

PATIENT-CENTERED TEAM-BASED CARE IN WISCONSIN

A WORKING CONCEPTUAL MODEL

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EXECUTIVE SUMMARY

Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model builds upon the existing and emerging work of many partners in Wisconsin and the nation to foster health care transformation that advances patient-centered team-based care and moves toward value-based care, improved patient health and safety, and improved health of the population. The Wisconsin Nurses Association (WNA), in collaboration with a community of partners and reviewers, developed the model. This work was supported by the Wisconsin Department of Health Services, Division of Public Health through its Wisconsin Chronic Disease Prevention Program (2014 to present), under funding opportunity No. CDC-RFA-DP 13-1305 from the Centers for Disease Control and Prevention, Department of Health and Human Services.

The model responds to an expressed need by the funders to conceptualize a Wisconsin-centric model for patient-centered team-based care. The model, based on literature and evidence, was tempered by the wisdom of our collaborators during its development and external review. Following a description of the model are five appendices that include:

Appendix A. A provisional set of expectations for teams, parent organizations, and workforce members developed by WNA's Multidisciplinary Grant Advisory Council (2015).

Appendix B. An enriched glossary.

Appendix C. A list of common themes identified by an expert panel convened on September 14, 2016, to improve the prevention, detection, and management of undiagnosed and uncontrolled hypertension, applied to two core elements of the model (teams and parent organizations).

Appendix D. A summary of an evidence-based training program known as *TeamStepps*.

Appendix E. Summary of key perspectives and practical approaches to developing and sustaining high-functioning patient-centered teams.

The model was originally developed to address two highly prevalent conditions: hypertension and diabetes. As the model evolved, collaborating partners concurred that a flexible and adaptable model was needed for application in a wide array of settings to address specific conditions and diseases, including prevention initiatives. The collaborating partners recommended that the model depict antecedent conditions necessary for successful team development. The proposed model incorporates these recommendations. It also emphasizes the importance of interprofessional approaches needed by teams and parent organizations.

The model intends to:

- Summarize the core and influencing elements of the model;
- Foster environments leading to active, informed, and engaged patients;
- Foster durable linkages between health systems, communities, and the public health system;
- Accelerate the adoption of patient-centered team-based care in Wisconsin;
- Offer a non-categorical model potentially adaptable to countless conditions, diseases, and prevention initiatives in health care, public health, and community settings; and
- Show the application of two of the core elements of the model (team and parent organization) to undiagnosed and uncontrolled hypertension (Appendix C).

The model is strongly patient-centered leading to patient engagement. The model reflects the principles and values identified by the National Academies' Roundtable on Value and Science-Driven Health Care (Mitchell et al., 2012; Okun et al., 2014) and other national and global sources. It relies on the dynamic interplay of an engaged patient, three core elements, three influencing factors, and durable linkages and connections to communities.

Engaged Patient:

- Empowered by the team and parent organization to be active, informed, and engaged
- The central focus of the model
- Aspires to achieve “care by me” and not just “care to me” (Okun et al., 2014)

Core Elements:

- Team (shared values and team expectations)
- Workforce (interprofessional workforce diversity)
- Parent organization (shared values and infrastructure expectations)

Influencing Factors:

- Core principles and shared values
- Hallmarks of Wisconsin Practice
- Triple (quadruple) Aim of Health Care™

Community Linkages and Connections:

- Mutual investment in durable linkages and connections between health systems and communities is critical. Patients (caregivers, family, and support systems) live, grow, work, learn, and play in communities. Investing in durable connections by health systems contributes to healthy people in healthy communities.

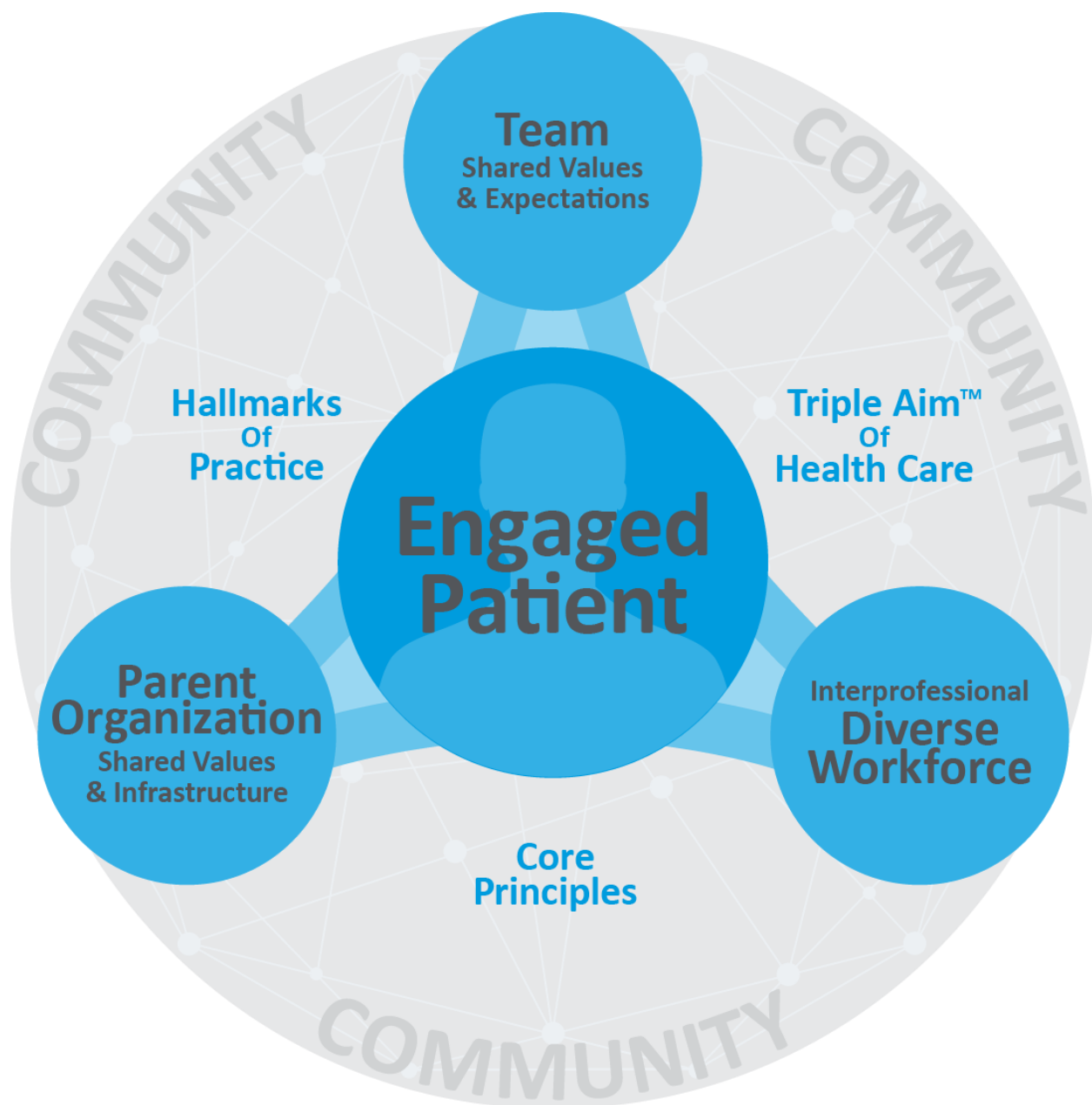
Taken together, the core elements, influencing factors, community linkages and connections, and engaged patients work harmoniously to support, nurture, guide, and sustain the work of high-functioning health care teams and their connections to communities.

Limitations

Although the model has not been formally tested for validity and reliability, it has been applied in two situations.

Next Steps

The model will be disseminated for use and improvement by Wisconsin health care organizations, academic centers, professional societies, and public/community health organizations. It will be available electronically using a variety of websites and incorporated into educational offerings. WNA recommends that this work ultimately be housed in a setting that embraces innovation and interprofessional education, practice, and research. WNA remains committed to advancing patient-centered team-based care.



ASSUMPTIONS

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

- The patient's current and emerging needs are considered in the context of his/her support system (including caregivers), family/community resource supports, literacy level, and risks/benefits stemming from the determinants of health.
- The parent organization provides the infrastructure to develop and sustain teams by embracing patient-centered team-based care as their mission – as part of its organizational vision for excellence (Smith, 2015).
- Leadership is not enough. The infrastructure support provided by the parent organization is crucial for successful teams. The parent organization helps create the environment for team success (Smith, 2015).
- The principles of team-based care are embraced by the three core elements: team, workforce, and the parent organization.
- Success in achieving health care transformation through team-based care rests upon a foundation of shared values, shared vision, and shared mission, with active inclusion of the patient.
- The current fee-for-service model needs to transition from volume-based to value-based care. In the primary care setting, payment appropriately recognizes the added value to patients served in a patient-centered team-based care environment (Patient-Centered Primary Care Collaborative, 2007).
- Interprofessional education and training is continuous and focuses on knowledge, abilities, and attitudes of the individual members, the team, and the parent organization (Smith, 2015).
- Health care transformation is dynamic. Many designs, models, and approaches are being published, explored, and tested in Wisconsin and throughout the nation.
- New designs must be developed to simultaneously pursue the dimensions of the Triple (quadruple) Aim of Health Care™ (Institute for Healthcare Improvement, 2015).
- Health care providers will experience improved professional satisfaction when working in a team-based care environment, as team-based care addresses, in part, documented dissatisfiers.
- Interprofessional education enables collaboration and improvement in health outcomes (World Health Organization [WHO], 2010).

KEY MESSAGES

Key messages aim to:

1. Accelerate awareness leading to the adoption of patient-centered team-based care as an important health care transformation-strategy in Wisconsin to achieve the dimensions of the Triple (quadruple) Aim of Health Care™.
2. Offer a fresh look at a potential model that is framed around the antecedent conditions necessary to develop and support effective patient-centered team-based care. The antecedent

conditions arise through the dynamic interplay and connectivity of the three core elements: (1) team, (2) parent organization, and (3) interprofessional diverse workforce. The antecedent conditions are necessary for health care transformation as they support, nurture, guide, and sustain the work of high-functioning health care teams.

3. Provide an overview of the principles, practices, components, applicability, and dynamics of patient-centered team-based care and the importance of interdisciplinary and interprofessional foundations.
4. Expand interest in patient-centered team-based care as a health care transformation strategy to improve patient safety and health outcomes, reduce or eliminate dissatisfiers in the delivery of care, stimulate payment reform that rewards value-driven over volume-driven care, control health care costs, and support and improve population health.
5. Present a rich set of definitions (Appendix B) to inform organizational leaders, professionals, and assistant staff members participating on patient-centered health care teams.
6. Show how two core elements of the model (team and parent organization) were used to identify improvements for undiagnosed and uncontrolled hypertension (Appendix C).
7. Acknowledge the importance of dialogue and collaborative leadership in nurturing systems thinking, innovations leading to patient-centered team-based care, and engaged patients.
8. Reaffirm the importance of durable linkages and connections between health systems and communities.

LIMITATIONS

Although the model has not been formally tested for validity and reliability, it has been applied in two situations:

1. In June 2016, WNA collected reflections from a convenience sample of health system executive leaders in Wisconsin concerning the organizational assets and challenges to delivering patient-centered team-based care by teams and parent organizations. This was a part of a semi-structured study jointly conducted by the Wisconsin Division of Public Health and WNA.
2. In September 2016, an expert panel, convened by WNA, applied two of the core elements of the model (team and parent organization) to undiagnosed and uncontrolled hypertension. Appendix C includes an initial set of common themes extracted from extensive dialogue by the expert panel to improve system processes by teams and parent organizations to prevent and control hypertension.

Finally, although the proposed model was developed by many collaborators and formally reviewed by key health, academic, and public health reviewers, there remains a continued need for interprofessional review, dialogue, and scrutiny.

NEXT STEPS

The model will be disseminated for use and improvement by Wisconsin health care organizations, academic centers, professional societies, and public/community health organizations. The model will be available electronically using a variety of websites and incorporated into educational offerings. WNA recommends that this work ultimately be housed in a setting that embraces innovation and

interprofessional education, practice, and research. WNA remains committed to advancing patient-centered, team-based care.

DEFINITION – PATIENT-CENTERED TEAM-BASED CARE

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

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

APPLICABILITY OF CONCEPTUAL MODEL

- The working conceptual model is broad by nature and reflects current literature and guidance from collaborating partners and is designed to be applied in many health and community settings.
- The model expresses that the whole is greater than any individual part, resulting in patient-centered team-based care supported by the parent organization and a diverse interprofessional workforce. The model is strongly patient-centered, as evidenced by the placement of patient engagement (caregivers/support system) in the model's center.
- The model depicts the dynamic interplay of three core elements supported by three influencing factors with durable linkages to the community. This adaptable model has the potential to stimulate planning and implementation of patient-centered team-based care for patients and population groups in need of primary, secondary, or tertiary care.
- The elements identified in the model provide a potential structure in which to incorporate team processes published by AHRQ and others. These processes have a “good fit” with the core elements of the model.

DYNAMICS OF THE CONCEPTUAL MODEL

This is a relationship model with an engaged patient at the center supported by three core elements, three influencing factors, and linkages and connections between health systems and communities. The three core elements, when interconnected create synergy and are herein known as the “antecedent conditions” – conditions necessary to develop, design, improve, and sustain an applied health care transformation strategy. Health care transformation requires connectivity of the core elements and do not exist in isolation of one another. A truly transformed strategy like patient-centered team-based care can serve as a force in building durable connections to communities

Three core elements directly support patient-centered care, population health, and engaged patients:

- A high-functioning team who delivers patient-centered team-based care;
- An interprofessional and diverse workforce from which teams are drawn; and
- The systems and operations of the parent organization. The parent organization provides and supports the infrastructure necessary to develop and sustain high-functioning teams and connections to the community.

Three influencing factors inform, nurture, and contribute to the delivery of high-quality and safe care by teams, the workforce, and the parent organization:

- Core principles of patient-centered team-based care (Mitchell et al., 2012);
- Hallmarks of practice of high-functioning teams; and
- Triple (quadruple) Aim of Health Care™ to drive system transformation that achieves positive outcomes for patients and the population.

COMMUNITY LINKAGES AND CONNECTIONS

Mutual investment in durable linkages and connections between health systems and communities is critical. Patients (caregivers, family, and support systems) live, grow, work, learn, and play in communities. Investing in durable connections by health systems contributes to healthy people in healthy Wisconsin communities.

A CLOSER LOOK AT THE ELEMENTS OF THE MODEL

The Engaged Patient (caregivers, families, and support systems)

An active, informed patient rests at the center of the model, with care influenced by interaction of all other model elements (Improving Chronic Illness Care, 2015). The patient receives care delivered on a continuum, where the patient experience transitions from *care to me* to *care with me* to *care by me* (Okun et al., 2014). Transformed teams will be prepared to deliver best practices to achieve *care by me*. This level of patient engagement is critical to achieve good self-care practices and, in turn, promote patient self-efficacy. The patient receives care that effectively addresses one or more conditions/diseases (e.g., diabetes, hypertension, heart disease). The team delivers care that promotes and protects health and patient safety. It is assumed, to the extent possible, that the patient is an active, motivated, and engaged member of the team and is willing to perform self-management (alone or with caregiver/family support).



The term *patient* is preferred for this model over person-centered or client-centered. “Client-centered implies a transactional relationship, while person-centered is devoid of the health care context. In contrast, the use of the term patient attaches one to a health care system. When used in the model, it exposes the responsibility and moral obligation of health care systems to not only provide care, but to create health” (M. Smith, personal communication, 08/30/16).

Core Element 1: The Team

The team functions as a patient-centered microsystem of the parent organization. The team informs and relies on the infrastructure supports and leadership provided by the parent organization. The team has its own set of adopted principles, team-based processes, and actions designed to promote a prepared proactive team (Improving Chronic Illness Care, 2015). The team engages patients and their caregivers/supports to foster shared accountability, safety, and satisfaction and to empower patients to achieve and sustain healthy life outcomes and well-being. Each patient has an ongoing relationship with a team prepared to provide first contact, continuous, and comprehensive care (Patient-Centered Primary Care Collaborative, 2007).



The anatomy of a team includes knowledge, skills, and attitudes. That means, teamwork related knowledge, teamwork related skills, and teamwork related attitudes all must be in place to be an effective team (Smith, 2015):

- Knowledge: What we are doing.
- Skills: How we should be working.
- Attitudes: Why we are doing our work.

Core Element 2: An Interprofessional Diverse Workforce

A diverse workforce reflects what each individual brings to the team (both professionally and through role assignments). The composition of team aspires to reflect the demographic diversity in the community. Team members work at the top of their license and education. The clinical practice of each team member is grounded in a set of shared values that are formally adopted by the team (Mitchell et al., 2012), which include:

- Honesty
- Discipline
- Creativity
- Humility
- Curiosity



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

Core Element 3: The Parent Organization

Leadership is not enough. The parent organization is a crucial element if the team is to be successful. It creates the organizational culture to grow, flourish, improve delivery, assure patient safety, and achieve health outcomes (Smith, 2015). Health care teams must be linked to the work of the larger system, the parent organization, of which they are part. Teams should not exist in isolation from the parent organization and the larger community. Linking teams to the parent organization advances shared leadership, fosters dynamic communication, and promotes shared decision-making with results. The parent organization provides the infrastructure (system, operational, and resource) supports necessary to achieve and sustain prepared, proactive, high-functioning teams (Improving Chronic Health, 2015) and assure durable connections to the community.



Infrastructure supports are rooted in the culture, shared vision, and shared values of the parent organization and informed by conditions in the community (determinants of health). The parent organization and the team support five team-based honored, applied, and integrated core principles (Mitchell et al., 2012):

- Shared goals
- Clear roles
- Mutual trust
- Effective communication
- Measurable processes and outcomes

Influencing Factor 1: Core Principles

Core principles guide action, behavior, and performance of the team, parent organization, and workforce elements and are foundational to patient-centered team-based care. These core principles include the following (Mitchell et al., 2012):

- **Shared goals:**
The team – including the patient, caregivers, family members, and other support persons – work to establish shared goals that reflect patient priorities that are clearly articulated, understood, and supported by all team members.
- **Clear roles:**
The team establishes clear expectations for each team member. This includes practice authority (top of license), scope of practice, functions, responsibilities, and accountabilities. It includes understanding one's own role and the role of team members to optimize team efficiency and harmony and to distribute work and accountability, thereby, accomplishing more than the sum of its parts.



- **Mutual trust:**
Team members earn each other's trust and create strong norms of reciprocity and greater opportunities for shared achievement.
- **Effective communication:**
The team prioritizes and continuously refines its communication skills. The team has consistent channels for candid and complete communication, accessed and used by all team members across all settings.
- **Measurable processes and outcomes:**
The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and in the achievement of the team's goals. This provides a source of data and information to track and improve performance immediately and over time.

Influencing Factor 2: Hallmarks of Wisconsin Practice

Hallmarks of practice are a set of suggested care and services that should be distinguishable in patient-centered team-based care environments. These hallmarks, often grounded in the literature, were originally formulated in 2015 by WNA's Multidisciplinary Advisory Council and include:

- "Health providers working in concert with patients and family caregivers to achieve positive experiences and mutually agreed-upon outcomes" (Okun et al., 2014, p. 7).
- Delivered by a high-functioning collaborative team (Mitchell et al., 2012; Okun et al., 2014).
- Grounded in the principles of team-based care: shared goals, clear roles, mutual trust, effective communication, and measurable processes and outcomes (Mitchell et al., 2012).
- Guided by a set of core values: honesty, discipline, creativity, humility, and curiosity (Mitchell et al., 2012).
- Safe, competency-based (e.g., knowledge, skills, attitudes) and evidence-based care (Baker, Salas, King, Battles, & Barach, 2005).
- Keep the patient as healthy as possible and proactively focused on all three levels of prevention (primary, secondary, and tertiary).
- Delivered on a continuum, where patient engagement transitions from *care to me* to *care with me* to *care by me* (Okun et al., 2014).
- Designed to actively foster patient engagement to achieve patient outcomes and improve patient satisfaction (Okun et al., 2014).
- Care is coordinated and/or integrated across all elements of the complex health care system and the patient's community (Patient-Centered Primary Care Collaborative, 2007).
- "Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner" (Patient-Centered Primary Care Collaborative, 2007, p. 2).



Influencing Factor 3: Triple (quadruple) Aim of Health Care™

The Triple Aim of Health Care™ is both a driver and a stimulus leading to the development of health care system transformation to achieve the three dimensions/aims of health care proposed by the Institute for Healthcare Improvement (2015). At this writing, the current literature is reflecting a growing interest in a fourth (quadruple) aim that would address dissatisfaction within the health care workforce. The authors believe that team-based care and interprofessional education should emerge as possible solutions to workforce dissatisfaction. The Triple Aim of Health Care™ includes:

- Improve the patient's experience of care (including quality, safety, and satisfaction)
- Improve the health of populations
- Reduce per capita costs of health care

Community: Durable Linkages and Connections

Infrastructure extends beyond the walls of the health system to the community. It includes durable linkages and connections to communities. Patients, caregivers, and their family and support systems live outside the walls of health care systems. The health and well-being of patients, families, and their support systems are influenced by the community, including the determinants of health (e.g., education, health literacy, income and employment, physical environments, social environments, housing). Durable linkages and connections between health systems and communities (organizations, agencies, providers, health departments, community health workers) represent a critical and reciprocal interface of mutual influence. It provides a mechanism and opportunity for investment in healthy communities. Durable linkages and connections extend the services of the health system into the community where patients (caregivers, families, and support systems) live, grow, work, learn, and play.

Health care systems are important members of the community. However, outside of a community health crisis, there is often little interaction between health care institutions and community/public health agencies and providers. This is likely true at all three levels of the system – local, regional, and statewide. Developing durable linkages with the community requires the convergence of the three core elements of the model: team, parent organization, and workforce.

According to the Agency for Healthcare Research and Quality (AHRQ, 2015):

Creating sustainable, effective linkages between the clinical and community settings can improve patients' access to preventive and chronic care services by developing partnerships between organizations that share a common goal of improving the health of people and the communities in which they live, grow, work, learn, and play. The goals of clinical-community linkages include:



- Coordinating health care delivery, public health, and community-based activities to promote healthy behavior.
- Forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services.
- Promoting patient, family, and community involvement in strategic planning and improvement activities (AHRQ, n.d., para. 1-2).

Shared strategies that improve access to clinical preventive services and health care treatment connected to community-level activities can prevent, promote, and protect health of people in communities, improve population health, and build important community assets and capacity. Durable linkages present a win-win scenario for participating organizations, clinical teams, patients, and the community as a whole. What do effective clinical-community linkages offer?

- Patients get more help in changing unhealthy behaviors.
- Clinicians get help in offering services to patients that they cannot provide themselves.
- Community programs get help in connecting with clients for whom their services were designed (AHRQ, n.d., para. 4-5).

Developing durable linkages between teams, parent organizations, and communities requires co-leadership with communities. It takes the work of many to improve the health of all. The authors of this publication recommend review of the inclusive systems model and partners described on page 46 in the Wisconsin Department of Health Services publication, *Healthiest Wisconsin 2020: Everyone living better, longer*. It is available online at <https://www.dhs.wisconsin.gov/hw2020/report.htm>.

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APPENDIX A

Evolving Expectations of the Team, Parent Organization, and Workforce

This list, originally developed by Wisconsin Nurses Association (WNA), is not exhaustive. It is the result of input gathered by WNA (circa 2014) from clinicians and grant partners and is offered to stimulate thinking and action.

Team Expectations:

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

- Model team-collaboration and collaborative leadership.
- Support conflict resolution.
- Promote continuous team and self-learning.
- Demonstrate growth in cultural competence at the organization and team levels and with community partners.
- Maximize electronic health record capacities (e.g., patient registries, record-scrubbing) to identify patients and subpopulation groups at risk.
- Include health literacy and cultural assessments of the patient into the plan of care.
- Include consideration of social, education, and economic determinants of health in plan of care.
- Foster patient-engagement and patient self-efficacy to transition from *care to me* to *care by me* to *care with me*.
- Model interdisciplinary and interprofessional approaches to build collaboration and influence health outcomes within the organization and within the community.
- Link services to community agencies and providers, including community health workers and local health departments.
- Agree upon team values.
- Assure joint development of evidence-based policies, protocols, and work-flow processes with teams.

Interprofessional Diverse Workforce:

Each patient has an ongoing relationship with a health care provider prepared to provide first contact, continuous, and comprehensive care (Adapted from Patient-Centered Primary Care Collaborative, 2007). Teams will vary in size and composition. All members of Wisconsin's health workforce who comprise the team play a role, directly or indirectly, in quality improvement, health outcomes, patient safety, patient satisfaction, and population health improvement.

Core and expanded team members include, but are not limited to:

- Advanced practice registered nurse
- Care coordinator
- Community health worker
- Health coach
- Health educator
- Informaticist
- Licensed practical nurse
- Medical assistant

- Medical specialist (e.g., cardiologist, endocrinologist)
- Mental health provider
- Navigator
- Osteopath
- Pharmacist
- Physician
- Physician assistant
- Receptionist
- Registered dietitian
- Registered nurse
- Social worker

Note:

For more information about diversifying the workforce, refer to U.S. Department of Health and Human Services (2001).

Parent Organization (system, operational, infrastructure) Expectations:

Teams do not exist in isolation of the parent organization and the larger health system. The system itself is a crucial element if the team is to be successful. The system creates the environment for team success. There must be a dynamic interplay between the team, the parent organization, and the workforce. Suggested expectations for parent organizations include, but are not limited to:

- Nurture an organizational culture that supports patient-centered team-based care.
- Support continuous quality improvement.
- Implement and evaluate staff education and training standards.
- Assure joint development of evidence-based protocols and workflow processes with teams.
- Support full practice authority and top-of-license for clinicians
- Support staff to work at the top of their education.
- Support and encourage interprofessional education, training, and staff development.
- Model collaborative leadership within the parent organization and with external community partners.
- Integrate parent organization policies into team processes.
- Model population health-focused care.
- Identify and develop durable linkages to the community. Linkages connect patients to community organizations, networks, and providers. They can improve and protect the health of population groups and benefit the community as a whole.
- Support changes to reimbursement strategies that reward transformed care delivery models, like patient-centered team-based care, as a value-based versus volume-based care model.
- Reflect shared vision, mission, and values of the parent organization into team processes.
- Adhere to evidence-based standards of care.
- Maximize use of information technology to assist teams' efforts to improve population health (e.g., registries).

APPENDIX B

Glossary

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

Antecedent conditions. Although the core elements can function semi-autonomously, the antecedent conditions arise through the dynamic interplay and connectivity of the three core elements: (1) team, (2) parent organization, and (3) interprofessional diverse workforce. The antecedent conditions are necessary for health care transformation and are essential to effectively operationalize, support, nurture, guide, and sustain the work of high-functioning health care teams.

Clear roles: A principle with clear expectations for each team member's functions, responsibilities, and accountabilities, which optimize the team's efficiency and often make it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts (Mitchell et al., 2012, p. 6).

Collaboration: Exchanging information, altering activities, sharing resources, and enhancing the capacity of another for mutual benefit and to achieve a common purpose. The qualitative difference between collaborating and cooperating in this definition is the willingness of organizations (or individuals) to enhance each other's capacity for mutual benefit and a common purpose. In this definition, collaborating is a relationship in which each organization wants to help its partners become the best that they can be at what they do. This definition also assumes that when organizations collaborate, they share risks, responsibilities, and rewards, each of which contributes to enhancing each other's capacity to achieve a common purpose. Collaborating is usually characterized by substantial time commitments, very high levels of trust, and extensive areas of common turf. A summary definition of organizational collaboration is a process in which organizations exchange information, alter activities, share resources, and enhance each other's capacity for mutual benefit and a common purpose by sharing risks, responsibilities, and rewards (Himmelman, 2002, p. 3).

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

Community health worker: A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services in the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities, such as outreach, community education, social support, and advocacy (American Public Health Association, 2015, para. 2 and 3).

Creativity: A team value, in which team members are excited by the possibility of tackling new or emerging problems creatively. They see errors and unanticipated bad outcomes as potential opportunities to learn and serve (Mitchell et al., 2012, p. 5).

Cultural awareness: The process of conducting self-examination of one's own biases toward other cultures and the in-depth exploration of one's cultural and professional background. Cultural awareness also involves awareness of the existence of documented racism and other "isms" in healthcare delivery (Transcultural C.A.R.E. Associates, 2015).

Cultural competence: A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. {Adapted from Cross, 1989}. (U.S. Department of Health and Human Services, Office of Minority Health) (n.d.).

Cultural knowledge: The process in which the health care professional seeks and obtains a sound educational base on culturally diverse groups. In acquiring this knowledge, health care professionals must focus on the integration of three specific issues: health-related beliefs, practices, and cultural values; disease incidence; and disease prevalence (Transcultural C.A.R.E. Associates, 2015).

Cultural skill: The ability to conduct a cultural assessment to collect relevant cultural data regarding the client's presenting problem, as well as accurately conducting a culturally-based physical assessment (Transcultural C.A.R.E. Associates, 2015).

Curiosity: A team value in which team members are dedicated to reflecting upon the lessons learned in the course of their daily activities and using those insights for continuous improvement of their own work and the functioning of the team (Mitchell et al., 2012, p. 6).

Determinants of health: The conditions in which people are born, grow, live, work and age (WHO, 2015). Circumstances shaped by broader forces, including economics, social policies and politics. (CDC, 2015). Examples of the social determinants of health include employment, community safety, income, educational attainment, family and social support, as well as racism and other forms of discrimination (Wisconsin Department of Health Services, 2010).

Discipline: A team value in which team members carry out their roles and responsibilities with discipline, even when it seems inconvenient. At the same time, team members are disciplined in seeking out and sharing new information to improve individual and team functioning, even when doing so may be uncomfortable. Such discipline allows teams to develop and stick to their standards and protocols, even as they seek ways to improve (Mitchell et al., 2012, p. 5).

Effective communication: A principle in which the team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication, which is accessed and used by all team members across all settings (Mitchell et al., 2012, p. 6).

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

Note: It is WNA's position that in Wisconsin the above definition, "Full Practice Authority" encapsulates all of the advanced practice registered nurses. The other advanced practice nurse roles are Certified Nurse Midwives, Certified Registered Nurse Anesthetists, and Clinical Nurse Specialists.

Health Care Transformation: Health care transformation is the effort to improve health outcomes, access to health services, the way patient care is delivered, and ultimately, changing from a volume-based to a value-based health care system (Illinois Hospital Association, 2013).

Health literacy: Obtaining, processing, and understanding basic health information and services needed to make suitable health decisions. Health literacy includes the ability to understand instructions on prescription bottles, appointment cards, medical education brochures, provider's directions, and consent forms. It also includes the ability to navigate complex health care systems. Health literacy is not simply the ability to read; it requires a complex group of reading, listening, analytical and decision-making skills, and the ability to apply these skills to health situations (U.S. Department of Health and Human Services, 2010). The degree to which individuals have the capacity to obtain, process, and understand basic information and services needed to make appropriate decisions about their health (U.S. Institute of Medicine, in Wisconsin Department of Health Services, 2010).

Health risk: Health risk is best defined using the definition of risk factors. A risk factor is any attribute, characteristic, or exposure of an individual that increases the likelihood of developing a disease or injury. Some examples of the more important risk factors are underweight, unsafe sex, high blood pressure, tobacco and alcohol consumption, and unsafe water, sanitation, and hygiene (WHO, 2016, para. 1).

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

Hiding in plain sight: Describe a subset of patient populations without a hypertension diagnosis who have documented high blood pressure readings $\geq 140/90$ mmHg. (Wall, et.al., 2014).

Honesty: A team value in which team members put a high value on effective communication within the team, including transparency about aims, decisions, uncertainties, and mistakes. Honesty is critical to continued improvement and for maintaining the mutual trust necessary for a high-functioning team (Mitchell et al., 2012, p. 5).

Humility: A team value where team members recognize differences in training, but do not believe that one type of training or perspective is uniformly superior to the training of others. Team members also recognize that they are human and will make mistakes. A key value of working in a team is that fellow team members can rely on each other to help recognize and avert failures, regardless of where they are in the hierarchy. As Atul Gawande has said, "Effective teamwork is a

practical response to the recognition that each of us is imperfect and no matter who you are, how experienced or smart, you will fail” (in Mitchell et al., 2012, p. 5).

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

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

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

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

Measurable processes and outcomes: A principle where the team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team’s goals. These are used to track and improve performance immediately and over time (Mitchell et al., 2012, p. 6).

Mutual trust: A principle and means in which team members earn each other’s trust, creating strong norms of reciprocity and greater opportunities for shared achievement (Mitchell et al., 2012, p. 6).

Parent organization: A health care organization that exercises responsibility and control over policy, employees, expenditures, structures, and services it oversees. It creates and provides tools and technologies to maintain quality. It is a resource that invests in the community it serves. It is

responsible to assure its resources are used to benefit staff and the patients they serve (Source: Working definition proposed by Maureen Smith, Gina Dennik-Champion, & Margaret Schmelzer, September 2016, Madison, Wisconsin).

Patient engagement: Patient engagement focuses on the relationship between patients and health care providers as they work together to promote and support active patient and public involvement in health and health care and to strengthen their influence on health care decisions, at both the individual and collective levels (Coulter, 2011, p. 10).

Patient (and family) engagement: Patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system – direct care, organizational design and governance, and policy making – to improve health and health care (Carman et al., 2013).

Quadruple aim: At this writing, a proposed fourth (quadruple) aim that would address burnout and dissatisfaction in the health care workforce (see also Triple Aim).

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

Self-management: The tasks individuals must undertake to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management, and emotional management of their conditions (Institute of Medicine, 2004, p. 57).

Self-management support: The systematic provision of education and supportive interventions by health care staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support (Institute of Medicine, 2004, p. 57).

Shared goals: A principle in which the team – including the patient and, where possible, family member and other support persons – works to establish shared goals that reflect patient and family priorities and can be clearly articulated, understood, and supported by all team members (Mitchell et al., 2012, p. 6).

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

Top-of-license: Top-of-license practice means matching the right provider with the right skill set to provide the right level of care at the right time and place. When clinicians function in this way, everyone's education and skills are used to their fullest extent, and the result is powerful and synergistic, maximizing team productivity, promoting engagement and satisfaction, and ultimately, leading to improved outcomes (Purdy et al., 2010).

Triple Aim of Health Care™: The framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance by pursuing three dimensions, called the *Triple Aim*. These three dimensions include: (a) improving the patient experience of care (including quality and satisfaction), (b) improving the health of populations, and (c) reducing the per capita cost of health care (Institute for Healthcare Improvement, 2015). (See also Quadruple Aim)

APPENDIX C

Application of Hypertension to Core Elements of the Model

On September 14, 2016, the WNA convened a hypertension expert panel experienced in team-based care and drawn from the following provider groups: family medicine, preventive cardiology, advanced practice registered nurses (nurse practitioners), PharmDs, and physician assistants. The panel was joined by a small group of external WNA collaborating partners, who were also focusing on the prevention and control of chronic diseases, particularly hypertension, heart disease, and diabetes through the state-level 1305 granting process (refer to Acknowledgements).

The expert panel focused its work on two of the core elements (antecedent conditions) in the patient-centered team-based care model: (1) team and (2) parent organization. Using nominal group processes, the panel members identified strategies to be taken by teams and parent organizations to improve the health of two important subpopulation groups served in Wisconsin health systems:

- Patients with hypertension who are undiagnosed and *hiding in plain sight*.
- Patients with diagnosed hypertension who are not controlled.

The panel members responded to the following questions: “What can parent organizations do to address undiagnosed and uncontrolled hypertension?”, “What can patient-centered teams do to address uncontrolled hypertension?”, and “What can patient-centered teams do to address undiagnosed hypertension?” The expert panel also identified strategies that teams and parent organizations can take to improve population health by building and sustaining durable linkages between health systems and communities.

A subcommittee of the panel met to review the responses collected from the September 14 event and identified a provisional set of common themes. The list of themes can be found in this appendix. Time did not permit the subcommittee to achieve consensus on common themes concerning durable community linkages.

WNA will reconvene the expert panel in early 2017 to:

- Approve the provisional themes and propose recommendations for:
 - Patients with hypertension who are undiagnosed and *hiding in plain sight*.
 - Patients with diagnosed hypertension who are not controlled.
- Approve themes and propose recommendations for durable community linkages.
- Align recommendations of the expert panel to the goals of “Million Hearts.”
- Disseminate recommendations to stimulate dialogue in support of the Triple Aim. TM.

WNA extends its gratitude to the expert panel and external partners for their time, thought provoking ideas, leadership, and commitment to improve the health and safety of patients and the health of the population. WNA also extends its gratitude to the Wisconsin Department of Health Services’ Division of Public Health, Chronic Disease Program, for its leadership and making this and other work possible by WNA.

Common Themes #1 (Provisional)

Core Element: Parent Organization

“What can parent organizations do to address undiagnosed and uncontrolled hypertension?”

Vision:

Wisconsin health systems invest in and make primary care patient-centered team-based care a priority because of its long-term benefits and cost savings in creating health for patients (and their families/support systems) and improving population health.

Note: *Because hypertension can be prevented, diagnosed, treated and controlled, it becomes an excellent condition in which to test and expand patient-centered team-based to other diseases and conditions. Patient-centered team-based care is a health care system transformation strategy.*

1. Establish a culture of patient-centered team-based care for hypertension prevention and control.

- a. Invest in patient-centered team-based care as the delivery standard.
 - i. Primary care settings that adopt patient-centered team-based care offer powerful benefits to patients, team members, populations groups, and health systems because of the investment in prevention and health promotion.
- b. Develop and support a culture that allows the team to actively measure patient blood pressures and provide interventions to patients at every appointment/contact.
 - i. Develop clear expectations for all health care team members.
 - ii. Measure blood pressure appropriately at all visits/contacts.
- c. Establish and provide real-time hypertension registries and data flows generated by system information technology services for the local teams to outreach patients at risk and in need of follow up.
- d. Create and allow adequate time for educational programs to support continuous learning by all team members. This must include training and retraining when there is turnover.
- e. Recognize and respond to the needs of the team through the provision of human and equipment needs to support team member satisfaction.
 - i. The team must be consistent in its care, regardless of available care providers, from check-in to check-out.
 - ii. Appropriate time is allowed to room patients.
 - iii. Allow appropriate time for staff to educate, coordinate, and motivate their patients.
 - Staff include physicians, osteopaths, nurse practitioners, physician assistants, pharmacists/PharmDs, registered nurses, medical assistants, and support staff.
 - iv. Foster shared accountability and responsibility by allowing team members to practice at top of license and highest level of education.
- f. Recognize and disseminate best practices.
- g. Allocate time for regular team meetings that will grow and develop high-functioning teams.
- h. Develop, support, train (educate), and disseminate evidence-based and standardized processes and protocols beyond medication and treatment.

- i. This includes patient education, food choices, activity levels, and stress management elements.
 - ii. This applies to all staff, including non-clinical staff. They must be able to readily access this information.
- 2. Establish a system-wide principle: all health providers are involved in the prevention, diagnosis, and treatment of hypertension.**
 - a. Allocate time for health promotion and disease prevention in support of the Triple (quadruple) Aim of Healthcare™.
- 3. Improve DASHBOARD capacity for the electronic medical record to support efficiencies in care delivery and patient safety.**
 - a. Dashboard alerts are needed for all providers and team members, system-wide.
 - b. Dashboard alerts allow easy access to:
 - i. Informational resources.
 - ii. Guidelines for treatment.
 - iii. Goals for blood pressure control.
 - iv. Appropriate medications for treatment.
 - c. Develop improvements to:
 - i. Create same-day rapid-access appointments.
 - ii. Schedule appointments and make referrals.
 - iii. Allow a patient into the next step of blood pressure management (using links).
- 4. Establish system-wide goals for hypertension.**
 - a. Measure blood pressure accurately at each visit anywhere in the system and a system for reporting measurement results.
 - b. Offer and encourage all visitors, caregivers, and family members accompanying the patient to have their blood pressure measured.
 - c. Assure every patient has access to accurate electronic blood pressure measurement equipment for personal use. (Parent organizations should purchase in bulk and distribute).
 - d. Assure every patient (caregivers, family, and other supports) knows how to use blood pressure measurement equipment and how and where to report results.
 - e. Offer on-site screening of patients, caregivers, family, and other supports.
 - f. Offer community educational and support groups on self-management of hypertension.

Common Themes #2 (Provisional)

Core Element: Teams

“What can patient-centered teams do to address uncontrolled hypertension?”

- 1. Measure blood pressure accurately and appropriately at all visits.**
 - a. Provide initial and ongoing training for new and current staff.
 - b. Competency testing should occur at least annually.
- 2. Improve communication within and among team members (physician, nurse practitioner, pharmacist, physician assistant, registered nurse, medical assistant, and other staff).**
 - a. Simplify educational materials.
 - b. Hold regular team meetings to discuss strategies for improving patient compliance.
 - c. Incorporate evidence-based and best practices into team-based care.

- d. Establish electronic medical record alerts, information, and updates to allow rapid interactions within the team and with patients.
 - e. Allow quick changes in therapy by all appropriate team members.
 - f. Identify patients' health literacy level to support improved compliance.
 - g. Identify issues that may impact the patient's compliance with their treatment plan.
- 3. Allow all team members to act to the full level of their license (or education for non-licensed team members).**
 - a. Create a system for same-day, rapid-access appointments.
 - b. Allow data entry into the medical record by all team members.
 - c. Refer patient-to-patient education/support groups.
 - d. Follow up with patient on educational offerings.
- 4. Establish clear roles for all team members to assure care coordination with linkages to community resources.**
 - a. Develop blood pressure measurement protocol as part of visit.
 - b. Simplify distributed materials.
 - i. After-visit summaries can be overwhelming.
 - ii. Solicit patient (caregiver and supports) understanding of the after-visit summary giving them the information they need and understand.
- 5. Establish an "uncontrolled blood pressure team."**
 - a. Create a system for same-day, rapid-access appointments.
 - b. Team members actively engage patients regularly by working patient population registries.
 - c. Contacts with patients allow for medication changes and further education.
 - d. Scheduling appointments or labs.
 - e. Providing advice and counseling.
 - f. Promote and allow appropriate scheduling time for physician, PharmD, nurse practitioner, physician assistant, registered nurse.
 - g. Explore "Smart Set" automatic referral system
- 6. Collaborate with the parent organization and information technology services to develop registries, dashboards, and other system improvements that work for teams.**
- 7. Acknowledge and disseminate team successes shown to improve efficiencies and effectiveness of operations and patient care.**

Common Themes #3 (Provisional)

Core Element: Teams

"What can patient-centered teams do to address undiagnosed hypertension?"

- 1. Measure blood pressure accurately and appropriately at all visits.**
 - a. Provide initial and ongoing training for new and current staff.
 - b. Competency testing should occur at least annually.
- 2. Allow all team members to act to the full level of their license (or training for non-licensed team members).**
 - a. Create a system for same-day, rapid-access appointments.
 - b. Allow data entry into the medical record by all team members.

- c. Refer patient-to-patient education/support groups.
- d. Follow up with patient on educational offerings.
- 3. Develop a rooming system that allows appropriate blood pressure measurement.**
 - a. Allow sufficient time for rooming to include 2nd or 3rd blood pressure prior to provider visit.
 - b. Assure efficient equipment is available for blood pressure retesting during the rooming process (e.g., automatic and programmable blood pressure equipment).
- 4. Establish an *undiagnosed blood pressure team*.**
 - a. Create a system for same-day, rapid-access appointments.
 - b. Team members actively engage patients regularly by working patient population registries.
 - c. Contacts with patients allow for medication changes.
 - d. Scheduling appointments or labs.
 - e. Providing advice and counseling.
 - f. Promote and allow appropriate scheduling time for physician, PharmD, nurse practitioner, physician assistant, registered nurse.
 - g. Explore “Smart Set” automatic referral system
- 5. Establish relationships with community-based providers and organizations to support identification and reporting of patients presenting with hypertension.**

Note:

The list of provisional themes identified by the expert panel for the topical area of “durable community linkages” will be forthcoming in early 2017.

APPENDIX D

Summary of TeamSTEPPS

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MetaStar, Inc., Madison, WI**

Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) is a program developed by the Agency for Healthcare Research and Quality (AHRQ) that instructs health care providers to collaborate more efficiently and safely with one another using a variety of communication and teamwork strategies proven effective in other high-risk settings. Given the often hierarchical structure of professional interrelationships in health care, a chief feature of TeamSTEPPS is its encouragement of “lower ranking” teammates to overcome the reluctance to engage “higher ranking” team members with process-related safety concerns. A good example of this approach in health care is infection prevention during the insertion of a central venous catheter, where an observer, often lower in rank than a physician or nurse practitioner, must communicate when a break of sterility has occurred.

MetaStar, Inc. is a quality improvement organization dedicated to ensuring the healthiest lives possible. MetaStar, Inc. offers providers the best, most current information in the health care field. We bring providers together to share their wisdom and to collaborate and learn from one another. TeamSTEPPS was recommended by the Centers for Medicare and Medicaid Services as an evidence-based resource that can improve quality in patient safety. Staff will often say they are uncomfortable speaking up when mistakes happen. It is important to realize the entire team, at all levels, has a personal perception of the daily work of an organization and that all opinions are only valuable if allowed to be heard. Not everyone is able to handle conflict and not everyone is willing to speak up when necessary. TeamSTEPPS provides the tools that allow the team to interact as a unified alliance to support the most important goal – patient safety. Individuals who receive TeamSTEPPS training have the opportunity to emerge as stronger individuals.

The TeamSTEPPS emphasis on effective team communication, especially with regard to patient safety, can be appreciated more fully when one considers its origin in “Crew Resource Management” (CRM). CRM began formally in the late 1970s on recommendation of the National Transportation Safety Board after a number of high profile airplane crashes were investigated and found to be the result of the authoritarian command structure in the cockpit. With CRM training becoming the aviation standard in the 90s, the flight crew began embracing their role in questioning captains more directly whenever they observed mistakes. Essentially, communication barriers on the team are reduced or removed completely, so a clear picture of potential mistakes or problems emerges more clearly to the entire team, thereby leading to a quicker and safer solution. Advocates for TeamSTEPPS methodology in the workplace often find that those same skill sets translate into their personal lives, as well, thereby contributing to a healthier workforce overall.

In its present form, TeamSTEPPS has been successfully implemented across a wide spectrum of health care organizations, including hospitals, nursing homes, physician clinics, surgical teams, and more. Aside from its obvious value to safety, the program is also more broadly effective at improving quality and patient health

outcomes through its focus on strong team communication and teamwork skills. The program is initially implemented through a comprehensive set of ready-to-use resources and a training curriculum that incorporates levels of training mastery (e.g., Master Trainers). As an evidence-based methodology, the data in support of TeamSTEPPS implementation in various health care settings are convincingly documented – whether in the emergency department, ICU, labor and delivery, or other health care settings (see AHRQ’s TeamSTEPPS website <http://www.teamsteppsportal.org/>).

Four key competency areas are the focus of the teamwork principles learned through TeamSTEPPS training.

1. Leadership compels all levels of team members to take an active leadership role when the situation warrants they do so.
2. Situation monitoring incorporates a shared mental model that team members can use to monitor teammate performance.
3. Mutual support during high stress situations or processes is both expected by and offered by all team members.
4. Communication itself, especially with regard to effective exchange of information among all levels of team members, is a critical component. In support of these competency areas, additional tools, such as team huddles and check backs, are also incorporated into the training.

TeamSTEPPS initiatives undertaken by organizations are regarded as having three continuous phases:

1. As the introduction of TeamSTEPPS methodology into an organization’s processes often constitutes a culture change, assessment is necessary as the first stage to ascertain readiness and receptivity to the program. It is important at this phase to identify a specific problem to address and to formulate a strong vision for the organization.
2. Phase two is the planning and execution itself – training. Once specific tools or strategies have been selected, the effectiveness of these needs to be tested.
3. Finally, the third phase – sustainment – spreads the method more widely throughout the organization and applies it to a variety of problems on a daily basis so that the culture change is more complete and lasting.

APPENDIX E

Excerpts: “Summary of Proceedings: Building a Culture for Patient-Centered Team Based Care”

The purpose of this appendix is to highlight important content and perspectives concerning patient-centered, team-based care by: Maureen Smith, MD, MPH, PhD; Andy Anderson, MD, MBA; and Gina Dennik-Champion, MSN, RN, MSHA. This conference was sponsored by the Wisconsin Council on Medical Education and Workforce and held on November 12, 2014, Wisconsin Dells, Wisconsin. The proceedings were prepared by the Wisconsin Nurses Association and jointly published by the Wisconsin Council on Medical Education and Workforce, May 2015. It is available online at http://wisconsinnurses.org/wp-content/uploads/2016/12/Proceedings-5_29_15-with-credits.pdf

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

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; 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

Executive Vice President and Chief Medical Officer, Aurora Health Care

President, Academic Affairs Aurora UW

President Aurora UW Medical Group

Associate Dean, University of Wisconsin School of Medicine and Public Health (Milwaukee Campus)

Milwaukee, Wisconsin

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: <ul style="list-style-type: none"> • Health care costs expected to reach \$4.4 trillion in 2018 • Unnecessary services • Inefficient delivery of care • Missed prevention opportunities 	Results in: <ul style="list-style-type: none"> • Proactive care management of patient populations (including prevention) • Leveraged caregiver teams working at the top of license • Easy access to 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: <http://www.ihl.org/resources/Pages/IHIWhitePapers/GoingLeaninHealthCare.aspx>
- 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 mnemonic: “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.

The Day’s Recap and Next Steps

Speaker: Gina Dennik-Champion, RN, MSN, MSHA

Executive Director, Wisconsin Nurses Association

Project Director, 1305 Chronic Disease Prevention Grant (2014 to present)

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-centered 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

identify illness, injury, and premature death 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 processes 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 wants 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 of today's conference 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.

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