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

Wisconsin Nurses Association

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Table of Contents
(To be formatted)

<table>
<thead>
<tr>
<th>Title page</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td></td>
</tr>
<tr>
<td>Working conceptual model schematic</td>
<td></td>
</tr>
<tr>
<td>Executive Summary</td>
<td></td>
</tr>
<tr>
<td>Overview</td>
<td></td>
</tr>
<tr>
<td>Assumptions of the working conceptual model</td>
<td></td>
</tr>
<tr>
<td>Purposes of the working conceptual model</td>
<td></td>
</tr>
<tr>
<td>Key messages of the document</td>
<td></td>
</tr>
<tr>
<td>Limitations</td>
<td></td>
</tr>
<tr>
<td>Next steps</td>
<td></td>
</tr>
<tr>
<td>Definition: patient-centered team-based care</td>
<td></td>
</tr>
<tr>
<td>Accessibility and dynamics of the working model</td>
<td></td>
</tr>
<tr>
<td>Description / definitions of the model’s core elements and external rings</td>
<td></td>
</tr>
<tr>
<td>Core element #1 – The team</td>
<td></td>
</tr>
<tr>
<td>Core element #2 – Diverse workforce</td>
<td></td>
</tr>
<tr>
<td>Core element #3 – The system and operations</td>
<td></td>
</tr>
<tr>
<td>External driver – Core principles</td>
<td></td>
</tr>
<tr>
<td>External driver – Hallmarks of practice</td>
<td></td>
</tr>
<tr>
<td>External driver – Triple Aim of Healthcare™</td>
<td></td>
</tr>
<tr>
<td>References</td>
<td></td>
</tr>
<tr>
<td>Appendices</td>
<td></td>
</tr>
<tr>
<td>Appendix A – Evolving expectations of the team, parent organization, workforce</td>
<td></td>
</tr>
<tr>
<td>Appendix B – Definitions</td>
<td></td>
</tr>
<tr>
<td>Appendix C – Launching team-based care using hypertension as a starting point</td>
<td></td>
</tr>
<tr>
<td>(To be written)</td>
<td></td>
</tr>
</tbody>
</table>
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Executive Summary
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Overview

The development of the working conceptual model was led by the Wisconsin Nurses Association (WNA) in collaboration with a diverse community of interest and reviewers. This work emerged out of a Chronic Disease Prevention Grant awarded to the WNA by the Wisconsin Department of Health Service and the U.S. Centers for Disease Control and Prevention (2014 to present).

This working conceptual model responds to an expressed need by the funders to promote a Wisconsin-centric model for patient-centered team-based care model. This model is based on science, literature, and evidence. Moreover, it is tempered by the wisdom of collaborating partners in both its development and the review process.

The model was originally developed to improve patient outcomes specifically for two highly prevalent and conditions identified by the CDC and Wisconsin Department of Health Services: hypertension and diabetes. However, based on consultation with the collaborating partners, including the Wisconsin Department of Health Services, it was agreed that a “flexible and adaptable model” was needed instead of another categorical model for specific disease states. A model whose principles and elements would be foundational to patient-centered team-based care approaches to prevent and control of hypertension and diabetes, yet a model that could also be applied, in whole or part, in response to the full array of conditions and diseases in health care and community settings, including addressing risks in the community associated with the determinants of health.

The model’s principles and values discussion leans strongly on recent publications from the Institute of Medicine of 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. The model is strongly patient-centered leading to patient-engagement. It relies on the dynamic interplay of three core elements:

1. Team expectations
2. Interprofessional workforce diversity
3. Systems and operations expectations

These three core elements are supported and advanced through three external drivers:

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

Taken together, the three core elements and the three external drivers work harmoniously to support, nurture, guide, and sustain work of health care teams and connections of the health system to the community. The elements and drivers are seen as “antecedent conditions” for patient-centered team-based care where processes (published by many sources) inform implementation and improvement. Furthermore, it enables teams to protect and promote patient health and safety; prevent injury and disease; and contribute to healthy people in healthy communities in the places where the people of Wisconsin live, grow, work, learn, and play.
Assumptions of the Working Conceptual Model

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

- The patient’s current and emerging needs are considered in the context of his/her support system (including caregivers); family/community resource supports; literacy level and risks/benefits stemming from behavior, health care, determinants of health, and the environment.
- 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 (WCMEW/WNA, 2015).
- Leadership is not enough. The system operation support provided by the parent organization to the team is a crucial element if teams are to be successful. The system creates the environment for team success (WCMEW/WNA, 2015).
- The principles of team-based care are embraced by the three core elements: team, workforce, and systems/operations of the parent organization.
- Success in achieving health care redesign through team-based care rests upon a foundation of shared values, shared vision, and shared mission.
- The current fee-for-service model needs to transition from volume-based to value-based care. In the primary care setting, payment appropriately recognizes the added value to patients served in a patient-centered team-based care environment (Adapted: 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 as cited in WCMEW/WNA, 2015).
- Health care redesign is dynamic. Many designs, models, and approaches are being explored and tested.
- New designs must be developed to simultaneously pursue the dimensions of Triple Aim of Health Care™ (Institute of Healthcare Improvement, 2015).
- Health care providers will experience improved professional satisfaction when working in a team-based care environment because team-based care addresses, in part, documented dissatisfiers.
- Interprofessional education enables collaboration and improvement in health outcomes (World Health Organization [WHO], 2010).

Key Messages of the Document

Key messages are aimed at:
1. Accelerating awareness leading to the adoption of patient-centered team-based care as an important health care redesign strategy in Wisconsin to achieve the dimensions of the Triple Aim of Health Care™.
2. Providing a fresh look at the principles, practices, components, and dynamics of patient-centered team-based care and the importance of interdisciplinary and interprofessional foundations.
3. Expanding interest in patient-centered team-based care as a redesign strategy to: improve patient safety and health outcomes; reduce/eliminate dissatisfiers in the delivery of care; stimulate payment
reform that rewards value-driven over volume-driven care; control health care costs; and improve population health.

4. Sharing a rich set of definitions to inform organizational leaders, professionals, and assistant staff members participating on patient-centered health-care teams.

5. Acknowledging the importance of ongoing dialogue and collaborative leadership by the WNA, its Multidisciplinary Advisory Grant Council, and the Wisconsin Council on Medical Education and Workforce in nurturing “systems thinking” and innovation leading to patient-centered team-based care.

The narrative presents key messages and important contextual information about the working conceptual model. It offers, through the combined thinking of many, a blueprint for thinking and action related to the six components of the model as expressed in Venn diagrams of the model as a whole and its individual components. In addition, the document includes a definition of terms and appendices including the opportunity to “jump start” patient-centered team-based care to prevent and control hypertension.

**Next Steps:**
During January 2016 – April 2016, the WNA shared the model with stakeholders to identify strengths, weaknesses, and limitations of the working conceptual model. Following this, the working model will be revised and web-published by the WNA in June 2016. WNA will widely disseminate the model to its many collaborating partners for use and improvement by Wisconsin health care organizations, academic centers, and public / community health organizations. The WNA and its partners are desirous of identifying a home, ideally in an academic center, in partnership with the Wisconsin Department of Health Service’s Division of Public Health for further scrutiny, enhancement, and possible testing.

**Definition, Applicability, and Dynamics of the Working Conceptual Model**

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

> Team-based care is the provision of health services to individuals, families, and/or their communities by at least two 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 (as cited in Mitchell et al., 2012, p. 5).

**Applicability:**
The working conceptual model is broad by nature and reflects current literature and guidance from collaborating partners. It is designed to be applied in many health settings. The model expresses that the whole is greater than any individual part resulting in care that is patient-centered. The model is strongly patient-centered as evidenced by the placement of the patient (and caregivers/support system) in the model’s center. The model depicts the dynamic interplay of three core elements supported by three external drivers. These six components are antecedent to implementing patient-centered team-based care and requisite to achieve the triple aims and one that favors value over volume and improves patient safety, health, outcomes, cost, and population health.
Dynamics:
The six components of the model are interwoven and interconnected and are depicted in the working as a Venn diagram.

- Three core elements directly support patient-centered care and include:
  1. A high-functioning team who delivers patient-centered team-based care.
  2. An intraprofessional and diverse workforce from which teams are drawn.
  3. The system and operations of the parent organization that provides the essential infrastructure to develop and sustain high-functioning teams that are connected to the broader community.

- Three external drivers that influence and nurture the delivery care and contribute to the health of communities. These external drivers support and nurture the model’s core and include:
  1. Core principles of patient-centered team-based care (Mitchell, et al., 2012)
  2. Hallmarks of practice of high-functioning teams.
  3. Using the Triple Aim of Health Care™ to guide system redesign and achieve outcomes.

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

Limitations
(To be developed in collaboration with partners, reviewers, advisors)

Descriptions / Definitions of the Model’s Core Elements and External Drivers

“The Patient (care givers and support systems)”
An active informed patient rests at the center of the model and care is influenced by interaction of all other model elements (Improving Chronic Illness Care, 2015). Care is delivered and received on a continuum where the patient experience transitions from “care to me” to “care with me” to “care by me” (Okun et al., 2014, p. 11). The patient receives care that effectively addresses one or more conditions (e.g., diabetes, asthma, COPD, hypertension, heart disease). The care delivered by the team promotes and protects health and patient safety. The patients and their support systems benefit from primary, secondary, and tertiary levels of care to address current and emerging threats to health. It is assumed, to the extent possible, that the patient will be an active, motivated, and engaged member of the team and is willing to perform self-management (alone or with caregiver / family support).
Core Element #1– “The Team”
The team functions as a patient-centered microsystem of the parent organization. The team is dependent on the infrastructure supports provided by the parent organization. It has its own set of adopted principles, team-based processes, and actions designed to promote a prepared proactive team (Improving Chronic Illness Care, 2015). The team partners with patients and their supports to foster shared accountability, safety, and satisfaction. These partnerships result in patient empowerment to achieve and sustain healthy life outcomes. Each patient has an ongoing relationship with a health care provider trained to provide first contact, continuous, and comprehensive care (Adapted: Patient Centered Primary Care Collaborative, 2007).

Core Element #2– “Interprofessional Diverse Workforce”
A diverse workforce reflects what each individual brings to the team (both professionally and through role assignments). The composition of teams must aspire of reflect the demographic diversity in the community. The clinical practice of each team member is grounded in a set of shared-values that are formally adopted by the team. These values include:

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

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

Core Element #3 – “The System and Operations”
To grow, flourish, and produce improvement in care delivery and health outcomes, health care teams must be linked to the work of the larger system (parent organization) of which they are a part. Teams should not exist in isolation from the parent organization and the larger community. Linking teams and 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 teams and provides durable connections to the community (Improving Chronic Illness Care, 2015).

Infrastructure supports are rooted in the culture, shared vision,
and shared values of the parent organization regardless if it is a health system, a health department, or a community agency (WCMEW/WNA, 2015). Like the team, the parent organization supports five team-based core principles that are honored, applied, and integrated by both the team and the parent organization.

These core principles include:

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

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

**External Driver – “Core Principles”**

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

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

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

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

- **Effective communication:**
  The team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication which are accessed and used by all team members across all settings.
• **Measurable processes and outcomes:**
  The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team’s goals. This provides a source of data and information in which to track and improve performance immediately and over time (Mitchell et al., 2012).

**External Driver – “Hallmarks of Wisconsin Practice”**
Identifies the services of the patient-centered team-based care. The hallmarks of practice include care and services that are:

- Delivered by a high-functioning collaborative team (IOM 2012, 2014)
- Grounded in the principles of team-based care: shared goals, clear roles, mutual trust, effective communication, and measurable processes and outcomes.
- Guided by a set of core values: honesty, discipline, creativity, humility, and curiosity (IOM, 2012).
- Safe, competency-based (e.g., knowledge, skills, attitudes), and evidence-based care (JCAHO, 2005).
- Preventive oriented to keep the patient as healthy as possible (CCM) and proactively focuses on all three levels of prevention (primary, secondary, and tertiary) (CCM/WNA).
- Delivered on a continuum and where patient engagement in the experience transitions from “care to me” to “care with me” to “care by me.” (IOM, 2014).
- Designed to actively foster patient engagement with patients to achieve patient outcomes and improve patient satisfaction (IOM).
  
  (Note: need to format and include references above.)

**External Driver - Triple Aim of Health Care™**
This element is both a driver and a stimulus leading to the development of new health care system designs to achieve the three dimensions/aims of health care proposed by the Institute for HealthCare Improvement (2015) that include:

1. Improving the patient’s experience of care (including quality, safety, and satisfaction).
2. Improving the health of populations.
References


Okun, S; Schoenbaum, S.C; Andrews, D; Chidambaran, P; Chollette, V; Grunman, J; LeaL, S; Lown, B.A; Mitchell, P.H; Parry, C; Prins, W; Ricciardi, R; Simon, M.A; Stock, R; Strasser, D.C; Webb, E; Wynia, M.K; and Henderson, D. Patients and health care teams forging effective partnerships. The authors are participants in the activities of the Institute of Medicine Roundtable on Value and Science-Driven Care. The report is intended to help inform and stimulate discussion and is not yet an official publication of the Institute of Medicine of the National Academies.


Additional Sources:
This would include resources not cited but useful background
Appendix A
Evolving Expectations of the Team, Parent Organization, and Workforce
(Likely needs an introduction as originally developed in the context of HTN and A1c)

The Patient:
The patient (including caregivers / family) is at the center of this patient-centered team-based care working conceptual model. Patients (and their supports) receive care that is respectful of the patient, values, expressed needs, and his / her circumstances (Washington Department of Health, 2013). The patient is encouraged and motivated to participate in self-management activities that improve and sustain good health.

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

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

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

Core and expanded teams may be drawn from the following list that includes but is not limited to:

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

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

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

• Community networks and resources are identified and linked.
• Continuous quality improvement
• Culture and organizational change are embraced.
• Education and training standards
• Evidence-based protocols
• Full-practice authority for clinicians
• Inter-professional education
• Leadership
• Policies of the parent organization are integrated into team processes.
• Population-health focused
• Primary care system redesign
• Shared vision, mission, and values ground the organization and are reflected in team processes.
• Standards of care
Appendix B
Definitions*

*Note: The definitions that follow include all major terms used in model. Additional definitions have been added to enhance the reader’s understanding and provide a bridge to such sources (e.g., 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).

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

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

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

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

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

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

Cultural acceptance means acceptance and respect for difference, continuing self-assessment, and careful attention to dynamics of difference, continuous expansion of knowledge and resources and
adaptation of services to better meet needs of diverse populations (U.S. Department of Health and Human Services, Office of Minority Health, 2015).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Humility** is a team value and means team members recognize differences in training but do not believe that one type of training or perspective is uniformly superior to the training of others. They also recognize that they are human and will make mistakes. Hence a key value of working in a team is that fellow team members can rely on each other to help recognize and avert failures, regardless of where they are in the hierarchy. In this regard, as Atul Gawande, MD, has said, “effective teamwork is a practical response to the recognition that each of us is imperfect and no matter who you are, how experienced or smart, you will fail” (as referenced in Mitchell et al., 2012, p. 5).
**Informatics (clinical)** is the application of informatics and information technology to deliver healthcare services. It is also referred to as applied clinical informatics and operational informatics. The American Medical Informatics Association considers informatics when used for healthcare delivery to be essentially the same regardless of the health professional group involved (whether dentist, pharmacist, physician, nurse, or other health professional). Clinical Informatics is concerned with information use in health care by clinicians. Clinical informatics includes a wide range of topics ranging from clinical decision support to visual images (e.g. radiological, pathological, dermatological, and ophthalmological); from clinical documentation to provider order entry systems; and from system design to system implementation and adoption issues (American Medical Informatics Association, 2015).

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

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

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

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

**Parent organization** means (discuss a working definition with reviewers and advisors)

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

**Mutual trust** is a principle and means team members earn each other’s trust, creating strong norms of reciprocity and greater opportunities for shared achievement (Mitchell et al., 2012).
**Self-management** means the tasks that individuals must undertake to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management, and emotional management of their conditions (Institute of Medicine, 2003).

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

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

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

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

**Triple Aim of Health Care™** means the framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance by pursuing three dimensions, call the “Triple Aim.” These three dimensions include (1) improving the patient experience of care (including quality and satisfaction), (2) improving the health of populations, and (3) reducing the per capita cost of health care (Institute for Healthcare Improvement, 2015).
Appendix C
Hypertension: A Suggested Starting Point to Initiate Patient-Centered Team-Based Care
(To be developed – work with Pam Myhre and Rebecca Cohen)