# **POPULATION HEALTH 2025 & BEYOND**

Evaluating the Community Partner-IPE Practicum Collaborative Experience.

# **OBJECTIVES**

- Demonstrate the use of community partners academic collaboration as a viable model for integrating inter-professional practicum experiences into advanced practice nursing curriculum
- Demonstrate challenges and successes of the IPE partnership & student



- 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
- Achievement of mutually agreed upon family goals for at-risk families within the PCMH model
- · Improved population health outcomes & care experience for patient and
- 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



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

Ignite

MISSION

Xavier University Health 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.

PATIENT -

CENTERED

**CARE** 



# IDENTIFY

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

# INVOLVE

STRATEGIC

Lead interprofessional roups to frame and explore important health issues.

Foster innovation to develop meaningful outcomes.

implementing solutions for the benefit of all affected stakeholders.

**ABSTRACT** 

Titles:
Interprofessional (IP) collaboration is the cornerstone of delivering high quality, patient-centered, safe, and cost-effective care. Integrating IPE core competencies into the advanced practice nursing curriculum prepares Family Nurse Practitioners (FKPs) to work as members of an interprofessional health care team of physicians, nurses, social workers, nutritionists, mental health workers, and community members. With experience in an interprofessional collaborative practice, FNPs will be more able to provide comprehensive, holistic primary health care patients and families in the community. This poster presentation is an evaluation of a community-academic interprofessional partnership model designed as an integrated practicum experience for FNP students. The Community Partner-IPE Practicum Collaboration model was previously introduced at a nursing faculty development workshop. The community partner-IPE Practicum Collaboration model was previously introduced at a nursing faculty aceleopment workshop. The community partner specified in the purpose of providing FNP students with an active role in interprofessional collaboration through service in a high-need, resource challenged, urban neighborhood. Students work collaboratively with a community partner to develop goals and objectives for the practicum experience that meet the service needs of the community partner the learning needs of the student, and the health care needs of selected families. 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 members of the interprofessional team and include improved access to primary care services, coordination of care for the family unit, navigating the health care sional team and include improved access to primary care services, coordination of care for the family unit, navigating the health care dutilization of community services (primary care, oral health, specialty services, social services, mental health services, and community ncies). This innovative model has implications for interprofessional education and practice by incorporating service learning with a specific and







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