<table>
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<tr>
<th>Track</th>
<th>Description</th>
<th>Proposal Topics of Interest</th>
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| **Equity** | Reducing inequities in health and health care by focusing on populations that have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, mental health, disability, sexual orientation, gender identity, geographic location, or other characteristics historically linked to discrimination or exclusion. | • Improving access to care for marginalized populations  
• Understanding and addressing racism in health care  
• Improving person-centered care for transgender patients  
• Moving from stratifying data by Race, Ethnicity, and Language (REAL Data) to results-focused improvement  
• Quality improvement interventions to close gaps in health equity  
• Story of your successes, challenges, Lessons learned in addressing health equity in your setting |
| **Improvement Capability** | Ensuring that improvement science drives our work and that we extend the reach and impact of the improvement community | • Applying innovation and improvement methods  
• Implementing and sustaining improvement  
• Spread and scale improvement across organizations & regions  
• Using practical measurement approaches  
• Developing the Science of Improvement  
• Evaluating and learning from improvement |
| **Person- and Family-Centered Care** | Putting people, patients, and care partners at the heart of every decision and empowering them to be genuine partners in their care | • Patient engagement within diverse care settings and for underserved populations  
• Adding “what matters” to “what’s the matter” and demonstrating reliability of the process  
• Integrating concepts of person-centeredness in health education  
• Creative ways to use data to further person- and family- centered care  
• Demonstration of the connection between creating value and person-centeredness  
• Integrating person-centeredness in existing improvement initiatives  
• Experienced based co-design- examples and case studies  
• Person- centered care across the care continuum |
| **Patient Safety** | Making the health care continuum safer by reducing harm and preventing mortality | • Transitions within and between the following settings: Ambulatory, SNFs/Frail Elder Safety, Rehab, Community, Home Health  
• Patient-centered safety initiatives  
• Patient safety journey through the healthcare system  
• Successful patient safety program spread across health systems to address infection  
• Safety initiatives targeted at-risk/diverse populations  
• Mental health and patient safety  
• Advancement of patient safety culture  
• Models of Ambulatory Patient Safety  
• Delayed diagnosis, test and referral management  
• Journey to high reliability and safety  
• EHR and patient safety  
• Psychological harm and Empathy  
• Innovation measures for safety |
| **Quality, Cost and Value** | Driving affordability and sustainability through quality improvement | • Partnerships and collaboration between quality and finance teams  
• Frontline engagement in efforts to improve the value of care for patients and families  
• Focus on whole system value – not just marginal savings  
• Measurable cost savings, including description of financial model and outcomes assessment approach  
• Improving health care outcomes under new payment models  
• Improving the value of care to the patient, including patient reported measures and/or decreasing the cost of care to patients  
• Approaches to decreasing variation with evidence of improved outcomes, cost, and patient/staff experience. |
| **Triple Aim for Populations** | Applying integrated approaches to simultaneously improve care, improve population health, and reduce costs per capita | • Population and community health  
• Value-based payment models  
• Health Equity and Disparities  
• Maternal and neo-natal health  
• Mental and Behavioral Health  
• Care for population segments  
• Care for those with chronic diseases  
• Health system journey toward population management  
• Community partnerships and transformation  
• Primary Care Transformation  
• Team-Based Care, including Patient Centered Medical Home  
• Social Determinants of health, including social care, non-medical related supports  
• Telehealth and Mobile Health; HIT Implementation |
| **Leadership** | Engaging leaders at all levels in driving high quality care | • High-impact leadership  
• Leadership behaviors and focus  
• The leader’s role in driving high quality care  
• Leading across boundaries - how to lead when you are not the boss  
• Joy in Work: a happy workforce and your organization’s effectiveness |