

Improving Health and Learning Outcomes by Advancing Interprofessional Collaboration: A Roundtable Dialogue

Executive Summary

Despite decades of investment in interprofessional education, meaningful and sustained interprofessional practice and education (IPE) remains uneven across U.S. health systems. We have not achieved the goals of effective interprofessional collaborative practice: high quality, safe, efficient, timely, person-centered care. While pre-licensure programs have made substantial progress in preparing learners for team-based care, these gains frequently dissipate as learners transition into clinical practice. The clinical learning environment (CLE)—the place where education, patient care, organizational culture, and system pressures converge—has emerged as the critical space where the misalignment between interprofessional education and interprofessional practice becomes visible.

To address this persistent gap, a national Roundtable, **Advancing Health and Learning Outcomes by Transforming Interprofessional Collaboration: A Roundtable Dialogue Reimagining the Clinical Learning Environment Together**, was convened to reimagine how health systems might intentionally design CLEs that leverage interprofessional collaborative practice to achieve the Quadruple Aim.¹ The Roundtable brought together educators, clinicians, health system leaders, accreditation experts, patient and family advisors, and learners. Through a structured, multi-day process, participants examined why prior innovations fail at scale, articulated a shared vision of high-functioning interprofessional care, generated audacious ideas for transformation, and stress-tested those ideas through pre-mortem exercises.

This white paper synthesizes the purpose, process, key themes, and outcomes of the Roundtable. It offers practical guidance for academic–practice partnerships, health systems, and national bodies seeking to redesign CLEs as engines of interprofessional learning, teaming, and improvement. It also identifies limitations of the Roundtable process and proposes next steps toward a coordinated national movement.

Acknowledgements

The Roundtable dialogue and this white paper were made possible through a grant by the Josiah Macy Jr Foundation. (P-25-08). The conclusions and recommendations included in this report represent a consensus of the group and do not necessarily represent the views of the Josiah Macy Jr. Foundation. A special thank you to Cleveland Clinic and the National Center for Interprofessional Practice and Education for their support in making this work possible.

Suggested Citation

National Center for Interprofessional Practice and Education. (2026). Improving Health and Learning Outcomes by Advancing Interprofessional Collaboration: A Roundtable Dialogue. Cleveland, Ohio.

<https://nexusipe.org/advancing/advancing-health-and-learning-outcomes-transforming-interprofessional-collaboration-roundtable>.

Introduction

Achieving the Institute for Healthcare Improvement's Quadruple Aim¹ requires current and future healthcare professionals to work together effectively in interprofessional teams. Unfortunately, the preclinical curriculum alone does not adequately prepare learners with the team-oriented mindset, knowledge, and skills needed to become effective interprofessional collaborators in the clinical learning environment (CLE). Moreover, when poor teaming is modeled in clinical settings, it undermines the teamwork skills that students and other professionals-in-training utilize in their future practice.

To address these challenges, an invitational Roundtable convened educators, practicing health care professionals, national leaders in healthcare and education, learners, patients, and other key stakeholders. The aim was to develop actionable recommendations to advance academic/health system partnerships that improve team-based care and patient outcomes. Roundtable participants identified specific strategies to accomplish these goals by striving to incorporate impactful interprofessional education throughout practice settings and across the continuum of health professions education - from novice through continuing professional development. This will lead to successful interprofessional collaborative practice that improves health and learning outcomes in the CLE and future practice. It is important to note that interprofessional practice and education appropriately spans well beyond medical or health system learning environments and ultimately must include a full range of community practice environments and partners to achieve optimum health for the public. However, the scope of this Roundtable was limited to academic/ health system partnerships to focus the conversations and maximize short-term impact.

Background: What problem are we seeking to address?

In the quarter century since the landmark publication of *To Err Is Human: Building a Safer Health System*² called attention to the need for effective interprofessional practice and education in order to promote safety in America's health system, enormous resources have been directed toward improving safety.^{3, 4} However, only incremental progress has been made in reducing errors and improving safety and quality. While many factors influence patient safety, effective interprofessional education to ensure practitioners are prepared to practice in highly effective teams has long been recognized as one of the most effective interventions to promote safety and quality.²

Interprofessional education “occurs when students or members of two or more professions learn with, from, and about each other to enable effective collaboration and improve health outcomes.”⁵ Over the last decade there has been a growing emphasis on developing the ability of all health professionals to more effectively communicate and collaborate in the care of individuals, families, communities, and populations to achieve the Quadruple Aim.¹ Competencies for interprofessional practice have been defined by the Interprofessional Education Collaborative⁶ and accrediting bodies for most health professions programs now require the integration of interprofessional education into mandatory curricula. Additionally, teaming is one of six focus areas in the Accreditation Council for Graduate Medical Education’s Clinical Learning Environment (CLE) Review program because “the optimal clinical learning environment supports high-performance teaming” in which “team members collaborate and share accountability to achieve outstanding results.”⁷

A growing body of work has addressed the need and opportunity to enhance the interprofessional clinical learning environment in order to improve interprofessional learning and collaborative practice outcomes. Examples that synthesize existing literature and best practices include Developing Quality Interprofessional Education for the Health Professions by the Health Professions Accreditors Collaborative and the National Center for Interprofessional Practice and Education⁸ and the National Academies of Medicine report, Measuring the Impact of Interprofessional Education on Collaborative Practice and Patient Outcomes.⁹

Despite the growth of interprofessional education across institutions, effective teamwork in the CLE remains inconsistent. Though students are required to participate in interprofessional education early in their professional training, it is usually infrequent, short, and focused merely on how different professions approach clinical cases. There is little emphasis on teaching and practicing effective teamwork behaviors and skills. As a result, many learners enter the CLE unprepared for interprofessional collaboration or without sufficiently developed skills to distinguish between poor and effective practices. Furthermore, effective interprofessional collaboration in the CLE is modeled inconsistently. Preceptors and others in the CLE may not have had formal interprofessional education themselves and may not be familiar with or practicing high-quality, evidence-based interprofessional collaboration in their own work. Consequently, toxic work environments that lack psychological safety and team cohesion are much too

common, failing to foster inclusive workplaces where all team members are heard regardless of their roles, diverse training, or lived experiences.¹⁰ These challenges were exacerbated by the lingering impact of Covid-19 that resulted in high levels of burnout, turnover, unprecedented job vacancies, and increased use of temporary personnel in many healthcare settings.

Partnerships intentionally designed to address this challenge at the intersection of practice and education have the potential to improve health and learning outcomes that matter to the people they serve, to learners and practicing members of health teams, and to healthcare organizations.¹¹ Systems-level partnerships that bring together healthcare systems and academic institutions with shared goals can leverage their unique strengths and expertise to foster learning environments in which they work together to achieve the Quadruple Aim outcomes.¹²

Project Purpose: What are the purpose and goals of the project?

The purpose of this Roundtable dialogue was to co-create best practices and concrete recommendations to support sustainable academic-practice partnerships. This built on the current interprofessional education and learning health system literature, informed by the experience and practical wisdom of Roundtable participants.

The organizers, representatives from health systems and academic institutions who are already in committed partnerships, professional organizations, learners and patients convened to contribute to this important work. The design of the Roundtable aimed to highlight the strengths and shared values of these academic and clinical partnerships. By exploring the key attributes, approaches, and complementary data sets that exemplify their mutually beneficial impact. With a focus on shared goals around student learning, individual and team performance, organizational learning, and health outcomes. This work advances the Josiah Macy Jr Foundation's commitment to Increasing Collaboration Among Health Professionals, builds on investments the Macy Foundation has made in the National Center for Interprofessional Practice and Education (National Center), and aligns with initiatives at Cleveland Clinic (CCF) over more than a decade.

The goals of this Roundtable dialogue were to:

1. Articulate a shared vision of our desired future state of interprofessional care.
2. Identify best practices to develop and sustain academic and practice partnerships that engage in formal and informal interprofessional learning in practice.
3. Build on current work and conceive scalable strategies.
4. Define meaningful metrics that demonstrate improved outcomes for our learners, our practice teams, our institutions, and our patients both locally and nationally.

This White Paper describes the conversations and work of the Roundtable and provides action-oriented strategies and lessons for academic/practice partnerships as they work to implement Roundtable recommendations within their local environments.

Roundtable Design and Process

The Roundtable was structured as a multi-day, team-based convening that deliberately combined brainstorming, ideation, sensemaking, critique, and synthesis.

Activity 1: Initial Conversation

At the beginning of the Roundtable, participants were assigned to tables to ensure teams included clinicians, educators, health system leaders, accreditation experts, as well as patient and family advisors. Each person introduced themselves and shared one initial thought or idea that they had related to the Roundtable goals and vision. In the second round, after hearing from everyone at the table, participants offered their comments and were invited to share a past or current experience that could contribute to the goal of the Roundtable. The table work for this activity concluded with the generation of two ideas that would accomplish the goal of the Roundtable. The conversations explored the current state of interprofessional learning and practice, with particular attention to where and why progress stalls. Participants at each table explored perceived barriers, cultural and structural constraints, and misalignments between education and practice. This activity surfaced frustration with the fragility of existing interprofessional learning

initiatives and the lack of system-level infrastructure to support interprofessional collaboration. This activity emphasized the importance of psychological safety, shared mental models, mutual respect, honest communication, and collective accountability. Roundtable facilitators also highlighted the centrality of leadership behavior, onboarding practices, and cultural norms in helping to shape high-impact team performance.

Activity 2: World Cafe

Before beginning the second activity, all but one person at each table rotated to another table based on predetermined assignments. The person who remained at the table presented the two ideas that the initial team created to accomplish the Roundtable goals. The new team then discussed and critiqued the two ideas based on the conversations they had at their previously assigned table and their lived experience in interprofessional settings. The teams were then asked to select one idea to move forward in the design phase and draw a visual representation of the idea. These visual representations were then presented to the larger group. The teams developed ambitious proposals aimed at transforming CLEs at scale. These included interprofessional onboarding models, learner-embedded quality improvement systems, micro-credentialing and certification pathways, interprofessional coaching infrastructures, and national collaboratives.

Activity 3: Premortem

At the beginning of day two, the teams from activity two met again to review their work from the previous day, and make any desired modifications to their team's proposed idea for achieving the Roundtable's goals. A new presenter was selected, and the other members of the team rotated to another assigned table. The new teams at each table then conducted a pre-mortem, which entails assuming that the project has failed and then work backward to identify why. This exercise proved pivotal in shifting the conversation from aspirational design to structural realism. Participants consistently identified leadership turnover, fragile ownership, misaligned payment models and return-on-investment (ROI) logic, lack of macro-level mandates, scalability constraints, and culture-structure mismatch as dominant failure modes. However, opportunities such as emerging value-based payment models and new ROI logic to address ongoing workforce challenges emerged as opportunities. These insights suggest a key opportunity to develop frontline leaders capabilities and prepare them to understand ROI as seen from the c-suite. This includes supporting them in making the case for the evidence and

business rationale for investing in making interprofessional teamwork more effective, locally. Additionally, senior health system leaders should be educated in the value of improving teamwork to meet financial, workforce, and patient care priorities.

Activity 4: Co-Creation of Team Projects

The Roundtable organizers then led the entire group through a process of selecting and co-designing the projects that participants would work on for the remainder of the Roundtable. At the end of this activity, five projects were brought forward, and each participant self-selected which project to focus on (see Appendix for description of projects). Through the remainder of the Roundtable the five teams worked together to further develop their chosen projects, based on guidelines provided by the organizers.

Key Themes

The Roundtable discussions, pre-mortem exercises, final presentations, and participant reflections revealed a set of interrelated themes that explain both the persistent limitations of interprofessional learning efforts and the conditions under which meaningful, scalable change becomes possible. To improve clarity while preserving narrative flow, the themes are organized below under integrative headings that reflect how participants themselves described the issues.

1. The Clinical Learning Environment as an Opportunity

Participants consistently identified the CLE as the primary space where the link between interprofessional education and practice breaks down, offering an opportunity for interprofessional transformation. While learners acquire teamwork concepts in formal educational settings, those behaviors are often neither modeled nor reinforced, undermining collaborative efforts. Instead, they enter environments governed by productivity pressures, siloed workflows, and hierarchical norms. Several participants emphasized that this disconnect does not reflect a failure of education, but rather systematic challenges in the environment into which learners are socialized. One participant noted that the Roundtable clarified “the gap in interprofessional education and health system dynamics and the intentionality needed to bridge the two,” underscoring the CLE as the missing middle between education and practice. Interprofessional learning, rather than curriculum alone, was identified as the structural bottleneck.

2. Culture as the Primary Determinant of Interprofessional Practice

Across small group discussions, participants repeatedly returned to the idea that culture, not the curriculum, ultimately determines whether interprofessional practice takes root. While many institutions have developed toolkits, frameworks, and training modules, these technical or curricular fixes have failed to gain traction because they are not supported by leadership behaviors, onboarding practices, workplace norms, and what organizations reward. These factors were described as far more consequential than formal training content, so rather than viewing these efforts as poorly conceived or unnecessary, participants framed their fragility as predictable outcomes of cultural misalignment. As one reflection suggested, the Roundtable challenged participants to confront whether current efforts are truly making a difference or simply giving the appearance of progress. This reframing shifted the focus from adding new interventions to re-examining how organizations signal what truly matters.

3. Onboarding as an Opportunity for Cultural Norm Formation

Shared interprofessional onboarding emerged as one intervention viewed as both scalable and measurable. Participants described orientation as one moment when professional identities are still forming and malleable and where behaviors are not yet entrenched. Shared interprofessional onboarding with a focus on roles, communication, patient safety, collaboration, and psychological safety was viewed as both feasible and essential. In contrast to initiatives that require long-term exposure to demonstrate impact, onboarding was repeatedly described as an intervention with more immediate and observable effects, particularly related to retention and early engagement. Thus, this emerged as an opportunity to study the impact of intentional interprofessional onboarding on improvements in the CLE.

4. Patients as Partners and Co-Creators of Culture Change

A critical first component to achieving needed culture change is to shift the prevailing model of designing healthcare “for” patients, which has largely been driven by existing payment models, to one of co-creation with patients, families, and community members. The health needs of populations, communities, and individuals will only be met by fully engaging with them to understand priorities and design care models and outcomes measures that meet those goals. Similarly, health professions education and the CLE need to be designed and assessed in full partnership with people served to achieve optimal outcomes.

5. Opportunity to Develop, Engage and Empower Preceptors and Frontline Leaders

The discussions also surfaced broad agreement that clinical preceptors and frontline leaders represent both a challenge and an opportunity in translating interprofessional learning into practice. Participants described a system in which preceptors and frontline leaders are expected to model collaborative behaviors in the absence of interprofessional facilitation training and misaligned incentives for clinicians and clinical educators. Inconsistent feedback, lack of protected time, and limited recognition for teaching interprofessional teamwork were cited as barriers that erode even well-designed learning experiences. Misaligned incentives between and among frontline leaders and lack of understanding of the complex business of healthcare disempowers them from making the business case for implementation of strategies to improve interprofessional teamworking locally even when the potential ROI is substantial. The dissonance that learners experience when interprofessional principles emphasized in training are contradicted by what they observe in daily practice frequently reinforces undesirable behaviors. Without systematic preceptor development, interprofessional learning innovations were viewed as unlikely to scale. This also supports the need for team development and coaching.

6. Learners as Contributors to System Learning and Improvement

Another theme involved rethinking the role of learners within the clinical learning environment. Rather than viewing learners primarily as recipients of instruction or potential sources of error, participants reframed learners as potential system sensors capable of identifying near-misses, workarounds, and inefficiencies. Embedding learners into quality and safety processes was described as a strategy that could simultaneously strengthen systems, improve care, and cultivate systems thinking. This perspective reframed interprofessional learning as a mechanism for organizational learning, not solely professional development. One reflection captured this shift succinctly, calling for new ways to *“engage and harness experiences of learners to better inform this effort.”* This reframing positioned interprofessional learning not as an educational add-on, but as an integral component of organizational learning.

The Big Challenge: Why Interprofessional Initiatives Struggle to Scale and Sustain

The pre-mortem exercise yielded a strikingly consistent explanation for why interprofessional initiatives so often fail to endure. Participants identified leadership turnover, fragile or diffuse ownership, lack of macro-level mandates, short-term return-on-investment framing, scalability constraints, and misalignment between cultural aspirations and operational realities. Many reflected on patterns of enthusiasm at launch followed by gradual erosion once champions depart, competing priorities emerge, or senior leadership changes. Importantly, these discussions moved beyond critique to acknowledge that failure is often structural rather than personal, suggesting the need for governance, stewardship, and clearer accountability. These discussions shifted the tone of the Roundtable from optimism about isolated success stories to a more disciplined realism about structural barriers.

The New IPE Lens: Macro-, Meso-, and Micro-level Alignment Is Essential

Underlying all themes was the recognition that isolated interventions are insufficient. Participants repeatedly emphasized the need for alignment across national policy and accreditation (macro-level), health-system culture and infrastructure (meso-level), and unit-level teaming and learning practices (micro-level). For many, this represented a meaningful shift in perspective, from focusing on local projects to considering how national systems might be leveraged to support sustained change. One participant reflected that the Roundtable moved their thinking from individual initiatives to shared national challenges, reinforcing the need for coordinated action rather than fragmented innovation. This shift toward systems thinking ultimately laid the groundwork for calls to move from fragmented innovation toward coordinated national stewardship.

Outcomes of the Roundtable

The Roundtable produced three primary outcomes.

First, it generated a shared diagnostic narrative explaining why interprofessional practice and education (IPE) innovations often fail at scale. Participants moved from optimism about local success stories to disciplined realism about structural failure modes. This shift in framing led to rich conversations and concrete ideas to advance impactful and sustained interprofessional learning and practice outcomes in real-life clinical environments, as described below.

Second, it produced a coherent vision of CLEs as ecosystems rather than programs. This vision emphasized the need to work across macro-, meso-, and micro-levels for integrated solutions that can be sustained at the level of an individual, unit or patient care team across institutions and nationally.

Third, it activated participants. Reflections demonstrated perspective shifts from local projects to national movement-building, from toolkits to ecosystems, and from practitioner-centric to multi-stakeholder framing. Many participants reported concrete plans to engage health system leaders, academic partners, and national bodies.

Practical Guidance for Improving Interprofessional Collaborations

For Health Systems

Health systems have an opportunity to implement shared interprofessional onboarding tied to team norms, safety culture, and role clarity. Interprofessional proficiency should be required for leadership advancement at all levels (c-suite, mid level and frontline leaders), and team coaching or teaming consult services should be established for struggling units. Protected time for teamwork development, patient, family, community and learner engagement, and team-oriented quality improvement work are essential for short- and long-term success in achieving Quadruple Aim outcomes for individual patients, clinical units, and health systems. While this white paper specifically addresses issues within healthcare systems, similar principles apply across all health settings, including community-based practices, social service providers and safety net services working to advance health in their communities.

For Academic–Practice Partnerships

Partners may adopt co-designed onboarding, preceptor development pathways, and approaches to teach and reinforce interprofessional competencies aligned across professions. Learners should be actively engaged in interprofessional teams that deliver day-to-day care and work to improve quality, safety, patient experience and value over time. Competency language, opportunities for reflection, learning, team development, and feedback practices should be harmonized across all levels of learners, from pre-licensure through continuing professional development of practicing teams. Patients, families and community advocates should be engaged as co-creators of education, service delivery and evaluation of health and learning outcomes at every stage of this process.

For National Bodies and Accreditors

National organizations can delineate the features of high-functioning interprofessional teams, integrate IPE expectations into practice-space accreditation, and develop micro-credentials for interprofessional facilitation and coaching. Currently, a diverse group of academic and clinical practice accreditation standards address interprofessional practice and education expectations. There is an opportunity to collate these recommendations and standards to support academic and practice partners to create robust, integrated strategies to achieve compliance while advancing the goals of interprofessional collaborative practice to improve health and learning outcomes.

Limitations

The Roundtable brought together a highly engaged, self-selected group of IPE champions, which may limit generalizability. Perspectives from resource-constrained institutions and frontline staff not already invested in IPE were underrepresented. The design emphasized qualitative synthesis rather than formal empirical evaluation, and long-term outcomes of proposed strategies are largely untested.

Next Steps

The National Center will continue its role as an unbiased neutral convener to engage key stakeholders from across practice and education to advance meaningful partnerships and strategies to achieve important learning,

organizational, and health outcomes by expanding academic/practice partnerships. Such partnerships have been demonstrated to be effective in achieving meaningful outcomes for learners and patients,^{11, 12} but perceived and real barriers have limited implementation. The National Center will work in partnership with Cleveland Clinic to design, implement and disseminate findings of this project and will provide infrastructure through its NexusIPE.org platform to facilitate a longitudinal Community of Practice among participants as a means of supporting implementation, evaluation, and dissemination of Roundtable recommendations.

The next step to move forward the work of the Roundtable will be coordinated by the National Center and will involve convening a national working group to develop the proposed **Interprofessional Co-Production Roadmap: Shared Voices, Shared Impact** which was articulated during the Roundtable and was overwhelmingly selected by participants to be the focus of ongoing work. The National Center is working with Roundtable participants and other partners to explore collaborative opportunities to advance the other projects proposed as part of the Roundtable conversations.

Conclusion

The Roundtable revealed that the persistent failure of interprofessional learning innovations is not due to lack of ideas or motivation but to structural misalignment, fragile ownership, and failure to account for cultural differences. The clinical learning environment is the missing middle that must be intentionally designed if interprofessional collaborative practice is to be realized at scale. Moving from fragmented innovation to a coordinated national movement will require stewardship, macro-meso-micro alignment, and a shift from programs to ecosystems. The Roundtable represents a first step toward that transformation.

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Appendix: Project Descriptions

Interprofessional Co-Production Roadmap: Shared Voices, Shared Impact

While the evidence for collaborative practice is indisputable, the absence of a shared national strategy has resulted in fragmented progress and a measurable decline in clinical performance. This project addresses that gap through a Co-Produced Roadmap designed to transform the Interprofessional Clinical Learning Environment (IP-CLE). By leveraging the National Center's unique convening power, the project moves beyond incremental changes to launching a unified movement focused on the systemic levers of power.

Strategic Impact and Benefits Rooted in co-production, this project brings educators, clinicians, learners, leaders and patients as a "team of teams" to jointly design, test, and refine approaches that translate academic principles into clinical practice:

- **Frontline Agency:** Addresses workforce pressures and competing priorities by listening to clinical teams and learners to ensure change is practical and relevant.
- **Institutional Empowerment:** Equips mid-level leaders with a "change package" that clarifies the ROI of collaboration and aligns workforce development with institutional goals.
- **Systemic Scalability:** Engages C-suite executives, policy leaders, and political appointees to realign systemic incentives with the values of interprofessional care.

Implementation Timeline The roadmap is developed through a four-phase process grounded in humility and appreciative inquiry:

1. **Inquiry & Discovery:** Gathering qualitative and quantitative data through deep listening with diverse stakeholders, from patients to policy-makers.
2. **Convening:** Bringing together shared voices to unearth the educational, professional, and organizational cultures that drive practice.
3. **Synthesis & Prioritization:** Distilling insights into a structured yet flexible roadmap for national change.
4. **Empowerment:** Disseminating the final change package to pull the levers of influence and sustain long-term improvements.

This project elevates the "iceberg" of untapped collaborative value into a visible, national movement that reinforces the essential link between interprofessional teaming and health excellence.

High Reliability Learning Ecosystems: Integrating HRO Principles with Clinical Education

This project proposes a strategic shift in healthcare training by leveraging **High Reliability Organization (HRO)** principles to optimize the interprofessional clinical learning environment. The core premise is that "everybody teaches and everybody learns." By aligning existing HRO frameworks—traditionally used for patient safety—with educational goals, this project creates a seamless ecosystem where clinical excellence and professional development reinforce one another.

Strategic Impact and Benefits Rather than introducing a new burden, this model utilizes established infrastructure and leadership buy-in to drive systemic change:

- **Unified Principles:** The project bridges the gap between HRO values—such as sensitivity to operations and deference to expertise—and the core characteristics of high-performing interprofessional teams.
- **Flattened Hierarchy:** By fostering mutual trust and clear communication, the model prepares all learners to be "system changers" who are recognized by the interprofessional team as effective collaborators.
- **Reliability Through the Patient Lens:** Patient and family perspectives are intentionally integrated into learning and improvement efforts, ensuring that team-based care remains grounded in the lived experience of those the system serves.

Implementation Timeline The project moves from existing safety infrastructure toward a national educational standard:

1. **Early Adopter Selection:** Identifying sites where HRO is already a strategic priority to pilot the integration of educational goals.
2. **Resource Development:** Creating toolkits that translate HRO behaviors (like preoccupation with failure) into practical interprofessional learning activities.
3. **Impact Evaluation:** Measuring how HRO-informed training influences learner readiness, team communication, and patient trust.
4. **National Scaling:** Sharing results across institutions to establish reliability as a continuous, collaborative learning process.

This initiative ensures that the principles keeping patients safe also empower the next generation of clinicians to lead in complex environments.

Environmental Scan of Accreditation Entities

This project addresses a critical gap in healthcare: the misalignment between national industry accreditations and how teamwork unfolds in the Interprofessional Clinical Learning Environment (IP-CLE). While current recognitions shape organizational priorities, they often overlook the collaborative practices that underpin patient safety and high-quality care. By strategically embedding IP-CLE characteristics into existing accreditation frameworks, this project reframes interprofessional collaboration from "extra work" to "the work," aligning compliance efforts with the daily realities of high-functioning clinical teams.

Strategic Impact and Benefits By aligning with national standards, this project delivers three core benefits:

- **Organizational ROI:** Demonstrating how team-based learning improves workforce stability, reduces clinician burnout, and lowers costs associated with medical errors.
- **Enhanced Patient Outcomes:** Incorporating patient partners feedback into accreditation metrics accreditation standards to drive authentic, responsive, and collaborative care.
- **Workforce Readiness:** Providing learners with mentorship and a curriculum that reflects modern, team-centered practice, ensuring they are practice-ready upon graduation.

Implementation Timeline The project unfolds over four distinct phases:

1. **Preparation (Months 1–6):** Recruiting a multi-disciplinary committee and inventorying priority accrediting organizations.
2. **Alignment:** Developing "crosswalks" to map IP-CLE characteristics against existing accreditation standards to identify gaps and integration opportunities.
3. **Advocacy:** Presenting formal recommendations to national spheres of influence and healthcare system leaders.
4. **Evaluation:** Measuring success through the adoption of updated criteria and the downstream impact on clinical learning environments.

This project transforms IP-CLE from an optional enhancement into a nationally recognized standard of excellence, improving both the provider experience and patient care.

Interprofessional Innovation Coaches

This project introduces a national, scalable coaching model designed to transform fragmented healthcare delivery into a unified "team of teams." By positioning **Interprofessional Innovation Coaches** as catalysts for change, the proposal focuses on enabling local teams to develop context-specific solutions that achieve macro-level impact. The model utilizes a centralized structure to assemble teams of coaches—including patient experts, design thinkers, and industry partners—tailored to unique local cultural and operational demands.

Strategic Impact and Benefits This framework moves beyond short-term intervention to create a self-sustaining ripple effect of innovation and resilience:

- **Context-Specific Solutions:** Coaches empower individual teams to solve daily challenges using their own expertise, ensuring solutions fit their specific workflow rather than being imposed from the top down.
- **Institutional Empowerment:** The program builds leadership at the departmental level, turning clinical units into independent "agents of change" capable of sustaining improvements long after the coaching concludes.
- **Systemic Scalability:** By fostering bi-directional communication, the model ensures that local successes are captured and shared widely, validating national investment through localized excellence.

Implementation Timeline The initiative is built on a sequence of validation and national expansion:

1. **Foundation & Buy-In:** Building a robust value proposition to secure macro-level leadership support and establishing a national organizing body to house the program.
2. **Architecting the Network:** Recruiting the coaching roster and defining the interprofessional criteria for assistant coaches from design, industry, and patient advocacy.
3. **Operational Excellence:** Launching proof-of-concept examples at select sites to refine the coaching methodology and document early clinical impact.
4. **Dissemination & Certification:** Establishing national certification pathways for coaches to standardize excellence and scale the model.

This program yields a unified healthcare culture characterized by agility, humility, and measurable improvements in patient and community outcomes.