Wisconsin Council on Medical Education & Workforce

Building a Culture for Patient-Centered Team Based Care

Summary of the Proceedings

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

May 20, 2015

Wisconsin Nurses Association
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Foreword

The conference proceedings are a joint publication of the Wisconsin Council on Medical Education and Workforce (WCMEW) and the Wisconsin Nurses Association (WNA). On November 12, 2014, WCMEW sponsored a statewide conference in the Wisconsin Dells, Wisconsin, entitled: *Building a Culture for Patient-Centered Team-Based Care*. This conference was designed to assess the current status of patient-centered team-based care in Wisconsin and establish a platform to collectively move this concept forward – together.

To chronicle the visionary work already occurring throughout Wisconsin, the conference planners determined, in advance of the conference, that a compendium of abstracts and the conference proceedings be published and widely disseminated. Taken together, these documents provide important documentation of evidence, frameworks, practical considerations, team location, and wisdom to formally move patient-centered team-based care forward as a critical health care redesign strategy. A redesigned healthcare system focusing on high-functioning patient-centered teams has the potential to improve and protect the health of patients; use emerging technologies for self-care; seamlessly connect patients and their families to community resources; and address all levels of prevention: primary, secondary, and tertiary.

To improve and protect health will require leadership from many Wisconsin organizations, health care systems, community organizations, and consumer groups to advance patient-centered team-based care as a health care redesign priority. This will require investments to assure capacity to achieve high-functioning teams to advance and sustain health and organizational outcomes. It will also require commitment to learn through interprofessional collaboration and cooperation and assure patient-centeredness. Achieving this will result in the delivery of high-quality and safe care that has the potential to improve and protect the health of the 5.7 million people of Wisconsin and the communities where they live, grow, work, learn, and play.

For More Information Please Contact

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WCMEW and the WNA express their gratitude to the Wisconsin Department of Health Services, Division of Public Health, Chronic Disease Section, and the U.S. Centers for Disease Control and Prevention for the resources to produce three conference documents: compendium, executive summary, and proceedings. Resources were made possible through a chronic disease prevention grant awarded to the Wisconsin Nurses Association in October 2014.

Background and Conference Development

The Wisconsin Council on Medical Education and Workforce (WCMEW) was formed in 2004 as a response to one of the recommendations from the publication "Who Will Care for Our Patients?" That report – from a Wisconsin Hospital Association task force convened to address Wisconsin's future physician workforce – predicted a future shortage of physicians available to serve Wisconsin's citizens, and recommended actions to address this concern: specifically increasing medical school enrollment, expanding graduate medical education, understanding changes in care delivery, and creating a statewide focus on medical education policy in Wisconsin.

The creation of WCMEW was the first outcome of the report. The Wisconsin Hospital Association (WHA) and the Wisconsin Medical Society (WMS) coordinated the recruitment of a comprehensive set of stakeholders in healthcare workforce and education, including: representatives from WHA and WMS; the Wisconsin Academy of Family Medicine; various health practitioners; and Wisconsin's two medical schools. In recent years, membership in WCMEW has been increased to reflect its broader role in the healthcare workforce.

WCMEW has operated over its first ten years as a voluntary collaborative, serving as a venue for dialogue and a public platform to highlight healthcare workforce issues. In 2011, WHA, with WCMEW input, published *100 New Physicians a Year: An Imperative for Wisconsin.* The report predicted a shortage of over 2,000 physicians by 2030 and made the following recommendations:

- Expand Wisconsin graduate medical education programs and increase the number of graduates from Wisconsin's medical schools.
- Understand future health care delivery and redesign education and training accordingly.
- Strengthen WCMEW.

Since the publication of the 2011 report, there have been several significant developments.

- New funding for graduate medical education (GME) totaling $5 million was included in the 2013-2014 biennial budget. The funds will be used to finance the expansion of existing GME programs and in establishing new programs. The funding represents the first increase in state funding of GME in over 20 years. This was a WCMEW initiative, with members shaping the proposal and leading the advocacy for its passage.
- In 2013, WCMEW planned and sponsored a statewide conference on graduate medical education, where stakeholders convened to share information about strategies and practical issues in starting and operating GME programs.

WCMEW Moving Forward:

WCMEW has proved to be a positive force in influencing Wisconsin's health care workforce agenda. Looking to the future, WCMEW will continue its mission of ensuring a healthcare workforce that meets the needs of Wisconsin citizens. To carry out that mission, WCMEW will continue the work it has done in the past, but also expand its efforts. For 2015, the WCMEW work plan includes:

- Increase and Broaden Efforts to Strengthen Post-graduate Training – We will work to refine and/or expand GME funding in the state budget. To accomplish this goal, we will form a workgroup to explore possible inter-professional post-graduate programs.
- Address Anticipated Changes in Care Delivery – WCMEW will continue to study the evolution of Wisconsin's medical care delivery system to identify strategies that maximize the most effective use of all caregivers. In 2015, WCMEW will publish a compendium of the results of the 2014 conference to

disseminate best practices, and begin a dialogue with educational institutions on integrating team based care into curriculums.

- Continue to Inform the Public and Policymakers – Past publications have been important vehicles for informing the public about Wisconsin's healthcare workforce and have served as catalysts for change. In 2015, WCMEW will continue this effort by publishing an update of *"100 New Physicians a Year."*

Acknowledgements

WNA and WCMEW extend their gratitude to the following:

- Andy Anderson, MD, MBA, Aurora Health Care, for his keynote presentation that addressed operational and practical considerations when envisioning, implementing, and measuring patient-centered team-based care.
- Conference facilitators who included Tim Bartholow, MD; Barbara Nichols, DHL, MS, RN, FAAN; and Sarah Sorum, PharmD, for their skillful management of teams that addressed mission and driving forces; team interaction and culture; and patient populations and outcomes.
- Conference planning committee: Lea Acord, RN, PhD, President, Wisconsin Nurses Association; Tim Bartholow, MD, Chief Medical Officer, WEA Trust; Richard A. Dart, MD, President, Wisconsin Medical Society; Gina Dennik-Champion, MSN, RN, MSHA, Executive Director, Wisconsin Nurses Association; Jennifer Frank, Vice President of Education & Marketing, Wisconsin Hospital Association; Julie Lederhaus, Director of Education and Training, Wisconsin Academy of Physician Assistants; Nancy Nankavil, Senior Vice-President, Quality and Efficiency, Wisconsin Medical Society; George Quinn, Executive Director, Wisconsin Council on Medical Education and Workforce; Chris Rasch, Director of State and Federal Relations, Wisconsin Medical Society; Charles Shabino, MD, Chief Medical Officer, Wisconsin Hospital Association; Tim Size, Executive Director, Rural Wisconsin Health Cooperative; Maureen Smith, MD, Professor, Departments of Population Health Sciences, Family Medicine, and Surgery, University of Wisconsin School of Medicine and Public Health; Sarah Sorum, PharmD, Vice President of Professional and Educational Affairs, Wisconsin Pharmacy Society
- Conference panelists who were specifically selected to share their expertise and practical wisdom in designing and implementing patient-centered team-based care in twelve settings throughout Wisconsin.
- Maureen Smith, MD, MPH, PhD, University of Wisconsin, for her high-level overview of evidence-based approaches to team learning by systematically focusing on a three-pronged approach: knowledge, skills, and attitudes.
- Poster presenters who shared their models and approaches and engaged participants in active learning and dialogue.
- Richard Dart, MD, President, Wisconsin Medical Society, for his perspectives on the driving forces and the importance of health care system redesign.
- Rural Wisconsin Health Cooperative for its contributions in planning the conference and recording the entire conference using MediaSite technology and making this recording widely available through its web site.
- Wisconsin Department of Health Services, Division of Public Health and the U.S. Centers for Disease Control and Prevention for the grant resources awarded to the Wisconsin Nurses Association that enabled the development of the conference compendium and proceedings. These funders are especially interested in team-base care processes, protocols, and systems and their impact on health improvement to persons with hypertension and diabetes.
- Wisconsin Hospital Association for its contributions in planning the conference and logistical support.
- Wisconsin Nurses Association for its leadership and contributions in planning the conference and the preparation of the conference compendium and proceedings.

Accessing the Conference Recordings

Video and audio recording of the entire conference is available on-line through the Rural Wisconsin Health Cooperative at: http://bit.ly/1FYTCwt

To log in to the recordings:
User Name: WCMEW2014
Password: NOV12

- The recorded presentations match the "on-site" conference agenda.
- There are two options in the lower right hand corner of the viewer screen to access the presentations:
    - Use the "paperclip button" to download PDFs of the keynote presentation slides.
    - Use the "chapter's button" to select a specific conference panel/topic to view.

For questions and/or assistance using MediaSite technology please contact Ms. Carrie Ballweg, Education Coordinator, Rural Wisconsin Health Cooperative, via email at cballweg@rwhc.com or via voice (608) 644-3248.

Welcome and Opening Remarks

Definition of WCMEW:
The Wisconsin Council on Medical Education and Workforce (WCMEW) is a multi-stakeholder group whose purpose is to identify and implement innovative strategies to meet the provider workforce needs in Wisconsin now and into the future. This group has been working together since 2006. (Refer to background section of the proceedings to learn of WCMEW's development. One of the key foci of our work is centered on the concept of patient-centered team-based care.

Background:
Earlier this year, a small group of WCMEW partners came together to plan the conference and examine the current state of team-based care in Wisconsin. In our work, we identified five critical questions that we could not answer alone. Answering these questions will require broad collective engagement if we are to move team-based care forward in Wisconsin. Please keep these questions in mind throughout the conference. Our final speaker, Gina Dennik-Champion, Executive Director, Wisconsin Nurses Association, will provide a summary of today's learnings – a critical step as we move forward, together.

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

Please visit the posters during break and lunch activities. Talk with the presenters. Presenters and poster presentations are identified in the conference compendium. Please also complete your evaluations to help us craft the next steps in team-based care.

Keynote #1
The New Role of Teams in the New American Population Health

Speaker: Maureen Smith, MD, MPH, PhD
Professor of Population Health Sciences, Family Medicine, and Surgery
Director, Health Innovation Program
University of Wisconsin
Madison, Wisconsin
Click here to access slides.

Dr. Smith addressed the new role of teams in American population health and approached this from a high-level perspective. She laid important groundwork in setting the stage to developing and supporting high-functioning teams. Equally important, she stressed creating and sustaining a team-culture in our organizations. Her guidance consistently centered on a three-pronged approach to team development.

How do we create a better culture around teamwork? A three-pronged approach:
1. Train your team in skillsets correlated to success.
2. Build your team training around a project.
3. Create an environment that supports your team.

What is a team?
In this context, the definition of team requires two or more people assigned to specific roles with specific tasks. They are required to interact / coordinate with each other to reach shared goals. They make decisions and often have specialized knowledge and work under a high workload for the entire team. This gets us to the important concept of "team interdependency." Team does not just mean groups of people; rather, it means groups of people who are interdependent. What a team member does affects everyone on the team. "Patient-centeredness" is a critical component of teamwork and that can increase the effectiveness of the team. An effective team can achieve a lot: reduce medical errors; improve quality of care; reduce and improve workload issues; reduce burnout among health care professionals; and build cohesion across a unit.

Anatomy of an effective team (three components):
The following three components must not be confused with processes. The anatomy of a team includes knowledge, skills, and attitudes (KSAs). One approach is to train directly on knowledge, skills, and attitudes in the change we are attempting to make. That means teamwork related knowledge; teamwork related skills; and teamwork related attitudes. All must be in place to be an effective team.

1. Knowledge: what you're doing
1. Skills: how we should be working
2. Attitudes: why we are doing our work.

Dr. Smith then addressed a specific case study concerning patient ambulation and the dynamic interplay of fall risk-prevention, patient protection, and ultimately restoring ambulatory functionality. She described how competencies in knowledge, skills, and attitudes around ambulation can create an effective team and improve patient and population outcomes.

(1) Knowledge: identify knowledge competencies:
This can be achieved through shared task models; task-specific responsibilities; knowledge of team mission, norms, and resources; familiarity with teammate characteristics; and cue strategy associations.

- *Knowledge: identifying knowledge expectations and competencies can result in:*
  Barrier identification (this is critical). Knowledge increases shared-knowledge about team purpose and creates a unit-level expectation that a patient will be ambulated.

(2) Skills: identify skill competencies:
Skills, in this context, are a learned capacity to interact with other team members and include the following characteristics: adaptability; situation awareness; performance monitoring and feedback; leadership; interpersonal relationships; coordination; communication; decision-making. Examples of training around skill competencies may include: mutual performance monitoring across the team; changing the question from "did your patient walk today?" to "how much did your patient walk today?" Other aspects included the addition of daily ambulation goals on the patient's in-room whiteboard and including ambulation as a structured component in shift-to-shift reports.

- *Skills: identify skill-related expectations and competencies can result in:*
  Approaches that include mutual performance monitoring; flexibility and adaptability; supporting back-up behaviors; team leadership; conflict resolution; feedback; and closed-loop communication; and information exchange.

(3) Attitudes: identify attitude competencies
Often, we don't think we can train on attitude. A positive attitude is critical to successful teamwork. Collectively oriented individuals tend to perform better in teams and results in team success.

- *Attitudes: identifying attitude-related expectations and competencies can result in:*
  improved team morale; collective efficacy; shared vision; team cohesion; mutual trust; and the importance of teamwork.

What do we know about the best ways to train teams?
Training really makes a difference when you focus on knowledge, skills, and attitudes. There are three major types of training:

1. Information-based: (didactic lectures): here you can give a lot of information in a short period of time. This approach to training is often used but may not be the best.
2. Demonstration based: (behavior modeling videos): here you can tap into the many ways in which people learn.
3. Practice-based: (simulation, role-playing).

High-yield team training approaches include:

- Simulation-based trainings: focuses training on knowledge, skills, and attitudes.
- Metacognition training: focuses on knowledge, what it means to be a team, and developing shared mental-models for the team.
- Guided team self-correction: focuses on skills and attitudes that are evolving on the team.

Evidence-based training frameworks include:

- TeamSTEPPS:
  Known as *Team Strategies to Enhance Performance and Patient Safety*, this "train-the-trainer" framework was developed by the U.S. Department of Defense, Agency for Healthcare Research and Quality, and the American Institutes for Research. There is a national infrastructure for this framework which can be customized for any organization. It uses knowledge, skills, and attitudes. To learn more, go to: http://www.ncbi.nlm.nih.gov/books/NBK43686/
- Medical Team Training:
  This framework was developed by the Veterans Administration Center for Patient Safety and Medical Team-Training. This is a "train-the-staff" model focusing on "teams building teams." This includes learning sessions led by a multidisciplinary team that includes leadership; peer-to-peer communication; follow up support to teams that are trained; and simulation. To learn more, go to: http://www.ncbi.nlm.nih.gov/pubmed/17566541

Training is important but not sufficient. The most effective training programs employ a "bundled intervention" approach designed to support interventions ultimately resulting in meaningful change due to bundling of tools, training, and broader organizational interventions. Don't think about teams in isolation from the parent organization.

Select and implement a project:
Identify the problem and make sure the problem is relevant as opposed to "having a hammer and looking for a nail." Train around the project. Success is to be found in the same measures we use for quality improvement. Defining team success includes the following guideposts:

- Start small
- Make it measurable
- Put the patient at the center
- Search the literature
- Don't reinvent the wheel
- Maximize preexisting resources
- Get input
- Revise

Build the team around the change you desire and don't send individuals to train separately. Additional steps to success include:

- Train the team around the project.
- Use tools to keep on track (checklists, reminders, peer coaches).
- Change organizational policies and procedures to overcome barriers.
- Build incentives around new processes.
- Measure outcomes and give feedback.

Creating an environment that supports the team:
Teams are not teams in isolation. Leaders create the environment. They set the tone for team success. See keynote slide #34 concerning safety leadership team training. Characteristics of strong leaders include:

- Exhibits a caring approach and attitude
- Demonstrates a welcoming and non-defensive attitude
- Encourages speaking up
- Facilitates communication and teamwork
- Takes action
- Mobilizes information
- Seeks input

Leadership is not enough. The system itself is a crucial element if the team is to be successful. The system creates the environment. Engineers bring a critical perspective to team processes and success using a systems-engineering to improve patient safety. Essentially, how do we structure our facilities to minimize patient risks and maximize our team capacity? Dr. Smith addressed the *Systems Engineering Initiative for Patient Safety* (SEIPS) program currently underway at the University of Wisconsin (http://cqpi.wisc.edu/seips-main.htm). This model is comprised of five variables (team, tools/technology, tasks, organization, and environment). You can place any of these five variables in the center (e.g., team). The model identifies barriers and supports to help the team. You can then bring into the view the sources of barriers and/or supports that flow from tools/technology, tasks, the organization, and the environment. All of these variables impact the quality and safety of care provided. This program offers the following:

- Not physician-centered.
- Reduces the culture of blame.
- Results in positive patient and employee outcomes.

If the system is not working for everyone, then it is not working. To advance systems-level change, several options are available to us:

1. We can redesign systems to make it "easy to do the right things right and hard to do things wrong."
2. Engage physicians and all the professions at the beginning of the process.
3. Promote balance in the work system by "sharing the load."
4. Promote a healthy work organization that results in good outcomes for both patients and staff.

Case study: Dr. Smith closed her keynote with a description of how the UW *Systems Engineering Initiative for Patient Safety* provides a useful framework to identify barriers and facilitators using a simulated recall methodology. This complex approach was designed to fully engage families during family-centered rounds using video-recordings. Here the families and health care workers recalled barriers and facilitators by jointly viewing the playback of the video by providers and the family. Dr. Smith then described the barriers and facilitators to improved team functioning using the five variables of the model (team, environment, tools/technologies, tasks, and the organization). If one employs this approach, always start with the team element.

Final Thoughts / Takeaways:
Dr. Smith wrapped up with the following points:

- The SEIPS framework (addressed above) can guide system redesign and create an environment that supports the team.
- The roadmap to success is paved with human errors.
- Focus training on all three parameters: knowledge, skills, and attitudes.
- Train staff in skillsets using a three-pronged approach.
- Build your team around a project.
- Create an environment that supports this change that includes leadership and the system.

Suggested Reading:
Salas, Eduardo; Wilson, Katherine A.; Murphy, Carrie E.; King, Heidi; Salisbury, Mary. Communicating, Coordinating, and Cooperating When Lives Depend on It: Tips for Teamwork; Joint Commission Journal on Quality and Patient Safety, Volume 34, Number 6, June 2008, pp. 333-341(9)

Keynote #2
Cultures that Make Teams Successful

Speaker: Andy Anderson, MD, MBA
Senior Vice President, Academic Affairs
President, Aurora UW Medical Group
Associate Dean, University of Wisconsin School of Medicine and Public Health (Milwaukee Campus)
Aurora Health Care
Milwaukee, Wisconsin
Click here to access slides.

Dr. Anderson spoke from a high-level at first and then he drilled down locally. In his keynote, he addressed the need for communicating "a burning platform for change and the elements of a team-based culture." The first slide, *Basic Psychological Needs Must be Fulfilled,* depicted a three-element Venn diagram (competence, relatedness, and autonomy). Overarching questions about behavior are important and the slide provided an important framework in which to answer such questions. Each element is important to building an effective team.

- *Competence* – the perception of feeling effective; capable of achieving a goal; competence as a professional with expertise; competence as an educator/teacher. Here, learning is continuous.
- *Autonomy* – directing one's behavior; perception of having a choice; opportunity for self-direction; volition; and control.
- *Desire to feel connected* – feeling valued and connected; a feeling of belonging to a group and to a community; peers, patients, family, faculty, students and so forth.

References:

- Kusurkar RA, ten Cate O, et al. AM Last Page: Education is not filling a bucket, but lighting a fire: Self-Determination Theory and Motivation in Medical Students. Acad Med. 2013;88(6):904.
- Deci, Edward L., and Richard M. Ryan. *Self-Determination*. John Wiley & Sons, Inc.,2010.
- Ryan, Richard M., and Jennifer G. La Guardia. "What is being optimized? Self-determination theory and basic psychological needs." (2000).

What will health care look like in the future?
No one knows exactly. Will it be population health? Will it focus more on health than health care? Our current state is not sustainable and our spending is disproportionate to the outcomes we are achieving. Dr. Anderson recommended that the participants look at the *Dartmouth Atlas Project* to get a sense of the variability across our nation and see why the current state is simply not sustainable. Forces that will drive change include but are not limited to:

- Moving toward team-based care, working at the top of our licenses, and working together more efficiently and effectively.
- Consumerism – people are already making decisions on value, outcome, co-pays, deductibles, and employers are pushing decisions on employees. Consumerism will drive health care to be more effective.
- Market disrupters and increased competition (e.g., Walmart, telehealth).
- Changing workforce and demand.
- Aging of the population.

Our current health care model does not support the need. We don't segment our patients, rather we continue to use a "cookie-cutter" approach and give the same care to all. There are patients with multiple comorbidities and patients who are healthy, yet we don't tend to segment to maximize our resources. (The chart below, representing one of Dr. Anderson's slides, depicted the health care landscape.) Moving from volume to value-based care will rely on the availability of high-functioning teams. To facilitate change requires that you answer the question "why." Value is achieved through high-quality and high-service at the best possible cost. Again, value is, in part, achieved by teams.

Health Care Landscape

Current State: volume-based/episodic care	**Future State: value-based/continuous care**
Results in: • Health care costs expected to reach $4.4 trillion in 2018 • Unnecessary services • Inefficient delivery of care • Missed prevention opportunities	Results in: • Proactive care management of patient populations (including prevention) • Leveraged caregiver teams working at the top of license • Easy access to care • Efficient delivery of quality health care

Leadership:
Teaming in this context means to be able to provide health care effectively. To achieve this, leadership is critical. Our mindset should focus on "we" as depicted in the following quote: "The leaders who work most effectively, it seems to me, never say 'I' - that's not because they have trained themselves not to say 'I' - they don't think 'I' - they think 'we' - they think 'team.' They understand their job to be to make the team function. They accept responsibility and don't sidestep it, but 'we' gets the credit. This is what creates trust, what enables you to get the task done" (Peter Drucker).

Aurora Health Care Primary Care Redesign and Culture Change:
Dr. Anderson then drilled down locally to the initiative he's leading in primary care at Aurora Health Care. Aurora Health Care employs over 500 primary care physicians and has over 100 sites where primary care is delivered.

- *Project hypothesis:* implementation of team/LEAN training for all providers and caregivers at a clinic site will result in improved patient experience metrics and caregiver satisfaction at that site.
- *Objective:* "Foundations Training" – here we integrated TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) and LEAN concepts, tools, and methodologies to build a

systems-based self-improving culture that energizes, empowers, and enables caregivers to improve their work and solve the problems they and their patients' experience.

This initiative is a package that includes a project component and a training component leading to a self-improving culture in the organization. This has been piloted in five Aurora clinics and is now moving to a market-level (moves across all clinics in the organization by 2015). Methods and milestones of our journey include:

- Identified the key elements of a redesigned primary care clinic including optimized roles and functions.
- Defined the elements of culture change needed and built the team/LEAN training intervention for physicians and the primary care team to leverage redesign.
- Held an all-primary care physician meeting that included level-setting, feedback, and promotion of redesign, including team-based culture.
- Piloted primary care redesign in two sites then expanded to an additional three clinic sites.
- Team and LEAN training model are positioned as core tactics for system roll-out to all primary care sites in 2014 and 2015.

Improvement Tools – Reminding People Why We're Doing This:
Dr. Anderson reminded the audience to always think about "why." As discussed at the outset of his keynote, it is important to remind people of our shared goals and why we are moving in this direction. Our shared goals include:

- Offering patients quicker, easier access to the care they need.
- Redefining roles to tap the full potential of every member of the care team (all working at the top of licensure).
- Coordinating care efficiently across our hospitals and clinics, home health, and pharmacy.
- Empowering caregivers to work together to drive a culture of self-improvement.

Improvement tools:
Our improvement tools included a modified TeamSTEPPs curriculum that included a LEAN component to instill in our culture at Aurora. We have master trainers (some trained at the national level) and worked with local human resources staff to assist with training and change management. We used a survey tool to assess team perceptions of how things were going and used feedback loops and a scorecard to track outcomes. We are always learning and always looking for improvement.

Convergence of ideas:
Dr. Anderson shared a slide depicting the convergence of ideas that represents the journey to a desired future state: achieving access, improving capacity for patients, and increasing population health. This includes design efforts on the vertical and horizontal axes. He and his team are also focusing on one to two clinics to accelerate progress and achieving the vision. The journey is measured by:

- High quality services and team-based care.
- Efficient operations and increased revenue.
- Decreased emergency room visits and hospitalizations.
- Provider time and cost efficiencies.

Benefits of current initiatives:

- TeamSTEPPS/LEAN Training:
  Training fosters a physician-led team to identify and eliminate inefficiencies in day-to-day practice and foster sustainable methods of communication and team-based care. To learn more go to:
  - TeamSTEPPS: http://teamstepps.ahrq.gov/

    - LEAN: https://www.entnet.org/sites/default/files/GoingLeaninHealthCareWhitePaper-3.pdf
- Team huddles: This technique is conducted around a "how are we doing board" – allows caregivers the opportunity to communicate issues and take proactive steps toward remediation.
- Role and processes: This assures proper assignment of day-to-day tasks and evaluating processes that produce value (e.g., quality scores, revenue, and time).

The importance of teamwork and building a strong organizational culture: Common Teamwork Elements (as cited in Salas et al, 2004):

- Hold shared mental models
- Have clear roles and responsibilities
- Have clear values and shared vision
- Optimize resources
- Have strong team leadership
- Engage in the regular discipline of feedback
- Develop a strong sense of collective trust and confidence
- Create mechanisms to cooperate and coordinate
- Manage and optimize performance outcomes

Reference:

- Salas, E., Stagl, K. C., & Burke, C. S. (2004). 25 years of team effectiveness in organizations: Research themes and emerging needs. In C. L. Cooper, & I. T. Robertson (Eds.), International review of industrial and organizational psychology (pp. 47–91). New York: John Wiley & Sons.

Interconnected benefits of teamwork at Aurora Health Care:

1. Impact on clinical quality and patient safety:
   As seen in improved patient outcomes, improved clinical outcomes, and improved patient safety.
2. Impact on service quality:
   As seen in improved care coordination, improved patient/family communication with their team, improved handoffs, and improved patient satisfaction
3. Improved process outcomes:
   As seen in increased service quality, increased caregiver engagement, and reduced malpractice claims.

Tools and techniques:

Effective Team Members: "achieve a mutual goal through interdependent and adaptive actions"

- Improved ability to predict the needs of other team members.
- Provide quality information and feedback.
- Engage in higher level decision-making.
- Manage conflict skillfully.
- Understand their roles and responsibilities.
- Reduce stress on the team as a whole through better performance.

Importance of mutual support:

- Essence of teamwork: to protect team members from work overload situations that may reduce effectiveness and increase the risk of error.
- Mutual support is our responsibility: people have different responsibilities but all of us are accountable for bringing issues or concerns forward and to offer or request support where and when it is needed.

Task assistance:

- This is a specific offering of assistance. It is important to speak up and create openness as it will create a culture of patient safety. Team members foster a climate in which it is expected that assistance will be actively *sought* and *offered* as a method for:
    - Anticipating what might go wrong and proactively planning to mitigate the risk.
    - Reflecting on what has already happened and determining how to fix it and prevent recurrence.

The importance of feedback:

- Reporting can be an issue but must be cultivated in the team so we can report problems or a near miss. This is important to our culture.
- Dr. Anderson shared an industry study (e.g., errors, rule-breaking, patient deaths due to mistakes in hospitals) and related it to the importance of feedback and developing a sense of comfort in giving and receiving feedback. It takes courage to give and receive feedback. An open culture of feedback fosters high-functioning teams.
- Characteristics of effective feedback include:
    - Timely – it is best given when fresh in the mind of the receiver
    - Respectful – focus on the behavior not the personality
    - Specific – use fact-based "I" statements
    - Directed toward improvement which helps prevent the same problem from recurring in the future
    - Considerate – be fair and respectful
    - Constructive and reinforcing

The assertive statement – critical for effective feedback:
This is a technique of "speaking up" about patient safety. It demonstrates respect and support of authority and when used properly clearly asserts concerns and suggestions using a nonthreatening approach to assure that critical information is addressed. This is done by:

- Making an opening
- Stating the concern
- Stating the problem
- Offering a solution
- Reaching an agreement

Please use CUS words – but only when appropriate:
This is a pneumonic: "CUS" and used to reflect the following - I am **concerned**; I am **uncomfortable**; and this is a **signal** that something is about to go wrong.

Closed-loop communication:
This is an important technique and pharmacists excel in it. It is a skill that needs to be practiced. It has three components:

1. Sender initiates a message.
2. Receiver accepts the message and provides feedback confirmation.
3. Sender receives that the message was verified.

SBAR – situation, background, assessment, recommendation:
This is a shared communication model and a standardized method for team members to effectively communicate information with one another. It is a way to handle a handoff or to organize the presentation of a problem you want to solve:

- Situation: a statement of issue concern (your name and position; patient's name; and reason for the communication).
- Background: a synopsis of pertinent facts (current diagnosis; date and reason for admission; synopsis of patient treatment to date and patient's response; pertinent physical assessment findings and results of diagnostic testing).
- Assessment: your assessment of the situation (working hypothesis; statement of what you think the problem is).
- Recommendation: what you think needs to be done with a timeline of when things need to happen.

Patient-centeredness: partner with and center on the patient:
Embrace patients as valuable and contributing members of the patient care team. All members of the team share these role attributes:

- Learn to listen to patients.
- Assess patients' preferences regarding involvement.
- Ask patients about their concerns.
- Speak to them in plain language and lay terms.
- Ask patients for their feedback.
- Give patients access to relevant information.
- Encourage patients and their families to proactively participate in patient care.

Huddles and "how are we doing boards" (HAWD):
Daily huddles are conducted around a HAWD. This is a way to center on daily and monthly measures. It's a great way to customize and will have some variation between clinics. It's based on measures such as service quality and clinical quality. HAWDs be even be used to understand the reasons why a team is leaving late every day. Some teams incorporate, as part of the HAWD, direct patient feedback on a daily basis so all members of the team hear it. Dr. Anderson went on to address metrics that measure the patient experience in the clinics. He and his team are also measuring panel size, financial outcomes, and other parameters.

Final thoughts:

- Connect existing health system initiatives (patient service quality tactics and hand-off tools like SBAR) with ongoing training initiatives.
- Optimize care delivery through teams of caregivers who work at the highest level (top of license) with clear roles, scope of practice, and confidence in their skill sets.
- Influence an empowered and self-improving culture.
- Balance system and local.

Panel Presentations
Panel #1: Mission and Driving Force
Four Panel Presentations Follow

Facilitator: Tim Bartholow, MD, Chief Medical Officer, WEA Trust

Community Care, Inc.
Team Name: PACE and Family Care Partnership
Team Leader: Mary Parish Gavinski, MD, mary.gavinski@communitycareinc.org
Contact Information: 262-207-9318
Type of Presentation: Panel #1

In 1990 Community Care, Inc. became one of the first four On-Lok replication/ PACE (Program for All-Inclusive Care for the Elderly) programs in the United States. The program was developed to offer an alternative to nursing home and institutional care that allowed delivery of all necessary services 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. 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. This program uses an interdisciplinary team that pairs with a community physician and is more mobile for rural settings.

The population served in the PACE program are adults 55 years of age and older who meet functional criteria for nursing home care (~8+ medical conditions; functional disabilities - intellectual disabilities, physical disabilities, frail elderly – and low income). In the partnership program, are adults 18 years of age and older who meet the same medical / functional and income criteria for nursing home placement. Community Care serves members in nine counties in southeastern Wisconsin.

The composition of the core team is registered nurses, nurse practitioners, social workers, and physicians. Additional team members include rehabilitation specialists, home care providers, transportation, behavioral health specialists, and dieticians. Additional resources for teams include an internal wound consultant, infection control, provider quality department, and an advanced disease support team.

The Community Care Inc. 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.

1. The mission of the care team is to work with the member (persons enrolled in Community Care programs are identified as members) to identify the members' goals and outcomes and to collaboratively develop a member care plan and services to meet the desired outcomes and goals.
2. 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.
3. Community Care provides care and services consistent with emerging consumer demands for individual choices in health care and services.
4. Community Care combines adult day health center settings, home care, interdisciplinary teams, transportation systems, and capitated payment systems so providers can respond to the unique needs of each individual served.
5. 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.

The initial driving force to bring the PACE model of care to Milwaukee was a belief that given the choice, persons with complex health and/or functional needs would prefer to remain in their homes and communities rather than move to institutional settings. This led the board of directors to hire a core of dedicated clinicians and administrators who drove the development and fostering of the initial PACE team. This leadership group was a part of the executive team of the organization and had a direct connection to the board of directors. The board of directors and the executive team were intimately involved in assuring the vision of the PACE program was instilled in the direct care staff and supported the staff's growth and learning about team work and true interdisciplinary work. Community Care was also a driver of the development and leadership of the fledgling National PACE Association which is a national group that promotes trains and supports the dissemination of the PACE model of care across the country.

The interdisciplinary care team which includes the member at its core and is the hallmark of the PACE model of care. The interdisciplinary team is responsible for assessing members and providing direct care and/or care management for all member needed services. The team is also directly responsible for the quality of care and utilization of services for those needed services.

Each team is trained not only in their discipline specific role (physician, nurse, social worker, etc.) in member care but also in the process of how to work in a truly interdisciplinary/trans-disciplinary care team. It is often this aspect of the PACE model that takes additional training and mentoring from leadership. Each team also has a facilitator who is responsible for the development of that team.

Community Care's PACE team has been operating for 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 they operate.

The interdisciplinary teams assess each member on admission and then reassesses every six months or with any major change of condition. The team along with the member and caregivers develop a comprehensive holistic plan of care to meet all health and long term care needs identified.

The team meets several times a week to discuss any changes to the member's needs and/or adjustments needed to the care plan. The member care plan is robust and can be quickly changed to meet the needs of a complex member with chronic health, functional, and behavioral health needs. If a member has a change of condition or a new need is identified, it can be assessed that day and new interventions started immediately. This leads to a decrease in acute care and residential care as well as preventing deterioration in health and functional status. The team also uses the Driscoll Reflective Practice method to discuss complex challenging cases, all admissions, readmissions, ethical, and quality concerns that may arise.

Comparing like dually eligible populations, PACE and Partnership show improved quality metrics (e.g., vaccination rates, preventative screenings, hypertension and diabetes control, decreased emergency room and hospitalization usage) and high member and caregiver satisfaction.

For consumers, PACE & Community Care, Inc. 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, PACE & Community Care, Inc. provides:

- An additional resource that can be used 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, PACE & Community Care Inc. 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.

PACE and Community Care, Inc. provides:

- Twenty year operation with good outcomes and low member disenrollment while continuing to be financially viable. Community Care, Inc. has developed programs that decrease the fragmentation seen for this population in the current health care system.
- Community Care, Inc. has successfully developed multiple teams in different locations that provide this care for members across southeastern Wisconsin.
- 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

Initially the major barrier we faced was demonstrating that persons with complex chronic care needs could be successfully managed with good quality outcomes in a community setting. This includes providing timely, robust, and intensive outpatient medical care as needed. In each new community, Community Care, Inc. develops 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. Additional barriers include: finding enough experienced and qualified nurse practitioners, nurses, and other health care disciplines to work in this model of care; training staff in truly interdisciplinary/trans-disciplinary care; and hiring staff who truly want to work in a trans-disciplinary team-based community based model.

Future plans include: defining each team members' role to prevent duplication and operate most efficiently; developing efficiencies with our electronic medical record and sharing information with contracted care providers; and continuing to develop advanced care models for members with complex chronic healthcare needs.

Ministry Health Care
Team Name: Advanced Practice Registered Nurse in Rural Critical Care Access Hospitals
Team Leader: Laura Magstadt, MSN, RN, Director, Patient Health Services
Contact Information: 715-479-0248, laura.magstadt@ministryhealth.org

Ministry Health Care (MHC) operates in 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. Critical access hospitals 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 critical access hospital physician staffing. MHC's success in recruiting and retaining physicians in critical access hospital 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 track. 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 in critical access hospitals, MHC identified that we must develop alternate care models which are less dependent upon rural family practitioners. The driver behind the development of the team-based model was our difficulty recruiting physicians in a timely manner and the cost pressures associated with low inpatient volumes. A comprehensive program was created including the development of inpatient curriculum and training, ongoing clinical and educational support, as well as the processes through which telemedicine supports daily inpatient management.

Champions of our program included our senior medical executives and local hospital administration. Program development work occurred between 2011 and 2013 with initiation of the program as our patient care model in May 2013.

Roadblocks to successful implementation were focused primarily on regulatory requirements. To implement the program as envisioned, Ministry Eagle River Memorial Hospital 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 advanced practice nurse prescribers (APNP) to admit patients and be responsible for the provision of medical care, thus fulfilling the role of an attending provider. Additional hurdles that arose as the project progressed were related to clarifying the communication and process flow between the APNP and the physician hospitalist working remotely. Once the workflows and legal components were clearly defined, we had the full support of the medical staff. Through the integration of telemedicine, APNPs now provide on-site critical access hospital hospitalist inpatient services supported through the remote connection to Ministry Medical Group physician hospitalists thirty miles away.

Our mission was developed by operational and medical staff leaders from Ministry Eagle River Memorial Hospital and Ministry Medical Group worked collaboratively to develop an innovative new model for inpatient care. All of our work is based on the MHC Catholic Health Care mission to further the healing ministry of Jesus by continually improving the health and well-being of all people, especially the poor, in the communities we serve. By using APNPs in a redefined way, and incorporating telemedicine to support their practice, our team believes that we are living out the mission of the organization by finding innovative ways to improve health care.

The future of this program is bright. Ministry Health Care has already expanded the program to our critical access hospital in Stanley, Wisconsin, and is working on further expansion to a third site. We have received a great deal of interest in the program from other hospitals and health systems both in Wisconsin and nationally, and we have hosted several site visits and conference calls to discuss our model of care delivery. Since its inception, this model of care has been widely accepted by our 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 Ministry Eagle River Memorial Hospital 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.

The success of our team is based on a commitment to person-centered care and the desire to offer the highest level of service and quality to patients across our system. The APNP's work in a very interdisciplinary manner with the entire patient care team, including nursing, therapists, case managers, 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.

Principles of LEAN and Six Sigma as well as general project management concepts and tools were the team processes used during the two year development and implementation phases. We began the project by clearly defining the desired outcome and investigating the regulatory components involved. A review of the current workflow was completed in order to crosswalk new workflow development. Detailed action plans were created for all key components of the project including training, regulatory requirements, credentialing/privileging, care delivery, telemedicine, documentation, and billing/coding. The project was piloted and during the initial few weeks the team frequently evaluated the workflow and scheduling processes, revising as necessary. With the expansion of the program eighteen months after initial launch, the team has gone back to revisit the workflow and has made adjustments based on provider feedback. The team will continue to monitor outcome data closely as it is directly tied with hospital quality and patient satisfaction.

Our project team was built based on operational roles and content expertise. The interdisciplinary team that functions on a day-to-day basis includes all of the clinical disciplines that provide direct patient care.

William S. Middleton Memorial Veterans Administration Hospital
Team Name: VA GRECC Connect Geriatrics Clinic
Team Leader: Lauren L. Welch, PharmD, BCPS, CGP
Contact Information: 574-360-8630, lpyszka@gmail.com
Type of Presentation: Panel #1 and Poster

The GRECC (Geriatrics Research and Education Clinical Center) Connect team comprises an interdisciplinary team consisting of a geriatrician, geriatric psychiatrist, geriatric pharmacist, nurse case manager, social worker, and neuropsychologist. This team was created to fill an unmet need for veterans residing in rural settings who have difficulties accessing geriatric specialty care due to living a great distance from the main medical center. The clinic's main focus is in utilizing clinical resources and innovative technology modalities to move beyond the current model of delivering in-person interdisciplinary specialty care to veteran patients. Initially, GRECC Connect was created through a government sponsored grant for five other GRECC sites around the country. Most of our clinical staff already existed in some capacity at our site, however, the initial grant money assisted in protecting staff's time in completion of clinic's responsibilities. All geriatric specialty clinics at our site operate as an interdisciplinary team approach, a key to providing comprehensive geriatric care. Currently, the concept of GRECC Connect clinics providing geriatric specialty care to rural primary care clinics is present at nine different VA sites across the country. Our project is currently funded through the Office of Rural Health.

The clinic functions as a consult service in which primary care providers in rural settings refer patients identified as experiencing complex, geriatric related issues. Providers can access the GRECC Connect Clinic by one of three venues: E-Consult, Tele-huddles, and Tele-medicine visits. E-Consults are completed as comprehensive chart reviews are conducted by the interdisciplinary team. The referring provider then receives a comprehensive set of recommendations to assist in managing complex geriatric cases, which includes interdisciplinary input. Tele-huddles occur monthly with the various rural outpatient clinics (providers, nurse care managers, and support staff) in which brief discussions are held between the interdisciplinary team and patient aligned care team (PACT) regarding specific, geriatric related patient issues and can serve as a venue to follow-up with recommendations made through one of the other venues. Tele-medicine clinic visits occur by way of video tele-conferencing where an actual clinic visit is conducted between the patient / caregiver at a rural clinic site and the GRECC Connect interdisciplinary team at the main medical center. We recently expanded our tele-health visits to conduct neuropsychological testing for our geriatric veteran patients who are unable to receive this service due to traveling difficulties which is needed for many cognitive impairment diagnoses and treatment plans.

Some issues that we have identified since our clinic was initiated include issues surrounding dual care (patient's receiving care both from community providers and VA providers). Often times, GRECC Connect Clinic recommendations are not easily implemented due to disconnects between providers at various sites and systems. Initially, our clinic provided recommendations to the primary care team after a patient was evaluated for his / her six month or annual check-up. This made it difficult for recommendations to be followed through in a timely manner. GRECC Connect then implemented a process known as Panel Co-Management. Through this process, a proactive approach is taken to review rural primary care provider panels of patients prior to the patient coming in for a scheduled clinic visit. GRECC Connect team members developed criteria to use when reviewing patient's medical record to determine individuals that are at high-risk relating to their geriatric syndromes. A chart review is then conducted for these patients prior to their scheduled clinic, thus GRECC Connect team's recommendations can be implemented in a timelier manner through providing a more proactive approach to care of these patients.

Once consults are received, the interdisciplinary team triages each consult to ensure that the service requested is most beneficial for the provider and patient. Patients may be seen across multiple venues depending on the complexity of the case. With the team's great success thus far, we hope to expand our services to rural VA clinics in northern Wisconsin and the Upper Peninsula in Michigan in the near future.

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 two to ten 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. The review of the literature led 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.

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 a 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.

Research findings indicate that depressive disorders affect and weaken the immune system allowing HIV to progress more rapidly, decrease medication and appointment adherence, and increase risk behaviors. Preliminary data also suggests that providing mental health treatment within an HIV clinic may improve health outcomes and increase adherence. These research findings provided the backdrop for the creation of an integrated care team, including mental health providers within the HIV program and focused on HIV

infected individuals with co-occurring mental health and AODA issues. In addition, a driving force for the inclusion of mental health providers on the team was a lack of mental health resources in the community; especially those accepting underinsured patients. The creation of the team was also consistent with the mission of the organization to provide comprehensive integrated care to all their patients.

Our team was developed and built over time although a vision of our full integrated HIV team was in place from the very beginning. The initial team members were physicians and nurses. As we were able to fiscally justify the addition of team members and demonstrated the importance to quality patient care, a social worker/case manager was added, then a pharmacist, followed by a psychiatric advanced practice nurse prescriber (APNP), and a psychiatric therapist.

To facilitate the team process, we have designated team meetings / staffings to identify the most appropriate treatment plan for the individual patient. In addition, the environment facilitates spontaneous team staffings. Team members are located in a "work room" to chart when they are not seeing patients. The work room allows for the interaction of team members to review patient cases on a daily basis.

The psychiatric component of the team initially started with the addition of mental health APNP who also was certified to provide psychotherapy. Within a few months, the schedule was full. The APNP hours were increased and subsequently another therapist was added, in addition to having psychiatric fellows rotate into the clinic. Outcome measures included anecdotal patient reports, visit and treatment adherence data, CD4 and viral load values, and Quick Inventory of Depressive Symptomatology (QIDS) scores. All of these parameters were positively impacted by the expansion of the team to include mental health services.

Although this presentation is highlighting the addition of the mental health component to the team, it is imperative that we do not lose sight of the importance of the team and team composition. Team-based care is just that; the creation of a team to provide care to a specific patient population. Teams work together and it is the integration that provides the best results. The HIV team consists of physicians, nurses, APNPs, pharmacists, case managers, retention-in-care specialists, social workers, residents, fellows, psychiatric APNP, and a psychiatric therapist. Martha Rogers, one of our founding nurse theorists, believed individuals and care are greater than the sum of its parts. This is what team-based care provides; care that is greater than the sum of the individual components.

Team-Based Care – A Commentary
Luncheon Address

Richard Dart, MD
President Wisconsin Medical Society, 2014-2015

I have selected team-based care as my priority theme during my current term as President of the Wisconsin Medical Society. Let me begin by asking "why now and why not in the past?" We simply cannot continue on the current path and we need to demonstrate our commitment to making the concept of patient-centered team-based care work. We are facing complexities in medical care that we need to harness. In the past, we would make a diagnosis, order therapies, and treat conditions. Today, it's much more complicated and is influenced by dynamic elements that include: the social and environmental determinants of health; insurance; formularies; guidelines/protocols; treatment history; and genetics. All of these influence diagnosis and therapies and make the process more difficult and complex than in the past.

We all can agree that computers are important tools to aid physicians and health care providers, yet social, environmental and health literacy have huge impacts on the delivery of primary, secondary, and tertiary care to patients and population groups. We face significant problems and complexities that shape our diagnoses, treatments / interventions, and patient outcomes. In terms of scientific publications alone, a practitioner would need to read 70 articles every day of the week just to keep up. Our complex environment provides an

important case for team-based care and why such a change makes a sense. In my medical specialty, nephrology, effective treatment of hypertension is guided by a minimum of five to six treatment guidelines which, in turn, impacts the quality of care and payment.

Dr. Dart then discussed his seventh and eighth slides (replicated below) concerning team-based care, complex care management, and attributes of team-based care.

Team-based Care
Complex care management (CCM)
PowerPoint Slide #7

- Small number of patients account for the largest cost of care
- Most cared for in small to medium clinics and rural settings
- Infrastructure is not in place to aid in complex care management
- Many barriers exist
- Team-based care and complex care management have many components

Hong, CM; Abrahms, MK, Ferris, TG
New England Journal of Medicine 2014, 371:6:491-3

Team-based Care
Components of Team-Based Care
PowerPoint Slide #8

Key components to team-based care:

- Leadership and the physicians role
  - Relationships
  - Reputation
  - Requirements
  - Rewards
  - Reciprocity
  - Resolution of issues, opinion, legitimate disagreement
  - Respect
- Compassion and caring

L. Solberg, Implementation Science, 26 October 2006 1:25;1-7

Dr. Dart then reflected on the morning session. Key points included:

- Team-based care is a means to manage very complex care management (CCM).
- Recognition of barriers is not only important, it is absolutely mandatory.
- We need processes to work through issues and learn together to get better at what we're doing.
- Solberg's 7R's apply (refer to slide replication #8 above).
- Meet the needs of a population / provider mismatch and learn together:
  - It is projected that in the year 2030, 35 percent of the Wisconsin population will be 65 years of age or older. Disparities between top-to-bottom age of the population and physician availability is a pressing issue familiar to all in this room.
- Potential benefits:
  - Cited an example of a study that measured the lasting results (for at least six months) on patient outcomes when using a physician-nurse-pharmacist team.

- Value to society as a whole and to individuals:
    - Value here is not only in health outcomes but our collective ability to drive down costs. Kaiser Permanente is documenting the lasting benefits of team-based care in the management and reduction of hypertension, heart attack, and stroke.
- Support and sustain team-based care:
    - Expressed confidence that payors would support team-based care if we can align and demonstrate potential value and the benefits of team-based care. We are engaged in an important dynamic – we are in the process of learning. We need to take pride in the leadership Wisconsin is demonstrating to the nation when it comes to team-based care.

Recently, the American Medical Association awarded $10 million to ten different medical schools ($1 million per school) to start teaching medical students differently by designing curricula where medical students take course together with other health disciplines to foster interdisciplinary approaches to practice and how we care for our patients. In real terms, these health professionals will learn to talk "with" and not "at" one another. Also, at a recent meeting of the American Medical Association in Dallas, Texas, team-based care was very high on the agenda / radar screen of the American Medical Association, American Academy of Family Physicians, and the American College of Physicians. In Wisconsin, team-based care is being driven by the American Heart Association and the American College of Cardiologists with the intention of driving smart care and improving performance and outcomes. He then reflected on examples of wide differences in billing and payments around the country visibly demonstrating disparities in payment between Medicare and Medicaid.

Physicians have a duty to lead the caring and compassionate team. This leads to opportunities to enhance care; practice satisfaction; professional enhancements; potential to be more efficient and cost-effective; and better outcomes. We need to lead in a collaborative and respectful manner – or follow - or get out of the way. Health care is important and it's expensive, insurance companies and employers state that health care costs a lot and they pay the bills. We are obligated to show them "what are we going to do about this." Dr. Dart closed with Volatire's quote: *Don't let the perfect be the enemy of the good.*

Panel Presentations
Panel #2: Team Interaction and Culture
Four Panel Presentations Follow

Facilitator: Barbara Nichols, DHL, MS, RN, FAAN, Wisconsin Center for Nursing and the University of Wisconsin-Milwaukee, College of Nursing

University of Wisconsin Hospital and Clinics
Team Name: Acute Care for Elders – ACE Team
Team Leader: Colleen M. Foley, MS, CMSRN, ACNS-BC, APNP
Contact Information: 608-890-6093, cfoley@uwhealth.org
Type of Presentation: Panel #2, Poster

Our purpose and mission is 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. Our team has been in place since 2006.

The building of our ACE Team originated with an advanced practice nurse and a geriatrician who recruited a pharmacist, social worker, and physical therapist with an interest and expertise in geriatrics. It was built upon the interdisciplinary model of care.

Recognition of an aging population of patients along with meeting the special health care needs of the geriatric patients represented driving forces behind the creation of the team. An interdisciplinary team led by

an advanced practice nurse was established to: (1) provide consultative services house-wide for geriatric patients, and (2) educate interdisciplinary staff on evidence-based practices and guidelines as it relates to the geriatric patient.

Hospitalized patients age 65 years of age and older represents the target population served by the Acute Care for Elders 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 geriatric patients and has a vested interest in the team. An 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 both the 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 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 helps formulate recommendations to decrease the burden of polypharmacy. Our team is also currently developing a role for a health psychologist. The health psychologist evaluates patients for depression and completes interventions such as improving coping mechanisms and cognitive behavioral therapy.

Acute Care for Elders is an interdisciplinary consultative service. A consult may be initiated by any interdisciplinary staff member 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 with 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, therapies, and are supportive of the patient.

Key outcomes measures include but are not limited to:

- Cost savings: $3,039 total hospital cost reduction of geriatric patients seen by Acute Care for Elders (ACE) as compared to matched controls.
- Improved provider satisfaction: University of Wisconsin Hospital staff perceives the ACE teams to be helpful 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 medications have on falls, cognition, sleep, and appetite for the geriatric patient.

Our successes include a system-wide awareness of the special physical, psychological, and psychosocial needs of geriatric patients. The team has been instrumental in the dissemination of evidence-based practices regarding the care of the geriatric population. Barriers include lack of awareness of geriatric nursing and medicine as a specific area of specialty practice; ageism; and staffing.

Our future plans include assessing the impact of health literacy among hospitalized older adults and their health care outcomes and service expansion to include working 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.

As for team processes, each team member serves an important role by representing their discipline and formulating recommendations with their expertise. Every few years ACE completes a survey to collect our

teams "pulse." We measure items such as how team members feel ACE is helping patients, other staff, one another, and feel their role is important.

Wheaton Franciscan Healthcare – All Saints
Team Name: Wisconsin Avenue Clinic Patient-Centered Team
Team Leaders: Gregg A. Albright, BSPharm, RPh, BCACP and Beth Buckley, RPh, PharmD, CDE
Contact Information: gregg.albright@wfhc.org
Type of Presentation: Panel #2, Poster

Racine has a high rate of underserved / uninsured patients who seek primary care through the emergency department and /or urgent care without continuous follow-up. The Wisconsin Avenue Patient-Centered Health Team evolved from a multidisciplinary teaching team to a medical home model-type team to provide improved access to quality primary care for patients served by All Saints Hospital and Wheaton Franciscan Medical Group located in Racine, Wisconsin. The multidisciplinary team, which already existed within the ambulatory clinic, was expanded to target high-risk vulnerable patients without primary care providers. The patients are identified via utilization of the emergency department and / or urgent care. They are also eligible for team care if they have one or more chronic diseases, multiple or complicated medication regimens, and are uninsured.

The team is comprised of two physicians, two nurse practitioners, inpatient and ambulatory care pharmacists, nurses, medical office assistants, a community health worker, a financial counselor, and customer service associates. Each member of the team has specific tasks to reduce risks and address barriers in order to provide routine medical care for chronic conditions and to avoid emergency department /urgent care use and hospital admissions. A unique aspect of this team includes the dual role that pharmacy plays in both inpatient and ambulatory care settings. The pharmacists' roles are to identify barriers and institute action plans for medication access and adherence, which includes:

- Communication across all platforms.
- Review of medication regimen in the emergency department and hospital.
- Modification of drug regimens to meet clinical outcomes and reduce medication barriers.
- Coordination of a personal clinic visit with ambulatory care pharmacist post discharge
- Providing recommendations to improve affordability of and access to medications.
- Enrollment in medication management programs (if needed).
- Patient education and adherence counseling on medications.
- Designing a workable medication action plan, with patient input, which is communicated to the primary care provider for approval

The culture and processes of the team are all driven by each member's mission to care for the patients and each other. The success of the team is due to processes that include:

- Communication - meetings of the team and of members in their respective departments. Access to common communication tools such as EPIC is also important.
- Relationships – building of the team members' abilities to enhance mutual respect and develop caring for each other as people, not just colleagues.
- Solid leadership support - on a systematic level, it is supported as a strategic initiative. The physician leader is a role model for respect and relationship building.
- Allowance for growth and flexibility - here each member works at the top of their license in their areas of strength and knowledge.
- Reinforcement (reminders) of team success - for individual patients in order to impact each team member's satisfaction with the work.

Since 2012, the team has been successful in providing primary care to greater than 400 patients which include disease and medication management; financial counseling; group diabetes visits; and referrals to other resources. Outcomes include: (1) a reduction in emergency department use and admission rates by approximately 40 percent; (2) a significant increase in access to insurance; and (3) a high patient satisfaction rate.

Aurora Health Care
Team Name: University of Wisconsin Family Medicine Clinics
Team Leader: Chris Klink, chris.klink@aurora.org
Contact Information: 414-649-6483
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 comprised 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: (1) patient education; (2) provider and medical resident education; and (3) 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 disproportionally 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. 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, and population management, 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, 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 pharmacists' referrals. As primary care continues to advance, the pharmacists will proactively adjust their role in the clinic to meet the needs of patients and providers.

Monroe Clinic
Team Name: Palliative Care
Team Leader: Sue Monson, RN, BSN and Gains Richardson, MD
Contact Information: 608-324-2155, sue.monson@monroeclinic.org and gains.richardson@monroeclinic.org
Type of Presentation: Panel #1

Monroe Clinic Palliative Care team was established in 2008. 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.

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. We 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.

Panel Presentations
Panel #3: Patient Population Served and Outcomes
Four Panel Presentations Follow

Facilitator: Sarah Sorum, PharmD, Vice President of Professional and Educational Affairs, Pharmacy Society of Wisconsin

Children's Hospital of Wisconsin
Team Name: Tracheostomy / Home Ventilator Program
Team Leader: Cecilia Lang, APN, clang@chw.org
Contact Information: 414-266-2484
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 ENT); nurses; advanced practice nurses; social workers; respiratory care practitioners; physical, occupational, and speech therapists; inpatient case managers; and a dietician who works collaboratively to serve those children who are tracheostomy and/or home ventilator dependent.

The mission and team purposes include: (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 the 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 the 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.

An overview of our outcomes include: the *n*umber of children who have successfully transitioned from hospital to home (average 150/year); the number of children who are decannulated each year (average 20-30); and the number of new tracheostomy / ventilator patients (average 20 per year). Other outcome data tracked in our program include: ventilator associated pneumonia rate; time to next appointment; patient and provider satisfaction; and inpatient safety events related to children with tracheostomies.

Program Statistics (Year: 2013):

- *Tracheostomy Program*
  - Admissions (17)
  - Transfers into the program (2)
  - Decannulations (11)
  - Transfer out of the program (3)
  - Deaths (0)
- *Home Ventilator Program*
  - Admissions (23)
  - Transfers into the program (1)
  - Decannulations (2)
  - Transfers out of the program (1)
  - Deaths (2)

The team has identified several barriers that include: increased acuity and complexity of patients; increased number of chronic lung disease and a complex cardiac population; growth of new interdisciplinary team members needed for team-based care and limitations of full-time equivalent requirements; increased outpatient clinic space and appointment needs; and 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 are aimed at: (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) growing local and statewide community services collaboration and outreach opportunities; (3) outpatient follow up and assuring care closer to home; and (4) growth of team-based education and integration of simulation into care delivery and education.

In terms of team processes, our team utilizes weekly rounding with the interdisciplinary team members for discharge planning; weekly pulmonary sign-out rounds and updates on medical plans for all current inpatients; and daily rounding with pulmonary and critical care teams on inpatient units. Our team also works closely with families during weekly care conferences to discuss overall care of the child and progress towards

discharge. Finally, we hold pre-clinic huddles and patient review with interdisciplinary clinic team members to plan goals of clinic visits and identify those patients who are a priority to be seen by team members (e.g., speech, nutrition, and respiratory therapy).

Our team was first organized in 1984 in collaboration with physicians from the Medical College physicians and respiratory therapy staff from Children's Hospital of Wisconsin. Since then, members have evolved based on patient care needs. For example, we added a speech therapist several years ago to address feeding and communication issues on both the inpatient and outpatient units. Similarly, we added more respiratory therapists to our team due to increased clinic volume. We continue to meet yearly to evaluate clinic staffing needs and set goals for the upcoming year as well as reflect on the year's accomplishments in our program and identify work that needs to continue in the following year.

ThedaCare Physicians, New London
Team Name: New London's Lineup
Team Leader: Tina Bettin, DNP, MSN, FNP-BC, APNP
Contact Information: 920-596-3435, tina.bettin@thedacare.org
Type of Presentation: Panel #3

The ThedaCare Physicians primary care offices provide care to a rural population on the Outagamie Waupaca county line with satellite offices further into rural Waupaca County. A portion of the service area is in a federal designated Health Professional Shortage Area (HPSA). The population is 98 percent Caucasian. 11.7 percent of the population is below the national poverty level with 17 percent of the children below the poverty level. Twenty-seven percent of the children are in single parent homes. The median income is $48.000. Nineteen percent of the population is 65 years of age or older which is higher than that of the state average.

The outcomes measures are based on quality and cost. The outcome data collected is based on the quality indicators selected by the Wisconsin Collaborative for Healthcare Quality (WCHQ). Early each year, ThedaCare senior leadership sets the ten quality indicators that are the focus for the year—these are usually based on high risk diseases and / or preventative health maintenance issues. The senior leadership sets the goal percentage, which can keep increasing annually for specific measures. In addition to this data, there are 33 factors being measured by the Centers for Medicare and Medicaid (CMS) due to ThedaCare Physicians being one the of the Pioneer Affordable Care Organizations (ACOs). The goal is for the best quality at the lowest cost.

The methods used to the track the outcomes are data entry from laboratory tests, diagnostic tests, and cost factors made available by the electronic medical record. This data is transparent and is shared with providers and staff monthly. This data is also transparent and shared on the WCHQ website for the public and other health care organizations/providers to view. The data is also reported to CMS monthly for being part of the Pioneer ACO. The Centers for Medicare and Medicaid typically reports the outcome on an annual basis including cost factors.

Success for outcomes is evaluated by the percentage of patients meeting the outcomes being measured. In addition, success is evaluated by patient satisfaction scores from their visit. Staff and providers evaluate each other and management for continued improvement/success.

We at ThedaCare Physicians are successful because providers and staff all have the same goal of providing the best care to the patient and using best practices as a guide. The team is successful because everyone shares in the success. The providers are also provided a financial bonus for meeting the quality matrix.

Our team processes are patient-centered. Attributes of our teams are hallmarked by: (1) team-sharing; (2) transparency; (3) team interconnectedness (the staff aid in the providers meeting the goals); (4) positive attitudes; (5) use of LEAN for changes with data and follow up matrix; (6) visible tools / matrix to track data; and (7) friendly intra-team competitions.

Our team was built by bringing on individuals through the hiring process that the team feels will be a good fit. This includes having staff and providers interview potential candidates (staff and providers) for input. If the team does not think the individual is a good fit, they are not hired. The focus is patient-centered and the ability to change due to the team process.

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

The Ambulatory Pharmacy Department at Froedtert and the Medical College of Wisconsin started in 1996 with the formation of the Anticoagulation Clinic. The intent behind this development was to increase the quality of patient care and to enhance patient and provider satisfaction. Since then we have expanded the volume of pharmacist support for the ambulatory environment from 0.2 FTE to 16 FTE and have expanded into an additional 15 clinics.

The purpose and mission of the Froedtert and the Medical College Ambulatory Pharmacy Department is to (1) support patients in achieving the best medication related outcomes; (2) enhance provider care and workflow; and (3) demonstrate value for our organization. Our department is a part of the overall Pharmacy Department at Froedtert Hospital. Our retail/outpatient pharmacy services sit at the corporate Froedtert Health level. Ambulatory pharmacist deployment has been structured to support the pharmaceutical management needs of patients in areas with the most need. Populations served currently include those with complex disease states and a high medication burden. The current clinics where pharmacists are a part of the care team include: (1) anticoagulation and medication therapy (including an anemia management service); (2) transplant; (3) infectious disease; (4) primary care / internal medicine; (5) cardiology; (6) pulmonary; (7)Sickle Cell; (8) endocrine; (9) Metabolic Syndrome; (10)pre-admission testing; (11) gastroenterology / hepatology; (12) rheumatology geriatrics; and (13) oncology.

The composition of the care teams can vary based on the needs of the patient and clinic structure. We have several models of care with pharmacists working alongside physicians, advanced practice providers, nurses, and others. The pharmacist may be involved in collaborative visits with the entire care team or see their own patients or a mixture of both. In other settings the pharmacist works in a segregated clinic while still operating as a distinct team member in that patient's care. An example of this more independent practice model is in our Anemia Management Clinic where a pharmacist meets one-on-one with patients; orders and assesses labs; administers erythropoiesis-stimulating agents; documents the encounter the patient's electronic health record; and communicates, as needed, with the patient's physician(s).

With regard to successes, the start of ambulatory pharmacy services at Froedtert and the Medical College of Wisconsin being narrow in scope, initially performing anticoagulation management where these roles are well supported in the literature. Through the years, we have expanded pharmacy services to unique and new models and disease states, something we consider a big success. We also are excited about the achievements we have had in positively impacting patient lives by improving their clinical outcomes as well as boast high patient satisfaction scores. We've seen our integration in the patient-centered medical home grow from twice a month educational presentations to pharmacists embedded into clinical practice and involvement in administrative and population health efforts. We also have been able to integrate well into multidisciplinary committees to assist the organization with making smart decisions on medication safety issues, formulary choices, managing recalled medications, implementing care guidelines, among others.

We have also integrated well with our outpatient medication management mail order service. This provides a concierge ongoing service to high-risk patients, which includes performing monthly medication reconciliation to assure accuracy of the patient's pharmacy medication profile, and telephone calls to the patient to asses 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.

As for barriers, we continue to struggle with the lack of reimbursement options for ambulatory pharmacist services. We also continue to encounter providers who are unfamiliar with the role or value a pharmacist may bring to a clinic, and so relationship building and education is important to our continued success. As the model of how pharmacists should support patient care in the ambulatory clinic setting is still very institution-dependent, we also struggle with determining appropriate benchmarks. 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 in a team approach.

Outcomes of the Ambulatory Pharmacy Department:
Anticoagulation Clinic:

- INR's within goal range are 57 percent vs. 47 percent for patients managed in the anticoagulation clinic by a pharmacist vs. physician managed patients, respectively.

Medication Management Mail Order Service:

- 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. Medication adherence rates were superior in the mail order group compared to standard of care (91 percent intervention vs. 65 percent control). Blood pressure was improved in the intervention group compared with standard care (63 percent at goal BP in the intervention group vs. 35 percent in the control). Hemoglobin A1c levels also improved in the intervention group compared with standard care (74 percent at A1c goal in the intervention group vs. 36 percent in the control).
- Infectious disease clinic patients who saw a pharmacist in clinic and received 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).

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 also have seen successful efforts in reducing the number or cost medications for patients seen by the pharmacist.

Cardiology Clinic:

- The pharmacist was able to identify on average two 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 that required an intervention to preclude harm.

Team processes are evidenced by embedding a pharmacist directly within the ambulatory clinic. The pharmacist has the challenge to integrate him or herself in existing workflows, which involves working with the clinic manager, physician medical director, other providers, nurses, and medical assistants. The pharmacist will often work individually with these stakeholders or as a part of existing team structures. We also have the ambulatory pharmacy team members coordinate to align workflows, and metrics across multiple departments. Our team was built over time as patient and provider needs were determined. Pharmacists with expertise and interest in the patient care area were identified and then worked to integrate themselves into the team of providers and care team.

Currently we have a wide breadth of pharmacists touching various specialty and primary care areas. However, with regard to future goals, we would like to increase our depth within these clinics (e.g., time dedicated to each clinic and better defined roles and accountabilities for the pharmacists within them). We also will work to be involved in population health efforts as our health care system moves more towards accountable care.

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

In 2014, Sixteenth Street Community Health Center served more than 36,000 people with 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; 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 poverty level, which in 2014 was $24,250 for a family of four.

Wisconsin community health centers track and annually report patient demographics; services provided; staffing; clinical indicators; utilization rates; costs; and revenues to the Bureau of Primary Health Care, U.S. Department of Health and Human Services. Sixteenth Street follows a strategic planning process with quality improvement goals and objectives that are updated annually. Measures are identified through this process as well as through our Joint Commission accreditation and Patient Centered Medical Home recognition. Most patient-related data is derived from Practice Analytics (a business intelligence and report creation tool) that is a part of our electronic medical records. Other types of data (such as patient satisfaction) are collected using paper and pencil counting.

Departments use a variety of formats to track outcomes, both qualitative and quantitative. Clinical data comes from electronic health records, such as Practice Analytics reports, EXCEL database reports, simple lists and so forth. Interventions, activities, and patient education sessions may also be tracked and outcomes or impact measured through patient surveys. When data is required by a funding or credentialing body their specific format is used.

We measure our success according to the satisfaction of our patients and our employees in addition to clinical quality improvement monitoring. Patient satisfaction surveys are administered randomly to selected groups of patients quarterly. Our Human Resources Department tracks employee turnover rates and conducts exit interviews to monitor the health of our workplace. For the past five years, we have participated in the employee survey administered by Workplace Dynamics, done as a part of the Milwaukee Journal Sentinel's Top Workplaces in Southeastern Wisconsin program. For the past four years in a row, we have been proud to receive the designation as a Top Workplace.

- We further base our success upon maintaining our accreditations which demonstration our excellence and quality. Sixteenth Street has been accredited by The Joint Commission since 2010, the nation's oldest and largest standards-setting and accrediting body in health care. We earned the Gold Seal of Approval which means we follow quality improvement and state-of-the-art performance standards for agency leadership, information management, environment of care, human resources, as well as other agency operations.
- We are a Patient-Centered Medical Home, which requires that patient encounters address smoking, emergency department follow up, visit summary, medication reconciliation, depression screening, and a variety of changing quality improvement items.

- Most recently we joined the Wisconsin Collaborative for Healthcare Quality, an organization that aggregates and publishes health care quality information. The information published is centered on standards related to mammogram rates; pap smear rates; birth weights; entry to prenatal care; colorectal cancer screenings; HgA1c; BMI documentation and counseling; smoking status and counseling; and vaccine rates.

Additional examples of our success reveal that:

- 70 percent of our diabetic patients have HbA1c levels less than or equal to 9 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, and an astoundingly low 6 percent 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.

Our team is successful because employees join Sixteenth Street Community Health Center truly believe in our mission and want to live it out every day. Our 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, 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." We support each other in working towards this mission and thus consistently renew our commitment to it.

With regard to team processes, each department meets for two hours monthly to review updates from directors and administrators and discuss concerns and develop ideas for improvement. Department directors (Clinical Leaders' Team) meet weekly to address and solve problems. The entire staff meets annually for four hours to receive training on some aspect of diversity and learn about new programs. A newsletter is published every quarter. We have an internal communication tool called SharePoint (a web application and platform for content management and collaboration) on which departments can post documents pertinent to others in an easily searchable format.

Building our team has been a steady process. Sixteenth Street Community Health Center was founded in 1969, using a nursing model of care. We provided easy access for people in a community setting and assembled a team that could coordinate care and provide the services of health care professionals from multiple disciplines to meet the needs of the patients. Like many small community health centers, we grew as support (both federal government and other agencies) was obtained to meet the need which became clear. The need only increased as word-of-mouth spread about a neighborhood health center where Spanish is spoken and good care provided. As we added providers and sites, we developed more comprehensive services for special needs such as HIV, diabetes, asthma, and obesity.

The Day's Recap and Next Steps

Speaker: Gina Dennik-Champion, RN, MSN, MSHA
Executive Director, Wisconsin Nurses Association
Project Director, Chronic Disease Prevention Grant
Grantors: Wisconsin Department of Health Services, Division of Public Health and the U.S. Centers for Disease Control and Prevention
Madison, Wisconsin

Ms. Dennik-Champion acknowledged the contributions of all presenters and the planning committee including all conference participants who will go home and make a change.

Response to the five questions posed by Dr. Shabino at the outset of the conference:

1. *What is the current state?*
   Ms. Dennik-Champion reminded all participants that 40 incredible abstracts demonstrating innovation have been documented in the conference compendium including the twelve panelists who formally described their work on the three panel presentations. There is room for more. Patient-center team-based care is occurring at the rural, urban, and metropolitan sectors throughout Wisconsin. Many population segments are being addressed. Many types of health professionals are part of these teams. Team-based care has the potential to produce an incredibly high rate of patient satisfaction by listening to patients and their stories and getting them the help they need.

2. *Why are teams created?*
   Most of what we're doing now doesn't meet patient, provider, and payor expectations. It's now time to identify and try something different. We've learned that it's about population health; effectiveness; accessibility; delivering high-quality care-management services; and primary, secondary, and tertiary prevention. Teams are created to assure patient safety, quality, and patient-centered care. Let's not forget that teams are also created to control costs – we all know about penalties associated with re-hospitalization. We also learned that teams are created because providers want more time with their patients. Teams are created to detect risks and early identification of illness, injury, disease, and disability as well as to assure community outreach and continuity of care. It is important that parent organizations see team-based care as their mission – as part of their organizational vision and striving for excellence.

3. *What are the key ingredients needed for teams to be successful?*
   A critical ingredient is organization support manifested in recognizing the value of team-based care and embracing it as part of the organizational vision, mission, and culture. Another ingredient is recognizing the value of team-based care as a systematic and organized approach to care and a pathway to health care redesign. Other, equally important ingredients include: respect for the team and the individual team members; team empowerment; passion and compassion; and enthusiasm. Each of these attributes was evidenced in every panel presentation. Team-based care is about process improvement and working at the top of our licenses. It's about team planning and listening. It's about agreed upon process for conflict resolution and really listening. Requisite ingredients include ensuring a ready supply of individuals who are willing to embrace and lead change. Ingredients include flexibility, consensus-building knowledge, passion, and adaptation. It includes knowing about and using technology and knowing where can I get started and learn more. We need to make team-based care patient-centered and patient-driven – it's about patients and what we can do for them. It is about their experience.

4. *What are common barriers to team-based care?*
   Barriers include reimbursement; the fee-for-service model; health literacy; health disparities; growing systemic workforce shortages; cultural differences of the parent organization; and where one want to go as a team. Another barrier is technology. For example, our electronic health records do not have a readily identifiable place where one can find out about team-based care for the patient. Team preparation and training is about new learning, learning about others, and learning about ourselves in the process. It's about regulation. We have to not only huddle about the patient and but we also need to huddle about how are we doing and how we are feeling as a member of the team. It's not about I, me, my, mine.

5. *How do we, as a state, move team-based care forward?*
   We need leadership at all levels to create the environment for systems change and innovation. Patient-centeredness should be a major driver. We need to disseminate information and evidence about team-based care models and best-practices. Our models have to inform how we work within a team based on our education and practice preparation. At the macro-level, we need collective support and collaborative engagement from our parent organizations to embrace this in our state. At the micro-level we need to develop strong and powerful teams. I don't think we have to invent because much is known and there

are models to replicate. There is a desire to move forward and keep the awareness growing. We have to brag and share the positive experiences of what both patients and providers are saying.

In closing, I want you to know that the Wisconsin Nurses Association (WNA), a formal member of WCMEW, has received a grant from the Wisconsin Division of Public Health and the U.S. Centers for Disease Control and Prevention to examine, at a deeper level, patient-centered team-based care with a focus on processes, protocols, policies, and plans specifically concerning hypertension and diabetes. WNA will jointly prepare the proceedings with WCMEW and will be working as a collaborative partner to WCMEW and our partners throughout Wisconsin in determining next steps to advance team-based care in Wisconsin.

Adjournment