



COMMUNICATION  
KNOWLEDGE  
LEADERSHIP  
PROFESSIONALISM  
BUSINESS SKILLS

# Nurse Executive Competencies: Population Health



# OVERVIEW

Health care systems increasingly are identifying strategies and interventions to improve the health of their patients and the communities they serve. Acute, ambulatory and post-acute care organizations are realizing the promotion of health and wellness outside their settings creates improved outcomes. This shift in care delivery focuses on partnerships across the health care settings and addressing specific health needs of particular populations. Population health management (PHM) programs seeks to improve the health outcomes of entire populations through the effective utilization of patient data and analyzing that data into actionable efforts that lead to improved clinical and financial outcomes. Tantamount to the development, execution, and refinement of PHM programs is leadership from the nurse executive. As an advocate for community health needs and patient populations, the nurse executive serves as an agent of change in this strategic effort.

## ASSUMPTIONS

- Health care systems will consolidate and become a predominant model of integrated care delivery.
- The health care enterprise will be patient centric.
- Enterprise-focused executive nursing leadership is essential to the success of integrated delivery networks.
- Nursing practice must be aligned to the future state of integrated delivery.
- Academic practice partnerships are critical to current and future workforce development.
- “Hospital” will not be centric to care delivery; the health care continuum will be the focus.
- Interprofessional collaboration is critical to future state.
- Legislation, policy and regulation should be guiding principles aligned with effective care delivery systems.
- The shift to population health management will continue.
- Value-based purchasing will decrease health care costs through efficiencies across the integrated delivery networks.
- The pressure for standardization based on sound evidence based practice will continue.
- Health care system transformation will continue to evolve.
- Population Health Management is the foundation for value-based reimbursement.
- Competencies for nurse executives to lead Population Health Management initiatives are requisite educational preparation in current and future health care delivery environments.

Reliability and validity for the AONE Nurse Executive competencies is established by periodic job analysis/role delineation studies. These competencies are based on *A National Practice Analysis Study of the Nurse Executive* (2014).

# 1 COMMUNICATION AND RELATIONSHIP BUILDING



## A. EFFECTIVE COMMUNICATION

- Produce and present cogent and persuasive communication materials to address population health issues appropriate to diverse audiences with the outcome of engaging people, communities and organizations.
- Effectively resolve and manage conflict with direct reports and colleagues.
- Possess excellent negotiation skills related to contracts and programs.
- Competently navigate of social media to ensure effective communication across a wide audience.

## B. RELATIONSHIP MANAGEMENT

- Build trusting, collaborative relationships with stakeholders that demonstrate interprofessional partnerships across the continuum of care, practice settings and the community. Include the integration of virtual technologies where appropriate.
- Facilitate direct and honest interactions in a credible and supportive manner.
- Demonstrate integrity, including follow-through on promises and concerns.
- Provide service recovery to dissatisfied stakeholders.
- Demonstrate empathy and concern for individuals and groups while ensuring that organizational goals and objectives are met.
- Assert views in non-threatening, non-judgmental ways.
- Build relationships with communities, organizations and health care providers to provide smooth transitions throughout the continuum of care and within population served.
- Acknowledge and celebrate successes and accomplishments of the team.

## C. INFLUENCING BEHAVIORS

- Collaborate with stakeholders to create and communicate a shared vision related to population health.
- Collaborate with stakeholders to develop, communicate and monitor behavior expectations.
- Demonstrate confidence and boldness in addressing sensitive or emotional issues.
- Provide feedback and mentoring to new leaders, including coaching.

## D. DIVERSITY

- Create an environment which recognizes and values differences in staff, health care providers, patients, families and the community at large.
- Assess current environment and establish indicators of progress toward cultural competency.
- Define diversity as understood by stakeholders, patients, families and communities.
- Incorporate population data to identify cultural clusters within communities and engage patients and families in assessing needs, defining and implementing solutions, and evaluating outcomes.
- Define cultural competency and permeate principles and expectations throughout the organization.
- Address inappropriate behaviors and attitudes toward diverse groups.
- Develop processes to incorporate cultural health beliefs and alternative treatment options into care delivery.
- Promote diversity (and divergent thinking) as a mechanism that will drive innovative idea sharing and problem solving within population health management.

## E. SHARED DECISION-MAKING

- Promote the development of integrated structures for shared decision-making.
- Utilize the strategic plan to engage internal and external resources in a structured partnership.
- Ensure representation of patient and communities populations affected by decision-making.

## F. COMMUNITY INVOLVEMENT

- Apply systems thinking to providing care for communities and populations.
- Represent the organization in the community as a nurse leader.

## G. PROVIDER RELATIONSHIPS

- Build relationships and thereby, credibility, with provider groups as a champion for health care consumers, quality outcomes, population health and nursing professionalism.
- Address inappropriate behavior towards health care consumers and their significant others/families and staff.
- Represent nursing at provider executive committee and other provider staff committees.
- Collaborate with provider staff leaders in determining needed population health services.
- Collaborate with providers to develop population health protocols, policies and procedures.

- Collaborate with providers to determine health care consumer needs.
- Utilize provider/staff mechanisms to address provider clinical performance issues.
- Facilitate dispute resolution and team building involving providers and nurses or other disciplines.

## H. ACADEMIC RELATIONSHIPS

- Determine current and future supply and demand for nursing care.
- Identify educational needs of population health of existing and potential nursing staff.
- Identify and collaborate with academic partners to provide required population-focused resources.
- Serve on academic advisory councils as a nurse leader representing population health.
- Collaborate with nursing faculty in nursing research and incorporate nursing research with populations into practice.
- Provide the foundation that supports the continuum of learning and professional development by closing the gap between the population health setting, academic institutions and health care organizations.
- Partner with academic institutions by offering clinical site placements as a method of recruitment into community health nursing.
- Acknowledge the need for interprofessional collaborative practice and education across professions.

# 2 KNOWLEDGE OF THE HEALTH CARE ENVIRONMENT



## A. CLINICAL PRACTICE KNOWLEDGE

- Understand the differences between population health and the medical care model/episodes of care.
- Maintain knowledge of current nursing practice and the roles and functions of patient care team members.
- Articulate patient care standards as published by The Joint Commission, DNV, CMS, CHAP, ACHA and professional nursing literature.
- Understand, articulate and ensure compliance with the state nurse practice act, state board of nursing regulations, regulatory agency standards and policies of the organization.
- Ensure that written organization clinical policies and procedures are reviewed and updated in accordance with current clinical practice, evidence-based practice and population health strategies.
- Role model lifelong learning, including clinical subjects such as health promotion, illness prevention, disease processes, chronic disease management, pharmaceuticals, clinical technology and community engagement.

## B. DELIVERY MODELS/WORK DESIGN

- Advance knowledge of current nursing practice and the roles and functions of patient care team members and community partners.
- Identify, develop and evaluate various delivery systems and patient care models.
- Serve as change agent and new partner when patient care work/workflow related to population health is redesigned.

- Identify the accessible community resources and work to build linkages to the health care organization.
- Collaborate, partner and build relationships to incorporate community health resources into strategic goals and management priorities.
- Understand and interpret the components of a community assessment, epidemiological data, social determinants of health, environmental influences, community based partnerships, health literacy and community participation.

## C. HEALTH CARE ECONOMICS

- Articulate federal and state payment systems and regulations, as well as private insurance issues which affect organization finances and patient care in a new value-based environment.
- Understand what correlated data, and the relevance of that data, are available—public, community, federal health, and social—regarding the health of the community served; allowing for understanding of the relevance of the data to interpret its ramifications to other health care leaders. Specific social determinants should include wellness, health literacy, environmental (living conditions), cultural (health beliefs, language, nutrition), personal characteristics (gender, race, ethnicity) and socioeconomic (income, education status) factors that impact health.

## D. HEALTH CARE POLICY

- Articulate federal and state laws and regulations that affect the provision of patient care (e.g., tort reform, malpractice, negligence reimbursement).

- Participate in the legislative process concerning population health care through membership in professional organizations and personal contact with public officials.
- Educate patient care team members and community partners on the legislative and regulatory processes and methods for influencing both.
- Influence and impact state and federal legislation on professional policies affecting nursing practice and health care organizations, as well as community benefit.
- Advocate for population health by becoming a nurse leader in the community.

### E. GOVERNANCE

- Articulate the roles and responsibilities of the relevant accountable bodies directing the services of all components of the comprehensive program of care delivery including:
  - » Fiduciary responsibilities
  - » Credentialing
  - » Performance management
- Represent care delivery and member issues to the governing body.
- Participate in strategic planning and quality initiatives with the governing body.
- Represent nursing at all governance functions.

### F. EVIDENCE BASED PRACTICE/OUTCOME MANAGEMENT

- Interpret evidence-based practice and information from research for use in population health initiatives.
- Utilize research findings for the establishment of standards, practices and patient care models in the organization.
- Disseminate research findings to care delivery team members and incorporate into practice as appropriate.
- Participate in studies that provide outcome measurements.

- Allocate nursing resources based on measurement of population needs.
- Apply research where applicable within the context of a seamless provision of care across the continuum.
- Evaluate outcomes of practice within the context of a seamless and comprehensive program of care delivery along the health continuum.

### G. PATIENT SAFETY

- Support the development and implementation of a patient safety program pertinent to every aspect of a comprehensive program of care delivery along the health continuum.
- Design safe clinical systems, processes, policies and procedures.
- Evaluate clinical activities to identify and address both expected and unexpected risks.
- Support a non-punitive reporting environment and a reward system for reporting unsafe practices.
- Support safety surveys, responding and acting on safety recommendations.
- Ensure staff is clinically competent and trained on its role in patient safety in general and as it relates to population health management.
- Articulate and take action to support the Joint Commission National Patient Safety Goals, as well as other national and professional standards.

### H. UTILIZATION/CASE MANAGEMENT

- Articulate organization decision-making for the criteria model adopted by the population health management organization.
- Communicate the key points of the model to all constituents, including, but not limited to, nursing, financial, medical staff, payers and members.
- Involve physicians and other providers in ongoing utilization management practices.

## 2 KNOWLEDGE OF THE HEALTH CARE ENVIRONMENT

- Design continuum of care mechanisms for managing patient throughput through the continuum of care, including, but not limited to, skilled nursing facilities, long-term care facilities, urgent care centers and ambulatory care centers.
- Develop processes which enhance every clinician's and team member's ability to anticipate member needs at all stages of the health care delivery system.

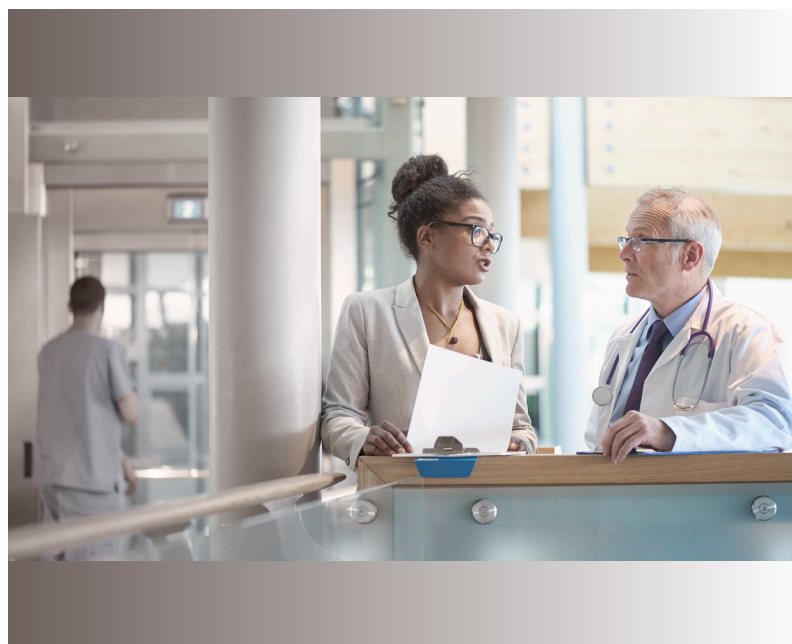
### I. QUALITY IMPROVEMENT/METRICS

- Articulate the organization's quality program and goals, in general and specifically as related to population health.
- Determine patient/member care quality improvement goals and objectives in relation to population health.
- Define process improvement metrics for appropriate components of the population health program.
- Explain and utilize metrics as a unit of measure for any process.
- Articulate the link between metrics and goals.
- Articulate the link between organization metrics and national and professional quality initiatives/metrics.

- Target outcomes that are evidence-based (comparison data benchmarking).
- Define quality metrics by:
  - » Identifying the problem/process
  - » Measuring success at improving specific areas of patient care
  - » Analyzing the root causes of variation from quality standards
  - » Improving the process with the evidence
  - » Controlling solutions and sustaining success

### J. RISK MANAGEMENT

- Partner with risk management and other leaders to identify areas and trends of risk/liability in aspects of practice and operations.
- Ensure staff is educated on risk management and compliance issues as applicable to their practice environments.
- Develop systems which encourage/require prompt reporting of potential liability by staff at all levels in all practice environments.
- Envision and take action to correct identified areas of potential liability.



# 3 LEADERSHIP



## A. FOUNDATIONAL THINKING SKILLS

- Critically analyze research-based evidence and apply to evaluation of population health management, organizational issues and policy.
- Demonstrate curiosity and eagerness to explore new knowledge and ideas.
- Promote nursing leadership through application of evidence and insight.
- Demonstrate leadership through application of decision-making strategies appropriate to varying situations both internal and external to the organization.
- Provide visionary thinking on population health management and new care delivery systems.
- Develop and support roles and processes that demonstrate a focus on issues germane to population health (e.g., health promotion, disease prevention, wellness, care coordination).
- Promote the practice of nursing to the full extent of knowledge and education.

## B. PERSONAL JOURNEY DISCIPLINES

- Integrate feedback regarding strengths and weakness into personal and professional development.
- Practice lifelong learning through the identification of learning opportunities.
- Develop a professional portfolio as part of career-planning strategy.
- Seek and provide mentorship in the fields of leadership and population health.
- Engage in learning activities related to population health management and care coordination across the continuum of care.
- Forge professional relationships within and beyond the fields of nursing and population health to extend collaboration and integration of knowledge.

## C. SYSTEMS THINKING

- Demonstrate and promote systems thinking as a means of addressing health across the full continuum of care.
- Consider the impact of nursing decisions on the health of the population.
- Promote engagement throughout the organization to serve the needs of the population across the continuum of care.
- Synthesize and integrate divergent viewpoints for the benefit of patients and populations along the health care continuum.
- Identify and integrate the complex needs of population health through the inclusion of people and communities in the assessment, development, implementation, and evaluation of initiatives.

## D. SUCCESSION PLANNING

- Promote population health as a meaningful specialty.
- Address organizational need for succession planning at all levels of the system.
- Serve as subject matter expert, role model and mentor in the area of population health.
- Establish mechanisms to identify and mentor those with leadership potential in the field of population health.
- Extend mentoring opportunities to the community-at-large, including health care providers, academic institutions and professional organizations.



#### E. CHANGE MANAGEMENT

- Use change theory to plan for and manage changes affecting the population and caregivers.
- Serve as a change agent, assisting others in understanding the importance, necessity, impact and process of change as the paradigm shifts to manage population health across the continuum.
- Support those affected by change during the transition.
- Demonstrate openness to change, particularly during periods of transition.
- Reward creative and innovative thinking.
- Adapt leadership style to meet situational needs.



# 4 PROFESSIONALISM



## A. PERSONAL AND PROFESSIONAL ACCOUNTABILITY

- Collaborate with stakeholders across the care continuum to establish goals with measurable outcomes. Foster an environment of performance transparency predicated on outcomes to create culture of accountability across the care continuum.
- Create innovative governance structures which encourages community and care continuum accountability with clear responsibility to achieve goals.
- Align one's own personal core values with those of their organization and/or professional organizations and apply regularly to their personal and professional lives.
- Establish trust through timely communication of reliable and valid information to the appropriate stakeholders.
- Create and maintain a professional portfolio based on the AONE Nurse Executive Competencies.

## B. CAREER PLANNING

- Create an environment in which professional and personal growth is an expectation.
- Evaluate potential for innovative career paths emerging in the population health space.
- Encourage pursuit of and collaborate with academic partners to instill needed competencies for skills acquisition.

## C. ETHICS

- Create a cross continuum collaboration that encourages frank and open discussion around ethical challenges and problem solving.
- Provide a venue for raising ethical issues or concerns across disciplines and care settings, inclusive of patients and their families.

- Evaluate the communication between nurses, our interprofessional colleagues and persons/populations served to assess the quality of health information, care and experiences without bias.
- Analyze potential human ethical violations that place at risk the basic fundamental ethical principles of autonomy, beneficence and nonmaleficence.
- Recognize and integrate the ANA Nursing Code of Ethics into one's own professional practice.

## D. EVIDENCE-BASED CLINICAL AND MANAGEMENT PRACTICE

- Analyze large datasets across the care continuum and develop platforms/venues for communication of results and recommendations for action.
- Communicate best clinical and management practices effectively given the likelihood of innovative perspectives with population health metrics.
- Promote interoperability of disparate systems to allow for data transparency and aggregation across episodes of care to optimize care delivery/improvement of handovers.
- Establish information technology infrastructure to measure systemic performance across boundaries.
- Allow for all ideas to be communicated and validated with evidence, as appropriate.

### E. ADVOCACY

- Promote and support community and systems approach. Lead collaboration/partnership initiatives to improve goal alignment across care settings to benefit patient outcomes and experience.
- Advocate for inclusion of disparate viewpoints when making decisions.
- Ensure quality of life of the population served.

### F. ACTIVE MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS

- Lead cross organizational efforts to enhance population health, including the creation of collaborative partnerships.
- Explore and integrate boundary spanning work by other disciplines and organizations.
- Be engaged in at least one professional organization promoting leadership development and refinement to improve population health management.
- Maintain awareness of and demonstrate commitment to the expectations set forth by the representative professional organizations.



# 5 BUSINESS SKILLS



## A. FINANCIAL MANAGEMENT

- Articulate business models that support programs to address population health.
- Describe insurance and reimbursement models as they apply to population health management.
- Analyze data to measure key financial metrics.
- Manage financial resources by developing sound business plans.
- Ensure accurate billing and charging mechanisms through collaboration with appropriate business units.
- Educate patient care team members regarding financial implications of patient care decisions across the population.
- Identify common demographic influences on population health management.
- Integrate financial management to outcomes in decision-making.

## B. HUMAN RESOURCE MANAGEMENT

- Participate in workforce planning and employment decisions.
- Champion a diverse workforce and understand cultural norms.
- Provide constructive feedback to address workplace opportunities for improvement.
- Interpret and evaluate employee satisfaction/quality of work surveys.
- Create opportunities for employees to be involved in decision-making (e.g., shared leadership).
- Reward and recognize exemplary performance.
- Formulate programs to enhance work-life balance.
- Interpret legal and regulatory guidelines.
- Manage collective bargaining environments or implement programs to avoid the need.

- Identify and eliminate sexual harassment, workplace violence and safety, and verbal and physical abuse.
- Implement ergonomically sound work environments to prevent worker injury and fatigue.
- Develop and implement bioterrorist, biohazard and disaster readiness plans.
- Identify clinical and leadership skills/competencies necessary for performing job related tasks.
- Provide mentorship and career counseling to aspiring clinicians and leaders to develop required skill sets (e.g., succession planning).
- Identify future skill sets needed to remain competitive.
- Analyze market data in relation to supply and demand and manage resources to ensure appropriate compensation.
- Develop and implement recruitment and retention strategies.

## C. STRATEGIC MANAGEMENT

- Connect with community leaders to collaborate on industry growth.
- Project health care needs in the communities being served.
- Collaborate with and inspire multidisciplinary teams to provide seamless and holistic care.
- Be open to and encourage innovative and creative ways to provide care.
- Measure and analyze performance from the learning and growth, business process, customer and financial perspectives to remain competitive.
- Recognize and support the role of accountable care organizations in population health management.

### D. MARKETING

- Create a formal marketing plan, including strategies, budget, communication plan and referral goals.
- Consider needs of the community and population served in creating marketing plan.
- Use public relations and media outlets to promote your organization.
- Develop individual presentations that are professional looking, articulate and knowledgeable.

### E. INFORMATION MANAGEMENT AND TECHNOLOGY

- Maintain competency in office technology and web-based programs and applications, including use of telehealth platforms.
- Translate data into actionable information to improve clinical practice and patient outcomes in population health.
- Optimize computer and technical applications to promote population health.

- Participate in system change processes and utility analysis.
- Participate in evaluation of information systems in practice settings.
- Evaluate and revise patient care processes and systems.
- Utilize electronic medical record systems to collect, manage and integrate data.
- Promote nursing involvement in the planning, design, choice and implementation of information systems in the practice environment.
- Demonstrate awareness of societal and technological trends, issues and new developments as they apply to population health.
- Demonstrate proficient awareness of legal and ethical issues related to client data, information and confidentiality.
- Analyze and interpret data relevant to clinical and business intelligence.

