

**Site Locations:**

**Seamless Care: Interprofessional Education for Innovative  
Team-based Transition Care**

5. **The Acute Stroke Program** is located in the Halifax Infirmary site of the Queen Elizabeth II Health Sciences Centre. About 350 people annually are admitted to the in-patient service because of stroke or transient ischemic attack. These individuals receive coordinated, evidence-based, patient and family-centered care from a multidisciplinary team comprising expertise from food and nutrition services, medicine, nursing, occupational therapy, physiotherapy, speech-language pathology and social work. Over 40% of patients return home (or to the home of a relative or friend); about 25% are transferred to another unit for more prolonged rehabilitation; about 20% are transferred to nursing homes; and about 15% die in hospital, most often after a few days of palliative care. About 500 people annually are seen in the Neurovascular Clinic which focuses on optimizing prevention therapies in individuals at high risk of stroke. The research interests of the group focus on the evaluation of new treatments, outcome after stroke, clinical epidemiology, knowledge translation and health services delivery.

**Acute Stroke Program**

**What experiences will I have as a member of the interprofessional student team?**

- Work collaboratively with my student team to develop a transition plan of care for assigned patient/family
- Interact with professionals from other disciplines
- Attend meetings of the multidisciplinary team
- Participate in the clinical assessment of the functional status and transition care needs of a number of patients
- Participate in discussion of discharge/transition care options with patients and their caregivers and families, and the multidisciplinary team
- Observe how the transition process works, is implemented and evaluated
- Participate in "Follow-up Clinic" sessions conducted by a nurse practitioner
- Possibly participate in a home visit

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4. **The Capital Health Integrated Palliative Care Service**, in collaboration with its health care service delivery partners, serves patients who suffer from incurable illnesses which are expected to progress to death. A consensus-based model, developed by the Canadian Hospice Palliative Care Association in consultation with experts across the country, guides practice based on patient and family needs, creates a shared vision, and sets the stage for a consistent and standardized approach to patient and family care. The program sees approximately 900 consults per year and at this time, eighty percent of the patients have progressive malignancy. Patients may be seen early or late in the illness. Care is provided by an interdisciplinary team across care settings, including home, in-patient consultation, in-patient unit, outpatient clinics and long term care. Care is focused on patient/family centered assessments with a view to identifying and addressing issues in the physical, psychological, social and spiritual domains. Efforts are made to facilitate coordinated care among primary and consultant caregivers and across care settings.

**What experiences will I have as a member of the interprofessional student team?**

- Work collaboratively with my student team to develop a transition plan of care for assigned patient/family
- Be involved in assessment of the patients’ current status and needs
- Interact with caregivers and other family members
- Participate in rounds
- Participate in weekly care team meetings usually with the continuing care coordinator
- Interact with professionals from other disciplines
- Participate in home visits
- Have access to an on-line WebCT learning module on patient-centered palliative care

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1. **The Centre for Health Care of the Elderly (CHCE)** is a multi-service, interdisciplinary Capital Health program based primarily in the Veteran's Memorial Building of the Queen Elizabeth II Health Sciences Centre. The cornerstone of care is interdisciplinary comprehensive geriatric assessment, treatment and education of frail older persons and their families. There is a prominent role of research, centered in the Geriatric Medicine Research Unit. CHCE researchers are recognized nationally and internationally as leaders in research on frailty and cognitive impairment. CHCE services include Geriatric Day Hospital (includes a Fall Clinic), Geriatric Assessment Unit, Geriatric Restorative Care, Progressive Care Unit, Geriatric Ambulatory Care/Memory Disability Clinic and satellite clinics throughout the province.

**What experiences will I have as a member of the interprofessional student team?**

- Work collaboratively with my student team to develop a transition plan of care for assigned patient/family
- Attend team rounds in the Geriatric Assessment and Geriatric Restorative Care Units (with professionals from Medicine, Nursing, Social Work, Occupational Therapy, Physiotherapy, Home Care Nova Scotia)
- Attend team goal-setting sessions in the Geriatric Day Hospital
- Be involved in the assessment of the patient's current status and needs
- Assist the patient in making the transition from acute care to home
- Participate in home visits
- Interact with caregivers and other family members
- Identify needs for this population
- Interact with professionals from other disciplines
- Learn how the transition process works, is implemented and evaluated

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2. **The Endocrinology Clinic, Diabetes Case Management Team and the Diabetes Management Centre** are staffed by endocrinologists, nurses, dieticians, social workers, psychologists, podiatrists, and physiotherapists. While participating in this project, students will have an opportunity to work with patients in various settings of the diabetes healthcare continuum. While working with teams in the Endocrinology Clinic and Diabetes Management Centre, students will be involved in assessment, care planning and education for ambulatory patients and will be included in rounds and evaluation discussions. Students will also work with the Diabetes Case Management Team (consisting of three advanced practice nurses) in the tertiary setting (emergency department and multiple inpatient units). Diabetes Case Managers specialize in comprehensive individual and system assessment, including knowledge translation and dissemination of best practice research. While working with Diabetes Case Managers, students will be involved in collaborative discussions with tertiary healthcare teams and community primary care providers to identify optimal management strategies, lab work, consults and community connections for complex diabetes patients. Students will also work with Diabetes Case Managers in completing some follow-up telephone assessments. At the end of the project, students will have an increased understanding of the diabetes team and roles, of the many opportunities and challenges diabetes patients and teams face in striving to achieve diabetes control. Finally, they will have an opportunity to enhance diabetes assessment and management skills as per evidence-based recommendations from the CDA Nationally approved Guidelines.

**What experiences will I have as a member of the inter-professional student team?**

- Work collaboratively with my student team to develop a transition plan of care for assigned patient/family
- Learn about “best management practices” for diabetes
- Follow patients across the continuum of health care – in the emergency, in-patient, out-patient and home/community contexts
- Assess patients’ status with respect to “stages of change”
- Assist patients in identifying needs
- Assist patients in developing a self-management plan
- Consider the many critical social factors involved in diabetes management.
- Gain an enhanced appreciation for how diabetes affects multiple systems and parameters of individuals lives

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7. **The Division of Gastroenterology** at Dalhousie University functions in a multidisciplinary role in close cooperation with colleagues in the Department of Surgery and the Department of Nursing. The Division provides secondary and tertiary care to patients with gastrointestinal diseases in both Nova Scotia and the Atlantic Provinces at large. The Division provides expertise in liver disease for the entire Atlantic Region and it is the coordinating centre for liver transplantation for patients from this area. Nine of the 11, clinical members are hospital based at either the Victoria General Hospital or the New Halifax Infirmary Sites. There are currently also two community-based members.

**What experiences will I have as a member of the interprofessional student team?**

- Work collaboratively with my student team to develop a transition plan of care for assigned patient/family
- Assist the patient in making the transition from acute care to home
- Be involved in team goal-setting session
- Be involved in the assessment of the patients' current status and needs
- Interact with family members and other caregivers
- Participate in home visits
- Interact with professionals from other disciplines and gain on increased appreciation for the challenges in navigating the health care system

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3. **The Heart Failure Clinic** The Heart Failure Clinic is a nurse practitioner managed, physician supervised clinic which is operated by the department of General Internal Medicine. The clinic is based at the Dickson Centre, VG site of the QEII HSC. The patient population served consists of adult individuals with heart failure who are referred to the clinic by primary care physicians, emergency room physicians, or attending staff who care for patients during hospital admissions. The target patient population is persons who have frequent admissions to emergency room or inpatient units because of exacerbations of heart failure. Patients served in the clinic are primarily elderly persons with heart failure and co-morbid diseases including diabetes, chronic kidney disease, hypertension, and COPD.

**The Heart Failure Clinic**

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3. **The Hypertension Clinic** The Hypertension Clinic is a primary and secondary cardiovascular risk reduction Capital Health Program based in the Dickson Building at the V.G. Site of the Queen Elizabeth II Health Sciences Centre. The focus of care is interdisciplinary, risk reduction of patients with hypertension with the goals of optimizing quality of life, primary and secondary prevention of cardiovascular events, and promoting self-management through education about the medical condition, medications and lifestyle changes. Patients are referred to the Hypertension Clinic by General Practitioners and Specialists from across the Maritimes. The interdisciplinary team consists of registered nurses, a specialty nurse practitioner and general internists who provide comprehensive assessment, treatment, and education of persons with hypertension and their families. There is a close affiliation with the Heart Failure Clinic. The team also educates other health care providers to ensure appropriate diagnosis, testing and evidence-based management.

**The Hypertension Clinic**

**What experiences will I have as a member of the interprofessional student team?**

- Work collaboratively with my student team to develop a transition plan of care for assigned patient /family
- Participate in the physical assessment of out-patients recently diagnosed with hypertension
- Assess patients' ability to cope with the medical condition
- Assist in patient education to help patients understand: the nature of the condition, why they are taking medication, what makes the condition worse
- Assist in patient education concerning lifestyle changes
- Assist patients in developing a plan for maintaining a medication regimen and healthy lifestyle
- Liaise with family physician and other health professionals
- Learn about research projects currently underway in the Hypertension Clinic

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6. **Physical Medicine and Rehabilitation** is located on the corner of Summer Street and University Avenue. The Rehab Centre, in partnership with clientele and their communities, provides quality service in the areas of physical rehabilitation. The center works with persons who have physical and associated disabilities to develop their potential through specialized rehabilitation programs and services.

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- Be involved in the assessment of the patients' current status and needs
- Interact with family members and other caregivers
- Participate in home visits
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