Abstract: A 2012 Institute of Medicine report calls primary and public healthcare workers to action, tasking them with working together to improve population health outcomes. A Practical Playbook released in 2014 enables this public health/primary care integration. Primary care NPs are in an excellent position to lead the charge and make this integration happen.

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Primary care NPs: Leaders in population health

A 2012 Institute of Medicine (IOM) report calls primary care and public healthcare workers to action, tasking them with working together to improve population health outcomes. Primary care and public health personnel are often present in the same communities but work independently toward related goals. Population health experts agree that population health outcomes are “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.” In the context of a local community, the outcomes of interest could be specific to the health of any group with some commonality. Examples of commonalities could include a specific age-group, ethnic group, school, or employee setting. Shared goals may include working toward improving any troublesome health metric for the specified population group. For example, health metrics of interest might relate to the Healthy People 2020 objectives or some other identified health issue.

Working together requires more than just a mandate: it requires organized local leadership. All primary care NPs,

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and especially those with doctoral preparation, are in an excellent position to lead the charge and make this integration happen. *A Practical Playbook*, newly distributed in 2014 and easily accessible electronically, provides step-by-step guidance (https://www.practicalplaybook.org).3

**IOM report**

The IOM report, “Primary Care and Public Health: Exploring Integration to Improve Population Health,” provides the theoretical background and support for creating primary care/public health integration efforts. The necessity of this integration is emphasized as crucial to improve national health outcomes and reduce healthcare costs. The report describes integration as a continuum of movement that occurs as partnerships develop. The continuum begins with mutual awareness in which primary care and public health entities are aware of each other but function independently. Cooperation follows mutual awareness and occurs when the two entities are sharing plans and resources. The next degree of integration on the continuum is collaboration. Collaboration occurs when primary care and public health personnel are coordinating and executing plans together. Finally, full partnership emerges when the population being served views the primary care/public health effort as one entity.5

The report includes a comprehensive literature review and case examples of successful past and present integration efforts. A set of core principles for successful integration are derived from these efforts. Those necessary core principles include:1

- A shared common goal of population health
- Community engagement
- Aligned leadership
- Sustainability
- Collaborative use of data and analysis

**A practical playbook**

*A Practical Playbook* moves the theory from the IOM report into an action guide that is accessible, understandable, and efficient, especially for busy clinicians. A *Practical Playbook* is a web-based tool divided into three sections: “Learn,” “Do,” and “Share.” Helpful tools, more in-depth explanations, tips, and examples are integrated in web links throughout. The first section, “Learn,” defines terminology and walks users carefully through the application of each of the IOM report’s core principles. For example, the first principle requires the partners to have a shared common goal. A link in this section takes you to the Partnership Trust Tool Survey from the CDC Prevention Research Center, which can be printed out and used by all partners as they work toward moving along the integration continuum from mutual awareness to partnership. The Partnership Trust Tool Survey was developed to stimulate group discussions and is not meant to be used as a measurement or research tool.6

The next section of the playbook, “Do,” provides action steps for starting a collaborative project. Five stages (organize and prepare, plan and prioritize, implement, monitor, and evaluate), which are interconnected and continual, guide the process. As with the first section, helpful web links are abundant, including links to primary care organizations (national NP organizations are included) for use by public health personnel looking for primary care provider partners.

The last section, and perhaps the most important of the playbook, is “Share.” Once a project is underway or complete, “share” provides a public Internet tool for uploading the “story” so users can learn from others’ experiences. Each story includes “lessons learned,” project contact information, and other tools to support replication of the project in another community. The playbook includes a group forum (although the website is still under construction). The group forum will provide a place for interaction between primary care and public health professionals.

**NP leadership**

Primary care NPs have the skills and ability to lead public health/primary care integration efforts and subsequently complete projects, which improve the health of their community. Prelicensure nursing programs establish a basis for understanding public health concepts. The National Organization of Nurse Practitioner Faculties (NONPF) competencies provide the basis for NP educational programs regardless of exit degree (MSN or DNP).7 NONPF core NP competencies include seven leadership competencies as well as other competencies that prepare NPs to understand and navigate the complexities of the healthcare delivery system (see NONPF core leadership competencies). As the Doctor of Nursing Practice (DNP) degree evolves as the entry-level degree for NP practice, DNP students receive a curriculum inclusive of the educational compen...
tencies set forth by the American Association of Colleges of Nursing (AACN) in the DNP Essentials for Advanced Nursing Practice. DNP Essential VII ensures that advanced nursing practice curriculum includes preparation in population health (see AACN DNP Essential VII: Clinical prevention and population health for improving the nation’s health).

An example of integration in action
A primary care family nurse practitioner (FNP) becomes concerned after seeing a patient with mumps. She is aware that reduction in U.S.-acquired cases of mumps is a Healthy People 2020 objective (objective IID-1.5). She observes that more and more parents are opting out of infant/toddler vaccines. She obtains administrative approval to run a vaccine report from her clinic’s electronic medical record and discovers that the number of unvaccinated children in her practice, although not huge, has been steadily increasing for the past few years.

She reaches out to the local health department, discovers they are also concerned (based on occurrences of reportable diseases), and plans a meeting with the director. With proper permissions, de-identified data are shared. At the meeting, the FNP and health department director identify a number of key community stakeholders to invite to a conversational meeting.

The FNP volunteers to organize and lead the conversation. The health department director agrees to provide a room and communication support. Evolving from that initial meeting, a community-wide population health strategy to increase vaccination rates is eventually implemented. The strategy involves many healthcare providers, daycares, schools, churches, a popular recreation center, and other places parents of young children frequent. The health department evaluates the project by monitoring communicable disease reports. The FNP monitors vaccination rates in her own practice and encourages other primary care providers to do the same. A community partnership develops, and once the vaccination issue is addressed, the partnership decides to tackle other population health issues together.

An opportunity
The timing for primary care NPs to lead public health/primary care integration efforts is right now. The economics of healthcare are rapidly changing under the Affordable Care Act (ACA). Healthcare must become more efficient and cost conscious. Insurers are increasingly focused on population outcomes rather than just individual patient outcomes. Some states are pushing for more autonomy for NPs as a solution to primary care physician shortages, as less than 25% of medical students choose primary care and yet many states still restrict NP practice. Emerging publicly as leaders in improving population health will further increase NP visibility, credibility, and value. All NPs can:

- Become familiar with and use the resources in A Practical Playbook (https://practicalplaybook.org).
- Seek out a public health leader in the community and move along the IOM report’s continuum starting with mutual awareness. Meet for a cup of coffee, and share ideas

AACN DNP Essential VII: Clinical prevention and population health for improving the nation’s health

The DNP program prepares the graduate to:

- “Analyze epidemiological, biostatistical, environmental, and other appropriate scientific data related to individual, aggregate, and population health.”
- Synthesize concepts, including psychosocial dimensions and cultural diversity, related to clinical prevention and population health in developing, implementing, and evaluating interventions to address health promotion/disease prevention efforts, improve health status/access patterns, and/or address gaps in care of individuals, aggregates, or populations.
- Evaluate care delivery models and/or strategies using concepts related to community, environmental and occupational health, and cultural/socioeconomic dimensions of health.”

NONPF core leadership competencies

- “Assumes complex and advanced leadership roles to initiate and guide change.”
- Provides leadership to foster collaboration with multiple stakeholders (for example, patients, community, integrated health teams, and policy makers) to improve healthcare.
- Demonstrates leadership that uses critical and reflective thinking.
- Advocates for improved access, quality, and cost-effective healthcare.
- Advances practice through the development and implementation of innovations incorporating principles of change.
- Communicates practice knowledge effectively both orally and in writing.
- Participates in professional organizations and activities that influence advanced practice nursing and/or health outcomes of a population focus.”


about the priority health issues facing the community.

- Join the local health department’s community advisory board or other workgroup.
- Contact a local NP program for assistance from students or faculty. Many NP students must complete a project as part of their graduation requirements.
- Consider strengthening expertise in leadership and population health by pursuing a doctoral degree.

Primary care expectations are changing. NPs must move their care beyond just individual patient needs and address the needs of the populations they serve. The Practical Playbook makes guidance and resources readily available so primary care NPs can rise to the challenge!

REFERENCES

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