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# Incorporating Interprofessional Education and Practice into Nursing

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Thirteenth Report to the  
Secretary of the Department  
of Health and Human  
Services and the United States  
Congress

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National Advisory Council on Nurse  
Education and Practice (NACNEP)  
Based on the 130th and 131st Meetings of  
the NACNEP 2015

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## **NACNEP Council**

The Secretary and, by delegation, the Administrator of the Health Resources and Services Administration (HRSA), are charged under Title VIII of the Public Health Service Act, as amended, with responsibility for a wide range of activities in support of nursing education and practice. This includes enhancement of the composition of the nursing workforce, improvement of the distribution and utilization of nurses to meet the health needs of the nation, expansion of the knowledge, skills, and capabilities of nurses to enhance the quality of nursing practice, development and dissemination of improved models of organization, financing and delivery of nursing services and promotion of interdisciplinary approaches to the delivery of health services particularly in the context of public health and primary care.

### *Authority*

Section 851 of the Public Health Service Act, as amended (42 USC 297t). The Council is governed by provisions of Federal Advisory Committee Act, as amended (5 USC Appendix 1-16), which sets forth standards for the formation and use of advisory committees.

### *Function*

The Advisory Council advises and makes recommendations to the Secretary and Congress on policy matters arising in the administration of Title VIII including the range of issues relating to the nurse workforce, nursing education and nursing practice improvement. The Advisory Council may make specific recommendations to the Secretary and Congress regarding programs administered by the Division of Nursing and Public Health particularly within the context of the enabling legislation and the Division's mission and strategic directions, as a means of enhancing the health of the public through the development of the nursing workforce.

Additionally, the Advisory Council provides advice to the Secretary and Congress in preparation of general regulations and with respect to policy matters arising in the administration of this title including the range of issues relating to nurse supply, education and practice improvement.

## **Executive Summary**

Nurses, the largest body of health providers, have a critical role to play in the current transition within today's health systems to interprofessional team-based models of practice. These teams typically include professionals from different backgrounds and with complementary skills, who collaborate to improve patient care. For team-based care to succeed, students in the health professions will need to learn the value of teamwork and how to work with other health professionals, while providers will need ongoing training and support to function within teams in their professional roles. Interprofessional team models are designed to provide better care coordination and improved patient experiences and outcomes, at a lower overall cost of care (Institute of Medicine [IOM], 2015; Sullivan, et al., 2015).

Achieving the transition to team-based care will require fundamental changes in health provider education. All schools in the health professions need to develop programs for interprofessional education (IPE), in which students from two or more disciplines learn about, from, and with each other. The Institute of Medicine (2013) describes IPE as a tool to link the education system with the health care delivery system to achieve better patient care and improve public health.

In the United States, the passage of the Affordable Care Act in 2010 has introduced new incentives that are driving demand for better coordination between different health care settings and providers. Provisions of the ACA promote interprofessional team-based care to improve quality and manage the new stresses placed on the health care delivery system.

IPE and interprofessional collaborative practice are not new concepts, but they are gaining greater attention of late. Improved communication and collaboration, along with respect for each profession's unique knowledge base, promises to help providers better address the multiple factors that influence the health of individuals, families, and populations. No single provider or profession can address today's health care challenges alone.

In the classroom, nursing students may be taught the importance of working together with other health care professionals. However, when they begin their clinical training, they often experience a professional hierarchy that inhibits collaboration. Still, nurses are involved in every aspect of health care and their contributions are linked to the availability, cost, and quality of health care.

Collaborative care models in which nurses work to the full extent of their training are critical for the future of health care. Ways to enhance nursing involvement include removing the practice limitations placed on advanced practice registered nurses (APRNs) and opening federally-funded primary care residencies to APRNs.

### *Recommendations*

Intensive efforts over the past decade, funded in part through Title VIII, have helped to ease a projected shortage of RNs. However, continued focus on education is needed in order to produce a stable, adequate supply of nursing professionals to meet the nation's health care needs. Without effective Congressional intervention, the nation risks having a nursing workforce ill-prepared to lead and work within team-based health care environments to assure a high quality and safe health care system. Noting the urgency to transform nursing education and practice to incorporate IPE and interprofessional collaborative practice, this report provides three primary recommendations:

**Recommendation 1:** Congress should increase Title VIII funding for interprofessional education and practice, and expand current sources and existing funding categories to promote new models of healthcare to improve population health and value.

**Recommendation 2:** Congress should fund joint demonstration projects between academia and practice, to include community-based and rural settings, that develop innovative models of clinical education to prepare health professionals for team-based care.

**Recommendation 3:** Explore and develop new models of interprofessional clinical practice to achieve the key health care goals of better care, improved health outcomes, and lower cost.

These recommendations underscore the benefits to the nation when sufficient Title VIII funding is provided to support the essential development of the nursing profession, as well as to align nursing education and practice with new and emerging models of effective health care. Nurses and APRNs are key primary care providers. They are the leading providers for rural and underserved populations. Without realignment of funding, nursing may be left out of crucial interprofessional training models.

Furthermore, it is imperative that Congress fund research into joint models of education and practice. There are insufficient demonstration models to understand what works best under what conditions to lead to measurable improvements in health.

This report emphasizes investments needed to strengthen nursing's ability to lead and to practice team-based care effectively. These investments promote nursing education and practice. They provide necessary support for educational institutions and partners to devise new models of care and move the nation toward better health.

## Introduction

Nurses are the largest body of health providers and form the foundation of the nation's healthcare workforce. As such, nurses play a critical role to in the transition going on within today's health systems to develop interprofessional team-based models of practice, in which team members from different health care professions collaborate to improve patient care. Interprofessional teams may be comprised of health care professionals, such as physicians, nurses, APRNs, and pharmacists, as well as other providers such as community health workers and patient navigators. According to the National Diabetes Education Program, a collaborative program of the National Institutes of Health and the Centers for Disease Control and Prevention, health care teams typically include "health care professionals with complementary skills who are committed to a common goal and approach" (National Diabetes Education Program, 2013, p. 9). The interprofessional team models are designed to provide better care coordination and improved patient experiences and outcomes, at a lower overall cost of care (Institute of Medicine [IOM], 2015; Sullivan, et al., 2015).

For team-based care to succeed, students in the health professions need to learn the value of teamwork and how to collaborate with other health professionals during their educational careers. Meanwhile, providers will need ongoing training and support to function and collaborate within teams in their professional roles.

This transition requires a fundamental shift in health provider education away from the traditional academic model of isolating each profession in separate and independent schools. Institutions involved in training health professions students need to develop programs for interprofessional education (IPE), in which students from two or more disciplines learn about, from, and with each other to enable effective collaboration (Centre for the Advancement of Interprofessional Education, 2002). "Inadequate preparation of health professionals for working together, especially in interprofessional teams, has been implicated in a range of adverse outcomes, including lower provider and patient satisfaction, greater number of medical errors and other patient safety issues, low workforce retention, system inefficiencies resulting in higher costs, and suboptimal community engagement" (IOM, 2015, p. 11-12).

The World Health Organization (WHO) (2010) describes IPE as being about preparing a "collaborative practice-ready" health workforce better able to respond to both local and global health needs. According to WHO, collaborative practice happens when care providers from different professional backgrounds work together to provide the highest quality of care. A collaborative practice-ready health worker has learned to work competently within these interprofessional teams, and incorporate the knowledge and skills of others into plans of care to achieve the health goals of patients, families, and communities.

In the summary report of a recent Institute of Medicine (IOM) workshop on IPE, Dr. George Thibault stated: "Interprofessional education is a tool...to accomplish linkages between the

education system and the health care delivery system. It is a tool to achieve better patient care [and] better health for the public” (IOM, 2013, p. 25). According to Dr. Thibault, IPE is critical for the “triple aim” of health care, a framework developed by the Institute for Healthcare Improvement (2015) to achieve:

- Better patient care
- Better health outcomes
- A more efficient and affordable health care system

Within the health care system, interprofessional collaborative practice depends on the formation of teams of providers with a range of experience, education, professional knowledge, and training, all able to communicate with each other to share ideas and insights (Sullivan, Kiovsky, Mason, Hill, Dukes, 2015). In the United States, the passage of the Affordable Care Act (ACA) in 2010 has introduced new reimbursement models and financial incentives for health care providers, which in turn are driving demand for better coordination between different health care settings and providers. Provisions of the ACA support interprofessional team-based care to improve the quality of care while handling the stresses placed on the health care delivery system by the increase in the number of individuals with health insurance (Newhouse et al., 2012).

IPE and interprofessional collaborative practice are not new concepts, but they are gaining greater attention of late. Respecting the contributions of each profession’s unique perspective promotes communication and collaboration, helping providers better understand and influence the multiple factors that affect the health of individuals, families, and populations. No single provider or profession can address today’s health care challenges alone (Newhouse et al., 2012; Sullivan et al., 2015).

## **Background**

Federal support for nursing education and practice under Title VIII spans over fifty years. Funding through Title VIII has served to improve the ability of nurses to address the health needs of those in underserved populations and has resulted in major contributions to the health care available to the country’s population. These funds, although limited, have been used to develop numerous innovative approaches that enhance nursing’s ability to address new and emerging health care issues, provide care to the underserved, and recruit into nursing more individuals from minority and disadvantaged backgrounds. Current levels of funding are inadequate to accomplish all the clearly indicated objectives of the Title VIII legislation, especially given the passage of the ACA. Continued funding at least at the current levels is essential, while an assessment of the funds required to meet rising critical demands in the development of a well-trained and diverse nurse workforce is needed.

Over the past two decades, the United States has focused on addressing the critical changes needed to improve the quality of our nation’s health care. Care models have emerged that are

designed to provide better care coordination and better quality outcomes while improving the health of all patients and empowering them to be active partners in their care. The goal of these care models is to improve timely access to care and the value of care.

Provisions of the ACA emphasize prevention and early intervention to reduce the development of chronic disease and avoid costly interventions, such as the inappropriate use of the emergency department for primary care. Patients can also expect expanded services providing greater access to care. Another component supported by the ACA, the electronic health record, gives patients and providers greater access to health records, promoting continuity of care. In addition, newer mobile and virtual technologies can allow providers to reach patients in their homes and communities—models of care again designed to keep patients healthy. These areas are well-suited to collaborative nursing involvement within interprofessional teams.

Health care reform requires redesigning care processes, using health information technologies, improving care coordination, and designing appropriate performance and outcome measures. Reform must also be responsive to contextual factors such as socio-economic indicators, ethnicity, and differences between urban and rural healthcare systems. Numerous reports document the need to prepare health professionals to practice collaboratively to improve patient safety, health care quality, and health outcomes (IOM, 2001; IOM, 2003a; IOM, 2003b; IOM, 2010; IOM, 2011; Interprofessional Education Collaborative Expert Panel, 2011; WHO, 2010).

Calls for IPE and collaborative practice are gaining global attention as important strategies to improve health care quality. The WHO (2010) *Framework for Action on Interprofessional Education & Collaborative Practice* summarizes evidence that effective collaborative practice optimizes health-services, strengthens health systems, and improves health outcomes. In particular, IPE helps students gain real-world experience and learn about the work of other practitioners. Meanwhile, collaborative practice can improve access to and coordination of health services, health outcomes for people with chronic disease, and patient safety, while decreasing hospital admissions, patient complications, clinical errors, and conflict among caregivers.

### *Interprofessional education in nursing*

In classroom-based instruction, nursing students may be taught the importance of working together with other health care professionals. However, when they get to their clinical training, they often have a very different experience. They go into the hospital setting and quickly realize that professionals tend to practice within their own silos, and there are barriers, for example, between nurses and doctors that prevent them from fully working together.

IPE is intended to break down these professional silos. It involves training health professions students in a different way—teaching them what it means to work together as a team and giving them practical experiences in successful interprofessional practice clinical settings (American Association of Colleges of Nursing, 2012; Newhouse, et al. 2012).

IPE and training experiences in interprofessional collaborative practice environments facilitate the development of a health care workforce that is capable of providing high quality, high-value care to patients, families and communities in new and transforming delivery systems. Many academic health centers, where the majority of physicians receive their training, have embraced the principles and elements of IPE and the need for delivery systems to achieve better health outcomes, at a lower cost, for the population served. However, many nurses and allied health professionals are prepared at colleges and universities that are not affiliated with an academic health center, limiting opportunities for contact with students in other professions.

The 2011 IOM report, *The Future of Nursing: Leading Change, Advancing Health*, calls for the transformation of nursing education “to prepare graduates to work collaboratively and effectively with other health professionals in a complex and evolving health care system in a variety of settings” (p. 164). While the primary goals of nursing education remain the same—nurses must be prepared to meet diverse patients’ needs; function as leaders; and advance science that benefits patients and the capacity of health professionals to deliver safe, quality patient care—the IOM report also underscores that major changes in the U.S. health care system and practice environments will require equally profound changes in the education of nurses both before and after they receive their professional licenses.

#### *From IPE to interprofessional collaborative practice*

Nurses are involved in every aspect of the health care system and nursing impacts the availability, cost, and quality of health care. Intensive efforts over the past decade, funded in part through Title VIII, have helped to ease a projected shortage of Registered Nurses (RNs). Still, a continued focus on education is needed in order to produce a stable, sufficient supply of nursing professionals with appropriate education to meet the nation’s health care needs and priorities (U.S. Department of Health and Human Services, 2014). Along with the contemporary changes in the healthcare system to expand healthcare coverage through the ACA, nursing education is evolving based on best practices, new technologies, and innovations in and out of the classroom. More nursing services are being provided outside of the hospital environment, within complex community-based health care systems that involve a wide range of health care workers.

Collaborative practice cannot be separated from IPE. “Making this important linkage between interprofessional education and collaborative practice will create an environment within which all participants learn, all teach, all care, and all collaborate. It invites recognition that better outcomes for individuals and populations; better quality, safety, and value within healthcare systems; and better education, training, and life-long professional development of healthcare workers are all connected” (Cox & Naylor [Eds.], 2013, p. 22). High performing teams require an educational foundation in teamwork and collaboration, and they are an essential tool for a patient-centered, coordinated, and effective health care delivery system (IOM, 2013).

Historically, health care has been delivered within a professional hierarchy, with the medical doctor as the dominant figure. This traditional health care professional hierarchy is no longer sufficient and often fails to promote teamwork, inhibiting efficient, accessible, and safe care. The primary care physician workforce has dwindled (Association of American Medical Colleges, 2015), becoming increasingly mal-distributed and struggling to care for an aging population. As a result, this hierarchy of care is not sustainable (IOM, 2011). Collaborative care models, composed of interprofessional teams, are critical for the future of health care (Newhouse et al., 2012).

Transitioning to a team-based model is encumbered with challenges that need to be addressed through IPE and collaborative practice. A significant barrier involves the practice limitations placed on APRNs, such as nurse practitioners and nurse midwives. One recommendation from the *Future of Nursing* report states: “Advanced practice registered nurses should be able to practice to the full extent of their education” (IOM, 2011, p. 278).” Without the removal of these barriers and the opportunity for healthcare professionals to learn together to the full extent of their education and training, it is unlikely team-based care will reach its full potential.

## **Discussion**

### *Challenges to IPE*

The lack of trust combined with stereotypes and hierarchies contribute to poor communication and dysfunctional relationships among health care providers. These challenges in the health care delivery system compromise good health outcomes and need to be addressed. Early training in IPE is one strategy for addressing communication and relationship challenges (Zierler, 2014).

Health care education accrediting bodies are beginning to include expectations for health professions programs to incorporate IPE in their education processes as a requirement for attaining and maintaining accreditation. However, these bodies lack a collective mandate to require IPE. Without a full embracing of IPE as a requirement of accreditation, academic institutions may be slow to fully integrate IPE competencies in their curricula.

Educational programs for health professions remain isolated from each other. Such an arrangement limits opportunities to develop teamwork. Successful transition to collaborative practice begins with the socialization of students into collaborative educational experiences during college. This could begin with a joint course introducing students to interprofessional concepts and behaviors followed by strategically designed collaborative clinical rotations. If students can transfer IPE competencies and skills into practice, then future health care teams will function at a higher level to deliver safer and more cost-effective care (Bankston & Glazer, 2013).

An important feature of IPE is the availability of partners and settings that provide opportunities for health professional students to share in the educational experience. Schools or colleges that

are fully integrated into an academic health center and those without an academic health center but in locations near to other health profession programs are better positioned to engage in IPE. Stand-alone schools and colleges without other health care professional schools can experience greater challenges. It is not impossible to create IPE opportunities while lacking partnerships within the same university; however, greater commitment between institutions and between the different colleges, schools, and practice partners is needed. Use of communication technology, such as through distance learning or shared patient simulation exercises, may facilitate these vital connections (Bridges, Davidson, Odegard, Maki, & Tomkowiak, 2011).

Faculty development programs are needed to focus on IPE-specific skills such as developing interprofessional teams, providing constructive feedback, and post-event debriefing. The health care system has a historical hierarchy among healthcare professionals that may cause power struggles when planning and teaching an interprofessional curriculum. Faculty may not have the skills necessary to develop and perform IPE adequately (Buring, et al., 2009; Sullivan, 2015). Many educational programs have not fully embraced IPE or incorporated it strategically into their programs and curricula. Interprofessional collaborative practice best occurs when it has been fully integrated into educational programs. Consideration should be given to all approaches that enhance IPE competencies. A number of agencies, such as the Agency for Healthcare Research and Quality (2014), have published models for improving teamwork skills designed to enhance patient health outcomes and safety. New models of interprofessional collaborative practice need to be developed, evaluated, and reimbursed accordingly. Some institutions have developed a single course to integrate IPE into their curricula. Such a course may be didactic, experiential (or service learning), clinical/simulation, or a combination of the three. Other institutions may elect to require an IPE course for all health profession students or offer the course as an elective. Still others integrate IPE content and experiences in multiple courses foregoing a single course model. Some examples of programs that support IPE are provided below.

- The National Center for Interprofessional Practice and Education (National Center) is a public-private partnership created in October 2012 through a cooperative agreement with HRSA and three private foundations: the Josiah Macy Jr. Foundation, the Robert Wood Johnson Foundation and the Gordon and Betty Moore Foundation. The aims of the National Center include breaking down the silos between the health care professions and facilitating the preparation of a health care workforce able to work in team-based care delivery systems that improve health care quality, safety, and access. The National Center has created the Resource Exchange, a community-led, fully searchable source for information about interprofessional practice and education, and is working to develop accurate measures for the impact of IPE (Lutfiyya, Brandt, Delaney, Pechacek, & Cerra, 2015; IOM, 2015).

- Rosalind Franklin University of Medicine has developed an Interprofessional Healthcare Teams course as a required experiential learning opportunity. Students learn within interprofessional healthcare teams with emphasis on team interaction, communication, evidence-based practice, and quality improvement (Bridges et al., 2011).
- The University of Florida instituted an Office of Interprofessional Education within the Office of Health Affairs to promote the successful integration of IPE within the health profession disciplines. Under this office, the University implemented an Interdisciplinary Family Health (IFH) course that is required for all first-year students in medicine, dentistry, nursing, physical therapy, nutrition, and clinical and health psychology. The office is charged with facilitating and supporting multiple cross-college curricular development activities in addition to the IFH course. The course spans two semesters and incorporates didactic, experiential, and care coordination components. Students across disciplines are required to meet a set of learning objectives based on interprofessional competencies (Bridges et al., 2011).
- The University of Washington (UW), through its Center for Health Sciences Interprofessional Education, offers a wide range of collaborative interprofessional offerings for students in the health sciences. These courses have a variety of IPE foci such as substance abuse, the care of the medically underserved, etc. The UW IPE courses include didactic, service learning, and experiential training activities, along with a simulation component. Student teams collaborate to provide care in patient simulation experiences, which allow participants to practice and demonstrate team-based skills in a safe environment (Bridges et al., 2011).

*A challenge to collaborative practice: lack of APRN eligibility for postgraduate residencies in teaching health centers*

One provision of the ACA authorized a new graduate medical education program, under Title VII of the Public Health Service Act, for graduate medical and dental residencies in Teaching Health Centers (THCs) (Health Resources and Services Administration, n.d.). This federally funded program differs from the graduate medical education that is funded by the Center for Medicaid and Medicare Services (CMS) to teaching hospitals. Eligible THCs are community-based ambulatory patient care centers, including federally-qualified health centers (FQHCs), rural health clinics (RHC), health centers operated by Indian Health Service or tribal organizations, and entities that receive funds under Title X of the Public Health Service Act. Payments cover the costs of new residency programs in community-based ambulatory primary care settings such as health centers. The new training models are distributed around the nation and train physician residents in family medicine, internal medicine, and general dentistry.

APRNs, in particular nurse practitioners, play a valuable role in providing primary care in the THCs where these residencies are conducted. However, they are not eligible for these residencies. Because these new postgraduate training models were created to strengthen primary

care and there is a national trend to develop nurse practitioner residencies, it is essential that nurse practitioners also receive training support in these interprofessional primary care residency programs.

### *Licensure barriers*

Licensure barriers form another challenge to nursing. APRN practice is regulated by each state. Only about one third of the states have adopted practice authority licensure and regulations that support the full extent of APRN practice, which should include the ability to evaluate patients, diagnose, order and interpret laboratory and diagnostic tests, initiate and manage treatments, and prescribe medications (Hain & Fleck, 2015). As a result, APRNs with the same educational preparation and national certification often face restrictions in practice when moving from one state to another (Safriet, 2011). Licensure or regulatory requirements for physician supervision also limit APRN and midwifery practice (Newhouse et al., 2012). Restrictions in the scope of practice of APRNs directly impacts access to care for patients and payment policies (Newhouse et al., 2012; Yee, Boukus, Cross, & Samuel, 2013), and inhibits interprofessional collaboration.

### *Next steps*

Moving beyond the development, implementation, and testing of IPE models to the promotion and inculcation of values in which IPE is a central mission of universities and colleges is an important next step. Such an educational shift reflects the embrace of core competencies in preparing students for interprofessional collaborative practice as an essential component for all health professionals to provide integrated, high quality care (Interprofessional Education Collaborative Expert Panel, 2011). There is insufficient evidence that these efforts are occurring.

## **Recommendations**

Since its inception in 1998, NACNEP has conducted its examination of the Title VIII administration and regulations with respect to the nurse workforce, education, and practice improvement during a time of continual and rapid change in the health care environment. Nursing must be responsive to these changes to fulfill its responsibility to provide timely, high-quality health care to the nation's populace. NACNEP specifically targets aspects that influence federal policy and for which the federal government can be instrumental in effecting change, while recognizing that change can come about only through the concerted activities of all public and private partners, including those in the profession, the health care industry and consumers, and all levels of government. However, NACNEP sees a distinct role of leadership for the Federal government through Title VIII and other Federal government vehicles that fund nursing education and nursing services. NACNEP developed the following three recommendations in the following categories: Education, Practice, and Policy and Research.

## *Education*

**Recommendation 1:** Congress should increase Title VIII funding for interprofessional education and practice, and expand current sources and existing funding categories to promote new models of health care to improve population health and value.

**Recommendation 1.1:** Congress should direct the Centers for Medicaid and Medicare Services to realign Graduate Medical Education (GME) funding to support interprofessional education programs, along with post-graduate training programs such as advanced practice nursing residencies, in order to restructure the health professions workforce.

**Recommendation 1.2:** HHS should establish and support a network of interprofessional clinical practice environments necessary to better leverage existing interprofessional education training investments and to forge efficient partnerships between academia and health care delivery systems.

**Recommendation 1.3:** HHS should provide professional development for faculty preceptors and the clinical nursing workforce to ensure competence to teach interprofessional practice and students for collaborative models of care.

## *Practice*

**Recommendation 2:** Congress should fund joint demonstration projects between academia and practice, to include community-based and rural settings, that develop innovative models of clinical education to prepare health professionals for team-based care.

**Recommendation 2.1:** Congress should convene and require all HRSA national advisory councils to develop joint recommendations regarding strategic direction for Interprofessional Education and Practice across disciplines.

## *Policy and Research*

**Recommendation 3:** Explore and develop new models of interprofessional clinical practice to achieve the key health care goals of better care, improved health outcomes, and lower cost.

**Recommendation 3.1:** HHS should invest in initiatives that enhance the nation's ability to collect, analyze, and report on interprofessional collaborative practice.

**Recommendation 3.2:** Congress should fund the National Institutes of Health to grant research opportunities in the areas of interprofessional education and practice including the areas of safety, quality improvement, and organizational change.

**Recommendation 3.3:** Congress should fund the National Healthcare Workforce Commission with a mandate to examine how enhancements can be made to interprofessional practice.

**Recommendation 3.4:** HRSA should establish a mechanism within the National Center for Health Workforce Analysis to examine the impact of the ACA on nursing quality and skillset related to interprofessional practice.

**Recommendation 3.5:** HHS should reinstate and fund initiatives that promote Interprofessional Education and Collaborative Practice (IPECP) in reducing profession-specific silos for funding by expanding the funding opportunity announcements to support interprofessional education and collaborative practice.

**Recommendation 3.6:** Congress and HHS should designate a portion of the total amount appropriated for HRSA funded health centers and Nurse-Managed Health Centers in order to promote and sustain interprofessional collaborative practices to serve underserved populations and contribute to the reduction of health disparities.

**Recommendation 3.7:** CMS should realign its payment system with interprofessional practice in order to recognize all member of the interprofessional team.

## **Conclusion**

Education and practice transformation in nursing hinges on effective interprofessional primary care training models, especially new community-based programs. Educational realignment will not achieve maximum impact without including reimbursement model reform and assuring that the contributions of all the team members are recognized. This is especially challenging to nurses who often are inadequately reimbursed for services provided and hidden within a reimbursement hierarchy that does not recognize nursing's direct contribution.

This report of the NACNEP addresses the health care system's need for a more targeted focus on IPE and collaborative practice, and emphasizes investments in policy and action that are needed to strengthen nursing's ability to lead and to practice team-based care effectively. These investments promise to solidify the link between education and practice, and provide critical support for educational institutions and partners to devise new models of care that serve to move the nation toward better health.

Recognizing the integral role of nursing in our health care system, the NACNEP strongly believes that prioritizing clinical training in interprofessional team-based care will increase the capacity of health care teams to deliver quality, coordinated, safe, and efficient care to patients, families, and communities.

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