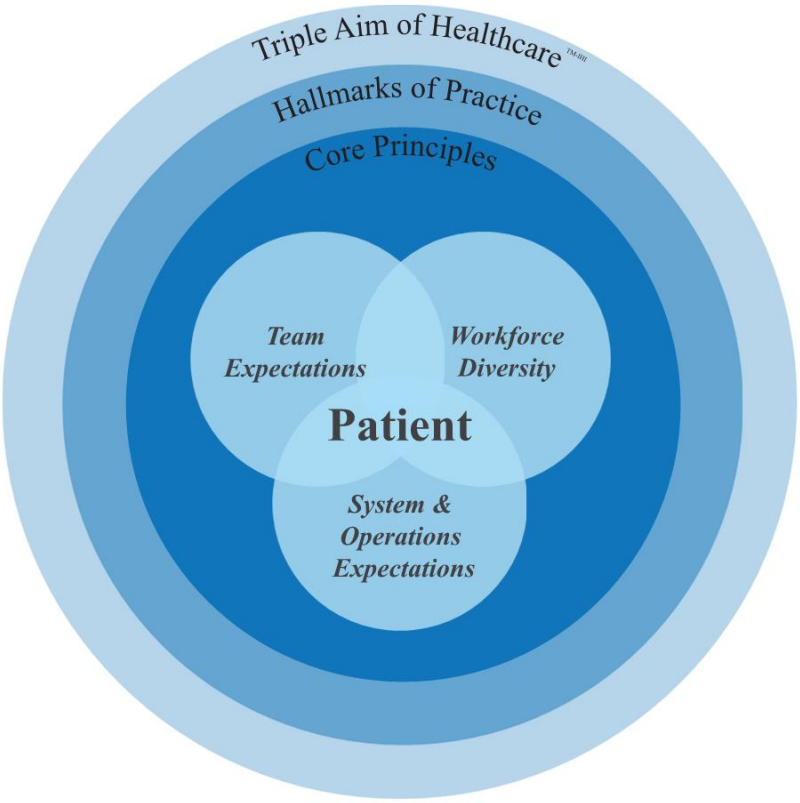

WISCONSIN NURSES ASSOCIATION

Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model

January 19, 2016 (Draft)

Contributors:
Wisconsin Nurses Association (lead)
WNA Grant Multidisciplinary Advisory Council (2015)
Wisconsin Council of Medical Education and Workforce

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WISCONSIN NURSES ASSOCIATION

Patient-Centered Team-Based Care in Wisconsin:
A Working Conceptual Model

For more information please contact:
Gina Dennik-Champion, RN, MSN, MSHA
Executive Director
Wisconsin Nurses Association
6117 Monona Drive
Madison, Wisconsin 53716
gina@wisconsinnurses.org
(608) 221-0383

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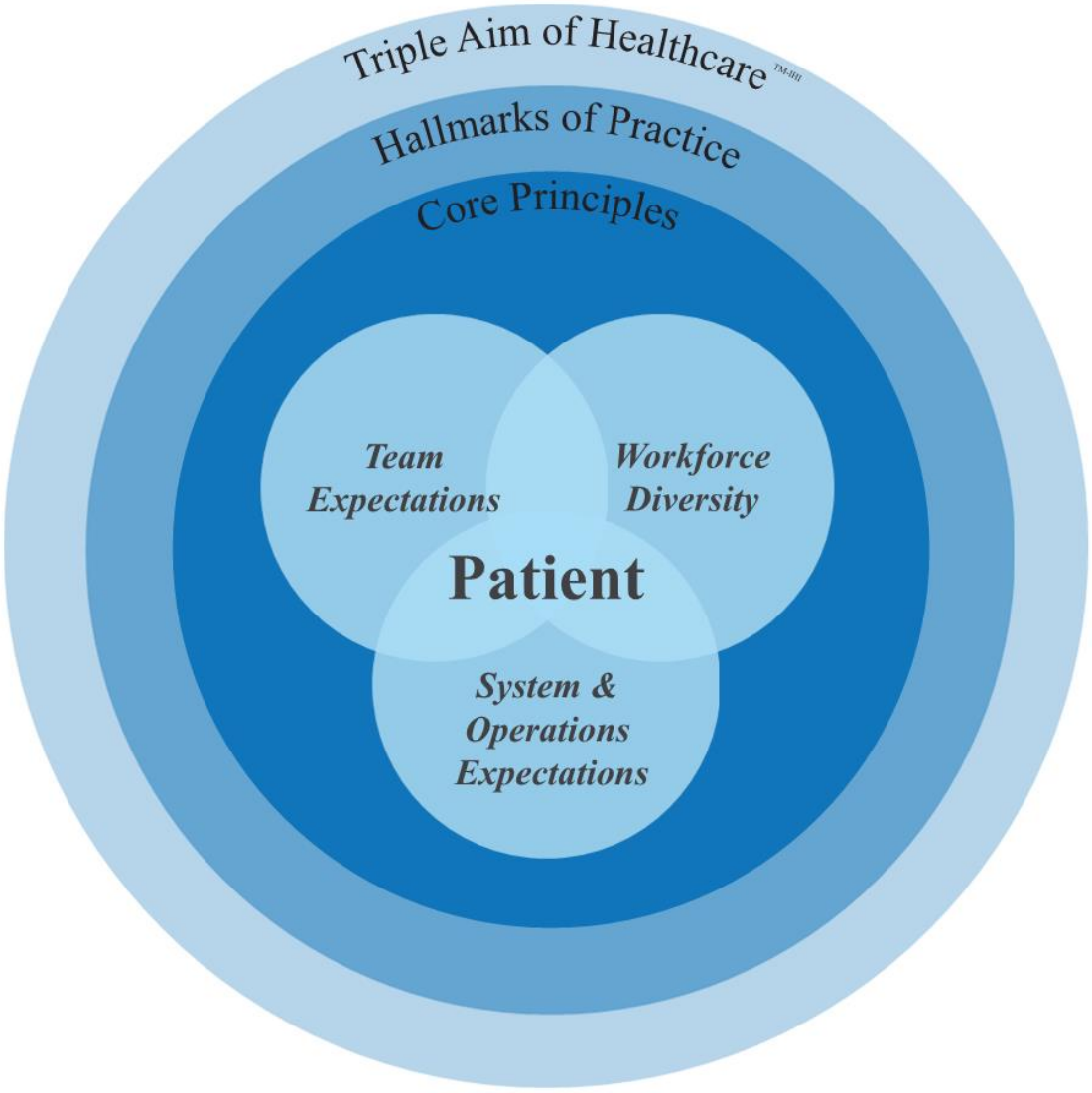
Acknowledgements:
Collaborators:
Gina Dennik-Champion, RN, MSN, MSHA, Executive Director, Wisconsin Nurses Association
Multidisciplinary Grant Advisory Council (2015), Wisconsin Nurses Association
Margaret Schmelzer, MS, RN, Grant Coordinator, Wisconsin Nurses Association
Charles Shabino, MD, Chief Medical Officer, Wisconsin Hospital Association
Wisconsin Council on Medical Education and Workforce

Technical Support:
Bridget Elizabeth Abraham, AIA, Graphics
Anne C. Schmelzer, BA, BSN, RN, Copy editor and layout
Minority Health Program, Division of Public Health, Wisconsin Department of Health Services

Table of Contents



WISCONSIN NURSES ASSOCIATION

Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model
(1/19/2016)

Background

The development of this proposed "working conceptual model" and its accompanying narrative was led by the Wisconsin Nurses Association (WNA) in collaboration with the 2014-2015 WNA Multidisciplinary Grant Advisory Council and the Wisconsin Council on Medical Education and Workforce (WCMEW). This work emerged out of a Chronic Disease Prevention Grant awarded to the WNA by the Wisconsin Department of Health Service's Division of Public Health and the U.S. Centers for Disease Control and Prevention (2014 to present).

The model was originally developed to improve patient outcomes specifically for hypertension and diabetes, the chief foci of the grant. However, based on consultation with the WNA Multidisciplinary Council, WCMEW, and the Wisconsin Department of Health Services, it was agreed that a "general model" was needed given the myriad of patient-centered team-based care needs within diverse settings where health care, community, and public health systems deliver care to the Wisconsin population.

This working conceptual model responds to an expressed need by the funders to define patient-centered team-based care. The model was developed through an extensive literature review that leans strongly on recent publications from participants on the Institute of Medicine of the National Academies' Roundtable on Value and Science-Driven Health Care, and other national and global resources. The model is strongly patient-centered. It relies on the dynamic interplay of **four central elements**:

1. Patient
2. Team
3. Diverse workforce
4. System and operations (of the parent organization)

Furthermore, the model is supported by three **external rings** that include:

1. Core principles
2. Hallmarks of Wisconsin practice
3. Triple Aim of Health Care ™

Taken together, the four central elements and external rings work harmoniously to support, nurture, guide, and sustain work of the health care teams and connections to the community. Furthermore, it enables teams, in the context of the parent organization and community, to protect and promote patient health and safety; prevent injury and the extension of disease; and contribute to healthy people in healthy communities in the places where the people of Wisconsin live, grow, work, learn, and play.

Next Steps:
During January – April 2016, the Multidisciplinary Advisory Council, WCMEW, and WNA will share the model with key stakeholders to identify strengths, weaknesses, and gaps in the model. The WNA will web-publish the model in June 2016 and include any needed revisions. WNA will then disseminate the model for use by Wisconsin's health care providers, academic partners, and public health / community systems.

Purposes of this Document

1. Describe the importance of moving toward patient-centered team-based care as an important health care redesign strategy in Wisconsin.
2. Advance the working conceptual model as part of the foundation in envisioning and designing patient-centered team-based care in Wisconsin.
3. Provide a picture of the conceptual underpinnings of patient-centered team-based care that dovetail with evidence-based approaches to inter-professional team development (e.g., Team STEPPS, Lean).
4. Model interdisciplinary cooperation and collaboration between the agencies, organizations, and professionals represented by the WNA, WCMEW, and the WNA's Multidisciplinary Advisory Council.
5. Secure broad-based review from core professional organizations, practitioners, agencies, organizations, academic centers, and communities prior to web-publishing in June 2016.

Working Definition: Patient-Centered Team-Based Care

Patient-centered team-based health care in Wisconsin supports the definition originally proposed by Naylor, Coburn, and Kurtzman (*nd*) and adopted by the U.S. Institute of Medicine:

> *Team-based care is the provision of health services to individuals, families, and/or their communities by at least two heath providers who work collaboratively with patients and their care givers – to the extent preferred by each patient – to accomplish shared goals within and across settings to achieve coordinated high-quality care* (as cited in Mitchell et al., 2012, p. 5).

Applicability and Dynamics of the Proposed Model

Applicability:

The proposed working model is broad by nature and reflects current literature and guidance. It is designed to be applied in many health settings. The model contains seven elements which are interconnected expressing that the whole is greater than any individual element resulting in care that is patient-focused. Four central elements provide the core of the model surrounded by three outer rings. The three rings anchor the core by directly linking it to the model's principles, hallmarks of practice, and the Institute of Healthcare Improvement's (2015) Triple Aim of Health Care ™.

Dynamics:

The four elements and external rings are interwoven and interconnected and include a central core supported by three outer rings.

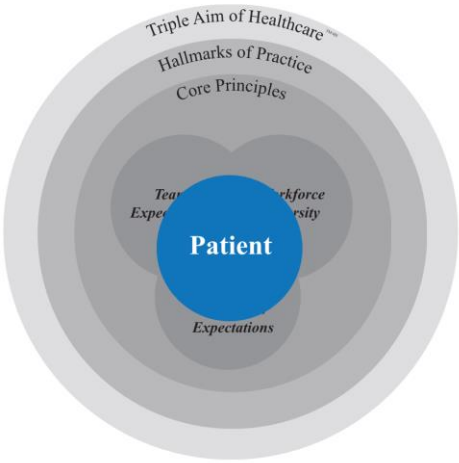
- Four elements represent the central core of the model as expressed in a Venn diagram. These elements foster an activated and informed patient and sustain a prepared proactive team.
    1. Patient
    2. Team expectations
    3. Diverse workforce
    4. System/operations expectations (of the parent organization)

- Three outer rings that anchor, enable, and enrich the elements contained in the central core.
    1. Core principles
    2. Hallmarks of practice
    3. Triple Aim of Health Care ™

Descriptions / Definitions of the Model's Elements and External Rings

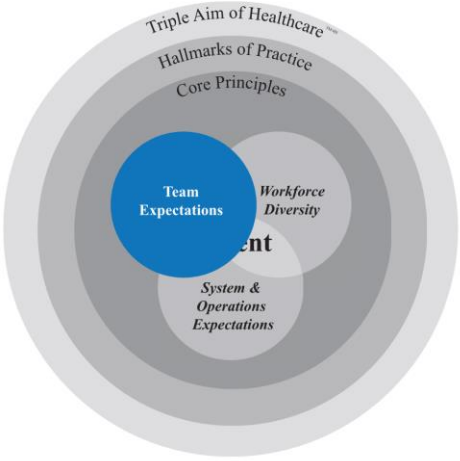
Element #1 – "The Patient"

An active informed patient rests at the center of the model and care is influenced by interaction of all other model elements (Improving Chronic Illness Care, 2015). Care is delivered and received on a continuum where the patient experience transitions from *"care to me"* to *"care with me"* to *"care by me" (*Okun et al., 2014, p. 11). The patient receives care that effectively addresses one or more conditions (e.g., diabetes, asthma, COPD, hypertension, heart disease). The care delivered by the team promotes and protects health and patient safety. The patients and their support systems benefit from primary, secondary, and tertiary levels of care to address current and emerging threats to health.



Element #2 – "The Team"

The team functions as a patient-centered microsystem of the parent organization. The team is dependent on the infrastructure supports provided by the parent organization. It has its own set of adopted principles, team-based processes, and actions designed to promote a prepared proactive team (Improving Chronic Illness Care, 2015). The team partners with patients and their supports to foster shared accountability, safety, and satisfaction. These partnerships result in patient empowerment to achieve and sustain healthy life outcomes.

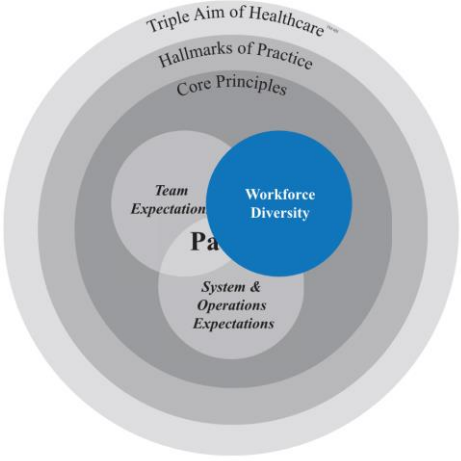


Element #3 – "Diverse Workforce"

A diverse workforce reflects what each individual brings to the team (both professionally and through role assignments). The clinical practice of each team member is grounded in a set of shared-values that are formally adopted by the team. These values include:

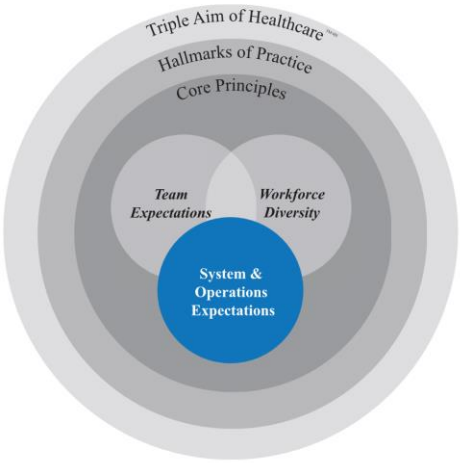
- Honesty
- Discipline
- Creativity
- Humility
- Curiosity (Mitchell et al., 2012)

All members of workforce that comprise the team play a role (directly/indirectly) in patient safety, quality improvement, health outcomes, and population health improvement (Appendix 1).



Element #4 – "The System and Operations"

The parent organization provides the infrastructure (system and operational) supports necessary to achieve and sustain prepared proactive teams (Improving Chronic Illness Care, 2015). Infrastructure supports are rooted in the culture, shared vision, and shared values of the parent organization regardless if it is a health system, a health department, or a community agency (WCMEW/WNA, 2015). The system and operations element provides a source of leadership and supports five team-based core principles that are honored, applied, and integrated by both the team and the parent organization.



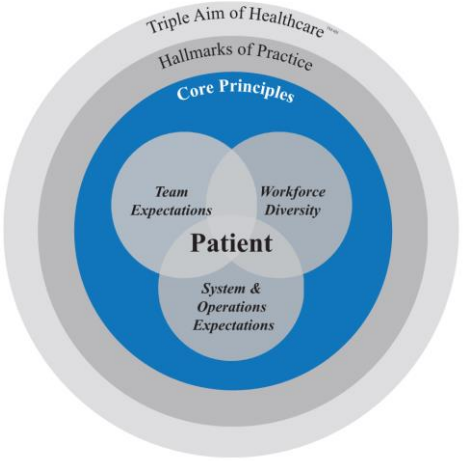
These core principles include:

1. Clear roles
2. Effective communication
3. Mutual trust
4. Shared goals
5. Measurable processes and outcome (Mitchell et al., 2012)

Infrastructure extends beyond the walls of the health system as it is linked to community health services/providers, local health departments, and community health workers (Ohly, 2015). Further, organization leadership recognizes the importance of population health improvement and is responsive to current and emerging population and individual health risk factors that include health literacy and the determinants of health.

External Ring – "Core Principles"

The following core principles guide action, behavior, and performance of the team, parent organization, and workforce elements. The core principles are foundational to patient-centered team-based care. These principles include:



- ***Shared goals:***
  The team – including the patient and, where possible, family member and other support persons – work to establish shared goals that reflect patient and family priorities that are clearly articulated, understood, and supported by all team members.

- ***Clear roles:***
  Establishing clear expectations for each team member is essential. This includes practice authority, scope of practice, functions, responsibilities, and accountabilities. Understanding one's own role and the role of team members optimizes team efficiency and harmony and distributes work and accountability, thereby accomplishing more than the sum of its parts.

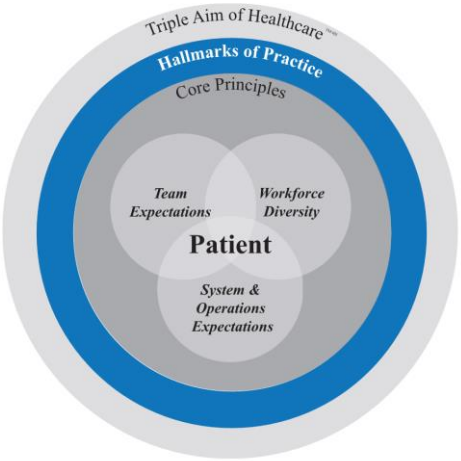
- ***Mutual trust:***
  Team members earn each other's trust and create strong norms of reciprocity and greater opportunities for shared achievement.

- ***Effective communication:***
  The team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication which are accessed and used by all team members across all settings.

- ***Measurable processes and outcomes:***
  The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals. This provides a source of data and information in which to track and improve performance immediately and over time (Mitchell et al., 2012).

External Ring - "Hallmarks of Team-Based Practice"

This external ring identifies the services of the patient-centered team-based care delivery system. The hallmarks-of-practice is an ever-emerging set that includes but is not limited to:



- Delivery of services is provided by a high-functioning collaborative team. Services foster partnerships with patients to achieve outcomes and improve patient satisfaction (Mitchell et al., 2012).

- Delivery of care is on a continuum and where patient engagement transitions from *"care to me"* to *"care with me"* to *"care by me"* (Okun et al., 2014, p. 11).

- Delivery of safe, competency-based, and evidenced-based care (Baker, Salas, King, Battles & Barach, 2005).

- Care and services that extend beyond the clinic and the institution. Care and services are linked to community health services, community-based providers, and local health departments.

- Care is population health-focused and considers health literacy, social, educational, economic factors that influence health (Institute for Healthcare Improvement 2015; Wisconsin Department of Health Services 2010; Stout, et al., *nd*).

- Care is designed to effectively address patients experiencing one or more conditions (e.g., diabetes, asthma, COPD, hypertension) (Improving Chronic Illness Care, 2015; WCMEW/WNA, 2015).

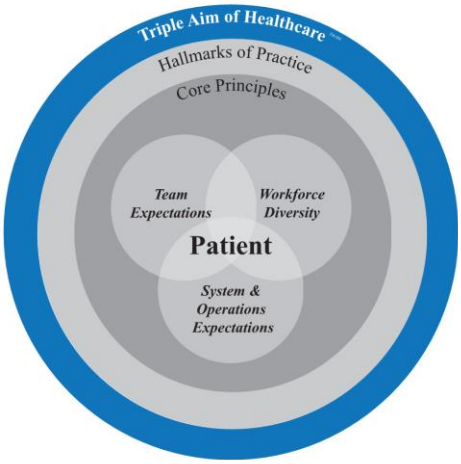
- Care is grounded in the principles of team-based care.

- Teamwork is guided by a formally adopted set of shared core values (Mitchell et al., 2012).

- Teamwork is designed to keep the patient as healthy as possible and proactively focuses on all three levels of prevention (primary, secondary, and tertiary).

External Ring - Triple Aim of Health Care ™
This element grounds practice in the three aims of health care as set forth by the Institute for Healthcare Improvement (2015):

- Improving the patient's experience of care, including quality and satisfaction.
- Improving the health of populations.
- Reducing per capita costs of health care.



Assumptions about the Proposed Model

Assumptions, in this context, means accepting a fact or statement, proposition, axiom, postulate, or notion as true and taken for granted. The assumptions undergirding this model include:

- The patient's current and emerging needs are considered in the context of his/her support system, family/community resource supports, socioeconomic status, and literacy level.
- The parent organization embraces patient-centered team-based care as their mission – as part of its organizational vision and its vision for excellence (WCMEW/WNA, 2015).
- Leadership is not enough. The system/operation itself is a crucial element if the team is to be successful. The system creates the environment (WCMEW/WNA, 2015).
- Team, workforce, and systems/operations interface with the principles of team-based care.
- Success in achieving health care redesign through team-based care rests upon a foundation of shared values, shared vision, and shared mission.
- The current fee-for-service model needs to transition from volume-based to value-based care.
- Education and training is continuous and focuses on knowledge, abilities, and attitudes of the individual members, the team, and the parent organization (Smith, 2015 as cited in WCMEW/WNA, 2015).
- Health care redesign is dynamic. Many designs, models, and approaches are being explored and tested.
- New designs must be developed to simultaneously pursue the Triple Aim of Health Care ™ (Institute of Healthcare Improvement, 2015).
- Health care providers will experience improved professional satisfaction when working in a team-based care environment because it addresses, in part, documented dissatisfiers.
- Inter-professional education enables collaboration and improvement in health outcomes (World Health Organization [WHO], 2010).

Appendix 1
Evolving Expectations of the Team, Parent Organization, and Workforce

The Patient:
The patient is at the center of this patient-centered team-based care working conceptual model. Patients (and their supports) receive care that is respectful of the patient, values, expressed needs, and his / her circumstances (Washington Department of Health, 2013)

Team Expectations:
Team expectations are expressed to assure quality, competence, and patient safety that each team member brings to the patient experience. Team expectations are a product of the team and the parent organization. Team expectations evolve from continuous team and self-learning about knowledge, skills, and attitudes. Team expectations include but are not limited to:

- Collaboration
- Conflict resolution
- Continuous team and self-learning
- Cultural competence
- Electronic health record capacities are maximized (scrubbing).
- Evidence-based approaches in the diagnosis, treatment, and education of the patient / family supports.
- Needs and risks emerging from health literacy needs of patient / family supports are factored into the plan of care.
- Needs and risks emerging from the social, educational, and economic determinants of health are factored into the plan of care.
- Interdisciplinary and inter-professional approaches are used to build collaboration and influence health outcomes.
- Linguistic competence
- Patient registries are generated to identify population groups at risk.
- Policies and protocols are agreed-upon and used.
- Patient self-monitoring tools are encouraged (e.g., hypertension as documented in the Washington Department of Health reference).
- Services are linked to community agencies and providers including community health workers and local health departments.
- Team values are discussed, agreed-upon, and used.
- Work-flow processes are developed and used.

System and Operational (Parent Organization) Expectations:
Teams do not exist in isolation of the parent organization and the larger health system. The system itself is a crucial element if the team is to be successful. The system creates the environment for team success. There must be a dynamic interplay between the team and the parent organization. These system/operations expectations of the parent organization include but are not limited to:

- Community networks and resources are identified and linked.
- Continuous quality improvement
- Culture and organizational change are embraced.
- Education and training standards
- Evidence-based protocols
- Full-practice authority for clinicians
- Inter-professional education

- Leadership
- Policies of the parent organization are integrated into team processes.
- Population-health focused
- Primary care system redesign
- Shared vision, mission, and values ground the organization and are reflected in team processes.
- Standards of care

Workforce Diversity:
Teams will vary in their size and composition. All members of Wisconsin's health workforce that comprise the team play a role, directly or indirectly, to quality improvement, health outcomes, patient safety, patient satisfaction, and population health improvement. Core and expanded teams may be drawn from the following list that includes but is not limited to:

Advanced practice registered nurse
- Care coordinator
- Community health worker
- Doctor of osteopathy
- Health coach
- Health educator
- Informaticist
- Licensed practical nurse
- Medical assistant
- Medical specialist (e.g., cardiologist, endocrinologist)
- Mental health provider
- Navigator
- Pharmacist
- Physician
- Physician assistant
- Receptionist
- Registered dietician
- Registered nurse
- Social worker

Note:
For more information about diversifying the workforce, refer to U.S. Department of Health and Human Services, Office of Minority Health (2001). *National standards for culturally and linguistically appropriate services in health care*. Washington, D.C.

Appendix 2
Definitions*

***Note:** *The definitions that follow include all major terms used in model. Additional definitions have been added to enhance the reader's understanding and provide a bridge to such sources (e.g., Inter-professional Education). Definitions for "new and emerging workforce roles are included but not for traditional roles (e.g., physician, pharmacist, advanced practice registered nurse, physician assistant, receptionist).*

Clear roles is a principle and means there are clear expectations for each team member's functions, responsibilities, and accountabilities, which optimize the teams' efficiency and often make it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts (Mitchell et al., 2012).

Collaboration means "exchanging information, altering activities, sharing resources, and enhancing the capacity of another for mutual benefit and to achieve a common purpose" (Hillelman, 2012, p. 3). According to Himmelman (2012):

> *The qualitative difference between collaborating and cooperating in this definition is the willingness of organizations (or individuals) to enhance each other's capacity for mutual benefit and a common purpose. In this definition, collaborating is a relationship in which each organization wants to help its partners become the best that they can be at what they do. This definition also assumes that when organizations collaborate they share risks, responsibilities, and rewards, each of which contributes to enhancing each other's capacity to achieve a common purpose. Collaborating is usually characterized by substantial time commitments, very high levels of trust, and extensive areas of common turf. A summary definition of organizational collaboration is a process in which organizations exchange information, alter activities, share resources, and enhance each other's capacity for mutual benefit and a common purpose by sharing risks, responsibilities, and rewards* (p. 3).

Collaborative practice in health-care occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, supporters, and communities to deliver the highest quality of care across settings. Note: practice includes both clinical and non-clinical health-related work, such as diagnosis, treatment, surveillance, health communications, management, and sanitation engineering (WHO, 2010).

Community health worker means a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services in the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, social support, and advocacy (American Public Health Association, 2015).

Creativity is a team value and means team members are excited by the possibility of tackling new or emerging problems creatively. They even see errors and unanticipated bad outcomes as potential opportunities to learn and serve (Mitchell et al., 2012).

Cultural acceptance means acceptance and respect for difference, continuing self-assessment, and careful attention to dynamics of difference, continuous expansion of knowledge and resources and

adaptation of services to better meet needs of diverse populations (U.S. Department of Health and Human Services, Office of Minority Health, 2015).

Cultural awareness means the process of conducting self-examination of one's own biases towards other cultures and the in-depth exploration of one's cultural and professional background. Cultural awareness also involves being aware of the existence of documented racism and other "isms" in healthcare delivery (U.S. Department of Health and Human Services, Office of Minority Health, 2015).

Cultural competence means a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations (U.S Department of Health and Human Services, Office of Minority Health, 2015).

Cultural humility means a lifelong process of self-reflection and self-critique. The starting point this approach is a consideration of one's own assumptions and beliefs. Training around cultural competence and proficiency emphasizes promoting understanding of the client, which is important, with her/his "own culture", but often neglects consideration of the providers' worldview (U.S. Department of Health and Human Services, Office of Minority Health, 2015).

Cultural knowledge means the process in which the health care professional seeks and obtains a sound educational base about culturally diverse groups. In acquiring this knowledge, healthcare professionals must focus on the integration of three specific issues: health-related beliefs practices and cultural values; disease incidence and prevalence (U.S. Department of Health and Human Services, Office of Minority Health, 2015).

Cultural proficiency means holding culture in high esteem; seeking to add to knowledge base of culturally competent practice, influencing approaches of care, and improving relations between cultures—promotes self-determination (U.S. Department of Health and Human Services, Office of Minority Health, 2015).

Cultural skill means the ability to conduct a cultural assessment to collect relevant cultural data regarding the client's presenting problem as well as accurately conducting a culturally-based physical assessment (U.S. Department of Health and Human Services, Office of Minority Health, 2015).

Curiosity is a team value and means team members are dedicated to reflecting upon the lessons learned in the course of their daily activities and using those insights for continuous improvement of their own work and the functioning of the team (Mitchell et al., 2012).

Determinants of health means social, economic, and educational factors that influence health – also known as the social determinants of health – are defined by the World Health Organization (WHO, 2015) as "the conditions in which people are born, grow, live, work and age." The Centers for Disease Control and Prevention (2015) further explains the social determinants of health as circumstances that are shaped by broader forces, including "economics, social policies and politics." Examples of the social determinants of health include: employment, community safety, income, educational attainment, family and social support, as well as racism and other forms of discrimination (Wisconsin Department of Health Services, 2010).

Discipline is a team value and means team members carry out their roles and responsibilities with discipline, even when it seems inconvenient. At the same time, team members are disciplined in seeking out and sharing new information to improve individual and team functioning, even when

doing so may be uncomfortable. Such discipline allows teams to develop and stick to their standards and protocols even as they seek ways to improve (Mitchell et al., 2012).

Effective communication is a principle and means the team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings (Mitchell et al., 2012).

Full practice authority means the collection of state practice and licensure laws that allow for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications—under the exclusive licensure authority of the of the state board of nursing (Ginsberg et al, 2012).

Health risk is best defined using the definition of risk factors. "A risk factor is any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury. Some examples of the more important risk factors are underweight, unsafe sex, high blood pressure, tobacco and alcohol consumption, and unsafe water, sanitation and hygiene" (Institute of Medicine 2001; WHO, 2016.)

Health literacy means whether a person can obtain, process, and understand basic health information and services that are needed to make suitable health decisions. Health literacy includes the ability to understand instructions on prescription bottles, appointment cards, medical education brochures, provider's directions, and consent forms. It also includes the ability to navigate complex health care systems. Health literacy is not simply the ability to read. It requires a complex group of reading, listening, analytical, and decision-making skills, and the ability to apply these skills to health situations. (U.S Department of Health and Human Services, 2010). (Option 1, definition)

Health literacy means the degree to which individuals have the capacity to obtain, process, and understand basic information and services needed to make appropriate decisions about their health (US Institute of Medicine as referenced in Wisconsin Department of Health Services, 2010). (Option 2, definition)

Health worker is a wholly inclusive term which refers to all people engaged in actions whose primary intent is to enhance health. Included in this definition are those who promote and preserve health, those who diagnose and treat disease, health management and support workers, professionals with discrete/unique areas of competence, whether regulated or non-regulated, conventional or complementary (WHO, 2010).

Honesty is a team value and means team members put a high value on effective communication within the team, including transparency about aims, decisions, uncertainties, and mistakes. Honesty is critical to continued improvement and for maintaining the mutual trust necessary for a high-functioning team (Mitchell et al., 2012). .

Humility is a team value and means team members recognize differences in training but do not believe that one type of training or perspective is uniformly superior to the training of others. They also recognize that they are human and will make mistakes. Hence a key value of working in a team is that fellow team members can rely on each other to help recognize and avert failures, regardless of where they are in the hierarchy. In this regard, as Atul Gawande, MD, has said, "effective teamwork is a practical response to the recognition that each of us is imperfect and no matter who you are, how experienced or smart, you will fail" (as referenced in Mitchell et al., 2012, p. 5).

Informatics (clinical) is the application of informatics and information technology to deliver healthcare services. It is also referred to as applied clinical informatics and operational informatics. The American Medical Informatics Association considers informatics when used for healthcare delivery to be essentially the same regardless of the health professional group involved (whether dentist, pharmacist, physician, nurse, or other health professional). Clinical Informatics is concerned with information use in health care by clinicians. Clinical informatics includes a wide range of topics ranging from clinical decision support to visual images (e.g. radiological, pathological, dermatological, and ophthalmological); from clinical documentation to provider order entry systems; and from system design to system implementation and adoption issues (American Medical Informatics Association, 2015).

Informatics (nursing) means "a specialty that integrates nursing science, computer science, and information science to manage and communicate data, information, knowledge and wisdom in nursing practice. Nursing Informatics facilitates the integration of data, information, knowledge to support patients, nurses, and other providers in decision-making in all roles and settings. This support is accomplished through the use of information structures, information processes and information technology. The goal of nursing informatics is to improve the health of populations, communities, families, and individuals by optimizing information management and communication" (American Nurses Association, 2008).

Informatics (public health) means the person who provides strategic and technical support to informatics executives and management to meet the goals and objectives of specific public health programs, in alignment with an agency mission. This position is a senior-level professional position within a public health agency. The incumbent provides leadership and carries out complex scientific and information assessments to support public health policies and practices, including community health improvement, decision support, and stakeholder engagement. The incumbent must be able to work in a complex environment with national, state, and local professionals in public health, epidemiology, evaluation, and information technology. Proficiency in informatics and public health program areas and practice is expected (Public Health Informatics Institute, 2015).

Inter-professional education occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes. Professional is an all-encompassing term that includes individuals with the knowledge and/or skills to contribute to the physical, mental and social well-being of a community (WHO, 2010).

Measurable processes and outcomes is a principle and means the team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals. These are used to track and improve performance immediately and over time (Mitchell et al., 2012).

Quality Metrics are parameters or ways of quantitatively assessing a project's level of quality, along with the measures to carry out such measurement. Metrics outline the standard that work will be measured against and are often unique to each project and/or product. Quality metrics are defined in the planning phase of the project and then measured throughout the project's life to track and assess the project's level of conformity to its established quality baseline (Centers for Disease Control and Prevention, 2006).

Mutual trust is a principle and means team members earn each other's trust, creating strong norms of reciprocity and greater opportunities for shared achievement (Mitchell et al., 2012).

Self-management means the tasks that individuals must undertake to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management, and emotional management of their conditions (Institute of Medicine, 2003).

Self-management support means the systematic provision of education and supportive interventions by health care staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support (Institute of Medicine, 2001).

Shared goals is a principle and means the team – including the patient and, where possible, family member and other support persons – works to establish shared goals that reflect patient and family priorities, and can be clearly articulated, understood, and supported by all team members (Mitchell et al., 2012).

Social risk means social and psychological conditions (e.g., socioeconomic status; social support and networks; occupational stress, unemployment, and retirement; social cohesion and social capital, and religious belief) that seem to influence morbidity and mortality directly through physiological processes and indirectly via behavioral pathways (Institute of Medicine 2001; Stout et al., *nd*).

Top of License means performing the work that reflects the fullest extent of their (health provider's) education and training (Ginsberg et al, 2012).

Triple Aim of Health Care ™ means the framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance by pursuing three dimensions, call the "Triple Aim." These three dimensions include (1) improving the patient experience of care (including quality and satisfaction), (2) improving the health of populations, and (3) reducing the per capita cost of health care (Institute for Healthcare Improvement, 2015).

Appendix 3
Wisconsin Nurses Association's Grant Multidisciplinary Advisory Council

The Multidisciplinary Council was convened in 2015 by the Executive Director of the Wisconsin Nurses Association to provide advice, guidance, and consultation to the 2014-2015 Chronic Disease Prevention Grant awarded to the WNA from the Wisconsin Department of Health Services, Division of Public Health and the U.S. Centers for Disease Control and Prevention.

Among other contributions, the Council actively collaborated with the WNA in the development of the proposed Patient-Centered Team-Based Care Conceptual Model (October 20, 2015). The Multidisciplinary Council together with the WCMEM will collaborate with WNA in identifying the strengths and weaknesses of the model during January – April 2016.

Member	Title	Affiliation
Lea Acord, PhD, RN, FAAN	WNA President	Marquette University College of Nursing
Gregg A. Albright, RPh, BCACP	Disease Management Pharmacist; Residency Program Director	Wheaton Franciscan Health Care
Andy Anderson, MD, MBA	Senior Vice President, Academic Affairs; President, Aurora-UW Medical Group	Aurora Health, Inc.
Tina Bettin, DNP, APNP	Primary Care Provider – Nurse Practitioner	ThedaCare
Rebecca Cohen, MS	Health Systems Coordinator; Grant Project Officer	Wisconsin Department of Health Services, Division of Public Health, Chronic Disease Prevention Unit
Pam Crouse, MS, RN	Clinical and Quality Improvement Director	Wisconsin Primary Health Care Association
Richard Dart, MD	Past President State Chairperson, Million Hearts	Wisconsin Medical Society
Gina Dennik-Champion, RN, MSN, MSHA	Executive Director, Chair, Multidisciplinary Council	Wisconsin Nurses Association
Carrie Easterly, RN	Nurse Navigator, Public Health Nurse	Adams County Department of Health and Human Services (Community Wellness Program)
Mary Funseth, CSW, BS-HCM, CIRS-A	Medicare Task Lead- Diabetes Disparities and Patient Engagement; and Quality Consultant Healthcare Transformations	MetaStar, Inc.
Ashely Green	Quality Consultant	MetaStar, Inc.
Lynda Gruenewald-Schmitz, RN, MSN	Vice President and Chief Nursing Officer - Non-Acute Services	Wheaton Franciscan Healthcare
Rhonda Hoyer, ARNP	Nurse Practitioner	UW Health
Deana Jansa, MBA/HCM, BSN, RN-BC Informatics	Ambulatory Implementation Manager – Primary Care	UW Health
Laura Magstadt, MSN, RN	Director, Patient Health Services	Ministry Health

Member	Title	Affiliation
Jeffery Miller, DNP, ACRN, APNP	Assistant Professor; Clinical Director of Outpatient Care at Tosa Center	Medical College of Wisconsin, Department of Psychiatry and Behavioral Medicine
Sherri Ohly, BSW	Special Projects Coordinator; Independent Health Promotion Consultant, Wisconsin Division of Public Health	Wisconsin Institute for Healthy Aging
Eric Penniman, MD	Family Physician	Marshfield Clinic Family Practice Stettin Clinic
Betj Peterman, RN, MS, APNP	Assistant Professor; Director, House of Peace Nursing Center	University of Wisconsin – Milwaukee, College of Nursing
Larry Pheifer	Executive Director	Wisconsin Academy of Family Physicians
Kristine Pralle, RN	Diabetic Educator	Jackson Correctional Institution
George Quinn	Executive Director	Wisconsin Council on Medical Education and Workforce
Jean Roedl, APRN, FNP	Nurse Practitioner	Wisconsin Tribal Clinic
Margaret Schmelzer, MS, RN	Project Coordinator, Chronic Disease Prevention Grant	Wisconsin Nurses Association
Charles Charles, MD	Chief Medical Officer	Wisconsin Hospital Association
Virgina Snyder, PhD, PA-C	*Director*, Physician Assistant Program	University of Wisconsin School of Medicine and Public Health
Patrice Streicher, Patrice, APRN, FNP-BC, LLC (retired)	Family Nurse Practitioner	University of Wisconsin School of Nursing and UW Medical Foundation
Sarah Sorem, PharmD	Vice President of Professional and Educational Affairs	Pharmacy Society of Wisconsin
Jing Wu, RPH	Doctor of Pharmacy Candidate, 2017; Master of Public Health Candidate, 2017; UW Multicultural Affairs Program in Pharmacy Student Senate Representative	University of Wisconsin, School of Pharmacy and School of Medicine and Public Health
Lee VermeuVermeulen, MS, RPH	Clinical Professor and Director	Center for clinical Knowledge Management, University of Wisconsin
Hashim Zaibak, RPh, PharmD	Clinical Pharmacist	HAYAT Pharmacy Milwaukee, WI

Appendix 4
Wisconsin Council of Medical Education and Workforce
2015 Leadership and Members
(In process – insert credentials)

- Rick Abrams, Wisconsin Medical Society
- Sandy Anderson, Rural Wisconsin Health Cooperative
- Mark Belknap, Wisconsin Medical Society
- Tina Bettin, ThedaCare
- Eric Borgerding, Wisconsin Hospital Association
- Steve Brenton, Wisconsin Hospital Association
- Byron Crouse, UW School of Medicine and Public Health
- Gina Dennik-Champion, Wisconsin Nurses Association
- William Hueston, Medical College of Wisconsin
- Mark Kehrberg, Affinity Health
- Dessie Levy, ANEW
- George Quinn, Wisconsin Council on Medical Education and Workforce
- Charles Shabino, Wisconsin Council on Medical Education and Workforce
- Kenneth Simons, Medical College of Wisconsin
- Tim Size, Rural Wisconsin Health Cooperative
- Rachel Skenandore, Governor's office
- Virgina Snyder, Wisconsin Academy of Physician Assistants
- Sarah Sorum, Pharmacy Society of Wisconsin
- Art Walaczek, UW School of Medicine and Public Health
- Paul Wertsch, MD, Wisconsin Medical Society

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