AIAMC National Initiative VII
Capstone Presentations
Cohort Four

Teaming to Improve Care

March 26th (1:30-3:00 ET)

Cohort Four teams

- Baylor Scott & White
- ChristianaCare Health Services
- Guthrie Robert Packer Hospital (4 projects)
- Aurora Health Care – Cardiology
- Aurora Health Care – Internal Medicine

National Initiative

Capstone Questions

1. What did you hope to accomplish?

2. What were you able to accomplish?

3. Knowing what you know now, what might you do differently?

4. What surprised you and why?

5. Expectations versus Results:

   On a scale of 1 to 10 (with “1” meaning nothing and “10” meaning everything) how much of what you set out to do was your team able to accomplish and how were your results the same or different from your expectations?

National Initiative

NI VII Meeting Four – Capstone Presentation
Cohort Four: Teaming to Improve Care

The ART of Teaming

Incorporating Teaming for Long-Term Sustainment of a Communication Program

Megan Newman, MD

Wendy Hegefeld, PhD

Martha Howell, EdD

Q1. What did you hope to accomplish?

- The ART of Communication is a day-long workshop offered to all members of the healthcare team, usually around the time of onboarding. It focuses on open ended questions, structured communication, and empathetic communication with patients as well as other members of the healthcare team.
- ART of Communication has been offered for nearly 5 years to physicians, residents, and the healthcare team and has been well received by participants. Targeted interventions of reinforcement to certain individual providers has yielded impressive improvements in their HCAHPS and CG-CAHPS scores. The effects of the initial workshop on internal medicine interns has shown they achieve mastery of communications milestones sooner than previous peers who did not receive the training.
- A need was identified to reinforce the lessons learned in the workshop, and no plan was in place to provide these reinforcements. This became the primary aim of our project.

- Our AIM Statement: *We hope to reinforce the lessons from the Art of Communication workshop for our rounding team composed of diverse healthcare workers to sustain the educational impact and improve communication of the entire team.*

Q2. What were you able to accomplish?

- We identified a team and group of stakeholders that are supportive of the reinforcement of the principles of the ART of Communication workshops.

- We were able to extensively plan a project that will accomplish our aims, design a data collection strategy, as well as a plan for scholarly dissemination of our work.

- Our project will be ready shortly after COVID restrictions on group meetings lift. Unfortunately, we are unclear on the timeline of the lifting of restrictions, as the restrictions were reinforced in communications by our leadership just this week.

- We are encouraged by the continued need in our institution for our project as HCAHPS scores continue to be an area needing improvement. COVID only magnified the need for good interprofessional communication among our teams, and our leadership is supportive of our efforts to begin once meetings can take place again.

Q3. Knowing what you know now, what might you do differently?

- Not plan a didactic-based intervention in the middle of a pandemic. I underestimated the amount of time that we would not be able to meet in person.

- We initially planned an overly-ambitious project with multiple interventions that proved not to be feasible, despite initial enthusiasm from our stakeholders. I think it is always better to plan a smaller project and scale it up if it is successful, than a large one that is dependent on many unpredictable variables. It is also important to plan a solution that achieves the outcomes of the project.

- Our second intervention plan was much more do-able. It had a targeted, specific, measurable intervention that was a better fit for the team and would have been feasible to implement if not for the pandemic. I look forward to continuing the project when in-person meetings are possible again.

Q4. What surprised you and why?

- After we restructured our project, I expected our new intervention would be easy to implement and test. It was something requested by senior leadership to help sustainment of an effort that had already been ongoing for nearly 5 years.

- I was not expecting to have all in-person didactics and meetings cancelled for over a year due to COVID. I thought that as the surge decreased we would be allowed to meet periodically, but that was not possible.

- Many team members lost bandwidth required to help with our project as other COVID demands on their time came to the forefront.

- We ended up spending a great deal of time in the planning phase of our project. This has the added benefit of being ready to go as soon as didactics can begin again.

Q5. Cohort Four – Expectations versus Results

- **On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything) how much of what you set out to do was your team able to accomplish and how were your results the same or different from your expectations?**

- 2 out of 10

- Our team ended up planning a completely different intervention that was better suited to our learner group.

- COVID prevented any meetings larger than 10 people. We attempted to hold our educational sessions virtually, but after 2 sessions it became clear that these were not effectively accomplishing our educational objectives. Our intervention required role-playing activities and observation and feedback on nonverbal communication behaviors, which were not as effective on virtual platforms.

- We continually hoped to be able to perform our interventions, but we are still unable to meet, and have been for the past year.

Intervention Timeline

Jun 2018	June 2019	June 2020	August 2020	September 2020	Next Steps
• ART of Communication Workshop for Interns, class of 2021	• ART of Communication Workshop for Interns, class of 2022	• ART of Communication Workshop for Interns, class of 2023	• PEARLS reinforcement for classes of 2021-2023	• PEARLS reinforcement for classes of 2021-2023	• ART of Communication Workshop each June • PEARLS reinforcements for PGY 1-3 and nurses monthly

QUESTIONS

National Initiative

ChristianaCare

AiAMC
Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort Four: Teaming to Improve Care

Team Based Care in our Family Medicine Residency Practice at ChristianaCare

Jamie Rapacciuolo, DO, Sara Cabrera (Practice Manager), Jaime Ayala (Senior MA), Alan Schwartz, PsyD (Behavioral Health), Lauren Carter, MD (PGY3), Ben Golden, MD (PGY5), Alyssa Hancock, FNP, Anna Filip, MD

National Initiative

Q1. What did you hope to accomplish?

- Our goals were as follows:

1. To provide a unique patient experience in a practice that has many transitional parts.

2. To provide a unique caregiver experience for support staff (MA,OA and RN) and providers to engage and improve their satisfaction at work.

3. Define roles of care team and demonstrate the difference between foundational members and temporary members as needed based on the needs of the situation.

Q2. What were you able to accomplish?

- We were able to obtain baseline data through a survey around current state of the office around the team and roles within the team.

- We came together and brainstormed around barriers and identified areas where we could intervene or change current day work to promote more satisfaction at work.

- We began to implement some of the identified strategies.

Q3. Knowing what you know now, what might you do differently?

- We know that for any successful team there needs to be some component that is standard and not transitional/changing beyond the patient.

- Figuring out how to remain connected as a team is difficult when you are physically distanced.

- Our response to the covid 19 pandemic, we think, would have gone much smoother if the opportunities we were trying to address already were established within the practice.

Q4. What surprised you and why?

- Identifying where “teaming on the fly” was already occurring within our residency and practice once we defined it.

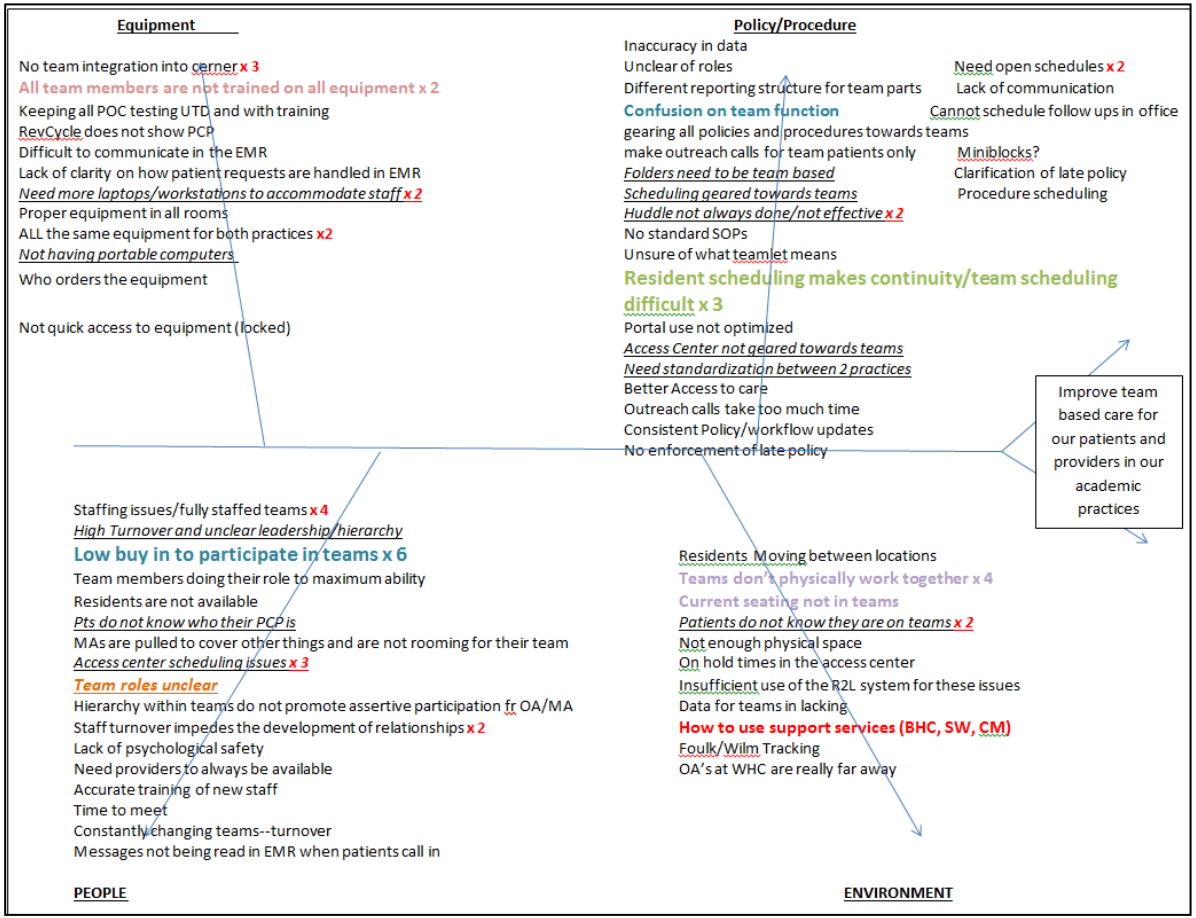
- Resiliency patterns of the different parts of the team

Q5. Cohort Four – Expectations versus Results

- *On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything) how much of what you set out to do was your team able to accomplish and how were your results the same or different from your expectations?*

- We would give this project a rating of "3".
  - > We were able to come together and identify/agree on areas of opportunity and needed attention if we were to attain our goals.
  - > We identified strategies for having team members have more of a relationship and ultimately a commitment to their teams.
  - > We were unable to complete our project over this timeline secondary to 3 identified barriers
    - Global pandemic and shift of concentration and to virtual medicine
    - Office flood and closure for over 8 weeks
    - Complete support staff turnover during this time

Optional – Graph, table picture, etc., to aid in telling your story



QUESTIONS

National Initiative

GUTHRIE

AiAMC
Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort Four: Teaming to Improve Care

Assessing & Improving Ambulatory Quality Metrics in a Resident and Faculty Internal Medicine clinic

Victor O. Kolade, Sydney Silverman, John Pamula

National Initiative

A Nuanced Definition

Diabetes bundle – system definition

- Diabetic Patients Seen in the Past 2 Years With:
  - an A1C <= 8 in the Past 6 Months,
  - an LDL < 70 (or currently prescribed a moderate or high dose statin) in the Past Year and age 40-75, and
  - medical attention for nephropathy (a microalbumin test in the past year, or a nephrology visit, or are on an ACE/ARB, or have ESRD/CKD Stage 4)
- Included: Patients Who Have: Diabetes On Their Problem List, an encounter with a Diabetes diagnosis in the past 2 Years, or a HM modifier for Diabetes
- Patients must have an active Guthrie PCP and have had an office visit in the past 2 years
- Excluded: Gestational Diabetes & Long-Term Care Patients

National Initiative

Q1. Goals

- 7 System-prescribed aims:
  - To improve the ‘diabetes bundle’ compliance to 62% across patients in Sayre Internal Medicine being cared for by non-resident providers (faculty, non-faculty doctors, and advanced practice providers) by June 2021
  - To improve the ‘diabetes bundle’ compliance to 54.6% across all patients in Sayre Internal Medicine being cared for by resident providers by June 2021
  - To see or maintain a colorectal cancer screening rate of 70% or more among patients in Sayre Internal Medicine being cared for by non-resident providers by June 2021
  - To see a colorectal cancer screening rate of 65.2% or more among patients in Sayre IM being cared for by resident providers by June 2021
  - To see or maintain a diabetic retinopathy screening/assessment rate of 72% or more among patients in Sayre Internal Medicine being cared for by non-resident as well as resident providers by June 2021
  - To see or maintain a depression screening rate of 80% or more among patients in Sayre Internal Medicine being cared for by non-resident as well as resident providers by June 2021
  - To see or maintain a fall screening rate of 85% or more among patients 65 and older in Sayre Intern Medicine being cared for by non-resident as well as resident providers by June 2021

Q2. 5 of 7 goals achieved so far:

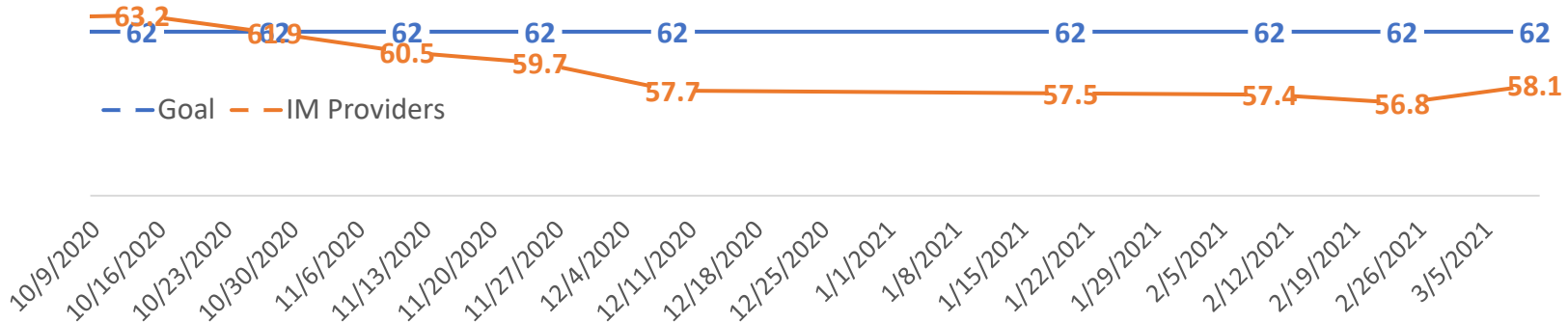
- The ‘diabetes bundle’ compliance **reached 62%** across patients in Sayre Internal Medicine being cared for by non-resident providers in **August 2020, but fell to 56.4% in February 2021 before rebounding to 58%**
- The ‘diabetes bundle’ compliance had not **reached 54.6%** across patients in Sayre Internal Medicine being cared for by resident providers as of **early March 2021**
- The colorectal cancer screening rate **was 70% or more** among patients in Sayre Internal Medicine being cared for by non-resident providers by **July 2020**, and **stayed at goal through early March 2021**
- The colorectal cancer screening rate exceeded 65.2% among patients in Sayre IM being cared for by resident providers by October 2020, likely due to a resident-led QI initiative, and **stayed at goal through early March 2021**
- The diabetic retinopathy screening/assessment rate **was 72% or more** among patients in Sayre Internal Medicine being cared for by non-resident as well as resident providers by **July 2020, but the resident rate fell to 66.9% in December 2020 before rebounding to 73.5% in early March 2021**
- The depression screening rate **was 80% or more** among patients in Sayre Internal Medicine being cared for by non-resident and resident providers by **July 2020**, and **stayed at goal through early March 2021**
- The fall screening rate **was 85% or more** among patients in Sayre Internal Medicine being cared for by non-resident and resident providers by **July 2020**, and **stayed at goal through February 2021 for residents, while staff providers fell to 84% in January-February 2021 and rebounded to 85% in early March 2021**

Surge protector photo from BestBuy.com, USB hub photo from Amazon.com

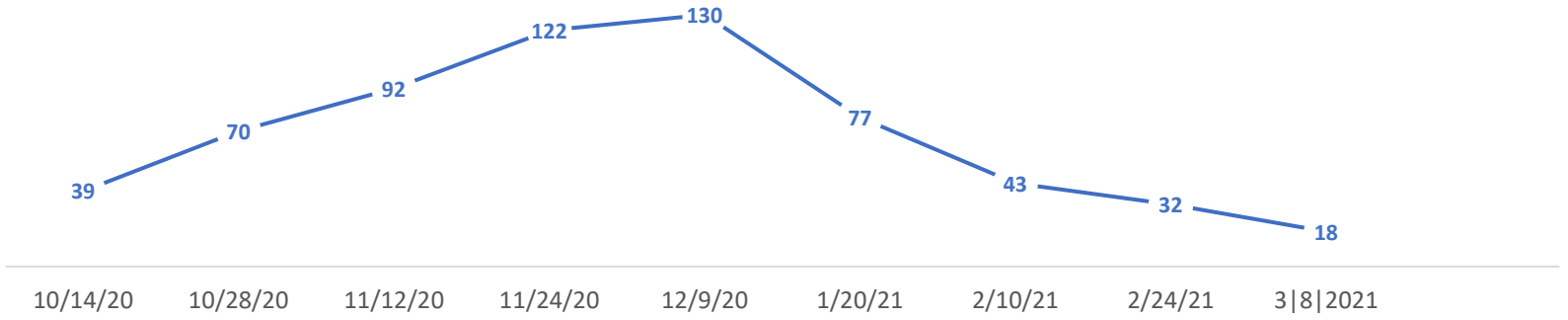
Q3. ‘Plug & Play’

- Create a more targeted approach to resident quality metrics; the approach applicable to staff providers did not produce the same results for residents
  - > Enhanced data sharing was initiated in January 2021, making provider data freely available to nurses and patient service specialists
- Encourage the intersection of as many related quality improvement projects as possible

DIABETES BUNDLE AS % FROM JULY 2020 TILL DATE



POSITIVE COVID-19 TESTS AT GUTHRIE



Q4. Surprise -

- Residents trailed staff providers in 3 of 5 listed metrics as of July 2020 - and 4 of 5 in early March 2021
  - > Our clinic does not use the primary care exception, so an attending sees each patient with the resident – allowing for the possibility that resident metrics would be better than those of non-resident providers
- Our huddle processes did not close the data gaps between resident and non-resident providers

Q5. Cohort Four – Expectations versus Results

- *On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything) how much of what you set out to do was your team able to accomplish and how were your results the same or different from your expectations?*

- 6.5 for early improvements in diabetes bundle #
  - > **Initial progress was lost in October 2020 - February 2021 possibly due to a nursing shortfall and COVID-19 related process disruption**

- 10.5 for expansion of project reach beyond the diabetes bundle to 4 other metrics
  - > **COVID-19 notwithstanding, the project expanded**

Questions?

- Thank you!

GUTHRIE

AiAMC
Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort Four: Teaming to Improve Care

Inter-disciplinary approach to improve Transitional Care Management Compliance in Ambulatory Clinic

Dr. Tejaswini Maganti, Dr. John Pamula, Dr. Victor Kolade, Dr. Sheela Prabhu

National Initiative

Q1. What did you hope to accomplish?

- **Given that many studies have shown that timely provision of transitional care services significantly reduce the number of hospital readmissions, the Primary Aim of our project was**

  - **To improve the Transitional Care Management visit compliance rate by leveraging the process of interdisciplinary morning huddles among the care team**

- **We pursued this via a multidisciplinary approach and multiple interventions at different times**

- **Specifically, we aim to improve the TCM rate in the Internal medicine clinic by 10% from 7/2020 to 6/2021**

Q2. What were you able to accomplish?

- We have achieved our goal for the 1-week TCM rate but not for the 2-week TCM rate:
- The TCM visit rate within 1 week increased from 50% in June 2020 to 62.5% by the end of September 2020 but fell to 44.3% by the end of November 2020 and was back to 50% by the end of December 2020
  - With a second intervention - starting of virtual visits from January 2021 - and decrease in COVID-19 cases there is increase in this rate to 61.3% by the end of February 2021
- The TCM visit rate within 2 weeks increased from 70% in June 2020 to 78.1% by end of September 2020 but fell to 67.2% by the end of December 2020
  - This rate rose to 71% by the end of February 2021

Q3. Knowing what you know now, what might you do differently?

- As a large fraction of our patient population is elderly, some patients find it difficult to come to clinic within 1 week of discharge; we realized offering virtual visits would have been a great benefit
- We would have started the virtual visits from the beginning; however, our clinic only gained this capability as part of our pandemic response – and it was extended to residents slowly

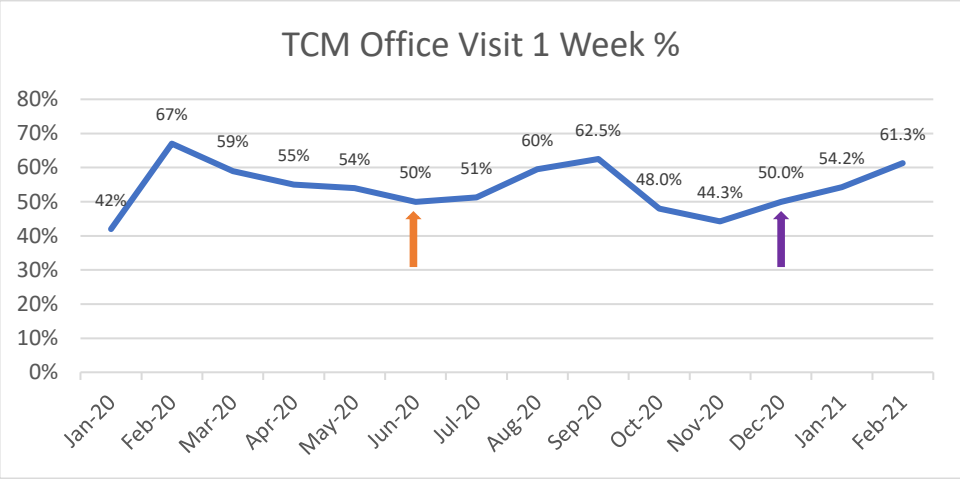
Q4. What surprised you and why?

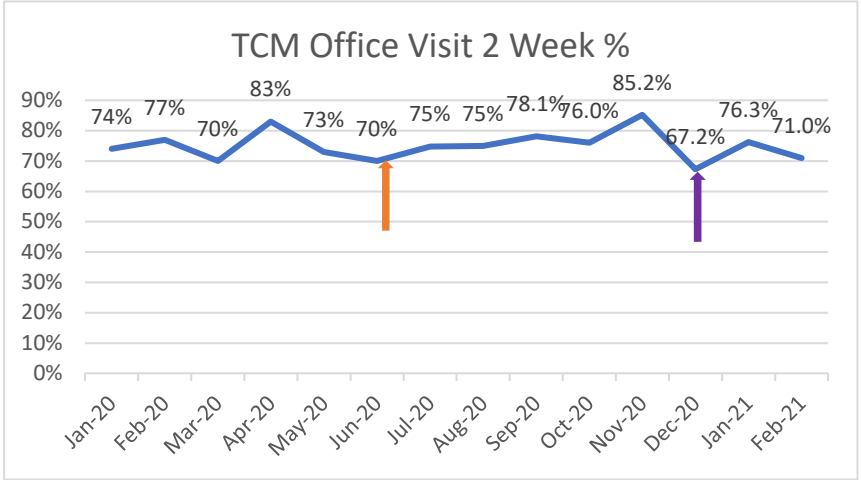
- The 2-week TCM rate did not respond to our interventions to the same degree as the 1-week TCM rate
- The reason for this is unclear

Q5. Cohort Four – Expectations versus Results

- *On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything) how much of what you set out to do was your team able to accomplish and how were your results the same or different from your expectations?*
- *7: We were able to achieve our goal for the 1-week TCM rate*
- *There is a downfall in between and we believe below are the reasons*
  - Due to the COVID Pandemic, fewer patients were willing to come for appointments
  - Fewer staff were available to coordinate care in inpatient and outpatient settings due to employee cutbacks related to the COVID pandemic

Results





Intervention One

Intervention Two

QUESTIONS

National Initiative

GUTHRIE

AiAMC
Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort Four: Teaming to Improve Care

A multidisciplinary care team model to improve diabetic bundle compliance

Manisha Raikar MD, Miji Kim MD, John Pamula MD, Victor Kolade, Sheela Prabhu MD

National Initiative

Q1. What did you hope to accomplish?

- The aim of our study was to improve diabetes bundle compliance in our internal medicine resident clinic by >7.5% in 7 months (from 46.9% to 54.6% from August 10, 2020 to March 8, 2021)

Definition

Diabetes bundle – system definition

- Diabetic Patients Seen in the Past 2 Years With:
  - an A1C <= 8 in the Past 6 Months,
  - an LDL < 70 (or currently prescribed a moderate or high dose statin) in the Past Year and age 40-75, and
  - medical attention for nephropathy (a microalbumin test in the past year, or a nephrology visit, or are on an ACE/ARB, or have ESRD/CKD Stage 4)
- Included: Patients Who Have: Diabetes On Their Problem List, an encounter with a Diabetes diagnosis in the past 2 Years, or a HM modifier for Diabetes
- Patients must have an active Guthrie PCP and have had an office visit in the past 2 years
- Excluded: Gestational Diabetes & Long-Term Care Patients

National Initiative

Q2. What were you able to accomplish?

- We performed 3 PDSA cycles:
- PDSA-1 identified non-compliance / low health literacy.
- PDSA-2 identified patients' hesitancy to come to hospital during the COVID-19 pandemic.
- PDSA-3 found that residents had difficulty in accessing EHR dashboards and therefore intervention was addressed with many workshops which led to an uptrend in bundle score.
- Although our goal was not reached, we were able to identify root causes at multiple levels and after addressing those, we found a sustained rise in bundle % and we expect it to continue to rise given we have likely addressed the issue.

Q3. Knowing what you know now, what might you do differently?

- We started our intervention at many levels presuming we are in a low literacy area and need more focus on population but to my surprise in my PDSA cycle 3, we realized residents had difficulty accessing dashboards and therefore I did my intervention with workshops.
- Workshop included distribution of individual diabetic patient panels to the residents with a focus on deficiencies in the diabetes bundle while they had access to the EHR and could order relevant tests. And I was able to troubleshoot any problems that arose.
- We thereby feel if we had done the workshop initially, we would have enough timeline for patients to get lab work, and bundle scores would have improved further.

Q4. What surprised you and why?

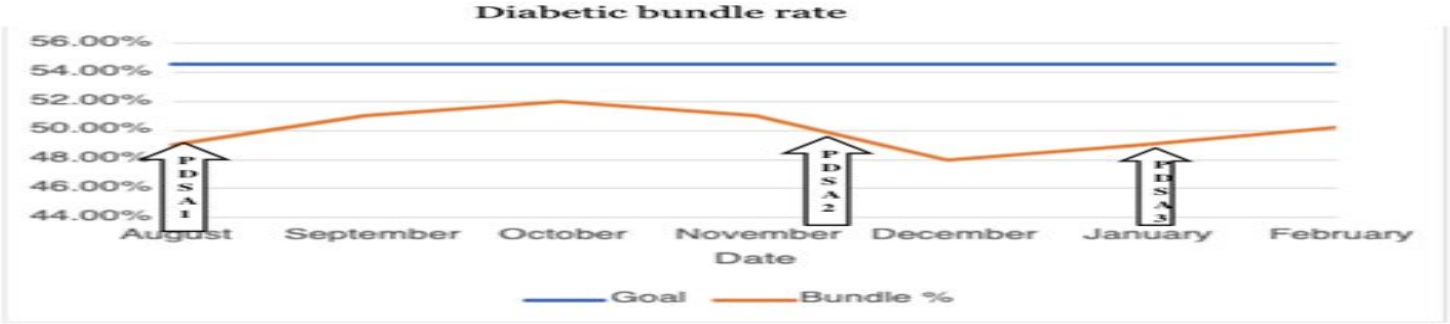
- There were patients who were not diabetic yet were in the diabetes registry.
- Residents' difficulty in accessing EHR dashboards was the main barrier rather than patient non-compliance.

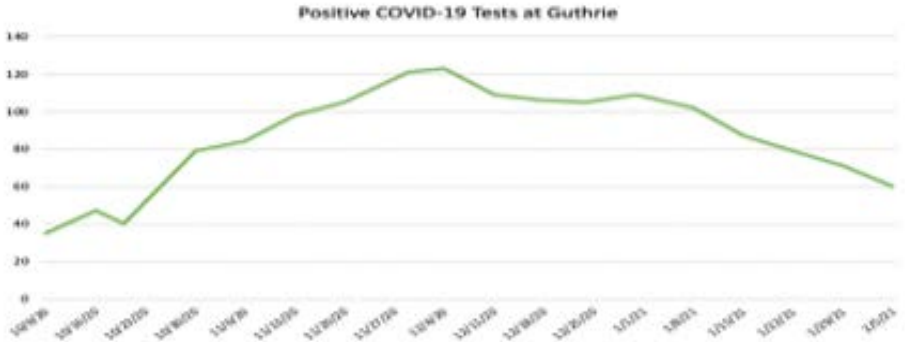
Q5. Cohort Four – Expectations versus Results

- *On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything) how much of what you set out to do was your team able to accomplish and how were your results the same or different from your expectations?*

- 5/10
- Although we were not able to reach our goal, we were able to identify barriers.
- Therefore, in future we know what to focus our time on.
  - >It takes less time to teach residents rather than ordering labs and getting patients to come in and get them done.

Bundle completion, PDSA cycles, and COVID-19 positivity





QUESTIONS

National Initiative

GUTHRIE

AiAMC
Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort Four: Teaming to Improve Care

Interprofessional Collaboration Practice (IPCP) to Improve Colorectal Cancer Screening

Shobha Mandal, MD

PGY-2, Internal Medicine

National Initiative

Q1. What did you hope to accomplish?

- Before the beginning of my project in August, the percentage of colorectal screening was 56.4% in the Sayre Internal Medicine (IM) resident clinic.
- My goal was to see the colorectal cancer screening rate improve to 66.4% or more among patients in Sayre IM being cared for by resident providers by June 2021.

Q2. What were you able to accomplish?

- We were able to improve the colorectal screening rate to 66.9% which exceeded our goal of 66.4% among patients in Sayre IM being cared for by resident providers.
- We continued to stay at goal and continued to improve through early March – when the rate of colorectal screening was 68.5%.

Q3. Knowing what you know now, what might you do differently?

- After getting involved in this project, I came across few things:

➢Residents were not aware of how many patients on their panels were due for colonoscopy. It will be a good idea to update resident physicians about quality metrics.

➢As Guthrie is serving a rural community with low health literacy, I will continue to work on patient education explaining the importance of screening and will also discuss all the alternative options to colonoscopy.

Q4. What surprised you and why?

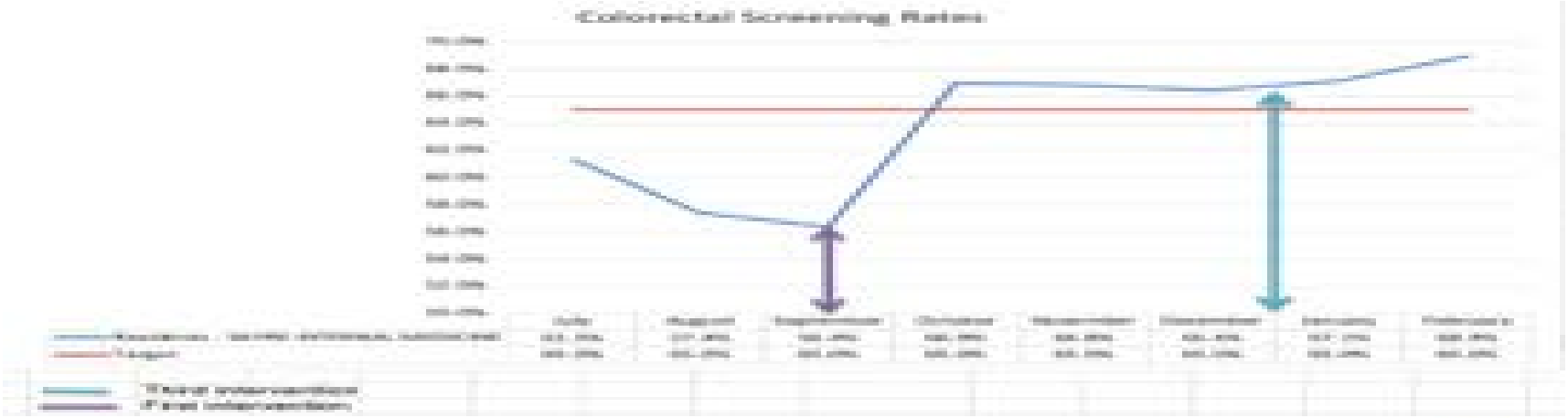
- I was surprised by 10% improvement in screening within one month of intervention.
- Educating patients on alternatives and importance of screening and direct calls by providers worked. Patients in our rural community have low health literacy compared to patient populations in urban areas, hence they need good counseling and discussion of screenings.

Q5. Cohort Four – Expectations versus Results

- *On a scale of 1 to 10 (with "1" meaning nothing and "10" meaning everything) how much of what you set out to do was your team able to accomplish and how were your results the same or different from your expectations?*

- 10 - I was able to exceed the target of 66.4%.

Graph showing percentage improvement in colonoscopy screening by the end of February 2021



Questions ??????

Thank you

Aurora Health Care

We are AdvocateAuroraHealth

AiAMC Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort Four: Teaming to Improve Care

Interprofessional Communication in the Cardiac Catheterization Laboratory

Matthew McDiarmid DO, Charnai Sherry PA-C, Jodi Zilinksi MD, Tonga Nfor MD, Deborah Simpson, Renuka Jain MD

Cardiology, Electrophysiology, and Interventional Cardiology Fellowship

@AAH_StLukesCV

National Initiative

Q1. What did you hope to accomplish?

- Improve communication/feedback between fellows & faculty

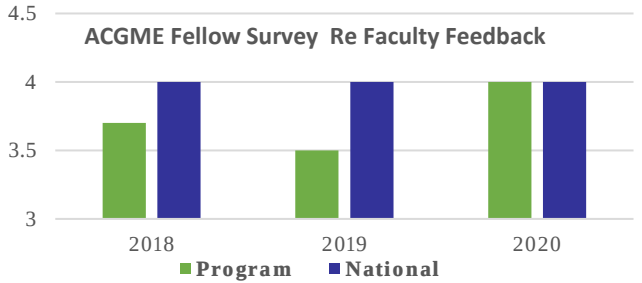
- Improved the effectiveness and efficiency of the Cardiac Cath Lan (CCL)

Q2. What were you able to accomplish?

Communication & Feedback

- Explicitly defined CCL fellow's performance expectations x PGY status, with level of supervision x whom (attending, IC fellow)
- Feedback training to Faculty & Fellows focused on actionable, brief feedback
  - Need for frequent feedback, formality, timing (pre-post procedure) with improved CCL communication

Cardiac Cath Lab PGY Year and Rotation/Semester → Objectives w Levels of Supervision ↓	1st Yr PGY4/Fel1	2nd Year PGY5/Fel2			3rd Year PGY6/Fel 3	Interv PGY7	
	No formal lab rot	1st & 2nd Blk	3rd & 4th Blk	5th & 6th Blk		1st Sem	2nd Sem
Level of Supervision*		A	B	C	D	E	F
Communication/feedback*		A	B	C	D	E	E
Medical Knowledge: Assumes prior level knowledge unless otherwise noted							
1. Coronary anatomy as pertaining to LV function and wall motion	1						
2. Coronary anatomy and role with patients presenting with Acute Coronary Syndrome	1						
3. Indications for invasive diagnostics	1						
4. Basic understanding Coronary Angiogram films and views o Identification of view and projection o Identification of coronary anatomy o Identification of basic angiographic abnormalities	1						
5. Procedural H&P, sedation note, AUC, consent			1				



Efficiency

- Increased frequency of earlier procedural case assignment to the fellows
- Increase in procedure consent secured for in office for outpatient procedures through improved workflows

Q3. Knowing what you know now, what might do differently?

- **Establish clear expectations for team participation**
  - Clear accountabilities
  - Supported by each interprofessional team members respective supervisors to avoid things occurring at last minute
- **Focus post cath procedure feedback by**
  - Creating and posting small short lamented feedback checklist to assure key features are addressed
  - These structured expectations would build on the success of the fellows' expectations by block x PGY year – providing both fellows and faculty with clear expectations and accountabilities

Q4. What surprised you and why?

- **Project Leader work one-on-one with team members**
  - Team meetings rare

- **Feedback:**
  - Attendings appear to be providing increased feedback despite extremely busy clinical practice – there is time!

Q5. Cohort Four – Expectations versus Results

- 7/10 rating
- **Changing the culture** of a high-volume interprofessional procedure lab (eg, cardiology) occurs over time
- **Visible progress** was made towards achieving our aims with more work to be done

QUESTIONS

National Initiative

Aurora Health Care

We are AdvocateAuroraHealth

AiAMC Alliance of Independent Academic Medical Centers

NI VII Meeting Four – Capstone Presentation
Cohort Four: Teaming to Improve Care

Advancing Advance Directives in Internal Medicine Residency Clinic

Tanya Shah, MD; Ramandeep Dhaliwal, MD; Zeba Shethwala, MD; Henok Hardilo, MD; Jasmine Webster, MSW; David Hamel, MD; Deborah Simpson, PhD

Internal Medicine Residency Program, Milwaukee, Wisconsin

National Initiative

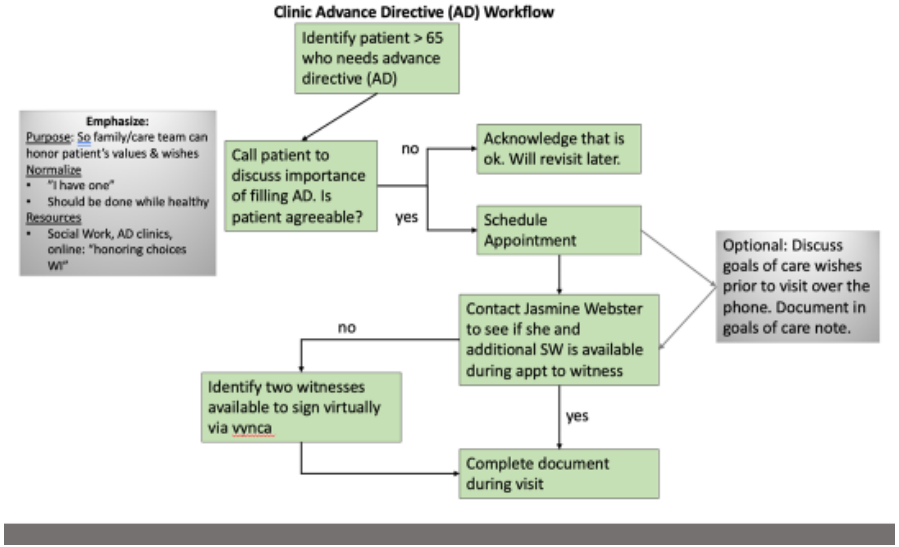
Q1. What did you hope to accomplish?

- **AIM**: To increase our advance directive (AD) completion numbers for patients ≥ 65 in Internal Medicine Residency and Faculty Clinics to >59% by project completion
  - > Starting point: 47%

- **Secondary Goals:**
  - > Standardize AD clinic workflow
  - > Educate residents on discussion strategies for advance directive and goals of care
  - > Improve resident and faculty comfort with having these discussions in the outpatient setting

Q2. What were you able to accomplish?

- 49% of patients ≥ 65 have completed advance directives
  - ↑ 1% Jan-Dec 2020; + 1% Jan 2021
- Created a clinic workflow to standardize AD completion process
- Set up educational sessions to teach strategies for AD and goals of care conversations



- Improved teamwork and communication between residents and the clinic social worker
- Established an online AD completion tool in the clinic setting (VYNCA) and trained staff in its use

Q3. Knowing what you know now, what might you do differently?

- **Incentivize early steps in a complex process**
  - > For example: Create incentives for residents to discuss the need for AD over the phone and schedule office visits for that specific purpose
- **Focus** more resources and attention to AD completion specific visits as opposed to expecting patients to fill out document outside the clinic
- **Earlier introduction** of and education on how to use online (VYNCA) platform to virtually fill out AD paperwork to the clinic

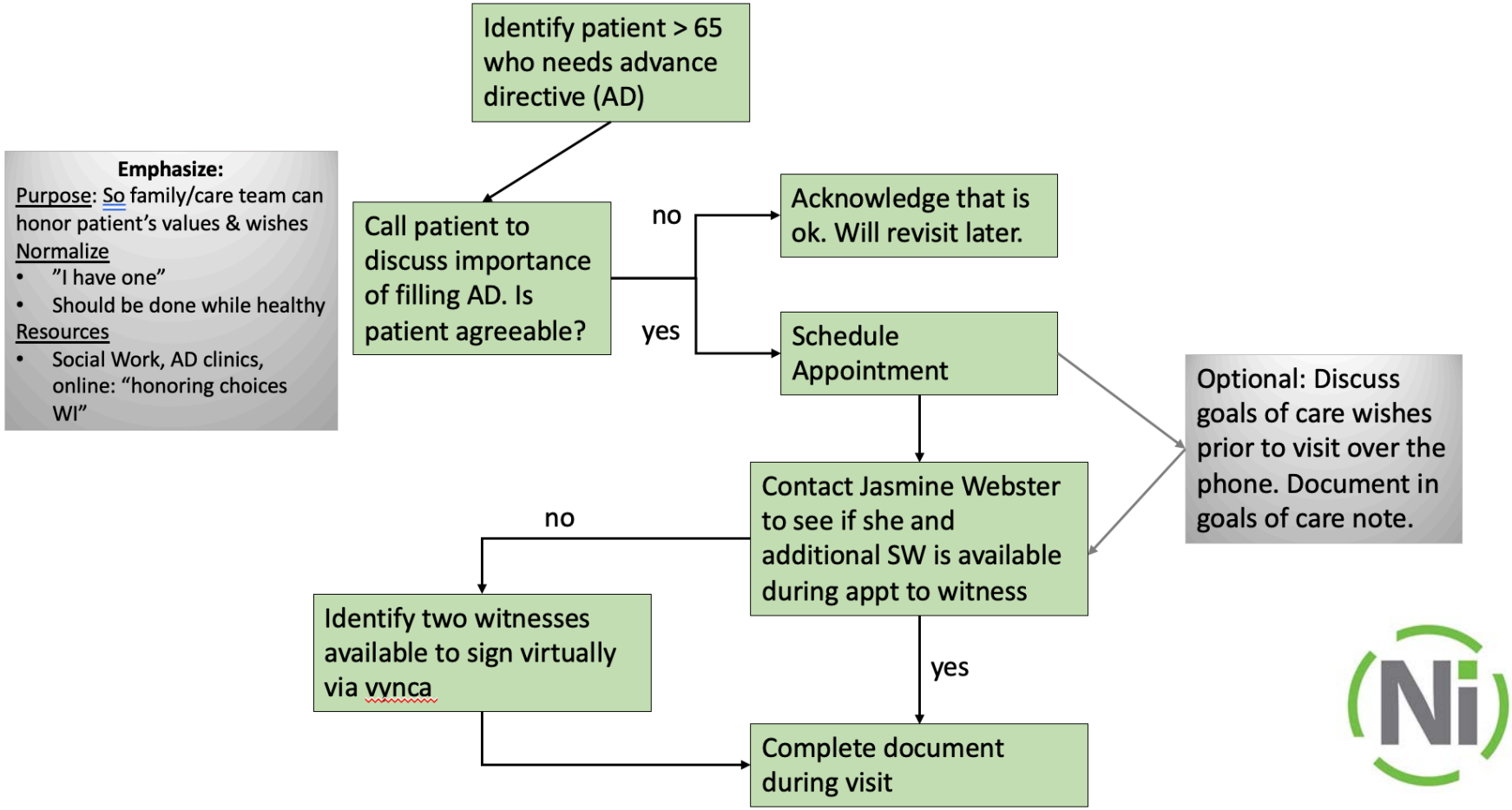
Q4. What surprised you and why?

- **Global Pandemic:** Halted in-person visits - project relied on the ability to hand the paperwork to the patient
- **Two Witnesses:** The difficulty for patients to find 2 witnesses (per Wisconsin law) who were not listed as POAs, close relatives, or medical caregivers
- **Complexity of the AD completion process**
  - Unlike many other QI measures, filling out AD requires patient legwork
  - There are limits to what doctors and the care team can do
  - Limited resident knowledge of interprofessional team member roles/workflows
  - Mistrust members of the public & value AD's importance in own care

Q5. Cohort Four – Expectations versus Results

- Score 4 out of 10
- Areas where accomplishment met expectations
  - > Implemented an educational series to train residents in strategies for initiating AD discussions
  - > Created a clinic workflow standardizing the process of AD completion
  - > Involved input from many different members of the clinic team (“teaming”)
- Areas where accomplishments didn’t meet expectations
  - > Moving the needle on the overall percentage of AD completions in our goal population

Clinic Advance Directive (AD) Workflow



QUESTIONS

National Initiative