opportunities are welcomed to make a difference.

As advanced care practitioners, we play a vital role in identifying highrisk patients and tracking improvements in care outcomes (Advisory Board, 2016). Healthcare is changing and roles are expanding to include many diverse jobs to build and engage population health principles and roles.

Framing the Issues

Barr (2015) frames three issues in population health as follows:

“1) Population health management techniques are taking hold in different ways across the country. 2) Technology is playing a big role in population health management, but so is maintaining the human side of the equation. 3) Ignoring population health is probably a mistake” (p.23).

Healthcare systems need to get in the game for population health strategies and implementation investments to be successful. The goal must be to improve the health of the community (population) for as broad as the agency can reach. For example, Trinity Health seeks to reach 20 million people and describes this as a “kid in the candy store” (Barr, 2015, p. 23). An essential element in spread and reach requires a comprehensive technology platform to support coordination and navigation of care. Technology needs to be inclusive of human services, public safety, acute care, rehabilitation, longterm care, office practices, schools, churches, retail businesses, and more. Additionally, technology must be user friendly and without stereotypes, have ease of use, be friendly, and have a meaningful push of data to end users. For example, a friendly reminder could be delivered to take a medication or make an appointment.

Business Imperatives for Population Health

Six business imperatives for population health management as de-

scribed by Hegwer (2016) include “physician and clinical integration, contracting strategy, network optimization, operational efficiency, enabling infrastructure, and clinical management” (p. 11). These are slightly different and add the perspective of the value of alignment of goals for improved clinical outcomes. Across the continuum, care must be aligned so all parties accept risk and align with goals. “Creating a high-performance delivery network often requires detailed consumer insight such as knowing how consumers choose their providers and understand which types of consumers prefer specific settings for care” (Hegwer, 2016, p. 14). This changes the focus on consumerism. What do our customers want? How do we deliver upon their needs and not ours? The questions and challenges are as follows: Does this change our practice hours? Does this determine how we care for patients across transitions of care? An example is the geriatric population who wants to see their attending in acute care, when at rehab, and at a skilled nursing facility—how can this new model best be managed? Many questions arise, and we must challenge ourselves to think through the heart, mind, and soul of the clients, community, and population we serve.

Many facets of population health have been identified in the literature. There is no one clear strategy or process for success. Throughout the book, we selected critical concerns related to population health to help the advanced care practitioner shift his or her focus to the broader community, through the eyes of the client/patient, and mobilize change to improve quality while decreasing cost. The shift to population health is a venue for healthcare reform moving from 5% ill to 20% in good health, as described earlier in this chapter.

To start, it is critical that the APN understands how we integrate population health into our practice, thinking outside the box, elevating quality and experience while decreasing cost, and most importantly impacting the broader good of larger groups of people versus the next patient that walks into the office or clinic. This takes understanding the Patient Protection and Affordable Care Act (also referred to as the Affordable Care Act, or ACA) or its replacement, increasing access to care, advancing education for APNs, and getting involved at a local and national level, to close the gaps on health disparity and health literacy. Can we shift our practice to more preventative care? How can we improve compliance with screening for disease or compliance with dietary recommendations to minimize risks from such conditions as obesity and heart disease?

Advance Practice Nurses Application

APNs is a broad term that is used throughout the book to reflect generalists and specialists in advanced nursing care delivery who have a minimum of a master's degree and advanced nurse training, including Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Registered Nurse Anesthesiologists (CRNAs), Certified Nurse Midwives (CNMs), and Clinical Nurse Leaders (CNLs). APNs are advanced care providers in all arenas of public health, acute care, long-term care, primary care, and more, who need to know where to find information about their populations. We call this information *big data*. Do you look to the state and community health department(s) for needs assessment and gaps in care, the Center for Disease Control and Prevention (CDC), and many other sources of data to revolutionize your care delivery model and strategy to make a broader impact? "No health system can help an entire population without the right data, and the analytics to derived from the data will identify those in greatest need and suggest strategies" (Knight, 2015, p. 145). Looking at big data, it is important to understand that sources are a collection system to support storage and analysis of data and report data (what, by whom); then the data must be presented in a meaningful way so it applies to populations and the community at large. Knight also suggests reducing data silos and understanding data governance. Do you have an opportunity to share information in a data registry to look at larger sums and collections of data to identify trends and patterns that can improve care delivery? APNs must understand that data are used as a tool to improve outcomes and reduce cost. Data transparency is not new, and as APNs, we will also have our outcomes shared and will be accountable for the care populations receive. The information will be readily available and accessible. The attention and focus are necessary for our success in quality service and cost reductions.

What is Next in the Book?

Meaningful data can be used to drive health policy and our work with unique populations. As noted above, population health is defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig & Stoddart, 2003). Further, according to the Institute of Healthcare Improvement, population health "is an approach to health that aims to improve the health

of an entire human population” (IHI, 2017, para. 1). When we look at groups of individuals, we have selected key population groups that the world has identified as needing focused attention and improvements based on the Triple Aim and opportunities. Several of these populations are the military and care for veterans, pediatrics, geriatrics and the aging, trauma victims, substance abuse, obesity, and those with chronic illness. Remember the win will be when we focus on the large percentage of the population that has a chronic illness, such as hypertension [HTN]; however, currently this group of patients, when asked, will state they are in a *good state of health*. Many patients with HTN say they are asymptomatic for longterm periods, yet the HTN causes systemic ill effects on and throughout the body. Managing the HTN early in the disease management process with frequent blood pressure checks and diet and weight management will offer greater opportunity to reduce chronic disease secondary to HTN. The impact will be greater, and the APN contributes to improving care while lowering cost of care over time.

Additionally, this book will identify valued initiatives the APN can utilize to embrace care for populations, such as health coaching/advisors (leading to behavior modifications). In a study by Hohl *et al.* (2016), health advisors and coaches in the community contributed to compliance of the population in healthier behaviors, improving the outcomes and decreasing disease progression. Ultimately, this demonstrated improved health and reduced cost for healthcare in the community at large.

The use of social media is a way to improve communication about healthcare, options, and preventive care measures. Hence, access to critical data to improve care delivery and compliance in populations can easily be accessed through social media and marketing. This goes beyond WebMd and other sources of medical information that are viewed frequently. There are many applications, games, and other options to support a fun interactive system of information for the APN to strengthen population health.

As APNs focus on providing care with a broader focus on population health, it is critical that they care for themselves, in particular, reducing compassion fatigue and burnout. As APNs, we challenge our effectiveness to make a difference. APNs can drive health policy and advocacy. We must see health policy through the eyes of the receivers of care and from the perspective of different disciplines (Gatter, 2016). The challenge is developing ways to keep up with policy changes and the shifting data systems. Often nursing education is challenged to include pop-

ulation health in the curriculum, which plays a vital role in the future transitions of care delivery for success. As educators, we are challenged to teach effective communication and outcomes for our behaviors in a variety of practice settings. The APN can work collaboratively with nursing executives to focus on the three dimensions of the Triple Aim. The nurse executive faces the challenges, as care shifts to a varied setting beyond acute care, and must foster innovation and support lean strategies to reduce cost of care. According to Haas, Vlases, and Havey (2016), population health management lends way to developing new staffing models with a shift to other venues throughout the transitions of care. This requires support for a healthy work environment based on high quality investments in the community. “All of these challenges require highly competent providers willing to change attitudes and culture such as movement towards collaborative practice among the interprofessional team including the patient” (Haas, Vlases, & Harvey, 2016, p. 126).

These broader aspects will be covered in the book to help the APN make necessary transitions and applications in daily practice, to align with population health and overall improvements in care associated with the Triple Aim. Population Health requires support systems that align providers, communities, incentives, and all aspects of the programs developed. This includes the health services venues, retail market, and the people. Despite the many challenges that lie ahead, the APN can embrace population health and serve as a conduit for success.

Tool Kit and Resources

Advisory Board—www.advisoryboard.com

Health Affairs-Population Health—<http://healthaffairs.org/blog/2015/04/06/what-are-we-talking-about-when-we-talk-about-population-health/>

Institute for Healthcare Improvement—www.ihl.org

Institute for Healthcare Improvement—Triple Aim—www.ihl.org/Engage/Initiatives/TripleAim/pages/default.aspx

Population Health News, a *Health Policy Publishing* publication—(<https://www.managedcarestore.com/ypg/hpp.htm>), administered by MCOL (<http://www.mcol.com/>)

1101 Standiford Ave. Suite C-3, Modesto, CA 95350, 209.577.4888—info@populationhealthnews.com

Discussion Questions

1. How do you define population health?
2. What are the three elements of the Triple Aim? And how do Advanced Practice Nurses (APNs) play a role in each element?
3. As an APN, what are three measures you can put into practice to advance population health?
4. Who are two stakeholders and community partners that you can include in your practice to improve population health and care outcomes?
5. What is an APN's influence on health determinants focusing on wellness and delaying of chronic illness?

Case Study

As an APN, you are looking for community work. Your son attends a public school that has a high percentage of low-income people who are eligible for the free lunch program. Last week, you went to the classroom to read to the children and stayed for lunch period. You were concerned about the foods served to the children. As an advocate, you scheduled an appointment to meet with the principal, physical education (PE) teacher, school nurse, and head of the cafeteria food program.

1. Where would you gather information on the free lunch program and the school guidelines for meeting the requirements for federal and state funding?
2. What would be some suggestions you could make to provide healthier foods and portions for the children?
3. Working with the school nurse, are there any additional suggestions you could make for promoting wellness?
4. What suggestions could you make to support the PE teacher and increase the activity level for the school age children?

Your meeting at your son's school with the team was a success and you were invited to come to school once a week to continue your campaign and efforts for promoting wellness. Many of the teachers wanted you to come to the classroom to speak to the young children.

1. What would your first three lessons be? What materials/curricula would you cover to engage the child's family in wellness?
2. Name one activity you would have the children take home to do as a family to turn in the following week.

3. How would an advocacy program like this improve population health?
4. Identify two other advocacy programs you could lead to support the principles of population health.

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