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Message from the President

The Professionalism Pillar

Jennifer L. Embree, DNP, RN, NE-BC, CCNS

Professionalism? What does this mean as an Indiana nurse? Is it about being "cool, calm, and collected?" as my first Director of Nursing-Belle challenged me to be, when I first interviewed for a leadership position? Or was it when my friend Sammie, nurse, author, editor and artist then depicted me hanging from my collar on a hook, looking sheepish? (I do not think I was exhibiting my best behavior at that time, apparently I was very transparent with my emotions)! Is it about riding the fence and not exhibiting decisiveness?

Is it that talent that I see in my mentors, and why I asked them to be mentors by formal invitation or when I drop by asking for their guidance? Is it about being a great listener, guiding others, with a kind, calm and balanced demeanor?

Is professionalism about being a supporter and providing resource for self-improvement? Is it about being insightful and structured and then asking how you are and really caring about your response and well-being? It is embracing an issue as an opportunity and not a "problem?"

Is it about providing the knowledge power, historical perspective, and wisdom as a mentor to those newer in nursing roles? Is it about my colleagues from other countries, role modeling respectful behavior, providing the support that I need to be successful, and teaching me what real kindness and reverence is really all about?

Could professionalism also be about creativity, enthusiasm, and excitement for the possibilities for nursing and healthcare? What about the laughter, support, and networking that I gain from my fellow nurses? What about the realistic overall view of the wise nurses? And the support and check stepping of others to assure we all are on target with our work at hand?

How about the possibilities, the ideas of those who bring a different flavor to our nursing work? Is it about being a dreamer? A visionary? A believer? Is professionalism about how we look? The expression plastered on our faces? Or the compassion in our souls for those in need? Is it about nurse pride? Or is it about our communication style?

As I thought about the ISNA professionalism pillar and viewed the great leaders in nursing around me, I looked to these leaders and the literature and found some answers to my questions. As I asked myself-is it selecting a model to live by, I found that the literature described one study about professionalism views held by nursing faculty and students where consensus was not found (Danesh, Baumann, Kolotylo, Lawlor, Thompkins & Lee, 2013). (Was anyone really surprised?)

Professionalism includes generally recognized descriptors of knowledge, specialization, intellectual and individual responsibility, and well-developed group consciousness. (Remember it is not all about us….) How do we gain well-developed group consciousness? (Continuing self-development and team development is a must) (Danesh, Baumann, Kolotylo, Lawlor, Thompkins & Lee, 2013).

Four viewpoints emerged from this literature. *Humanists* were respectful regarding human dignity, personal integrity, patient privacy, and protection of patients from harm. *Portrayers* believed professionalism was exemplified by image, attire, and expression. *Facilitators* felt this behavior included standards and policies, personal beliefs, and values. *Regulators on the other hand,* believed this behavior was fostered by a workplace that embraced and implemented suitable beliefs and standards. (Danesh, Baumann, Kolotylo, Lawlor, Thompkins & Lee, 2013).

As we think about leaders, we need to ask ourselves what talents of our leaders we most admire. Kouzes and Posner embrace modeling the way, inspiring a shared vision, challenging the process, enabling the actions of others and encouraging the heart (2012). Chapman hails "servant leadership" as an aspiration (2007). We cannot think about our behavior without thinking about Kotter and his innovative strategic network-because standing still is not reflective of professionalism (2012). Which of your talents do you need to improve?

Do you want to enhance those previous identified capabilities in ourselves? If so, how can we best accomplish that self-improvement? Do we have to have cosmetic surgery to boost our image? Hire a personal trainer and executive coach to augment our abilities? Take a sabbatical to the mountain to search for our true self? Find the fantasy island healthcare institution to live out our dream? Study the crusaders of past to determine how those who came before us succeeded and those who failed to avoid the pitfalls?

How can we strengthen our own talents? For each of us, the answer to that question is different and requires a plan. We know that "hope is not a plan." Not identifying in writing how we will heighten our professionalism sets us up for failure. We all have a different starting places and baggage that we choose to hang on to, shine up, or discard. And we all need assistance in enhancing our mystic abilities!

Over my years in nursing, I have attended multiple leadership enhancement opportunities. From Stephen Covey's 7 Habits, to multiple state, national, and international conferences I have gained new insight into how I can enrich my talents and the way that I behave. With every educational session and every new person that I meet, I find the sparkle in their eyes as they talk about the passion in their life. As I listen to them, I gain additional wisdom and think about how I can assist them in meeting their goals. But their passion is not what drives me. My passion is leadership, education and enabling others towards their "moments of excellence" as author Donna Wright declares on a frequent basis! Though each of my days are not filled with breathtaking excitement, I somehow manage to continue to challenge myself about how I can heighten my effectiveness while hoping that nothing else falls out of my brain!

As nurses, we all have a personal responsibility to exemplify professionalism, since all nurses are leaders. We have responsibilities and expectations to carry out. No matter what our title-how we behave is paramount. We are nurses, therefore leaders with the expectation of conducting ourselves as professionals. Joining ISNA is one example of exhibiting your professionalism. Take the step, join your association and begin the journey in one of Indiana nursing's finest organizations. We are waiting for you to take the next step!

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CEO Note

Licensure Jurisdiction for Cross-Border Nursing Practice

Gingy Harshey-Meade, MSN, RN, CAE, NEA-BC, CEO

On March 21, 2014, I was at ANA to be a member of the *Licensure Jurisdiction for Cross-Border Nursing Practice*, a topic which originated with the 2013 ANA Membership Assembly. The ANA Board chartered Taskforce included representatives from the ANA board, Constituent /State Nurses Association (C/SNA) leadership, regulators and other nursing thought leaders. Taskforce members were charged with a review of the current state of cross-border nursing practice and to make recommendations to the ANA Board of Directors for strategies to move forward with a futuristic view of nursing practice and regulation by September 2014. A sense of high level of urgency was expressed for finding a solution, acknowledging regulation has not kept pace with nursing practice

Virtual practice has and will continue to grow. A number of other health professions are also facing regulatory challenges when engaged in cross border practice. Although, agreement as to whether the state of practice is where the nurse is located versus the patient was not reached, consensus was achieved with regard to the stakeholders and next steps. The four most significant stakeholders were deemed to be: nurses; consumers; states, in particular nursing regulators; and insurers, with some overlap of interest.

The group engaged in an exercise designed to generate ideas on how to address the issue of cross-border practice. This resulted in many suggestions focused on a single license model; however, there were significant differences on how best to implement such a model. Other ideas included a more consistent movement toward licensure uniformity; state licensure with a dual option for national licensure with a database; and federal requirements that are state enforced.

In order to continue some forward momentum, the dialogue shifted to focus on challenges associated with uniform requirements that regulate nursing practice. The group had a substantive discussion about criminal background checks, issues associated with impaired practice, mandatory reporting requirements, continued competency and new, emerging areas of nursing practice.

As a final activity, the group discussed some potential next steps that included:

1. Review of uniform licensure requirements, particularly as they pertain to criminal background checks and impaired practice.
2. Identify a regulatory model that could address new, emerging practice areas.
3. Develop a standardized decision tree for determining scope of practice.

I will keep you up-to-date as this journey continues.

ISNA Welcomes Our New and Reinstated Members

Rhonda Akers	Lafayette, IN
Elizabeth Alchin	Oaktown, IN
Jessica Alvarez	Valparaiso, IN
Theresa Amerman	Indianapolis, IN
Brennan Barrett	Richmond, IN
Marjorie Bell	Richmond, IN
Lisa Benson	Wilkinson, IN
Mary Blackburn	Indianapolis, IN
Joshonda Bonner	Ft. Wayne, IN
Jacqueline Braun	Evanston, IN
Leslie Erin Braun	New Castle, IN
Lawrence Brodhead	Kokomo, IN
Kimberly Bryant	Noblesville, IN
Heidi Buffenbarger	Ft. Wayne, IN
Ryan Butler	Evansville, IN
Karen Butrum	Danville, IN
Ruby Cass	Kokomo, IN
Stephanie Chamberlin	Indianapolis, IN
Cheryl Champagne	Brownsburg, IN
Anne Chegar	Indianapolis, IN
Tina Childress	Mooresville, IN
Melissa Claflin	Zionsville, IN
Stephanie Collins	Nashville, IN
Judith Crafton	Shelbyville, IN
Lisa Crane	Hope, IN
Jennifer Daugherty	Liberty Center, IN
Rosalinda De Luna	Hammond, IN
Jennifer Dougherty	Columbus, IN
Susan Duval	Huntingburg, IN
Lativia Edmond	Schererville, IN
Teresa Elliott	Anderson, IN
Stephanie Elliott	Avon, IN
Jacqueline Ensign	Lafayette, IN
Jenny Erkfitz	Noblesville, IN
Karan Faust	Galveston, IN
Sara Fickle	Indianapolis, IN
Amber Floyd	Indianapolis, IN
Lisa Foldesi	Ft. Wayne, IN
Marinelle Ford	Carmel, IN
Jessica Frantz	Decatur, IN
Stephanie Fuller	Vincennes, IN
Samuel Gichuhi	Harlan, IN
Kelly Herbert	Hammond, IN
Bobbi Herron-Foster	Valparaiso, IN
Chelsea Holmes	Indianapolis, IN
Karen Hooker	Culver, IN
Elizabeth Hudson	Portland, IN
Lois Hughes	Indianapolis, IN
Angel Jennings	Ft. Wayne, IN
Carmen Jones	Monticello, IN
Nancy Justice	Greenfield, IN
David Keith	Camby, IN
Nichole Kelly	Marion, IN
Stephanie Kemery	Noblesville, IN
Saraphine Latchie	Indianapolis, IN
Bernadette Linne	Evanston, IN
Katrina Lock	Rising Sun, IN
Angela McNelis	Indianapolis, IN
Hannah Merriman	APO, AE
Dorothy Mertz	Goshen, IN
Clarissa Morrow	Plymouth, IN
Debbie Mullin	St. John, IN
Robin Munson-Rose	Ft. Wayne, IN
Alyssa Murphy	Bedford, IN
Kristina Neal	Lafayette, IN
Naquetta Newsome	Ft. Wayne, IN
Roberta Norris	Plymouth, IN
Modupeola Okeowo	Indianapolis, IN
Carol Perkins	Washington, IN
Kristine Probst	Wheeler, IL
Melony Rayle	Westfield, IN
Robin Riddle	Tippecanoe, IN
R. Joseph Riley	Charlestown, IN
Lori Risley	Indianapolis, IN
Cheryl Riwitis	Muncie, IN
Mary Beth Schaefer	Carmel, IN
Shawna Shaffer	Madison, IN
Shelly Shields	Greenwood, IN
Sarah Shima	Terre Haute, IN
Gloria Skinner	Columbus, IN
Cecelia Smith	Bloomington, IN
Linda Smith-Moore	Indianapolis, IN
Emily Staley	Brownsburg, IN
Stephanie Stallman	Ferdinand, IN
Marcia Strain	Bloomington, IN
Mary Strawsma	Lafayette, IN
Jessica Taylor	Carmel, IN
Constance Thomas	Terre Haute, IN
Sharon Thompson	Brownsburg, IN
Christiana Thompson	Middlebury, IN
Jody Thresher	Muncie, IN
Nancy Todd	Indianapolis, IN
Renee Twibell	Muncie, IN
Kimberly Valich	Lowell, IN
Debra Vanwoerden	Crown Point, IN
Rachel Verhoeve	Schererville, IN
Kathryn Wallace	Valparaiso, IN
Cibele Webb	South Bend, IN
Sarah Whipker	Seymour, IN
Mary Woolums	Anderson, IN

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Web site: www.indiananurses.org

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Gingy Harshey-Meade, MSN, RN, CAE, NEA-BC, CEO
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Marla Holbrook, BS, Office Manager

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ISNA Mission Statement

ISNA works through its members to promote and influence quality nursing and health care.

ISNA accomplishes its mission through unity, advocacy, professionalism, and leadership.

ISNA is a multi-purpose professional association serving registered nurses since 1903.

ISNA is a constituent member of the American Nurses Association.

Bulletin Copy Deadline Dates

All ISNA members are encouraged to submit material for publication that is of interest to nurses. The material will be reviewed and may be edited for publication. To submit an article mail to ISNA Bulletin, 2915 North High School Road, Indianapolis, IN. 46224-2969 or E-mail to info@indiananurses.org.

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If you wish additional information or have questions, please contact ISNA headquarters.

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APPLICATION FOR RN MEMBERSHIP in ANA / ISNA

Or complete online at www.NursingWorld.org

PLEASE PRINT OR TYPE

Last Name, First Name, Middle Initial

Name of Basic School of Nursing

Street or P.O. Box

Home phone number & area code

Graduation Month & Year

County of Residence

Work phone number & area code

RN License Number State

City, State, Zip+4

Preferred email address

Name of membership sponsor

1. SELECT PAY CATEGORY

_____ **Full Dues – 100%**
Employed full or part time.
Annual – $281
Monthly (EDPP) – $23.42

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Annual – $140.50
Monthly (EDPP) – $11.88

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Card Number

VISA/Master card Exp. Date

Signature for Bankcard Payment

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To authorize this method of monthly payment of dues, please read, sign the authorization below, and enclose a check for the first month (full $23.42, reduced $11.88).

This authorizes ANA to withdraw 1/12 of my annual dues and the specified service fee of $0.50 each month from my checking account. It is to be withdrawn on/after the 15th day of each month. The checking account designated and maintained is as shown on the enclosed check.

The amount to be withdrawn is $_____ each month. ANA is authorized to change the amount by giving me (the under-signed) thirty (30) days written notice.

To cancel the authorization, I will provide ANA written notification thirty (30) days prior to the deduction date.

Signature for Electronic Dues Payment Plan

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American Nurses Association

Nurse Health Coaching As the Faculty

Sue Lasiter, PhD, RN

Commonly used in community and outpatient settings, nurse health coaches are moving into the acute hospital settings with the intention to improve client and family outcomes and to decrease inappropriate post-discharge healthcare utilization. Nurse health coaching is an application of practice and expertise that registered nurses provide to the field of health and wellness lifestyle coaching. Implementing health-promoting and evidence-based strategies, nurse health coaches support client behavioral and lifestyle changes to enhance growth, overall health, and well-being (ANA, 2013).

The role of a nurse health coach is to listen and encourage discussion about client concerns, help the client set client-identified goals, and discuss ways the client would like to take action and accomplish goals. The client leads the discussion and the nurse coach guides the client to develop reasonable solutions that are consistent with client-identified values.

Health coaching delivered by student nurses and nurses is different from client education in that client education is focused on providing information and is driven by the healthcare provider who must teach client-specific care so that clients can self-manage. Having the patient and family receive both client education as well as health coaching enhances client health and functioning and improves health-related outcomes. Preparing student nurses early in the curriculum to be health coaches enhances communication skills of the student and assists them in improving their comfort level in client interactions (Embree, 2014).

Nurses are uniquely positioned for health coaching, because nurses encounter multiple situations where opportunities for coaching can be blended with education to provide a powerful effect on client self-management. Nurses have perfected client-education and are now learning to be health coaches so that each client encounter becomes an opportunity to listen carefully and evaluate whether the client needs coaching, education, or both.

Health Coaching As the Coach

Kristy Biro, IU School of Nursing, BSN Student

As I approached my first semester in nursing school at IUPUI, I did not know what to expect. When I found out that my clinical would be health coaching, I was not sure what to think about coaching as a clinical experience. However, as the semester went on, I soon realized that educating and teaching others is a huge part of nursing. Health promotion is becoming more important, and that is where health coaching comes into play. Rather than telling a client what to do, health coaching allows you to guide them to their desired outcome, whether it is eating healthy, quitting smoking, or exercising.

Health coaching is a thought provoking process that challenges the client to learn about themselves, allow them to maximize what they are capable of doing, and allow goals to take action by providing support. As the coach, I was there to listen to my client Jeni, provide support, and ask questions to motivate her to make changes. I was not there to advise her or tell her what to do, but rather support her and create the mind set needed to help Jeni make changes. My coaching experience with Jeni was a little different from my classmates because unlike some of their clients, Jeni was motivated and knew what she wanted out of health coaching.

After eight weeks of learning about health coaching, I was a nervous wreck before my first coaching session. I was in my first semester of nursing school and everything was new to me. My first session with Jeni went a lot better than I thought, and week after week I looked forward to talking with her to see what improvements she had made. My role was to motivate Jeni and allow her to come up with goals for herself that we could talk about the next week. Jeni and I felt the same frustration because her biggest barrier was physical pain, rather than the lack of motivation. I could tell Jeni was motivated and wanted to reach her goals every week, but pain was holding her back from meeting those goals. Because of this, we had to work around the frustration and gear our coaching sessions towards talking and allowing her to express how she was feeling.

Health coaching is an important skill for nurses, especially since all clients are unique and have different needs and wants. I am thankful that health coaching was my first experience in nursing school because it allowed me to be myself and break out of my shell. I have no hospital experience, so my biggest fear has always been that my nerves will get to me the first time I meet a client. This opportunity allowed me to realize that meeting a client (or patient) for the first time is nothing to worry about. I know health coaching will be useful as a nurse because nursing is not only about caring for clients, but also providing them with the skills necessary to maintain their health and well being.

Nurse Health Coaching As the Coachee

Jennifer Embree, DNP, RN, NE-BC, CCNS

As the opportunity presented itself (or as I was encouraged by my colleague Sue Lasiter) to be coached as a faculty member at my school of nursing, I have to admit that I was interested, but not very hopeful. I had been experiencing unrelenting pain from a surprise herniated lumbar disc for several months. I was a nurse, so I remained strong (only in my mind or perhaps not so much). I experienced frustration at not being in control of my own healing and was unable to stand or walk without pain. I had read the Art and Science of Nurse Coaching: The Provider's Guide to Coaching Scope and Competencies, so I knew what to expect from the coaching experience (ANA, 2013).

I recognized that I needed to have a health coach because I was not improving and I was increasingly frustrated since I had not immediately healed. I asked for help by signing up to be coached by an Indiana University BSN student. And in asking for help I had to be open, flexible and get unfrozen from my impatience. I had to become more patient with my body, as it took time to heal. Even though I just woke up with a herniated disc, it was not going away overnight (or over five months). I recognized that I was motivated but limited by physical pain. I recognized personal frustration.

I was very fortunate in getting Kristy Biro as my health coach. Kristy was a great listener and recognized that I was frustrated but motivated. She helped me set goals that I could hopefully accomplish. When I was not able to meet all my goals-Kristy did not dissuade me from trying, but supported what I was able to accomplish and asked how I wanted to re-adjust my goals. Kristy accepted my independence, supported me, kept me goal-oriented and focused. And she kept asking-where did I want to go? What was *my* time frame?

The day before our last coaching session in a series of six, it occurred to me that Kristy and I needed to tell our story of health coach and coachee. As a nursing student, new to the role of coach, Kristy needed to learn a new role. Kristy was coached by her faculty in this new role to provide skilled, purposeful, results oriented coaching. As someone in need, I required refocusing and to see some success before I further deteriorated physically and mentally. Kristy coached me, supported me and helped me refocus!

Having experienced the value of my own health coach, I appreciate this quote of Barbara M. Dossey *"Nurse Coaching is a role that speaks to the heart of nursing, but one that all providers can embrace. It's all about interaction with clients in a skilled, purposeful, and results-oriented way."*

For more information about the Art and Science of Nurse Coaching: The Provider's Guide to Coaching Scope and Competencies, see: http://ananursecoaching.com/about-ana/

Certification Corner

Sue Johnson

Remember Nichole Reynolds' story of her first certification experience. Let's follow Niki as she progresses on the next step of her certification journey.

"When we are little we often engage in imaginary role play. We are valiant knights protecting the throne and mothers having tea parties. We enjoy the visualizations that embellish our lives. So, at what point as an adult do we start to sabotage our dreams? Why do we often let self doubt and uncertainty make decisions for us? I shared my story of goals unfulfilled in the fall; here is my golden sunset story of success.

The journey to obtain certification starts with getting registered with that organization. I have been a member of the neuroscience nursing association for 9 years. The certification exam is offered at a discounted price for association members. Many companies offer certification reimbursement if you pass. Look into this benefit; my company would cover the entire cost of the exam if I passed. Talk about incentive! The association uses an online testing company I used to complete the sign up process. I was able to pick a date within a window and the testing site is a mile from my home.

Passing certification requires studying. For me, I studied the areas of neuroscience nursing I don't practice in, such as the ICU, first. July would be my test month. I broke the content up into monthly goals and weekly information musts. The AANN offers two online practice tests I took advantage of during my journey to July. Then, I woke during the night in excruciating pain, somehow I had herniated a lumbar disc! This injury put my whole life on hold! I did not require surgery but I worked from home often lying or standing, sitting in a chair was an unobtainable goal! Fortunately, the test center allows you to reschedule for certain life altering events! I now had an October test date.

After healing and continuing to prepare, October arrived. I took a test drive to the test site and even walked into the building to make sure I knew where I was going to go on test day. I also called the test center to ensure bathroom breaks, the operator laughed at my anxiety but the confirmation put my mind at ease! I scheduled a test time for the afternoon to help with my success. I am not a morning person by any stretch!

Test day arrived. I spent the night before watching movies and went to bed at a reasonable time. I felt confident and prepared. When you arrive at the test center you have to surrender all of your possessions, even car keys. You show your driver's license and sign to take the test. I was then escorted into a glass walled room with cameras keeping an eye on the exam participants from every angle! For those of you new grads, an online test is no big deal. I took my State nursing exam on paper; this was all new to me! Because you have no possessions in the room, the man two seats down kept snorting to keep his cold at bay! A young mother was also yelling loudly at the sign in booth because she didn't see any reason why her child could not sit on the floor next to her while she took the test she came to complete. It was a very hostile situation, paired with the runny nose two seats down; I buckled down and tried to concentrate on my 18 inch corner of the world.

After three and a half hours I was done. I felt emotionally and mentally drained! I had four hours to complete the test but did not want to go back over my answers. I was ready to get my car keys and journey home. The lady at the sign in booth was all smiles. I told her I didn't think I passed again; she kept the permanent grin and said, "Let's see." I then said to her, "I bet this is the worst part of your job" as she had her back turned to me at a printer. She responded with, "No, this is my favorite part." As negative thoughts flowed through my head, she turned around smiling and placed a paper report in front of me. She was still smiling ear to ear; I was still thinking negative thoughts! I couldn't read English. The lady paused from her smiling to state, "Look, you passed!" She was right, I did pass!!! If it wasn't for the four foot counter between us I know I would have hugged her!! I had no idea that you get your results there in real time! No going home to worry for weeks like the last time I took the test! I passed! I have now joined the ranks of the best neuroscience nurses in the country!! My dream realized!

When you are a beginner nurse you envision becoming that expert nurse peer, you want to become a leader. As you evolve through your own nursing practice continuum don't lose sight of your dreams!! Make certification a reality! Join the ranks of your peers that are certified in your area of expertise. Then, pass that torch of knowledge to that new grad who someday wants to be just like you!"

Niki Reynolds, RN, BSN, CNRN

Niki told me that she is thinking of adding stroke certification to her credentials and wants to complete her Master's degree in about four years. That is true dedication to lifelong learning and we both hope that her experiences, both negative and positive, in her certification journey will inspire YOU to take the road to certification. You will be glad you did and I'd love to write about *your* certification accomplishments!

Policy Primer

Blayne Miley, JD
ISNA Director of Policy & Advocacy

I'm excited to see more nurses and nursing students realizing the importance of public policy and getting involved! We need more of you to take that initiative and help shape our world! Here's what's been going on in nursing policy:

Policy 101 Legislative Conference

The ISNA Policy 101 Conference in January provided an introduction to public policy. ISNA staff reviewed how a bill becomes a law and discussed ISNA's policy activities. ISNA's lobbyist provided insight into the legislative process. Attendees received presentations on the role and operations of the Indiana State Board of Nursing and Indiana Center for Nursing from Executive Directors Elizabeth Kiefner Crawford and Kimberly Harper, respectively. The afternoon included a panel discussion by ISNA members involved in various advocacy avenues. Altogether these provided a well-rounded education on the many aspects of nursing policy. Attendees left with a better understanding of how nursing policy is shaped.

Advanced Policy Legislative Conference

An enthusiastic, engaged group attended the ISNA Advanced Policy Legislative Conference in February. Senator Michael Crider and Representative Ed Clere each made time in their busy schedules to address the attendees and take questions. Breakout exercises created lively discussions on the collaborative practice agreement requirement and future policy goals. Janet Haebler, Associate Director of State Government Affairs for the American Nurses Association, provided a national perspective on evolving nurse policy issues. She also helped moderate the breakout discussions. Brian Tabor, Vice President of Government Relations for the Indiana Hospital Association (IHA), shared his take on the legislative session and IHA's current lobbying initiatives. This conference will continue to be a premiere event for sharing ways to advance Indiana's nurses. If you have suggestions regarding future ISNA event offerings, email bmiley@indiananurses.org, we'd love to hear from you!

Session Overview

The 2014 Indiana General Assembly session wrapped on March 14th. On June 17th, the General Assembly will reconvene to make technical correction. Below is an overview of bills considered by the General Assembly. Titles in bold indicate the legislation passed the General Assembly, have been signed by Governor Mike Pence, and will become Indiana law upon their effective date, which is contained in each bill. Titles that are not in bold indicate the legislation was introduced, but it did not complete the legislation process to become law. These bills may be re-introduced next year in another attempt to have them become law. ISNA members received this information back in March through our weekly e-newsletter, the ISNAbler. The ISNAbler also provided weekly updates on the legislative progress of all bills impacting nursing.

"SEA" refers to Senate Enrolled Act, "HEA" means House Enrolled Act, for bill that completed the legislative process. Bills labeled "HB" and "SB" refer to bills that did not complete the legislative process. The full text of all the legislation is available at http://iga.in.gov/.

Commemorating the 100th Anniversary of IU School of Nursing House Concurrent Resolution 17: The General Assembly passed this resolution congratulating the IU School of Nursing on its achievements. Representative Ed Clere, who had two doctoral nursing students interning with him during the session, introduced the resolution. The co-authors of the resolution were Representatives Charlie Brown, Steve Davisson, Patrick Bauer, and Justin Moed. In the Senate, the resolution was introduced by Senator Patricia Miller and sponsored by Senators Michael Delph and Brent Waltz. Dean Marion Broome was given the opportunity to address the legislature during the event.

APRN Authorization to Perform Physical Exams for School Bus Driver Applicants HEA 1303: At the start of session, three separate bills were introduced providing this authorization: SB 145 (Senator Michael Crider) / SB 278 (Senator Jean Breaux) / HB 1088 (Representative Kreg Battles). Only SB 278 passed its chamber of introduction, but that bill did not receive a hearing before the House Education Committee. Fortunately, that was not the end of the story. HB 1303, which dealt with school bus inspections and signage was amended to add the content of SB 278, and passed into law. This authorizes physical exams for school bus driver applicants to be performed by any health care professional registered in the Federal Motor Carrier Safety Administration's National Registry of Certified Medical Examiners. APRNs are eligible to receive the certification for this registry, thus can be authorized to perform the exams.

CRNAs, Anesthesiologist Assistants, Pharmacy Technicians, Diabetes Educators SEA 233: This potpourri healthcare professionals bill designates certified registered nurse anesthetists (CRNAs) as Advanced Practice Nurses (APN) under Indiana law without altering their scope of practice. The APN designation was put into Indiana statute to structure prescriptive authority. CRNA practice does not include prescribing, as defined in Indiana law, which is why CRNAs were not originally included in the designation. Nationally, the term Advanced Practice Registered Nurse includes CRNAs, Clinical Nurse Specialists, Certified Nurse Midwives, and Nurse Practitioners. Designating CRNAs as APNs under Indiana law is consistent with the national recognition. The bill also elevates pharmacy technicians and diabetes educators from certification to licensure under the pharmacy and medical licensing boards, respectively. Finally, the bill authorizes anesthesiologist assistants, an extender position similar to physician assistants, to work in Indiana.

Stock Epinephrine in Schools SEA 245 / HEA 1323: Schools will be allowed to stock and administer unassigned epi-pens. SEA 245 covers local school corporations and HEA 1323 applies to colleges and universities. SEA 245 permits all school employees to receive training in recognizing anaphylaxis and the proper administration of auto-injectable epinephrine. HEA 1323 authorizes any student, faculty member, or staff member to receive training.

INSPECT Expansion & Opioid Treatment Program Regulations HEA 1218: The possibility of expanding the INSPECT program to all prescription drugs is headed for summer study committee again. The bill calls for regulations for opioid treatment programs geared toward reducing the use of methadone. HEA 1218 reduces the threshold for requiring prior authorization for opioid treatment medications from 14 days to 7 days. The bill also requires a prescription for the purchase of insulin. INSPECT is the Indiana Scheduled Prescription Electronic Collecting & Tracking program that allows prescribers, dispensers, and law enforcement to check an individual's controlled substance prescription history. Information about INSPECT is available at www.in.gov/pla/inspect. Information about the Indiana Attorney General's initiative to reduce prescription drug abuse can be found at www.in.gov/bitterpill.

Neonatal Abstinence Syndrome SEA 408: NAS refers to the adverse effects that occur in a newborn infant who was exposed to addictive illegal or prescription drugs while in the mother's womb. Initially, SB 408 established mandatory reporting by hospitals of data regarding NAS, however that was removed. The final version creates a government study of the issue, and also sets up a data collection pilot program for voluntary hospital participation.

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Good Samaritan Licensed Health Care Services HB 1097: This bill would have provided civil immunity to individuals licensed to provide health care services who do so voluntarily in a setting other than a medical clinic or health care facility as long as they provide services within their scope of practice without gross negligence or willful misconduct. HB 1097 passed the House and Senate in different forms and did not make it out of the conference committee process. The bill can be re-introduced next year.

Medical Professionals Responding to Emergency Disasters HB 1372: This bill would have provided that licensed medical professionals, including nurses, may not be disciplined by their employer for absence or injury as a result of responding to a call for emergency management to respond to a disaster. This bill did not advance out of committee. It could be re-introduced next year.

Licensure SEA 421: The initial version of this bill created a committee to review all professional licenses, permits, and certifications in Indiana to determine which are unnecessary. Through amendment, this was replaced by a review of the necessity of licensure and an assessment of the charged fees for regulated professions, including nursing.

Sexual Assault Examinations SEA 255: The state police are instructed to develop and distribute a standardized sexual assault examination kit. Health care providers must use the kit if practicable. SEA 255 also authorizes a forensic examination of an unconscious person suspected to be the victim of a sexual crime. Providers have civil immunity for following these procedures absent gross negligence or wanton misconduct.

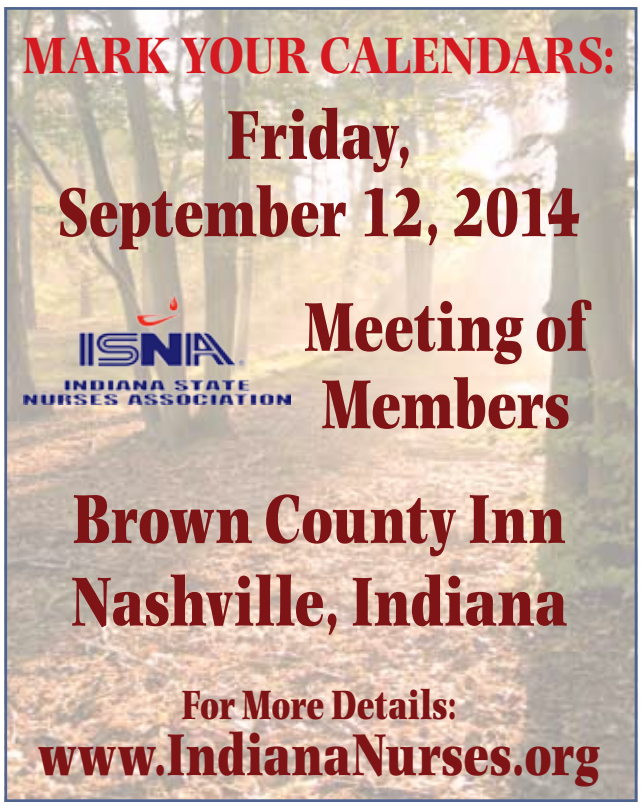
Biosimilar Substitution SEA 262: Pharmacists may substitute an interchangeable biosimilar product for a prescribed biological medical product if (1) the substitute has been determined to be interchangeable by the FDA, (2) the prescriber authorizes substitution, and (3) the pharmacist informs the customer of the substitution. The pharmacist must notify the prescriber of the substitution within 10 days. A biologic medical product is a substance made by a living organism or derived from a living organism by means of recombinant DNA or controlled gene expression methods, such as a vaccine or allergenic product. A biosimilar is interchangeable with a particular biologic product, somewhat like a generic for a name brand drug, because there are no clinically meaningful differences in safety, purity, and potency.

Same-Sex Marriage Amendment HJR 3: The proposed amendment to the Indiana Constitution passed the General Assembly after being amended. The change removed the sentence stating "A legal status identical or substantially similar to that of marriage for unmarried individuals shall not be valid or recognized." For constitutional amendments, identical language must pass in two separately elected legislatures, which has not occurred, to advance to the public ballot.

What's Next

The 2014 legislative session has wrapped, but advocacy opportunities are year-round. The Legislative Council will meet sometime after the Primary Election to assign topics to the 17 interim study committees. Actual meetings of those committees probably won't begin until late June or July. The committees convene to gather information on issues that are the potential subject matter for bills in the next legislative session. Nurses can contact committee members to weigh in on the issues. Committee meetings are open to the public and available live via webcast. Committee topics, members, schedules, and webcasts will be available at www.in.gov/legislative. The next issue of the Bulletin will include the interim study committee topics pertinent to nursing. ISNA members will receive this information the week it's announced through the ISNAbler.

Additionally, the summer and fall represent an opportunity to reach out to your legislators about issues of concern while the landscape of the 2015 legislative session is taking shape. You can urge your legislator(s) to introduce a bill to improve Indiana law. For example, the budget passed by the General Assembly in 2013 eliminated the Nurse Scholarship Program, which provided need-based funding to over 300 undergraduate nursing students annually. Over 1 million of the nation's 2.6 million RN's are over the age of 50, and over 275,000 are over the age of 60. Indiana will face an estimated shortage of 22,076 RN's by 2020. In 2015, the General Assembly will once again be crafting a budget, and this represents an opportunity to get nurse education funding back in the budget!



Independent Study

Interprofessional Collaboration: The IOM Report and More

Introduction

"The rapid relentless evolution of the health care system brings with it the need to periodically revisit important concepts. Nurse physician collaboration is one such concept. In a climate constantly demanding efficiency, cost-effectiveness, and quality improvement, interprofessional collaboration warrants re-examination because maximizing nurse-physician collaboration holds promise for improving patient care and creating satisfying work roles" (Lindeke & Sieckert, 2005). Health care has become increasingly complex as evidenced by sicker patients that can be revived and kept alive by more specialized practitioners, including nurses. Patients that are managed on a general medical/telemetry unit today were in intensive care units 15 years ago. However, with this complexity comes responsibility to do more with less, the authority to work within our scope and the accountability to manage the care of these patients in a more efficient manner. Responsibility, authority and accountability are the edicts of transformational leadership by Mary Koloroutis in her book *Relationship Based Care*.

Health care has become specialized, but this has caused the care, and consequently the communication of that care, to become compartmentalized. The socialization of physicians, nurses and other health care providers has also contributed to this phenomenon. The resultant communication barrier has become one of the causes of the 'fragmentation' of care. This fragmentation may be the root of many of our sentinel events. In 2006 The Joint Commission reports were estimating that "communication issues" were the root cause for roughly 70% of Sentinel Events. Communication is one of the key components of teamwork and reports have shown a positive link between teamwork and patient care outcomes (Salas, et al 2008).

"A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, 'or the risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called 'sentinel' because they signal the need for immediate investigation and response." (TJC, retrieved 11-1-12)

Background

In 2008, The Robert Wood Johnson Foundation (RWJF) approached the Institute of Medicine (IOM) to offer a partnership to evaluate and react to the nursing profession's role in health care reform. The two groups recognized nursing's commitment to the future and the challenges the new health care laws would present. These two organizations formed a committee and established a 2-year Initiative on the Future of Nursing. The 2010 report *The Future of Nursing: Leading Change, Advancing Health* was the result of this partnership. It is a 586 page report available at no cost at http://books.nap.edu/openbook.php?record_id=12956. The report begins with the assumption that nurses will fill the expanded roles in redesigning the health care system.

Since this report was published, the Affordable Care Act was passed and will have a significant impact on all aspects of health care: providers, insurers and patients. Nursing must be able to face the challenge of improving the management of chronic conditions through care transitions and case management; nursing must show improvement in illness prevention and wellness, as well as prevention of adverse events such as hospital acquired conditions. Nursing will also be asked to affect change in providing mental health services, school health services, long-term care and palliative care, to include end-of-life care. These interventions will be measured by cost as well as care outcomes. (IOM, 2011)

The nursing profession is the largest division of the health care profession with 3 million members, so it stands to reason that the nursing profession will be affected the most by the vision created by the writers of the IOM report.

The four key recommendations formulated by the committee as a result of their negotiations may sound familiar to you:

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and an improved information infrastructure (IOM, 2011) (http://www.thefutureofnursing.org/)

Chapter 5 of the IOM/RWJF report: Transforming Leadership

Key Message #3: Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States.

The committee cited studies of a new model of leadership that does not rely on traditional models of the physician dictating orders to the nurse or other care providers. This new leadership style must have competencies with it at all levels to include working from "bedside to the boardroom." This transformation of nursing leadership requires that all nurses are leaders and must be able to work with other healthcare professionals, business managers, policy makers and family members of patients. Nurses must be competent to speak to the meaning of quality health care, preventing adverse outcomes, and reducing medication errors. They must hold themselves and their peers accountable to improving these outcomes; they must break down the division in which they and their physician colleagues have been socialized.

The committee went on to cite the prestigious Gallup polls. In 2009 Gallup polled 1500 national opinion leaders and summarized the results in a report titled *"Nursing Leadership from Bedside to Boardroom: Opinion Leaders' Perceptions"* (IOM, 2011, p. 224). Nurses were identified as one of the most trusted sources of health information, alongside their physician colleagues, yet nurses and patients are seen as having the least amount of influence in health care reform over the next 5-10 years.

Furthermore, few opinion leaders polled felt nurses have influence on increasing access to care. They think the barriers to nurses being important decision makers are that nurses are not perceived as revenue generators compared with doctors. Additionally, that nurses are focused on acute rather than preventive care. Finally they felt that nurses do not have a solitary voice on national issues.

The opinion leaders suggested that nurses take a bigger leadership role so their voices could be heard but also to have higher expectations of their selves as a profession. Many opinion leaders were clear that they also felt nurses should play a vast role in the influence of reducing medical errors, promoting wellness and increasing quality of life for patients.

Collaboration and teamwork have been studied for decades. Interprofessional collaboration has been classified by many terms in the past such as interdisciplinary communication, teamwork and interdisciplinary teams. In fact, the IOM report cited many innovative studies and models that have been developed over the years; some information was qualitative or quantitative research data and some were exemplars from communities.

The IOM report recommends leadership competencies for nurses. Some of these competencies are already recommended by the American Association of Colleges of Nursing (AACN) for baccalaureate education. Those competencies include a "knowledge of the care delivery system, how to work in teams, how to collaborate effectively within and across disciplines, the basic tenets of ethical care, how to be an effective patient advocate, theories of innovation, and the foundations for quality and safety improvement." (IOM, 2011, p. 214). More competencies are needed if a nurse plans to be an entrepreneur or a business developer.

"Collaboration is a complex process that requires intentional knowledge sharing and joint responsibility for patient care" (Lindeke & Sieckert, 2005). Communication and collaboration require effort that may take time to develop and requires trust among all parties. When the goal is client focused or organizational outcomes, innovation must be fostered and that takes a group of individuals with skill in problem solving. The roles of health care providers and patients and families are becoming increasingly interdependent. No single solution is correct for every problem that will arise. Interprofessional collaboration must begin in the education setting; the stage for changing the culture must be set early on and each professional group should strive to hold each other accountable from the beginning of their career.

Interprofessional Collaboration in Education

"The traditional model of educational system is not conducive to open and transparent discussions across multiples levels of the academic institutions, nor does it support transformational change" (Bandali, et al 2011). Innovative healthcare education must be able to effectively and efficiently respond to contemporary, dynamic, interdependent and complex challenges; these challenges are driven by interprofessional collaboration (Bandali, et al 2011).

An extensive review of the literature was done by Reeves et al (2011) in an effort to provide conceptual clarity to interprofessional education (IPE) and interprofessional collaboration (IPC). They acknowledge that part of the conceptual problem is the use of a range of terms such as interdisciplinary collaboration, multiprofessional learning, interprofessional learning and transdisciplinary practice.

One definition of IPE is "when two or more professions learn with, from and about each other to improve collaboration and the quality of care" (Reeves, et al 2011). When the professions leave the academic setting and collaborate in the clinical setting, another definition of interprofessional collaboration is "…an interprofessional process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided" (Reeves, et al 2011).

In Canada and several other countries interprofessional collaboration has been integrated into the curriculum. Students who once were educated in "silos" now learn in an interprofessional environment and experience a collaborative model (Bandali, et al, 2011). There are 24 U.S. Interprofessional Education programs that are affiliated with universities, but few nursing or medical schools are integrating interprofessional education into their curriculum.

A competency framework was developed by the Canadian Interprofessional Health Collaborative (CIHC) Interprofessional Competency Working Group. This framework depicts the integration of knowledge, skills, attitudes, values and judgments that enables interprofessional collaboration by guiding successful assessment of each occupation. The domains are role clarification, Patient/Client/Family/Community-centered, team functioning, collaborative leadership, interprofessional communication, and dealing with interprofessional conflict. The pictorial model and explanation for each domain can be found at www.cihc.ca.

There are numerous positive outcomes to interprofessional collaboration during the medical education curricula. One such study conducted in England paired medical students with nurse tutors. Their "main objectives were to facilitate students' earlier integration into their future community of practice and foster a deeper understanding of the diverse roles within the multidisciplinary team" (Mathastein & Klingenberg, 2010). The medical students kept a reflective diary throughout the course. The themes identified a positive change in attitude toward their nurse colleagues (Mathastein & Klingenberg, 2010).

The Centre for the Advancement of Interprofessional Education (CAIPE) was founded in 1987 and is dedicated to promoting and developing interprofessional education. It responds to the complex needs when lapses in communication and trust contribute to undetected abuse of children or any clinical errors. It embraces all fields of health and social care including patient safety and public health. CAIPE has widened their range of professions to include lawyers, police officers, probation officers and teachers. They feel it is hard to conceive of any profession not exercising its public accountability without collaboration and opportunities to learn with, from and about each other. (http://www.caipe.org.uk/about-us)

Interprofessional Education in the US

In 2003, IOM's report, *Health Professions Education: A Bridge to Quality*, stated: "all health professionals should be educated to deliver patient-centered care as members of an inter-disciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics." (p. 45).

In June 2010 the Josiah Macy Jr. Foundation and the Carnegie Foundation for the Advancement of Teaching held a workshop in California to enhance new models for interprofessional education in US academic health centers. Attendees' were deans and other leaders from 7 academic medical and nursing schools across the nation. They believe if nursing, medical students and other health professional students learn together in clinical settings, then as clinicians they will improve patient outcomes by working more collaboratively, communicating better and fostering a health care delivery system that assures quality and patient safety. They shared accomplishments thus far and ideas to further their efforts. The members of the workshop also

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identified barriers, discussed overcoming those barriers and identified current exemplars in interprofessional education. They also identified the need for faculty development in interprofessional collaboration as well as the need for better evaluation and measurement tools for collaboration. (Josiah Macy Jr. Foundation Annual Report, 2010, p. 15)

Another group, the Interprofessional Education Collaborative (IPEC), is arranging a consensus statement of interprofessional competencies required for high-performing teams which will "eventually delineate learning objectives, educational strategies, and assessment tools that can be advanced across the professions" (Tilden 2011). This group published *Team Based Competencies: Building a Shared Foundation for Education and Clinical Practice* which is available at http://macyfoundation.org/publications/publication.

In 2011 the Health Resources and Services Administration (HRSA) partnered with the Josiah Macy Jr. Foundation and other groups to develop a set of core competencies for interprofessional collaborative practice. As these competencies are rolled out, there continues to be important discussion among the groups about how they will promote interprofessional education and practice. The idea started to form around a national center that could coordinate interprofessional activities and spur action around the country.

The American Interprofessional Health Collaborative is a North American organization that crosses borders to "transform learning, policies, practices, and scholarship" to an improved system of health and wellness for individual patients, communities, and populations. Their conferences focus on an exploration of common issues around interprofessional education (IPE) and practice (IPP).

They support Interprofessional Education programs throughout the US and Canada. The Collaborative believes educating those assigned with the health of individuals, communities, and populations to value and respect each other's unique expertise and skills and to work together is fundamental to care that is effective, safe, high quality, and efficient in terms of cost, resources, and time. They also commit some of their resources to ongoing research. Interprofessional education also includes post licensure interventions such as Continuing Medical Education (CME). http://www.aihc-us.org/ (11/ 13/12)

Interprofessional education happens on many levels; some occur post licensure at the continuing medical education (CME) level. Overstreet, et al (2006) searched the literature to analyze articles regarding CMEs presented to interdisciplinary teams and the lasting effect. The research question was; "Does participation in CME activities focused on developing Interdisciplinary teams improve physician performance or patient health outcomes?" Published articles regarding certified educational interventions addressed Interdisciplinary Teams that taught the core competencies of cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable. These CME activities lectured to several members of the health care team together such as nurses, physicians, dieticians and community care givers. In most cases the outcome improvement was noted in office practice patterns, knowledge, skills, attitudes, cooperation, and medication compliance." (Overstreet, et al 2006).

Interprofessional Simulation in Education Programs

Simulation in health care has been around since the 1960's with "Resusci ® Anne" and even a full sized mannequin named Harvey. Harvey was a simulator used to train professionals in cardiology (Jeffries, 2007). "Simulations are described along a continuum – from low-fidelity to high fidelity – regarding the degree to which they approach reality" (Jeffries, 2007, p. 3). Low fidelity may not actually use mannequins but rather case studies to help students immerse in a clinical situation. Along the continuum are partial task trainers such as low technology mannequins or IV cannulation arms to help students with clinical skills. "Full scale, high fidelity patient simulators are extremely realistic and sophisticated and provide a high level of interactivity and realism for the learner" (Jeffries, 2007, p.3).

With the advent of these high fidelity simulation mannequins full simulation "labs" that resemble a patient's room have been built around the mannequin to provide an environment of enhanced learning outcomes in a field that requires a high level of critical thinking and psychomotor skills (Jeffries, 2007, p.60).

Subsequently, there have been a lot of research articles, books and theories about the role of simulation in nursing education, as well as medical education. Learning in a simulation lab eliminates the risk to actual patients while offering a virtual reality for the students; all of the complexities are present except "actually" losing a patient to a nursing or medical error.

The next step in simulation is the integration of multiple disciplines in the same arena. This accomplishes several missions; individuals and groups learn appropriate responsibilities for each role, they learn how to work together under the stressful situation of caring for a patient. Furthermore, they learn to communicate with one another under those stressful conditions and consequently they develop mutual respect for the contribution each member of the health care team makes to the team (Jeffries 2007). While this may seem simplistic, there are many examples and frameworks that demonstrate early interdisciplinary learning opportunities have positive outcomes. One simulation study with medical students and nursing students created a mock code situation with a mannequin who has a cardiac arrest. The code was 'unsuccessful' and the medical and nursing students had to pronounce the death and inform the wife, who was a standardized patient (a live volunteer). "The students' attitudes toward doctor-nurse collaboration were surveyed pre and post intervention. The students agreed strongly that doctors should be educated to establish collaborative relationships with nurses… and that it should be included in their educational programs" (Worzala, Glaser & McGinley, 2006).

Simulation labs have now been built at many hospitals and medical centers across the country. The literature does not represent how many facilities are actually integrating multiple professions into simulation scenarios. Fairfield Medical Center (FMC) in Lancaster, Ohio is a 222 bed community hospital one hour south east of Columbus that serves more than 250,000 residents in Fairfield County and the surrounding Appalachia area. This hospital is small to medium size but has invested in 2 simulation labs and a skills lab. The Center has also partnered with Ohio University Heritage College of Osteopathic Medicine and Mount Carmel College of Nursing to house a branch of each of their schools in the hospital. In 2012, Fairfield Medical Center's Clinical Education Coordinator that runs the Simulation Lab began conducting multidisciplinary simulations that may include Physicians, Medical Residents, Registered Nurses, Respiratory Therapists and Unlicensed Assistive Personnel depending on the scenario, goals and intended outcomes. Kim Anderson, MSN, RN, NE-BC states "Multidisciplinary simulations improve teamwork and communication between caregivers therefore elevating the standard of care for our patients." Participant feedback from the multidisciplinary simulations has been very positive. FMC continues to be cutting edge in regards to simulation and in 2013 plans to incorporate baccalaureate nursing students into the multidisciplinary simulations as well.

Interprofessional Collaboration in the Clinical Setting

So how do we perform in the clinical setting? First we should define collaboration to prevent misinterpretation (Lindeke & Sieckert 2005). It is an interchange of ideas and a viewpoint that believes all perceptions of the collaborators are equal and valid. Mutual respect and trust are paramount, perhaps more so when the collaborators do not reach an agreement during the communication (Lindeke & Sieckert 2005).

When communicating in the complex, fast –paced healthcare setting, one must take into consideration many elements. Sometimes the interactions are in a relaxed environment of a calm nurse's station with physicians, nurses and other care team members who have created a team with mutual respect. There are other environments that are not so desirable; the team may be new to one another or they may be in a crisis such as a code blue. High stress situations can lead to miscommunication.

Other types of communication in this culture now include email, text, voice messages and paging. These electronic forms of communication have become so cryptic that the intent of the sender can often be misinterpreted. When an electronic message is read, the sender's thoughts and ideas may not have been considered fully. In other words, ideas may not get shared back and forth effectively. Therefore a collaborative exchange was not successful (Lindeke & Sieckert 2005). It is crucial for health care teams to co-create an understanding amongst themselves of how they want to communicate within their environment (Hovey & Craig 2011).

As in a simulation environment, the clinical environment has positive outcomes when collegial and collaborative relationships are maintained. Kramer and Schmalenberg (2003) interviewed 279 staff nurses from 14 magnet hospitals and found there was a positive correlation between the quality of nurse/physician relationships and reported patient care quality. They defined "positive" relationships as "collegial" and "collaborative" and even "student-teacher" but each of these had different definitions and a different category for scoring. These healthy relationships took some extra effort, including a physician socialization program that was initiated by the medical chief of staff and nurse managers but the effort paid off in improved care outcomes.

Researchers in Canada designed a 4 step intervention to create improved communication between providers with the ultimate goal of providing higher quality care. While the clinicians initially embraced the idea and administration supported them, their findings were disappointing. The obstacles cited were a "lack of time" and an adherence to traditional communication style due to the history of hierarchical method of caring for patients. The physician intervention leader in the study was interviewed after the study and eloquently implied that it will take much more than a 30 minute explanation of why interprofessional collaboration is important when physicians have been socialized to have other disciplines carry out their orders without question (Rice, et al 2010).

Other researchers also had clinicians embrace the opportunity to practice interprofessional collaboration. Rider and Brashers (2006) developed a 3 hour interactive session that they presented at a professional forum. At the evaluation of the session, the participants recognized that their lack of education and skills were a barrier to effective collaboration and communication for varied health care providers.

There are many examples of successful models of interprofessional collaboration. The Institute of Health Care Improvement (IHI) has a national initiative called the State Action on Avoidable Rehospitalizations (STAAR). This initiative uses the Transitional Care Model to transition patients from place to place whether it is from an acute care facility to home or to rehab or to their primary care physician or back to the acute care facility. It also supports the patient or care giver in self-management techniques. Hospitals around the country have implemented the STAAR project to reduce preventable readmissions, thereby saving tens of thousands of dollars and unwanted hospitalizations for patients. DMC Sinai-Grace in Detroit, Michigan was able to reduce its heart failure readmissions by 30%. (Readmission rates…2010). The transitional Care Model is an evidence based approach where the team, which is often led by a nurse, fills the gap in our health care delivery, caring for chronically ill, high risk, older adults (Naylor 2011).

The Patient Centered Medical Home (PCMH) is another team based model that includes nurses as integral members of the primary care team. This is a health care team that supports the patient as a member of the team and provides comprehensive primary care. This concept was introduced in 1967 by the American Academy of Pediatrics (AAP) as a means of improving the care of children with special health care needs (Houde, et al 2012). Since then the AAP, the American Academy of Family Physicians, the American College of Physicians and American Osteopathic Association have developed seven principles to define the PCMH. The first principle is that the Patient Centered Medical Home must be physician directed (Houde, et al 2012). The federal government has addressed the growing need for services of the chronically ill by employing the patient – centered medical home with the passage of the Patient Protection and Affordable Care Act (ACA) of 2010.

Since the PCMH model received federal support, it also includes funding to strengthen the primary care workforce which allows the leader of the team to be an Advanced Practice Registered Nurse (Houde, et al 2012) depending on the scope of practice of each state (Henderson, et al 2012). In Ohio, APRNs lead the PCMH team as acknowledged in House Bill 198 under the 128th General Assembly. Furthermore, in the PCMH, the services of a care coordinator, which is often a nurse, are acknowledged and reimbursed under federal law (Henderson, et al 2012).

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Our APRN colleagues have been collaborating successfully for years, even decades, without a blip on the radar. Look around you to see the wonderful exemplars of collegial relationships between professionals. Advance Practice Registered Nurse (APRN) is an umbrella term for the four professional groups you know as Nurse Midwives, Clinical Nurse Specialist, Nurse Practitioners and Nurse Anesthetists. This group of nurses has worked somewhat dependently and yet interdependently with their physician colleagues to take care of patients in many settings. Many states require some APRN-physician relationship in order to practice while there is also a level of autonomy in caring for patients. It has required excellent communication and collaboration skills to fill the gap in our health care industry.

It is often difficult to identify, confront, and subsequently change, established communication habits, but the efforts pay off not only for patient outcomes but for overall staff satisfaction and the prevention of burnout. Poor job satisfaction and burnout in turn lead to greater mistakes. Numerous leadership texts have been written to deal with difficult people but there is no other industry than healthcare where the stakes are as high as the life of a patient. As a result, a number of hospitals are investing in Team Training.

Health Care Team Training

Team training is the tactic for building interprofessional relationships that result in safer environments for our patients. Communication is one of the central components of teamwork and the Rand report demonstrated the link between teamwork and patient outcomes (Salas et al, 2008). The report reviewed experiments that demonstrated the relationship between teamwork behaviors such as mutual respect, role clarity, shared goals and debriefing and clinical patient outcomes such as mortality, cardiac arrests, nosocomial infections and adverse events. Since the Department of Defense has released the TeamSTEPPS program and the linkages between team training and patient safety are becoming more widely available, there are more healthcare organizations bringing TeamSTEPPS to the areas they identify at high risk for communication breakdown. (Salas, et al 2008) http://teamstepps.ahrq.gov/

"Teams are defined as interrelated individuals that are tasked to accomplish a common goal. More specifically, a team is defined as a set of two or more individuals who must interact and adapt to achieve specified, shared, and valued objectives" (Salas et al 2008). Teams are interdependent and they rely on multiple sources of information to make decisions. In order to be effective, a team should also have a shared objective or objectives that they value. This is not possible without a concerted method of communication.

"Teamwork is an interrelated set of team member thoughts, behaviors, and feelings needed for the team to function as a unit." (Salas, et al 2008). While team training is actually utilizing set of tools and methods with a teaching plan to offer team members the chance to put into practice these new skills and receive feedback. Team training can take on many different forms but usually includes the assessment of knowledge, skills and attitudes. Team building, on the other hand, is a team growth activity that is popular and is frequently held in an outdoor setting. It is actually a group process dialog which focuses on results. The goal is for improved team attitudes through the group process of scrutinizing, identifying their behavior and changing their behavior as well as interpersonal relationships. (Salas, et al 2008).

Salas et al (2008) reviewed three separate meta analyses on team training and team building interventions. They found that team building is effective for improving team outcomes such as resolving interpersonal conflicts within a team and other process improvements.

When team training is taken to the simulation lab there are even more opportunities to apply the tasks and team related skills but in a safer arena where an opportunity for debriefing and processing is provided. This post-simulation advice is meant to be judgment-free to allow for all members of the team to learn and grow even more from the experience (Salas et al 2008).

Patient Centered Care

In the health care environment it has been established that high functioning teams with healthy communication result in better outcomes for our patients. The "quality-of-relationships" between and among health care providers, patients and families are the key principle of interprofessional collaboration, yet they are frequently disregarded (Hovey and Craig 2011). Patient centered care has many meanings to many institutions, teams and even patients but the patient and their family must be included as part of the interprofessional team to add another layer of safety (Longtin, et al, 2010).

For decades patient advocacy organizations have encouraged the inclusion of patients and their families into the care team, primarily in the decision making process.

More recently there has been success with patient participation in all aspects of health care redesign (Longtin, et al, 2010). However, healthcare workers' acceptance of the patient as part of the team is influenced by many factors including lack of time, personal beliefs, their desire to maintain control and training in patient-caregiver relationships.

Clinical Nurse Leader

The Clinical Nurse Leader (CNL) role rose out of the critical need for change in today's health care system due to the fragmentation in care that has become the nature of our health delivery system today. This role was originally proposed by the American Association of Colleges of Nursing (AACN) after numerous meetings with stakeholders in 2003 to collaboratively design a clinical and leadership role to meet the demands of the changing health care system. "New ways of educating health professionals, including inter-professional education and practice, and new practice models, must be developed that better use available resources and address the health care needs of a rapidly, growing, diverse population." (http://www.aacn.nche.edu/publications/white-papers/cnl, p.2)

The CNL is a Masters prepared nursing role with curriculum that covers research, informatics, advanced assessment and pathophysiology, to name a few, but it is not an Advanced Practice nurse such as a Clinical Nurse Specialist or Nurse Practitioner.

- "The CNL is a leader in the health care delivery system across all settings in which health care is delivered, not just the acute care setting. The implementation of the CNL role, however, will vary across settings. The CNL role is not one of administration or management. The CNL functions within a microsystem and assumes accountability for healthcare outcomes for a specific group of clients within a unit or setting through the assimilation and application of research-based information to design, implement, and evaluate client plans of care. The CNL is a provider and a manager of care at the point of care to individuals and cohorts. The CNL designs, implements, and evaluates client care by coordinating, delegating and supervising the care provided by the health care team, including licensed nurses, technicians, and other health professionals" http://www.aacn.nche.edu/publications/white-papers/cnl

Ten Assumptions for Preparing Clinical Nurse Leaders

- **Assumption 1: Practice is at the microsystems level.**
  In addition to being direct care providers managing complex cases, the CNL is accountable for the care outcomes of clinical populations or a specified group of clients in a healthcare system. As clinical decision-maker and care manager, the CNL coordinates the direct care activities of other nursing staff and health professionals.
- **Assumption 2: Client care outcomes are the measure of quality practice.**
  CNL performance is measured by the success of clinical and cost outcomes such as improvement in Pressure ulcers, catheter associated UTIs or hospital readmission for congestive heart failure.
- **Assumption 3: Practice guidelines are based on evidence.**
  The CNL will use evidence-based practice for their daily clinical practice as well as the education of their patients and their colleagues.
- **Assumption 4: Client-centered practice is intra- and interdisciplinary.**
  The CNL has significant knowledge about the patients so they are accountable for coordinating the patients care and communicating with the interdisciplinary team members, including other nurses, in order to agree on a care plan. This is necessary for care to be patient-centered.
- **Assumption 5: Information will maximize self-care and client decision-making.**
  Clients' participation in their own health care and promotion as well as disease prevention has advanced to a new level with advances in technology and genetics. However, the principle of health literacy must be the basis for patient education.
- **Assumption 6: Nursing assessment is the basis for theory and knowledge development.**
  CNLs use their assessment skills to connect to patients and communicate with them. They will also "upload" assessment data for analysis, decision support and evidence based practice.
- **Assumption 7: Good fiscal stewardship is a condition of quality care.**
  The CNL will be accountable for cost-effective and efficient care.
- **Assumption 8: Social justice is an essential nursing value.**
  The CNL will be able to address health care disparities at the point of care, within the microsystem while advocating for the most vulnerable.
- **Assumption 9: Communication technology will facilitate the continuity and comprehensiveness of care.**
  Visits with a health care provider will no longer be limited to traditional hospital or clinic. Advances in communication technology are creating other options and the CNL may facilitate non-traditional interactions with care providers.
- **Assumption 10: The CNL must assume guardianship for the nursing profession.**
  The CNL is a nursing leader that is expected to take on roles in policy and regulatory agencies as well as faculty and other professional positions that will promote nursing's leadership position in the community. http://www.aacn.nche.edu/publications/white-papers/cnl

The change agent is a critical element to the complex and changing health care environment in which we live. CNLs are leaders of change at the point of care; the CNL anticipates risk to the patient, and sometimes to staff, and has the power and authority to make changes to reduce future risk by communicating and collaborating. Competencies for the CNL include the development of excellent communication skills so they can be full partners with all health care providers at the point of care. Across the country CNLs are improving quality and promoting a team-based approach to care by understanding the bigger picture. They are coming up with innovative ways to reduce hospital acquired conditions such as pressure ulcers, catheter associated urinary tract infections, falls, and central line blood stream infections. Most of the innovations have to do with improving communication and collaboration with their colleagues. For these reasons, and because they are present for families and all health care providers to supply information about the patient, the CNLs are the ultimate role models of interprofessional communication.

Bandali, et al (2011) supports change agents in the academic environment as well; those individuals that can foster that shift in culture that must come when change must happen to save the lives of patients.

Interprofessional Organizations

Interprofessional organizations can vary in size, mission and scope. Most of them are focused on their own institution as Reeves, et al (2011) found in their extensive search of the literature. However, some interprofessional organizations have reached beyond the organization to the local or even international community with the goal to improve health care. There is expected to be growth in the number of interprofessional organizations in the United States over the next few years since the RWJ/IOM report and more data highlight not only improved quality but lower cost of the collaborative efforts.

One International group is called "The Network: Towards Unity for Health." It is a non-governmental organization in an official relationship with the World Health Organization comprised of academic health professional institutions, academic health professionals and organizations consisting of interprofessional health providers and as well as stakeholders in health systems development from all over the world. The Network promotes equity in health through community-oriented education, research and service. This organization also addresses health policies and participates in actions for a change of policies. (www.the-networktufh.org/ accessed 12-1-12)

In Ohio, The Council for Ohio Health Care Advocacy is a group of professionals who have united to create a new political advocacy association. This organization is formed of numerous heath care professionals with a patient-centered focus; to promote legislative changes that will enable professionals to practice to the full scope of their education, training and ability. This is an example of an organization that works collaboratively for the best outcome of patients. They have pooled their skills, education and experiences and have come together to advocate for legislative change for the benefit of Ohio. (www.cohcaonline.org/).

In 2001, health students in the state of Georgia created a student-led nonprofit, interprofessional organization that seeks to "make being active in the health community a professional habit." The organization is called Health Students Taking Action Together (HealthSTAT). This group offers workshops in political advocacy, media training, networking, and fundraising. Its leadership is made up of medical, nursing, public health and other students from the state that meet annually at its symposium to learn about health issues facing the state. They work together to create prospective solutions (IOM, 2011, Future of Nursing, p. 219).

"The Alliance for Continuing Education in the Health Professions is a community of professionals dedicated to accelerating excellence in health care performance through education, advocacy, and collaboration" (www.acehp.org, 12-1-12). This organization was originally founded in 1975 to support medical education for physicians but expanded its scope in 2010 to include all health care-related continuing education and continuing professional development. The Alliance takes action to close the

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gaps in health care performance and improve quality in patient care and in clinical outcomes through its inclusive, collaborative and inter-professional efforts. By growing their membership, introducing a broader focus and placing a greater emphasis on educational and health care outcomes, they intend to promote their vision and through their proactive leadership will shape the future of health care. They will also form strategic relationships with other healthcare organizations. The Alliance will continue to advance the field through research and scholarly actions.

Interprofessional collaboration exists in the research realm as well. "The Robert Wood Johnson Foundation's Interdisciplinary Nursing Quality Research Initiative (INQRI) is a prime example of interprofessional collaboration among scholars from nursing and many other disciplines such as social scientists. This important initiative is uncovering the linkages between nursing and the quality of patient care. Studies supported by INQRI are exploring the importance of collaborations between health care professionals, making the case to provide nurses with an equal role in providing care, deciding on courses of care and making decisions about how health care systems operate" (Naylor 2011). This important research in this country will assist us as the US health care system advances in interprofessional collaboration efforts. This information has taught us how collaboration and shared leadership has improved patient outcomes and quality of care.

An Action Plan for the Future-Nursing's Unique Role

Nursing has a unique role individually and collectively. Individually we often spend the most time with our patients getting to know who they are as well as their primary support persons; we know their likes and dislikes. They are at their most vulnerable state when they are under our care and often reveal things to us that they may not reveal to other health care providers. It is only through good communication and the development of the nurse-relationship that nurses can identify the needs of their patients. Therefore the nurse has a possible greater advantage than other team members in understanding individual patient needs and requirements (Burzotta & Noble 2011).

What can you do to improve your collaboration skills?

Ensure you possess the characteristics that improve your ability to collaborate. Those are:

- Higher emotional IQ or emotional intelligence, which is an awareness of one's own emotions and those of others. This is a maturation process that is also linked with higher self esteem. Know that there is always room for improvement, that no one is perfect especially in communication and collaboration. (Lindeke & Sieckert 2005)
- Understand the perspective of others. Nurses and physicians are socialized differently during their education process (Lindeke & Sieckert 2005). As nurses, we are actually trained to reach consensus, which may make us seem uncertain. On the other hand, physician education process socializes them to rule out alternatives. In this country we are not educated and socialized together as they are in some other countries so our collaborative skills are a challenge from the beginning. Other care providers and families also have a perspective that must be considered.
- Avoid compassion fatigue (Lindeke & Sieckert 2005). All professionals are at risk for compassion fatigue and burnout. When we are emotionally exhausted we are less able to communicate effectively. Compassion fatigue can be reduced and sometimes prevented with lifestyle changes and self-care measures.
- Negotiate respectfully. "One way to balance power and authority might be to drop titles and use given names to neutralize the deleterious effects of an unequal playing field" (Lindeke & Sieckert 2005). This is a standard practice in the Six Sigma work group setting and it is an effective means of opening up lines of communication.
- Use electronic communication thoughtfully. "Project openness with a friendly, courteous tone; evaluate the content of received messages before reacting because messages are sometimes composed in haste and might not reflect the sender's intent; clarify your understanding of messages, being sure to critique the message itself and not the sender; send messages with only pertinent details, paying attention to what the receiver will find useful and avoiding jargon; summarize issues without being overly repetitious, be as brief as possible." (Lindeke & Sieckert 2005)
- If you are in a management position, you can create a power base with your nursing staff to develop collegial relationships with physicians in 3 ways:
  - At meetings nurture "Equal but different." Explain how a nurse's knowledge is different from our physician colleagues' but it is as important as theirs to build a care plan for each patient.
  - Create a culture that values, expects and rewards positive nurse/physician relationships.
  - Encourage educational programs of all types. Keeping nurses competent is just one more way of advocating for patient care and in turn improves relationships with physicians. (Kramer & Schmalenberg 2003)

Summary

Nurses are the largest group of health professionals with the farthest reaching circle of influence; our communities, our patients, their loved ones, our lawmakers, public health officials and our chief officers. This puts us in a unique position. We are undoubtedly in the best position to influence every level of health care change; you can call it reform if you want to, but that sounds too lofty and out of reach. We make small changes each day that result in big outcomes for our patients; each of us is a leader at the point of care by advocating for our patients. With our collaborative efforts we can do more with a louder voice- but not one of chaos- one of unity. So find your voice and find the group to join so our collective voices are heard for the good of our patients and our community. We clearly have some work to do to get our voices heard in the policy-making arena because that is an area of huge impact for our patients. Advocacy happens at all levels, not just the bedside.

"If we do not accomplish this goal, we will continue to perpetuate a fragmented health care system of professionals who do not respect each other's roles and who cannot provide the quality of care that patients require. We will continue to be frustrated with role inconsistencies. We will miss the most important opportunity in our history to take our place as true, equal members of a health care team that functions in a healthy system." (Jeri Milstead, 2012 COHCA newsletter)

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Continuing Education Credits Have Been Applied For

Interprofessional Collaboration: The IOM Report and More

Post Test and Evaluation

Name:_____

Date:_____ **Final Score:**_____

DIRECTIONS: Please complete the post-test and evaluation form. There is only one answer per questions. The evaluation questions must be completed and returned with the post-test to receive a certificate.

1. The Joint Commission reports estimate that _____ is the leading cause for medical errors and sentinel events in North America
   a. Nurses texting on their cell phones
   b. Physician bullying
   c. Poor communication
   d. Lack of experience

2. Which is not a common term that has been used in the past to describe interprofessional collaboration
   a. Interdisciplinary communication?
   b. Teamwork
   c. Interdisciplinary teams
   d. Coaching

3. The Clinical Nurse Leader:
   a. is a nurse practitioner with administrative duties
   b. is a masters prepared nurse with leadership responsibilities
   c. is another term for Clinical Nurse Specialist
   d. works only in acute care settings

4. The IOM report and the AACN recommends leadership competencies that include:
   a. learning to work in team, and to collaborate effectively within and across disciplines
   b. creating care plans for communities.
   c. going back to school for a masters degree
   d. becoming a business developer

5. The traditional model of educational system supports transformational change.
   a. True
   b. False

6. The American Interprofessional Health Collaborative:
   a. is a United States organization focused on undergraduate education
   b. educates and researches issues around interprofessional education
   c. researches simulation scenarios for medical schools
   d. devotes all of its resources to nursing schools only

7. High Fidelity Simulation is the only effective simulation experience used.
   a. True
   b. False

8. Interprofessional Simulations are used widely all across the nation.
   a. True
   b. False

9. Which report stated "All health professionals should be educated to deliver patient centered care as members of an interdisciplinary team"?
   a. Nursing Leadership from Bedside to Boardroom: Opinion Leaders' Perceptions
   b. Health Professions Education: A Bridge to Quality
   c. Team Based Competencies: Building a Shared Foundation for Education and Clinical Practice
   d. The Future of Nursing: Leading Change, Advancing Health

10. One of the Assumptions for preparing the Clinical Nurse Leaders is "Client-centered practice is intra- and interdisciplinary."
    a. True
    b. False

11. The Canadian Interprofessional Health Collaborative developed a competency framework that includes what domains:
    a. Knowledge, skills and attitudes
    b. Curriculum development and team learning
    c. Role clarification, team functioning and collaborative leadership
    d. TeamStepps

12. When interprofessional collaboration is incorporated into the curriculum of medical education, what is one positive outcome?
    a. A positive attitude toward their professors
    b. A positive attitude toward their patients
    c. A positive attitude toward their nurse colleagues
    d. A positive attitude toward their physician colleagues

13. A sentinel event always involves the death of a patient.
    a. True
    b. False

14. What did the Gallup Poll Opinion Leaders Perception Survey say was one of the barriers to nursing's' lack of influence in health care reform?
    a. Nurses do not have a solitary voice on national issues
    b. Nurses don't reduce medical errors
    c. Nurses don't collaborate with physicians
    d. They were unsure

15. Numerous studies have shown that improved interprofessional collaboration results in:
    a. More time for staff to spend with their patients
    b. Fewer sentinel events
    c. Improved care outcomes for patients
    d. improved friendships between physicians and staff

16. The Kramer and Schmalenberg study defined all but one as "positive" forms of nurse/physician relationships. Which one was not in their definition?
    a. Collegial
    b. Hierarchical
    c. Collaborative
    d. Student-teacher

17. The Clinical Nurse Leaders across the country have reduced hospital acquired conditions such as_____ by collaboration.
    a. Pneumonia
    b. Pressure ulcers, catheter associated urinary tract infections and falls
    c. Congestive heart failure
    d. Diabetes

18. Which one is an effective means of improving your collaboration skills?
    a. Don't be concerned if you or a colleague is suffering from burnout
    b. Don't worry if you are sending lengthy emails
    c. Always use titles
    d. Understand the perspective of others

19. If you are in management or leadership you can help your nursing staff develop collegial relationships with physicians by encouraging educational programs to keep your nurses competent.
    a. True
    b. False

20. Benefits of team training include all of the following except:
    a. More team conflicts
    b. Improved patient outcomes
    c. Improved team communication
    d. Improved teamwork

Evaluation

1. Were you able to achieve the following objective?

	Yes	No
a. Describe strategies to enhance the profession of nursing based on recommendations of the IOM/RWJF report.	☐	☐
2. Was this independent study an effective method of learning?	☐	☐

If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form? _____.

4. What other topics would you like to see addressed in an independent study?

Registration Form

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