Association of Community Health Nursing Educators (ACHNE) Response to the
American Association of Colleges of Nursing (AACN)
Draft Essentials Document Dated November 5, 2020.
Titled: *Draft the Essentials: Core Competencies for Professional Nursing Education*

Submitted by the

ACHNE President

Lori Edwards, DrPH, MPH, BSN, RN, APHN, BC

ACHNE President Elect

Krista Jones, DNP, MSN, RN, PHNA-BC

ACHNE Education Committee Co-Chairs

Joy E. Hoffman, DNP, RN, PHNA-BC and Regina (Gina) H. Johnson, MS, RN (**Lead**)

ACHNE Policy Committee Co-Chair

Susan Harrington, PhD, RN

ACHNE, Research Committee

Ann M. Stalter, PhD, RN, M. Ed.

ACHNE Member-at-Large Committee

Florence Weierbach, PhD, MSN, MPH, RN and Kelly Strickland, MSN, RN

ACHNE Representative to the Council of Public Health Nursing Organization (CPHNO)
Gina Alexander, PhD, MPH, MSN, RN

ACHNE Past President
Pam Levin, PhD, APHN-BC

The Association of Community Health Nursing Educators (ACHNE), established in 1978, is the national specialty organization for professional education in community/public health nursing (C/PHN). Our mission is to advance population health (local to global) through quality community and public health nursing (C/PHN) education, practice and research. Our core values center on being a catalyst for excellence in education, innovative academic/practice partnerships, evidenced-based practice, leadership development, public health policy, professional development, research, scholarship, and mentorship to internal and external organizations.

ACHNE's vision for the nurse of the future (Entry-Level Professional Nurse and Advanced-Level Nursing) is in alignment with the American Association of Colleges Nursing (AACN) and The Essentials Task Force (TETF) vision of the future nurse who will be able to meet the needs of a dynamic, global society, and a diverse population by:[1]

- Advancing diversity and inclusion in nursing education and practice.
- Transitioning to competency-based education and assessment.
- Increasing collaboration between education and practice through formalized academic-practice partnerships.
- Increasing emphasis on faculty development and career advancement.
- Exploring and adopting opportunities for resource efficiencies.

Our membership has a history of active engagement with AACN in this new re-envisioning and re-designing of the essential documents.

- **August 2018:**
  - ACHNE members were asked to participate in an AACN Baccalaureate Population Health Competencies Workgroup. The goals of this group were to provide information on population health competencies, identify and level the competencies for entry level professional nursing education and advanced-level nursing education, and provide progression indicators. This small workgroup was led by Dr. Joan Stanley and Dr. Sue Swider.
  - The ACHNE Education Committee completed a thorough review of the American Association of Colleges of Nursing [AACN] Public Health: Recommended Baccalaureate Competencies and Curricular Guidelines for Public Health Nursing: A supplement to the baccalaureate education for professional nursing practice (2013).[2]
- **February 2019:**
  - ACHNE Education Committee and the Executive Board submitted a letter outlining our review of the above documents, with comprehensive recommendations to AACN for their consideration[3].
- **May 2019:**
  - ACHNE Education Committee and the Executive Board submitted a letter in response to the *Future of Nursing Report*, 2020-2030.[4]
- **November 2020:**
  - ACHNE membership participated in an invitational forum of nursing organizations to provide input and address questions related to the Draft Essentials.
- **December 2020:**
  - After the forum in November, ACHNE membership was polled to gain collective insight on the *Draft Essentials: Core Competencies for Professional Nursing Education, dated November 5, 2020*[5]. We used the same questions posed by TETF.
    - What do you like best about the new Essentials?
    - What do you think is missing?
    - What do you still have questions about or need more information on?
    - How can AACN help you implement the new Essentials, such as tools, resources, and faculty development?

      (See Appendix A)

- This was followed by several key members, from academia and practice, who completed a thorough review of each domain and competency statement. **(See Appendix C: Domains 1-10)**
- These key members also reviewed the membership responses and incorporated their feedback in this document.

In our most recent and thorough review of the DE, these questions continued to come forward:

1. Are the proposed changes to the DE sufficient to enact bold and transformational efforts to move beyond cosmetic changes where a "biomedical/acute care centric embedded model" continues to lurk beneath the surface of each domain and competency that will silently and sometimes boldly diminish that "distant state of what the discipline of nursing needs to be"?
2. Is there real sustainable change in this work that will stop the discipline of nursing from doing something old (bio-medical/acute care centric model) and come out of the gate with the mindset of radical transformation (shifting to a population health mindset) of doing something new within the discipline of nursing?

These questions have been prompted by the following work of Drs. Fawcett and Ellenbecker (2015)[6]; Dr. Bekemeier (2008)[7]; and the recent *Future of Nursing 2020-2030* (National Academy of Medicine, 2020)[8] report. Dr. Fawcett and Ellenbecker have stated, "Improving the health of the nation's population by addressing system failures and factors that lead to these failures ***requires a shift in thinking from individually based disease care to population health care***" (Fawcett and Ellenbecker, p. 289). ***Nurses who comprise the largest group of health care providers***, ***are partially responsible for the poor health of the population because of a traditionally narrow focus on individuals and diseases***" (Fawcett and Ellenbecker, p.289). Dr. Bekemeier (2008) another leader in academia and practice, points out, ***nurses' participation in the current individual-centered health care system is a tacit agreement to improve "the health of the few" people they serve while at the same time participate, albeit with the best intentions, in "the illness and death of many"*** (p. 51). Finally, we have considered the tenets stated within the FON Report 2020-2030: 1) the nurse of the future, 2) the best path forward for creating a culture of health in the United States, 3) reducing health disparities, and 4) improving the health and well-being of our population (National Academy of Medicine, 2020). Given these calls to action, along with the new framework of the DE toward competency-based learning, one must envision the desired outcome at the end of an educational pathway (Englander, et al, 2013)[9], so our comments are framed with the end in mind, ***the nurse of the future and the role nurses play in being systems facilitators capable of creating a culture of health and health equity in the United States.***

In our review of the DE, we identified important issues have been identified that we would like to be addressed. A stark incongruence occurs between the introduction, the operationalization of the domains, competencies, and concepts. Disagreements exist, demonstrating inconsistency, lack of integration, and no standardization of population health concepts throughout the domains

and competencies. See **Appendix B** for an example. To resolve these issues with the DE, our key points are listed below.

- The DE needs to embrace the philosophical beliefs and foundational skills and practice of Florence Nightingale and the nursing metaparadigm which embraces the holistic care nurses provide, extending beyond the biomedical/acute care model and toward the comprehensive Nightingale model of nursing. She was an epidemiologist who considered the influence of the environment on health and included integrated concepts of holism when she developed the profession.
- The DE has biased language that leans toward an individual patient within an acute care environment, rather than inclusivity of "other points of care" across the life cycle continuum. The DE misses the opportunity to embrace a systems-based framework and accentuate that health includes places where people live, learn, work, play, worship and age.
- The DE lacks explicit integration of concepts (Health Policy, Evidenced-Based Practice, Compassionate Care, Communication, Clinical Judgment, Diversity Equity and Inclusion, Ethics and Determinants of Health) across the domains and competencies which does not provide the needed depth for understanding and operationalization across the curriculum.

Respectfully Submitted,

Lori Edwards, DrPH, MPH, BSN, RN, APHN, BC

Krista Jones, DNP, MSN, RN, PHNA-BC

Joy E. Hoffman, DNP, RN, PHNA-BC

Regina (Gina) H. Johnson, MS, RN

Susan Harrington, PhD, RN,

Ann M. Stalter, PhD, RN, M. Ed.

Gina Alexander, PhD, MPH, MSN, RN

Florence Weierbach, PhD, MSN, MPH, RN

Kelly Strickland, MSN, RN

Pam Levin, PhD, APHN-BC

Appendix A: Polling of ACHNE Membership

NOTE: Members of ACHNE were asked to review the Essentials and provide feedback, comments, or suggestions. The following is a synthesis of their collective expertise, knowledge and recommendations. Members from 10 different states represented an array of perspectives across the U.S.

I. What does ACHNE membership like best about the Essentials?

- The *Essentials* are more streamlined [BSN, MSN, DNP]; instead of separate for each degree process.
- The four spheres of care…are the way of the future for nursing education.
- The domains listed as competencies provides less of a silo focus and is more comprehensive
- It is forward thinking.
- The two-level perspective of nursing rather than multiple levels defined by different degrees is better. This makes it easier to explain to consumers.
- Thrilled to see the emphasis on social justice and structural racism.
- Improved emphasis on system-based practice.
- Emphasis and inclusion of population health, increasing knowledge about payment structures and application, and coordination of care, outside of an acute care focus.
- The inclusion of the terminology on health equity, health disparities, social determinants of health, interoperability, nursing informatics.
- The Essentials Model encourages scaffolding and transitioning nursing knowledge and education.

II. What do you think is missing?

- Specific tools or templates to help guide the curriculum.
- The Population Health Domain seems to have been written without input from Public Health Nurses. The three pillars of public health [assessment, policy and assurance] seems to have been danced around in the document. If the competencies were divided into 3 main competencies of: 1. Assessment, 2. Policy, 3. Assurance, it would make the most sense, with sub competencies included under one of these larger 3 competencies. The 4th competency could be emergency preparedness. It should be re-shuffled a bit.
- Disaster preparedness, response, and recovery needs to be evident…BSN or advanced nursing education.
- There is not enough on family and community. Person-centered care is better than patient-centered.
- Family based care is missing.
- Systems based practice is more abstract that just a focus on current issues and the health care expenditures. Systems thinking has been advanced by Phillips, Stalter, and Dolansky. Their work addresses an incremental approach inclusive of quality and safety to help advance beginning, intermediate and advanced level nurses toward leading in complex health care systems. Perhaps adding the words "within each sphere of nursing care and across the health care continuum" to 7.1b. Optimizing

system efficiency might be less abstract and more specific if explained as generating a positive impact.

- The link between thinking and doing as having an indirect impact *on the whole* is missing. Consider adding a competency that reads something like: Appreciates the impact of one's decisions within the practice environment (sphere of care) and acts upon information that can yield improved system level change.
- The Massachusetts Nurse of the Future system-based practice competency brought this link together nicely in the discussion of the work unit. Perhaps modifying this to include the spheres might be a helpful approach.
- It seems that an RN-BSN level is missing. We have experienced nurses that can meet aspects of both the entry level and advanced levels. I encourage you to consider using 3 tiers that take into consideration previous experience in education and health care such as LPNs/LVN, military, RN-BSN, and other experienced personnel.
- The concept of 'Community as Client' is important and should not be left out.
- When care for individuals, nurses need think about the population and what are the implications for chronic care and communities as places where care is provided.
- Needs more specificity, and stronger language that calls out structural racism. Nursing is very white privileged, and without centering structural racism language, we are not effectively calling out the need to address systemic oppression and suppression, and the terms equity, diversity and inclusion do not carry the same message that we are talking about dismantling systems. (page 6 when EDI is first introduced could be strengthened).
- Be explicit with language that embraces a focus on primordial factors as in the social determinants of health. Nursing left the holistic perspective in academia these last 25 plus years by not highlighting and encompassing nor valuing the prevention aspect of in order to have health we have to address housing, education, living wages, etc.
- Person - centered care should be defined this definition may extend to one's community/population pending upon what level a nurse may be working at. My "person-centered" care is at the community and population level.
- I don't see mention of climate change and preparing from an emergency preparedness and health impact perspective this is included as an important and rapidly emerging priority in nursing education. Climate change and health related impacts will affect the nursing profession at every level of nursing there is wherever one's practice is.
- The population health domain is better supported by the community/public health nursing competencies of which designates tiers based on educational background, sphere of care, and experience.
- Concepts and domains are broad enough and the geographic and contextual settings are subsumed.
- More direction on how nursing programs will provide the education and measure competencies.

III. What do you still have questions about or need more information on?

- It needs a stronger public health upstream focus. For example, competencies around vaccines should not only focus on giving the vaccine but planning for distribution of vaccines is clearly a nursing competency.
- The population health domain is better supported by the community/public health nursing competencies which designate tiers based on educational background, sphere of care and experiences.
- Can schools be flexible in differentiating MSN and DNP programs?
- Need a clearing house to provide access to content experts nationally and even globally to offer nursing students the best of the best (on-line/ virtual). Rural schools do not have access to content experts, which is a huge disparity
- Since practice is never static, how can we as expert educators continue to contribute? While it is a good start, refinement is needed to focus more on public health upstream factors.
- How can we ensure students engage with other health professionals if our agencies and schools do not offer such experiences?
- Some competencies are not realistic.

IV. How can AACN help you implement the new Essentials, such as tools, resources, and faculty development?

- Have workshops to help faculty integrate the Essentials.
- Toolkit, modules, and evolving materials that are links with updated information
- Faculty development will be instrumental along with suggested resources for curriculum redesign.
- Faculty development is needed with tools and conferences with diverse nursing experts so planning can be in inclusive environments.
- Skill development in social change focused on anti-racism in needed.
- A guide on ways to redesign curricula to meet the competencies.
- Provide virtual consultants to come into curriculum meetings
- Connect nursing programs in a collaboration of best or soon to be best practices. There may be programs that have already created these new changes, let's share.
- Advocate for funding and time to learn and implement. Faculty working 90 hours/ week, 52 weeks of the year, without time and adequate faculty will shoulder the responsibilities to accomplish this. It requires policies at all levels to support faculty's time to implement.
- Faulty development is critical for an effective transition.
- Seated at the table include key stakeholders such as nursing educators, organizational leaders, and NCSBN.

Appendix B: Important Issue for the TETF to Address

Stark incongruence occurs between the introduction, the operationalization of the domains, competencies, and concepts. Disagreements exist, demonstrating inconsistency, lack of integration, and no standardization of population health concepts throughout the domains and competencies.

The introduction of the DE provides an overview of the re-envisioned essentials. We applaud the TETF for forward thinking and creating an essentials document that will not only be relevant today, but also for the future ahead.

It is clear in the introduction of the DE there is a concerted effort in shifting the "nursing angle of vision" (Thorne, 2014[10], p.1; AACN, DE, pp. 3 and 18) from an individually-based disease (bio-medical model) where some previous "nursing education has emphasized clinical education in acute care"(p.7) to a broader approach where the role of the professional nurse is toward four Spheres of Care (Wellness and Disease Prevention; Chronic Disease Management; Regenerative/Restorative Care; Hospice/Palliative Care (pp. 7 and 20). Regardless of setting, "the goal of nursing is to support, enhance, and achieve optimal levels of wellness; to prevent illness, to restore health, and to alleviate suffering, while "considering the influence of environment on an individual's health and recovery" (p. 2). These "four spheres unify the various aspects of nursing" (AACN, DE, p.3) ***in all settings and in all cases.*** The discipline of nursing will always be focused on the individual, family, community and system whose wellness, health, or illness is at issue (Green, 2019)[11].

> However, the DE domains and competencies fall short in taking a more systems approach across all the domains and leveraging the four spheres that really unify the various aspects of the discipline of nursing ***from a population health approach***. As Dr. Fawcett and Ellenbecker note: "The primary focus of the Conceptual Model of Nursing and Population Health (CMNPH) is attainment of the highest possible quality of life for aggregates of people by means of nursing activities directed to promote or restore and maintain wellness and to prevent disease, thus making it relevant to both the improvement of population health ***and*** the practice of nursing" (Fawcett and Ellenbecker, 2015, p. 290).
>
> A capacity for nurses to participate in cognitive shifting back and forth among micro to macro level foci (individual, nurse, environment, and/or health) characterizes systems thinking. Two analogies that are often used are 1) a big picture perspective and 2) stepping away from or taking a crow's nest view of a situation at hand. The capacity to act upon that which predicts change, improves outcomes, and offers return on investments characterize systems-based practice.

The TETF makes clear in the introduction the continued focus on the expectations of the discipline of nursing regarding knowledge, skill and application across the educational trajectory. There are clear expectations centered on the ten domains with explicit

competencies for professional nursing practice and advanced nursing practice. Having a common set of domains across health care professions, employer-base, learners, faculty and the public provides a common language. This type of educational/practice pathway is not new to our ACHNE faculty and practice partners. We have a long, solid, and dedicated focus using this same structure with our *2018 Quad Council Competencies for Community and Public Health Nursing*[12]. This document houses eight domains, is competency-based, and has a tiered approach across three educational trajectories. It is a shared document across faculty and practice partners. The competencies build from entry to practice to advanced levels of knowledge, skill and application.

> We understand the challenge of leveraging the educational trajectory and recognize how the competencies and sub-competencies need to align. We found in some of the scaffolding there is inconsistency. One example, is found in the use of the terms diversity, equity and inequity, and inclusion. In the introduction of the DE, diversity, equity, inequity, and inclusion are mentioned several times and are acknowledged as a concept, "The integration of concepts within the competencies and sub-competencies is essential to ensure an application throughout the educational experience. As an example, can you imagine talking about person-centered care without also talking about diversity, equity, and inclusion?" (p.13)
>
> In Domain 2, Person-Centered Care, the concept of health equity or inequity does not appear within the competency for the Entry-Level Professional Nurse; however, it does appear as a competency at the Advance Level of Nurse Practice (2.1.e). This omission of addressing health inequities under the Domain of Person-Centered Care seems to be a negligent omission given the pervasive epidemic of inequities that exist in our US health care system and the language provided in the introduction (pp. 4 and 6). At the least, the entry-level professional nurse should be able to assess and address the health inequities for social needs (housing, transportation, food insecurity, access to care) within this domain.

The DE provides acknowledgement that "nursing education must refocus and move beyond previously held beliefs, such as primary care content is not important because it is not on the NCLEX-RN examination; students only value those skills required in acute care settings; faculty and preceptors only have limited community-based experiences" (AACN DE, 2020, p.8). ACHNE faculty members are aware of this issue with their content area being de-valued due to the content not being a focus on NCLEX; the notion that anyone can teach community/public/population health (C/PHN) content; and a history of clinical hours being cut from C/PHN only to be replaced with more acute care clinical hours; or didactic or clinical faculty unsure how to apply population health content to any and all settings. Our organization wrote a white paper, ACHNE Academic Faculty Qualifications for Community/Public Health Nursing (2009)[13], as a guide for deans and program directors due to the "shortage of qualified nursing faculty and the

difficulty in having sufficient numbers of faculty who are educationally and experientially qualified to teach in the Community/Public Health Nursing specialty" (p.1). This continues to be a concern for operationalizing the new essentials.

In many respects, those of us who have been a part of this work and past *Essentials* work, the words on the introductory pages read like *déjà vu*. The context remains the same with cosmetic changes.

Excerpts of past *Supplements and Essential* documents: Same words, but will there be a different story?

Excerpts from, *Public Health: Recommended Baccalaureate Competencies and Curricular Guidelines for Public Health Nursing, A Supplement to the Essentials of Baccalaureate Education for Professional Nursing Practice, 2013*:

> "Promoting health requires an educational focus that differs significantly from the illness-focused acute care skills traditionally taught in baccalaureate nursing programs. The AACN Essentials of Baccalaureate Education for Professional Nursing Practice (2008) in delineating the outcomes expected of graduates of all baccalaureate nursing programs clearly recognizes the need for a strong curricular focus on population health…the need for professional nurses to engage in community and population assessment, health promotion, and interdisciplinary efforts to improve health has never been greater…The knowledge and skills needed to empower professional nurses to achieve these goals are many, and nursing education is challenged to provide them" (p.7-8).

Excerpts from the *AACN, The Essentials of Master's Education in Nursing, 2011*:

> The implementation of clinical prevention and population health activities is central to achieving the national goal of improving the health status of the population of the United States. Unhealthy lifestyle behaviors continue to account for over 50 percent of preventable deaths in the U.S., yet prevention interventions remain under-utilized in healthcare settings. In an effort to address this national goal, Healthy People 2010 supported the transformation of clinical education by creating an objective to increase the proportion of schools of medicine, nursing, and other health professionals that have a basic curriculum that includes the core competencies in health promotion and disease prevention (Allan et al., 2004; USHHS, 2000)" (p.24).

Excerpts from the AACN, *The Essentials of Doctoral Education for Advanced Nursing Practice, 2011*:

> Consistent with these national calls for action and with the longstanding focus on health promotion and disease prevention in nursing curricula and roles, the DNP graduate has a foundation in clinical prevention and population health. This

foundation will enable DNP graduates to analyze epidemiological, biostatistical, occupational, and environmental data in the development, implementation, and evaluation of clinical prevention and population health. Current concepts of public health, health promotion, evidence-based recommendations, determinants of health, environmental/occupational health, and cultural diversity and sensitivity guide the practice of DNP graduates. In addition, emerging knowledge regarding infectious diseases, emergency/disaster preparedness, and intervention frame DNP graduates' knowledge of clinical prevention and population health (p.15).

Appendix C: Review of Domains 1 - 10

Domain 1: Knowledge for Nursing Practice

Descriptor: Integration, translation, and application of established and evolving disciplinary nursing knowledge and ways of knowing, as well as knowledge from other disciplines, including a foundation in liberal arts and sciences. This distinguishes the practice of professional nursing and forms the basis for clinical judgement and innovation in nursing practice.

Contextual Statement: Knowledge for Nursing Practice provides the context for understanding nursing as a scientific discipline. The "lens of nursing", informed by nursing history, knowledge and science, reflects nursing's desire to incorporate multiple perspectives into nursing practice, leading to nursing's unique way of knowing and caring. Preparation in both liberal arts and sciences and professional nursing coursework provides graduates with the essential abilities to function as independent, intellectually foundation for the development of intellectual and practical abilities within the context of nursing. Further, liberal education is the key to the understanding of one's self and others; contributes to safe, quality care; and informs the development of clinical judgement.

Entry-Level Professional Nursing Education Advanced-Level Nursing Education

1.1 Demonstrate an understanding of the discipline of nursing's distinctive perspective and where shared perspectives exist with other disciplines

1.1c Understand the historical foundation of nursing as the relationship developed between the individual/community and nurse.

1.1d Articulate nursing's distinct perspective to practice (This needs to be more fully defined. Leaves much room for interpretation)

1.2b Develop intellectual curiosity. How would this be measured?

1.2c Demonstrate social responsibility as a global citizen who fosters the attainment of health equity for all. Wow.

a. What do you like about your domain/competencies? I do agree there needs to be more in nursing education on professional identity.

b. Have you identified any gaps, redundancies, and/or concerns? Does the reference to liberal arts preparation mean there will be specific courses all schools should require? Right now pre-req's are similar but not all the same.

c. What do you still have questions about or need more information on? Liberal education as key- so will this be defined? What should make up this liberal education (are they talking pre-req's?)

d. How can AACN help you to implement the new Essentials, such as tools, resources, and faculty development?

Be specific, give lists, toolkits with resources- especially on history references to within the document.

Domain 2: Person Centered-Care

Descriptor: Person-centered care focuses on the individual within multiple complicated contexts, including family and/or important others. Person-centered care is holistic, just, respectful, compassionate, coordinated, evidence-based and developmentally appropriate.

Descriptor: Person-Centered care focuses on the individual within multiple complicated contexts including family and/or important others, where the individual lives, learns, works, plays, worships and ages. Person-centered care is holistic, just, respectful, compassionate, coordinated, evidence-based and developmentally appropriate.

Suggestion:
Multiple complicated context of care needs to be clear and well defined.

Rationale Related to the Change in the Descriptor:

- In the DE introduction it states:
  - "Competencies for professional nursing practice and advanced nursing practice are made explicit.
  - "…nursing is to be both a science and an art…conceptualizes the whole patient (mind, body, and spirit) …The influence of the environment on an individual's health…was of utmost importance…the interconnectedness with the multidimensional environment…" (p.2)
  - The DE provides acknowledgement that "nursing education must refocus and move beyond previously held beliefs, such as primary care content is not important because it is not on the NCLEX-RN examination; students only value those skills required in acute care settings; faculty and preceptors only have limited community-based experiences" (AACN DE, 2020, p.8).
- For the care to be "holistic" and evidence-based, the nurse needs to assess the environment of where the individual lives, learns, works, plays, worships, and ages. "To solve the fundamental challenges of population health, ***we [nurses] must address the factors that influence a person's overall health and well-being***. Education, safe environments, housing, transportation, economic development, access to healthy foods, access to care — these are the major social needs and determinants of health comprising the conditions in which people are born, live, work, and age"(Public Health 3.0)[14] and (Castrucci & Auerbach, 2019)
- County Health Rankings[15] have demonstrated that 80% of our health indicators/outcomes occur where individual lives, learns, works, plays, worships and ages.
- COVID 19 has brought to the forefront that health inequities have not diminished in the U.S. A population health perspective concentrates intervention at the SDOH as one way to focus on the inequities that currently exist. Per the Centers for Disease Control and Prevention's Promoting Health Equity[16] resource guide the SDOH are the "life enhancing resources, such as food supply, housing, economic and social relationships, transportation, education, and health care,

whose distribution across populations that effectively determines length and quality of life" (p. 6). Nurses have a role in adopting an understanding of population health, at an individual level, as contingent on addressing structurally embedded SDOH, they can be well-positioned as leaders in these efforts.

Contextual Statement: Person-centered care is the core purpose of nursing as a discipline. This purpose intertwines with any functional area of nursing practice, from the point of care where the hands of those that give and receive care meet, to the point of systems-level nursing leadership. Foundational to person-centered care is respect for diversity, differences, preferences, values, needs, resources, and the determinants of health unique to the individual. The person is a full partner and the source of control in team-based care. The focus of person-centered care is the individual and requires the intentional presence of the nurse seeking to know the totality of the individual's lived experiences and connections to others (family, important others, community). As a practice discipline, nurses employ a relational lens that fosters mutuality, active participation and individual empowerment. This focus is foundational to educational preparation from entry to advanced levels irrespective of practice areas.

With an emphasis on diversity, equity, and inclusion, person-centered care is based on best evidence and clinical judgment in the planning and delivery of care across time, spheres of care, and developmental levels. Contributing to or making diagnoses is one essential aspect of nursing practice and critical to an informed plan of care. Diagnoses at the system-level are equally as relevant, affecting operations that impact care for individuals. Person-centered care results in shared meaning with the healthcare team and the healthcare system, thus creating humanization of wellness and healing from birth to death.

Suggestions:

Point of Care: needs to be defined to include diversity in practice-settings, such as where individuals live (individual/family/community), learn (K-12 Schools and Universities), work (worksites), plays, worships (Faith Based Communities), and ages (Assisted Living, Long Term Care, and Acute Care, Ambulatory Care, Telehealth).

If there is a diversity in practice areas, there is shared meaning beyond a "health team and health care system". If I am in a school nurse practice position, my team may be a teacher and principle. If I am an occupational health nurse, my team might include the human resource director or CEO of the company.

Entry-Level Professional Nursing Education	**Advanced-Level Nursing Education**
2.1 Engage with the individual in establishing a caring relationship.	
2.1a Demonstrate qualities of empathy.	2.1d Promote caring relationship to optimize outcomes.
2.1b Demonstrate compassionate care.	2.1e Foster caring relationships to mitigate the impact of health inequities.

2.1c Establish mutual respect with the ~~patient~~ individual and family.	
Within this competency and sub-competency, should the BSN assess health equities or inequities, if the advanced level nurse is to mitigate impact of health inequities?	
2.2 Communicate effectively with individuals.	
2.2a Demonstrate relationship-centered communication.	2.2f Demonstrate advanced communication skills and techniques using a variety of modalities with diverse audiences.
2.2b Consider individual values in communications. I am curious why beliefs are not added here. There are certain indigenous beliefs that need to be considered.	2.2g Demonstrate emotional intelligence in all communications.
2.2c Use a variety of communication modes appropriate for the context. Rather than saying a "variety of communication modes" Motivational Interviewing should be added as a requirement, to have the knowledge, skill, and application if at the Advanced Level the Nurse would need to employ Motivational Interviewing.	2.2h Employ motivational interviewing.
2.2d Demonstrate the ability to conduct sensitive or difficult conversations.	2.2i Design evidence-based person-centered engagement materials.
2.2e Use evidence-based patient teaching materials, considering health literacy, vision, hearing, cultural sensitivity, and health inequities / social needs to inform person-centered interventions.	2.2j Apply personalized information, including genetic/genomics, to health care.
2.2k Facilitate difficult conversations and disclosure of sensitive information.	
2.3 Perform an assessment.	
2.3a Obtain a complete and accurate history in a systematic manner. Including an assessment of where individuals live, learn, work, play, worship and age; there social needs (housing, food insecurity, domestic violence, transportation, and utility needs) and other inequities. Add to either 2.3a or 2.3b.	2.3e Apply knowledge and skills of comprehensive assessment performance to area of advanced nursing practice.
2.3b Perform a ~~clinically~~ ~~relevant~~ holistic, health assessment. Including an assessment of where individuals live, learn, work, play, worship and age; the social needs (housing, food insecurity, domestic violence, transportation, and utility needs) and other inequities. Add to either 2.3a or 2.3b.	2.3f Employ appropriate screening and diagnostic protocols based on assessment findings, social needs (housing, food insecurity, domestic violence, transportation, and utility needs) ~~and determinants of health.~~ Determinants of health could be addressed in another domain, such as Population Health, Quality and Safety, Systems-Based Practice.

2.3c Perform point of care screening/diagnostic testing (e.g. social needs (housing, food insecurity, domestic violence, transportation, and utility needs), psychological testing, blood glucose, PO2, EKG). Adding screening makes it consistent with 2.3f. Foundational to person-centered care is respect for diversity, differences, preferences, values, needs, resources, and the determinants of health unique to the individual.	2.3g Communicate a comprehensive assessment.
2.3d Distinguish between normal and abnormal health findings.	
Suggested Reference for this section: Health Affairs (Castrucci, B. and Auerbach, J. (2019). Meeting individual social needs falls short of addressing social determinants of health. *Health Affairs Blog*, January 16, 2019. DOI: 10.1377/hblog20190115.234942 https://www.healthaffairs.org/do/10.1377/hblog20190115.234942/full/ 17	

2.4 Diagnose actual or potential health assets, problems and needs. The emphasis is to the negative. Suggest the assets as well as "problems and needs".	
2.4a Synthesize assessment data in the context of the individual's ~~patient's~~ current preferences, situation and experience. Removal of patient. Not consistent with domain descriptor person-centered care.	2.4e Employ advanced clinical reasoning to the diagnostic process.
2.4b Create asset and problem list. Suggest asset and problem list.	**This is a very bio-medical model!** 2.4.f. the way it is currently written is incongruent with the introduction and the direction the committee hopes to move the focus within nursing education and practice. Differentiate the Practice Domain. For DNP, specializing in direct 1:1 Care Yes! 2.4f Integrate knowledge of physiology, pathophysiology, and pharmacology into decision making in advanced nursing practice. For DNP, specializing in Public Health, Leadership, Informatics, NO!

	2.4g Integrate knowledge of epidemiology, environmental health, and emergency preparedness into decision making in advanced nursing practice. These students need to know epidemiology, environmental health, and emergency preparedness.
2.4c Prioritize problems.	
2.4d Understand the results of social screening needs (housing, food insecurity, domestic violence, transportation, and utility needs), psychological testing, ***and*** laboratory data, imaging studies and other diagnostic tests. This is a very bio-medical model of thinking. Employing a population health perspective, the nurse would understand the results of social screening needs (housing, food insecurity, domestic violence, transportation, and utility needs), psychological testing, ***and laboratory data, imaging and other diagnostics tests.*** "understanding health within the jurisdiction of the "persons lived experience" by collecting, monitoring, and analyzing data on health and factors that influence health to identify threats, patterns, and emerging issues, with a particular emphasis on disproportionately affected populations". At the minimum UGs should understand those threats at an individual level for example: food deserts/lead in water / ground / home or even COVID (churches, health care environments, small spaces (restaurants).	
2.4e Contribute as a team member to the formation and improvement of diagnoses.	

2.5 Develop a plan of care.	
2.5a Engage the ~~patient~~ individual/community and the ~~interprofessional~~ team in plan development. Removal of patient. Not consistent with domain descriptor person-centered care. Interprofessional infers "outside" of nursing. Engagement may be intra-professional and paraprofessionals (nursing assistants, community health workers, or other). Suggest using "team".	2.5g Lead an interprofessional team to collaboratively develop a comprehensive plan of care.
2.5b Organize care based on mutual health goals.	2.5h Prioritize risk mitigation strategies to prevent or reduce adverse outcomes.
2.5c Prioritize care based on best evidence	2.5i Develop evidence-based interventions to improve outcomes and safety.
2.5d Incorporate evidence-based intervention to improve outcomes and safety.	2.5j Incorporate innovations into practice when evidence is not available.
2.5d Anticipate outcomes of care (expected, unexpected, and potentially adverse).	
2.5e Demonstrate rationale for plan.	
2.5f Address ~~patients'~~ individual/community experiences and perspectives in designing plans of care.	

Removal of patient. Not consistent with domain descriptor person-centered care.

2.6 Demonstrate accountability for care delivery.	
2.6a Implement individualized plan of care using established protocols that integrates the values, beliefs, social issues, health equity. A protocol is only as good as the resources provided to an individual or community. If the resource is not there or available or if policies stand in the gap you are talking to a "brick wall".	2.6e Model best care practices to the ~~healthcare~~ team. Suggest using "team". This assumes every advanced practice nurse is going to be working with a "health care" team. Consider, School Nurse, Occupational Health Nurse. Keep it broad.
2.6b Communicate care delivery through multiple modalities. Clarity needed on multiple modalities.	2.6f Monitor metrics to assure accountability for care outcomes. Consider adding "epidemiological" metrics or population health metrics.
2.6c Delegate appropriately to ~~healthcare~~ team members. This assumes every nurse is going to be working within a health system.	2.6g Promote delivery of care that supports practice at the full scope of education.
2.6d Monitor the execution of the plan of care.	2.6h Contribute to the development of policies and processes that promote transparency and accountability.
2.6i Apply current and emerging evidence to the development of care protocols.	
2.6j Ensure accountability throughout transitions of care across the health continuum.	

2.7 Evaluate outcomes of care.	
2.7a Reassess the individual to evaluate health outcomes/goals. Should also include inequities in care	2.7d Analyze data to identify gaps and inequities in care and monitor trends in outcomes.
2.7b Modify plan of care as needed.	2.7e Monitor system-level aggregate data to determine healthcare outcomes and trends. Using epidemiological data
2.7c Recognize the need for modifications to standard practice. Should also include inequities in care	2.7f Synthesize outcome data to inform evidence-based practice, guidelines, and policies.

2.8 Promote self-care management for individuals.	
2.8a Assist the individual to engage in self-care management.	2.8f Develop strategies that promote self-care management.

2.8b Employ individualized educational strategies based on learning theories, methodologies, and health literacy.	2.8g Incorporate the use of current and emerging technologies to support self-care management.
2.8c Educate ~~patients~~ individuals/communities regarding self-care for health promotion, illness prevention, and illness management. remove patient use individual/community	2.8h Use counseling techniques to advance wellness and self-care management among colleagues, staff, and recipients of health care.
2.8d Respect ~~patients'~~ individual/family/community self-determination in their health care decisions.	2.8i Evaluate adequacy of community resources available to support self-care management
2.8e Identify community resources available to support self-care management. 2.8.e. - community is only mentioned twice at an entry level- this needs to be stated intentionally - one cannot identify resources unless they know how to assess for those resources. Perhaps, include as part of the holistic assessment	2.8j Foster partnerships with community organizations to support self-care management.
2.8k Educate individuals to enhance their participation in shared care decision making.	

2.9 Provide care coordination.	
2.9a Facilitate continuity of care based on assessment of assets and needs. Only focusing on needs fails to include the potential assets the individual/community brings to the care coordination. An example, a student is seen by the school nurse to help with asthma or diabetes management. The school nurse is an asset. OR, an employee goes to see the occupational health nurse at their work to monitor BP, the occupational health nurse is an asset.	2.9e Evaluate communication pathways among providers and others across settings, systems and communities.
2.9b Communicate with relevant stakeholders across health systems. Clarity is needed between stakeholders, health care team, and interprofessional team. Suggest a term that would be inclusive of (health care team, interprofessional team, stakeholder, and paraprofessional).	2.9f Develop strategies to optimize care coordination and transitions of care.
2.9c Promote collaboration by clarifying responsibilities among ~~patient~~ individual, family, community and team members.	2.9g Lead the coordination of care across health systems.

2.9d Recognize when additional expertise and knowledge is needed to manage the patient.	2.9h Analyze system-level, DOH, and public policies influence on care coordination.
2.9i Participate in system level change to improve care coordination across settings that remove barriers addressing social needs, health inequities, determinants of health and/or structural system barriers.	

Domain 3: Population Health

Descriptor: Population health spans the healthcare delivery continuum and describes collaborative activities among stakeholders for the improvement of an equitable population health outcome. Population health is the embedded assessment and delivery of health care in the interaction(s) with individuals and groups of individuals. It is an overarching/integrated umbrella of patient care to include traditional public health, clinical health care and policy development and advancement.

Contextual Statement: A population is a discrete group that the nurse and others care for across settings at local, regional, national, and global levels. Population health spans the health care delivery continuum and describes collaborative activities among stakeholders for the improvement of a population's health status. The purpose of these collaborative activities, including interventions and policies, is to strive towards health equity. Is health equity the only purpose and the only outcome to strive for?

Diversity, equity, inclusivity, and ethics must be emphasized and valued. Accountability for outcomes is shared by all, since outcomes arise from multiple factors that influence the health of a defined group. Population health includes population management through systems thinking, including health promotion and illness prevention, to achieve population health goals (Storfjell, et al., 2017). In addition, nurses respond to crises and provide care during emergencies, disasters, epidemics or pandemics. They play an essential role in system preparedness and ethical response initiatives. Although each type of public health emergency will likely require a unique set of competencies, preparedness for responding begins with a population health perspective and a particular focus on surveillance, prevention and containment of factors contributing to the emergency.
Is there a place at the planning table/ systems thinking for nurses?

Population Health
Across the curriculum and Across various contexts
Components of Population Health: DOH, measurability of disease spread or impact, interventions
Use of system thinking in population / why the need to think in systems in population health
Population tools (assessment/implementation/significance of distribution of outcomes)
The role of population health in behavioral health
Program planning, design, and development in population health (population health management)
Do we discuss/list competencies for healthcare reimbursement models
Do we discuss/teach value-based care or Population-based Theories

The Essentials provide a comprehensive overview of the needed/expected competencies of future nurses … graduating from any and all of the schools of nursing across this nation. The identification of gaps (practice) has been identified and a consistent set of domains and levels developed. This is a significant growth movement in nursing. This document needs to be viewed as a starting point/bridge between education and entry into practice (baccalaureate and graduate levels).

The Domains represent the unified voice of nursing and the trajectory of the profession as viewed from the lens of nursing education. The purpose of the Domains needs to be understood. They represent the future in the profession of nursing / the needed consistency in knowledge and skills required to meet the challenges of health care.

The Population Health Descriptor (Domain 3): Population health spans the healthcare delivery continuum and describes collaborative activities among stakeholders for the improvement of an equitable population health outcomes.

Embedded in this Domain is the necessity of a major refocus of nursing practice from acute care to primary care. The significance of population health appears blunted by the lack of verbiage and attributes listed in this document. How will the significance be upheld and emphasized in nursing curriculum? Additionally, the term population management is not expounded upon or defined as a concept/construct of delivery in a nursing curriculum (Swartout & Bishop, 2017). For the sake of continued consistency, will a glossary of terms or a tool kit per domain be developed?

Entry-Level Professional Nursing Education	Advanced-Level Nursing Education
3.1 Manage population health. **Across various contexts. Apply evidence based interventions to identified aggregates. More effective interventions.**	
3.1a Define a target population including its functional and problem-solving capabilities (anywhere in the continuum of care) through effective use of data and analysis.	3.1g Assess the efficacy of a system's capability to serve a target sub- population's healthcare needs. The competency should cut across all domains of practice if it is genuinely population-focused
3.1b Assess health status outcomes data, including health determinants, assets, barriers, and inequities.	3.1h Analyze primary and secondary health status outcome data for multiple populations against relevant benchmarks.
3.1c Assess the priorities of the community/population, history, assets, challenges, dynamics, and patterns of collaboration.	3.1i Use established or evolving methods to determine population-focused priorities for care. The competency should cut across all domains of practice. Some assumptions can be made based on obvious practice settings.
3.1d Compare and contrast local, regional, national, and global benchmarks to identify health patterns across populations.	3.1j Develop a collaborative approach with relevant stakeholders and community members to address population healthcare needs, including evaluation methods.
3.1e In collaboration with the members of the community and/or affected clinical population, develop an action plan to meet an identified need(s), including evaluation methods.	3.1k Collaborate with appropriate stakeholders to implement a sociocultural and linguistically responsive intervention plan.

3.1f Participate in the implementation of sociocultural and linguistically responsive interventions.	
3.2 Engage in effective partnerships.	
3.2a Engage with other health professionals to address population health issues	3.2d Create collaborative opportunities for individuals and organizations to improve population health.
3.2b Demonstrate effective collaboration and mutual accountability with relevant stakeholders, members of the community and/or affected clinical population.	3.2e Challenge biases and barriers that impact population health outcomes.
3.2c Use culturally and linguistically responsive communication strategies.	3.2f Evaluate the effectiveness of partnerships for achieving health equity.
	3.2g Lead partnerships to improve population health outcomes.
	3.2h Assess preparation and readiness of partners to organize during natural and manmade disasters.
3.3 Consider the economic impact of the delivery of health care. **Make argument for ROI**	
3.3a Describe access and equity resource implications of proposed intervention(s) in the context of structural competency.	3.3c Analyze cost-benefits of selected population-based interventions.
3.3b Prioritize community and/or patient-centric action plans that are safe, effective, and efficient in the context of available resources.	3.3d Collaborate with partners to secure and leverage resources necessary for effective, sustainable interventions.
	3.3e Advocate for interventions that maximize cost-effective, accessible, and equitable resources for populations.
	3.3f Incorporate ethical principles in resource allocation in achieving equitable health.
3.4 Advance equitable population health policy. **Contribute to policy formation/advancement**	
3.4a Describe the policy process and oppressive systems of power affecting implementation of change.	3.4f Identify opportunities to influence the policy process.
3.4b Describe the impact of policies on population outcomes, including social justice and health equity.	3.4g Design comprehensive advocacy strategies to support the policy process.

3.4c Identify best evidence to support policy development.	3.4h Engage in strategies with stakeholders and affected communities to influence policy change.
3.4d Propose modifications to or development of policy based on population findings.	3.4i Contribute to policy development at the system, local, regional or national levels.
3.4e Develop an awareness of the interconnectedness of population health across borders.	3.4j Assess the impact of policy changes
	3.4k Evaluate the ability of policy to address disparities and inequities within segments of the population.
	3.4L Evaluate the risks to population health associated with globalization.
3.5 Demonstrate advocacy strategies **Efforts to enlist support to a particular cause / purpose and effectiveness of lobbying**.	
3.5a Articulate a need for change. Employing advocacy to shape policymaking. Advancing policymaking to enhance population health efforts.	3.5f Appraise advocacy priorities for a population.
3.5b Describe the intent of the proposed change.	3.5g Strategize with others to develop effective advocacy approaches.
3.5c Define stakeholders, members of affected communities and/or clinical population, and their level of influence.	3.5h Engage in relationship-building activities with stakeholders at any level of influence, including system, local, state, national, and/or global.
3.5d Implement messaging strategies appropriate to audience and stakeholders.	3.5i Demonstrate leadership skills to promote advocacy efforts that include principles of social justice, diversity, equity, and inclusion.
3.5e Evaluate the effectiveness of advocacy actions.	
3.6 Advance preparedness to protect population health during disasters and public health emergencies. **Re-assess / Feedback loop related to preparedness plans throughout various disasters. Refine / Re-examine effectiveness response, mitigation, and recovery post disaster**	
3.6a Identify changes in conditions that might indicate a disaster or public health emergency.	3.6g Initiate rapid response activities to protect population health.

3.6b Describe Detail the health and safety hazards of disasters and public health emergencies.	3.6h Participate in ethical decision making that includes diversity, equity and inclusion in advanced preparedness to protect populations.
3.6c Describe the overarching principles and methods regarding personal safety measures, including PPE.	3.6i Collaborate to lead preparedness and mitigation efforts to protect population health with attention to the most vulnerable populations.
3.6d Implement infection control measures and proper use of personal protective equipment.	3.6j Coordinate the implementation of evidence-based infection control measures and proper use of personal protective equipment.
3.6e Describe general principles and practices for the clinical management of populations across the age continuum.	3.6k Contribute to system-level planning, decision making, and evaluation for disasters and public health emergencies.
3.6f Identify ethical principles to protect the health and safety of diverse populations.	
Resource for this domain: Meghan Swarthout, Pharm.D., M.B.A, Martin A. Bishop, Pharm.D., M.S, Population health management: Review of concepts and definitions, American Journal of Health-System Pharmacy, Volume 74, Issue 18, 15 September 2017, Pages 1405–1411, https://doi.org/10.2146/ajhp170	

Domain 4: Scholarship for Nursing Practice

Ideal Level 1 Nurse:

The level 1 nurse has the following attributes in the provision of providing care across the four spheres of care and three levels of prevention.

The nurse provides care that promotes health in accordance with the WHO definition of health. Care within the four spheres focuses on the client-nurse relationship through the lens of the social determinants of health with attention to inequities, structural racism and systemic inequities. Health promotion is an upstream approach that meets the client at their understanding and level of health. Disease management is a midstream approach that meets the client at their understanding and ability to manage their health, and alterations in their physiological or psychologic condition. Illness and disease treatment are a downstream approach that embraces the client at a time when their health is most fragile due to an alteration in systems that impact their ability to function physiologically and or psychologically.

Ideal Level 2 Nurse:

The level 2 nurse has the following attributes in the provision of providing care across the four spheres of care and three levels of prevention.

The advanced educated nurse builds on the level 1 nurse I the provision of specialized care that promotes health in accordance with the WHO definition of health, the four spheres focusing on the client-nurse relationship through the lens of the social determinants of health with attention to inequities, structural racism and systemic inequities. The advanced educated nurse has specialization in a specific area that focuses on public, community, population, family or individuals. Specialization includes advanced knowledge within a specialty practice that focuses on non-physiological and physiological systems. Advanced system knowledge is based on the specialty practice with each specialization determining the required concepts for the system(s) identified for their specialty. Examples of concepts for advanced system knowledge includes organizational/health systems for the nurse for the nurse executive, epidemiology/government systems for the public health nurse, pathophysiology for the nurse clinician. In addition, the advanced educated nurse is responsible for leading and collaborating with health care and non-health care teams in discerning and translating evidence into practice. Throughout advanced practice focus is placed on health promotion which is an upstream approach that meets the client at their understanding and level of health. Disease management is a midstream approach that meets the client at their understanding and ability to manage their health, and alterations in their physiological or psychologic condition. Illness and disease treatment are a downstream approach that embraces the client at a time when their health is most fragile due to an alteration in systems that impact their ability to function physiologically and or psychologically.

Descriptor: The generation, synthesis, translation, application and dissemination of nursing knowledge to improve health and transform health care.

The current contextual statement is narrow in its clinical focus. The four spheres of care need to be included within the contextual statement. Expanding the clinical focus provides an expansive view of nursing within the context of the levels of prevention which assists in placing emphasis on a holistic view of health, public health nursing, community-based care.

Revised Contextual statement: Focus is on the relationship of science to Scholarship and how science influences practice through implementation including policy, advocacy, interventions at the public, community, specific population, family and individual level. Scholarship includes discovery, application, integrations and teaching. Scholarship of discovery embraces primary empirical research, analysis of large data sets, secondary data analysis, theory development, methodological studies and community based participatory research. Scholarship of practice embraces evidenced based practice which interprets, draws together, applies findings from original research, develops contextually appropriate programs and engages recipients of care including the public, communities, specific population groups, families and individuals in accessible, available and acceptable interventions and programs. The scholarship of teaching focuses on the transmission, transformation and extension of knowledge (Boyer, 1999)

Knowledge of the basic principles of the research process, including the ability to critique research and determine its applicability to nursing's body of knowledge is critical. Ethical comportments in the conduct and dissemination of research and advocacy for human subjects are essential components of nursing's role across the four spheres of care and three levels of prevention. Focus is placed on the care provided in response to potential or actual alterations in health and associated condition(s) to the public, community, specific populations, families and individuals. Whereas the research process is the generation of best evidence into decision making that engages the public, community, specific populations, families and individuals that crosses the four spheres of care. It is paramount that research is operationalized by the nurse within the four spheres of care. Nurses must provide evidenced based care to the public, the communities, specific populations, families and individuals that are entrusted to their care. Nurses as innovators and leaders must engage and partner with recipients of care from the public to the individual in client focused care. Engagement and partnerships involve nurses to embrace collaboration across health and non-health care disciplines in addressing inequities, structural racism, systemic inequities that are associated with social determinants of health.

Advanced-Level Nursing Education

4.1i Engage in scholarship to advance health- Clarify scholarship-what aspect of the Boyer model

4.1k Collaborate to advance one scholarship. - Clarify scholarship-what aspect of the Boyer model

4.1m Advocate within the interprofessional team for the contributions of nursing scholarship.- Interprofessional team is narrow as it reflects health care professionals-change to include the health care team and other stakeholders-to include elected/appointed government officials and decision makers in business, non-profit, and faith-based organizations.

4.2i Evaluate potential impacts of policy and regulation in the face of new evidence.

4.2j Evaluate outcomes and impact of new practices based on the evidence.

4.2i and 4.2j Comment-The advanced-level nurse needs to be at the table when new policy/regulations are developed and when policies are revised. Suggest adding a new competency that addresses policy development-The advanced practice nurse should be at the table when policy is developed and revised. Recommended new competency: Collaborate in the development of new/revised policy and regulations when new evidence supports change.

4.3f Ensure the protection of participants and associated others in the conduct of scholarship. – Participants and associated other places focus on individuals, not on the whole. Recommended change: Ensure the protection of communities, populations, families and participants in the conduct of scholarship.

Domain 5:

General Comment/Concern

Across the document, 'patient' is used inconsistently. The Glossary states: ***Patient:*** *The term refers to the recipient of a healthcare service or intervention at the individual, family, community, aggregate level.* In this Domain and others, it is unclear whether community/aggregate is considered. Then, Domain8 (8.1) lists out 'care of patients, community, and population."

Domain 5: Quality and Safety

What do you like about the domain/competencies	• Contextual Statement: Recognition of synergy between worker health and safety and 'patient' care quality and safety • Competencies: recognition of psycho-social workplace hazards and incorporation of resiliency, well-being
Gaps, redundancies, and/or concerns	1. **Across Domain: Gap/Concern** • Use of the word 'provider' versus 'health care team'. Earlier in the document, there is much discussion around inclusion, equity. To insure quality and safety within the 'patient' care environment, requires consideration of all workers, e.g., nurses, assistants, clerical, housekeeping etc. In turn, considering professional behavior, nurses should be considering how their behaviors effect the health & safety of their fellow healthcare team members • Domain 6 uses 'care team members' rather than provider 2. **Descriptor Gap/Concern:** • Clarify that principles of safety and improvement science includes the science related to patient as well as worker safety. • As above, change *provider* to healthcare team 3. **Contextual Statement Gap/Concern:** *Safety is inclusive of attending to work environment violence, burnout, and ergonomics; there is a synergistic relationship between employee safety and patient safety.* • Per the CDC, NIOSH, OSHA, and the ANA, safety in the work environment inclusions consideration of more than psychosocial and physical hazards. Possible exposures to chemical and biological hazards also can effect both worker and patient health. • Possible rev: *Safety is inclusive of attending to work environment hazards, such as violence, burnout, ergonomics, chemical and biological agents; there is a synergistic relationship between employee safety and patient safety.* *Safety demands an obligation to remain non-punitive in detecting, reporting, and analyzing errors and near misses when they occur.*

	• As the earlier sentence focused on challenges viewed as system failures (*Quality or safety challenges are viewed primarily as the result of system failures, as opposed to the errors of an individual)* consider including a focus here on system level issue as well , such as possible exposures related to equipment, cleaning products, products etc. A past example is lack of alternative products provided across a system for those allergic to latex or preservatives used in latex gloves • Possible rev: *Safety demands an obligation to remain non-punitive in detecting, reporting, and analyzing errors, possible exposures, and near misses when they occur.* 4. **Competencies: Possible Redundancies** • across competencies within 5.3 and 10.1 • across sub-competencies 5.3g and 9.3n • across sub-competencies 5.3e and 10.1b 5. **Competencies: Gap/Concern** *5.3: Contribute to a culture of provider and work environment safety* • Revise to be inclusive of the healthcare team: *Contribute to a culture of ~~provider~~ healthcare team and work environment safety* • Include a sub-competency under Entry Level that parallels 5.2f for patient safety, to reflect use of national worker health and safety guidelines • 5.3a, possible revision: *Identify actual and potential level of risks to providers and team members within the workplace.* • 5.3b and 5.3c: revise to be more inclusive to the range of extensively documented hazardous exposures in healthcare work environments, beyond the psychosocial and physical hazards. And if the decision remains to limit to violence and injury, why was burnout dropped? • Include a sub-competency under Advanced Level that parallels 5.1n for patient safety OR revise 5.3f, to reflect that financial policies can impact safety within the work environment
Questions, more information needed	Across the sub-competencies in all of the Domains, I am not clear on the action verbs used re measurability. Was it expected that action verbs from Bloom's Taxonomy be used to ensure measurability?
How help to implement	Consider curriculum resources from NIOSH on healthcare worker safety and health, which includes collaboration with the ANA on shift work and long work hours: https://www.cdc.gov/niosh/topics/healthcare/default.html

Domain 6:

Interprofessional Partnerships (What about Intraprofessional and Paraprofessional Teams?)

Descriptor: Intentional collaboration across professions and with care team members, patients, families, and communities to optimize care, enhance ~~the~~ health~~care experience~~, and strengthen health outcomes for individuals, families, and communities.

Contextual Statement: Interprofessional, Intraprofessional, and Paraprofessional partnerships build on a consistent demonstration of core professional values (altruism, excellence, caring, ethics, respect, communication, and shared accountability) in the provision of team-based, person-centered care. Nursing expertise uniquely contributes to the intentional work within teams and in concert with patient, family, and community preferences and goals. Interprofessional, Intraprofessional, and Paraprofessional partnerships require a coordinated, integrated, and collaborative implementation of the unique knowledge, beliefs, and skills of the full team for the end purpose of optimized care delivery. Effective collaboration requires an understanding of team dynamics and an ability to work effectively in care-oriented teams . Leadership of the team varies depending on needs of the patient (this refers only to the individual level…) and context of care.

Entry-Level Professional Nursing Education	Advanced-Level Nursing Education
6.1 Communicate in a manner that facilitates a partnership approach to quality care delivery.	
6.1a Communicate the nurse's unique roles and responsibilities clearly.	6.1g Evaluate effectiveness of interprofessional communication tools and techniques to support and improve the efficacy of team-based interactions.
6.1b Use various communication tools and techniques effectively in a variety of settings (not just acute care).	6.1h Facilitate improvements in interprofessional communications of patient (individual level) information (e.g.EHR). example is mostly acute-care centric
6.1c Elicit the perspectives of team members to inform person care decision making.	6.1i ~~Role model respect for~~ Advocate for diversity, equity, and inclusion in team-based communications.
6.1d Articulate and acknowledge impact of diversity, equity, and inclusion on team-based communications.	6.1j Communicate nursing's unique disciplinary knowledge to strengthen interprofessional partnerships
6.1e Communicate patient information in a professional, accurate, and timely manner. Individual level	6.1k Provide expert consultation for other members of the healthcare team in one's area of practice.
6.1f Communicate as informed by legal, regulatory, and policy guidelines.	6.1L Lead resolution of interprofessional conflict.

	6.1m Formulate legal, regulatory, and policy guidelines with an interdisciplinary team
6.2 Perform effectively in different team roles, using principles and values of team dynamics.	
6.2a Apply principles of team dynamics, including team roles, to facilitate effective team functioning.	6.2g Integrate evidence-based strategies and processes to improve team effectiveness and outcomes.
6.2b Delegate work to team members based on their roles and competency.	6.2h Evaluate the impact of team dynamics and performance on desired outcomes for persons, families, and communities.
6.2c Engage in the work of the team as appropriate to one's scope of practice and competency.	6.2i Reflect on how one's role and expertise influences team performance.
6.2d Recognize how one's uniqueness (as a person and a nurse) contributes to effective interprofessional working relationships.	6.2j Foster positive team dynamics to strengthen desired outcomes for persons, families, and communities.
6.2e Apply principles of team leadership and management performance to improve quality and assure safety of persons, families, and communities.	
6.2f Evaluate performance of individual and team to improve quality and promote safety of persons, families, and communities.	
6.3 Use knowledge of nursing and other professions to address healthcare needs.	
6.3a Integrate the roles and responsibilities of ~~healthcare~~ professionals (shouldn't limit to just healthcare professionals) through interprofessional collaborative practice.	6.3d Lead interprofessional activities and initiatives.
6.3b Leverage abilities of team members to optimize care in a variety of settings.	6.3e Create interdisciplinary teams in a variety of care settings and contexts
6.3c Communicate with team members to clarify responsibilities in executing plan of care.	
6.4 Work with other professions to maintain a climate of mutual learning, respect, and shared values.	
6.4a Demonstrate an awareness of one's biases and how they may affect mutual respect and communication with team members.	6.4d Practice self-regulation and reflection to mitigate conscious and implicit biases toward other team members.
6.4b Demonstrate respect for the perspectives and experiences of other ~~health~~ professions.	6.4e Foster an environment that supports the constructive sharing of multiple perspectives and enhances interprofessional learning.
6.4c Engage in constructive communication to facilitate conflict management.	6.4g Integrate diversity, equity and inclusion into team practices.

6.4d Collaborate with interprofessional team members to establish mutual ~~healthcare~~ wellness goals for individuals ~~or~~ and populations.	6.4h Manage disagreements, conflicts, and challenging conversations among team members.
	6.4i Promote an environment that advances interprofessional learning.

Domain 7: Systems-Based Practice Descriptor: Responding to and leading within complex systems of health care. Nurses effectively and proactively coordinate resources to provide safe, quality, equitable care to diverse populations.

Italics is exactly what is written in the Proposed Essentials Document.
Regular Text is my thoughts/answers to the questions posed by the survey

Systems-Based Practice
Integrated healthcare systems that require coordination across settings as well as across the lifespans of diverse individuals and populations are emerging. Such systems are highly complex, where gaps or failures in service and delivery cause ineffective, harmful outcomes. These outcomes also span individual through global networks. As United States healthcare systems are revising strategic goals and reorganizing services to move more care from the most expensive venues – inpatient facilities and emergency departments - to primary care and community settings, cognitive shifting back and forth from focused to big picture is a crucial skill set. Similarly, the ability for nurses to predict change, employ improvement strategies, and exercise fiscal prudence should not be underestimated. Concomitantly, nurse employment settings are also shifting, creating a change in workforce distribution and the requisite knowledge and skills necessary to provide care in those settings. Knowledge differentiating equity and equality in healthcare systems and systems-based practice is essential. Evolving and integrated healthcare systems require nurses to lead the implementation of systems-based practice. This requires system's awareness, innovative thinking, and redesigning to address issues such as structural racism, systemic inequity, and discrimination. These examples do not downplay the importance of other health system priorities such as utilitarianism during disaster response, child and elderly abuse, human trafficking, opioid addiction, gender bias, etc. Equitable healthcare better serves the needs of all individuals, populations, and communities.

Nursing education, at both the undergraduate and graduate levels, must infuse the curricula with knowledge and skills in systems awareness (Phillips et al., 2016), change management, communication, team building, inclusivity as well as the development of competencies in informatics, data science, and design and systems thinking (Demeris, et al, 2020). These key competencies provide students with the tools to understand and implement innovative approaches. Importantly, an understanding of how local, national, and global structures, systems, politics, and rules and regulations contribute to the health outcomes of individual patients, populations, and communities will support students in developing agility and advocacy skills. Core values such as kindness, compassion and honesty must be fostered in the workforce socialization process so that transitions from academic to practice settings influence positive health effects. Factors such as structural racism, cost containment, resource allocation, and interdisciplinary collaboration are considered and implemented to ensure the delivery of high quality, equitable, and safe patient care (Plack, et al, 2018)

What do you like best about the new AACN Draft Essentials?

1. The spheres of care are nice.
2. Improved integration of systems-based practice to include today's challenges.

3. A unique compliment is Plack et al's. (2018) interprofessional effort. As a PT who works with Dr. Pintz at George Washington University, she leverages Dr. Pintz as a co-author for the proposed essentials (https://smhs.gwu.edu/news/margaret-m-plack-edd-dpt-pt-serve-interim-chair-department-clinical-research-and-leadership and https://nursing.gwu.edu/christine-pintz.) These are notable contributors for systems-based practice.
4. A unique compliment is Plack et al's. (2018) interprofessional effort. As a PT who works with Dr. Pintz at George Washington University, she leverages Dr. Pintz as a co-author for the proposed essentials (https://smhs.gwu.edu/news/margaret-m-plack-edd-dpt-pt-serve-interim-chair-department-clinical-research-and-leadership and https://nursing.gwu.edu/christine-pintz.) These are notable contributors for systems-based practice.

What do you think is missing?

1. Systems based practice is more abstract than its foci on current issues and the health care dollar. It builds from the foundation of systems thinking. System-based practice is the awareness that one's actions are at the microlevel (individual) extend through to macrolevels (families, communities, populations and organizations/systems). This involves making ethical and legal decisions based in professional standards of care and the profound comprehension that nursing actions can have a negentropic or synergistic effect as the "whole is more than than the sum of its parts" (Ludwig von Bertalanffy, 1968, p. 18).
2. Over the past several years, the science of systems thinking has been advanced by Phillips and Stalter. They began with a concepts analysis, developed a model, and completed integrated reviews exploring academic and practice systems. Their work addresses an incremental approach inclusive of quality and safety to help advance beginning, intermediate and advanced level nurses toward leading in complex health care systems.
3. Perhaps adding the words "within each sphere of nursing care and across the health care continuum" to 7.1b. Consider that the words "optimizing system efficiency" might be less abstract and more understandable if explained as *generating a positive impact organizational impact*.
4. A capacity for cognitive shifting back and forth among micro to macro level foci (man, nurse, environment, and/or health) characterizes systems thinking. Two analogies that are often used are 1) a big picture perspective and 2) stepping away from or taking a crow's nest view of a situation at hand.
5. The capacity to act upon that which predicts change, improves outcomes, and returns on investment characterize systems-based practice.
6. The link between thinking and doing as having an indirect impact on the whole is missing.
7. Consider adding a competency that reads something like: Appreciates the impact of one's decisions within the practice environment (sphere of care) and acts upon information that can yield improved system level change.

8. The Massachusetts Nurse of the Future competency brought this link together nicely in the discussion of the *work unit*. Perhaps modifying this to include the spheres might be a helpful approach.
9. Reference to systemic racism appears to have been added in as a response to political unrest of Summer 2020 in contrasted to an evidence-based phenomenon. Review medicine's definitions and examples of systems-based practice to reorient the focus of the description. https://www.umms.org/ummc/pros/gme/acgme-competencies/systems-based-practice
10. It seems that pathways to the undergraduate degree are missing. Our student audience, RN-BSN students, is completely missing. Although these nurses earn undergraduate degrees, they are *experienced* licensed nurses who can meet aspects of both the entry-level and advanced levels for competencies. Please consider using 3 tiers that take into consideration previous experience in education and health care such as LPNs, military, first responders, and the like.
11. It seems that a basic understanding of budgets is lacking. The Quad Council Competencies provide competencies specific to financial planning, evaluation and management skills using three tiers of experience/education. Please consider integrating these Quad Council Competencies into Domain 7 competencies.
12. To be clear, the document is deficit in systems awareness/thinking and leadership as incorporating ethical standards into organizations while mentoring others, reacting to change, preventing errors through continuous quality improvement, and advocating for policy changes that protect vulnerable peoples (including nurses), prevent disease, and facilitate equity. Again, the Quad Council Competencies specific to leadership and systems thinking skills use three tiers of experience/education. Please consider integrating these Quad Council Competencies into Domain 7 competencies.
13. The notion of workforce readiness to engage in crisis standards of care and to employ utilitarianism philosophies during disaster response is lacking. This ability is based in cognitive shifting which characterizes systems thinking and practice.

What do you still have questions about or need more information on?
The population health domain is better supported by the community/public health nursing competencies of which designates tiers based on educational background, sphere of care and experiences. Can these be added so that teaching/learning is more individualized and intentional for improved health and learning outcomes?

Domain 8: Informatics and Healthcare Technologies

a. What do you like about your domain/competencies?
   i. I like that informatics has matured as a domain with specific competencies necessary to promote effective use of data. So much has changed since 2008 in terms of capacity for technology to transform the spheres of care.
   ii. With emphasis on documentation and data management, standardized terminology is the gold standard: charting in the electronic health record, evidence-based practice and the provision of outcomes measurement.
   ii. I like that the five main competencies progress in a logical taxonomy, from identification to application: (8.1) identifying the tools used for communication and care; (8.2) applying tools to support data infrastructure; (8.3) applying tools for EBP to support safe, quality care for diverse populations across settings; (8.4) applying tools to support continuity of care and effective interprofessional communication; (8.5) implementing responsible use of data in compliance with ethical standards and policies.
b. Have you identified any gaps, redundancies, and/or concerns?
   i. The name of the domain narrows its focus to the healthcare setting (versus the cross-sector focus that is needed to have health in all policies, including the field of data science and analysis of big data –see below)
   ii. Sub competencies do not follow the logical taxonomy – they jump from higher level to lower level knowledge/skills.
   iii. The field of nursing informatics has grown, but very few faculty have expertise in this domain. How can we involve health information technology specialists to keep up with the possibilities? The learning curve is steep for all health professions faculty and students, and it will take intentional investments to keep up. What changes are necessary in nursing education to support sustainability, efficiency, accuracy, and currency in informatics?
   iv. The contextual statement mentions nurses interacting with communities and populations in technology-rich environments. However, there is no mention of the public health infrastructure for informatics, so this omission is another incongruence between the introduction and the operationalization of domain/competencies. The focus is (yet again) primarily on the private healthcare sector. The downstream focus on individual care is a consistent thread, as that is where most nurses practice at present. We need to extrapolate to a more upstream approach for the nurses of the future – so we should advocate for the inclusion of the community as client, as indicated in the introduction (redundancy would be valuable across domains/contextual statements).
c. What do you still have questions about or need more information on?
   i. How can we omit the need to modernize the public health infrastructure and the role of nursing informatics in the public health sector when we're in the middle of a pandemic?

ii. How can we build on the work of the TIGER/HIMSS initiative? It seems like this should be integrated as a resource somehow (see below).
iii. See other questions above.

d. How can AACN help you to implement the new Essentials, such as tools, resources, and faculty development?

i. This will be an area of profound need – not sure where to start to bring SONs up to speed, because the pace of change is extremely rapid. In addition, the digital divide is ever-present in rural and underserved areas (bandwidth, speed, and cybersecurity stewardship), so what are the ramifications for interoperability and seamless communication?

Resources/More Context (background information just scratches the surface)

Nursing informatics "is the specialty that integrates nursing science with multiple information and analytical sciences to identify, define, manage and communicate data, information, knowledge and wisdom in nursing practice" (ANA and HIMSS, 2020). Goal: Improve workflows for healthcare staff and best practices followed in the effective management of information structures, processes and technology.

- Technology Informatics Guiding Education Reform TIGER) is a grassroots initiative focused on education reform, fostering interprofessional community development and global workforce development. The spirit of TIGER is to maximize the integration of technology and informatics into seamless practice, education and research resource development.

- Nursing informatics resources for faculty are plentiful.
  - nursing informatics boot camps are available throughout the year. Refer to https://ania.org/nursing-informatics-boot-camp
  - Dr. Karen Monsen, director of the University of Minnesota Institute for Health Informatics offers a free Coursera on health informatics. Refer to https://www.coursera.org/instructor/karenmonsen
  - HIMSS (formerly TIGER) offers trainings and resources: https://www.himss.org/what-we-do-technology-informatics-guiding-education-reform-tiger

- TIGER landing page: https://www.himss.org/what-we-do-technology-informatics-guiding-education-reform-tiger

- Evolution of TIGER competencies: https://www.himss.org/sites/hde/files/media/file/2020/03/10/the-evolution-of-tiger-competencies-and-informatics-resources-final-10.2017.pdf

- CDC *Data Modernization Initiative*: https://www.cdc.gov/budget/documents/covid-19/COVID-19-Data-Modernization-Initiative-Fact-Sheet.pdf

- *A Roadmap to 21st Century Public Health Data Infrastructure* (Healthcare Information and Management Systems Society [HIMSS] webinar) https://www.himss.org/resources/roadmap-21st-century-public-health-data-infrastructure-webinar)

    - Public health infrastructure needs to be modernized. States are trying to rely on old systems and workforce gaps – significant investments are needed (all of the problems existed pre-COVID; operating crisis to crisis is unacceptable, and policymaking is critical). This time last year, CDC was drowning with surveillance/tracking of vaping/e-cigs).
    - Public health is far outdated – way out of pace with heavily invested healthcare and EHR developments – essentially zero investments in electronic case reporting and electronic lab and surveillance systems have resulted in profound problems.
    - This is not a science problem but a resource problem: all jurisdictions need to be online and well-integrated, using common systems that work across jurisdictions/states (cannot rely on fax machines but must have cloud-based data systems to maximize operability)
    - There are data science workforce needs – human capital AND technical capital – data alone is not enough, needs interpretation and must drive action and policy (public health hasn't been able to attract data scientists – stewardship is a complex skill set – they're all going to Google, so public health is fragmented)
    - Consolidated systems is the key; "garbage in; garbage out" (IT consultant)

Domain 9: Professionalism

Contextual Statement:

What could be added to the contextual statement:

A nurse is a leader who exemplifies professionalism in all that he/she does. Professionalism includes contextual awareness about the communities and populations where they work and live. Professionalism evolves over time through numerous career long experiences and the ongoing evaluation about one's relationship to the broader world, and a commitment to life-long learning and engagement as a moral citizen in society.

1) **Reflect on the following questions:**
    a. **What do you like about your domain/competencies?**
        - This domain highlights the importance of professionalism, and does include morals, ethics, and social justice. It also includes the concepts of mentorship.
        - Acknowledging that professionalism evolves through education is valuable, and that is it not linear is helpful.
        - Starting off with ethics and the statement that it is nursing's mission to society is clear and well defined, including emphasizing human rights.
        - Overall, the competencies in this domain were consistent and in line with Scope and Standards of professionalism.

    b. **Have you identified any gaps, redundancies, and/or concerns?**
        - Domain 9.2, describing participatory is individually focused. Also state participatory, and apply principles of participation and partnership when working with individuals and communities.
        - Domain 9.3, is focused on engaging in advocacy for the best interests of individual, community, and profession - Add family, and population.
        - Domain 9.3, state: Acknowledge historical and current inequities and structural and systemic racism and its impact on health
        - Domain 9.5e – Emotional intelligence – could add empathy
        - Domain 9.6a – Demonstrate respect for diverse individual differences, and diverse communities and populations
        - Domain 9.6 - Add facilitate care that considers health literacy (this is an added component to cultural and linguistic with specific competencies)
        - Domain 9.6 c – add human rights (directly state this)
        - Although mentoring is mentioned as a component of professionalism, it is only mentioned in a few competencies, such as "model" respect for .. Could add more language about mentoring.
    c. **What do you still have questions about or need more information on?**
        - How will emotional intelligence be fostered?
        - How can nurses commit to life-long learning and to improving the societal and community level, systems level, and population level outcomes?
        - How does professionalism include the commitment to modernize the public health infrastructure?

d. How can AACN help you to implement the new Essentials, such as tools, resources, and faculty development?

- Toolkits that emphasizes social justice principles and ethics. Ethical standards need to be revised to facilitate foundational knowledge and practicality for all nurses.
- Refer to the foundational principles of community based participatory research. These are a grounding framework for working in true partnership, with communities, and are relevant to all settings.
- The practice of presence and mindfulness could be added to helping build emotional intelligence.

Domain 10: Personal, Professional, and Leadership Development

This domain provides a thoughtful holistic review of competencies aimed at the development of professional leadership skills and personal self-actualization. The inclusion of self-care and nurse resiliency content is essential towards preparing nurses for the realities of challenging practice environments, addressing the issues behind stress, fatigue, and burnout. In moving forward, it is imperative that these competencies consider the scope of population health educational and practice settings and the development of academic practice partnerships to achieve them.

Practice is the essential piece of nursing education through which competencies develop. Formal teaching provides nursing students the information needed to achieve competency, while clinical practice opportunities allow students to develop and demonstrate competency in community/public health nursing (C/PHN) (ACHNE, 2019; Quad Council Coalition Competency Review Task Force, 2018). Assuring practice sites are involved in the development of the formal teaching of students across educational levels will help create realistic expectations for students from the practice site and ensure effective communication between academic sites with which they collaborate (American Association of Colleges of Nursing [AACN], 2019). Ongoing funding for practice sites and academic institutions to develop mutually beneficial partnerships is needed to ensure high-quality, positive experiences for students, practice sites, and clients alike (National Advisory Council on Nurse Education and Practice [NACNEP], 2019; AACN, 2019).

According to the American Association of Colleges of Nursing AACN-AONE Task Force on Academic-Practice Partnerships, "An academic-practice partnership is a mechanism for advancing nursing practice to improve the health of the public. (AACN, 2019b)." Academic Practice Partnerships (APPs) positively impact patient outcomes, patient satisfaction with care services, nursing staff outcomes, and student learners. These partnerships provide a formalized means for academic partners to share educational resources with health care institutions towards translating evidence based practice (EBP) principles to improve clinical decision making, increase staff knowledge of EBP, experiential learning, and inspire the growth of EBP population health initiatives (Gorski, et al., 2019; Erwin, 2018; AACN, 2016). Student learners immersed in APP settings become experienced in EBP analysis and translation while growing their ability to become skilled, compassionate caregivers, and attentive patient advocates (Tanriverdi et al., 2017). These partnerships provide opportunities to seek external funding to address population health concerns, build community capacity, and expand the existing PHN workforce (Davis, 2015). Overall, APPs benefit individuals, clinical agencies, school-based settings, ambulatory care, and health departments by providing an eager, competent student workforce to address individual, family and community concerns (Cygan, 2018; Erwin, 2018). In addition, we advocate for student experiences in practice partnerships that expand beyond traditional "clinical" sites that "contribute to the delivery of essential public health services" (CDC, The Public Health System, 2018) (e.g. faith based communities, libraries, dentist office, commercial businesses, etc.), as nurses are in the business of bringing "health to where people live, learn, work, play, worship and age" (Storfjell, et al., 2017, p.3). ACHNE understands in

order to accomplish this work faculty need to be prepared in population health to conceptualize these opportunities and to integrate into the new curricula (Gorski, et al., 2019).

The understanding of geographical correlations with health outcomes needs to be integrated more completely into nursing education throughout the curriculum at all levels, most importantly beginning as a starting point to truly understand health and illness. This aspect of health requires integration into acute care as well, specifically safe, effective, and efficient discharge and transitional planning. Equipping our students with the understanding, application, and meaning of 'educator', 'advocator', 'change agent', 'mediator', and systems thinking by identifying the social and population needs of our patients, families, and communities regardless of setting, within the intersection of health and nursing.

Education should be experiential, integrated, and collaborative across the learning continuum, including continuing professional development. Our aim in applying the operationalization of population health for early nursing students would be to demonstrate an understanding of how social, political, and economic factors determine health outcomes. To achieve, this we recommend the development of a tool kit and modules to guide curriculum redesign and faculty inservices, webinars and conferences with diverse panels of experts to lead faculty in the implementation of active learning strategies to achieve these competencies.

In summary, these suggestions will strengthen nursing education, support interdisciplinary collaboration, and improve the health of our nation with a more succinct and comprehensive idea of population health.

References

American Association of Colleges of Nursing (2019a). *AACN's vision for academic nursing*. Retrieved May 7, 2020 from https://www.aacnnursing.org/Portals/42/News/White-Papers/Vision-Academic-Nursing.pdf

American Association of Colleges of Nursing. (2019b). *Guiding principles to academic practice partnerships*. Retrieved May 7, 2020 from https://www.aacnnursing.org/Academic-Practice-Partnerships/The-Guiding-Principles.

American Association of Colleges of Nursing. (2016). *Advancing healthcare transformation: A new era for academic nursing.* Retrieved May 7, 2020 from http://www.aacnnursing.org/Portals/42/Publications/AACN-NewEra-Report.pdf

American Association of Colleges of Nursing. (2019). *AACN's vision for academic nursing. Executive summary*. Retrieved May 7, 2020 from https://www.aacnnursing.org/Portals/42/News/White-Papers/Vision-Academic-Nursing.pdf

Association of Community Health Nursing Educators (2019). *Recommendations for revisions to AACN's* Public health: Recommended baccalaureate competencies and curricular guidelines for public health nursing, a supplement to the baccalaureate education for professional nursing practice. Retrieved May 18, 2020 from https://www.achne.org/aws/ACHNE/asset_manager/get_file/408453?ver=3

Centers for Disease Control and Prevention, Center for State, Tribal, Local, Territorial Support (2018). Public Health Professional Gateway: Public health systems and the 10 essential public health services. Retrieved May 7, 2020 from https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html

Cygan, H., McNaughton, D., Reising, V., & Reid, B. (2018). An academic practice partnership: Building capacity to meet sexual health education policy requirements of a public-school system. Public Health Nursing, 35, 414-419.

Davis, R. & Gustafson, D. (2015). Academic-Practice partnership in public health nursing: Working with families in a village-based collaboration. *Public Health Nursing 32*(4), 327-338.

Erwin, P., Parks, R., Mazzucca, S., Allen, P., Baker, E., Hu, H., Davis-Joyce, J., & and Brownson, R. (2018). Evidence-based public health provided through local health departments: Importance of academic–practice partnerships. *AJPH*, 109(5), 739-747.

Gorski, M.S., Polansky, P., and Swider, S. (2019). *Nursing education and the path to population health improvement*. Robert Wood Johnson Foundation. Retrieved May 18, 2020 from https://campaignforaction.org/wp-content/uploads/2019/03/NursingEducationPathtoHealthImprovement.pdf

National Advisory Council on Nurse Education and Practice (2019). *Integration of social determinants of health in nursing, education, practice, and research.* Retrieved May 7, 2020 from https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/nursing/reports/nacnep-2019-sixteenthreport.pdf

Quad Council Coalition Competency Review Task Force. (2018). Community/Public Health Nursing Competencies. Retrieved May 18, 2020 from http://www.quadcouncilphn.org/wp-content/uploads/2018/05/QCC-C-PHN-COMPETENCIES-Approved_2018.05.04_Final-002.pdf

Storfjell, J. L., Winslow, B. W., Saunders, J. S. D. (2017). Catalysts for change: Harnessing the power of nurses to build population health in the 21st century. Produced with support from the Robert Wood Johnson Foundation. Retrieved May 18, 2020, from

https://www.rwjf.org/en/library/research/2017/09/catalysts-for-change--harnessing-the-power-of-nurses-to-build-population-health.html

Tanriverdi, G., Ozyazicioglu, N., Atay, S., Sivrikaya, S.K., Gursoy, M.Y., & Cetin, A. (2017). The recommended solutions of nursing students to bridge the gap between the school and practice areas. *International Journal of Caring Sciences*, *10*, 199-208.

General References

[1] American Association of Colleges of Nursing (2019). AACN's vision for academic nursing, executive summary. https://www.aacnnursing.org/Portals/42/News/White-Papers/Vision-Academic-Nursing.pdf

[2] American Association of Colleges of Nursing (2013). American Association of Colleges of Nursing [AACN] Public Health: Recommended baccalaureate competencies and curricular guidelines for public health nursing: A supplement to the baccalaureate education for professional nursing practice. https://www.aacnnursing.org/Portals/42/Population%20Health/BSN-Curriculum-Guide.pdf

[3] Association of Community Health Nursing Educators (2019). https://www.achne.org/aws/ACHNE/asset_manager/get_file/408454?ver=495

[4] Association of Community Health Nursing Educators (2019). https://www.achne.org/aws/ACHNE/asset_manager/get_file/467115?ver=278

[5] American Association of Colleges of Nursing (2020). AACN draft essentials document. https://www.aacnnursing.org/Portals/42/Downloads/Essentials/Essentials-Draft-Document.pdf

[6] Fawcett, J. and Ellenbeck, C. H. (2015). A proposed conceptual model of nursing and population health. *Nursing Outlook*, 63, 288-298.

[7] Bekemeir, B. (2008). "Upstream" nursing practice and research. *Applied Nursing Research*, 21, 50e52.

[8] National Academy of Medicine (2020) The future of nursing 2020-2030. A consensus study from the national academy medicine. https://nam.edu/publications/the-future-of-nursing-2020-2030/

[9] Englander, R., Cameron, T., Ballard, A., Dodge, J., Bull, J., & Aschenbrener, C. (2013). Toward a common taxonomy of competency domains for the health professions and competencies for physicians. *Academic Medicine,* 8(8), 1088-1094. https://www.aacnnursing.org/Portals/42/Downloads/Essentials/Englander-2013.pdf

[10] Thorne, S. (2014). What constitutes core disciplinary knowledge? *Nursing Inquiry, 21(1), 1-2.*

[11] Green, C. (2018). A philosophical model of the nature of nursing. *Nursing Research*, March/April, 67 (2), 93-98.

[12] Quad Council Competencies for Community and Public Health Nursing (2018). https://www.cphno.org/wp-content/uploads/2020/08/QCC-C-PHN-COMPETENCIES-Approved_2018.05.04_Final-002.pdf

[13] Association of Community Health Nursing Educators (2009). Academic faculty qualifications for community/public health nursing. https://www.achne.org/aws/ACHNE/asset_manager/get_file/facultyqualificationspositionpaper.pdf?ver=1360

[14] DeSalvo, K. B., Wang, Y.C., Auerbach, J., Koo, D., O'Carrolll, P. (2017). Public Health 3.0: A call to action for public health to meet the challenges of the 21st century. Prevention of Chronic Disease, 14:170017. DOI: http://dx.doi.org/10.5888/pcd14.170017

[15] ©County Health Rankings 2020. University of Wisconsin Population Health Institute. Supported by Robert Wood Johnson Foundation. Retrieve May 12, 2020 from https://www.countyhealthrankings.org/.

[16] Ramirez, B., Baker, E.A., Metzler, M. (2008). Promoting health equity: A resource to help communities address social determinants of health. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf

[17] Health Affairs (Castrucci, B. and Auerbach, J. (2019). Meeting individual social needs falls short of addressing social determinants of health. *Health Affairs Blog*, January 16, 2019. DOI: 10.1377/hblog20190115.234942 https://www.healthaffairs.org/do/10.1377/hblog20190115.234942/full/