EP5- Nurses are involved in interprofessional collaborative practice within the care delivery system to ensure care coordination and continuity of care.

Provide two examples, with supporting evidence, of nurses' involvement in interprofessional collaborative practice that ensures care coordination and continuity of patient care.

Example 1: 6 West Interprofessional Care Coordination Rounds

UVA provides care to the most complex patients, who require a variety of expert clinicians from multiple specialties and disciplines to provide care during their hospitalization. Continuity in nursing assignment making is supported to maintain consistency in care. In addition, the interprofessional team structures facilitate continuity in care planning throughout the patient's stay.

Discharge needs must be anticipated as soon as possible to ensure that the best plan is in place for continued care. Patient challenges often include socioeconomic factors and sometimes limited or absent family support. In addition, limited appropriate beds for rehabilitation or skilled care impact the ability to move patients quickly and effectively through the system. 6 West team members engage in interprofessional care coordination each day to ensure collaboration and continuity of care. This collaborative approach to practice is essential to achieving the best outcomes possible for each patient. Exhibit EP5.a is a document that outlines the goals of daily care coordination. (Exhibit EP5.a: Care Coordination Meeting Goals Poster)

6 West is an adult acute (and intermediate care) unit that cares for neurosurgery and head / neck cancer patients. Each weekday at 0830, the interprofessional team rounds outside each patient's room to discuss plans of care. Family members are then able to join the rounds if they choose to do so.

Each discipline participates by providing input to generate an individualized care plan. The RN gives a brief description of the patient and his or her current clinical status, what the RN anticipates will happen during the course of the day and what the patient might need to progress to his or her next level of care. The shift manager leads these discussions and guides newer staff in proactive planning and care management. The patient's unique needs, clinical challenges and medical care plans are taken into consideration as the team works together to coordinate care and provide as much continuity as possible. This organized approach ensures that each team member is providing the patient with a consistent message and expectations about the patient's participation in care. Team members make an effort to ensure that individuals participate for as many consecutive days as possible. This provides continuity for the patient and efficient teamwork. These team rounds and associated plans are documented daily in the patient's record to ensure that there is continuity of care, even if the team members change.

Table 1 includes the typical participants in daily rounds, in addition to the patient's assigned clinical nurse. Each morning between 0530 and 0700, the medical team rounds on each patient and creates a plan for the day. Before going into the OR, the residents and intern round with the nurse practitioner (NP) team to collaborate on clinical decisions and treatment plans while providing a thorough handoff of care. The NPs then share this information with the entire interdisciplinary team so everyone is updated on current plans.

In addition to these daily rounds, the NPs lead teaching rounds that are open to any discipline twice a week (once on night shift and once on day shift). These are nursing focused and detailed clinical care rounds that focus only on one or two patients, but delve more deeply into complex pathophysiology and potential care management concerns.

The nurse manager rounds with the interprofessional team daily to help resolve any issues that may require departmental or administrative input or decisions. This could include having the hospital agree to pay for equipment or medications that are necessary to transfer the patient to the next level of care, or discussions with rehab centers or nursing facilities where the care needed is not typical for them to deliver.

Participants:

EP5 Table 1: Typical Participants, Daily 6 West Interprofessional Rounds

Name	Discipline	Title	Department
Meghan Wilson	Physical Therapy	Physical Therapist	Therapy Services
Dale Shaw	Nursing	Advanced Practice Nurse 2-Nurse Practitioner	Patient Care Services
Susan Prather	Nursing	Nurse Manager	Patient Care Services
Erica Umback	Occupational Therapy	Occupational Therapist	Therapy Services
Sue Raju	Nursing	Case Manager	Case Management
Emily Spart	Social Work	Social Worker	Social Work
6 West RN (various)	Nursing	Clinician	6 West

The case detailed here demonstrates an example of how care is coordinated. Mr. X is a 21-year-old Russian immigrant, who was involved in a motor vehicle crash in February 2014. He suffered a T-9 spinal cord injury and resultant paraplegia. He was uninsured and did not have a Social Security number. There was no family present, and he was depending on a friend as his sole support. This case represents the complexity and

challenges that many of our patients face. To provide the care that this patient needed, many services were involved and coordination was critical.

In this case, the patient was understandably angry, grieving the loss of mobility at such a young age. He exhibited challenging behaviors, refusing care and interventions such as turning. The physician team consulted with psychiatry to evaluate him for depression, but he refused to talk to them.

The interprofessional team met each day during rounds to discuss this difficult situation. The nursing staff agreed that he was going through the normal stages of grieving, and while he would not be allowed to refuse turning and getting out of bed, every effort would be made to give him some choices about timing and positioning. Team members provided patient education to explain prevention of pressure ulcers, both in bed and out of bed in a wheelchair with mechanisms for frequent pressure relief. Nurses explained the importance of turning every two hours, but tried to give him some uninterrupted sleep time whenever it was possible.

Nurses coordinated the process of implementing bowel and bladder protocols as soon as the patient was medically stable. This included several setbacks requiring collaboration with the physicians to make adjustments that met his needs.

His limited resources were likely to create barriers to rehab facilities accepting him as a patient. Nurses coordinated with physical and occupational therapists to create daily plans to transition him to the acute rehabilitation phase of his care. The team began providing care to create as much of a rehab environment as was possible. This included nursing assuming some of the care that the therapists would typically provide in the acute care setting. With a daily schedule established through careful planning, nurses applied the patient's abdominal binder and lower extremity compression wraps and transferred him to the wheelchair. This provided time for the therapists to take him down to the gym for transfer and mobility training. Exhibit EP5.b is a note written by the trauma nurse practitioner (Tracy Hughes, NP), who serves as a central contact and coordinator for care. It contains updates from multiple services and disciplines. (Exhibit EP5.b: Notes 6W NP)

The chaplain and social worker coordinated with the team to provide the emotional and spiritual support that the patient needed to cope with his situation. The social worker (Jill Guiffre, LCSW) also contacted the State Department and Russian Embassy for help in obtaining a Social Security number for him. (Exhibit EP5.c: Notes 6W SW) The RN case manager (Susila Raju, RN) looked throughout the state for a charity bed that would accept him for SCI rehab. (Exhibit EP5.d: Notes 6W CM)

The daily rounds were the central point of contact for these disciplines to provide continuity, communication, progress updates and as much consistency as possible. The

team collectively collaborated with the physicians to create a cohesive plan of care that would best support this vulnerable patient.

Example 2: Nursing Coordination in the Interprofessional ALS Clinic

Nursing Care Coordinator is a position that is used within the Health System to provide continuity, support and a consistent point of contact for patients with complex, specialized and / or chronic conditions. Care coordinators can be found in a variety of clinics, predominantly in ambulatory settings.

Amyotrophic lateral sclerosis (ALS) is a progressive illness that has devastating impacts on the patient and family. As the patient's status declines, many resources, changes in care plans and training are needed for these individuals and their support structure to maintain the highest quality of life. The services that the patient and family need are spread across the organization and community, making coordinating efforts challenging. Community providers often know little about this disease and impact on the patient and family, making it difficult for families to advocate for their loved ones' needs.

UVA offers an interprofessional, comprehensive, disease-specific clinic that optimizes care as the patient's disease progresses. Specifically, this means consistent patient follow-up to monitor health status, providing services as they are needed and the resources and information needed to maximize health status until the next clinic visit. The highly experienced team within this clinic includes neurologists, nurses, OT, PT, speech therapists, dieticians, respiratory therapists, social workers and community agency volunteers. This team assumes care for the evolving, complex needs inherent in each patient's situation. The RN Clinic Coordinator, Debbie Eggleston, MSN, RN, serves as a primary contact for patients and their families. A dedicated phone number is provided for families to leave messages for Eggleston and is checked frequently during the day. Upon diagnosis, patients are given a resource notebook with contact information for all of the disciplines in the ALS clinic. Eggleston reviews the notebook with the patient and family to make sure they are aware of the many resources they have if they need anything between clinic visits. Topics covered in the notebook include cognition and anticipated changes, exercise, nutrition and other aspects of life impacted by this disease process. Education tools from each discipline are included in the notebook. Two examples found in the notebook of topics that would be reviewed by the therapists during their visit with the patient and reinforced by Eggleston are included as Exhibit EP5.e: ALS Dysphagia and Exhibit EP5.f: ALS ADL Hints.

Each clinic session begins with the interprofessional team meeting to discuss each patient scheduled for the day. Services are prioritized based on patient input and care issues from the last session that require follow-up.

As patients arrive, Eggleston begins a team "Patient Instructions" note in Epic. The patient and family are given a list of team members they will be seeing. As team members see the patient, they make notations on a clinic flow form so that all team members can see who has seen the patient and add to the team note in Epic. Eggleston monitors the clinic flow form to maintain flow and prevent delays. Exhibit EP5.g: ALS Clinic Flow is the tool used on May 1, 2014.

Throughout the day, the team communicates and coordinates to modify the patient's plan based on in-the-moment conversations and findings that require intervention. As patients are seen by the ALS team members in the clinic, Eggleston is informed of care needs and necessary arrangements. The patient's clinic visit is concluded with a review of the clinic visit with the Eggleston summarizing changes in care or new treatments or medications. Pertinent education is provided and a plan for needs between clinic visits is made.

Mrs. S is a 67-year-old woman with advanced ALS. She is cared for by her husband and her daughter. Exhibit EP5.h is a medical record note from January 2014 showing how each team member contributes to a single note that was reviewed with the patient by Eggleston. (Exhibit EP5.h: ALS Clinic Note)

The clinic day concludes with a follow-up team meeting. In this end-of-day meeting, the team is able to coordinate services and follow-up plans, and consider what is needed to make sure that continuity to the next appointment is provided. Based on team input, Eggleston will follow up on any needs that are identified. These items may include arranging durable medical equipment, communicating with insurance companies to explore coverage, or coordinating with community agencies such as hospice or home health. Eggleston is also able to coordinate with other services, such as chaplaincy or palliative care, if needed.

This model provides the patient and his or her family with a true interprofessional team of experts that is skilled in coordinating care throughout the disease progression. This model provides continuity of care across services within the system and across community resources.

Participants:

EP5 Table 2: Participants, The ALS Clinic Team

Name	Discipline	Title	Department
Ted Burns	Physician	Associate Professor of Neurology	Neurology
Lawrence Phillips	Physician	Professor of Neurology	Neurology
Debbie	Nurse Coordinator	RN Care Coordinator –	Neurology

Eggleston		Clinician III	
Melissa Fox	Physical Therapist	Physical Therapist – Clinician III	Therapy Services
Lara Wilkinson	Physical Therapist	Physical Therapist – Clinician III	Therapy Services
Kendra Sheard	Occupational Therapy	Occupational Therapist – Clinician III	Therapy Services
Renee Bricker	Speech-Language Pathology	Speech-Language Pathologist Clinician III	Therapy Services
Laura Knotts	Dietician	Dietitian	Nutrition Services
Patricia Wilkinson	Respiratory Therapist	Respiratory Therapist – Registered	Therapy Services
Ken Cady	Social Work	Clinical Social Worker – MSW	Social Work
(various)	Chaplain	Chaplain	Chaplaincy
Elizabeth Gay	Physician	Assistant Professor of Medicine	Pulmonary Critical Care
Leslie Blackhall	Physician	Assistant Professor of Medicine	General Internal Medicine
Kathleen Kelly	ALSA Care Services Coordinator	(not a UVA employee)	N/A
(various)	MDA Representative	(not UVA employees)	N/A