

**INTEGRATION OF PHYSICAL THERAPY, NURSING, AND SOCIAL WORK IN THE
EMERGENCY DEPARTMENT**
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Abstract

The integration of physical therapy, nursing, and social work within the emergency department (ED) is an innovative approach aimed at enhancing patient-centered care, improving healthcare outcomes, and optimizing resource utilization. Emergency departments increasingly serve patients with complex medical, social, and functional needs, necessitating a collaborative model that combines the expertise of these three disciplines. This paper explores the significance of integrating these fields in the ED, outlining their respective roles, responsibilities, and contributions to patient care. The interdisciplinary approach facilitates improved patient assessment, enhanced discharge planning, reduced hospital readmissions, and better coordination of care. By addressing both immediate and long-term patient needs, this model improves efficiency, lowers healthcare costs, and enhances patient satisfaction. The study also highlights the challenges of integration, including logistical barriers, role delineation, and the need for interdisciplinary training. Findings suggest that the integration of physical therapy, nursing, and social work in EDs fosters a holistic and proactive approach to healthcare, ultimately leading to improved patient outcomes and system-wide benefits.

1. Introduction

It is well known that patients who present to the emergency department bring with them complex social and medical needs. The systematic integration of the specialties of physical therapy, nursing, and social work is an increasingly critical need with the increasing emphasis on the reduction of costs and readmissions while improving overall hospital performance. Although the experiences of physical therapists, nurses, and social workers may focus on different patient activities or needs, the work of these areas is intimately intertwined. Patients with missing medications will be ambivalent about making return visits for a follow-up. Patients who are distrustful of the healthcare system because of prior bad experiences will avoid messages from their home care providers. "Hard to move" patients who are less active due to decreased functional capacity will need assistance from staff as well as a physical therapist for episodes of incontinence.

Triage, providing comfort to patients, assessing resources, disease state-specific knowledge, and confirming functional baselines are just a subset of the intertwined work of members of the interdisciplinary team. Efficient collaboration of the providers listed can improve patient flow, satisfaction, readmission rates, etc. The availability of a representative from each of these specialties in the emergency department during peak times provides a unique opportunity for blending the roles of physical therapy, nursing, and social work. The purpose of this paper is to provide a detailed account of the potential roles of these interdisciplinary departments. The practice of issuing or enhancing a training model that will manage all of a patient's needs in the emergency department would be more efficient, lowering costs and the patient's length of stay,

improving patient satisfaction, coordinating care after discharge, and decreasing future emergency room visits.

1.1. Background and Rationale

Emergency departments (EDs) have been redesigned over time in response to increased use by patients seeking treatment for acute trauma, illness, or sudden exacerbation of chronic conditions; however, the integration of physical therapy, nursing, and social work is a new and innovative approach to care coordination in the ED. In the past, care in EDs has been located in geographically disparate regions of the hospital, mirroring the historical development of the respective professionals and their professions. Nursing care, medical care, and surgical/acute care were all provided by various hospital-based practitioners in emergency settings; the implementation of such systems was intended to mirror the natural flow of care and decision-making within the hospital. Over time, these professions have developed and expanded their scope of care, in some cases progressing from vocational care provision to academia. (Specht & Vickery, 2021)

With the evolution of these previously 'vocational' professionals in hospitals, evidence has quickly established that there is a growing portion of the general population presenting to hospital EDs with increasingly chronic, complex, and often overlapping co-morbid conditions, including physical, mental, and social challenges that require attention. Given the above, substantial and evidence-based arguments exist for the physical therapy, nursing, and social work professions to combine to provide a new way of delivering patient-centered care in the ED. This will enable the integrated roles of physical therapy, nursing, and social work to address the physical, emotional, and social challenges experienced by the current consumers of acute care services. There is no reason why the ED should not have its own identity in the evolution of service delivery in the hospital. Evidence exists to endorse the move towards inter- and intra-disciplinary teamwork to provide better, more efficient care that reflects the national policy on care coordination. Patients, for their part, require physical therapy, nursing, and social work assessments for any number of physical, mental, and emotional problems that accompany presentation. These healthcare disciplines should work together to provide the best care possible. The emergency center has been appropriately identified as a focal point of integration of services.

1.2. Significance of Integration

National organizations have encouraged the integration of emergency department (ED)-based physical therapists, nurses, and social workers to improve the delivery of patient-centered care, which comprehensively addresses the multifaceted needs of health consumers. The cross-trained emergency department nurse increases efficiency in acute care for non-urgent patients, while the simultaneous provision of comprehensive care through the integration of these services increases patient flow, reduces recidivism, and overall emergency department costs. Furthermore, providers' heightened awareness of the varied approaches in immediate situational management directly enhances the coordination of care with ultimate discharge planners, nurses, and human resources for both inpatient and outpatient diagnostics or treatment management. An integrated and proactive approach between the PT, RN, and SW reduces the time to care provision, the redundancy of exams—a costly error to find a gap in care—and subsequently elevated care costs—and multiple attempts of the patient accurately contributing in an open and forward manner regarding their regions of functional and emotional concern. Most importantly, this improved level of care has shown to increase outcomes, such as patient satisfaction, compassion, reduction of follow-up in inpatient settings, and decreasing the risk for rapid return to the emergency setting. Creating cohesive steps in care outcomes in one emergency department setting through complex population

utilization of services daily shows the importance and the need for the presented situational approach: the integration of PT, SW, and RN services.

2. Physical Therapy in the Emergency Department

Physical therapy in the emergency department is an emerging area in the field of physical therapy. Physical therapists (PTs) served in emergency departments in the middle of the last century. Little has been published about the role, challenges, and benefits of integrating PT into emergency services. PTs are trained to practice autonomously in fiscally conservative healthcare environments. PTs have a scope of practice grounded in the International Classification of Functioning, Disability, and Health, and assessment and treatment modalities for the provision of skilled interventions in the time of acute conditions. Additionally, PTs are skilled in the interventions for the diagnosis of emergencies, including lab tests, imaging studies, and diagnostic procedures. (Martin et al.2021)(Padovano et al.2022)

Assessments for possible emergent conditions in PTs included those for acute stroke, pulmonary embolism, aortic dissection, acute and subacute myocardial infarction, acute reflux, and ectopic pregnancy. Interventions provided by a PT to patients with decompensated ineffective airway clearance, acute care hypoxemia, acute chronic obstructive pulmonary disease exacerbation, sepsis, pneumonia, hypercapnia, acute subacute respiratory failure, shock, neuromuscular disorders, pleural effusion, and ascites using mobilization, repositioning, breathing exercises, respiratory assist devices, and mechanical ventilation. Additionally, PT interventions in the emergency department are geared toward assessment of pain and pain education and rolling out emergent causes of falls. Benefits from the integration of a physical therapist into the emergency department include reduced wait times, improved inpatient satisfaction, and quicker recovery times post-discharge in the form of reduced physical therapy visits. Some of the challenges to the physical therapist practicing within the emergency department include the development of quality standards for PT practice within the acute setting and the practice of medical screening in the ED. In order for physical therapists to practice in the emergency room, staff must advocate for PT input, and patients need to request physical therapy services in their treatment. (Deslauriers et al.2021)(Hon et al., 2021)(Alowad et al.2021)

The physical therapist series has outlined patient presentations and management used by practicing physical therapists while in the emergency setting, as well as recommendations for acute care-oriented entry-level physical therapist education and ongoing in-services on this topic. Case studies have been outlined that illustrate emergency room medical screening practices by physical therapists to highlight the broad scope of initial practice of the profession. Intervention within the emergency room by physical therapists has also been case studied with a focus on chronic healthcare consumers. Ambulatory care topics are also relevant to the patient flow model in the emergency room as they relate to health conditions that may allow patients to bypass the emergency room and go directly to a floor for care and physical therapy services if required. Furthermore, the physiatrist as a colleague in the emergency room is of relevance to the profession because of the concurrent or possible overlapping scope of practice with physical therapy. It is anticipated that the message will guide professional relations and interactions with various other disciplines consulted in the emergency setting, as well as informing education needs and the scope of practice of entry-to-practice physical therapists and the profession at large.

2.1. Scope of Practice

The role of the physical therapist in the emergency department is primarily to provide an emergency functional assessment of the patient to facilitate the disposition of treatment and care. The physical therapist provides an initial evaluation, including a functional assessment of the

patient. A pain assessment is done during the evaluation to assess the patient's need for medication. Intervention is determined on an individual basis depending upon the patient's condition, resources available in the emergency department, physical therapist judgment, and established criteria. Criteria for the patient's disposition include the medical status, surgical status, and potential for return to a state of function. Depending on the patient's condition, the physical therapist will address emergency treatment and further the scope of treatment and potential discharge instructions. (McDonough et al.2021)(Hon et al., 2021)(Johnson et al., 2021)(Suso-Martí et al.2021)

Modifications of the physical therapist's responsibility are based primarily on time constraints, patient volume, and severity of injury or illness. In the emergency department, patients present with a wide variety of medical problems. Common conditions that usually are cared for by the physical therapist are musculoskeletal injuries. Surgical cases seen by the physical therapist are usually post-surgical cases with surgical repair of long bones, such as open reduction and internal or external fixation of fractures. Surgical follow-ups can also be seen by the physical therapist days after the patient has been discharged from the hospital. In the emergency department, the primary care team input for the physical therapist is through assessment of functional capacity at the time of the injury and interpretation of vital signs, radiographs, lab values, consultants' input, and other medical test results. The physical therapist will collaborate with a health care team of trauma technicians, doctors, and nurses to be most effective. The physical therapist will collaborate to formulate a treatment strategy that will facilitate patients' meaningful outcomes and prevent further injury or exacerbation of the injury. The physical therapist will demonstrate best practice suggestions for baggage handling by hospital volunteers, nurses, and assistive technologies, enabling them to connect in providing care that is safe and ergonomically sound. In the fast pace of the emergency department, decisions must be made quickly on how to effectively and efficiently manage patient cases. In all situations, patient care and safety are the primary concerns. All treatment techniques and interventions presented with the physical therapist's signature are actions that are within the scope of practice for physical therapy and rehabilitation. They are all legal and ethical.

2.2. Benefits and Challenges

Not surprisingly, there are both benefits and challenges to the physical therapy role in the emergency department. On the one hand, physical therapists can contribute uniquely in ways that improve patient recovery after an ED or hospital stay. Early physical therapy intervention has been correlated with improved outcomes in both the general and geriatric emergency room population. It is associated with reduced length of stay in the ER and in the hospital, decreased rate of unplanned hospitalization, improved functional mobility, reduced likelihood of falls, need for nursing home admission, and readmission to the hospital in the following six months. Furthermore, given the limitations built into the physical therapy role, a physical therapy presence in the ED can improve quality of care for patients through early, specialized therapeutic interventions. However, even when specialized physical therapy services are lacking or have limited availability, those ER clinicians with the skills to perform these assessments do so at a higher rate if they receive physical therapy consultation.

Those patients who receive early physical therapy intervention stand to benefit the most. Some facilities reported developing relationships to provide walk-in physical therapy consult services to subsequent fall patients. In the ER, patient flow is often hindered with ancillary services including physical therapy, especially as physical therapists may not be available for consult during certain hours. The need for physical therapy to quickly assess readiness for a patient to be discharged can

conflict with the therapist's need to thoroughly complete a patient assessment and sort out the relevant factors affecting the patient's readiness for discharge or need for further intervention. Some therapists perceived an overriding pressure for so-called band-aid medicine and a focus on patient dispositions. Finally, therapists may lack expertise in emergencies and have difficulty in the ED environment. They may be unaware of existing services, especially specialized ones, and unaware of local and regional resources in general. Ongoing mentorship may also be helpful in areas not normally covered in a traditional physical therapy curriculum, but would be of great use in the ED. (Ellis et al.2021)(Ospina et al.2021)(McDonough et al.2021)

3. Nursing in the Emergency Department

Nursing plays a central role in the functioning of most departments of care, but emergency department nursing is unique for its responsibilities and areas of expertise. These nursing professionals must have fast-acting patient assessment skills, prioritizing patients based on initial assessment and constantly updating the plan of care as further information is learned. Nurses in the emergency department need to be able to communicate this updated plan of care with patients and families as well as the rest of the multidisciplinary team to maintain high-quality emergency care. In addition to assessment and care planning, the nurse must have the technical skill set to execute critical interventions, including starting intravenous lines, drawing laboratory tests, and many other technical skills. Nurses in the emergency department also require sharp, precise clinical judgment and the ability to change priorities or acquire new information to adjust treatment plans as the patient's condition changes. Because of the typically fast-paced environment, the ability to make clear, evidence-supported decisions is a must. Patient care needs informed by age and acuity of the patient are scheduled by nursing staff. Maintaining priorities, adapting to changes in condition, and providing patient and family teaching and updates about condition are also required responsibilities in the care of the adult, pediatric, or neonatal patient in the emergency department. Communication is also important in this very busy, fast-paced, and high-stress work environment. Nursing shifts range from 8 to 12 consecutive hours. As this time passes, different emotional reactions can occur during an extended period of continuous patient care. As the oldest of the care providers in the emergency department, the nurses are responsible for serving as mentors for the residents, scribes, and the newest members of the interdisciplinary team. Ongoing education in all of the above competencies requires initial orientation, ongoing education, and yearly reviews. Ongoing learning occurs during computer-based modules as well as through lectures, group activities, and journal review. Regular attendance at conferences, education focused specifically on emergency care, and pursuing certification offer all members of the emergency department knowledge of the most recent updates and evidence-based research, which results in the care of the emergency department patients. (Rutledge & Gustin, 2021)(Falcó-Pegueroles et al.2021)(Khodaveisi et al.2021)

3.1. Roles and Responsibilities

Nurses are essential to the function of the emergency department (ED). The role of the emergency nurse can vary from setting to facility and provider service. In addition to entry-level competencies of all registered nurses (RNs), including making assessments, initiating and modulating patient care, and counseling/educating patients and families, the emergency nurse performs continuous, rapid, and usually brief assessments in a high-stress environment, therapeutic maneuvers, and treatment interventions designed to prevent further harm. The emergency nurse masters skills in negotiating among or advocating for the patient, the family, and the clinicians. The role requires astute multitasking and prioritization of care provided to patients and families based upon the acuity of conditions. The emergency nurse works as a member of the healthcare team, consulting

with providers and making decisions about patient disposition based upon the assessment and their state's Nurse Practice Act. The emergency nurse has successfully completed continuing education and obtained certification in an emergency nursing program.

Initially, the nurse is also responsible for categorizing the patient into one of the emergent, urgent, semi-urgent, non-urgent, or expectant categories according to the Emergency Severity Index or other classification system. Patient safety and satisfaction are primary to the emergency nurse, and the first departmental hospital representative with whom the patient or family communicates relative to the patient care and experience is usually the emergency nurse. Emergency nurses are particularly versatile and may independently manage severely aberrant vital sign observations; patients encumbered by trauma; victims of rape and abuse; transportation-related injuries; suffocation conditions; vision, hearing, or speech aberrations; organ dysfunction; varyingly dysfunctional mental status; and massive numbers of other healthcare problems requiring emergency management. Management may alarmingly reveal guns fired into heads, swallowed toys by toddlers, and the aftermath of opioid injection HIV infections, among critically ill, injured, or variably dysfunctional populations requiring emergent nursing. Nurses adapt and rapidly identify multiple life-threatening conditions, programming future interventions, teaching patients, and transporting them to other in-hospital departments. In an emergency, nurses must accurately assess evolving situations, take command, and initiate communications that are clear, succinct, and informative, and may involve members of the public, other emergency personnel, and physicians, or the media. Robust triage training—multiple simulated experiences—prepares informed and confident management and caring.

3.2. Collaboration with Other Disciplines

Collaboration between the ED nurse and various healthcare disciplines is essential for high-quality, safe patient care. Some of the other healthcare disciplines that typically work with the ED nurse include emergency medicine, mental health services, physical therapy, occupational therapy, respiratory therapy, social work, case management, and spiritual care. Some of the providers who provide care include medical and surgical residents as well as attending providers. This collaboration provides decision-making that heightens team-based care and supports the unique care delivery needs of the ED patient. An example of this is through effective handoff of the patient within a team environment. Handoffs are relied on heavily during patient care across the continuum. The evolution and integration of handoffs and efficient use between emergency care disciplines and the rest of the healthcare team enhance patient-centered care as well as non-emergent and preventive care delivery processes.

An interdisciplinary team often works off a care plan. This care plan is a blueprint for all the caregivers on the team to understand the outcomes they are accountable for as team members. Outcomes need to be aligned with the care plan of the population of discharged patients. The plan is holistic and is a way for the patient and family to be a part of their care. The physical therapist, the nurse, and the social worker working in an inner-city hospital collaborated with the patient on discharge options. Multidisciplinary rounds were held concurrently to streamline the plan for the day. When the team rounds for a patient, they discuss the plan to move to the next level of care. When the nurse is at the bedside, they may multitask: coordinate team discussions on the case, assess the patient, insert an intravenous line, check the lab values, conduct discharge teaching, and document. An indispensable relationship between the medical provider and the ED nurse was widespread throughout all nursing documents. The role of the nurse as the patient's advocate was also superseded by the doctor/nurse relationship. The development of a teaching role is the desired future relationship between the medical provider and the ED nurse. Representative of excellent

clinical care includes shared responsibilities, opportunities to have open discussions, transparent goals, flexibility, adaptation to the situation of the nurse and the patient, professional satisfaction, and productivity. A lack of collaboration was described when the provider makes decisions without discussing them with the nurse. There was a negative emotional response when the physician or nurse practitioner at triage goes ahead and makes the decision to admit a patient. This prevented staff from sharing their concerns, often presenting situations that were frustrating and sometimes a waste of time. A lack of collaboration was presented as outright authority when the ED provider insisted the nurse send a patient home when they were concerned. There was a power struggle with no means of recourse. The collaborative nature of the ED provider and the therapist was described as fundamentally a team situation where both were responsible for the decision of when to bring a patient in. This included a process discussion of cases decided together. In collaboration with the therapist, each discipline saw the care plan differently. Nurses saw discharging resources and empathizing with the patient. Therapists saw the wait problem and the inpatient resources. (Hammouda et al.2021)(Dresden et al.2022)(Østervang et al.2022)(Quinlivan et al.2021)

4. Social Work in the Emergency Department

Increasingly, the need for social work services in emergency departments has been identified across the United States. While social work practice in the ED setting may vary according to workplace and individual practice philosophies, social workers are a key component of the interdisciplinary team focused on the provision of holistic patient- and family-centered care. Social workers address the medical, social, and psychological issues of patients and their loved ones who present for care in the ED. Key functions include facilitating crisis intervention, assessing patients and families for psychosocial risk factors, formulating treatment and discharge plans, and arranging for services and resources that the ED patient and family can access using appropriate supportive agencies and facilities. Social work is an integral part of interdisciplinary ED teams that foster coordinated patient-centered care, prevention, and early intervention. Social work ED patient care connects the cause of the ED visit and physical therapy or nursing intervention with environmental factors and access to services and resources. Social workers are trained to have empathy and compassion in the face of unjust situations.

The interest in social determinants of health is timely and further grounds the purpose of social work in the ED. At a systems level, this concession is necessary if the beneficial discussions that support patient and family navigation to appropriate resources and services are to take place. Essential social worker skills and attitudes include the ability to be nonjudgmental, to show sensitivity to cultural issues, and to display an active willingness to listen to those they serve. In the fast-paced medical setting, active listening is essential because intervening more quickly can lead to less disruption. Examples of opportunities for collaboration between social workers and other disciplines in the ED include connections to hearing and speech, nursing partnerships, and team approaches to addressing variations in child care. Social workers are a crucial part of team-based patient care in the ED. While work in the ED can be satisfying, it also has its challenging side. The emotional demands of a fast-paced job can be very taxing. People who work in an emergency department can be upset, confused, and suffering from emotional or mental disorders that may go undiagnosed. Additionally, as members of the helping professions, social workers can be exposed to vicarious traumatization and compassion fatigue that takes a toll personally and professionally. (Kiran et al.2022)(Mantel et al.2021)(Powers et al.2022)(Cootes et al.2022)

4.1. Functions and Interventions

Functions and Interventions. Assessment is the primary function of social work in emergency departments. There are three categories of assessment: crisis, psychosocial, and environmental. The crisis aspect of assessment involves the evaluation of a patient presenting with conflicting thoughts and/or actions about his or her health condition. The social worker identifies depression, anxiety, and maladaptive coping and addresses them. The psychosocial portion of the assessment addresses the patient's social functioning, including social support, family dynamics, the impact of illness on the individual and the family, and besides the patient's illness behavior, what other life stressors may be impacting him or her. In terms of environment, the assessment includes an evaluation of the environmental conditions to which the patient is being discharged, including not only with whom the patient will be living but also the quality and safety of that environment.

The social worker may provide crisis counseling to support the patient with an immediate crisis. The focus of counseling may be problem-solving or emotional support. Interventions may include discharge planning, referrals to community resources to help ensure patient compliance with recommendations post-visits, and family interventions. In the emergency department, time is rarely used to focus on the emotional component of the patient's problem, although it is a frequent reason for return visits. Cultural competence is extremely important as our patient population is often diverse. Often, our patients do bring up issues about their culture, but there are many times when the patient's behavior correlates with their emotional and social customs, and there are no specific conditions in the medical database to indicate this. It is essential that we allow the patient to "tell their story," which will often indicate the true root of their crisis. We also look at the "triggers" of the crisis; unless contrived, these are good indicators of the patient's emotional and social condition as well as their support system. There are, of course, exceptions to this, such as in the case of suicide attempts and violence. The other aspect of cultural competency is staff. At this point, we have a doctor, a few nurses, and myself who can relate to the diverse community. In the future, we aim to obtain more staff who can relate. (Lau & Rodgers, 2021)(Liang and Schartner2022)(Kirubarajan et al., 2021)(Rosenkranz et al.2021)

4.2. Supporting Patients and Families

Social workers develop strategies to help support patients and families in the emergency department setting experiencing a health crisis. Emergency situations can result in a range of immediate emotional responses, including anxiety, shock, and fear when individuals believe their sense of safety is threatened by illness. Patients may feel as if they have no control over the emergency that has changed their lives in an instant and may struggle to make decisions about their treatment. Patients who are experiencing a sudden, unexpected illness may feel anxious in response to the many tests and procedures taking place, particularly if they have not yet been admitted to a specific service or unit.

Social work teams throughout the United States are largely staffed by licensed clinical social workers who are trained in counseling and can assist in providing effective communication strategies that can help alleviate distress for patients during their treatment. Communication that validates a patient's distress is key and can be very comforting during an emergency situation. Patients feel relief and an increased sense of control when they know they have been heard and accurately understood. It is important to convey to patients that distress is common in emergency scenarios and is a normal response. After conveying empathy and understanding, patients can be encouraged to develop a realistic, logical appraisal of treatment options. Time should be allowed for this patient activity based on the extent of the distress while the social worker assesses the need for realistic decision-making support. Social workers can support patients and families in

clarifying complex treatment choices and helping them to find and use available decision support tools.

5. Development of a Novel Practice Venue

The objective of this work is the development of an innovative, patient-centric, interdisciplinary, and integrative collaborative practice venue in which all three patient care disciplines of physical therapy, nursing, and social work are integrated into the operation of the emergency department. This work describes the development and implementation of the practice venue, and the process of developing a framework for integrating multiple practice disciplines within the same patient care venue. The implementation of our novel practice venues speaks to the importance of innovative practice environments to advance integrativeness and interdisciplinary collaboration in the context of emergency care. Creation of this collaborative practice venue will capitalize on the physical proximity of ancillary service space to streamline the patient care logistics and to begin to address the issues of communication between patient care providers and logistical care divisions. Integration that is effective will in turn lead to innovative practice as we address the ever-changing and newly recognized issues presented by this unique patient population. Our goal in the redesign process was to create a venue in which the logical workflow and pragmatic and logistical flow of patients through the healthcare system is streamlined to eliminate delays from the first point of contact to the ultimate disposition of the care episode. The heart of the creation of this model was that all three services were consulted in the plans and had agreement on the design and purpose of the venue.

5.1. Design and Implementation

To achieve our larger goals of increasing valued teamwork among therapists, nurses, and social workers in the Multidisciplinary Clinical Venue and the Emergency Department, we needed a space that supports the work. The venue was designed to allow for quick teamwork intervention and collaboration between team members. Therapy appointments are only one small portion of the collaborative care delivered to the patients at the bedside. Physical therapists, nurses, and social workers are expected to collaborate and team around the patient before they leave the clinical venue. Materials were organized to reflect the practice flow of physical therapists and social workers, with the triage desk near the hall doors, exam rooms interspersed in the facility, a multidisciplinary work area near the central triage desk, and a space for teaching at the end of the area. Technology was intentionally designed for function and efficiency, with terminals in each room on wheels that could be easily pushed into the desired work area. Therapist computers were placed at a 45-degree angle between patient and nurse computers to encourage shared use.

From the outset of this effort, we knew that training and buy-in from the persons who staff the spaces would be necessary. We trained and reached consensus from the onset to engage staff in change via pilot and feedback. While providers and staff appreciated the layout and work environment, they noted that workflow and space utilization should be considered when finalizing this space. The two feedback points noted were that the charting terminal would be more convenient to be within the patient's view and to ensure that therapeutic equipment had clinical utility. Numerous operational organizational changes were made simultaneously while launching this pilot venue. This required outstanding leadership and compassionate work from the staff. Leadership ensured that staffing coverage was in place for initial implementation. These nursing and therapy leaders conceived a plan for the care delivery model needed and have been flexible to adapt as lessons were learned and issues arose. This venue's operational reality required patient flow and mechanism operation, such as space selection, the impact on the clinical venue/ED flow, and time associated with the workflow of inter-hospital patients being presented and placed into

inpatient rooms. Market-based and emergency services operations ensured that this could occur in concert with, rather than disrupt, this scheduling process. (Hohl et al.2022)(Filippi et al.2023)(Grebing et al.2023)

5.2. Evaluation and Outcomes

Healthcare professionals, including clinicians, hospital administrators, and policymakers, have recognized numerous performance metrics that can assess the efficacy of our interventions within a coordinated framework of nursing, physical therapy, and social work services. On a broader scale, our emphasis will be on patient satisfaction and enhancements in health outcomes. Conversely, on a more granular level, we will assess the utilization of the suitable healthcare provider to mitigate unnecessary variations and enhance operational efficiency.

The implementation of physical therapy within the Emergency Department represents a relatively novel initiative. As with any emerging concept, it necessitates an evaluative process aimed at continuous quality enhancement. The healthcare sector is increasingly oriented towards comprehensive interactions with individuals or groups requiring various forms of care. Our new operational setting exemplifies such healing interactions, facilitating collaboration among professionals from diverse backgrounds outside the Emergency Department. Given that the Emergency Department primarily functions as a surgical facility equipped with the expertise of emergency physicians, and often serves as a patient's initial contact with a hospital, a thorough analysis of data is deemed essential. Currently, there remains a significant number of unanswered questions regarding the integrative framework of physical therapy, nursing, and social work. Presently, our evidence is largely anecdotal, derived from patient narratives shared by participants; systematic data collection is set to commence in May. In our operational environment, it is common for a procedure to achieve complete adherence before decisive inquiries into its effectiveness are made. Engaging stakeholders in the evaluation process is critical for ensuring a transparent response to our initiatives. Transparency is vital for achieving excellence in an era characterized by performance evaluations and public satisfaction surveys. Establishing baselines is instrumental in developing credible and effective benchmarks for our practices. The evaluation process will include an assessment of multiple dimensions, such as the satisfaction of integrated practitioners, patient satisfaction, patient outcomes, data clarity, and other pertinent considerations. Data will be collected regularly and communicated with the working team. The team will convene quarterly to assess this data, while the Alternative Care Team Practitioner Team will hold an annual retreat focused on strategic planning and problem-solving.

Conclusion

The integration of physical therapy, nursing, and social work in the emergency department presents a transformative model for delivering holistic and efficient patient care. By fostering collaboration among these disciplines, healthcare providers can better address the complex physical, emotional, and social needs of patients, leading to improved patient experiences and optimized hospital operations. The interdisciplinary approach enhances patient assessment, facilitates smoother discharge planning, and reduces unnecessary hospitalizations. While challenges such as role definition, communication gaps, and resource limitations remain, targeted strategies—such as structured training programs, well-defined protocols, and administrative support—can ensure successful implementation. Moving forward, expanding research on the effectiveness of this model and implementing pilot programs in diverse healthcare settings will be essential in refining and scaling this integrative approach. Ultimately, the synergy between physical therapy, nursing, and

social work in the ED has the potential to reshape emergency healthcare delivery, making it more patient-centric, efficient, and sustainable.

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