Interprofessional Student Community-based Learning Experiences (ISCLE)
Transitions of Care Activity Description

Objectives:

- Learn the value of working as part of an interprofessional team in the delivery of health services and transitions of care.
- Gain increased knowledge and skills regarding interprofessional care during transitions of care health care services.
- Gain increased knowledge of the tools and resources available for improved communication to minimize risks associated with transitions of care.

Outcomes associated with transitions of care (Transitions of Care in the Long Term Care Continuum):

- Patient-centered review of the risks and benefits in the transitioning of care.
- Reduction in costs associated with readmissions to the hospital.
- Duplication of diagnostic services avoided
- Reduction in medication-related errors.
- Increased patient/family satisfaction
- Better patient safety and quality achieved.
- Improved communication between care providers.

Activity:

1. A student leader is selected for the team. A team just needs to be two or more disciplines. **Not every discipline needs to be included every time (but could be), just 2 or more.** It is anticipated that you could have one patient per week. An ideal situation is 2 or more students from 2 or more disciplines on-site for 2 or more concurrent/consecutive weeks.

2. When any of the students become aware of a patient transfer from nursing home to hospital or hospital to nursing home (i.e., from a charge nurse or physician-), the student provides the information to other team members via text message, phone call, e-mail, etc.) and planning for your individual assessments begins. Depending on the composition of your team, some or all of the assessment tools may be used-individuals will do the assessments appropriate for their discipline, you may divide them up as your team sees fit. The assessment information can be
brief and completed over one or two days as your time allows. However, the composition of
the student team can be any of 2 or more disciplines. There is no required set of disciplines
for a student team to perform assessments.

3. The student leader initiates planning for a 15 or 20 minute meeting with the team to discuss
the case and develop a discharge or transition plan for the patient. Students present their
findings to their individual preceptors.

Students are advised to do the assessments to the best of their ability and to do the assessments in
a safe and appropriate manner (i.e., fall assessment). Students enjoyed some independence, and
enjoyed the interaction with each other and well as the ability to form a treatment plan.
Interprofessional Student Community-based Learning Experiences (ISCLE)  
In-Home Transitions Assessment Tool

<table>
<thead>
<tr>
<th>Patient</th>
<th>Assessment Date</th>
<th>Referred by</th>
<th>Provider</th>
<th>Contact Phone Number</th>
<th>Reason for Referral</th>
</tr>
</thead>
</table>

**PART I: MEDICAL REVIEW**

**A. FALLS ASSESSMENT**

<table>
<thead>
<tr>
<th>Incidents</th>
<th>Frequency</th>
<th>Date</th>
<th>Other pertinent information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of falls per month</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall related fractures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postural hypotension (orthostasis)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syncope or dizziness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unsteady or shuffling gait</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Episodes of confusion/delirium/disorientation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agitation, increased anxiety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensory deficits</td>
<td>Decreased hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aphasia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Information</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Number of Incidents:**
Interprofessional Student Community-based Learning Experiences (ISCLE)  
In-Home Transitions Assessment Tool

**B. GAIT/BALANCE**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Gait balance normal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Balance problem while standing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Balance problem while walking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Decreased muscular coordination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Change in gait pattern when walking through doorways</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Jerking or unstable when making turns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Requires use of assistive devices</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PREDISPOSING DISEASES**

- Hypotension
- Vertigo
- CVA
- Parkinson’s Disease
- Loss of Limb (s)
- Seizure
- Arthritis
- Osteoporosis
- Fractures
-...

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None present</td>
</tr>
<tr>
<td>2</td>
<td>1-2 present</td>
</tr>
<tr>
<td>4</td>
<td>3 or more present</td>
</tr>
</tbody>
</table>
## Interprofessional Student Community-based Learning Experiences (ISCLE)
### In-Home Transitions Assessment Tool

### C. MEDICATION REVIEW

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Frequency</th>
<th>Medication</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antihypertensive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diuretic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antipsychotic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypnotic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sedating antidepressant or antihistamine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzodiazepine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSAID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Narcotic Analgesic</td>
<td>Mild</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anticonvulsant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypoglycemic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Interprofessional Student Community-based Learning Experiences (ISCLE)  
In-Home Transitions Assessment Tool

D. DISEASE

<table>
<thead>
<tr>
<th>Type</th>
<th>Frequency</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incontinence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bladder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrhythmia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic/Psychiatric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parkinsonism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Casts/Splints/Slings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthesis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Number of Incidents</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RISK RANGES: Minimal 0-3       Moderate 4-7       High 8 or more

TOTAL SCORE (from Part 1 A, C & D): _____
Describe Interventions: (may include decrease or change in antihypertensive or diuretics; change antianxiety med to buspirone; increase Anti-Parkinson med or change dosage regimen; change or decrease sedative analgesic or antihistamine to a less sedating one; decrease or change Hypoglycemic med (adopted from Cooper JW, Preventing Falls & Fractures in Nursing Facility Patients. Nurs Home Pract 1994; 2(6):28-30).

- Medication Changes:
- Therapy Changes:
- Fractures and other injuries (area of body):
- Transition Options (if any):

ASSESSORS:
Name: Signature: Date:

Team Members:
PART II. NURSING ASSESSMENT:

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>Lying</th>
<th>Sitting</th>
<th>Standing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No drop between lying/standing</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
<td>Drop less than 20 mm Hg</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Drop more than 20 mm HG</td>
<td></td>
</tr>
</tbody>
</table>
Interprofessional Student Community-based Learning Experiences (ISCLE)  
In-Home Transitions Assessment Tool

PART III. ENVIRONMENTAL ASSESSMENT

1. Are you concerned about your safety or ability to get around your home or neighborhood? __ Yes ___ No

2. Have you experienced any falls in your home or while out in the community? If yes, please complete the table. __ Yes ___ No

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls in past 3 months</td>
<td></td>
</tr>
<tr>
<td>1-2 falls in past 3 months</td>
<td></td>
</tr>
<tr>
<td>3 or more falls in past 3 months</td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td>Yes</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>1. Do you reduce your risk of slipping by wiping up grease, water, and other spilled liquids or foods right away?</td>
<td></td>
</tr>
<tr>
<td>2. Do you use step stools or ladders?</td>
<td></td>
</tr>
<tr>
<td>3. Do step stools have a guard rail to hold on to?</td>
<td></td>
</tr>
<tr>
<td>4. Are frequently used kitchen supplies and food stored in an easy to reach location to avoid climbing and bending?</td>
<td></td>
</tr>
<tr>
<td>5. Do you turn the tub/shower faucets on and off while standing outside the tub/shower?</td>
<td></td>
</tr>
<tr>
<td>6. Are their non-skid strips or a mat on the floor of the shower or bathtub?</td>
<td></td>
</tr>
<tr>
<td>7. Are there well-secured grab bars installed in the shower or tub?</td>
<td></td>
</tr>
<tr>
<td>8. Are there grab bars or a raised seat if you have difficulty getting on and</td>
<td></td>
</tr>
<tr>
<td>9. Are towels, shampoo, and soap within easy reach?</td>
<td></td>
</tr>
<tr>
<td>10. Are bath oils or creams used that would make the tub slippery?</td>
<td></td>
</tr>
<tr>
<td>11. Is the floor safe, not slippery (no loose rugs or loose tiles)?</td>
<td></td>
</tr>
<tr>
<td>12. Is there lighting within easy reach of the bed?</td>
<td></td>
</tr>
<tr>
<td>13. Is there a phone within easy reach of the bed?</td>
<td></td>
</tr>
<tr>
<td>14. Is there a nightlight or bright light for your path to the bathroom?</td>
<td></td>
</tr>
<tr>
<td>15. Are walkways in rooms, halls, stairways and outdoor areas</td>
<td></td>
</tr>
<tr>
<td>16. Are carpets, rugs, other floor coverings well secured?</td>
<td></td>
</tr>
<tr>
<td>17. Are rubber-backed, non-slip rugs used?</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>18. Are casters or rollers on chairs, rickety tables and furniture with sharp edges?</td>
<td></td>
</tr>
<tr>
<td>19. Are stairs, walls, railings, porches, and balconies sturdy and in good condition?</td>
<td></td>
</tr>
<tr>
<td>20. Do stairways have secure hand rails?</td>
<td></td>
</tr>
<tr>
<td>21. Is there a light within easy reach when entering each room?</td>
<td></td>
</tr>
<tr>
<td>22. Do you wear comfortable, low-heeled shoes that have good traction?</td>
<td></td>
</tr>
<tr>
<td>23. Are there any pets that could get in the way, causing tripping/falling?</td>
<td></td>
</tr>
</tbody>
</table>
Interprofessional Student Community-based Learning Experiences (ISCLE)  
In-Home Transitions Assessment Tool

PART IV: PSYCHOLOGICAL ASSESSMENT - MENTAL STATUS EVALUATION  
(Ask questions only and score 1 for each incorrect response ("no" response is treated as incorrect). A correct response score is zero. Complete the weighted score after test is complete.

ORIENTATION-MEMORY-CONCENTRATION TEST  
(KATZMAN ET AL., 1983)

Example scoring

<table>
<thead>
<tr>
<th>Items</th>
<th>Maximum Errors</th>
<th>Score</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What year is it now?</td>
<td>1</td>
<td>x</td>
<td>4</td>
</tr>
<tr>
<td>2. What month is it now?</td>
<td>1</td>
<td>x</td>
<td>3</td>
</tr>
<tr>
<td>3. About what time is it? (within 1 hour).</td>
<td>1</td>
<td>x</td>
<td>3</td>
</tr>
<tr>
<td>4. Count backwards 20-1.</td>
<td>2</td>
<td>x</td>
<td>2</td>
</tr>
<tr>
<td>5. Say the months in reverse order.</td>
<td>2</td>
<td>x</td>
<td>2</td>
</tr>
<tr>
<td>6. Repeat the memory phrase (once).</td>
<td>5</td>
<td>x</td>
<td>2</td>
</tr>
</tbody>
</table>

Interpretation: maximum weighted error score = 28, a score of 10 or more is consistent with the presence of dementia. Excluding refused: Score 29, NA: Score 30

TOTAL WEIGHTED ERROR SCORE: _____
Interprofessional Student Community-based Learning Experiences (ISCLE)  
In-Home Transitions Assessment Tool

Eight Foot Up-and-Go Test - Test Protocol: Modified TUG Test for Home Care.

Set an arm chair against a wall facing a cone marker exactly 8 feet away; measure from the back of the cone to a point on the floor, even with the front edge of the chair. Start the timer on the signal to "go" whether or not the individual has started to move and stop the timer at the exact instant the person sits down on the chair. Do one practice trial and repeat the test twice, Use the fastest time as the score.

Instructions for the patient: Sit in the middle of the chair with your back straight and against the back rest. Place your feet flat on the floor, one slightly in front of the other. Place your hands on your thighs. When I say "go", get up from the chair; walk as quickly as you can around either side of cone and return to the chair and sit down.

Scores: Practice Trial _____ Seconds  Trial #1 _____ Seconds  Trial #2 _____ Seconds  
0-8.4 seconds is the range for predicted non-fallers  
8.4 seconds or more is the range for predicted fallers (sensitivity of 76% and specificity of 86% Rose et al., 2002)

Sharpened Romberg (Tandem)
Instructions for the patient: Stand with one foot directly in front of the other in a straight line. Keep your eyes open. Place your arms on your chest crossed with your hands touching your opposite shoulder. Do this test three feet from the wall and focus on a visual target. Stand with your eyes open for 30 seconds. Now close your eyes and maintain your balance for 30 seconds. Criteria for stopping the test: Feet move on the floor. Eyes open during the closed test. The feet are no longer in a straight line. Arms move from the starting position. Record the number of seconds it takes to stop the test:

Trial #1 _____ Seconds  Trial #2 _____ Seconds  Trial #3 _____ Seconds

ASSESSORS:  
Name:  
Signature:  
Date:

Team Members:
**Nutrition Assessment Tool**

**Step #1: Assessment**

<table>
<thead>
<tr>
<th>Nutrition Assessment</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food/Nutrition History</td>
<td></td>
</tr>
<tr>
<td>Anthropometric Measurements</td>
<td></td>
</tr>
<tr>
<td>Biochemical Data, Medical Tests and Procedures</td>
<td></td>
</tr>
<tr>
<td>Nutrition Focused Physical Examination</td>
<td></td>
</tr>
<tr>
<td>Client History</td>
<td></td>
</tr>
<tr>
<td>Comparative Standards</td>
<td></td>
</tr>
</tbody>
</table>

**Estimated Needs:**
Step #2: Diagnosis

1. Problem______________________________as related to
   Etiology____________________________________________as evidenced by
   Signs/sympt.__________________________________________

2. Problem______________________________as related to
   Etiology____________________________________________as evidenced by
   Signs/sympt.__________________________________________

3. Problem______________________________as related to
   Etiology____________________________________________as evidenced by
   Signs/sympt.__________________________________________

Step #3: Nutrition Intervention

Nutrition Prescription: (nutrient needs + recommended diet/regimen)
________________________________________________________
________________________________________________________
________________________________________________________

Interventions: (actions &/or recommendations)

1. ____________________________
   Goal(s)_________________________________________________

2. ____________________________
   Goal(s)_________________________________________________

3. ____________________________
   Goal(s)_________________________________________________

4. ____________________________
   Goal(s)_________________________________________________
Step #4: Nutrition Monitoring & Evaluation

How you will monitor success of intervention(s) and evaluate progress toward goal(s)
When/time frame you plan to reassess: ____________________________

| 1. | Indicator: __________________________________________________ |
|    | Criteria: __________________________________________________  |
| 2. | Indicator: __________________________________________________ |
|    | Criteria: __________________________________________________  |
| 3. | Indicator: __________________________________________________ |
|    | Criteria: __________________________________________________  |
| 4. | Indicator: __________________________________________________ |
|    | Criteria: __________________________________________________  |

If a reassessment, address goal progress:

Goal #1 ____________________________ ☐ Met ☐ Establish new goal  
☐ Not Met ☐ Continue

Goal #2 ____________________________ ☐ Met ☐ Establish new goal  
☐ Not Met ☐ Continue

Goal #3 ____________________________ ☐ Met ☐ Establish new goal  
☐ Not Met ☐ Continue
Patient Transfer Form

We are participating in an Interprofessional Student Community-based Learning Experience (ISCLE) project. Please notify us any time a patient is transferred from a nursing home to the hospital or from the hospital to the nursing home. Please fill out the chart below and notify the student team. Thank you!

<table>
<thead>
<tr>
<th></th>
<th>Patient name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transferred from:</td>
<td>Transferred to:</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transferred from:</td>
<td>Transferred to:</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transferred from:</td>
<td>Transferred to:</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transferred from:</td>
<td>Transferred to:</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transferred from:</td>
<td>Transferred to:</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transferred from:</td>
<td>Transferred to:</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transferred from:</td>
<td>Transferred to:</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transferred from:</td>
<td>Transferred to:</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transferred from:</td>
<td>Transferred to:</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transferred from:</td>
<td>Transferred to:</td>
</tr>
</tbody>
</table>
In-home Client Assessments Activity Description

Phase 1: Patients/clients would be referred to an interprofessional team for an in-home skills assessment. The interprofessional team is composed of current students on rotation at the site, site clinical faculty/preceptor and UND faculty as requested. As the plan develops, video conferencing could be used to draw from the expertise of a larger interprofessional student team to discuss the findings and provide recommendations. Potential off-site students included in the interprofessional team could be from pharmacy, physician assistant program, social work, physical therapy, occupational therapy, nutrition and dietetics. The opportunity for in-home assessments would be advertised within the community. Referrals could potentially come from family and/or friends of residents living independently in the community who may need alternative living arrangements, or from administrators of assisted living or long term care units. Medical providers could also use this system to conduct in-home assessments for their patients. Using a patient assessment tool, student team members (usually two students) will visit the client and bring their findings to the interprofessional team for discussion and recommendation. The transitions care planning could entail working with patients from the hospital to the nursing home, nursing home to hospital, hospital to specialty care or services, and/or “frequent flyer” emergency patients.

Phase 2: As the plan develops, video conferencing could be used to draw from the expertise of a larger interprofessional student team to discuss the findings and provide recommendations. Potential off-site students included in the interprofessional team could be from pharmacy, physician assistant program, social work, physical therapy, occupational therapy, nutrition and dietetics.

Department of Family and Community Medicine Faculty:
Eric L. Johnson, MD
Mary Amundson, MA
ISCLE Evaluations
Student Satisfaction Survey

The purpose of this survey is to examine the student satisfaction with the integration of a team-based activity within the clinical rotation. How would you rate the following questions ranked 1– dissatisfied to 5– highly satisfied.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Dissatisfied</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Through this activity, I learned the value of working as part of an interprofessional team.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I gained increased knowledge and skills regarding interprofessional care during this activity.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I received sufficient orientation and guidance to participate in the activity.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. The activity was beneficial in my clinical learning.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. The composition of the student team or resources available was sufficient to complete the assessments.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Alerts to patient referrals were timely to accomplish our assessments.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. There was sufficient time to complete this activity.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

What did you learn or discover that you weren’t expecting?

What suggestions do you have to improve the activity or process?

Other comments.

Interprofessional Education
Preceptor Satisfaction Survey

The purpose of this survey is to determine the site coordinator’s satisfaction with the integration of a team-based activity within the clinical rotation for health profession students. How would you rate the following questions ranked 1 – dissatisfied to 5 - highly satisfied.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Dissatisfied</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The role of the students and on-site staff/preceptors was well defined.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Students were well-prepared for their interprofessional health care experience.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Leadership by the UND faculty was sufficient to carry out the tasks associated with the activity.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. There was value in the interprofessional health care experience that directly relates to the practice environment.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Participating in this activity will help improve communication among members of the health care team.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. This activity provides an opportunity for patient-centered review of the risks and benefits in the delivery of health care services</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Overall, participating in this experience was a benefit to our facility and patients.</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

What suggestions do you have to improve the activity or process?

Other comments.
Site Coordinator Satisfaction Survey

The purpose of this survey is to determine the site coordinator’s satisfaction with the integration of a team-based activity within the clinical rotation for health profession students. How would you rate the following questions ranked 1 – dissatisfied to 5 - highly satisfied.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Dissatisfied</th>
<th>Highly Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The role of the students and on-site staff/preceptors was well defined.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>2. Students were well-prepared for their interprofessional health care experience.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>3. Leadership by the UND faculty was sufficient to carry out the tasks associated with the activity.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>4. There was value in the interprofessional health care experience that directly relates to the practice environment.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>5. Participating in this activity will help improve communication among members of the health care team.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>6. This activity provides an opportunity for a patient-centered review of the risks and benefits in the delivery of health</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>7. Overall, participating in this experience was a benefit to our facility and patients.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

What suggestions do you have to improve the activity or process?

Other comments.
Resources
Interprofessional Learning at the University of North Dakota: 
Background, History, Current Experiences, and Future Opportunities

Eric L. Johnson, M.D.
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Background

Interest in Interprofessional health care education and collaboration goes back to the 1970’s. In 1972, the Institute of Medicine at issued their landmark report, “Educating for the Health Team” (1). This report was generated as a result of the first IOM meeting that year, “Interrelationships of Educational Programs for Health Professionals”; 120 health care professionals from a variety of disciplines participated. Initiatives considered at that time are ongoing today: promotion of resource and cost efficiency, delivering health care as teams across disciplines that included patients, families, and communities, and cooperative efforts to share common quality treatment goals. At the same time, the necessity of incorporating interprofessional practice behavior into educational systems for health care professional students was recognized.

The IOM has remained at the forefront of the push for mainstreaming of interprofessional health care education and patient care settings. In its 1999 publication “To Err is Human”, noted that up to 98,000 patient deaths in the U.S. were due to medical error, and that many of these were largely preventable (2). The 2001 follow-up report, “Crossing the Quality Chasm”(3), IOM noted that “All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches and informatics”.

This was further detailed in the IOM’s 2003 “Health Professions Education: A Bridge to Quality”(4). The culture of patient safety has been a critical component of this ongoing reshaping of health care delivery. In the 21st century, promotion of efficiency and equitability further reinforce the need for interprofessional health care education.
Support for interprofessional education is supported by a number of health care and educational organizations, including:

- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- The Accreditation Council for Graduate Medical Education (ACGME)
- Commission on Collegiate Nursing Education
- American Association of College of Nursing
- Association of Schools of Allied Health Professions
- Commission on Dental Accreditation
- Accreditation Council for Pharmacy Education
- Interprofessional Professionalism Measurement Group

In May of 2011, “Core Competencies for Interprofessional Collaborative Practice: Report of an Expert Panel” (5) was published by the following collaborating groups:

- American Association of Colleges of Nursing
- American Association of Colleges of Osteopathic Medicine
- Association of Schools of Public Health
- American Association of Colleges of Pharmacy
- American Dental Education Association
- American Association of Medical Colleges

In this comprehensive document, the authors identified these desired principles of interprofessional competencies:

- Patient/family centered (hereafter termed “patient centered”)
- Community/population oriented
- Relationship focused
- Process oriented
- Linked to learning activities, educational strategies, and behavioral assessments that are developmentally appropriate for the learner
- Able to be integrated across the learning continuum
- Sensitive to the systems context/applicable across practice settings
- Applicable across professions
- Stated in language common and meaningful across the professions
- Outcome driven

With this publication, institutions educating health care professionals have clear consensus on developing interprofessional education programs that train students to become leaders in developing the new health care paradigm to promote efficiency, satisfaction, and quality.
**History of Interprofessional Education at the University of North Dakota**

In 2003, a task force for developing interprofessional education was established by then-Dean H. David Wilson and Dr. Mary Wakefield along with the Center for Rural Health. After considerable interdepartmental research and collaboration on the needs and resources of the University of North Dakota, the Interprofessional Health Care course (IPHC) was launched in 2006. This once-weekly six-week course provides an introduction for health care professional students to interprofessional collaboration concepts through a team-based collaborative case study approach. Team STEPPS is a central curricular piece for IPHC. Developed by the Agency for Health Care Research and Quality (AHRQ) and the Department of Defense, Team STEPPS is “an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and teamwork skills among health care professionals. It includes a comprehensive set of ready-to-use materials and a training curriculum to successfully integrate teamwork principles into any health care system” (6). Five Team Resource Centers at Duke Medical Center, Durham, North Carolina; Carilion Clinic, Roanoke, Virginia; University of Minnesota Fairview Medical Center, Minneapolis, Minnesota; Creighton University Medical Center, Omaha, Nebraska; and University of Washington Medicine, Seattle, Washington further the mission of Team STEPPS in education and clinical implementation.

Currently, eight different programs are participants in the IPHC course. Occupational Therapy, Physical Therapy, Nursing, Medicine, Communication Sciences and Disorders, Nutrition and Dietetics all require their respective students to complete this course, with Music Therapy and Social Work offering it as an elective. University of North Dakota is somewhat unique in the broad range of students taking part in the course. Thousands of students have completed this course at the University of North Dakota. Student generally find the experience useful (7), but have noted difficulty translating it to clinical experiences as they advance through their training, despite Team STEPPS training at a number of facilities across North Dakota done as a collaboration by AHRQ, North Dakota Health Care Review, Center for Rural Health, and ND CAH Quality Network. The course is led by co-team leaders from the College of Nursing and SMHS and the course coordinator is from SMHS.

In 2012-13 UND was one of 6 invited participating institutions for a Macy Foundation grant project involving development of interprofessional faculty. Over the lifetime of this grant, these partners developed and shared relevant interprofessional education activities, consistent with the competencies previously cited. Three faculty members from UND were part of this grant activity; the Director of IPE at SMHS, one from the College of Nursing and Professional Disciplines, and one from College of Arts and Sciences (Music Therapy). This grant project was jointly hosted by the University of Washington and the University of Missouri. Recent efforts have also sought to further share interprofessional care and education strategies across these institutions as an outgrowth of the Macy project. The Collaborations Across Borders Conference III in Tucson, Arizona (2012), Collaborations Across Borders Conference IV in Vancouver, BC (2013), and All Together Better Health Conference 7 in Pittsburgh (2014) allowed faculty from the University of North Dakota School of Medicine and Health Sciences to present posters and lectures on interprofessional education activities, some in collaboration with other
institutions, including the University of Washington, the University of Missouri, and Medical University of South Carolina in a variety of patient care and educational settings, most notably the “Error Disclosure” activity developed by University of Washington.

In 2012-13, in part due to the Macy collaboration, the Interprofessional Health Care Course underwent extensive revision to remove barriers noted above (i.e., differing level and intensity of clinical experience) and to facilitate team building skills with an emphasis on roles, responsibilities, and patient-centeredness. The course previously was focused on Team STEPPS and case based learning, but now as a 5 week course with both large- and small-group activities. Topics and learning activities include:

- Intro to IPE and patient safety concepts
- Team STEPPS training
- Medical Pictionary
- Error Disclosure University of Washington module- role playing simulation activity where students form “medical teams” and disclose an error to a “family member of a patient” (also a student)
- Dr. Warren Jensen (aerospace) lecture: "Threat and Error Management" - focus on high functioning aviation team behavior and its application to medical settings.
- "Too Much Too Fast" documentary on a person with Amyotrophic Lateral Sclerosis (ALS aka Lou Gehrig’s Disease) as an enhanced case study activity.
- Case studies emphasizing concepts learned in the course with an emphasis on their role on the team.

The course has been “re-engineered” with the competencies in mind and also was mapped according to program-wide curriculum objectives. Students and faculty generally are favorable to the new, more dynamic 1 credit course.

As well, previous clinically oriented experiences such as SEARCH and CRISTAL have provide opportunities for students’ interprofessional learning. The Collaborative Rural Interdisciplinary Service Training and Learning (CRISTAL) project was designed to provide students opportunities to understand the importance of working as a health care team to address health care issues on American Indian Reservations in North Dakota. Similarly, the Fellowship of Primary Health Care Professionals and Student/resident Experiences And Rotations in Community Health program were designed in much the same way but included rural, urban underserved, and American Indian Reservation clinical-community-based interdisciplinary experiences. The goals of these programs were to provide students with an opportunity to gain an understanding of issues in health care delivery in more rural and underserved areas of the state and to develop an appreciation for the interdisciplinary team approach to the delivery of health care services.
Clinical Activity for Interprofessional Interaction
A variety of commonly encountered clinic scenarios lend themselves well to a team based approach for management. In North Dakota, cancer care, diabetes management, rehabilitation, and long term care are areas where teams are often used. Health Sciences Education in North Dakota is somewhat unique in that the University of North Dakota does not have a large university hospital and clinic system; clinical medical education is done in partnership with a number of health care systems statewide. Students often have direct one-on-one interaction with clinical faculty in “every day” practice, affording opportunity for more interaction with patients and their families. In addition, UND students have opportunity to interact with students from other institutions during their clinical experiences.

Given the status of medical education in North Dakota, student-led teams would serve well to develop interdisciplinary care, particularly in more rural clinical settings. This benefits not only the patient and student, but also can result in substantial “work product” for the clinical faculty, providers, and host health systems. Functionally, many of these interprofessional clinical activities would be a natural extension of the student’s clinical experience; thus, this diminishes the need for substantial re-configuring of rotations or clerkships. As well, Associate Professor Eric L. Johnson, M.D., will be available for in-person or teleconference precepting of interprofessional group activity and to work “hands on” with customizing an activity for a given site. As most students would’ve taken the classroom IPHC experience, themes of team based care learned in the course may resonate within these clinical experiences.

Other Proposed Interprofessional Student-Led Team Clinical Activities
1. Diabetes Management: Guideline based team management of a specific set of patients or problems (i.e., A1C >9, hypertension clinic, diabetes prevention, barriers)
2. Long Term Care (i.e., fall prevention, diabetes management, polypharmacy)
3. Fall Prevention in the Home Setting
4. Polypharmacy in the Outpatient Setting
5. Transition of Care (i.e., hospital to long-term care, transfer to other facility, hospital to home)
6. Other Community Identified Needs

Any or all of these activities could be undertaken at a given site, depending on students available and workload. Many of these activities would be streamlined with the students’ usual clinical rotation/clerkship/experience. A predefined number of students or professions would not be necessary for many of these activities; tools available could be used by 2 or more students across disciplines. We would anticipate that these projects would have ongoing development and quality improvement based on patient, student, clinical faculty, and host health care system input and experience.
Potential partners and programs for these activities include:

1. UND School of Medicine and Health Sciences (medicine, physician assistant, physical therapy, occupational therapy, medical lab sciences)
2. UND College of Nursing and Professional Disciplines (nursing, social work, nutrition and dietetics)
3. UND College of Arts and Sciences (music therapy)
4. NDSU College of Pharmacy
5. NDSU College of Nursing
6. UND/NDSU Masters of Public Health
7. Health Science Programs at other North Dakota Institutions

To date, this has been successfully piloted in Hettinger, ND and Devil’s Lake ND.

Future of Interprofessional Education at the University of North Dakota

Interest in further development at the University of North Dakota is apparent. Integrating interprofessional concepts learned in the classroom setting, although case based, are a challenge for training health care professional students. Previous efforts, including CRISTAL and SEARCH have organized and placed teams of interprofessional students in primarily rural areas. As well, the recent emphasis on the School of Medicine and Health Sciences’ mission to recruit and develop students as future health care providers for North Dakota gives more contexts to develop health care teams for care models suitable for the health care needs of the populace for today and the future. For example, “Medical Home” and other chronic disease management models for health care delivery are favorable to this primary care oriented approach, particularly with the passage and implementation of the Patient Protection and Affordable Care Act of 2010.

Continuing medical education, developed and sponsored by the University of North Dakota (and partner institutions) will also be delivered to sites participating in these interprofessional clinical activities. For example, health care team development and strategies, diabetes guideline management update, long-term care topics, use of electronic health record as an interprofessional team communication and management tool, or more community-based education can be presented compatible with the interests and activities at a given clinical site. Workforce development-oriented activities would also be developed. For example, specific activities for science teachers and students in local schools could also be developed. As well, ND STAR (North Dakota Simulation for Teaching and Research simulation lab), along with 4 mobile simulation labs, has directed interprofessional learning for students and providers across the state with state of the art technology.

Other more novel interprofessional education activities have included the development of an Interprofessional Lecture Series, which brings in experts to present to the students, faculty, and community with our local health system partners. As well, a Medical Humanities Symposium is in the preliminary stages with the North Dakota Humanities Council. Continued and ongoing collaborations with other institutions introduced on the Macy Grant is likely.
References

7. Interprofessional Health Care Course. UNDMSHS, data on file
Interprofessional Educational Collaborative (IPEC)

Learning experiences culminate with students working in an interprofessional team to address a patient care, population health, or community problem.

1) Assert values and ethics of interprofessional practice by placing the interests, dignity and respect of patients at the center of health care delivery, and embracing the cultural diversity and differences of health care teams.
2) Leverage the unique roles and responsibilities of interprofessional partners to appropriately assess and address the health care needs of patients and populations served.
3) Communicate with patients, families, communities and other health professionals in support of a team approach to preventing disease and disability, maintaining health and treating disease.
4) Perform effectively in various team roles to deliver patient/population-centered care that is safe, timely, efficient, effective and equitable.

Domain 1: Values/Ethics for Interprofessional Practice: (including “new professionalism” approaches).

Students were patient-centered in their approach to the transitions activity (interviewing family members to ensure the right decisions were being made as a team on behalf of the patient being able to return home).

- Approach 1 – interprofessional professionalism: “Demonstration and honing these competencies require reflection, flexibility, and adaptability to the spectrum of care contexts – from prevention and health maintenance to acute, chronic, long-term and palliative care – and the overall goals of care in specific situations.” I think the students provided reflection on their case through their discussions with us during the case presentation; the medical students were flexible and sensitive to the needs of the psych student during her family emergency and helped walk her the ISCLE activity.

- Approach 2 – “ethical principles for everybody in health care to hold in common, recognizing the multidisciplinary nature of health delivery systems.” Our student team thought outside the box; students discussed a home visit to ensure the patient was in a safe environment and was continuing to improve his health status.

Approach 3- interprofessional ethics: “the values that should undergird relationships among the professions, joint relationships with patients, the quality of cross-professional exchanges, and interprofessional ethical considerations in delivering health care and in formulating public health policies, programs, and services.” It was clear in the students’ discussion of the patient they were taking in comments and suggestions from other health professionals in the care and transition of this patient.
**Specific Competencies:**

VE1. Place the interests of patients and populations at the center of interprofessional health care delivery.

VE2. Respect the dignity and privacy of patients while maintaining confidentiality in the delivery of team-based care.

VE3. Embrace the cultural diversity and individual differences that characterize patients, populations, and the health care team.

VE4. Respect the unique cultures, values, roles/responsibilities, and expertise of other health professions.

VE5. Work in cooperation with those who receive care, those who provide care, and others who contribute to or support the delivery of prevention and health services.

VE6. Develop a trusting relationship with patients, families, and other team members (CIHC, 2010).

VE7. Demonstrate high standards of ethical conduct and quality of care in one’s contributions to team-based care.

VE8. Manage ethical dilemmas specific to interprofessional patient/ population centered care situations.

VE9. Act with honesty and integrity in relationships with patients, families, and other team members.

VE10. Maintain competence in one’s own profession appropriate to scope of practice.

**Domain 2: Roles/Responsibilities**

I believe this is what is accomplished in the IPHC that will complement students working in their clinical sites. Perhaps we need to be sure that students from other institutions that have not had a course are given the appropriate tools to be included in the ISCLE activities.

**Specific Competencies:**

RR1. Communicate one’s roles and responsibilities clearly to patients, families, and other professionals.

RR2. Recognize one’s limitations in skills, knowledge, and abilities.

RR3. Engage diverse healthcare professionals who complement one’s own professional expertise, as well as associated resources, to develop strategies to meet specific patient care needs.

RR4. Explain the roles and responsibilities of other care providers and how the team works together to provide care.
RR5. Use the full scope of knowledge, skills, and abilities of available health professionals and healthcare workers to provide care that is safe, timely, efficient, effective, and equitable.

RR6. Communicate with team members to clarify each member’s responsibility in executing components of a treatment plan or public health intervention.

RR7. Forge interdependent relationships with other professions to improve care and advance learning.

RR8. Engage in continuous professional

**Domain 3: Interprofessional Communication**

This also is an area addressed in IPHC to prepare our students for clinical activities (TEAMStepps) “.communication is considered a core aspect of interprofessional collaborative practice.

**Specific Competencies:**

CC1. Choose effective communication tools and techniques, including information systems and communication technologies, to facilitate discussions and interactions that enhance team function.

CC2. Organize and communicate information with patients, families, and healthcare team members in a form that is understandable, avoiding discipline-specific terminology when possible.

CC3. Express one’s knowledge and opinions to team members involved in patient care with confidence, clarity, and respect, working to ensure common understanding of information and treatment and care decisions.

CC4. Listen actively, and encourage ideas and opinions of other team members.

CC5. Give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others.

CC6. Use respectful language appropriate for a given difficult situation, crucial conversation, or interprofessional conflict.

CC7. Recognize how one’s own uniqueness, including experience level, expertise, culture, power, and hierarchy within the healthcare team, contributes to effective communication, conflict resolution, and positive interprofessional working relationships (University of Toronto, 2008).

CC8. Communicate consistently the importance of teamwork in patient-centered and community-focused care.
Domain 4: Teams and Teamwork
Interprofessional competencies ultimately are demonstrated through teamwork and team-based care in concrete clinical learning situations. Students worked as a team to work up the patient transition assessment and relied on each other’s expertise.

Specific Competencies:
TT1. Describe the process of team development and the roles and practices of effective teams.

TT2. Develop consensus on the ethical principles to guide all aspects of patient care and team work.

TT3. Engage other health professionals—appropriate to the specific care situation—in shared patient-centered problem-solving.

TT4. Integrate the knowledge and experience of other professions—appropriate to the specific care situation—to inform care decisions, while respecting patient and community values and priorities/preferences for care.

TT5. Apply leadership practices that support collaborative practice and team effectiveness.

TT6. Engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among healthcare professionals and with patients and families.

TT7. Share accountability with other professions, patients, and communities for outcomes relevant to prevention and health care.

TT8. Reflect on individual and team performance for individual, as well as team, performance improvement.

TT9. Use process improvement strategies to increase the effectiveness of interprofessional teamwork and team-based care.

TT10. Use available evidence to inform effective teamwork and team-based practices.

TT11. Perform effectively on teams and in different team roles in a variety of settings.

Learning Activities, Examples: Our student ISCLE experience is in the service learning category presented in the Core Competency Report. “Service learning projects are frequently used as values-based educational opportunities to help students develop person and patient-centered knowledge and skills with a community/population-orientation around the health and health care needs of the at-risk, vulnerable, and underserved.” These activities “incorporate advocacy skills and the delivery of prevention and health promotion activities”.
If we look at the Toronto Advancing the Interprofessional Education Curriculum 2009 diagram, we have incorporated elements into their basic constructs (collaboration, communication, values and ethics) in developing the ISCLE activity; the entry level assessments have included the exposure/introduction elements and immersion/development which are embedded in the classroom work; and the competence/entry to practice element would be the ISCLE activity/experience where students are working collaboratively in the practice setting.

It is our hope that through IPHC and ISCLE students will build team work competencies and transform ways of knowing (based on Medical University of South Carolina conceptual framework for advancing interprofessional education – Act as a team member, Practice as a team member, Think as a team member, and Prepare self as a team member) and through UM core interprofessional competency domains defined as professionalism, ethics, communication, teamwork.

**IOM 2003 Core Competencies**

- delivering patient-centered care,
- working as part of interdisciplinary teams,
- practicing evidence-based medicine,
- focusing on quality improvement and
- using information technology (“ability to use informatics. Teamwork and team-based competency for better patient-centered care requires mastery of numerous new communication technologies”
American Medical Directors Association Checklist
(May be incorporated into electronic health record)


1) Facility Pre-Transition Checklist: Issues That Should Be Addressed Before a Planned

Patient Transfer to Another Setting or Level of Care

- Discuss transition with the patient and/or family or significant others well in advance
- Have a “discharge appointment” with the patient and others as appropriate to plan a smooth transfer
- Ensure that medication reconciliation has been performed, that the medication list is given to the patient, and that medication questions are answered
- Explain to the patient and/or family that after the transfer he or she should take only the medications on the current list and should not resume taking any prior medications that are not on the current list
- Have a facility policy on what medical information is to be sent with the patient to insure a smooth transition of care
- Designate one or more specific facility staff members who are responsible for arranging transitions, gathering information to ensure a smooth transfer, and who are available for questions and calls before and after the patient’s departure
- Have a process for copying and assembling medical information that transfers with the patient and designate a staff member who is accountable for implementing this process
- Define next steps in the patient’s care
- Clarify, where appropriate, that the family or significant others have the necessary information to make arrangements for:
  - durable medical equipment;
  - follow-up physician appointments;
  - follow-up appointments for tests;
  - support services (e.g., home health care, Meals on Wheels);
  - ensure that the patient is stable for transfer; and
  - contact the next site of care to communicate special patient needs and confirm the next site’s readiness to receive the patient and ability to deliver the necessary care.
- Review advance directives with the patient and others as appropriate and desired by the patient
- If the patient is transitioning to a community home
  - identify who will care for the patient at home,
  - determine patient’s ability to acquire needed medications (including cost and transportation),
  - provide the patient and family with a list of community care resources (e.g., home health care, Meals on Wheels),
  - establish when the patient should see his or her primary care physician or primary medical point of contact; and
  - ensure that relevant medical information is sent to the patient’s primary care physician or medical point of contact.
### 2) Summary of Suggested Common or Essential Elements for Medication Reconciliation

<table>
<thead>
<tr>
<th>Category</th>
<th>Essential</th>
<th>Optional</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment on access to care (e.g., admission to hospital or nursing facility)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demographic information</td>
<td>Patient name Date of birth ID number Gender</td>
<td>Primary language Religious, cultural factors</td>
</tr>
<tr>
<td>Medications</td>
<td>Contact information Medication name (generic/trade) Dose</td>
<td>Name of prescriber Compliance level</td>
</tr>
<tr>
<td>Routine</td>
<td>Form Frequency Reason for use</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>OTC products Herbal remedies</td>
<td>Prescription benefits Out-of-pocket costs</td>
</tr>
<tr>
<td></td>
<td>Nutritional supplements Time-limited medications</td>
<td></td>
</tr>
<tr>
<td>Patient access to medications</td>
<td></td>
<td>Prescriber’s NPI</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>Known conditions in patient’s medical history</td>
</tr>
<tr>
<td><strong>Assessment/reconciliation on transfer of care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuing medications</td>
<td>Medication name (generic/trade) Dose</td>
<td>Monitoring parameters, frequency</td>
</tr>
<tr>
<td></td>
<td>Form Frequency Reason for use</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Expected duration of use</td>
<td></td>
</tr>
<tr>
<td>Patient access to medications</td>
<td></td>
<td>Prescription benefits Out-of-pocket costs</td>
</tr>
<tr>
<td>Validation of transfer information</td>
<td>Name Date Signature</td>
<td>Public/private assistance programs Access to a</td>
</tr>
<tr>
<td>Point of contact at transferring facility</td>
<td>Name Department</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contact information</td>
<td></td>
</tr>
</tbody>
</table>
3) Essential Information That Should Accompany Every Transitioning Patient

- Patient name
- Primary diagnosis for admission to sending facility
- Accurate medication list with prescription and non-prescription drugs, with doses and frequency*
- Allergies and medication intolerances
- Vital signs
- Copies of advance directives including AND/DNR status
- Name and specific contact information for:
  - Sending facility (including phone number of facility/wing of facility and nurse name)
  - Responsible practitioner at sending and receiving sites of care
  - Responsible family member/decision-maker
- Barriers to communication
  - English comprehension is poor: provide primary language spoken by the patient
  - Vision: requires glasses to appropriately see, blind, etc.
  - Hearing impairment: requires hearing aid to hear spoken communication, etc.
  - Cognitive issues that impair decision-making; who should be contacted for decision-making
  - Health literacy or cultural issues that may inhibit communication
- Reason for transfer (i.e., the acute change in condition or problem precipitating the transfer) along with any acute changes from baseline associated with this transfer (e.g., confusion, unable to walk, unresponsive)
- Medical devices, lines (e.g., central line, dialysis site, pacemaker) or wounds
- Patient’s ability to feed self, special dietary needs (e.g., pureed foods, low-salt diet)
- Significant test results
- Tests with results pending, consults or procedures ordered but not yet performed
- Prognosis and goals of care

*In some settings, the patient’s medication administration record could serve as the medication list.
4) AMDA Universal Transfer Form

AMDA has developed and recommends the use of the Universal Transfer Form (UTF) to facilitate the transfer of necessary patient information from one care setting to another. Patient transfers are fraught with the potential for errors stemming from the inaccurate or incomplete transfer of patient information. Use of the UTF can help to minimize the occurrence of such errors by ensuring that patient information is transmitted fully and in a timely fashion.

<table>
<thead>
<tr>
<th>Patient's name:</th>
<th>Patient Identifier #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting Discharged from:</td>
<td>Patient's date of birth:</td>
</tr>
<tr>
<td>Setting Discharged to:</td>
<td>Patient's gender Male: Female:</td>
</tr>
<tr>
<td>Attending physician in setting discharged from:</td>
<td></td>
</tr>
<tr>
<td>Admission date: / /</td>
<td>Discharge date: / /</td>
</tr>
</tbody>
</table>

A. Admitting diagnosis: ____________________________

B. Other diagnoses from this admission:
   1. ____________________________
   2. ____________________________
   3. ____________________________
   4. ____________________________
   5. ____________________________
   6. ____________________________

C. Current diagnoses prior to admission:
   1. ____________________________
   2. ____________________________
   3. ____________________________
   4. ____________________________
   5. ____________________________
   6. ____________________________

D. Surgical procedures and endoscopies during admission (include name of physician who performed the procedure) None ____________ Physician name: ____________________________ Date/results ____________________________ (may attach)
   1. ____________________________ Date/results ____________________________ (may attach)
   2. ____________________________ Date/results ____________________________ (may attach)
   3. ____________________________ Date/results ____________________________ (may attach)

E. Laboratory values (please record most recent results, with date)
   - WBC / / __________
   - BUN / / __________
   - Hgb / / __________ Creatinine / / __________
   - Na+ / / __________ CL / / __________
   - K+ / / __________ CO2 / / __________ Fasting glucose / / __________ Other / / __________

F. Results and dates of pertinent studies (radiology, CT, MRI, nuclear scans, etc.) (may attach)
   1. ____________________________
   2. ____________________________
   3. ____________________________
   Chest X-ray: Date performed: ________ Results: No active disease: ________ Or description if abnormal: ____________________________

G. Allergies:
   - Medication: ____________________________ Reaction: ____________________________
   - Medication: ____________________________ Reaction: ____________________________
   - Foods: ____________________________ Reaction: ____________________________
   - Other: ____________________________ Reaction: ____________________________

H. Admission weight: ________ Discharge weight: ________
I. Advance directives:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Artifical Nutrition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Further hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Attach copies)

J. Has patient had a recent fall? Yes ___ No ___
Did the patient wander unsafe while hospitalized? Yes ___ No ___

K. Comments on inpatient course: (may attach narrative)

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

L. Is the patient aware of his/her diagnos(es)? Yes ___ No ___
If No, why not? ______________________________________________________________________

M. Patient's cognitive status for decision-making:

___ Independent  ___ Modified independence (some difficulty in new situations)
___ Moderately impaired (decisions poor)  ___ Severely impaired (never/rarely makes decisions)

N. Is the patient a candidate for rehabilitation therapy? Yes ___ No ___
If yes, state goals for rehabilitation:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

O. Discharge medication orders:

1. Dose ________ Route ________ Frequency ________
   Rationale: ________________________________

2. Dose ________ Route ________ Frequency ________
   Rationale: ________________________________

3. Dose ________ Route ________ Frequency ________
   Rationale: ________________________________

4. Dose ________ Route ________ Frequency ________
   Rationale: ________________________________

5. Dose ________ Route ________ Frequency ________
   Rationale: ________________________________

6. Dose ________ Route ________ Frequency ________
   Rationale: ________________________________
7. Dose _____ Route _______ Frequency ________ 
   Rationale: ____________________________

8. Dose _____ Route _______ Frequency ________ 
   Rationale: ____________________________

9. Dose _____ Route _______ Frequency ________ 
   Rationale: ____________________________

10. Dose _____ Route _______ Frequency ________ 
    Rationale: ____________________________

11. Dose _____ Route _______ Frequency ________ 
    Rationale: ____________________________

P. Diet: __________________________

Q. Immunizations: Influenza: ___ Date: _____ 
   Pneumococcal: ___ Date: _____
   Tetanus-Diphtheria: ___ Date: _____
   Tests: PPD: ___ Results: ___ +/- ___ Date: _____

R. Additional orders: __________________________
   __________________________
   __________________________

S. Follow-up on consults/tests/procedures recommended: 
   __________________________
   __________________________

T. Is patient the primary decision maker? Yes ___ No: ___
   If no, name of the substitute or surrogate: 
   __________________________
   __________________________

Name of physician/designee completing form: __________________________
Contact phone number: (___) ______-_____ Extension or beeper: __________________________
Date form completed: __/__/____

Name of Primary Care Physician
Contact phone number: (___) ______-_____ Extension or beeper: __________________________
Recommended Elements of a Discharge or Course-of-Treatment Summary

- Reason for course of treatment (i.e., disease process)
- New diagnoses arising during course of treatment
- Surgery or other procedures performed during course of treatment
- Consultants utilized during course of treatment
- Complications encountered during course of treatment (e.g., falls, iatrogenic infections, patient harm)
- Changes from pre-admission baseline (e.g., change in ability to communicate, cognitive issues, functional decline)
- Treatment goals and advance directives discussed with patient/family
- Anticipated treatment goals at time of transition:
  - return to previous site of living vs. stay at a level of care different from pre-admission status;
  - total recovery vs. partial recovery vs. recovery not likely (i.e., rehabilitation potential); and
  - palliative care/hospice.
- Test results pending at time of transition (e.g., biopsies, lab tests, radiology studies)
- Next steps planned in patient’s care plan, with specifics as to why and when and which practitioner(s) need to be involved

Practitioner Request for Notification of Medication Changes

Dear Receiving Physician,

I am the practitioner for (name of patient)

Before discontinuing or changing the following medications, please contact me.

Dr. __________________________ Facility __________________________
Phone __________________________ Pager __________________________

Your cooperation is greatly appreciated.
**RESIDENT TRANSFER FORM**

**Name of Nursing Home**

**Address**

Date of Transfer to the Emergency Room _/__/____

Print only and answer each question (Please do not leave any blanks) Shaded areas may be completed prior to the Date of the emergency and updated as needed.

<table>
<thead>
<tr>
<th>Resident’s Last Name</th>
<th>First Name</th>
<th>M/F</th>
<th>Date of Birth</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>/</strong>/____</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of unit/floor resident transferring from</th>
<th>Phone No. of unit/floor</th>
<th>Unit Fax No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attending Physician</th>
<th>DNR Orders</th>
<th>Advance Directive sent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name Resident’s Next of Kin/Health Care Power of attorney</th>
<th>Phone Number</th>
<th>Next of Kin notified</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### (Check if present)

<table>
<thead>
<tr>
<th>Disabilities</th>
<th>Incontinence</th>
<th>Impairments</th>
<th>Mental Status</th>
<th>Indep</th>
<th>Asst</th>
<th>Depend</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Amputation</td>
<td>☐ Bladder</td>
<td>☐ Speech</td>
<td>☐ Feeding</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>☐ Paralysis</td>
<td>☐ Bowel</td>
<td>☐ Hearing</td>
<td>☐ Bathing/Dressing</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>☐ Contracture</td>
<td>☐ Saliva</td>
<td>☐ Vision</td>
<td>☐ Transfer</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>☐ Pressure Ulcer</td>
<td></td>
<td></td>
<td>☐ Ambulation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

### Behavior Issues

Copy of the MAR with current medications (within the last 24 hrs.) highlighted.

☐ Yes ☐ No (if no, list current medications below)

Chief complaint(s) that bring(s) the patient to the Emergency Room (If altered mental status is the chief complaint, please describe behavior prior to the change.) Date of onset/duration __/__/____.

Lab or other Tests ordered prior to transfer or within 24 hrs. ☐ Yes (send copy of results) ☐ No

Resident uses

☐ Glasses ☐ Feeding tube ☐ Canes ☐ Other (explain) __________

☐ Hearing aid ☐ Folsom Catheter ☐ Crutches __________

☐ Dentures ☐ Tracheostomy ☐ Walker __________

☐ Ostomy ☐ Dialysis Access (describe) __________

Name of MD/NP/PA who made the decision to send patient Beeper Number

Physician’s orders attached:

☐ Yes ☐ No

Vital signs at the time of transfer

T _______ P _______ R _______ B/P _______

Signature of the Transfer Nurse

Print Name

Date of transf. __/__/____

Time of transf. __/__/____

ER Dispatch Fax # __/__/____ (Cover letter required.)

Last rev. 3/21/02

ER Dispatch # __/__/____ (Phone notification of NH transfer to the ER. Call to be brief and to the point.

Give patient name, NH name, exact reason for patient transfer to the ER & ETA. (Do not give a full report.)

Resident Transfer form.

DNR = Do Not Resuscitate; MAR = medication administration record; NP = nurse practitioner; PA = physician assistant; NH = nursing home; ER = emergency room; ETA = estimated time of arrival

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UND SCHOOL OF MEDICINE
UNIVERSITY OF NORTH DAKOTA

Interprofessional Education
Facility Post-Transition Checklists - Issues That Should Be Addressed Upon or Shortly After a Planned Patient Transfer to a Community Home

- Ensure that patient’s PCP or other medical point of contact has been notified of the following:
  - that the patient has been discharged;
  - when the patient has been advised to arrange a follow-up appointment;
  - what information about the patient has been sent to the PCP, when, and how;
  - name and contact information of attending practitioner in the LTCC facility who may be contacted if the PCP considers this appropriate; and
  - name and contact information for a facility staff member that the PCP may contact for further information.

- If the patient does not have a PCP or medical point of contact, reaffirm the need to acquire one.
- Reaffirm that the facility cannot be the patient’s PCP.
- Advise the patient/family that the facility is willing and able to send information to the new caregiver.

- Call the patient/family 24-48 h after discharge for follow-up with the following:
  - confirm that previously arranged support services (e.g., home health care, Meals on Wheels) have made contact and initiated services. If not, provide contact information for these services to the patient/family again; in exceptional instances the facility may assist the patient in contacting support services;
  - review the list of medications given to the patient at discharge from the facility and the schedule for taking them;
  - reinforce the importance of adhering to this new medication schedule and not resuming prior medications until the patient is seen by his or her PCP;
  - verify that the patient/family has contacted the patient’s PCP to make a follow-up appointment;
  - verify that the patient/family has made appointments for follow-up tests as necessary or has kept previously made appointments;
  - verify that the patient/family understands the next steps in the patient’s care; and
  - document all of the above contacts in the patient’s record, noting the date, time, and a summary of the information exchanged.

Issues That Should Be Addressed Upon or Shortly After a Planned Patient Transfer to Another Facility or Level of Care

- Ensure that patient’s PCP or other medical point of contact has been notified of the following:
  - that the patient has been discharged;
  - name and contact information of attending practitioner in the LTCC facility who may be contacted if the PCP considers this appropriate;
  - name and contact information for a facility staff member that the PCP may contact for further information; and
  - document the call to the medical point of contact in the patient record, noting the date, time, and a summary of the information exchanged.
- Advise the patient/family and receiving facility that the sending facility is willing and able to send information to the patient’s new caregivers.
- Provide contact information for the person at the sending facility who can provide this information.
- Call both the receiving facility and the patient/family 24-48 h after transfer to confirm the patient’s arrival at the new facility and obtain closure of any unresolved questions or issues.
Interprofessional Education

What is Interprofessional Education?
Interprofessional Education (IPE) occurs when two or more professionals learn with, from, and about each other to improve collaboration and the quality of care. The IPE program is available for students in North Dakota who have completed a portion of their health education program. Participants in the IPE program will complete a two week rotation in a rural underserved area and will learn how interprofessional partnerships can enhance medicine in rural North Dakota.

Interprofessional Education
• Encourages communication
• Promotes respect
• Expands understanding by working with other disciplines
• Develops teamwork
• Enhances leadership

What does IPE do for Health care?
• Improves patient safety
• Increases both patient and provider satisfaction
• Reduces medical errors
• Controls cost
• Enhances communication

What does IPE do for Students?
• Increases knowledge of roles, contributions, and expertise among various health care professionals while delivering health care to clients and patients.
• Expands knowledge and understanding of interprofessional collaboration and communication.
• Builds interprofessional relationships and teamwork.
• Prepares students for ongoing and upcoming changes in the way health care is delivered and compensated.
• Shares experiences with other health care professionals.

“The AHEC IPE project I participated in during this rotation showed me that it is possible to work in interprofessional groups in a small town. It also showed me that small towns have a lot to offer in entertainment options, fun for all ages.”  Nikki Snyder, Pharmacy Student
What is involved in IPE?

- Health care profession students (medical, nursing, dentistry, physical therapy, etc.) are on site for their regular rotation/clerkship/internship/externship, learning together.
- On site health facility coordinator works to bring students together for interprofessional public health projects.
- University of North Dakota School of Medicine and Health Sciences (UND SMHS) preceptor facilitates IPE activities by teleconference so that the onsite preceptor’s teaching load is not expanded.
- Students evaluate patients and develop plans of care.

Student Perspective

- Integrates patient care activity as part of usual “workflow” for the student on their rotation/clerkship/internship/externship.
- Provides potential for team building and leadership with student led team for these prescribed activities.
- Offers the opportunity for students to work independently and as a team to enhance their usual duties.

Organizational Perspective

- Occupies the time of the student during down times in patient care.
- Offers an opportunity to recruit students to the community.
- Provides facility with a marketable project that encourages students to participate.
- Does not increase workload for onsite faculty – student IPE activity is facilitated through UND SMHS.

Community Perspective

- Provides opportunity for the student to be immersed in the community.
- Increases students’ knowledge about the community and population base.
- Offers students the chance to learn from real life experiences.

Interprofessional Education is important for ensuring quality in health care. The program expects student teams to interact a few hours a week, within the context of their usual rotation/clerkship/internship/externship duties. These IPE team activities are facilitated by a preceptor from the University of North Dakota School of Medicine and Health Sciences.

**Dr. Gwen Halaas, Senior Associate Dean, UND, SMHS**

“The important thing about interprofessional teams is that the teamwork is visible. That means team members, actively communicating with each other, always include the patient. Ultimately this is about both safety and quality in medicine—it helps to develop very specific communications skills and tools to prevent errors. About 80% of errors in medicine are communication errors.”

**Dr. Eric Johnson, Director of IPE, UND, SMHS**

“It’s apparent that students enjoy the opportunity to meet, interact, and understand what other students do. These tasks fit in well with the normal student workflow, and enhance learning in a way that helps the patient, their preceptor, the health care facilities, the patient, and the patient’s family. Health care is moving toward these team approaches, we want to see students as leaders in this area.”
Interprofessional Education
Publications, Presentations, Posters
Publications


Presentations/Posters


Amundson, M., Lang, T., Hosford, C., Schauer, R., Halaas, G., Johnson, E. *An Examination of Interdisciplinary Student Experiences: Impact on Student Attitudes. Transformative Change from the Classroom to Practice, Collaborating Across Borders IV international interprofessional conference Vancouver, BC, Canada; June 20, 2013.

Amundson, M. *NHSC SEARCH Program*. National Rural Health Association Annual Conference; Miami Beach, FL; May 2008.


Muus, K., Amundson, M., Kruger, G., Park R. *North Dakota Student/Resident Experiences and Rotations in Community Health Program Assessment*. National Rural Health Association annual conference, Salt Lake City, UT; May 2003.