



Viewing Practice through the Lens of Population Health: An Online Introduction Course

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Objectives

- Identify the resources in developing a course in population health
- Describe the course development process, course content, teaching strategies, evaluation methods, and delivery of the population health course
- Explain the benefits of a population health course to nursing faculty, students, and experienced nurses

BACKGROUND

- CT Nursing Collaborative – Action Coalition (CNC-AC)
 - Robert Wood Johnson Foundation grant
 - 3 Goals
 - Achieve an effective workforce data management system
 - Seamless progression of nursing education to increase diversity
 - Prepare nursing faculty and experienced nurses to integrate evidence-based concepts of population health & wellness care to support quality advancement of education and practice



Population Health Course Development Action Steps

- Convened a population health workgroup
- Summarized best practices in population health from evidence-based resources
- Formed a smaller task force to develop the curriculum with periodic meetings with the workgroup
- Ultimately developed a short introductory population course that is now available on the CLN's website, one of the collaborative partners

Curriculum Development Task Force

- Small task force focused on curriculum development
 - Faculty
 - Practice
 - Student
 - Online curricula consultants
- Reported to and received feedback from the larger population health work group

Design Principles for Course Development

- Introductory overview
- Brief, text based, and broken up with sidebars and videos from reliable sources: foundations and organizations focused on population health
- Continuing education rather than credit
- Self-paced and reflective rather than graded
- Conversational in tone
- Divided into smaller chunks convenient for practicing nurses' staff development, and for students for a flipped classroom exercise

A New Paradigm for Health Care

- Our guiding paradigm: The RWJF Culture of Health Framework to improve health, wellbeing, and equity (n.d.)
- IOM: Future of Nursing Report (2010)
- Campaign for Action: partnership between Robert Wood Johnson Foundation and AARP
- The Institute for Healthcare Improvement's Triple Aim (n.d.)
 - *Improving the patient's experience of care*
 - *Improving the health of populations*
 - *Reducing per capita cost of health care*
- Ultimate goal explores how nurses can shape a **culture of health** for all Americans

"To build a Culture of Health, we need a vibrant nursing profession committed to making patients and communities healthier."

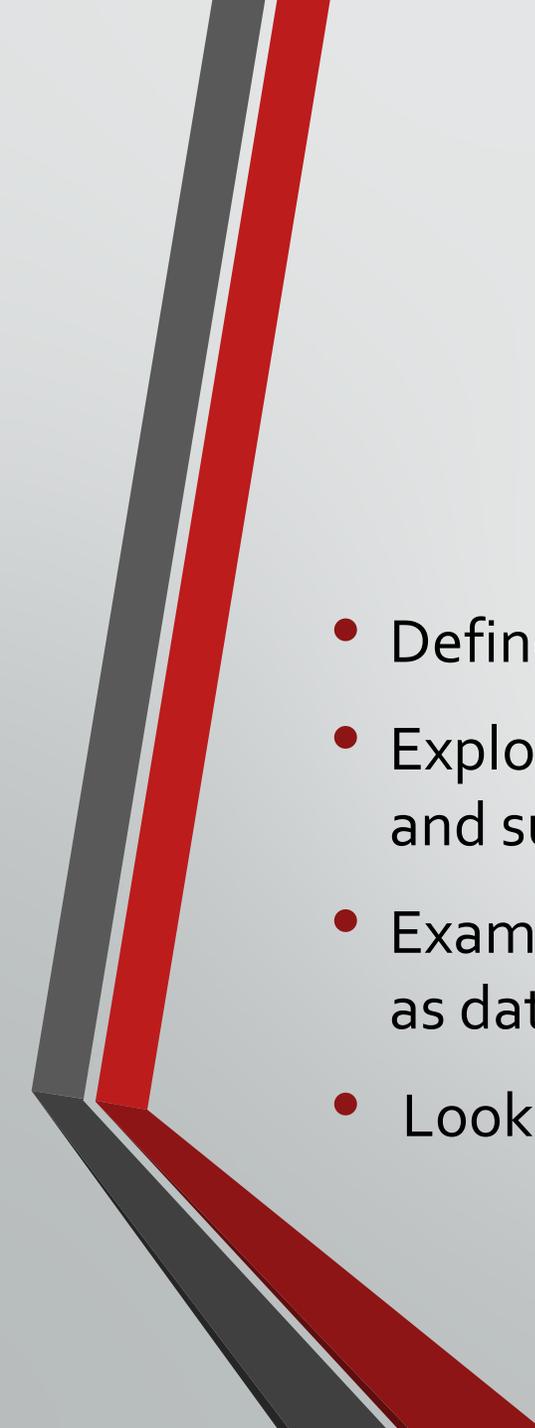
Challenges to Curriculum Development

- What is population health?
 - Differing definitions
 - Population health vs public health
 - Arrived at a mutual understanding of population health
 - Developed a working definition of population health



Definition of Population Health

- Population health is the study of well-being among defined groups. Populations can be defined by geography or grouped according to some common element, such as employees, ethnicity, or medical condition (Fabius et al., 2016).



Course Objectives

- Define population health and its social determinants
- Explore the role of private and governmental agencies in both stimulating and supporting its evolution
- Examine examples of new initiatives for improving population health as well as data to document the outcomes
- Look to the future for developing a culture of health in this country

Module One

- Discuss the concepts of upstream thinking and social determinants of health
- Compare health outcomes of the US health care system
- Identify at least one working definition of population health
- Differentiate the terms population health and public health
- Analyze selected case studies to evaluate the differential impact of the social, economic, physical, environmental, and individual characteristics or behaviors upon the health of individuals and families
- Describe new approaches to assessments and interventions that are prescribed by this new population health paradigm

Module One: Content Examples



<https://youtu.be/yluxjAaYlno>

Scenario:

Fred and Mark live in Anytown, a geographic area that is culturally and economically diverse.



Question: Fred and Mark are nearly neighbors, geographically, but so different in their life stories. Apply the HealthBegins Upstream Risks Screening Tool and Guide to each of them and think about the following questions. Can you see the difference in their upstream determinants of health? What are some of the upstream determinants that are having a negative impact on Mark's health? Think about one of them – what might be done to resolve this problem for him?

Module Two

- Describe the elements of the Institute of Healthcare Improvement's Triple Aim for the improvement of population health
- Identify an innovative project that has used the Triple Aim concepts to improve population health
- Discuss the vision and goals of the U. S. Department of Health and Human Services Healthy People 2020 initiative for population health
- Describe the measures of progress in health outcomes that are monitored by the Healthy People 2020 initiative
- Compare the plans and outcomes of two different states' Healthy People 2020 initiatives

Module Two: Content Examples



Explore different state plans, goals, strategies, and initiatives related to Healthy People 2020:

State and Territorial Healthy People Plans

Many States and Territories use Healthy People as a guide to improving health. Find your State or Territory below to learn about how they're working to achieve the Healthy People 2020 goals and objectives. Please note that not all State or Territory plans may be available online.



Each State and Territory has a Healthy People Coordinator who serves as a liaison with the Office of Disease Prevention and Health Promotion (ODPHP). The Coordinator's job is to ensure their State or Territory's plan is in line with Healthy People goals and objectives.

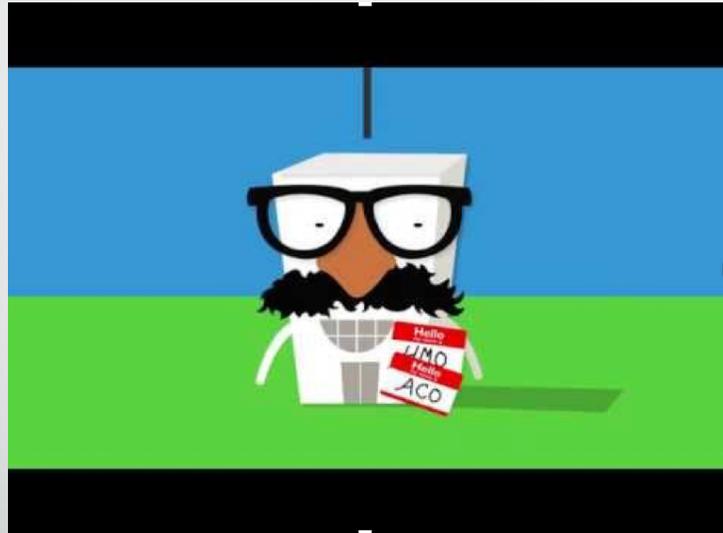
[Find the Healthy People Coordinator in your State or Territory.](#)

- **Reflection:** *Identify some of the population indicators, performance measures and strategies that your state has selected as priorities for Healthy People 2020 initiatives.*
- **Question:** *In your current practice setting, are there ways that nurses can support these state initiatives? How can nurses in a variety of settings implement interventions and resources to help achieve these performance measurements?*

Module Three

- Discuss how the IHI Triple Aim and the Healthy People initiatives influenced the national strategies for improving population health in the 2010 Patient Protection and Affordable Care Act (ACA)
- Describe the goals and characteristics of Accountable Care Organizations within the ACA
- Discuss how pay-for-performance incentive programs focus on the quality rather than the quantity of health care services
- Describe the goals and characteristics of the three pay-for-performance programs included in the ACA
- Describe how the mandates within the New Hospital-Benefit Requirements increase partnerships between hospitals and their communities to improve population health
- Review the plans and outcomes of two hospital initiatives to improve population health

Module Three: Content Examples



About Community Connections



Community Connections is an initiative of the American Hospital Association that was created to support and highlight the work hospitals do every day in America.

America's hospitals are about people taking care of people, often at the most vulnerable times in their life - a responsibility hospitals take very seriously. Day in and day out, the people of America's hospitals are on the front lines caring for the nation's poor, uninsured and others in their

FEATURED VIDEO

Palmetto Health
Columbia, SC



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Reflection: *As you look at these improvement projects, what types of partners did the hospitals collaborate with in carrying out the health improvement initiative? Do you see any themes emerging in the strategies used to effect the improvements?*

Questions: *Where do nurses fit in to these initiatives? What will be different in your role? In what ways? In what responsibilities?*

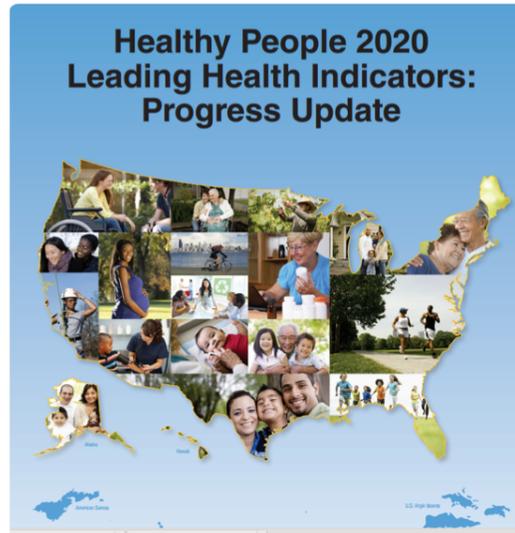


Module Four

- Review the data generated by the Healthy People 2020 initiative to assess progress in improving population health indicators
- Describe the goals and strategies of the Robert Wood Johnson Foundation's Culture of Health Framework for improving population health
- Review two examples of community projects that exemplify the Culture of Health Framework in action

Module 4: Content Examples

Click on the image below to see a Progress Update on each of the LHIs.



To see how real people across the nation have implemented Healthy People 2020 to improve the health of their communities, check out ***Stories from the Field***.



Centers for Disease Control and Prevention
CDC 24/7: Saving Lives. Protecting People.™

A-Z Index A B C D E F G H I J K L M N O P Q R S T U V W X Y Z #

Community Health Status Indicators (CHSI 2015)



CHSI

INFORMATION FOR
IMPROVING COMMUNITY HEALTH
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR DISEASE CONTROL AND PREVENTION

-- Select State --
-- Select County --
[Start Now](#)

CHSI 2015 is an interactive web application that produces health profiles for all 3,143 counties in the United States. Each profile includes key indicators of health outcomes, which describe the population health status of a county and factors that have the potential to influence health outcomes, such as health care access and quality, health behaviors, social factors and the physical environment.

The social factors and the physical environment are especially important because they represent the conditions in which people are born, work, and play. Neighborhoods with affordable healthy food, safe and accessible housing, and quality employment opportunities can positively influence behaviors and help to create healthy lifestyles. The World Health Organization and others call the living conditions that can affect health and quality of life the "social determinants of health".

Healthy People (HP) 2020 highlights the importance of addressing the social determinants of health by including as one of its four overarching goals, "Create social and physical environments that promote good health for all". CHSI 2015 supports this goal by including a broad range of indicators, including multiple indicators related to the social and physical environment.

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Reflection: *Think about your community and what some of the Leading Health Indicators might be. What about the people/clients you encounter in your own practice?*

Question: *Can you think of an initiative which would make a difference for a population in your community? Who are the entities that would be involved in developing this initiative? How could you collaborate to reach the widest audience?*

a ROBERT WOOD JOHNSON FOUNDATION



Outcomes of Pilot Offering

- Pilot-tested in April, 2017
- Pilot participants included: faculty (ADN, BSN, Graduate), students, and practicing nurses
- Results:
 - No recommended changes to content
 - Enthusiasm for use for students by faculty (flipped classroom)
 - Technical aspects



Current Status

- Over 1000 nurses, faculty, and students have completed all four modules
- Evaluations
- Next steps



Introduction To Population Health

web-hosted by
CT League for Nursing

<https://clnonlineeducation.com/login>

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