Duke University School of Nursing created the Population Care Coordinator Program (PCCP) in 2012 to prepare nurses for an emerging role that is crucial for meeting current and future healthcare needs.

The curriculum developed by Duke University School of Nursing provides a unique approach to training Population Care Coordinators:

- Duke's tightly-focused PCCP curriculum allows nurses to complete the program in 12 weeks, and requires 10 hours a week for coursework. This allows nurses to continue in their current employment while training for their new role as Population Care Coordinators.
- As part of the PCCP, students are placed in designated physician practices for guided learning and mentorship. Duke monitors, provides feedback, and evaluates each student’s progress during the mentorship experience.
- Participants who complete the program successfully will be awarded nine hours of graduate credit and 90 contact hours for continuing education from Duke University School of Nursing.
- In the first year 67 nurses have completed the program.

Crucial competencies: Duke’s Population Care Coordinator Program prepares nurses in crucial competencies:
- Population health management
- Care team leadership
- Continuous quality improvement
- Health coaching and education
- Approaches to behavior change
- Skill building for patient self-management
- Monitoring and tracking patient care goals and issues
- Integrating community resources
- Clinical registries, evidence-based alerts, and reminders

Core concepts in the curriculum include care coordination, multilevel processes, team collaboration, patient engagement, and evidence utilization. The training is delivered in an online format, supplemented with three intensive face-to-face sessions. A residency component serves as the capstone experience, integrating coursework with skills learned, to give students real-world understanding and experience in the role of Population Care Coordinator.

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Population Care Coordinators—
who they are and what they do
Population Care Coordinators are nurses who help create and implement a patient-centered approach to care that enables patients to access high-quality, comprehensive care delivered within the context of family and community. Population Care Coordinators are physically located within a specific medical practice to improve care coordination and increase patient engagement.

A growing need
Today’s primary care physicians must serve a larger number of elderly patients and patients with increasingly complex medical needs—needs which require expanded coordination of care and follow-up:

- More elderly. In 2010, 13% of the U.S. population was 65+ years old; by 2030, the total is projected to be 19%. The 85+ population is projected to increase from 5.5 million in 2010 to 6.6 million in 2020.
- More chronic conditions. In the U.S., 32% of those 65–69 years old and 52% of those 80-84 suffer from three or more chronic conditions, and 76% of the patients in general practice have three or more chronic conditions.*

Addressing the challenge
Working as an integral part of primary care teams, Population Care Coordinators help ensure comprehensive care, freeing physicians to focus on the clinical needs of the patients. As coaches and health advocates, Population Care Coordinators help make sure that patients get and stay healthy through preventive wellness care, management of care transition, and follow-up.