SE9- The organization supports nurses' participation in community healthcare outreach.

Provide one example, with supporting evidence, of organizational support for clinical nurse involvement in community healthcare outreach.

And

Provide one example, with supporting evidence, of organizational support for nurse leader involvement in community healthcare outreach.

Introduction:

UVA employees contribute thousands of hours of healthcare outreach in our local and regional communities. Outreach occurs through health fairs, service agencies and special events throughout the year. Human Resources Policy 600, "Leaves of Absence" (XREF Exhibit OO13.b), provides all regular employees eight hours of public service leave with pay per calendar year. The organization recognizes community service with annual Community Service Awards and encourages employees to participate in a variety of ways.

Example 1: Clinical nurse involvement in community healthcare outreach: Remote Area Medical clinic

Kimberly Morris, BSN, RN, CDE, CPT, Clinician III in the Diabetes Education and Management Program is committed to diabetes-related outreach. She is passionate about using her professional nursing knowledge and experience to help others that have been diagnosed with or at risk for diabetes.

Kim regularly attends community health fairs, teaches at local senior centers and offers to participate in diabetes health screening events. One event that Kim is committed to is the Remote Area Medical (RAM) clinic held in rural southwest Virginia every summer. Since 2001, volunteers from several surrounding states organize a massive event to provide free medical, dental and vision care to uninsured or underinsured individuals. This two-and-a-half day event provides care to nearly 3,000 people who live in the rural region, federally designated as a medically underserved area. Mortality rates from manageable conditions and infant mortality are higher than elsewhere in Virginia in part because of the lack of specialty care and overwhelmed primary care providers. Patients arrive the day before to stand in line so they can be seen. For the July 2014 event, 108 of the volunteers were from UVA.

Kimberly Morris, BSN, RN, CDE, CPT, Clinician III with a patient at the Remote Area Medical (RAM) clinic held in rural southwest Virginia every summer.

In January 2014, Kim sent an email to her peers and manager Ceil Ouwerkerk, BSN, RN, to ask for support to attend the July 2014 RAM event. Her schedule request to be off during this peak vacation time frame was granted by Ceil on February 4, 2014. (Exhibit SE9.a: Kim Morris Approval for RAM PTO) Kim used her eight hours of community service leave as outlined in HR Policy 600, and 16 hours of her paid time off. (Exhibit SE9.b: Proof of Kim Morris Public Service Leave Use)

July 18-20, 2014, Kim attended RAM and provided direct patient education for newly diagnosed Type 2 diabetes patients. She gave glucometers to these patients and instructed them on their use. She gave detailed information regarding lifestyle changes that needed to be made with the new diagnosis, as well as resources to guide them with their follow-up care.

These newly diagnosed patients also learned how to manage their disease with insulin, diet and lifestyle changes. She taught the patients about guidelines for insulin dosages, the kinetics of insulin, and how to use an insulin pen. Kim placed an emphasis on increasing activity, finding what they like to do, and encouraging each person to become more active every day, according to the AHA guidelines to get 30 minutes of some type of activity five days a week.

Kim also counseled patients and their families about lowering their sodium, fat and cholesterol intake to improve their heart health. She helped them identify small changes in their meal choices to improve overall health. Many of the patients she cared for at RAM live in extremely stressful conditions. She discussed ways to deal with stress management, and helped them identify resources available in their community. Every patient was seen by a social worker to determine the best plan for them for continued care.

Through this outreach activity, Kim was supported to share her diabetes skills with patients in extreme need. She provided tools and connected them with resources that will improve their quality of life.

Example 2: Nurse Leader involvement in community healthcare outreach.

The Program of All-inclusive Care for the Elderly (PACE) is a nationally-recognized alternative to nursing home care that provides comprehensive long-term services and support to Medicaid and Medicare enrollees. PACE provides for all social and medical needs through the coordinated care of an interdisciplinary team of health professionals. For most participants, the comprehensive service package enables them to receive care at home rather than receive care in a nursing home.

The Blue Ridge PACE mission is to enhance the lives of frail older adults by providing compassionate, quality care and services, and empowering participants to live in their homes and in the community for as long as medically and socially feasible. The program serves individuals who are age 55 or older, who are in need of nursing home care as certified by the state's Medicaid program, are eligible for both Medicare and Medicaid, are able to live safely in the community at the time of enrollment, and live in the Blue Ridge PACE area. An interdisciplinary team of providers delivers comprehensive, coordinated, patient-focused care designed to support the PACE participant to live safely in the community rather than be institutionalized. PACE provides transportation to the PACE center for socialization and medical care, medications, preventive care, and caregiving training. (Exhibit SE9.c: PACE Quick Facts) PACE began enrolling participants in February of 2012. (Exhibit SE9.d: Blue Ridge PACE Now Enrolling Participants)

Maggie Short, MSN, RN, NEA-BC, Administrator for Home Health & Social Services at University of Virginia Health System, also manages community services and worked with JABA over a multi-year period to help lay the groundwork for becoming a site for PACE. Through Maggie's extensive work, knowledge, management, and partnerships with JABA, UVA Geriatric Services, advanced practice nurses, and local geriatricians who practice in area nursing homes, she was an expert representative for UVA in partnering with PACE. Maggie's UVA connections and prior work led to strong

relationships within the organization. In addition to her official capacity duties as a UVA administrator, she has also facilitated outreach beyond the footprint of her role.

In September 2013, the Blue Ridge PACE Board of Directors unanimously voted to invite Maggie to join the board. As documented in the September 9, 2013, PACE board meeting minutes (Exhibit SE9.e, Blue Ridge PACE Board Meeting Minutes Sept 2013), the recommendation put forward for Maggie's membership on the board said that Maggie "has a thorough understanding of the needs of the geriatric population and would be a valuable addition to the board."

Maggie's contributions as a board member have included:

- Participated as a member of the Blue Ridge PACE Services and Education Planning Committee, Maggie participated in the design review of the new facility. In addition to providing input into the design, Maggie and the committee assisted the Blue Ridge PACE Board of Directors with:
    - Service provider planning, recruitment and coordination.
    - Identifying and establishing education and training opportunities for medical and nursing students as well as other students in health care fields.
    - Promoting membership of patients and clients in Blue Ridge PACE.
    - Marketing the design and benefits of the PACE model of health care delivery.
    - Coordinating timely access and services within and outside hospitals such as referrals, discharge, and transition planning.
- Accompanied a PACE recipient family member to meet with UVA Case Management and Social Work Leader to offer feedback that resulted in case manager practice.
- Facilitated communication between the UVA Emergency Department when a PACE client is registered to ensure communication between the PACE primary care physician and the ED physicians.

Maggie is fully supported in this endeavor by Chief Nurse Lorna Facteau by encouraging participation and allowing time to invest in the role. Maggie's commitment to PACE complements our Nurses Improving Care for Healthsystem Elders (NICHE) program and allows the Health System to provide our community with excellence in geriatric care across the continuum. We are proud to support her in this effort.