



Wisconsin Council on
Medical Education & Workforce

Building a Culture for Patient- Centered Team-Based Care in Wisconsin

Compendium of Pre-Conference Abstracts

Wednesday, November 12, 2014

9:00 am - 3:45 pm

Glacier Canyon Lodge

Wisconsin Dells, WI 53965

**A Joint Publication of the Wisconsin Council on
Medical Education and Workforce and the
Wisconsin Nurses Association**



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Foreword

The *Compendium of Conference Abstracts* includes all abstracts submitted in response to a call from the conference planning committee in 2014. The compendium is a companion to the conference proceedings and executive summary. The abstracts that follow were submitted by health care leaders, in their own words, who are carrying out patient-centered team-based care in Wisconsin.

In designing the conference agenda, Co-chairs Charles Shabino, MD, Chief Medical Officer, Wisconsin Hospital Association, and Gina Dennik-Champion, MSN, RN, MSHA, Executive Director, Wisconsin Nurses Association and the Wisconsin Council on Medical Education and Workforce (WCMEW) planning committee posed five key questions to guide planning processes:

1. What is the state of team-based care in Wisconsin?
2. Why are teams formed?
3. What are the key ingredients needed for teams to be successful?
4. What are the barriers to team-based care?
5. How do we as a state move team-based care forward?

Using these questions as a foundation, the planning committee reached out to health care organizations and professional associations for the purpose of developing the statewide summit. Abstracts were widely solicited from Wisconsin teams who could address one of three topics that provided the “best fit” for their team: (1) mission and driving forces; (2) team interaction and culture; and (3) patient population served and outcomes. In the end, 40 abstracts were received and published in this conference compendium, 12 abstract authors were invited to formally serve as panel presenters, and 25 poster presenters shared their team-based care approaches and experiences during the conference. Comments, suggestions, and requests for information may be addressed to:

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Building a Culture for Patient-Centered Team Based Care Compendium of Submissions

Aurora Health Care

Team Name: *Aurora Medical Center, Oshkosh*

Team Leader: Staci Schnaderbeck, RPh

Contact Information: staci.schnaderbeck@aurora.org

Type of Presentation: Poster

Numerous studies have been performed on patient outcomes after hospital discharge and readmission rates. Insurance companies and Medicare noticed trends in these reports and stated that procedures needed to change within hospitals and pharmacies or they would not reimburse for certain services. Professional pharmacy networks have also seen these studies and have discussed opportunities for pharmacists to assist with improving patient outcomes. Getting pharmacists involved with hospital discharges has shown to have a positive impact on patient readmission rates and improve patient outcomes.

One of Aurora Health Care's main values is "every patient deserves the best care." As an organization, our employees are called caregivers and we continuously strive to provide patients with the best care and experiences. Several Aurora locations have implemented a discharge program and we wanted to create one also. Our pharmacy manager had various meetings over the course of about a year with inpatient pharmacy, doctors, nurses, and department leaders. A process was created and agreed-upon by all.

The program was piloted with our Same-Day-Surgery Department. We wanted to get used to the changes we had to make in the pharmacy and to see if we needed to "tweak" the process in any way before launching the program with the entire hospital. Our pharmacy manager created a flow chart for nurses, Same-Day-Surgery staff, and our pharmacy team to follow. Prior to the patient's procedure, they were told about how the process worked and were given the option to participate or not. Same-Day-Surgery sent us a list the night before of the patients who would be participating in the program. This way we were able to prepare the night before and get all of the patient's information into our system. Once the physician signed the orders, they were sent to us through the facility's tubing system. When we completed the prescriptions, we either called or sent an instant message to the recovery room coordinator. The patient's family was notified that the medications were ready and could be picked up at the pharmacy. It was a win-win situation for everyone. The doctors knew their patients would go home with their medications; we were given time and notice to get the orders done quickly and efficiently; the families did not have to wait or go someplace else to pick up the medications; and the patients went home with their medications.

Since this pilot program started several months ago, we have expanded the program to include the entire hospital. This version of the program was set to be opt-out only. Inpatient pharmacy technicians perform an initial medication review with every hospital admission and the patient's file is automatically labeled to have their discharge medications filled at our outpatient pharmacy. Patients do have the option to opt out of the program if they wish to have their medications filled at another pharmacy, and in that case, the inpatient pharmacy technician labels the patients' files accordingly. Prior to discharge, the orders are sent to us in the outpatient pharmacy. When the prescriptions are finished, a pharmacist counsels the patient over-the-phone and an outpatient pharmacy technician delivers the medication to

the patient's room if they prefer, or a family member can come to the pharmacy to pick it up. If we have two pharmacists on staff, a pharmacist will deliver the medications to the patient's room and counsel face-to-face. In one of our first discharges after the launch, a neighbor came to the pharmacy to pay for the patient's prescriptions, and I volunteered to go back with him to the patient's room so I could show her how to use the new inhaler. I also noticed that she was eligible for a comprehensive medication review meeting with a pharmacist after discharge, and I discussed with her the option to schedule a meeting with us. She stated she did not live around here and did not want to travel back here. I asked her permission to contact the Aurora pharmacist in her area to see about setting up an appointment closer to her home. The patient's primary physician worked in the same clinic as the other pharmacist, and she allowed me to call. I later found out that the other Aurora pharmacist did set up a meeting with the patient and it went very well.

We are still working out some kinks in the process, but it has overall been a great program for our pharmacy, the hospital, and our patients. We are able to work more closely with the inpatient pharmacists to ensure patients are switched from IV inpatient medications to the equivalent oral outpatient medications. We have increased contacts with the inpatient nurses to more efficiently prepare the patient for discharge and ensure that each patient leaves the hospital with medications and instructions according to the physicians' care plans. Every month our pharmacy manager receives reports on our progress. Since the launch, we have doubled our prescription capture rates for almost all of the hospital departments, and on several occasions, we have been able to prevent medication errors. We are also currently working on expanding the program even further to include the oncology enter, the catheterization lab, and eventually radiology. "Every patient deserves the best care," and we are fulfilling that promise.

Aurora Health Care

Team Name: *Advanced Practice Registered Nurses and Physician's Assistant Leadership Council*

Team Leader: Jen Tenhover

Contact Information: 262-352-4944, jen.tenhover@aurora.org

Type of Presentation: Abstract Only

The Aurora Advanced Practice Registered Nurse / Physician's Assistant (APRN /PA) Leadership Council is a professional team within our organization. The Council represents all advanced practice registered nurses and physician assistants within the organization. These providers care for patients within every facet of the patient populations served by Aurora. The Council further works to serve the needs of their peers and respective professions, as well as to function as a resource and support to organizational partners regarding advance practice provider roles.

Aurora Health Care, Medical Groups

Team Name: *Registered Nurse Health Coach – Chronic Disease Coordination*

Team Leader: Jen Tenhover

Contact Information: 262-352-4944, jen.tenhover@aurora.org

Type of Presentation: Abstract Only

Driving Forces behind the Creation of the Team

The need for greater care coordination and intervention, focused on the highest risk patient cohorts, became more evident and quantifiable when our organization purchased predictive analytics tools that assisted us in identifying populations at greatest risk for hospitalization. The abundance and high acuity

of these patients presented us with the opportunity to employ some of the established best practices we had been proactively researching for some time in preparation for the changing healthcare environment, reimbursement structures and efficiency through top of license, team based care models.

Population Served

The RN Health Coach team is assigned patients based on primary diagnosis of heart failure and/or chronic obstructive pulmonary disease (COPD) and stratification to the most likely to be admitted population. This accounts for about 20 percent of our total COPD and heart failure population. We are currently piloting a pediatric asthma program as well but have no data at this time. While the team is assigned patients based on a diagnosis of COPD and/or heart failure; the team is an extension of the primary care practices, and therefore focus on all aspects of the patients' health and wellness.

Composition of the Team

The creation of the "RN Health Coach" role within our primary care practices was the beginning of an ever evolving team of caregivers dedicated to increasing wellness and disease management among our most at-risk patient populations. The engagement and inclusion of our employed pharmacists was the beginning of the formation of an interdisciplinary team approach and is the most mature partnership with the RN health coaches. The RN health coaches and pharmacists work with the primary care providers, clinical caregivers, and patients to establish treatment/care plans, emergency action plans for acute exacerbations and patient self-management goals. The team also partners with our home health nurses, hospital case managers, rehabilitation departments, specialty providers, educators, dieticians, social workers, and local organizations.

Purpose and Mission of the Team

The team works to increase the quality of life for this high acuity, at risk, patient population. This is accomplished by creating greater awareness of the patients' disease processes and medication treatment plans, engaging the patients in their own care, and coordinating resources to assist with financial and social burdens. The RN health coaches and pharmacists have become the first line of defense for the patients they serve and are often times assessing and triaging potential complications before they become incidents that will negatively impact the patients.

How the Team Fits Within the Organization

The RN health coaches and pharmacists have separate reporting structures but are both integrated system service lines. Their teamwork is a result of their respective departments partnering to develop high-quality care processes for the benefit of our patients.

Length of Time the Team has been in Existence

The team was developed in early spring of 2013 and began its work with patients in June 2013.

Outcomes and/or Outcome Measures

There are a number of different process measures that have been tracked as the team began its work in order to assure adherence to the new processes and easily identify missed opportunities. Some examples include:

- Percent of patients engaged with registered nurse health coach
- Percent of patients engaged with pharmacist
- Percent of patients with linked episodes of care (EPIC functionality)
- Percent of patients with recurring visits scheduled

Our outcomes measures are specific to the number of inpatient admissions, emergency department visits, and movement of the patients from the highest risk categories to lower deciles in the stratification. We were unable to find industry standards for improvement as a result of this type of intervention so we were not sure what to expect as results when we began. We set a goal of 20 percent reduction of admissions over the first year of intervention with the team understanding that this was probably a stretch target. Within the first six months of intervention the team had demonstrated a 65 percent reduction in admissions for their patient population from year prior. This number does not take into account that, historically, 33 percent of all heart failure and COPD admission result in readmissions and that those too were subsequently avoided. Decreases in emergency department utilization and a shift of patient from the highest-risk category to lower deciles, and in some cases quartiles, were also demonstrated.

Successes

Within the first six months of intervention the team had demonstrated a 65 percent reduction in admissions for their patient population from year prior. This number does not take into account that, historically, 33 percent of all heart failure and COPD admission result in readmissions and that those too were subsequently avoided. Decreases in emergency department utilization and a shift of patient from the highest-risk category to lower deciles, and in some cases quartiles, were also demonstrated. Our team has been fortunate enough to have been highlighted in presentations at the most recent AMGA, HIMMS, and Anceta conferences. Within our organization, our work has been recognized by our executive leaders and our team model has become a cornerstone of our organization's Primary Care Redesign system roll-out strategy for 2015.

Barriers

There is a cost associated with the full-time equivalent (FTE) positions required to form this team. Most of the cost is an "added" expense to the primary care practices. While the work of this team has demonstrated significant patient engagement, loyalty, satisfaction, and increased the quality and continuity of care our patients receive, there are actually potentially negative financial implications for our integrated system. The fact that we still function in a fee-for-service industry is counterproductive to the avoidance of costly admissions. Our biggest struggle at this point is to "hug the curve" and be proactive enough to be ready for the paradigm shift that will be coming in our reimbursement structures but not move so fast that we actually make our successes a detriment to the organization.

Future Plans

From fourth quarter 2014 through 2015, we will be expanding the team model into other markets with a total of 30 RN health coach FTE's across the system. We plan to continue the evolution of the team and incorporate programs specific to diabetes, hypertension and coronary artery disease within the next twelve to eighteen months.

Aurora Health Care

Team Name: *University of Wisconsin Family Medicine Clinics*

Team Leader: Chris Klink

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Type of Presentation: Panel #2

The family medicine clinics at St. Luke's Medical Center and Sinai Medical Center are primary care clinics. These clinics are composed of physicians, nurse practitioners, registered nurses, medical assistants, social workers, and phlebotomists. These clinics serve as the home for the Aurora Family

Medicine Residency Program which is affiliated with the University of Wisconsin, Department of Family Medicine. They also are teaching sites for medical students from multiple medical schools. A unique component to these clinics is the inclusion of a clinical pharmacist as part of the multi-disciplinary teams. Clinical pharmacists started part-time at the St. Luke's clinic in 1998 and rapidly expanded to a full-time presence. Clinical pharmacists started part-time at the Sinai clinic in 2000 and will be expanding to a full-time presence this summer. The clinics also serve as rotation sites for pharmacy residents and students.

The initial driving forces behind the addition of clinical pharmacists to the team were threefold: patient education; provider and medical resident education; and pharmacy student and resident education. This education initially happened as part of patient visits – in patient rooms and in staffing with residents and providers. Over time, pharmacists began to schedule patients for dedicated education appointments around diabetes, asthma, smoking cessation, and polypharmacy. Pharmacists developed a structured teaching curriculum for the family medicine residents which included case-based presentations on the pharmacotherapy of multiple chronic disease states and coordination of experiential learning experiences on living with chronic diseases. Pharmacists also frequently lecture on a variety of topics at the request of the family medicine program and have been incorporated into multi-disciplinary teaching teams at dedicated themed conference days and retreats. Pharmacist involvement in precepting pharmacy students and residents has increased over time due to the expansion of the residency program and an increase in pharmacy schools in the area.

In addition to a greater role in education, the scope of practice of the clinic pharmacists has expanded over time. The pharmacists focus on patients with complicated medical regimens for multiple chronic disease states as well as those with barriers to the proper use of medication. Pharmacists have become extensively involved in the clinical decision making around drug therapy management. This began in a collaborative interdisciplinary fashion as part of the patient's routine visit with their primary care provider. This led to increased respect and confidence from the medical providers on the team and more frequent requests to be more involved in the direct management of patient care. In 2010, a collaborative practice agreement was established that gave pharmacists authority to manage patients with diabetes, hypertension, hyperlipidemia, and smoking cessation. Patients referred for care to the medication management clinic were generally those who were care management outliers and had additional barriers that prevented them from meeting treatment goals. Additionally, pharmacists have expanded their polypharmacy visits from focusing just on the patient's proper use of medication to Comprehensive Medication Reviews and Assessments (CMR/As) that critically evaluate a patient's medications and provide recommendations to providers on how to optimize the patient's pharmacotherapy.

Due to both their geographic locations and their design as teaching clinics, these clinics serve a patient population with a high rate of Medicare and Medicaid coverage. This population is ethnically diverse and includes a number of minority and non-English speaking patient groups. Patients come from a variety of socioeconomic classes, but lower economic strata are disproportionately represented. These factors lead to high rates of low health literacy, concomitant mental health illnesses, and various levels of family, social, and community support.

The purpose of the family medicine clinics is consistent with that of Aurora Health Care: "we help people live well." Our vision is to provide people with better health care than they can get anywhere else. As such, the family medicine clinic serves as part of the larger continuum of care provided by Aurora Health Care. This includes primary care, specialty and subspecialty care, hospital care from

primary to tertiary, pharmacy, visiting nurses, and end-of-life palliative and hospice care. Pharmacist involvement in the family medicine clinics has led to more comprehensive team-based care for patients, particular those that are more medically complicated, have higher care needs, and have barriers to care.

A number of different outcome measures have been assessed related to pharmacist involvement as part of the patient care teams. In the pharmacist lead medication management clinic, significant improvements in clinical outcomes have been demonstrated. For diabetes, A1C was lowered by 2 percent and the percentage of patients meeting goal A1C levels increased from 2.2 percent to 52.8 percent. For hyperlipidemia, LDL was lowered by 46 mg/dl and the percentage of patients meeting goal LDL levels increased from 38.5 percent to 74.4 percent. For hypertension, blood pressure was lowered by 20.4/6.7 and the percentage of patients meeting goal blood pressure levels increased from 40 percent to 70 percent. For smoking cessation, cigarette usage was decreased by 5.7 cigarettes per day and the percentage of patients who were tobacco free increased from 0 percent to 50 percent. At our Sinai clinic, where we also provide smoking cessation, we have shown a 20 percent success rate in helping patients quit smoking. Patient satisfaction surveys for our medication management clinic have shown scores ranging from 4.4 to 4.76 on a 1 to 5 Likert Scale, with the highest score of 4.76 on the question “rate the overall care you received from the pharmacist today?” Referring providers have also been surveyed on their satisfaction with the medication management clinic. Their responses varied from 4.44 to 4.89 on a 1 to 5 Likert Scale, with the highest score of 4.89 for the questions: “do you feel that board certified pharmacists have adequate knowledge and training to provide medication management services to patients?” and “do you feel that the collaborative practice with the clinical pharmacists has helped you to improve overall primary patient care for the medication management disease states?”

In the Comprehensive Medication Review and Assessment (CMR/A) visits, pharmacists have provided an average of 3.42 patient recommendations and 6.35 provider recommendations per visit. Providers made changes on 2.6 recommendations per patient. While this might seem low, the great majority of non-accepted recommendations were due to them not being addressed (75.5 percent). This is addressed in the barriers section below, however a survey of providers showed overwhelming support of CMR/A’s and identified several ways to improve follow through on recommendations. Similar to medication management visits, patient satisfaction surveys have shown scores ranging from 4.43 to 4.71 on a 1 to 5 Likert Scale, with the highest score of 4.71 on the question: “rate the overall care you received from the pharmacist today?” Finally, in the most recent yearly survey of family medicine residents, the collective three class years of residents ranked the quality of professional relationships with pharmacists as 4.26 on a 1 to 5 Likert Scale, above all other relationships evaluated, with the next highest being teaching faculty.

Pharmacist involvement in the family medicine clinics has led to multiple successes as noted above. Pharmacists have improved clinical quality and patient experience. Pharmacists have had a positive impact on medical and pharmacy resident and student education and training. Providers have demonstrated a high rate of confidence in pharmacists’ professionalism and a true spirit of collegiality has developed. Pharmacists have been fully incorporated into the life and action of the clinic. Pharmacists have been involved in several clinic initiatives. This first included the Alliance of Independent Academic Medical Centers (AIAMC) National Initiative III, which focused on implementing TeamSTEPPS training. Next was the AIAMC National Initiative IV, which is focusing on Quality and Safety, specifically around the rooming process and ambulatory medication reconciliation. Pharmacists have been asked to be on the editorial board for the Journal of Patient-Centered Research and Reviews.

Additionally, pharmacists are actively involved in primary care redesign, with the Sinai clinic as one of the pilot sites.

The main barriers to team involvement have been around the areas of time, payment, and communication. To date, pharmacist services have been limited at the Sinai site due to only two staff days per week. This barrier is being overcome by the expansion to full-time services this summer. The other component of time that can be a barrier is the multitude of services and initiatives that pharmacists are involved with, which at times limits the pharmacist's immediate availability. This has been overcome by more frequent use of messaging through the electronic medical record (EMR). Payment is a barrier in the current fee-for-service model where pharmacists are not recognized as providers. There is some reimbursement through various mechanisms such as facility fee billing and medication therapy management billing, but it only covers a portion of the pharmacist's salary and benefits. With a national move toward recognition of pharmacists as providers as well as health care payment reform through accountable care organizations (ACO's), payment for quality, population management, and more opportunities for revenue generation and cost savings should develop. Finally, communication can be challenging with dozens of part-time providers with the residency model and pharmacists who may be unavailable at times due to involvement in direct patient care, teaching, and committee and administrative work. This is helped by the use of the electronic medical record (EMR) where all encounters are placed and messages are shared. The biggest challenge to communication has come around the CMR/A process mentioned above. Actions being taken in this area include closer coordination between pharmacist visits and follow up physician visits, having dedicated physician visits to follow up on CMR/A recommendations, and having more focused communication in the EMR to allow providers to clearly recognize pharmacist recommendations.

Immediate future plans focus on three areas. First is the expansion of pharmacist hours at the Sinai clinic and increased involvement in patient care initiatives, such as the medication management clinic, that were implemented at St. Luke's. Second is the primary care redesign pilot at Sinai (and future roll out at St. Luke's). This will stress even more team-based care with a focus on wellness and preventing hospital readmission with built in triggers for pharmacist referral. Third is the Quality and Safety initiative on the rooming process and medication reconciliation which is also being designed to have built in triggers for pharmacist referral. As primary care continues to advance, the pharmacists will proactively adjust their role in the clinic to meet the needs of patients and providers.

Children's Hospital of Wisconsin

Team Name: *Tracheostomy / Home Ventilator Program*

Team Leader: Cecilia Lang, APN

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Type of Presentation: Panel #3, Poster

Started in 1984, this program began as a multidisciplinary team to serve the tracheostomy and home ventilator patients of Wisconsin, Northern Illinois, and the Upper Peninsula of Michigan. The opportunity for critically ill children to be discharged to their home on a ventilator arose due to technology advances. This team was created to bridge the transition from hospital to home. Our team includes physicians (pulmonary and ears nose throat); nurses; advanced practice nurses; social workers; respiratory care practitioners; physical, occupational and speech therapists; inpatient case managers; and a dietician who work collaboratively to serve those children who are tracheostomy and/or home ventilator dependent. Our team's mission and purpose is: (1) provide case management across the continuum of care, for as long as the child has a tracheostomy, in both inpatient and outpatient settings;

(2) educate and prepare parents and caregivers of technologically dependent children for a successful transition to home; (3) optimize development; (4) identify safety concerns, resources and needs for discharge process; (5) minimize inpatient hospital length of stay and readmissions; (6) serve as a clinical resource for this population to all members of our Children's Hospital of Wisconsin interdisciplinary health care team; (7) serve as a liaison between home agency support (equipment, nursing, schools, therapy services) and the patient/family and hospital; (8) provide outpatient case management, long term follow up, and coordination of care; and (9) provide a multidisciplinary clinic for follow up and community integration

Barriers that our program has identified to team success include: (1) increased acuity and complexity of patients; (2) increased number of chronic lung disease and complex cardiac population; (3) growth of new interdisciplinary team members needed for team based care and limitations of full-time equivalency requirements; (4) increased outpatient clinic space and appointment needs; and (5) adaptation of the electronic health record to effectively reflect the needs and care of this complex patient population from an interdisciplinary perspective.

Future plans for program growth include: (1) evidenced-based research and Children's Health Association Collaborative opportunities for outcome based care and guideline development for weaning and liberation from a ventilator; (2) local and statewide community services collaboration and outreach opportunities; (3) outpatient follow up and care closer to home; and (4) growth of team-based education and integration of simulation into care delivery and education.

Success has been attributed to team respect for each other's roles and responsibilities and clinical expertise. We have established systems of ongoing team communication and collaboration that follow: (1) weekly discharge planning rounds; (2) weekly team-based family care conferences; (3) weekly interdisciplinary bedside rounds; (4) monthly team meetings focused on program growth and development; (5) monthly Pulmonary Section meetings with providers; and (6) community education and certification of over 700 nurses (LPN's and RN's) in the state of Wisconsin since implementation of Pediatric Ventilator Certification Course.

Children's Hospital of Wisconsin, Fox Valley Cardiology Clinic

Team Name: *Pediatric Cardiology*

Team Leader: Mary R. Butler, PhD, APNP

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Type of Presentation: Abstract Only

The pediatric cardiology clinic was established in the Fox Valley in 2002 to offer services to children and their families affected by congenital heart disease. This service provided cardiac care and evaluation without having to travel to Milwaukee at the Herma Heart Center. It was recognized early on that a team approach would best serve this community and therefore a pediatric cardiologist, nurse practitioner, and registered nurse comprised the initial team. Over the years, our team has grown as the practice has grown. We now have several pediatric cardiologists practicing, general pediatric cardiology, electrophysiology, and adult congenital cardiology here in the Fox Valley. Over the last 12 years, this practice has expanded and grown to accommodate a variety of children and families affected by congenital heart disease. Our practice has a full-time pediatric cardiologist and a full-time nurse practitioner living in the area to provide 24 hour care both inpatient and outpatient in the Fox Valley area. Our practice provides appointments for children 4-5 days a week offering electrophysiology testing, echocardiography, and consultation. We have developed a successful team approach working

with our partners in Milwaukee Children's to collaborate during the child's admission for surgery or other procedures. There have been several barriers to developing a successful practice including financial support, ancillary services and working between systems, and providing sufficient access to patient services. We continue to evaluate our practice to improve efficiency, access and best practices for our cardiology patients. We hope to continue to grow our services providing five day a week services by several providers.

Community Care, Inc.

Team Name: *PACE and Family Care Partnership*

Team Leader: Mary Parish Gavinski, MD

Contact Information: 262-207-9318, mary.gavinski@communitycareinc.org

Type of Presentation: Panel #1

Driving forces behind creation of the team

In 1990 Community Care, Inc., (CCI) became one of the first four On-Lok replication/ PACE (Program for All-Inclusive Care for the Elderly) programs in the United States. In 1996 Community Care, Inc., joined with the State of Wisconsin to develop the Family Care Partnership model of care, again using an interdisciplinary team to provide all inclusive services to all adults 18 years and older who are nursing home and Medicaid eligible. The program was developed to offer an alternative to nursing home and institutional care that allowed delivery of all the services needed to members while keeping them in the community and their own home. The PACE program is often referred to as the "Original ACO." This program was designed to use an interdisciplinary team to provide primary/acute and long term care services and case management for contracted services. This program uses an interdisciplinary team that pairs with a community physician and is more mobile for rural settings.

Population served

Adults 18 years and older who meet functional criteria for nursing home care (~8+ medical conditions, functional disabilities {intellectual disabilities, physical disabilities, and frail elderly} and low income). Community Care serves members in nine counties in southeastern Wisconsin.

Composition of the team

Core team: registered nurses, nurse practitioners, social workers, and physicians. Additional team members: rehabilitation specialists home care, transportation, behavioral health specialists, and dietitians. Additional resources for teams: wound consultant, infection control RN, provider quality department, and an advanced disease support team.

Purpose and mission of the team

The Community Care PACE and Partnership model is centered on the belief that it is better for the well-being of adults with chronic care needs and their families to be served in the community whenever possible. The mission of the care team is to work with the patient/member to identify the member's goals and outcomes and to collaboratively develop a member care plan and service plans that meets the desired outcomes and goals.

- The team provides or coordinates a full range of preventive, primary, acute and long-term care services that enable adults with disabilities to live in the community as independently as possible.
- Community Care provides care and services consistent with emerging consumer demands for individual choices in health care and services.

- Community Care combines adult day settings, home care, interdisciplinary teams, transportation systems and capitated payment systems so providers can respond to the unique needs of each individual served.
- Community Care provides all inclusive care to a target population to improve quality of care, decrease cost of care, and keep people in the community.

How team fits within the organization

The team is responsible for assessing members, providing direct care and care management for all services the member needs. The team is directly responsible for all the quality of care and utilization of services for all member services needed. The care team, which includes the member, is central and integral to the delivery of the care management. The care team is responsible for understanding all of the organizational and community support services that are available and appropriate for the member. The team also works with the member to coordinate access to those needed resources.

Length of time team has been in existence

Over 20 years. Although the model has been in existence for a number of years it continues to evolve with changes in health care and with the availability and diversity of services found in the counties in which they operate.

Outcomes and/or outcome measures

Research studies regarding national PACE statistics available upon request.

Comparing like populations

PACE and Partnership has shown improved quality (multiple metrics e.g., vaccination, preventative screening, decreased emergency room and hospitalization usage) and high member and caregiver satisfaction.

For consumers, CCI provides:

- A process for maintaining a connection between the member and the community in which the member lives.
- Caregivers who listen to and can respond to their individualized care needs.
- The option to continue living in their community as long as possible.
- One-stop shopping for all health care services.

For health care providers, CCI provides:

- An additional resource to use to assist with the management of members who have complex medical and behavioral needs.
- Capitated funding arrangement that rewards providers who are flexible and creative in providing the best care possible.
- The ability to coordinate care for individuals across settings and medical disciplines.
- The ability to meet increasing consumer demands for individualized care and support services.

For those who pay for care, CCI provides:

- A model that has a long history of successfully working with members who have complex medical needs, complex behaviors profiles and can have high utilization patterns.
- Cost savings and predictable expenditures.

- A comprehensive service package emphasizing preventive care that is usually less expensive and more effective than acute care.
- A model of choice for individuals focused on keeping them at home and out of institutional settings.

Successes (also see Outcomes)

1. Twenty year operation with good outcomes and low member disenrollment while continuing to be financially viable. CCI has developed programs that decrease the fragmentation seen for this population in the current health care system.
2. CCI has successfully developed multiple teams in different locations that provide this care for members across south eastern Wisconsin.
3. Successful orientation and on-boarding of each person who joins the team including not only orientation to their role as a discipline but to the process of working in a truly interdisciplinary team and interdisciplinary care planning.

Barriers

1. In each new community, CCI needs to develop the collaborative model with the contracted health care providers. This includes initial orientation, identifying how best to fit into the contracted providers system of care, and ongoing communication.
2. Finding enough experienced and qualified nurse practitioners, nurses and other health care disciplines to work in this model of care.

Future plans

1. Further defining each team members' roles to prevent duplication and operate more efficiently.
2. Developing efficiencies with our electronic medical record and sharing information with contracted care providers.

Dean Clinic, Baraboo

Team Name: *Baraboo Internal Medicine*

Team Leader: Trudy Mara, APNP, RN

Contact Information: 608-697-2796, ttmara@yahoo.com

Type of Presentation: Poster

This team is a long-time group geared to creating integrated primary care for patients with multi-system health issues. The patients are middle-aged to very old adults. We have worked together for 14 or more years, depending on the team member. The driving force for creation was the need for comprehensive health care. Our purpose is excellence in health care. We were in a separate clinic and were recently merged into a larger clinic. We function differently than the rest of the clinic, but are accepting of our differences so far and say they welcome them. We have no specific outcome measures.

Successes

Comprehensive care improved with diabetic and other complex multi-system patients.

Barriers

Insurance reimbursement

Productivity concerns with c patients

Future plans

Hopefully, we will gradually incorporate our model, or pieces of it, into the clinic at large.

Edgerton Hospital and Health Services

Team Name: *Interdisciplinary Team Rounding*

Team Leader: Elizabeth Luchsinger

Contact Information: 608-561-6620, eluchsinger@edgertonhospital.com

Type of Presentation: Abstract Only

Edgerton Hospital and Health Services developed a multidisciplinary rounding team to improve the entire patient experience including patient care, patient satisfaction, and patient safety. The population served by this team includes patients in our Medical/Surgical Unit. The types of patients in our Medical/Surgical Unit include acute inpatients, swing or short term rehabilitation patients, and observation patients. The team rounds on these patients each morning Monday through Friday.

The multidisciplinary rounding team includes a pharmacist, rehabilitation manager, social worker, nutritionist, safety/infection control officer, physician assistant/hospitalist, medical/surgical manager, patient's nurse, engineering staff, and a member of administration. A certified therapy dog often rounds with the team. The team's purpose is to ensure the highest quality care experience for our patients. Daily rounding maintains a collaborative approach to the patient's care. It keeps the patients involved and engaged in their care. The staff members work with the patients to set goals for treatment.

The organization's ICARE values include integrity, compassion, accountability, respect, and excellence which set the stage for these daily rounds. The team fits within the organization by providing exceptional health care to our communities which is Edgerton Hospital and Health Services' mission. The multidisciplinary rounding team has been in existence for approximately one year.

Some of the outcomes that the Medical/Surgical Unit has experienced are increased scores on our patient satisfaction surveys, decreased fall rates, decreased urinary tract infection rates, and faster service recovery opportunities. In October 2011, Edgerton Hospital and Health Services opened a new facility located just outside of Edgerton, Wisconsin, that includes a gorgeous Healing Garden allowing our patients to heal in a serene environment. When the hospital opened at its new facility it also went live with an electronic health record system, EPIC. Edgerton Hospital and Health Services became accredited by The Joint Commission in March 2013.

The multidisciplinary rounding team sparked change and has had many successes. Not only do our patients help plan their day, they plan their entire stay with us. Patients benefit from knowing a tentative discharge date as soon as they arrive as well as continuously planning for their discharge from our organization. Daily rounding promotes patient centered care and encourages staff members to be professional and accountable in their actions. A barrier that the team met was the commitment of time from all team members.

In the future, the team hopes to increase follow up with each patient so when issues are identified a team member will take the initiative to close the loop as soon as possible. The team is encouraging more physician involvement with rounding. Scripts for team members may be appropriate in the future to streamline the rounding process. Overall, the team hopes to be able to listen more closely to the patient and meet their needs.

Froedtert Hospital

Team Name: *Trauma Nurse Education Committee*

Team Leader: Colleen Trevino

Contact Information: 414-805-8649, colleen.trevino@froedtert.com

Type of Presentation: Abstract Only

The Trauma Nurse Education Committee is an interprofessional committee that was developed to educate nurses about the trauma and acute care surgery specialties and to improve communication between the providers (physicians, residents, advanced practice providers) and nurses. The team consists of the inpatient floor manager, the nurse educator, advanced practice providers (APP) from the Acute Care Surgery Inpatient Service and the Trauma Surgery Service, and the trauma surgeon medical director of the unit. The APPs and medical director are employees of the Medical College of Wisconsin and staff the inpatient services that admit to this specialty unit. This committee develops the learning opportunities for the unit nurse and surgical residents who staff these services. This team has been in place for over four years. Outcomes have improved in nursing satisfaction with communication with the residents after completion of the communication modules. There are few barriers to this committee. Implementation of the education modules is supported by both the providers and nursing leadership. We plan on continuing the communication focus and supporting more sophisticated learning modalities such as simulation.

Froedtert Hospital and the Medical College of Wisconsin

Team Name: *Ambulatory Pharmacy Department*

Team Leader: Erika Smith

Contact Information: 414-805-6579, Erika.smith@froedtert.com

Type of Presentation: Panel #3 and Poster

Froedtert and the Medical College of Wisconsin include a large academic medical center located in Milwaukee. Clinical Ambulatory Pharmacy services at Froedtert and the Medical College of Wisconsin started in 1996 with the formation of the Anticoagulation Clinic. The clinic was developed in an effort to increase both quality of patient care and patient and provider satisfaction. Over the past 18 years, there has been a vast expansion of services provided in the ambulatory areas with the volume of pharmacist support jumping from only 0.2 full-time equivalents (FTE) to 16 FTE and an expansion into 15 additional clinics.

Ambulatory pharmacist deployment has been strategically structured to support patients and areas with the highest needs. Populations served currently include those with complex disease states and/or a high medication burden. Clinics where pharmacists are a part of the care team include: anticoagulation and medication therapy (including an anemia management service and medication therapy service), transplant, infectious disease, primary care/internal medicine, cardiology, pulmonary, Sickle Cell, endocrine, Metabolic Syndrome, pre-admission testing, GI/hepatology, rheumatology, geriatrics, and oncology.

The composition of the care teams can vary based on the needs of the patient and overall clinic structure. There are several models of care employed, all of which involve pharmacists working alongside with other members of a patients' care team which may include, but are not limited to, physicians, advanced practice providers, nurses, dietitians, and social workers. Clinic pharmacists may be involved in collaborative visits with the entire care team or see their own patients or a hybrid of both.

In other settings, the pharmacist works under collaborative agreements in a segregated clinic as a distinct member in that patient's care (such as anticoagulation or anemia management).

The purpose and mission of the Froedtert and the Medical College Ambulatory Pharmacy Department is to support patients in achieving the best medication-related outcomes, enhance provider care and workflow, and demonstrate value for our organization. Our department is a part of the overall Pharmacy Department at Froedtert Hospital.

Successes

The start of ambulatory pharmacy services being narrow in scope to anticoagulation management, where these roles are well supported in the literature, to now expanding to unique and new models with novel disease state management is something we consider a big success. We are excited by our successes in positively impacting patient lives by improving clinical outcomes while still continuing to boast high patient satisfaction scores. Integration in the patient-centered medical home has additionally continued to grow from twice a month educational presentations to the clinics to pharmacists (embedded within clinical practice) who are involved in administrative and population health efforts.

Through integration into multidisciplinary committees, pharmacists have been able to assist the organization with making smart decisions on medication safety issues, formulary choices, how to manage recalled medications, care guidelines, etc. We have integrated well with our outpatient medication management mail order service. This provides a concierge ongoing service to high risk patients, following up each month to ensure medication reconciliation is performed and the patient maintains good adherence. We have found impressive improvement in outcomes when the patient has been touched by both the clinic pharmacist as well as enrolled in our mail order program.

Barriers

We continue to struggle with the lack of reimbursement options for ambulatory pharmacist services. With the pharmacist being an expensive resource with limited reimbursement options, we continually try to discern the discrete value of the pharmacist service which is challenging if the care provided is completely through a team approach. Relationship building and education continues to be imperative to our continued success as there are still providers who are unfamiliar with what the role or value of a pharmacist in clinic can be. As the model of how pharmacists should support patient care in the ambulatory clinic setting is still very institution dependent, we struggle with determining appropriate benchmarks.

Outcomes

Some specific examples of positive outcomes include:

- Anticoagulation clinic managed patients percent INRs exactly in range is 57 percent compared to MD managed patients is 47 percent.
- Hepatitis C patients who are seen by the clinic pharmacist at the outset of their therapy initiation and enrolled in our mail order service have demonstrated a higher percentage of reaching sustained virologic response than those not (95.7 percent vs. 82.3 percent).
- Within our anemia service for chronic kidney disease patients, we have encouraging results on more appropriate iron assessments and avoidance of unnecessary Procrit therapy.
- Transplant Clinic patients who saw a pharmacist in clinic and receive their medications in our mail order service had statistically significant better medication adherence rates and control of both blood pressure control and diabetes after one year. (Adherence rate 91 percent intervention vs. 65 percent control; BP at goal 63 percent intervention vs 35 percent control; HbA1c at goal 74 percent intervention vs. 36 percent control).

- Infectious disease clinic patients who saw a pharmacist in clinic and receive their medications in our mail order service had higher medication adherence rates (82 percent intervention vs 76 percent control), complete immunization assessment (85 percent intervention vs 78 percent control) and laboratory assessment (91 percent intervention vs 80 percent control).
- In our primary care setting, we have tracked pharmacist detection of drug related problems (average of 1.5 per patient) with a 93 percent rate of the provider accepting the pharmacist recommendation for resolving. We have seen successful efforts in reducing the number or cost medications for patients seen by the pharmacist.
- In our cardiology clinic, the pharmacist was able to identify on average 2 medication discrepancies per visit. Drug related problems were identified in 43 percent of patients seen by the pharmacist with 37 percent of those problems having a safety categorization of requiring an intervention to preclude harm.
- In rheumatology, the patients who saw the pharmacist prior to starting a new biologic medication had a much higher rate of appropriate immunizations ranging from 71-79 percent versus if the pharmacist was not involved the immunization rate was 43-54 percent. Having the pharmacist involved in the biologic medication workflow and education has also improved our ability to fill those prescriptions initially at a pharmacy on campus and get the patient enrolled in our mail order program. This has brought about an improved revenue source for the pharmacy department as well.

Future plans

We hope to continue to grow and align our services as the organization moves on its journey to becoming an Accountable Care Organization. This may include pharmacists working at more of a population health level, assisting with care guideline development. If team based care becomes more of a reimbursed service we would also hope to become more embedded in the primary care arena, supporting our community physicians' practices. We also hope to continue to standardize the care provided in certain areas such as anticoagulation and anemia, bringing a high reliability and level of patient care outcomes.

Froedtert Hospital and the Medical College of Wisconsin

Team Name: *Froedtert Health, Nurse Practitioner Health Care Clinic*

Team Leader: Angie Stefanich, MSN, APNP

Contact Information: angela.stefanich@froedtert.com

Type of Presentation: Poster

Driving Forces and Mission

The mission of the Froedtert Health Onsite Health Care Clinics is to improve employee health and reduce medical benefit plan costs by providing convenient, cost-effective, episodic medical services, dietitian consults, health coaching, care management, and medication therapy management for staff and eligible family members participating on the Froedtert Health Medical Plan. Utilizing a team-based approach, we promote patient-centered care to provide the best possible experience. The patient care team includes nurse practitioners (NP), pharmacist, registered dietitian, registered nurse (RN) and a collaborating physician. It is our goal to serve the Froedtert Health staff and their family members by enhancing timely access to health care services while assuring continuity of care between our team and their primary care provider. Our team assesses each patient's needs and coordinates multidisciplinary care within the Froedtert Health Onsite Services. The driving force for creating this team was to provide excellent care access and coordination as a no-cost benefit to our target population. This

multidisciplinary team practice enhances the patient experience through the provision of timely coordinated health care.

Population Served

Onsite episodic medical care, dietary counseling, medication therapy management, and RN care management are offered to the Froedtert Health staff members, spouses and adult children on the Froedtert Health Medical Plan. The population served extends among four different clinic sites across Waukesha County, Milwaukee County, and Washington County.

Our population served includes insured patients' ages 18-70 years of age. This population ranges from clinical health care staff to environmental service staff. Through the provision of multidisciplinary services we demonstrate cost savings to the individual, their department, and the organization as a whole by improving employee health and decreasing loss of work time. This also has the potential to reduce the overall population health care costs - which demonstrates a cost-benefit to the organization.

Composition of the Team

The leaders of this patient care team are the nurse practitioner, pharmacist, dietician, and registered nurse. The nurse practitioners are board certified advanced practice providers treating acute/episodic health conditions as well as work injuries. The pharmacist is trained to provide patient education regarding medication management as well as to answer any questions or concerns about the patients' medications. Diabetes and nutrition counseling is provided by our certified diabetes educator. The registered nurse provides care coordination between the multidisciplinary team and is also a certified wellness coach.

The team fits within a large health care organization by providing these services at no charge to the staff and family members on the Froedtert Health medical plan. Currently, patients can do a self-referral or primary care providers (PCPs) are able to refer to this multidisciplinary team. For example, traditional clinic-based dietitian visits charged to the patient and medical plan cost approximately \$200 per visit. Employees can easily be referred for those visits within our onsite clinics for no charge. Additionally, if a patient has stitches or staples placed in the Emergency Department or Urgent Care, he/she can come to the onsite clinic to have these removed free of charge. Patients are able to schedule appointments with this multidisciplinary team during their breaks or before or after work to meet with each of these providers. The patients may also have their blood pressure monitored by the registered nurse and charted in their electronic medical record. Patient's primary physicians are able to review the patient results based on the care management registered nurse's documentation. The care management registered nurse also provides communication through in-basket messages to each patient's primary physician through EPIC.

The team has been together for approximately five years. Originally, the team started with the nurse practitioner provider and then grew to include a dietitian, pharmacist, and care management RN. This cohesive working team is able to refer to each other and at times have consecutive visits such as a visit with the nurse practitioner and pharmacist visit right after for convenience and to meet each patient's needs.

Outcome measures

The onsite nurse practitioners are evaluated with a patient survey that asks specific questions regarding the quality of care he or she received that visit. The satisfaction surveys consistently reveal 98-100 percent staff satisfaction among all four clinics for the past three years on a quarterly basis. Metric data reports are derived from EPIC to measure the number of unique patients on the medical plan using the

clinics, different services provided based on diagnosis and CPT codes, and utilization rates of the four clinics. Data are used to plan for additional services to address concerns and improve engagement/utilization of services. Additional measurements include the pharmacist measure of medication changes recommended for compliance, as well as keeping cost down through generic prescription recommendations to improve care or adherence. The dietician monitors weights and lab results based on the nutrition counseling he/she gave using current evidenced based guidelines. The care management RN monitors the blood pressures and weights in EPIC and graphs it for patient monitoring. The care management registered nurse charts smoking cessation progress to keep track of goals met.

Successes, Barriers and Future Plans

Our internal referral process has been a huge success in that we are able to collaborate with each other to provide appropriate expertise in dietary, health coaching, and medication management care. One objective is to have each member of our health plan touched by a care provider in our Wellness Works clinics. Ongoing work has focused on collaborating with primary care providers to enhance understanding of the value and services of onsite care clinics offered to our population. We continue to strive to be viewed as part of a continuum of care rather than competition. The medical model taught in our academic medical college continues to teach physicians about the roles advanced practice providers can play in a collaborative health care world. The key piece of our integrative model is patient centered care.

Future plans include offering school and camp physicals to employees, spouses, and dependents as well as routine immunizations such as tetanus and influenza vaccinations. Options for medications that may be administered in the onsite clinics include Depo Provera and B12 as long as patients are being monitored by their primary care provider or obstetrician.

The Nurse Practitioner Healthcare Clinic enhances access to care, supports continuity of care, and assists with the planning and management of each individual's health through internal and external resources. This clinic supports a population-based approach to care incorporating risk-stratification of individuals. The clinic provides low cost convenient care for routine needs of the low-risk population, and supports an integrated approach to care management for those with chronic conditions or rising-risk. Patients needing a higher level of care are referred to a primary care provider or specialist in the organization to provide the right care at the right time and place. The unique team-based care of the Nurse Practitioner Healthcare Clinic plays an essential role for Froedtert Health in achieving ongoing recognition as one of the region's "Healthiest Employers, a Gold Well Workplace."

Lakeview Pharmacy

Team Name: *Lakeview Pharmacy*

Team Leader: Lisa Boerner, PharmD

Contact Information: lisa@lakeviewpharmacy.com

Type of Presentation: Abstract Only

I am a solo team member and the Wisconsin Pharmacy Quality Collaborative (WPQC) champion at my independent pharmacy, Lakeview Pharmacy located in Racine. I work with patients, caregivers and prescribers to identify patient populations that would most benefit from face-to-face time with a pharmacist. I help the patients set goals during their one-on-one time with me during their private Medication Therapy Management (MTM) session.

Driving force

Patients have access to their pharmacists at least nine hours per day and six days per week. Pharmacists are accessible, knowledgeable and work with many health care providers.

Population

All socioeconomic classes: Medicaid, Medicare, and privately insured.

Composition of team

Pharmacists are not islands and need many hands toward succeeding to our goal.

Purpose/mission

To decrease adverse drug reactions, improve medication adherence, decrease polypharmacy, and increase accessibility to all health care providers.

Team fit within organization

Pharmacists are the initial point of contact for both patient and prescriber. Pharmacists are the "voice" for all socioeconomic classes, especially Medicaid patients.

Length of time

Pharmacy has been WPQC accredited and pharmacist certified since 2009.

Outcome measures

WPQH pharmacies are under a three-year grant from the Centers for Medicaid and Medicare Services for data collection concerning specific disease states.

Successes

I am averaging two patients per week for face-to-face MTM visits.

Barriers

Physician acceptance and timely response of pharmacist recommendations found during MTM visit with patient.

Future

Increase collaboration with area prescribers to identify patients within their practice for the pharmacist to assess for disease states markers, adherence, polypharmacy, and drug interaction reduction.

Marshfield Clinic

Team Name: *Team Care: Minocqua and Marshfield Internal Medicine Departments*

Team Leader: Eric Penniman, D.O.

Contact Information: 715-847-3227, penniman.eric@marshfieldclinic.org

Type of Presentation: Abstract Only

First, recruitment of primary care physicians is becoming increasingly more difficult. In addition, there are increased burdens of work placed onto primary care such as meaningful use and patient-centered medical home requirements, as well as new quality initiatives. This is slowing down primary care work flows. This means that fewer patients are seen in a day which results in worsened access to primary care. Delays in primary care typically equates to worsened outcomes and increase overall costs of care. Second, the overall job satisfaction for the providers and staff in primary care has continued to decline.

This is resulting in early retirements and retention difficulties. This will exacerbate the above problem as well. Promoting a “team care model” for primary care will hopefully help staff and providers function more at the “top of their licenses” which should improve their job satisfaction. Fourth, the cost of care per patient is too high. Population served includes all patients who access primary care, regardless of their ability to pay.

Composition includes a provider (MD or DO, or PA or NP) plus 2.5 FTE medical support/providers. (Lower complexity practices will have mostly MA’s versus a high complexity practice will have mostly RN’s.)

Provide high-quality and cost effective patient centered care. Each team will complete all of the requirements of the federal mandated programs as well as our clinic’s quality initiatives during each visit while increasing the overall panel size for each provider and improving access into primary care. Each pilot team exists within the internal medicine departments at both the Minocqua Center and the Marshfield Center. These teams are held up as futuristic pilot programs that will likely exemplify the future of primary care. The pilot teams began their implementation of new ideas and care delivery models in the spring of 2014. As the processes mature, it is our goal to combine the best practices of each site and redefine what we feel will be the ideal team and processes to manage a population of patients.

A myriad of measures are being used to determine effectiveness of the new models and distinguish where we’ve succeed. Specifically, we are evaluating the practices in five different areas – advanced access metrics, quality of care, patient satisfaction, financial performance, and provider / staff satisfaction.

It’s too early to draw any major conclusions regarding the new models; however, the providers, staff, and patients seemed to be pleased with the changes we’ve made thus far. This is a significant change for all parties affected.

There were two significant challenges thus far. Firstly, this was a huge leap of faith for the providers and staff into a completely new model, where they needed to leave behind many of their old habits and put their trust into something they had never seen before. Secondly, our EMR was not intended for this type of care delivery model, we continue to make incremental improvements, but are still limited in many areas.

Upon completion of the pilot, redefining the practice models, we look forward to spreading our NEW WAY of delivering primary care throughout our system.

Medical College of Wisconsin

Team Name: *Division of Surgical Oncology – Regional Therapies*

Team Leader: Deborah Schneider, APNP

Contact Information: 414-805-5863, dschneide@mcw.edu

Type of Presentation: Poster

The Regional Cancer Therapy program provides a multi-faceted approach to fighting advanced cancers, including a combination of cytoreductive surgery, chemotherapy, and hyperthermia. Treatment is provided to a specific area, or “region” of the body, minimizing the negative side effects for patients. The primary customers for the Regional Cancer Therapy program are those with peritoneal

malignancies. Regional therapies can be applied to patients with the following diagnoses: colorectal cancer, gastric cancer, appendiceal cancer, mesothelioma, and peritoneal cancer. The primary benefit of a coordinated Regional Cancer Therapy program is improved outcomes. When treated appropriately, patients with metastatic appendiceal tumors could live for 20 years or longer and patients with metastatic colon cancer could live for over 5 years with 20 percent reaching long term survival (as compared to one-year median survival with chemotherapy alone).

Currently patients in the program come from throughout the state, region and country. Froedtert and the Medical College of Wisconsin have one of the only programs of this type in the nation and it has rapidly grown since its inception in 2010 thanks to the driving efforts of Dr. Kiran Turaga.

Patients undergoing HIPEC surgery often have a high level of physical, emotional, and psychosocial needs. Our Advanced Practice Providers (APPs) have led the efforts in improving patient satisfaction. The supportive oncology team consists of dietitians, physical therapists, psycho-oncologists, quality of life, fertility preservation, journey coordinators, and oncology trained nurses. These team members function simultaneously with the nurse practitioners. Methods to develop this program include: patient education handbook, staff team meetings, communication, staff nursing and operating room staff education, development of inpatient team handbook, development of standardized order sets in EMR, use of standardized pre op and post op testing, outpatient RN phone triage, development of alternative communication modalities with patients, and development of Pre-hab program.

Over the last three fiscal years, the program has seen a 31 percent annual growth rate with 67 new patients seen in Fiscal Year (FY) 2013, and projected 88 patients in FY 2014. All patients (100 percent) have consultations with oncology nurse practitioners and dietitians. A triage program is used to direct patients for pre-hab (pre-surgery rehabilitation) and 100 percent of patients receive inpatient physical and occupational therapy consultations. Two patients (3 percent) have utilized fertility preservation techniques and 1 percent received psycho oncology consultation. AVATAR patient top level satisfaction score results for FY 2012 were 94 percent, 92 percent, and 97 percent in the last three quarters.

Quality measures such as patient satisfaction, readmissions, and infection rates are constantly being monitored.

The mission of the Regional Cancer Therapy program is to provide cutting edge, personalized, multi-disciplinary cancer care for patients with advanced peritoneal surface malignancies. Our actions embody our core values of compassion, integrity, respect and excellence. We strive to be international leaders in delivering services and innovating in the field of regional cancer therapies.

Medical College of Wisconsin

Team Name: *Enterocutaneous Fistula Nutrition Committee*

Team Leader: Colleen Trevino

Contact Information: 414-805-8649, colleen.trevina@froedtert.com

Type of Presentation: Abstract Only

The Fistula Nutrition Committee is an interprofessional group developed in 2012 between the Medical College of Wisconsin and Froedtert Hospital to create a comprehensive evidence-based nutrition protocol for patients with enteric fistulae in effort to optimize healing. This patient population has disease specific needs that were being poorly addressed due to lack of standard practice which made healing inconsistent. The team is comprised of a nurse practitioner and physician from the Division of

Trauma and Critical Care, and a pharmacist and dietician from the hospital. Historically, due to the separation of the provider practice group and hospital there has been a barrier of collaboration between college and hospital employees. Due to this collaboration, the implementation of the protocol has been used on other services to improve patient care. Since implementation, three fistula patients have been healed while in the hospital and were able to go home. As a continued quality improvement strategy, we will be reviewing every case as a team to identify any issues with the protocol to ensure identification of any gaps.

Medical College of Wisconsin

Team Name: *HIV and Integrated Mental Health Services*

Team Leader: Jeffrey Miller, DNP, APNP

Contact Information: 414-955-8958, jgmiller@mcw.edu

Type of Presentation: Panel #1

Depression has been reported to be one of the most commonly observed mental health disorders in persons with HIV/AIDS with the prevalence estimated to be 2-10 times greater in comparison to persons without the infection (Bing et al., 2001; Pence, 2009). Research findings also indicate that depressive disorders affect and weaken the immune system allowing HIV to progress more rapidly (Pence, Miller, Gaynes, & Eron, 2007); decrease medication and appointment adherence; increase risk behaviors (Catz, Kelly, Bogart, Benotsch, & McAullife, 2000); and that 30 percent of HIV infected individuals in need of mental health services do not receive it (Taylor, Burnam, Sherbourne, Andersen, & Cunningham, 2004). Thus, consensus from the literature indicates depression has a higher prevalence in HIV-infected individuals; depressive symptoms impact HIV progression and adherence to treatment programs; there is a lack of mental health treatment resources for persons infected with HIV; and mental health treatment has a positive impact on health status. Preliminary evidence also suggests that providing mental health treatment within an HIV clinic may improve health outcomes. This review of the literature lead to the creation of an evidence based model involving the integration of mental health services into the treatment team in an HIV clinic.

The driving forces behind the creation of the team included the need for increased accessibility for mental health services; the number of “no shows” for appointments made in the community for mental health services; and the increased need for mental health services for this population. Specifics are outlined in the abstract above.

The population served includes the HIV infected population with co-occurring mental health and AODA issues in an urban HIV clinic. The composition of the treatment team includes physicians, nurses, advanced practice nurse prescribers, pharmacists, case managers, retention in-care specialists, social workers, residents, fellows, psychiatric advanced practice nurse prescribers, and psychiatric therapist.

The purpose and mission of the team is to provide comprehensive integrated care for individuals infected with or affected by HIV disease.

The team fits within the overall mission of the organization by providing integrated care. In addition, other than community based case managers, all team members are employed by the health care system and care is provided within the physical space of the clinic setting.

The integration of mental health services within the health care team occurred four years ago. The outcome measures include anecdotal patient reports, visit and treatment adherence data, CD4 and viral load values, and QIDS scores.

Successes include case studies of patient who have dramatically improved their health status since the addition of mental health services within the clinic.

The barriers to the integration of mental health services within the team include funding and security of non-mental health providers within an electronic medical record.

Future plans include the expansion of mental health services within the clinic.

Medical College of Wisconsin

Team Name: *Pancreatic Cancer Care Team*

Team Leader: Shannon Lahiff, NP

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Type of Presentation: Poster

Pancreatic cancer is now the fourth leading cause of cancer-related deaths and approximately 45,220 people will be diagnosed in the United States this year. Our multidisciplinary care team approach was built out of the concept of improving outcomes for patients with pancreatic cancer. The MCW approach to new patients is streamlined. Most often within 72 hours, all needed testing is completed and a treatment plan is formulated. New patients are initially seen by the nurse practitioner. During this visit, pertinent past history, oncologic, and diagnostic work up is reviewed. Pancreas education and counseling are provided. This prepares patients for their visit with the surgeon the following day where clinical staging is completed and a tentative course of treatment is outlined. A pancreatic cancer diagnosis is highly complex and therefore a multidisciplinary approach is ideal. Our care team is based in surgery and includes: nutrition, diabetes, gastroenterology, diagnostic radiology, pathology, interventional radiology, medical, and radiation oncology. These specialties come together at our weekly case conference to provide patients a comprehensive plan of care. Building on the relationship of the initial visit, the NP is a consistent team member and is key to the success of patients' care. Our team has been in existence for almost six years.

Instrumental to our development was the addition of Dr. Douglas Evans to MCW from M.D. Anderson in Houston, Texas. Changing the paradigm for pancreatic cancer treatment by using a neoadjuvant approach is one way we are positively impacting the prognosis of this disease. Using a clinical trial based on personalized medicine, individualized regimens of chemotherapy and radiation are given prior to surgical resection. One of the most significant barriers is the delayed diagnosis of pancreas cancer which is due to the vague nature of presenting symptoms. Our future plans have included the development of our high risk pancreatic cancer screening clinic. Patients with a strong family history of pancreas cancer, as well as genetic syndromes with a predisposition for pancreas cancer are targeted. Early diagnosis and identifying pre-malignant tumors is one of our main goals for this clinic. Thus our pancreatic cancer care team now includes a genetics counselor. We take pride in our care team approach, but most importantly, we recognize that the ultimate team member is our patient.

Ministry Health Care

Team Name: *Advanced Practice Registered Nurse in Rural Critical Care Access Hospitals*

Team Leader: Laura Magstadt

Contact Information: 715-479-0248, laura.magstadt@ministryhealth.org

Type of Presentation: Panel #1

Ministry Health Care operates primary and specialty care medical group practices, home care and related services and seventeen hospitals in central, northern, and eastern Wisconsin, including six critical access hospitals (CAH). CAHs are dependent upon a small cadre of primary care physicians to provide inpatient services. The risk of physician retirement, resignation, or illness leads to chronic uncertainty and risk for CAH physician staffing. Ministry Health Care's success in recruiting and retaining physicians in CAH communities has been challenging and is likely to grow more difficult. In 2012, only seven percent of graduating Wisconsin medical students identified primary care as a career tract. Only four percent of physicians graduating from residency programs have shown a preference for communities with populations of less than 50,000.

Additionally, work life balance is increasingly important to new graduates; medicine is what they do, not who they are – a fundamental redefinition of professional identity. Therefore, it is wishful thinking for us to believe that we can overcome these market trends by “recruiting harder.” If we are to continue offering inpatient services at CAH's, Ministry Health Care identified that we must develop alternate care models which are less dependent upon rural family practitioners. Operational and medical staff leaders from Ministry Eagle River Memorial Hospital (MERMH) and Ministry Medical Group (MMG) worked collaboratively to develop an innovative new model for inpatient care using Advanced Practice Nurse Practitioners (APNP) in a redefined way and incorporated telemedicine to support their practice.

A comprehensive program was created including the development of inpatient curriculum and training, ongoing clinical and educational support, as well as the process through which telemedicine supports daily inpatient management. This work occurred between 2011 and 2013, with initiation of the program as our patient care model in May 2013. To implement the program as envisioned, MERMH requested and was granted a three-year pilot waiver to Section DHS 124.04(2) (g) of the Wisconsin Administrative Code which states that “a person may be admitted to a hospital only on the recommendation of a physician, dentist or podiatrist, with a physician designated to be responsible for the medical aspects of care.” This variance allows our specially trained APNPs to admit patients and be responsible for the provision of medical care, thus fulfilling the role of attending provider.

Through the integration of telemedicine, advanced practice nurse prescribers (APNPs) now provide on-site CAH hospitalist inpatient services supported through the remote connection to MMG physician hospitalists thirty miles away. The APNP's work in a very interdisciplinary manner with the entire patient care team, including nursing, therapists, case management, social work, and the patient and family themselves. Daily interdisciplinary rounds are a venue for creation of person-centered goals and our commitment to patient and family involvement has led to frequent patient and family care conferences. Through telemedicine, the APNP's and our patients have access to consultation from physician hospitalists as well as a number of other specialties including infectious disease, surgery/wound care, and many others without having to travel.

Since its inception, this model of care has been widely accepted by MERMH patients who appreciate being able to remain in their home community while hospitalized. Inpatient core measure and patient experience metrics have improved since the program began and MERMH has achieved greater than 95

percent compliance with all core measure composites and greater than the 75th percentile for all eight HCAPHS composites, including six composites greater than the 90th percentile.

Monroe Clinic

Team Name: *Palliative Care*

Team Leader: Sue Monson, RN, BSN and Dr. Gains Richardson

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Type of Presentation: Panel #1

The driving force behind creation of the Palliative Care Team at the Monroe Clinic was to integrate palliative care at the end-of-life and to provide a standard of care integrating high quality, family-centered, compassionate care, guided by a sense of respect, empathy, and concern that addresses the unique needs of each patient and their family.

The population served consists of patients from Southern Wisconsin and Northern Illinois areas, ages 18 and older, with life limiting illnesses.

Monroe Clinic's palliative care team is led by a fellowship trained physician with board certification in palliative medicine and features a complementary team of medical experts including a nurse specialist, social worker, and chaplain.

The mission of the Palliative Care Service at the Monroe Clinic is to promote the dignity and quality of life of patients and families experiencing life-limiting illnesses, by controlling pain, managing their symptoms, and providing a setting for informed decision-making.

Palliative care fits within the organization by serving both patients receiving curative treatment (care focused on overcoming disease and promoting recovery) and the terminally ill. Palliative Care has become an integral part of the medical structure of the Monroe Clinic. The office is physically located in the outpatient clinic next to oncology, but clinical services are also provided on inpatient hospital units, local group homes, and nursing homes. The administrative oversight of Palliative Care has linked key departments that support each other in their respective goals. These departments include Oncology, Home Care, Hospice, Spiritual Care, and Social Services.

Monroe Clinic Palliative Care team was established in 2008.

Palliative Care utilizes a variety of outcome measures. These include measurement of number of inpatient deaths with Palliative Care's involvement and patient satisfaction. Patient satisfaction surveys provide opportunities for patients and families to offer feedback on how well the team addresses pain, spiritual and emotional needs, and how the team has assisted the patient and family to understand their condition and treatment options.

The Palliative Care team has experienced multiple successes. They have documented consistent growth of hospital and clinic encounters. Palliative Care offers a nationally recognized end-of-life education program twice a year to staff of Monroe Clinic and local nursing homes. Through this staff education and modeling quality end-of-life care, the team has positively influenced the culture of the organization, enhancing the care of this vulnerable patient population.

The team has experienced barriers to the growth of the Palliative Care services. These include a lack of understanding of the differences between Palliative Care and Hospice. The current size of our department precludes availability of 24/7 coverage with one provider. Current reimbursement systems do not recognize the time-intensive nature of this service and therefore it is not independently financially viable, although it benefits and supports multiple other departments of our organization.

Plans for future growth of Palliative Care Services include the addition of a mid-level provider to expand hours and coverage.

Pharmacy Society of Wisconsin

Team Name: *Wisconsin Pharmacy Quality Collaborative: A Team Based Approach to Optimizing Medication Therapy Outcomes*

Team Leader: Kari Trapskin, PharmD

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Type of Presentation: Poster

The Wisconsin Pharmacy Quality Collaborative (WPQC) is an initiative of the Pharmacy Society of Wisconsin (PSW) which connects community pharmacists with patients, physicians, and health plans to improve the quality and reduce the cost of medication use across Wisconsin. In 2012, PSW received a \$4.1 million Health Care Innovation Award (HCIA) from the Centers for Medicare and Medicaid Services to expand WPQC statewide. The aims of the WPQC HCIA are to help reduce health care costs in the state of Wisconsin by over \$20 million and improve health and health outcomes during the three-year project period. Methods include implementing a redesign of community pharmacy practices and facilitating medication management services, which include Intervention-Based Services and Comprehensive Medication Review and Assessment visits for eligible commercial and Wisconsin Medicaid members. The goals of WPQC are to: (1) improve medication use among participating patients; (2) improve patient safety; (3) reduce health care costs for participating patients and payers; and (4) establish partnerships between pharmacists and physicians to enhance health outcomes.

WPQC metrics are designed to evaluate both health care utilization and clinical outcomes subsequent to pharmacist intervention. Additionally, medication use measures will determine whether pharmacists are impacting care by improving medication adherence and coordinating with physicians to optimize medication regimens based on clinical guidelines. For example, WPQC hopes to reduce asthma exacerbation rates during the grant period. Pharmacists will meet with high risk patients who have asthma to ensure they are not excessively using rescue medications, are adherent to prescribed controller therapies, and know how to properly use their medication devices. This interaction may not only lead to a reduction in emergency department visits, but also may lead to an improvement in medication adherence rates and overall care of the patient.

WPQC depends upon the development of relationships within the health care team to encourage referrals for WPQC services and to enhance health outcomes for high risk patients. Pharmacists are eager to partner and collaborate with physicians and other health professionals across the state to complement the quality of care their patients receive and assist with the management of difficult medication-related cases. All pharmacist-initiated interventions, except medication device instruction and adherence consultation, involve contacting the patient's physician or other health care provider for authorization if a change in the prescription regimen is recommended. Pharmacists cannot make any changes without the approval of the patient's physician or other health care provider. Upon approval from a physician or other health care provider, the pharmacist will coordinate the approved changes.

Physicians may refer patients covered by participating health plans for comprehensive medication review and assessment services even if the patient does not meet the standard WPQC comprehensive medication review eligibility criteria.

Results of the program to date include: participation by 50 percent of Wisconsin community pharmacies in the WPQC program and 70-80 percent of pharmacist recommendations being accepted by prescribers. The majority of services communicated to prescribers have been related to focused-adherence and cost-effectiveness opportunities, and patient satisfaction for comprehensive medication review and assessment services is on average greater than four on a five-point scale. WPQC's main barrier is patient recruitment. To address this barrier, WPQC has begun coordinated outreach with physicians and other health care prescribers in specific areas of Wisconsin to educate and encourage referrals of high risk patients to WPQC pharmacies. Materials specific to physician outreach and detailing of the WPQC program have been reviewed by members of the Wisconsin Academy of Family Physicians and the Wisconsin Medical Society. Relationships are beginning to emerge across the state, which will help in the development of efficient referral workflows and team-based care champions.

Future plans include continued expansion throughout the state, health system partnerships and a focus on transitions of care.

Reedsburg Area Medical Center

Team Name: *Shared Governance Council*

Team Leader: Dena Jarog

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Type of Presentation: Poster

The Shared Governance Council was created as a way to move the multidisciplinary care team to make decisions regarding process change for patient care across the continuum. This Council serves all patient populations of the organization including clinic, outpatient, and inpatient. The team is comprised of all disciplines within the hospital including, nursing (all departments), dietary services, respiratory services, business office, environmental services, registration, lab, medical imaging, clinic services, clinical IT (ad hoc), and pharmacy. Services that are not consistently impacted are included on an ad hoc basis such as maintenance and medical records.

The purpose and mission of this team is to go beyond the expected to improve communication among the different disciplines of the hospital and clinic in order to improve patient care processes, professional development of the staff, and quality of care for all patient populations through collaborative process enhancement. Due to the diversity of the team membership, which was elected by the peers of those departments with representation, the Council is able to attend to care process issues throughout the organization. Education regarding shared governance began in December 2013. This led to application for positions and voting for representation in January 2014. The first meetings started in February 2014. At this time, a chair and co-chair were chosen and a charter was developed. In the four months they have been meeting, they have identified large and small projects and have started to work on process improvement for those areas in need.

Outcome measures are being identified at the next meeting of the teams for the projects they have identified as top priorities. One example is to improve the pre-code blue response and documentation. An outcome of this team will be to improve the electronic documentation for code blue situations. A second outcome for this team will be to develop criteria for calling a "rapid response/pre-code blue."

They will develop protocols for nursing to work from prior to the doctor arriving to assess the patient. The final outcome measurement will be the reduction of code blue calls on the general medical/surgical floor and the intensive care unit.

The first team success was to get the entire organization educated and understanding what shared governance entails. The next success was to identify participants who were actively enthusiastic in participating on this team. Given the non-traditional structure of this team, it was a success to have so many people interested in participating on this team. There were 30 applications for positions on the team. Reedsburg Area Medical Center is a 25-bed critical access hospital with a small pool of employees.

At this time, the barriers have been few but the major potential barrier will be freeing up the time necessary for this team to continue to work and improve care for patients. Given the small size of our organization and the pool of staff available to work, there is a fine balance to providing the time each month (one eight-hour day) for the meeting and the work to occur. Given that this is a new team, another potential barrier will be that as the team moves through group development they could get stuck in the early stages of development. It will be important to help them move through the transitions of group development to become effective participants on their team.

The future of this team will be that they continue to improve processes using LEAN tools and concepts, identify issues that impact patient care through the continuum of the system, and help the organization run more effectively and efficiently.

Rusk County Memorial Hospital

Team Name: *Fall Prevention Team*

Team Leader: Amanda Shimko

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Type of Presentation: Poster

Our Fall Prevention Team was created to decrease falls in our hospital. We had 17 falls in our inpatient unit for the year of 2013 and we wanted to decrease that number by 50 percent by December 2014.

Driving forces for our team were to decrease falls, increase patient safety and satisfaction, and prevent harm.

We care for an elderly population who are admitted to several different patient statuses for their stay such as: swing-bed, acute care inpatient, same-day surgery, and observation.

Our team is made up of the chief patient care officer, the medical/surgical coordinator, and frontline nursing staff. This team is integral in risk identification, including creating awareness of, and implementation of, interventions aimed at improving falls. The coordinator helps to facilitate the new interventions and disseminating that information to all nursing staff while the frontline staff implements the new changes.

Our purpose and our mission is to work as a team to decrease falls and increase responsiveness for improved safety and quality of care for our patients.

Our Fall Prevention Team works together with the Patient Care Council and the Multidisciplinary Fall Team and is focused on a hospital-wide initiative and is making great strides to decrease our fall rate. Our fall prevention efforts were given a higher level of focus in January 2014 in which we created a fall team.

As was stated earlier, the outcome that we wanted to achieve was to decrease our fall rate by 50 percent by December, 2014. We wanted to implement an evidence-based fall risk model to have a reliable tool to assess patients for risk of falls. We have created a “fall board” to make our days without a fall transparent to the facility and public. This has been the biggest factor in our reduction of falls by creating awareness. The team selected the Hendrich II Fall Risk Model because of its brevity, the inclusion of risky medication categories, and its focus on interventions for specific areas of risk rather than on a single, summed general risk score (Hendrich, 2013). It is designed to be administered in an acute care setting and focuses on eight independent risk factors (Wolters Kluwer, 2007). A fall team goal of thirty and 100 days without a fall was set to have something to work towards. In reward for meeting these goals, we decided to celebrate with cupcakes at thirty days and a hospital wide pizza party at 100 days. Lastly, an outcome the coordinator was hoping to achieve was to get frontline staff engaged with this initiative.

We as a group have celebrated the thirty day goal, 100 day goal, and are excited to be recognized in the Wisconsin Hospital Association “Valued Voice” for our fall prevention efforts. The staff is feeling more ownership of this project and has stated it is important to celebrate the goals achieved.

Two barriers that existed prior to our project were the lack of information communicated back to the staff regarding fall incidents and inexperience with process improvement plans.

In the near future, we will be implementing the “Clarity SafetyZone Portal” where incidents will be reported and disseminated to the appropriate personnel who then can do a process review and feedback can be given in real time. We hope to have sustainable result with our fall prevention efforts and continue to look at process improvement to deliver high quality care to our patients (Hendrich, 2013).

- References: Hendrich, A. P. (2013). *Fall Risk Assessment for Older Adults: The Hendrich II Fall Risk Model*. The Hartford Institute for Geriatric Nursing, New York University, College of Nursing. Wolters Kluwer (2007). *Predicting Patient Falls*. American Journal of Nursing, 50-58.

Sauk Prairie Health Care

Team Name: *Surgical Diabetes Management*

Team Leader: JoEllen Frawley, APNP

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Type of Presentation: Poster

Driving Forces and Population Served

Patients were arriving for surgery/procedures with uncontrolled blood glucose, both hypo and hyperglycemia, resulting in the need to cancel surgery. Primary care providers and surgeons were giving patients perioperative diabetes medication management instructions that were not evidence-based. Inconsistent perioperative diabetes management was identified. The need for evidence-based guidelines on diabetes medication management in the perioperative setting was recognized.

Team Composition, Fit in the Organization, and Time of Existence

Working in collaboration with our Joint Health Center leadership team, primary care providers, surgeons, pharmacists, anesthesiologists, preoperative nursing staff, and diabetes management, a tool for consistent perioperative diabetes management was developed. This multidisciplinary team is involved in the perioperative care within the organization and in the primary care arena. The team formed in 2009 and remains in existence today.

Purpose and Mission

Utilizing evidence-based guidelines for perioperative diabetes management from the American Association of Clinical Endocrinologists and American Diabetes Association, guidelines were developed to provide consistent diabetes management in the perioperative setting. We began checking fasting preoperative blood glucose on all surgical inpatients (including non-diabetic patients). Extensive provider and perioperative staff education was completed including carbohydrate counting; basal/bolus insulin therapy; IV insulin drip protocol; guidelines for patients with continuous insulin pumps; and patient education on diabetes self-management after discharge. Throughout the entire hospital stay, the "Perioperative Pre-Admission Diabetes Management Guidelines" were followed. All team members clearly understood their roles.

Outcomes and Successes

Patient outcomes demonstrated improved glycemic control with decreased incidence of hypoglycemia and hyperglycemia. The ability to utilize evidence based practice has allowed us to guide our patients with diabetes safely through the perioperative process. From January 1, 2009 to December 31, 2010, we saw a 56 percent improvement in fasting pre-op blood glucose reaching the target range recommended by AACE and ADA. In January 2009, glucoses ranged from 50mg/dL to 317mg/dL and in December 2010 the range was 114mg/dL to 240mg/dL. Cost savings were recognized in fewer cancelled surgeries and less burden on our patients and caregivers who had taken time off for surgery. Additionally, by checking blood glucose on all surgical inpatients (including non-diabetic patients), patients with unknown elevated fasting glucoses were identified. This program was presented as best practice with a poster at the American Society of Perianesthesia Nurses (ASPAN) national conference in Seattle, 2011 and was the first place poster at the First International Perianesthesia conference in Toronto, Canada, 2011.

Barriers

Barriers to implementation included time, physician inertia, need for staff and provider education, contradicting articles on preoperative management, and the reluctance to change.

Future Plans

Our providers and perioperative nursing staff continue to have yearly ongoing evidence-based education on perioperative diabetes management. The guidelines are updated annually to include new diabetes medications. Implementation of a standardized referral process in our electronic health record is needed. Our quality department continues to monitor outcomes and the program is in the process of being expanded to General Surgery preoperative patients.

Sixteenth Street Community Health Center

Team Name: *Primary Care Services for Hispanic Populations*

Team Leader: Karen Lupa, CNM, RN

Contact Information: 414-672-1353, Karen.lupa@sschc.org

Type of Presentation: Panel #3

Driving forces behind creation of the team

Multiple disciplines were needed to serve the needs of our patients.

Population served

In 2013, Sixteenth Street Community Health Center (SSCHC) served more than 33,000 people through more than 156,000 individual visits. Our patient and client population is very diverse, representing many cultures, ethnicities, and economic backgrounds. We serve people in communities with high needs who face challenges in accessing health care. The client population is 85 percent Hispanic; nine percent White; four percent African-American; and two percent Southeast Asian/Middle Eastern and other. Fifty-seven percent of people receiving medical care are women and girls and 41 percent are children under the age of 12. Sixty-six percent of people served reported incomes below 100 percent of the federal income poverty level. In 2013, the federal poverty level, for a family of four, was \$23,550.

Composition of the team

Team is composed of physicians, nurses, physician assistants, behavioral health providers, case managers, outreach workers, and community health workers.

Purpose and mission of the team

The mission is to improve the health and well-being of Milwaukee and surrounding communities, by providing quality, patient-centered, family-based health care, health education, and social services that are free from linguistic, cultural and economic barriers. Our goal is to keep people healthy and our role is to be the best stewards possible of our resources to help our patients thrive as people and contribute to society.

How team fits within the organization

Healthcare providers for SSCHC

Length of time team has been in existence

Sixteenth Street Community Health Center was founded in 1969, using a nursing model-of-care providing easy access for people in a community setting and assembling a team that could coordinate care and assemble the services of health care professionals from multiple disciplines to meet the needs of the patients.

Outcomes and/or outcome measures

Quality matters to us and our patients. We are a certified Patient Centered Medical Home, and we were the first community health center in the state certified by The Joint Commission. We are also a member of the Wisconsin Collaborative for Healthcare Quality.

- Seventy percent of our Diabetes patients have HgbA1c levels less than or equal to nine percent indicating that their diabetes is being well controlled.
- We facilitated the birth of 700 babies in the last year. Only 13 percent of the deliveries were done by Cesarean, a rate that is 20 percent less than the national average. An astoundingly low six percent babies were delivered with a low birth rate.

- The HIV program provided care and treatment for 187 People Living With HIV/AIDS (PLWHA) in the last year. In that same year over 70 percent of our HIV patients had undetectable viral loads.

Successes

See outcomes above.

Barriers

At capacity with medical providers.

Future plans

A new site, on the south side of Milwaukee, is proposed for 2015.

ThedaCare Physicians, New London

Team Name: *New London's Lineup*

Team Leader: Tina Bettin, DNP

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Type of Presentation: Panel #3

ThedaCare Physicians New London has participated in team based care since its inception over 15 years ago. ThedaCare Physicians New London is a primary care office in central northeast Wisconsin, which serves a rural population including a portion of the service area in a Federally Designated Health Manpower Shortage Area (HMSAs).

ThedaCare Physicians is based in the Fox Cities and this clinic was a satellite office that was started with two providers. Initially, the driving force for ThedaCare Physicians to open the clinic was to get market share and the local independent hospital was going to align with one of the two health care systems which serviced the community. The clinic has grown to a business group of three clinics (one main office and two rural offices), a critical access hospital, and 16 providers (eight physicians, five nurse practitioners and three physicians' assistants).

When the clinic was initially opened, the two providers were a physician and a nurse practitioner. The clinic was supported by senior leadership of the health care system. The community hospital, which was independent, but then aligned with ThedaCare Physicians, was supportive as they saw it as additional health care providers. The physician was near the end of his career and the nurse practitioner was early in his career. The workload, including call, was split evenly between the two.

The goal was to provide quality care and access for patients. This set the tone for all future providers who would join the practice. The biggest road blocks for a non-physician have been federal and state regulations. These roadblocks include: co-signatures on hospital admissions, orders for home health and hospice, ordering DNR bracelets, to mention a few.

Over the years, recruitment has been problematic at times. The physician side of recruitment, it has been difficult at times to find a provider to fit the needs (obstetrics, call, and full-time). On the nurse practitioner/physician assistant side of recruitment, it has been difficult, at times, to recruit for providers willing to do primary care and acute care with hospital call. Another difficult obstacle was finding reimbursement models for the nurse practitioner/physician assistant providers.

The ThedaCare Physicians team of providers' goal is to care and provide high quality and affordable health care to the patients we serve. Each health care provider can be the primary care provider of record. Essentially all of the providers take call.

ThedaCare Corporate determines the quality measures which are the same as WQHC and ACO pioneer measures, as the ThedaCare Bellin Partnership is one of the ACO Pioneer organizations. Quality data, patient satisfaction, and financial data are transparent and shared with each provider monthly.

Success per organizational standards is based on the three previous data measures. ThedaCare Physicians New London is repeatedly one of the best clinics for quality in the ThedaCare system over the past 10 years and ThedaCare System has some of the highest quality data for the State of Wisconsin. Patient satisfaction scores are high and the practice continues to grow despite stagnate local population. Financially, the clinic operates at break even, but the local hospital makes money.

Our team is successful because our focus is the patient and the best care for the patient. The team is also successful as all providers work to the full extent of their licensure which is allowed today by law. Each team member uses each of the other team members' strengths to strengthen our team to provide the best care locally to the patients we service.

University of Wisconsin-Madison, School of Pharmacy

Team Name: *Community Pharmacists and Physicians*

Team Leader: Michelle Chui

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Type of Presentation: Abstract Only

In an effort to improve coordination of health care and cost effectiveness of care for all Americans, the Affordable Care Act (ACA) was enacted in 2010.¹ This was primarily motivated by the widespread agreement of the need for fundamental reform of both health care delivery and payment systems.¹ As part of the ACA, health care providers were encouraged to focus on building accountable care organizations (ACOs). The primary function of ACOs is to coordinate care among providers and ensure that patients receive high-quality and efficient services.

Embedded in the idea of ACOs is the need for increased collaboration between health care providers from different health care settings,² such as hospitals, primary care clinics, and community pharmacies. Most patients receive medical care from multiple health care providers and pharmacies that may not be part of the same health care organization³ and often can complicate the ability of health professionals to access patient information, as it can be located in many places. Therefore, a challenge facing policy makers is ensuring implementation of ACOs across settings and communities.⁴ Physicians and pharmacists practicing in different settings need to be able to communicate and collaborate effectively and efficiently to ensure that patients receive high-quality, patient-centered care. Because physicians and community pharmacists do not interact face-to-face regularly, both professions may have incorrect perceptions or may generalize expectations from prior encounters.

A team composed of a UW researcher (Michelle Chui), the Pharmacy Society of Wisconsin (Kari Trapskin), and the Medical Society of Wisconsin (Susan Weigmann) was formed and conceptualized a project that would elicit and describe mutually agreed upon problems and associated solutions resulting from a facilitated face-to-face meeting between community pharmacists and physicians. This is the first study to describe an effective process by which physicians and pharmacists—working in separate

settings and not sharing the same computer system—can develop and sustain collaborative relationships. Face-to-face semi-structured interviews with pharmacists and physicians from the same community were used to build trust, dispel assumptions, and stimulate conversations about efficient, quality collaborative patient care. Ideas generated in which collaboration could improve patient care, including controlled substance monitoring, medication adherence, collaborative practice agreements for point-of-service issues, and a mechanism for urgent communication.

In conclusion, bringing physicians and pharmacists together for a face-to-face interaction successfully stimulated conversation on ways in which each profession could help the other provide optimal patient care. This interaction appeared to dispel assumptions and build trust. The results of this project may provide physicians and pharmacists with the confidence to reach out to their colleagues for collaborative initiatives.

University of Wisconsin Hospital and Clinics

Team Name: *Pharmacy*

Team Leader: Rohan Pradhan

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Type of Presentation: Poster

The University of Wisconsin Hospital and Clinics is a 592-bed facility which treats a myriad of patient populations from neonates to geriatrics and is nationally recognized in several specialties. In fiscal year 2013, the hospital had 28,120 inpatient admissions. Ensuring the fidelity of the medication list, the appropriateness of drug therapy, and facilitating the transition of care at discharge for these patients is a key priority for the UW Hospital and Clinics, and is supported by a team-based approach in the pharmacy department.

For planned admissions, specially trained pharmacy technicians contact the patient prior to their admission to complete their medication history, which is then verified by an inpatient pharmacist. For all admitted patients, medication reconciliation is completed within 24 hours of arrival barring any extenuating circumstances. This effort is completed by leveraging pharmacy interns, students, and residents to support the activities of our inpatient pharmacists. Once admitted, medication access specialists verify prescription drug coverage for patients in order to proactively identify any insurance issues which may impact care. They also facilitate prior authorizations and medication assistance program enrollment as those needs are identified during the patients stay. Inpatient pharmacists participate on interdisciplinary rounds and monitor every patient daily to ensure that ongoing medication therapy is appropriate and cost-effective. At discharge, pharmacists complete medication reconciliation to finalize the discharge medication plan. If enrolled on a participating unit, the patients discharge medications are delivered to the bedside by a medication access specialist. The pharmacists, pharmacy student, intern or resident provides medication counseling for patients and/or their caregivers.

We are currently piloting a process where, upon completion of counseling, the pharmacist documents a hospital care summary, any medication-related assessments, and various discharge prescription coordination activities into a note for communication to community pharmacies. A pharmacist discharge hand-off summary report including the hand-off note, updated medication list, recent vitals and labs, contact number for questions, scheduled outpatient follow-up, and other pertinent health information is then faxed to the patient's primary pharmacy to improve transparency of medication changes during the transitions of care process.

This approach to managing medication therapy across the acute care stay has evolved over many years beginning in 1964 with decentralized pharmacists staffing in patient care areas. Various measures are tracked across this care spectrum including inpatient drug cost, medication reconciliation audits, medication error reporting rates, HCAHPS scores, various processes of care quality metrics, and readmissions among others. These are used to identify opportunities to improve quality of care through process improvement.

Ongoing challenges to the team include rising drug costs and decreased reimbursement necessitating the provision of better quality care with less resources.

Future plans include further evaluation of how to best connect with community pharmacy providers and improve integration with ambulatory care pharmacists to better manage our patient population.

University of Wisconsin Hospital and Clinics

Team Name: *Acute Care for Elders – ACE Team*

Team Leader: Colleen M. Foley, MS, CMSRN, ACNS-BC, APNP

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Type of Presentation: Panel #2, Poster

Driving forces behind creation of the team

Recognition of an aging population of patients along with meeting the special health care needs of the geriatric patients. An interdisciplinary team led by an Advanced Practice Nurse was established to (a) provide consultative services house wide for geriatric patients, and (b) educate interdisciplinary staff on evidence-based practices and guidelines as it relates to the geriatric patient.

Population Served

Hospitalized patients age 65 and older

Composition of the team

The team includes five different disciplines including medicine, nursing, physical therapy, pharmacy, and social work. Each member is specially trained in the care of geriatrics and has a vested interest in the team. The Advanced Practice Nurse (APN) leads the team and has both an administrative and clinical role. The APN is responsible for organizing, training, marketing, managing and leading the team. The APN also serves as an educator for nursing and medical staff to teach appropriate management of geriatric syndromes. The geriatrician assesses the current level of function and cognition to help provide a trajectory of change and provide diagnosis that may be contributing to the geriatric syndromes. The physical therapist role includes early mobilization, appropriate gait device, and teaching nursing staff how to safely mobilize frail and confused patients. The social worker assesses previous living situation and whether or not needs are being met to help formulate a safe discharge plan. The social worker also helps the patient safely transition between hospital and discharge locations by effectively closing the loop with family and involving the patient with other community resources. The pharmacist reviews previous medications, current medications and help formulate recommendations to decrease the burden of polypharmacy. Our team is also currently developing a role for a health psychologist. The health psychologist evaluates for depression and completes interventions such as improving coping mechanisms and cognitive behavioral therapy.

Purpose and mission of the team

To offer hospitalized patients 65 years of age and older a proactive and comprehensive interdisciplinary team geriatric evaluation directed toward preserving function and independence as well as preventing the hazards of hospitalization.

How team fits within the organization

Acute Care for Elders (ACE) is an interdisciplinary consult service. A consult may be initiated by any interdisciplinary staff but the order must be generated by a physician or APN. The primary team provides a "reason for consult." Common reasons for consult include common geriatric syndromes, delirium being the most popular. We provide recommendations for the primary team and staff to help optimize care for the geriatric patient. Our team is unique in that we do provide an interdisciplinary approach and our recommendations are helpful for the physicians, nursing staff, pharmacy, therapy and supportive for the patient.

Length of time team has been in existence

2006 to present

Outcomes and/or outcome measures

- Cost savings: \$3,039 total hospital cost reduction of geriatric patients seen by ACE compared to matched controls.
- Improved provider satisfaction: University of Wisconsin Hospital staff perception of ACE teams helpfulness in patient care.
- Patient/family satisfaction: ACE contributes to improved patient satisfaction with ACE team involvement.
- Improved collaboration with community resources.
- Increased interdisciplinary staff awareness of the impact on medications on falls, cognition, sleep and appetite for the geriatric patient.

Successes

Our successes include a system-wide awareness of the special physical, psychological, and psychosocial needs of the geriatric patients. The team has been instrumental in the dissemination of evidence-based practices regarding the care of the geriatric population.

Barriers

- Lack of awareness of geriatric nursing and medicine as a specific area of specialty practice.
- Ageism
- Staffing

Future plans

- Assess the impact of health literacy among hospitalized older adults and their health care outcomes.
- We will continue to expand the ACE service. In the future, we hope to work closely with cardiac surgery to implement a pre-operative geriatric assessment to determine risk factors and interventions to prevent potential post-operative complications such as functional decline and delirium

University of Wisconsin Hospital and Clinics

Team Name: *Trauma Life Support Sedation Task Force*

Team Leader: Jeffrey Wells, MD / Jeff Fish, RPh

Contact Information: 608-263-1290, jfish@uwhealth.org

Type of Presentation: Abstract Only

Many patients in the intensive care unit (ICU) experience pain, anxiety and/or delirium. Both under and over-treatment of pain and agitation can cause harmful patient consequences. Some examples may include increased length of stay and accidental tube dislodgement. There is significant research regarding the assessment and management of pain, anxiety, and delirium for mechanically ventilated patients in the ICU, including the Society of Critical Care Medicine's evidence based practice guideline, which was published in 2013. Many barriers exist when translating evidence into practice to sustain measurable change.

A multidisciplinary Pain, Agitation, and Delirium Task Force was created in December 2011 to implement evidence-based guideline recommendations within our 24-bed medical/surgical/trauma ICU. The task force met monthly and consisted of medical and surgical intensivists, ICU nurses, an ICU nurse specialist, a clinical pharmacist, a respiratory therapy supervisor, a clinical systems analyst, and a quality improvement analyst.

The overarching goal was to improve patient and health care outcomes by decreasing ventilator time and ICU and hospital length of stay.

The main practice changes were: goal-directed analgesic and sedation administration; daily sedation awakening trial; and coordination of sedation awakening with ventilator liberation. Electronic order sets and nurse-driven protocols were developed to support practice changes. The updated protocol and guideline were implemented in September 2012. After one year, outcomes were compared to the year prior to implementation (table).

Descriptor	Pre	Post	P value
Number of patients	1147	1270	
Ventilator days	3.98	3.42	0.0021
ICU length of stay (days)	4.79	4.34	0.048
Hospital length of stay (days)	13.96	12.97	0.045
Mortality	19%	19%	0.96
Self-extubations per ventilator days	1.7%	1.7%	
Pain and Sedative Drug Costs			
Average cost / month	\$13,600	\$14,600	
Total cost/year	\$163,270	\$175,000	
Total cost/patient	\$142	\$138	

Ventilator days, ICU length of stay, and hospital length of stay were all decreased without an increase in mortality or self-extubations. An estimated \$800,000 of hospital costs were saved during the first year of implementation by decreasing hospital length of stay. This also allowed our ICU to take care of 123 more intubated patients during the first year of implementation.

The main barrier to implementation was obtaining buy-in from all the health care professionals. Keeping patients more awake was a different attitude and it was felt it would involve more work and more self-extubations. To help alleviate these issues, multidisciplinary discussions were held describing current evidence and practice changes and allowing an opportunity to ask questions. Task force members were also on the unit during early implementation to help with patient care issues and answer questions. This allowed for an efficient transition to the new practice and an improvement in patient care.

Process and outcome data was shared with staff at routine intervals to reinforce practice changes. Based on the success in our ICU, we are implementing the guideline and protocol in the other adult ICUs within the hospital. Multidisciplinary involvement with significant investment in planning and execution was essential in developing sustained practice change.

Team Members: Dr. Jeffrey Wells, MD; Dr. William Ehlenbach, MD; Dr. Jonathan Ketzler, MD; Anna Krupp, CNS, RN; Lara Leroy, RN; Dr. Mark Lingenfelter, MD; Dr. Ann O'Rourke, MD; Nicole Pernot, Clinical Systems Analyst; Jennifer Hendricks, Quality Improvement Analyst; Jeffrey Fish, RPh; Paula Breihan, RT.

University of Wisconsin Hospital and Clinics

Team Name: *Oral Chemotherapy Task Force*

Team Leader: Mary Mably, RPh, BCOP

Contact Information: 608-263-1263, mmably@uwhealth.org

Type of Presentation: Abstract Only

Oral chemotherapy has transformed the treatment of cancer patients in the last decade. Oral chemotherapy provides convenience for the patient and his/her family, but also presents unique challenges in prescribing, dispensing, cost to the patient, clinical monitoring, adherence, and patient and family education. The American Society of Clinical Oncology (ASCO) along with the Oncology Nursing Society (ONS) published an update in 2013 of their standards and recommendations for the safe administration of chemotherapy with the addition of specific recommendations regarding oral chemotherapy.

The pharmacists, physicians, and nurses of University of Wisconsin Hospital and Clinics recognized that there was potential to improve the prescribing, dispensing, and administration of oral chemotherapy in our institution. For example, although oral chemotherapy was intended to be prescribed through the use of electronic prescribing using well-developed treatment plans with included safety measures, there was a compliance rate of less than 70 percent. We implemented an Oral Chemotherapy Task Force in the late spring of 2013 with representation from pharmacy, physicians, nursing, and healthcare informatics to improve the safety of oral chemotherapy and the care of our oncology patients. The team had representation from inpatient and outpatient caregivers.

The team first performed a cross walk gap analysis using the newly published ASCO/ONS guidelines to determine where our performance with oral chemotherapy could be improved. We divided the identified gaps into three categories which then became subcommittees of the task force: education, information technology/electronic prescribing, and workflow. The current PGY2 Oncology Pharmacy Resident's yearlong research project "Development and justification of a pharmacist-led oral chemotherapy management program" was also part of the overall work on oral chemotherapy.

We are in the process of finalizing recommendations and will then begin implementation of the recommendations. Our recommendations will include modifying electronic treatment plans for some forms of oral chemotherapy so that the safety parameters, labs, dosing, etc. are present, but allowing for more efficient ordering through the medication activity section of our electronic health record to increase compliance, efficiency, and safety. Another important recommendation is to have clinical oncology pharmacist prospective review of all oral chemotherapy medication prescriptions before they are filled at either our outpatient pharmacy or an outside pharmacy. Dose modification documentation, standardization of education to patients and family, and a patient call back clinical monitoring system are also included in our recommendations.

We were pleased and surprised by the breadth and depth of interest in this workgroup. Many more people wanted to be a member of the group than we had available space, and became a challenge of including as many people as possible while retaining efficiency. The limits of our electronic health record have also been somewhat of a barrier as we have considered options to improve our oral chemotherapy processes. Finally, justifying new positions or repurposing existing full-time equivalent that we feel are necessary has been a challenge.

Future work in implementation and refining of new or revised processes will continue for at least the next year. We plan to reach out via publishing and presentations to share our experience, successes, and challenges with others that care for cancer patients in the hope that their care may also be optimized.

University of Wisconsin School of Medicine and Public Health

Team Name: *Wisconsin Area Health Education Centers (AHEC) – Interprofessional Healthcare Case Competition*

Team Leader: Keri Robbins

Contact Information: krobbins@wisc.edu, also www.ahec.wisc.edu

Type of Presentation: Poster

In support of the mission of Wisconsin Area Health Care Centers (AHEC) to deliver interprofessional and community-based education opportunities for health professions students and providers, the Interprofessional Healthcare Case Competition provides a unique experience. College students form teams and review a patient case, then develop recommendations and present their analysis to a panel of judges. Faculty and other health professionals serve as team advisors and competition judges.

AHEC leverages the strengths of our statewide networks and distinctive programming niche, yet faces the ongoing challenge of recruiting participants to make time for interprofessional experiences delivered in an extracurricular/non-degree-credit model. During the competition event day, a concurrent "Interprofessional Village" enables student participants to explore issues through dialogue with an array of health care providers by traveling among stations within the village.

This poster presents outcomes from the 2014 case competition (eight teams of students competed; nine health professions represented in the Interprofessional Village) and plans in progress for the 2015 competition (21 teams enrolled). Wisconsin AHEC is again coordinating the statewide competition, and welcomes participation from health professionals and organizations.

UW Health

Team Name: *UW Health, Controlled Substance Review Committee (UWH CRC)*

Team Leader: Carrie Boeckelman

Contact Information: 608-263-4895, cboeckelman@uwhealth.org

Type of Presentation: Abstract Only

The multidisciplinary UW Health Controlled-Substance Review Committee (UWH CRC) was created in response to the increasing prevalence of prescription drug abuse and the need for a more comprehensive and systematic approach to controlled-substance management across the UW Health system serving South Central Wisconsin.

This UWH CRC team is comprised of content experts and end users that include physicians, nurse practitioners, physician assistants, nurses, pharmacy department managers, pharmacists, medical residents, and pharmacy residents.

These team members share a vision of improving patient care through responsible controlled-substance use. Consequently, the purpose of this team is to: (1) improve dialogue between multidisciplinary stakeholders within the medication use process, (2) standardize the evaluation of high-risk controlled-substance prescribing and to provide peer feedback, and (3) provide multidisciplinary guidance to mitigate high-risk controlled-substance prescribing and dispensing. These objectives are consistent with the organization's strategic goals of following a consistent patient-centered model of care and promoting healthy communities through population health.

The UWH CRC remains in its formative stages; however, it is founded upon collaborative relationships established over the past year between the physician and pharmacy leaders working to identify appropriate guidance following the recent introduction of the Wisconsin Prescription Drug Monitoring Program. These relationships have already led to the successful creation of multidisciplinary consensus recommendations for pharmacist-initiated controlled-substance use evaluations in the UW Health Ambulatory Pharmacies. The UWH CRC intends to use similar consensus-building to create standardized processes for the multidisciplinary review of high-risk controlled-substance prescribing and dispensing, with the UWH CRC serving as an ad hoc committee for future review and guidance.

Barriers to optimizing the effectiveness of UWH CRC have included the logistical coordination of team meetings; identifying member roles and responsibilities reflecting expertise; defining the scope of UWH CRC guidance; identifying actionable outcome measures; and creating strategic planning timelines. Despite these barriers, the team continues to orient and adapt to these challenges through continued dialogue, with plans to use initial consensus-building exercises to further develop the collaborative, multidisciplinary relationships necessary for subsequent UWH CRC ad hoc responsibilities.

Ultimately, the UWH-CRC is aimed at empowering each discipline to take a more active role in managing controlled-substance use across the continuum of patient care – from prescribing to dispensing.

UW Health

Team Name: *Advance Care Planning Team*

Team Leader: Mia Morrisette

Contact Information: 608-890-9956, mmorrisette@uwhealth.org

Type of Presentation: Poster

Providing patients the opportunity to complete an advance medical directive (AMD) has been a long-standing strategic priority for UW Health, aimed at improving patient satisfaction and the delivery of patient/family-centered care. UW Health, as well as other health care systems in the state, first partnered with the Wisconsin Medical Society the fall of 2012 to enrich the and expand this opportunity.

This initiative was driven by an engaged steering committee of interdisciplinary champions across the UWHC system. The steering committee included representatives from the volunteer to the vice president from the following disciplines:

- Spiritual services
- Nursing
- Social work
- Medicine
- Patient relations
- Quality
- Patient and family advisory committee volunteer
- Health information services and electronic medical records

We have piloted and are now rolling out an initiative titled *Honoring Choices*. This initiative includes training facilitators to have a conversation with patients, allowing them to discuss in more depth their beliefs, values, and preferences in regard to their health care and quality of life. We believe this will lead to better informed patients and health care choices at the end of life that are more in line with their own beliefs regarding quality vs. quantity of life.

Goal

The goal is to ultimately provide this service to all UW Health patients. This initiative is supported at the CEO level.

Components of pilot and expansion

- Training facilitators
- Design and implementation of workflow in an ambulatory setting
- Pulling together a multidisciplinary team of staff/providers who championed the concept
- Identifying and recruiting patients
- Completing facilitated conversations
- Adapting electronic medical record so AMD information is retrievable to all
- Collecting data, including qualitative data pertaining to patient satisfaction

Teams

- Clinic manager
- Physicians and nurse practitioner
- Social workers
- Scheduler
- Medical assistants

- Nursing
- Steering committee
- ACP coordinator

Successes

We have learned during the pilot and subsequent expansion to several more ambulatory clinic settings that engagement of the interdisciplinary team is critical, including provider champions. Facilitators, patients and health care agents find the process to be mutually gratifying/satisfying. We have developed some standardization of workflow, yet are able to allow for team uniqueness. We have made significant progress in our electronic medical record (EMR) adaptation. We were able to obtain one full-time position for project coordinator to roll-out to the organization.

Barriers

- EMR functionality
- Time intensive with no additional full-time equivalent
- Need for improved data collection

Future Plans

Development of a long range strategic plan that encompasses:

- Standardization of the process
- Include inpatient settings
- Community outreach efforts in consort with our local partners
- Promote *Honoring Choices Wisconsin* to UWHC's 7,400 employees
- Development of computer-based training for employees
- Create more sophisticated data collection and analysis methods
- Customize efforts to reach out to diverse populations

Wheaton Franciscan Healthcare

Team Name: *Anemia Management Clinics*

Team Leader: Mary T. Sinnen

Contact Information: 414-874-4534

Type of Presentation: Abstract Only

Anemia management clinics were born out of work within a rapid-cycle process improvement team which convened in 2005 to analyze the treatment of patients needing erythropoietin stimulating agents for anemia secondary to chronic kidney disease (CKD). It became evident that both patient care and reimbursement could be improved. Utilizing evidenced based knowledge, a team approach to providing care, and standardization of tools the anemia clinics were formed at three hospital outpatient departments. Initially designed to treat anemia in the CKD patient population, these clinics have expanded to treat patients with anemia due to a variety of conditions including: antepartum, postpartum, menorrhagia, gastrointestinal disorders, and pre-operative elective major surgeries.

In addition to the referring provider, the team consists of a nurse practitioner, pharmacy residents, skilled nurses, unit secretaries, coders, and registration staff.

The mission of these clinics is to improve the quality of life for patients diagnosed with anemia and prevent the use of inappropriate blood transfusions. Blood is a precious resource. Transfusions are

linked to a variety of patient safety concerns. The anemia management team is an integral part of the system, receiving consultations and treating patients on a regular basis. Data is collected on the number of patients, beginning and ending blood test results, point of care testing for hemoglobin monitoring and satisfaction questionnaires. Further, research is underway to include a fatigue scale filled out by the patients in an effort to qualify clinical symptoms associated with anemia and interventions to correct this condition.

We have many, many stories of success with patient care from the anemia management clinics. These stories include care to patients with hemoglobin's below 7 g/dL who never needed a transfusion. The growth of referral with a variety of providers is also a measure of the success.

Barriers have included lack of time to educate and market the clinics to a larger extent within the system.

Future plans include presentations and publications on the lessons learned within the anemia management clinics. Another plan is to establish system-wide methods for identification of preoperative anemia in all patients being scheduled for elective major surgical procedures with a referral to the anemia clinics.

Wheaton Franciscan Healthcare – St. Joseph

Team Name: *Glycemic Process Improvement Team*

Team Leader: Joanne Archer, MSN, APRN, BC-ADM, CNS

Contact Information: 414-447-3672, joanne.archer@wfhc.org

Type of Presentation: Poster

The Wheaton Franciscan Glycemic Process Improvement Team was established in May 2011. The purpose of the team is to optimize care of the hospitalized patient with hyperglycemia and diabetes. We work to improve the care of our patients by early identification of those patients that enter our acute care setting hyperglycemic and to appropriately manage their care, provide an appropriate transition to home or another level of post-acute care, thereby avoiding unnecessary readmissions.

Our team is made up of all levels within the organization including the vice president for medical affairs, director of quality, advance practice nursing, hospitalists, director of pharmacy, pharmacy clinical manager, endocrinology, director of nursing, staff nurse, nutrition services and laboratory services. The team leader/facilitator is the clinical nurse specialist for diabetes management.

The team's purpose aligns with the mission of our organization to focus on clinical excellence to exceed the expectations of those we serve. Our value of stewardship calls us to carry out our work in a fiscally responsible manner with a strategic focus to avoid waste and duplication.

The team's first project was to develop and implement a subcutaneous basal-bolus insulin protocol. Research shows, and the American Diabetes Association (ADA) guidelines reflect, that basal-bolus insulin therapy is the gold standard treatment for most non-critical, hospitalized patients. Prior to the formation of our glycemic team, our hospital had order sets available for physicians to use that had options for ordering scheduled long and short-acting insulin as well as correction insulin. However, the problem was that they were not being utilized on a consistent basis. Many physicians would randomly decide what insulin to order with strong tendency to start with only sliding scale insulin. The ADA guidelines clearly state that the sole use of sliding scale insulin should be avoided. Therefore, a major

goal of the team was to increase the use of basal/bolus therapy and decrease sliding scale use. To accomplish this, the team developed a standardized basal bolus protocol. This protocol is initiated by the nurse on admission and starts with the initial bedside blood glucose reading. The nurse then follows a specific algorithm using research based selection criteria to determine a starting insulin dose. The information gathered includes patient weight, age, eating status, glomerular filtration rate (GFR) and if on insulin, the home dose. The results are then sent electronically to the pharmacist who then calculates the patient's dose using either a weight-based calculation or the patient's own total daily dose at home. The key to this process and its subsequent success is that it is automatically begun on admission for all patients exhibiting hyperglycemia defined as blood glucose greater than 180mg/dl times two readings. The initial doses are very conservative which provides a safe insulin dose starting point with very little hypoglycemia. The physician is then free to titrate future doses based on point of care testing to achieve/maintain glycemic control.

We collect data on all units within the hospital and compare those patients not on the protocol to those who are on the protocol. Currently our hospitalists and family practice physicians are using it but the independent physicians that admit to our facility are not. We look at four blood glucose ranges: under 70; 70-180 and 181-250 and greater than 250. Our results show a clear improvement when the protocol is used. For FY14 Quarter 2: *On Protocol* 3.77% under 70; 58.9% 70-180; 21.9% 180-250 and 15.3 % greater than 250 - compared to *Not on Protocol* 3.25% under 70; 47.4% 70-180; 28.1% 180-250 and 21.1% greater than 250. The average number of patients on the protocol each month is 60. The average length of stay for patients on the protocol in FYQ2 was 3.1 days and 3.3 days for those not on the protocol.

Our success is shown in the glycemic improvement noted in the monthly data but also in the positive attitude of the physicians whose patients are put on the protocol. In the beginning, they voiced a lot of concern over hypoglycemia and they did not like the "automatic start" of the protocol. After many months of seeing the glycemic improvement and no great increase in hypoglycemia they are positive advocates of the process. The initial barriers included the ones noted above from physicians but also we needed to work closely with the nursing staff to have them understand the importance of timing insulin and blood sugars as well as stress the benefits of good glycemic control on patient outcomes.

Our team is looking to move this protocol out to other hospitals within our system as well as getting the independent physicians on board. We are also looking to move on to a second project involving transitions of care across the healthcare continuum.

Wheaton Franciscan Healthcare – All Saints

Team Name: *Wisconsin Avenue Clinic Patient-Centered Team*

Team Leader: Gregg Albright

Contact Information: gregg.albright@wfhc.org

Type of Presentation: Panel #2, Poster

The Wisconsin Avenue Patient-Centered Health Team (WAPCHT), funded in part by a Clara Pfaender Grant, was borne of a need to provide quality health care to the uninsured population served by All Saints Hospital and the Wheaton Franciscan Medical Group (WFMG) in Racine, WI. With one of the highest unemployment rates in the state, Racine has a high proportion of uninsured individuals who typically seek care as they need it and in the most convenient place to get that care - the local hospital emergency department. Yet, providing primary care through the emergency department or urgent care clinic is typically the highest cost for care and the organization was seeking a more economical solution to meeting the needs of this population.

Beginning in August 2012, the existing WFMG clinic on Wisconsin Avenue in Racine began to see patients based on a set of criteria including: multiple emergency room visits and/or admissions within a six month period; one or more chronic diseases; multiple or complicated medication regimens; uninsured; and no primary care physician.

The team is composed of two physicians and nurse practitioners, nurses, pharmacists who practice within the clinic, medical office assistants, community health workers, a financial counselor, and customer service associates. The purpose of the team is to provide high-quality, cost-effective health care to high-risk, under-served patients with chronic diseases who don't have access to a primary care physician. "We're striving to help those who very likely need more help," says Dr. Jesse DeGroat. "By providing them with health care now, they have the opportunity to improve their health and decrease the risk of permanent or long-term issues."

Patients are referred to the program, most often through an emergency room visit or during an admission to the hospital. A team member makes sure patients meet the qualifications for the program and an inpatient pharmacist reviews medications prior to discharge to ensure a cost-effective regimen that the patient can afford. Both a physician or nurse-practitioner appointment and a pharmacist appointment are made before the patient is discharged from the hospital and the grant ensures access to medications at discharge as a bridge until their follow-up appointments.

During follow-up care, patients are seen shortly after discharge for a medical appointment with the physician or nurse practitioner to review their current health status, address post-discharge concerns, and a medical plan of care. The clinic pharmacist then reviews the medication list and develops a long-term plan for regular and affordable access to medications.

So far, the results of the program have been favorable. Many patients "graduate" once they obtain employment and/or insurance coverage, yet maintain their relationship with the Wisconsin Avenue Clinic team.

The team measured both emergency room visit rates and admission rates for the period six months prior to enrollment and compared these to the period six months post-enrollment. Emergency room visit rates per patient went from 2.5 per year to 1.5 per year, a reduction of 40 percent. Admission rates per patient went from 0.7 per year to 0.4 per year, a reduction of 43 percent. Since we know what our average emergency room and admission costs are, we can calculate an annual savings with these reduced visits.

Other positive results of the collaboration include the model being featured in a recent edition of the All Saints Foundation newsletter: *Heart and Soul*. This highlighted a patient whose life was positively impacted by the program - someone who is getting regular checkups and enjoys a better quality of life. In addition, since a pharmacist actively assesses medications for both effectiveness and affordability, patients are frequently enrolled in assistance programs that provide low-cost or free medications which decrease their medication risks.

Nevertheless, there are challenges for the team in the form of follow up appointments and participation of patients in their own health care. Because of the socioeconomic barriers facing these patients, simply getting to appointments or keeping a routine phone number can be difficult.

Future plans include

- Expanding the number of patients to include those that may have some type of high-deductible insurance plans that still pose a challenge for many.
- Developing ways to improve continued follow up care.
- Continuing to find effective ways to eliminate barriers to good health care access.
- Comparing indicators of quality such as HgA1C, blood pressure goals reached, LDL, asthma exacerbations, etc. to track improvements in these areas from the patient's baseline.

William S. Middleton Memorial Veterans Administration Hospital

Team Name: *Honoring Veteran Wishes*

Team Leader: Kayla Kastenmeier

Contact Information: 608-256-1902 (x15074), kayla.kastenmeier@va.gov

Type of Presentation: Poster

Driving forces behind creation of the team

Our interdisciplinary team was devised to address the significant need surrounding Advance Care Planning (ACP). In 2010, a Do-Not-Resuscitate (DNR) workgroup was formed at the Madison Veterans Administration (VA) Hospital with the intent of improving communication processes among the patient and/or patient surrogate, physicians, and nursing staff for clinical circumstances involving cardiac arrest and preferences for end-of-life care. Significant findings were gathered in 2012 to illustrate the need:

- Surrogate decision makers often had little understanding of patient wishes and their role in treatment decision-making.
- Veterans in the ICU with little chance for survival received aggressive care at the end-of-life with family members unclear about patient preferences.
- Pre-hospital advanced care planning was important to reducing conflicts during hospitalization, yet physicians felt they had limited time and/or felt uncomfortable approaching these potentially difficult conversations.
- Data from within the general VA population indicate that 38 percent of veterans had conversations about end-of-life planning with their providers.
- 23 percent of Madison VA primary care patients have an advance directive in their medical record.

The primary intervention of this work group was the initiation of the first VA Advance Care Planning clinic in the nation, called Honoring Veteran Wishes (HVW). This clinic would allow veterans to have the opportunity to discuss their goals of care with trusted family, friends, and/or surrogate in an outpatient setting, absent of a health care crisis.

Population served

All veterans who receive primary care at the Madison VA are encouraged to utilize this service.

Composition of the team

Historically, the social work department has held the principal responsibility of ACP in the majority of hospitals. HVW instead focused on an interdisciplinary approach to ACP, currently consisting of 1.0 full-time equivalent (FTE) nurse and 1.0 FTE social worker. While this combination for ACP is unusual, it has been an exceptional example of all-encompassing ACP service. The nursing role provides the required clinical knowledge of various medical conditions, end-of-life care and Life Sustaining Treatment options (LST), while social work role holds expertise in the advance directive documents and end-of-life care resources.

Additionally, an interdisciplinary steering committee comprised of primary care physicians, inpatient and outpatient nursing, social work, hospital leadership, and administrative support committee meets monthly to support and guide the ACP team.

Purpose and mission of the team

The mission of the HVW team is to ensure that veteran's end-of-life wishes are honored by making ACP a routine part of veteran's health care experience. To assist in obtaining this goal, the team was trained by Gunderson Health System's Respecting Choices program in fall of 2013 and continues to work in conjunction with Honoring Choices Wisconsin.

The primary goals of Honoring Veteran Wishes

- To offer the opportunity for ACP in an outpatient setting, absent of a healthcare crisis allowing time to reflect on what is important.
- Invite the veteran's family, trusted friends, and surrogate to join the conversation.
- Allow the time and space to have a structured conversation between the veteran and their support system to foster the development of shared understanding of the veteran's wishes.

HVW provides a truly patient-centered approach to ACP. During each ACP appointment the team starts where the veteran is at in terms of their understanding of ACP and assists in eliciting goals, values, and beliefs prior to discussing their preferences for medical care. An advance care plan is then constructed based on the shared understanding of the veteran, their surrogate, family, and their primary care provider. The model used supports the varying level of conversation necessary based on the veteran's comfort level and current health status.

How team fits within the organization

HVW is located in primary care as an outpatient based clinic. The team works closely with primary care providers in discussing goals of care and facilitating follow-up when needed. Primary care is a vital piece of the HVW team as they provide support and guidance in assisting veterans to understand the importance of ACP, recognize when they would benefit from ACP, continue ACP conversations, and complete any orders necessary to honor the veteran's wishes.

Length of time team has been in existence

The interdisciplinary steering committee was formed in 2010, and completed the Madison VA Advance Care Planning proposal September 12, 2012. The committee received approval the same year and clinic staff were hired and trained in the fall of 2013. HVW clinic opened to veterans in January 2014.

Outcomes and/or outcome measures

Below is a summary of HVW's overall first quarter results as of May 20, 2014:

- 55.8 percent appointments were completed with surrogate participation
- 61.1 percent of completed appointments have a completed AD in their chart
- 37.1 percent requested new state-portable orders after CPR discussion
- 10.2 percent requested a palliative care or hospice consult

HVW has additionally captured very interesting data regarding outreach efforts, differences in data between veteran's health status, as well as provider comfort and satisfaction of ACP. Long-term data is also being collected for completion of advance directives, surrogate-patient-provider congruence, use of palliative care and hospice, and the use of emergency department, inpatient admissions, and intensive care unit at end-of-life.

Successes

The biggest success of HVW is the veteran's interest and satisfaction with the program. One hundred percent of comments received by HVW have been positive. Some examples are:

- "As a wife of a veteran who has medical problems and some that could create a situation where I would have to make decisions for him. I never asked him what he wanted for himself if something would happen and hearing him say I would make those decisions for him. I feel it is a great program and I'll have to do this for myself really soon. I hope more vets have the chance to go through this program with you."
- "Greg and I both think the gals we met with did a fantastic job. Covered a lot of things I didn't know. She handled the topics with sensitivity. They made us decide to consider different alternatives. Very kind and personal."

Barriers

One of the biggest barriers HVW has faced is time restraints on primary care providers. This has created several obstacles in the amount of referrals received and timeliness of follow up when required from providers. HVW continues to work through this barrier by providing consistent care to veterans when referrals are made and working diligently when follow up is needed.

The second barrier is primary care provider comfort level of discussing ACP with their veterans. Talking about ACP and end-of-life planning has required a shift in culture at the Madison VA. In order to address this, HVW has held 25 educational sessions in the first six months of service. Additionally, HVW has created educational handouts specifically for staff on ACP and how to discuss the topic with their Veterans.

Future plans

As implementation for this initiative continues, HVW will be expanding in the near future. Locally, efforts for ongoing education to clinicians throughout the Madison VA and surrounding clinics will continue and expand. HVW has the intent to train additional ACP facilitators to support and standardize ACP discussions throughout care settings in the VA. This is essential for a cultural shift in how ACP is understood throughout the Madison VA.

HVW is also working with the National Center for Ethics in Health Care on a new initiative that will support personalized, proactive, patient driven care for patients at high risk of a life threatening clinical event. This initiative is being piloted in Madison during the summer of 2014 and expected to roll out nationally in the fall of 2014. Recent events indicate the ACP model that HVW is using may be considered for use on a national level.

William S. Middleton Memorial Veterans Administration Hospital

Team Name: *VA GRECC Connect Geriatrics Clinic*

Team Leader: Lauren L. Welch, PharmD, BCPS, CGP

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Type of Presentation: Panel #1 and Poster

The VA (Veterans Affairs) GRECC (Geriatrics Research and Education Clinical Center) Connect Clinic encompasses an interdisciplinary team consisting of a geriatrician, geriatric pharmacist, geriatric psychiatrist, neuropsychologist, geriatric nurse care manager, and geriatric social worker. The clinic has received its funding as part of a multisite collaboration with three other GRECCs (Bronx, NY; Pittsburg, PA; Puget Sound WA) and one VA Medical Center with geriatric resources (Canandaigua Rochester VA Medical Center, NY) and continues to be funded through the Office of Rural Health.

The GRECC Connect Clinic main focus is to utilize clinical resources to move beyond the current model of delivering in-person interdisciplinary specialty care using new technology modalities to increase access for Veterans residing in rural areas. The clinic leverages the existing expertise and collaboration amongst members of an interdisciplinary team and applies these clinical resources in a service delivery model that seeks to lower costs for both the veterans we serve and the VA as a whole. The clinic also expands the idea of incorporating an interdisciplinary team to include our partners at the rural community based outpatient clinics we serve, who have been instrumental in assisting us in developing and redefining the service to better meet their needs.

The team receives consults from rural primary care providers regarding complex, geriatric related cases. The majority of these patients live a great distance from obtaining geriatric specialty care at the main VA facility and have functional limitations that make traveling great distances a challenge. Providers can access the GRECC Connect Clinic by one of three venues: E-Consult; Tele-huddles; and Tele-health (Clinical Video Teleconferencing) visits. E-Consults are completed as comprehensive chart reviews conducted by the interdisciplinary team of the GRECC Connect Clinic. The referring provider then receives a comprehensive set of recommendations to assist in managing complex cases, including medical, pharmacy, psychiatry, nursing, and social work input. Tele-huddles occur bi-monthly with the various rural community based outpatient clinics (providers, nurse care managers, support staff) in which brief discussions are held between the interdisciplinary team and Patient Aligned Care Team (PACT) regarding specific geriatric related patient issues. Tele-health clinic visits occur by way of video tele-conferencing where an actual clinic visit is done with the patient/caregiver and GRECC Connect Interdisciplinary Team. We recently expanded our tele-health clinic visits to conduct neuropsychiatric testing for our geriatric veteran patients that have difficulty traveling to the main VA facility to complete this type of testing needed for many cognitive impairment diagnosis and treatment plans.

Once consults are received, the interdisciplinary team triages each consult to ensure that the service requested is most beneficial for the provider and patient. Oftentimes, patients are interacted across multiple venues depending on the complexity of the case. For example, the veteran may initially be referred for an E-Consult and once the E-Consult has been completed, the team may recommend additional follow up through a Tele-health Clinic Visit.

The team continues to measure various outcomes for the clinic, including recommendations accepted as a result of these visits, hospitalizations/institutionalizations at three month and one-year follow up patient satisfaction with clinical video teleconferencing visit and provider satisfaction of the overall program. The reduction in veteran travel time and distance, addition of geriatrics expertise when previously not available in rural primary care settings, and potential benefits in improving care for older adults while potentially reducing rates of institutionalization and hospitalization may support the financial case for sustainability of this newly initiated interdisciplinary team clinic.

The clinic continues to be extremely successful and has been implemented to three of our rural community based outpatient clinics. Identification of the need for neuropsychological testing for our rural patients was evident early on in the clinic development and the addition of a neuropsychologist to conduct neuropsychological testing through way of telemedicine has been instrumental for the enhancement of the clinic setting. We are pursuing proactive approaches with our rural primary care providers to provide “panel co-management services” which continues to be a strategy in development that is highly received by the rural primary care providers.

Wisconsin Nurses Association

Team Name: *Chronic Disease Prevention Program*

Team Leader: Gina Dennik-Champion, RN, MSN, MSHA

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Type of Presentation: Abstract Only

The Wisconsin Nurses Association (WNA) is the professional association with membership open to any Wisconsin registered nurse. One of WNA's organizational goals includes the implementation of deliberate strategies that promote patient access to comprehensive quality health care services. WNA has formed partnerships with key stakeholders, including the Wisconsin Division of Public Health, to identify health system improvements and strategies that support effective and efficient coordination of chronic disease and prevention services.

The Wisconsin Nurses Association (WNA) received a grant from the Wisconsin Department of Health Services, Division of Public Health, Chronic Disease Section, to contribute to ongoing statewide evidence-based efforts to promote health and prevent and control chronic diseases and their risk factors with a specific focus on hypertension and diabetes. The U.S. Centers for Disease Control and Prevention has identified, through its cooperative agreement with the Wisconsin Department of Health, four specific domains that provide strategies to the WNA and other grant recipients. These domains include: (1) epidemiology and surveillance, (2) environmental approaches that promote health, (3) health system interventions, and, (4) community-clinical linkages that improve management of chronic conditions. WNA will specifically focus on domain #4 above.

The Division of Public Health (DPH) is contracting with WNA as a key leader to drive statewide efforts for implementation of a patient-centered, team-based care approach with a specific focus on hypertension and diabetes. WNA will work with several partners who include the DPH, MetaStar, Wisconsin Primary Health Care Association (WPHCA), and the Wisconsin Council on Medical Education and Workforce (WCMEW) to identify recommendations that include but are not limited to: developing a compendium of abstracts and the proceedings of the *November 12, 2014 WCMEW conference entitled: Building a Culture for Patient-Centered Team-Based Care*; convene a multidisciplinary team resulting in a clearinghouse and inventory of patient-centered team-based care processes, protocols, policies, and procedures; identify on-line modules that support clinical and community-based health systems planning; continue to partner with the WCMEW in developing a best-practice model for team-based care.

WNA will work with partners to identify community-clinical resources and include best practices for populations disproportionately affected by diabetes and heart disease. This work will accomplish the following:

- Identify current and emerging champions and stakeholders
- Build common understanding and appreciation of the benefits of patient-centered team-based care
- Improve self-management plans for patients (including medication adherence, self-monitoring of blood pressure and blood glucose levels; increased consumption of nutritious foods and beverages; increased physical activity; maintaining medical appointments)
- Increase knowledge of the importance of self-monitoring of blood pressure and blood glucose by patients and their families.