**ABSTRACT**

**Title:** Integrating Interprofessional Education (IPE) into Family Nurse Practitioner Education: Evaluating the Community Partner-IPE Practicum Collaborative Experience

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**ABSTRACT**

Integrating IPE opportunities into advanced practice nursing curricula prepares Family Nurse Practitioners (FNPs) for the current and future needs of patients, families, and communities. The Community Partner-IPE Practicum Collaboration model was previously introduced at a nursing faculty meeting in 2010. This poster presentation is an evaluation of a community-academic interprofessional partnership model designed as an integrated practice experience for FNP students. The Community Partner-IPE Practicum Collaboration model uses a specific and comprehensive system, and utilization of community services (primary care, oral health, specialty services, social services, mental health services, and community education) to advance of population health. The implementation of the Patient-Centered Medical Home model in the context of family centered care is central to the experience. Specific goals are developed collaboratively with families and community partners, to meet the needs of selected families. Community partners include health providers and families. This innovative model has implications for interprofessional education and practice, providing service learning opportunities with measurable impact on health outcomes for families and modeling implementation of the patient-centered medical home model in community practice.

**OBJECTIVES**

- Demonstrate the use of community partners as academic collaborators in IPE as a viable model for integrating interprofessional practicum experiences into advanced practice nursing curriculum.
- Demonstrate challenges and successes of the IPE partnership & student experience.
- Engage with community partners in providing inter-professional collaboration through community & clinical service.
- Students learn to work & communicate effectively within complex organizations in the community.
- Experience allows for ongoing community partner collaboration and follow-up.

**STUDENT GOALS**

- Experience with interprofessional collaboration.
- Experience with the referral process & coordination of care.
- Meeting patient goals utilizing community resources.
- Improved assessment within the family & community for delivery of high quality, effective health care & improved patient outcomes.
- Better able to consider epidemiology, environmental & community factors, as well as family & individual risk factors.

**COMMUNITY PARTNER GOALS**

- Facilitate student-patient/family partnerships and general oversight of care coordination.
- Achievement of mutually agreed upon family goals for at-risk families within the PCMH model.
- Improved population health outcomes & care experience for patient and families.
- Decreased per capita health care costs.
- Provider and family satisfaction.

**OUTCOMES AND EVALUATION**

- Reduction in ED visit use for primary care & non-emergent issues/problems.
- Families better able to navigate health care system.
- Improved utilization of PCMH and primary care services.
- Improved management of chronic illness/conditions.

**VISION**

Xavier University Health will be the interprofessional collaborator in Population Health by 2025.

**MISSION**

Xavier University Health is taking the lead in shaping the future of Population Health through education, social justice, and service to others by leading innovation and inspiring interprofessional collaboration.

**STRATEGY**

To continuously identify the challenges hindering the advancement of population health in order to develop and share impactful and sustainable solutions.

**GOALS**

- Foster innovation to develop meaningful outcomes.
- Engage strategic partners in implementing solutions for the advancement of de-identified stakeholders.

**OUTCOMES**

- Improved assessment within the family & community for delivery of high quality, effective health care & improved patient outcomes.
- Provider and family satisfaction.
- Improved management of chronic illness/conditions.