Interprofessional Collaboration and Education

Working together to ensure excellence in health care.

The Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health*, identifies interprofessional collaboration among health care providers as an essential part of improving the accessibility, quality, and value of health care in the United States. The report highlights four key messages, one of which emphasizes nurses’ role as “full partners, with physicians and other health professionals, in redesigning health care.” Another underscores that nurses “must be accountable for their own contributions to delivering high-quality care while working collaboratively with leaders from other health professions.” This message emphasizes the importance of nurse leadership in advancing interprofessional collaboration in all settings, including in the boardrooms of organizations that have an impact on health and health care delivery.

The same year that the IOM report was published, the World Health Organization (WHO) released a blueprint for implementing interprofessional education and collaborative practice to meet demand in the face of a global health care workforce shortage. In the WHO framework, collaborative practice “happens when multiple health workers from different professional backgrounds work together with patients, families, carers and communities to deliver the highest quality of care.” It makes sense that the best care would be delivered by a team of “carers” or providers with diverse experience, education, and training—all of whom exchange information with one another and are dedicated to patient health and well-being.

Interprofessional collaboration is based on the premise that when providers and patients communicate and consider each other’s unique perspective, they can better address the multiple factors that influence the health of individuals, families, and communities. No one provider can do all of this alone.

However, shifting the culture of health care away from the “silo” system, in which clinicians operate independently of one another, and toward collaboration has been attempted before without enduring success. For nearly five decades a commitment to interprofessional learning has waxed and waned in health professions training programs. During this time, health care leaders have shown intermittent interest in interprofessional collaboration in the delivery of health care. Strong and convincing outcome data demonstrating the value of team-based care have been lacking, but changes in our health care system now require that we explore how we can make interprofessional collaboration the norm instead of the exception.

The Future of Nursing: Campaign for Action is a collaboration of the Robert Wood Johnson Foundation (RWJF) and AARP that was established in late 2010 to implement the IOM’s recommendations at the national and state levels. To date, 51 action coalitions and dozens of national organizations are committed to carrying out this important work. In this article, we highlight the imperative to shift professional cultures toward collaboration, current state initiatives designed to foster interprofessional collaboration, opportunities and resources for incorporating interdisciplinary efforts into daily practice, and the challenges that remain.
INTERPROFESSIONAL EDUCATION FOR COLLABORATIVE PRACTICE

Interprofessional education (IPE) and interprofessional collaborative practice (IPCP) are separate but related concepts. For health professionals, learning the skills to effectively work on IPCP teams is best gained through IPE, in which students from two or more health professions study together, so they can provide collaborative, safe, high-quality, accessible patient-centered care. Learners may not yet be licensed, or they may be practicing professionals. IPCP requires retraining of the current workforce, so that professionals can learn new skills and new ways to relate to one another.

One of the intentions of IPE is that students from different health professions practice to the full extent of their education and training and, in the process, explore the margins of their practices. At the same time, they learn how to have effective interprofessional relationships through collaborative sharing of skills and knowledge. Elements of collaborative practice include responsibility, accountability, coordination, communication, cooperation, assertiveness, autonomy, mutual trust, and respect.

The RWJF defines “effective collaborative practice” as promoting the active participation of each discipline in patient care, where all disciplines are working together and fully engaging patients and those who support them, and leadership on the team adapts based on patient needs. Effective interprofessional collaboration enhances patient and family centered goals and values, provides mechanisms for continuous communication among caregivers, and optimizes participation in clinical decision making within and across disciplines. It fosters respect for the disciplinary contributions of all professionals.

THE IMPERATIVE TO SHIFT PROFESSIONAL CULTURES

Several factors contribute to making IPCP a desirable model of care in the effort to improve health outcomes. These include current concerns about quality and safety, the need for cost containment, health care worker shortages, and the connection between IPE core competencies for team-based care and educational program accreditation.

Quality and safety. The link between interprofessional collaboration and quality and safety has been highlighted in several IOM reports (see The Institute of Medicine’s Reports). These detail the poor quality of care and high rate of preventable medical errors that occur when health professionals operate in silos.

“Collaboration” might simply mean handing the patient chart to the next provider. A lack of communication, however, can jeopardize the delivery of care and the safety of the patient. It can also lead to gaps in coverage or to an oversight by a responsible professional and a loss of information. A silo mentality eliminates the opportunity to build and learn from the strengths of others. Changing this way of thinking is dependent on educating practicing health professionals as well as students.

In 2013, a conference sponsored by the Josiah Macy Jr. Foundation brought together health educators and practice leaders to focus on aligning IPE and clinical practice redesign amid the changes brought about by health care reform. During the conference, a vision emerged of “a healthcare system in which learners and practitioners across the professions are working collaboratively with patients, families and communities and with each other to accomplish the Triple Aim,” which refers to efforts to improve the patient’s experience, improve the health of populations, and reduce health care costs. Participants also developed these five recommendations:

1. Engage patients, families, and communities in the design, implementation, improvement, and evaluation of efforts to link interprofessional education and collaborative practice.
2. Accelerate the design, implementation, and evaluation of innovative models linking interprofessional education and collaborative practice.
3. Reform the education and life-long career development of health professionals to incorporate interprofessional learning and team-based care.
4. Revise professional regulatory standards and practices to permit and promote innovation in interprofessional education and collaborative practice.
5. Realign existing resources to establish and sustain the linkage between interprofessional education and collaborative practice.

Shortage of health care workers. A projected shortage of health care providers will require clinicians to practice in smart and efficient ways that rely on excellent interprofessional communication. The Association of American Medical Colleges estimates a shortage of 45,000 primary care physicians and 46,000 surgeons and medical specialists by 2020, owing in part to the growing population of older adults and to the millions of people who will be covered by health insurance as a result of the Affordable Care Act.
Some analysts say the shortages can be avoided through practicing new models of team-based care that rely on clinicians other than physicians—such as NPs and physician assistants—for primary care. A RAND Corporation study found that this strategy could reduce the physician shortage by more than half.11

The nursing profession faces its own workforce challenges in meeting the nation’s health care needs, particularly the needs of the increasing number of older adults, who use more health care resources than younger populations. The RN workforce is projected to grow from 2.71 million in 2012 to 3.24 million in 2022—an increase of 19%.12 However, the increase in the number of U.S. nurses has been buoyed by older nurses who delayed retirement during the recent recession.13 As these nurses start to retire, a nursing shortage may arise again.

Competencies. In February 2012, six national associations of health professionals created the Interprofessional Education Collaborative (IPEC) to advance team-based care and education. These organizations included the American Association of Colleges of Nursing (AACN), the American Association of Colleges of Osteopathic Medicine, the American Association of Colleges of Pharmacy, the American Dental Education Association, the Association of American Medical Colleges, and the Association of Schools of Public Health.1

The IPEC established core competencies, or principles, that serve as guidelines for faculty and administrators creating a curriculum focusing on IPE. These competencies were subsequently endorsed by the Health Resources and Services Administration (HRSA), among other organizations. The competencies span four domains14:

- values and ethics for interprofessional practice
- roles and responsibilities
- interprofessional communication
- teams and teamwork

Policies as well as curricular and accreditation changes have strengthened IPE in health professions schools. The AACN’s “Essentials” documents, which summarize the curriculum content and competencies for baccalaureate, master’s degree, and doctor of nursing practice programs, require that these curricula integrate content and clinical opportunities on interprofessional collaboration (go to www.aacn.nche.edu/education-resources/essential-series for more). In 2008, the need for IPE was identified as an action issue by the Association of American Medical Colleges. Schools of dentistry, pharmacy, public health, and osteopathy have individually set competency expectations for their curricula. The result is an effort toward achieving IPCP across health professions.14

The Institute of Medicine’s Reports Driving interprofessional collaboration.

In addition to The Future of Nursing: Leading Change, Advancing Health, the following Institute of Medicine reports highlight problems in health care quality and safety and demand better interprofessional collaboration among health care providers.

To Err Is Human: Building a Safer Health System15 focuses on preventable medical errors as a leading cause of death in the United States, with many of these arising from poor interprofessional communication and collaboration.

Crossing the Quality Chasm: A New Health System for the 21st Century16 concentrates on assessing and improving the nation’s quality of care, and addresses system flaws and the need for patient-centered care to improve patient safety. The report notes a growing concern with the lack of clinical programs that have an interprofessional infrastructure and criticizes the health care system as “overly complex, requiring steps and handoffs that slow down the care process and decrease rather than improve safety.”

Health Professions Education: A Bridge to Quality17 notes that health professionals should be educated to deliver patient-centered care as members of interdisciplinary teams. According to the report, this would streamline the way professionals share and acquire information related to error prevention and quality improvement.

In 2012, the National Center for Interprofessional Practice and Education (https://nexusipe.org) was launched by HRSA through a five-year, $4 million cooperative agreement with the University of Minnesota, which houses the center. Three organizations—the Josiah Macy Jr. Foundation, the RWJF, and the Gordon and Betty Moore Foundation—provided more than $8 million in additional funding.16 Continuing funds depend on the center’s ability to demonstrate the beneficial outcomes of IPE and IPCP. According to the center’s Web site, HRSA has designated it as the “sole center to provide leadership, scholarship, evidence, coordination and national visibility to advance interprofessional education and practice as a viable and efficient health care delivery model.”16 The Web site includes community spaces for research exchange, popular forums open to the public, and opportunities for networking with other professionals interested in advancing interprofessional collaboration.

Several exciting studies of models of collaborative care demonstrate early results that suggest improvements in health outcomes and cost savings in both acute and ambulatory care. For example, as part of its Care Transformation initiative launched in 2009, Emory Healthcare in Atlanta is studying the effectiveness of structured interdisciplinary bedside rounds.
(SIBR) on a 24-bed accountable care unit.\textsuperscript{17, 18} SIBR focuses on improving interprofessional collaboration by using a nurse-led model of collaborative cross-checking (about discharge plans, for example, or medication orders), nurse-led bedside shift reporting, and daily huddles with additional health care team members.\textsuperscript{18}

Since the start of this study in 2010, Emory Healthcare has noted a reduction in the number of hyperglycemic episodes, catheter-related bloodstream infections, hyperglycemic episodes, and deaths on the unit as well as in lengths of stay.\textsuperscript{17, 18} Positive outcomes were also seen in the relationship between nurses and physicians. Willingness to participate in collaborative rounds is an example of how nurses and physicians are coming together to provide care. Conversations with unit staff indicated that they felt they had an effective working relationship.\textsuperscript{19} Notably, these improvements required little additional expenditure.\textsuperscript{17, 18}

\textbf{INTERPROFESSIONAL COLLABORATION IN ACTION}

In 2013, an analysis of preventable medical errors in the United States found that such errors result in 210,000 to more than 400,000 deaths each year\textsuperscript{19}—making these errors the third leading cause of death in Americans. More progress is needed to improve patient safety by breaking down professional silos.

This makes the work of the Campaign for Action all the more important. In a broad sense, interprofessional collaboration—or engaging diverse stakeholders in working toward a common goal—has been valued since the 2008 formation of the Committee on the RWJF Initiative on the Future of Nursing, the committee responsible for creating the \textit{Future of Nursing} report. The 18 members of this committee have diverse backgrounds and brought their unique perspectives to the crafting of the report, which was not the work of nurses alone, but rather included experts in the areas of federal and state administration and regulations, hospital and health plan administration, business administration, health information and technology, public health, health services research, health policy, workforce research and policy, and economics.\textsuperscript{1}

The professionals involved in the Campaign for Action were also selected to reflect the interprofessional collaboration the initiative espouses. This organizational structure was created to ensure the sustainability of the campaign’s work implementing the IOM report’s recommendations.

The members of the campaign’s Strategic Advisory Committee shape the campaign’s strategic vision and serve as its “chief ambassadors.”\textsuperscript{20} This committee, as well as the Champion Nursing Coalition—created by the Center to Champion Nursing in America (CCNA), a joint initiative of AARP and the RWJF established in 2007—intentionally include diverse representatives, such as business leaders, physicians, health care providers, and experts in health care quality. The campaign’s Champion Nursing Council, also created by the CCNA, consists of more than 50 national nursing organizations that have publicly committed to the campaign’s vision. The council and the coalition have been instrumental in advancing the IOM recommendations on the state and national levels. (For more on the members of the Champion Nursing Coalition, see \url{http://campaignforaction.org/whos-involved/champion-nursing-coalition}. For more on the Champion Nursing Coalition and the Champion Nursing Council, see the first article in this series, “A Bold New Vision for America’s Health Care System,” February.)

The campaign’s state-level work is led by action coalitions, which operate in 50 states and the District of Columbia. These coalitions are encouraged to involve diverse partners who have an interest in transforming health care. Although leadership structures vary by state, each action coalition is headed by two coleads, one a representative of nursing and one a nurse champion (from a nonnursing organization). The nurse champions broaden the perspectives of the people working in the action coalitions and facilitate connections that promote sustainability through in-kind and monetary support.

This infrastructure demonstrates an appreciation that nurses cannot transform health care by themselves. It also emphasizes the importance of engaging everyone with a stake in health and health care in supporting implementation of the IOM recommendations (see the five campaign imperatives at \url{http://campaignforaction.org/resource/campaign-imperatives}).

\textbf{ACTION COALITIONS}

Although nearly half of the Campaign for Action’s 51 action coalitions report that one of their goals is to develop or implement an interprofessional practice and education model in their state, 10 report that they are in the process of developing or implementing such efforts, two have completed development or implementation, and many are just getting started. Here are a few highlights of the state coalitions’ work.

\textbf{Utah.} Coalition members helped to initiate an IPE program at the state’s flagship university, the University of Utah. Unique aspects of this program and keys to its success include

- required curriculum components for all students in the University of Utah Health Sciences colleges.
- engaged, active learning with plenty of dialogue and debriefing.
- positive student response.
• faculty champions from all of the health sciences colleges, who design and deliver the curriculum together.
• the inclusion of both undergraduate and graduate nursing students in IPE.
All health sciences students participate in at least one IPE course during their program of study; some complete as many as five. These one-credit courses involve complex patient care management scenarios incorporating the use of simulation manikins or standardized patients.

The program is evaluated using student and facilitator feedback. In surveys completed after each required IPE course, students respond to a standardized set of questions about interprofessional attitudes and can also add comments. Facilitators give their feedback following each simulation-based IPE course, which includes student preparation and readings; a simulated, team-based patient care management experience; and facilitated debriefing sessions.

It was important to this program’s success to obtain start-up funding and support from the health sciences leadership, invest in a full-time IPE director for all health sciences students, and create a business plan to ensure sustainability by capturing program participation fees from all of the schools. This program of IPE courses is for students in the schools of medicine, nursing, pharmacy, dentistry, and allied health. It started with 278 students in the fall of 2012, expanded to 1,250 students by the 2013–2014 school year, and this school year increased to approximately 1,300 students, including those from the new dental school.

Wisconsin. The Wisconsin Action Coalition has been working with the Wisconsin Council on Medical Education and Workforce to raise awareness and further the discussion about how cooperation and integration among health professionals can lead to continuous improvements in patient care.

Through events like the one-day conference, “Building a Culture for Patient-Centered Team Based Care,” health professionals and students learn about the patient-centered work of health care teams from various health care organizations. Attendees at this November 2014 conference learned how health care teams have implemented interprofessional collaboration at their sites of care and heard examples of successful team initiatives throughout the state.

Colorado. The Colorado Center for Nursing Excellence is one of the Colorado Action Coalition’s coed organizations. In collaboration with the Metro Community Provider Network and the Colorado Community Health Network, the center received a grant from HRSA to support the implementation of IPCP teams across the state.

This program will run through June 2016 and focuses on building teams in federally qualified health centers and safety net clinics. Its three goals are to (1) create an institute to train emerging nurse leaders so they can learn interprofessional team leadership skills, (2) engage nursing students, and (3) develop interprofessional teams. Participants are RNs and all members of the integrated care team, including primary care providers; accountants; and human resources, behavioral health, and dentistry personnel.

Measures of improved leadership and team effectiveness include increased patient satisfaction with the team’s quality of care as well as a reduction in individual team members’ desire to leave the team.

Rhode Island. The Rhode Island Collaborative for Interprofessional Education and Practice is funded by Partners Investing in Nursing’s Future (www.partnersinnursing.org), a collaboration of the Northwest Health Foundation and the RWJF, and has the support of members of the Rhode Island Action Coalition. The collaborative’s focus is to develop and implement a statewide IPE program of shared learning, resources, curriculum, and evaluation methods. Its partners include the Rhode Island College School of Nursing and School of Social Work, the University of Rhode Island College of Nursing (where coauthor Mary Sullivan is a professor and interim dean) and College of Pharmacy, and the Warren Alpert Medical School of Brown University.

Development of the shared curriculum involved all members of the partner education programs. The curriculum model includes the four IPEC core competency domains. Existing practices were evaluated through surveying the partner school members to learn which IPEC competencies and subcompetencies the faculty and students considered to be most important, as well as to identify gaps in curricula.

Three components of the shared learning curriculum were developed, implemented, and evaluated. The first is a workshop consisting of a discussion of written case-based scenarios and a demonstration in which a “standard” patient (an actor playing the role of a patient) has an injury and is in the ED. The students must assess and manage the patient’s care. The second is a workshop using a team-building exercise and a standard patient case (again, an actor plays the role of the patient) that includes an interview with the patient and an examination. The students participating in this activity were second-year medical, fourth-year nursing, and fifth-year pharmacy students. For the third activity, three interprofessional student teams (each typically made up of a medical student, nursing student, and pharmacy student) worked together to conduct a history and physical, interpret laboratory and X-ray results, discuss the diagnosis, and develop a plan of care.
Surveys conducted before and after implementation of the program assessed student attitudes toward interprofessional practice. These showed that students’ knowledge of and attitudes toward IPE improved after their involvement in the program: 74% said they would have a positive view of IPE in the future.21

With the support of Partners Investing in Nursing’s Future, the Rhode Island Regional Collaborative for Interprofessional Education and Practice has developed a sustainability plan that includes a vision, a mission and values statement, a case statement, ongoing work on branding and identification of stakeholders, and the creation of an IPE clinical coordinator position.

**Indiana.** The colead of the Indiana Action Coalition (coauthor Richard Kiovsky) represented the coalition in its successful application for a federal grant—funded by HRSA under its Nurse Education, Practice, Quality and Retention Program—to advance IPE and IPCP at Indiana University. The coalition used this grant to focus on three aims:

- develop IPCP in the urban acute care setting, particularly promoting IPCP core values and enhancing the role of nurses on the team
- identify five rural ambulatory clinical sites in underserved communities and introduce IPCP with a focus on team building, communication, and improving patient care outcomes (with an emphasis on chronic disease care) while augmenting the role of nurses on the team
- identify one RN from each clinical site to participate in a nurse leader training program at the Indiana University School of Nursing

The Indiana Action Coalition has co-led activities with the Indiana Area Health Education Centers to improve IPE and IPCP. Activities have included a preconference meeting on IPE at the 2011 Indiana Rural Health Association Annual Conference to discuss what could be done within academic institutions to increase awareness of the importance of IPE and collaborative care.

There has also been the development of IPE criteria for interprofessional clinical sites via a statewide conference in 2013 for nearly 100 health professionals across all disciplines. Conference goals included highlighting the importance of linking IPE and IPCP in health professions education, understanding the relevance of IPE, and identifying opportunities to use IPE to advance the patient-centered medical homes model of care. One physician received feedback on an instrument he is developing to help clinical sites determine their preparedness for IPE learning. This work aims to ensure that IPE is not just theoretical learning and that students have opportunities to see IPCP in action.

Additionally, the Indiana Action Coalition IPE subcommittee has

- developed “IPE Snapshot,” a document that lists IPE events and experiences taking place across the state.
- hosted a statewide interprofessional student simulation event at which 25 students from four universities completed five simulations in a laboratory. The data collected from the students and faculty participants supported the need for IPE and showed that they considered it to be a positive experience.
- developed a user-to-user IPE database to enable those seeking IPE experiences to connect through the Internet. The database collects information about the IPE experience, such as type of students involved, objectives of their experiences, learning strategy used, and contact information of the IPE provider.
- started to plan a statewide, online IPE event that will feature a 3-D virtual environment using avatars as patients and providers. This virtual format will eliminate travel time and improve coordination when offering IPE.

**MOVING FORWARD: CHALLENGES AND OPPORTUNITIES**

Although this work is exciting and promises to advance interprofessional teamwork—and by doing so, to improve the quality and cost of care—many remaining challenges must be addressed to sustain interprofessional collaboration and to make it a reality throughout both the health care system and educational institutions.

Models of IPCP are emerging all over the country. A CFAR report funded by the RWJF describes promising practices for advancing IPCP in a variety of contexts.4 Success in implementing these models in the long term will require a focus on leadership and organizational buy-in.22 Effective collaborative care models also require defining the scope of practice for all health professions. A 2001 study by Way and colleagues showed that NPs are underutilized in the team setting, owing in part to a lack of interdisciplinary education.23 According to the Interprofessional Education Collaborative Expert Panel, one of the challenges to overcome is “a lack of top administrative leadership support for adequate resources to create an interprofessional component to health professions students’ education.”24

IPE remains one of the hurdles to embracing interprofessional collaboration in health care settings. The first step in fostering IPE is exploring initiatives already under way.24 Barnsteiner and colleagues recommend connecting with workers in other health professions to identify steps that can be taken by a group of committed individuals. Despite knowing that interprofessional collaboration can improve patient safety and
clinical outcomes, few schools include the training in their curricula; it must become a core element of curricula in all health professions schools. Faculty development is a key element in the creation of IPE. Simply bringing faculty from different health care disciplines into the same classroom, laboratory, simulation center, patient care facility, or other learning environment will not automatically result in a beneficial IPE experience. It’s important to identify opportunities for interprofessional teamwork. Departments and colleges must also be committed to addressing calendar and scheduling differences, curricular mapping (in which educators create a record of what they’ve taught so it can be reviewed and improved on), mentor and faculty training, a sense of community, and adequate physical space.

The IOM found several practices that prevent most health care organizations from being considered “high-reliability organizations,” or those that maintain high levels of safety despite the dangers inherent in the business. Kurtzman and Fauteux noted that these practices include “a lack of measurement and feedback to staff who participate in process improvement; an inconsistent commitment by organizations to sustain change over time in the face of adversity; and a lack of consistent involvement in process redesign by frontline staff—including nurses.”

Although strides have been made in transforming care, most health care organizations do not have programs in place that transform nurses’ work environments. Supporting nurse leadership is one area in which there is room for improvement. It is important that nurse leaders realize that their influence on the quality of patient care is far-reaching. Encouraging nurses to serve on governing boards of organizations that have an impact on health and health care is important to overcoming gender bias and underrepresentation.

Another hurdle in sustaining emerging models of collaborative care is funding. Many of the current programs are funded by grants, but will they be sustainable once the grant money is exhausted? New programs are funded by grants, but will they be sustainable once the grant money is exhausted? New models of reimbursement are on the horizon and may offer a source of funding. A variety of reimbursement plans based on health outcomes have emerged in the last decade. They include risk sharing, pay for performance, and “coverage with evidence development,” in which payment is made for some services if data gathered during clinical care demonstrate the impact of these services on the health of Medicare beneficiaries.

A CALL TO ACTION

What can you do to advance health and health care through interprofessional collaboration?

First, advocate for more IPE in health professions schools. Whether you are a practicing nurse, an administrator, an educator, a health professions student, or just interested in improving the quality and value of health care, you can ask the educational institutions in your area whether they support IPE and what their offerings include.

The Campaign for Action is doing just that on a national level. One of six measures of the campaign’s progress toward implementing the IOM’s recommendations is whether there is an increase in the number of required clinical courses or activities at top nursing schools that include both nursing students and other graduate health professional students (for more information about the campaign’s dashboard indicators, see http://campaignforaction.org/dashboard). More than half the tracked schools have increased the number of clinical courses or activities that include both nursing and other graduate health professional students.

Second, nurses and nurse champions can advocate for following a model of collaborative care where they work by sharing their ideas and taking leadership roles. One way you can become “full partners,

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with physicians and other health professionals, in redesigning health care”1 is to join a board or help someone else to join one. Additional resources regarding participation on boards can be found on the campaign’s Web site (see http://campaignforaction.org/resource/leadership-action-meetings-materials).

Finally, advocate for the removal of barriers to practice and care by encouraging all team members to practice to the full extent of their education. Connect with people who are passionate about implementing IPCP and IPE in your state, whether this is through your state’s action coalition, nursing organizations, educational institutions, or online communities. For information about how you can get involved in your state’s action coalition, visit http://campaignforaction.org/states. Also visit the Campaign for Action Web site (www.campaignforaction.org) to join this national online community, see the progress being made, and become a part of transforming health care through implementation of the IOM’s recommendations. ▼

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