Thursday, April 20: Minicourse

12:00 PM - 5:30 PM

M1 Learning to Coach and Coaching to Improve

*Learning Format: Buzz Session*

High-performing teams usually attribute much of their success to their coach, yet many improvement teams have no coach or facilitator to help them achieve goals and build capacity. As a result, they often lose energy and direction. This session will review the essential role and skills of an effective improvement coach, using exercises and coaching scenarios to apply participants’ coaching skills to typical improvement team challenges.

After this presentation, participants will be able to:

- Describe the critical role of improvement coaches within an organization
- Understand why coaches need to build skills not only in improvement methods and tools but, more importantly, in managing the human side of change
- Identify and practice key coaching skills, such as facilitating effective meetings, using team decision-making tools, understanding different working styles, and building effective measurement systems

Presenters: **Karen Baldoza, MSW**, Executive Director, Institute for Healthcare Improvement; **Robert Lloyd, PhD**, Vice President, Institute for Healthcare Improvement; **Phyllis Virgil, MHA, ASQ, CSSBB**, Improvement Advisor, PMV Consulting

M2 Overcoming Burnout—Leader and Team Actions

*Learning Format: Case Study*

Burnout is an enormous topic and can seem almost impossible to tackle. However, taking certain steps can make a difference, starting right away. Using IHI’s Joy in Work Framework and recent lessons from prototype health care organizations, participants will interact with colleagues to develop steps that leaders, teams, and individuals can take immediately, including examining causes of burnout, choosing high-impact behaviors that make a difference, and designing a path to create joy in work.

After this presentation, participants will be able to:

- Examine causes of burnout that may be present in their organization
- Identify high-impact behaviors for short- and long-term results in tackling burnout
- Design and construct a working path to create joy in work

Presenters: **Barbara Balik, RN, EdD**, Co-Founder, Aefina Partners; **Trissa Torres, MD, MSPH, FACPM**, Chief Operations and North America Programs Officer, Institute for Healthcare Improvement

M3 Personal Mastery for Relational Barriers to Change

*Learning Format: Case Study*

High-quality work relationships are key for successful transformation, but the volatility, uncertainty, and complexity inherent in health care make relational barriers very common. At times these stresses lead even those with outstanding relational skills to act in ways that inadvertently increase resistance and interpersonal tensions. Participants will learn high-leverage principles and strategies to sustain relational skills even in the most difficult situations and will practice applying them by thinking through case examples.

After this presentation, participants will be able to:

- Define reactivity, explain how to identify it, and describe how to shift to more productive responses
- Explain the dialogue principles that facilitate resolution of relational challenges
M4 Opening the Playbook of a Provider Driven ACO

**Learning Format: Lecture**

A primary care-driven ACO, Coastal Medical had a 2015 Medicare Shared Savings Program quality score of 100% and earned shared savings from its four largest payers. Leaders will describe their “all in” approach to population health management and discuss business models and strategy. With a focus on leadership of change and the interdependence of clinical and operational teams, they will also explore team-based care, the use of data, specific clinical initiatives, and collaboration with patients on program design.

After this presentation, participants will be able to:

- Describe a new idea to incorporate into their strategy for accountable care
- Explain how to make specific data truly actionable
- Identify an opportunity to remove one task for their office-based clinical teams in active peer sharing and learning

Presenters: **Al Kurose, MD, MBA, FACP**, President and CEO, Coastal Medical; **Marilyn Boichat, RN**, Director, Practice Management, Coastal Medical; **Katrina Thompson-Burnett**, Director Ancillary Services, Coastal Medical; **Sarah Thompson, PharmD, CDOE**, Director Clinical Services, Coastal Medical; **Dana Nolfe**, Director of Marketing, Communications and Public Relations, Coastal Medical

M5 Increasing Value with Patient Administered Self Care

**Learning Format: Lecture**

Engaging patients to deliver elements of their own care can improve outcomes, increase patient satisfaction, and lower system-level costs. In this session, we will learn from Parkland Hospital's approach to teaching patients to administer their own IV antibiotics, and we will share IHI's framework for a system of patient-administered self-care. Based on this information, participants will work to identify procedures from their home setting that might be compatible with self-care processes.

After this presentation, participants will be able to:

- Understand the concept of patient-administered self-care
- Describe a system-level approach to implementing patient self-care
- Identify one procedure in their home setting that could be primed for patient self-care and develop an initial plan for testing its adaptability to patient self-care

Presenters: **Alex Anderson**, Research, Innov | Co-Chair, IHI Diversity/Inclusion Council, Institute for Healthcare Improvement; **Kavita Bhavan, MD, MHS**, Associate Professor, Parkland Health and Hospital System
M6 Models to Advance Health Equity and the Triple Aim

Learning Format: Case Study

This session will present four models to advance equity with and for high-opportunity populations and conditions around the US: a model to prevent obesity and diabetes in New York; a model implementing an HIV/AIDS hospice and transitional care home model in place of acute hospital stays; and a model supporting medically complex, high-cost patients utilizing ED services in Boston.

After this presentation, participants will be able to:

- Identify and describe diverse models for advancing equity in person- and community-centered ways that promote better outcomes, better care, and lower costs
- Discuss opportunities for and barriers to implementation
- Evaluate opportunities to build partnerships and apply models in their own health system or community

Presenters: Marianne McPherson, PhD, MS, Director, 100 Million Healthier Lives Implementation, Institute for Healthcare Improvement; Yaminette Diaz-Linhart, Program Director, Boston Medical Center; Samantha Morton, Massachusetts, CEO, MLPB; Carlos Devia, Clinical Quality Manager, New York City Department of Health and Mental Hygiene; Kalpana Shankar, Assistant Professor, Dept of Emergency Medicine, Boston University Medical Center; Corey Miller, Vice President - Care Services, Saskatchewan Cancer Agency; Morris Markentin, Physician, Sanctum; Michael Schuman, Clinical Quality Specialist, DOHMH

M7 Improving Clinical Flow with Project ECHO

Learning Format: Simulation Encounter

This interactive session will provide insight into improving clinical flow and clinical outcomes through optimized-relationship, team-based care and the building of quality improvement capability through case-based learning. Lessons learned from a unique partnership between IHI and Project ECHO, the Improving Clinical Flow ECHO Collaborative, will be shared by staff from Cherry Health Community Health Centers, which has achieved outstanding improvement. Participants will participate in a QI tele-ECHO clinic and apply lessons to their own setting.

After this presentation, participants will be able to:

- Describe how empanelment, high-continuity, optimized-relationship, team-based care can improve efficiency and clinical outcomes
- Identify how quality improvement case-based learning, using Project ECHO's model, can support primary care improvement and build quality improvement capability
- Identify change ideas to test in their own clinic

Presenters: Roger Chaufournier, MHSA, President and CEO, CSI Solutions, LLC; Kathleen Reims, MD, Chief Medical Officer, CSI Solutions, LLC; Elizabeth Clewett, Program Specialist, Project ECHO; Kristin Batts, site manager, Cherry Health; June Gillespie, Site Manager, Cherry Street Health Services
M8 Practical Strategies for Managing Successful Improvement Projects

**Learning Format: Buzz Session**

Like any project, improvement projects need project management, but effectively managing improvement projects requires distinct skills that integrate improvement methods and typical project management tools. In this session, we will present key principles to strengthen the management of improvement efforts as well as tactical tools and outpatient examples to make these principles come to life. Participants will action-plan around the principles and identify strategies to manage improvement in their home organizations.

After this presentation, participants will be able to:

- Describe key principles for more effective management of improvement projects
- Identify a few tools, including aspects of coaching, that will help them better manage their improvement projects
- Strengthen their own improvement work through the application of these principles and tools

Presenters: Christina Gunther-Murphy, MBA, Executive Director, Institute for Healthcare Improvement; Gregg Heatley, MD, MMM, Vice Chair, Ophthalmology, UW Health; Julianna Spranger, Quality Improvement Specialist, UW Health

M9 Sustainable Care Design for Populations with Complex Needs and High Costs: Lessons from the Field

**Learning Format: Case Study**

In this interactive session, participants will begin to design impactful programs for patients with complex needs and high costs. Presenters from the Medicaid health plan BlueCare Tennessee and from Health PEI, which delivers publicly funded health services in Prince Edward Island, Canada, will share their expertise in the IHI design process. Participants will gain invaluable context for their own redesign process as the presenters share best knowledge from the literature and the field and the available resources.

After this presentation, participants will be able to:

- Describe what is known about “what works” for the care management of individuals with high needs and high costs
- Apply to their own context a tested process for redesigning care programs for individuals with high needs and high costs
- Identify resources available to support their work of redesigning care for individuals with high needs and high costs

Presenters: Cory Sevin, RN, MSN, NP, Director, Institute for Healthcare Improvement; Cy Huffman, MD, Medical Director, Blue Cross Blue Shield of Tennessee; Donna MacAusland, Program Development Lead, Primary Health Care, Health Prince Edward Island

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**Friday, April 21: Orientation**

7:00 AM - 7:45 AM

GenConfOr First-Time Attendee Orientation

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**Friday, April 21: Learning Labs**
L1 Reducing Burnout: Short-term Techniques and Long-term Solutions

Learning Format: Case Study

Presenters from Bellin Health and UnityPoint Health will share what they have discovered about how work units, teams, and organizations can take different approaches to building resilience and joy in work. The session will cover short-term techniques that address personal, interpersonal, and unit or team opportunities as well as Bellin Health’s successful transformation to team-based care as a long-term solution. Participants will discuss practical approaches and useful resources for engaging their teams in improvement.

After this presentation, participants will be able to:

- Identify root causes of burnout, how to recognize its extensiveness in their work group or organization, and how to deploy strategies to ease its effects
- Describe how advanced team-based care can transform an organization by effectively addressing the underlying causes of burnout
- Describe how the dual approach of applying short-term and long-term solutions effectively addresses burnout while restoring joy to the practice of medicine

Presenters: Gail Nielsen, BSHCA, FAHRA, IHI Fellow and Faculty, No Organization; Peg Bradke, RN, Vice President Post Acute Care, UnityPoint Health – St. Luke’s Hospital; James Jerzak, MD, Physician, Bellin Health; Kathy Kerscher, BA, Team Leader -Operations, Bellin Health

L2 Respecting Patients’ End-of-Life Wishes

Learning Format: Case Study

This session will introduce IHI and The Conversation Project’s tools and resources to engage patients and families in conversations about end-of-life care wishes. Participants will learn five key principles that are critical to the efforts of health care institutions to reliably receive, record, and respect their patients’ wishes for care. We will discuss best practices from different care and community settings around the country and offer participants testable ideas to take back to their institutions.

After this presentation, participants will be able to:

- Understand the resources available to help patients and families have “the conversation”
- Develop a plan for bringing best practices to their own institutions and communities

Presenters: Kate DeBartolo, National Field Director, Institute for Healthcare Improvement; Kelly McCutcheon Adams, MSW, LICSW, Director, Institute for Healthcare Improvement

L3 Comprehensive Care: Principles and Practice of Responsible Insourcing

Learning Format: Buzz Session

Primary care physicians who practice at the full scope of their expertise and whose workplaces support such practice provide substantial benefit to their patients and communities. In this session, we will present the principles of Responsible Insourcing, current gaps, and models of implementation. In small groups, participants will look at services that could be insourced, develop priority lists for their own practices, and develop action plans for implementation.

After this presentation, participants will be able to:

- Describe Responsible Insourcing and its place in routine practice
• Understand how Responsible Insourcing supports the Quadruple Aim

• Identify practice areas that are a priority and could be insured, and develop action plans to successfully implement insourcing in these areas

Presenters: Stephen Martin, Associate Professor, University of Massachusetts Medical School; Melora Simon, Director, Adult Demonstration Programs, Health Plan of San Mateo

L4 Interagency Care Coordination: High Risk Patients

Learning Format: Simulation Encounter

Because people with multiple chronic health conditions and social needs often have many health and human service supports providing fragmented care, they frequently use expensive hospital services without any improvement in their health status. This session will demonstrate how the identification of a lead care coordinator and the use of evidence-based tools to develop an interagency shared-care plan has improved communication between care providers and resulted in improved health for patients in Rutland, Vermont.

After this presentation, participants will be able to:

• Define the role of a lead care coordinator

• Use care coordination tools to engage high-risk patients and effectively communicate with other care providers

• Demonstrate how to use a patient care conference to develop a patient-centered shared care plan

Presenters: Sarah Narkewicz, RN, Director, Rutland Regional Medical Center; Sandra Knowlton-Soho, MS RN, ACO Clinical Consultant, OneCareVermont

L5 Diabetes Prevention: From Clinic to Community

Learning Format: Flipped Classroom

Owing to the proposed 2018 Medicare reimbursement for diabetes prevention services, clinical and community leaders will need innovative solutions in order to synchronize prevention efforts across clinical practices and communities to improve health, improve care, and reduce costs. This workshop will provide strategic and operational frameworks that integrate diabetes prevention services across the care continuum to prevent diabetes in individuals both within a health care system and in surrounding underserved communities.

After this presentation, participants will be able to:

• Describe diabetes prevention tools that can be used in clinical practice and community interventions to improve health outcomes by improving awareness, screening, and referral to treatment for at-risk individuals

• Identify the features of an integrative approach for synchronizing diabetes prevention services across the clinical and community care continuum

• Discuss the use of improvement science to synchronize prevention activities in clinical practice and in surrounding communities with underserved populations

Presenters: Kim Brunisholz, MST, statistician, University of Utah; Kate Kirley, MD, MS, Director of Chronic Disease Prevention, American Medical Association; Liz Joy, Medical Director, Community Health/Food and Nutrition Srvcs, Intermountain Healthcare; Janet Williams, MA, Senior Program Manager, American Medical Association
L6 Group facilitation processes for QI projects

**Learning Format: Buzz Session**

Teams undertaking an improvement project are by definition engaging in change efforts, and often under challenging conditions. To guide a group to the intended outcomes of its change efforts, a facilitator must have confidence, a wide variety of process skills, and sufficient knowledge. This session will use an interactive format to engage participants in learning simple, creative, and practical group facilitation approaches that support collaboration on improvement projects.

After this presentation, participants will be able to:

- Identify effective group facilitation methods to support a team at different stages of a quality improvement project
- Develop a facilitation plan for an upcoming session with an improvement team
- Demonstrate facilitation of a small-group conversation on a given improvement topic

Presenters: **John Lester, BSc., CPF**, Quality Improvement Coach and Facilitator, John Lester; **Christina Clarke, BSc, MHA**, Quality Management Consultant, Ideate Group

L7 Lessons & Tools from 100 Million Healthier Lives

**Learning Format: Buzz Session**

In 100 Million Healthier Lives, health systems, clinicians, community-based organizations, patients, and community members are working together in unprecedented collaboration (1,000+ members) to improve health, well-being, and equity. Learning Lab participants will hear case studies, receive tools, and practice improvement science and collaboration techniques to start using immediately to accelerate their journey to improve health and equity across a variety of specific topics and co-create solutions with their patients, colleagues, and community members.

After this presentation, participants will be able to:

- Assess where they are on the journey to improving health and equity in their clinic population or community and develop a plan for using improvement science methods (including data over time) to close equity gaps in health and well-being
- Identify and engage stakeholders, including patients and community members with lived experience, in sustainable partnerships toward a shared aim
- Apply both new and existing tools (such as the Community Health Needs Assessment) to build partnerships to address health and equity needs

Presenters: **Marianne McPherson, PhD, MS**, Director, 100 Million Healthier Lives Implementation, Institute for Healthcare Improvement; **Soma Stout, MD, MS**, Executive External Lead for Health Improvement, Institute for Healthcare Improvement; **Andrew Martin, MHCDS ’18**, 100MillionLives faculty, 100 Million Healthier Lives; **Laura Brennan, MSW**, Principal; Co-Chair, 100 Million Healthier Lives, Community Solutions; **Paul Howard, MPA**, Director of Community Initiatives, 100 Million Healthier Liv, Institute for Healthcare Improvement
L8 Back to the Basics: Building Essential QI Skills

Learning Format: Buzz Session

Designed for anyone who may not be sure how to run multiple PDSA tests in one day, determine if a change concept is ready for implementation, and sustain the improvements, as well as anyone who is new to the quality improvement journey, this session will demonstrate how to link the three questions related to aim, measurement, and change concepts to the sequence for success and provide an overview of key tools and methods for improvement initiatives.

After this presentation, participants will be able to:

- Provide an overview of the IHI Model for Improvement
- Detail the differences between QI testing, implementing, and spreading
- Identify key concepts and tools that should be part of their QI toolkit

Presenters: Robert Lloyd, PhD, Vice President, Institute for Healthcare Improvement; Ninon Lewis, MS, Executive Director, Institute for Healthcare Improvement

L9 Addressing the Opioid Crisis in Ambulatory Care

Learning Format: Case Study

Multiple strategies are needed to address the complex and worsening opioid crisis, including reducing the supply of prescription opioids, educating providers and patients, improving access to treatment, and partnering across the community. Health care organizations and providers, particularly in primary care, will play a critical role. This session will highlight the work of Cambridge Health Alliance, Outer Cape Health Services, and QuadMed, organizations that are deploying effective and innovative strategies to address the opioid crisis in their communities.

After this presentation, participants will be able to:

- Understand the magnitude of the opioid crisis in the United States
- Describe different strategies to address multiple drivers of the opioid crisis, including physician prescribing, prescriber education, treatment for opioid use disorder, and partnering with communities
- Identify change ideas and strategies to overcome barriers that they can test at their organization

Presenters: Mara Laderman, MSPH, Senior Research Associate, Institute for Healthcare Improvement; Andrew Jorgensen, MD, Associate Medical Director, Outer Cape Health Services; Mary Ellen Benzik, MD, Chief Medical Officer, QuadMed; Gregory Sawin, MD, MPH, Program Director, Cambridge Health Alliance; Randi Sokol, FELLOW, Cambridge Health Alliance; Alicia Agnoli, MD, MPH, resident physician, Cambridge Health Alliance

L10 Prototyping as a Practice Improvement Strategy

Learning Format: Simulation Encounter

Developing facility with prototyping can accelerate improvements in delivering patient-centered care in a practice. This session will highlight the journey of one health system in shifting its lens from piloting solutions to real-world experimentation in order to co-create solutions with patients and families. Participants will develop concrete skills in prototyping, and all will be given a toolkit with prototyping techniques and strategies at the conclusion of the session.

After this presentation, participants will be able to:

- Shift their mind-set to work in an experimental way
- Develop facility in prototyping as a quality improvement technique
Identify specific ways to engage community stakeholders in service of patients and families

Presenters: Peter Roberts, Executive Vice President, Children’s Medical Center Dallas; Elizabeth Stefanski, Chief Market Maker, Business Innovation Factory

Friday, April 21: Receptions and Meals

12:45 PM - 1:30 PM

LT1 Lunchtime Presentation: Wanting Joy for Myself: The Power of Groups

Learning Format: Lecture

Staff and clinicians working in health care settings often find that the job expectations overwhelm their personal desire to be in true relationships with their patients. This session will focus on the opportunity for health care providers to experience a new reality by providing care in groups. Specific examples of the joy shared by those working with centering health care groups will be highlighted.

After this presentation, participants will be able to:

• Identify personal challenges in the workplace that interfere with the ability to experience joy
• Discuss the power of the many relationships that develop through the provision of care in groups
• Describe the effect of providing group care on the satisfaction of staff and clinicians

Presenters: Amy MacDonald, CNM, MSN, Consultant and Nurse Midwife, Centering Healthcare Institute

5:30 PM - 7:00 PM

PosRec Storyboard and Networking Reception

Friday, April 21: Workshop A

1:30 PM - 2:45 PM

A1 Community-Based Improvement Collaboratives: From Design to Implementation

Learning Format: Case Study

Increasingly we see that the best approaches to achieving population health are multi-stakeholder and community-driven and address the upstream determinants of health. Moving beyond traditional organizational structures and into the community presents opportunities to adapt traditional improvement approaches. This interactive session will unpack the unique characteristics of community-driven improvement through case studies of three initiatives that employed the improvement methods used by health systems to improve care to tackle some of their toughest socioeconomic issues.

After this presentation, participants will be able to:

• Explore the design of a community-based improvement collaborative, from a theory of change to measurement considerations

• Understand key considerations for teaching improvement method basics in a community, including the impact of key stakeholders such as the social services sector, grantmakers, and the local government
18th Annual Summit on Improving Patient Care in the Office Practice and the Community

- Draw lessons and strategies from community projects that can be applied to the improvement efforts within their organization or community

Presenters: Marie Schall, MA, Director, Institute for Healthcare Improvement; Gregory Vandenberge, BS, Director of Giving and Community Engagement, US Venture, Incorporated; Amy Gedal Douglass, DrPH, MPH, Director, Quality and Capacity Improvement, Department of Health and Mental Hygiene; Afiesha McMahon, MHA, Sr. Relationship/Project Manager, Institute for Healthcare Improvement

[Green Box] SWA TBD

[Green Box] A2 Complete Care: Transforming Care Delivery

**Learning Format:** Lecture

Complete Care is a team-based approach aimed at improving outcomes through a focus on total health. It utilizes multiple integrated components, including decision support, health education, proactive care, centralized outreach, physician education, pharmacy services, and care/case management. Integrating the office practice with urgent care, inpatient care, and continuing care to promote wellness, prevention, acute and chronic care, and end-of-life care, Complete Care can improve quality and patient satisfaction and also decrease costs.

After this presentation, participants will be able to:

- Explain how to create a culture of Complete Care throughout the delivery system
- Determine the role of systematic care versus individualized care
- Understand the role of patient engagement tools to help patients manage their own health care

Presenters: Michael Kanter, MD, Medical Director, Quality & Clinical Analysis, Kaiser Permanente

[Green Box] A3 Joy in Work: Lessons from the Field

**Learning Format:** Case Study

Several health care organizations said, "Yes, we want to create joy in work!" and tested IHI’s new Joy in Work Framework. These pioneer organizations used the framework to test self-assessments, understand how to design useful measures, and take innovative steps to create a joyful environment for the entire team. Participants in this workshop will learn what they can take back to their organization to decrease burnout and create more joy in work.

After this presentation, participants will be able to:

- Identify key lessons learned from prototype sites about creating joy in work
- Apply self-assessment tests, useful measures, and actions to create joy in work in their setting
- Assemble a series of brief actions to test in their setting

Presenters: Barbara Balik, RN, EdD, Co-Founder, Aefina Partners; Julie Landsman, Building Capability Project Coordinator, Institute for Healthcare Improvement; Alexander Rakul, AMGA, Kaiser Permanente; Cydnee Crawley, Department Administrator, Kaiser Permanente
A4 Personal Mastery for Transformational Leadership

Learning Format: Case Study

Transformational change depends on how fast and how far people shift roles and ways of thinking and relating. As leaders tackle the difficult tasks of managing their own reactions, standing firm on decisions, and engaging others with individual consideration, they are constrained by the emotional tension and resistance that accompany almost all change efforts. Through case study, leaders will learn how to enhance their "personal mastery" to achieve desired results and creative relationships.

After this presentation, participants will be able to:

• Explain how to identify and respond effectively to their own personal reactions and reactions of others that may interfere with progress
• Identify strategies for reflection and communication that facilitate moving from reactivity to creativity
• Define ways to exercise authority that enhance motivation and engagement

Presenters: Neil Baker, MD, Principal, Neil Baker Consulting and Coaching

A5 Designing a Population-Based Behavioral Health Integration Program

Learning Format: Lecture

Organizations beginning to integrate behavioral health and primary care often struggle with the clinical, operational, and financial aspects of designing this new model of care. Often overlooked is the critical need to build an understanding of the needs and assets of each clinic's population into the program. Using practice examples, this workshop will describe strategies to meet those needs, support the primary care team, and manage other core features of an integration program, including funding and clinic resources.

After this presentation, participants will be able to:

• Describe the importance of designing a population-based behavioral health integration program
• Understand strategies to define population needs and then use those needs to inform changes in key areas such as staffing, workflows, and operational infrastructure
• Identify strategies and change ideas to test at their organization as they build their integration program

Presenters: Mara Laderman, MSPH, Senior Research Associate, Institute for Healthcare Improvement; Wendy Bradley, LPC, CAADC, Director, Health Integration, TMF Health Quality Institute

A6 Liberation in the Exam Room: How to Implement a Racial Justice Framework

Learning Format: Case Study

We often find ourselves treating the unjust health outcomes caused by structural racism, while never naming racism or acknowledging its specific impact on health care systems and our interactions within them. In this session, participants will join a conversation about what a small coalition of liberation-minded primary care providers in Boston are doing to advance racial justice and equity with their patients, on their teams, and in their communities.

After this presentation, participants will be able to:

• Identify shared definitions and context for why racial health inequities persist even after controlling for socioeconomic status and education
• Describe specific tools and frameworks to deepen their team’s understanding of the social determinants of health and oppression, as well as why and how working for racial equity improves outcomes for all
• Orient and train members of their medical team in strategies to advance racial justice, including the use of implicit bias data to impact policy, practice, and procedure

Presenters: Abigail Ortiz, MSW, MPH, Director of Community Health Programs, Brigham and Women's Hospital

A7 Better by Design

Learning Format: Buzz Session

Too often we rush to create the “perfect” solution without fully understanding the problem from the user perspective. In this interactive session, we will demonstrate how human-centered design tools can engage both patients and staff and move an organization’s improvement efforts farther, faster. Participants are encouraged to bring a problem to explore and be ready to engage. A basic understanding of human-centered design can help anyone leverage their organization’s most valuable asset—their people!

After this presentation, participants will be able to:

• Describe human-centered design and its utility in the health care environment
• Practice using two different human-centered design tools that they can bring back to their practice
• Identify strategies to overcome common barriers to engaging users, both patients and staff, in improvement efforts

Presenters: Jessica Moore, Director of Innovations, Petaluma Health Center; Danielle Oryn, DO, MPH, Chief Medical Informatics Officer, Petaluma Health Center

A8 The Basics: How to Build an Effective QI Team

Learning Format: Buzz Session

Many busy practices want to have an effective quality improvement program but are overwhelmed by the challenge of getting started. This presentation will cover the key steps in beginning a QI program at a small to medium-sized practice. Challenges, lessons learned, best practices, and a realistic timeline will be reviewed, and attendees will be offered tools and resources they can immediately put to use—such as teaching PDSA concepts with Mr. Potato Head!

After this presentation, participants will be able to:

• Develop an action plan to start a QI program at their practice
• Identify appropriate staff members for their QI team
• Practice teaching a new QI team the basics of Model for Improvement methodology

Presenters: Jennifer Snyder, Director of Process Improvement, Clinica Family Health Services; Amber Carlson, MS, CES, Project Manager, Clinica Family Health Services
**A9 Volume to Value: How Do We Sustain a Patient Focus?**

*Learning Format: Buzz Session*

Most definitions of value involve a ratio between quality and cost, but measuring quality in health care has been persistently problematic, often missing the mark on what matters most to patients, at times even promoting waste and causing harms. With value-based payment now upon us, what are the essential aspects of patient-centered care that should inform our drive for value? How can we incorporate these into measures of quality and value?

After this presentation, participants will be able to:

- Describe the ways in which inappropriate quality metrics cause harm to patients, primarily through opportunity costs and wasteful overtreatment
- Understand the ideal features of next-generation quality metrics and share their ideas for meaningful examples of such measures
- Identify strategies for aligning core elements of patient-centered care (respect, compassion, collaboration, etc.) with the need to provide “value” in health care

Presenters: **Gregory Sawin, MD, MPH**, Program Director, Cambridge Health Alliance; Ron Adler, Physician, University of Massachusetts Medical School

**A10 Creating an Inclusive Environment for LGBTQ Patients**

*Learning Format: Buzz Session*

Now that federal regulations require data collection on sexual orientation and gender identity, LGBTQ patients are increasingly visible in health care facilities. The stigma, homophobia, sexism, and transphobia present in some health care facilities, however, can have a severe impact on their health. Contra Costa LGBTQ Pride Initiative members will discuss their approach to increasing inclusion, improving staff competency, and addressing stigma and discrimination, as well as data collection, policy development, and responses to community needs.

After this presentation, participants will be able to:

- Identify inclusion strategies for data collection on LGBTQ patients and clients
- Create a more LGBTQ-welcoming environment with inclusive policies
- Utilize staff training to increase employee LGBTQ competency and overcome stigma

Presenters: **Joanne Genet**, Lead, LGBTQ Pride Initiative, Contra Costa Health Services; Erika Jenssen, Blue Zone, Design Director, Contra Costa Health Services

**Friday, April 21: Workshop B**
3:00 PM - 4:15 PM

B1 Community-Based Improvement Collaboratives: From Design to Implementation

**Learning Format:** Case Study

Increasingly we see that the best approaches to achieving population health are multi-stakeholder and community-driven and address the upstream determinants of health. Moving beyond traditional organizational structures and into the community presents opportunities to adapt traditional improvement approaches. This interactive session will unpack the unique characteristics of community-driven improvement through case studies of three initiatives that employed the improvement methods used by health systems to improve care to tackle some of their toughest socioeconomic issues.

After this presentation, participants will be able to:

- Explore the design of a community-based improvement collaborative, from a theory of change to measurement considerations
- Understand key considerations for teaching improvement method basics in a community, including the impact of key stakeholders such as the social services sector, grantmakers, and the local government
- Draw lessons and strategies from community projects that can be applied to the improvement efforts within their organization or community

Presenters: Marie Schall, MA, Director, Institute for Healthcare Improvement; Gregory Vandenberg, BS, Director of Giving and Community Engagement, US Venture, Incorporated; Amy Gedal Douglass, DrPH, MPH, Director, Quality and Capacity Improvement, Department of Health and Mental Hygiene; Afiesha McMahon, MHA, Sr. Relationship/Project Manager, Institute for Healthcare Improvement

B2 Complete Care: Transforming Care Delivery

**Learning Format:** Lecture

Complete Care is a team-based approach aimed at improving outcomes through a focus on total health. It utilizes multiple integrated components, including decision support, health education, proactive care, centralized outreach, physician education, pharmacy services, and care/case management. Integrating the office practice with urgent care, inpatient care, and continuing care to promote wellness, prevention, acute and chronic care, and end-of-life care, Complete Care can improve quality and patient satisfaction and also decrease costs.

After this presentation, participants will be able to:

- Explain how to create a culture of Complete Care throughout the delivery system
- Determine the role of systematic care versus individualized care
- Understand the role of patient engagement tools to help patients manage their own health care

Presenters: Michael Kanter, MD, Medical Director, Quality & Clinical Analysis, Kaiser Permanente
B3 Joy in Work: Lessons from the Field

Learning Format: Case Study

Several health care organizations said, "Yes, we want to create joy in work!" and tested IHI’s new Joy in Work Framework. These pioneer organizations used the framework to test self-assessments, understand how to design useful measures, and take innovative steps to create a joyful environment for the entire team. Participants in this workshop will learn what they can take back to their organization to decrease burnout and create more joy in work.

After this presentation, participants will be able to:

- Identify key lessons learned from prototype sites about creating joy in work
- Apply self-assessment tests, useful measures, and actions to create joy in work in their setting
- Assemble a series of brief actions to test in their setting


B4 Personal Mastery for Transformational Leadership

Learning Format: Case Study

Transformational change depends on how fast and how far people shift roles and ways of thinking and relating. As leaders tackle the difficult tasks of managing their own reactions, standing firm on decisions, and engaging others with individual consideration, they are constrained by the emotional tension and resistance that accompany almost all change efforts. Through case study, leaders will learn how to enhance their "personal mastery" to achieve desired results and creative relationships.

After this presentation, participants will be able to:

- Explain how to identify and respond effectively to their own personal reactions and reactions of others that may interfere with progress
- Identify strategies for reflection and communication that facilitate moving from reactivity to creativity
- Define ways to exercise authority that enhance motivation and engagement

Presenters: **Neil Baker, MD**, Principal, Neil Baker Consulting and Coaching

B5 Designing a Population-Based Behavioral Health Integration Program

Learning Format: Lecture

Organizations beginning to integrate behavioral health and primary care often struggle with the clinical, operational, and financial aspects of designing this new model of care. Often overlooked is the critical need to build an understanding of the needs and assets of each clinic’s population into the program. Using practice examples, this workshop will describe strategies to meet those needs, support the primary care team, and manage other core features of an integration program, including funding and clinic resources.

After this presentation, participants will be able to:

- Describe the importance of designing a population-based behavioral health integration program
- Understand strategies to define population needs and then use those needs to inform changes in key areas such as staffing, workflows, and operational infrastructure
- Identify strategies and change ideas to test at their organization as they build their integration program

Presenters: **Mara Laderman, MSPH**, Senior Research Associate, Institute for Healthcare Improvement; **Wendy Bradley, LPC, CAADC**, Director, Health Integration, TMF Health Quality Institute
B6 Liberation in the Exam Room: How to Implement a Racial Justice Framework

Learning Format: Case Study

We often find ourselves treating the unjust health outcomes caused by structural racism, while never naming racism or acknowledging its specific impact on health care systems and our interactions within them. In this session, participants will join a conversation about what a small coalition of liberation-minded primary care providers in Boston are doing to advance racial justice and equity with their patients, on their teams, and in their communities.

After this presentation, participants will be able to:

- Identify shared definitions and context for why racial health inequities persist even after controlling for socioeconomic status and education
- Describe specific tools and frameworks to deepen their team’s understanding of the social determinants of health and oppression, as well as why and how working for racial equity improves outcomes for all
- Orient and train members of their medical team in strategies to advance racial justice, including the use of implicit bias data to impact policy, practice, and procedure

Presenters: Abigail Ortiz, MSW, MPH, Director of Community Health Programs, Brigham and Women's Hospital

B7 Better by Design

Learning Format: Buzz Session

Too often we rush to create the “perfect” solution without fully understanding the problem from the user perspective. In this interactive session, we will demonstrate how human-centered design tools can engage both patients and staff and move an organization’s improvement efforts farther, faster. Participants are encouraged to bring a problem to explore and be ready to engage. A basic understanding of human-centered design can help anyone leverage their organization’s most valuable asset—their people!

After this presentation, participants will be able to:

- Describe human-centered design and its utility in the health care environment
- Practice using two different human-centered design tools that they can bring back to their practice
- Identify strategies to overcome common barriers to engaging users, both patients and staff, in improvement efforts

Presenters: Jessica Moore, Director of Innovations, Petaluma Health Center; Danielle Oryn, DO, MPH, Chief Medical Informatics Officer, Petaluma Health Center

B8 The Basics: How to Build an Effective QI Team

Learning Format: Buzz Session

Many busy practices want to have an effective quality improvement program but are overwhelmed by the challenge of getting started. This presentation will cover the key steps in beginning a QI program at a small to medium-sized practice. Challenges, lessons learned, best practices, and a realistic timeline will be reviewed, and attendees will be offered tools and resources they can immediately put to use—such as teaching PDSA concepts with Mr. Potato Head!

After this presentation, participants will be able to:

- Develop an action plan to start a QI program at their practice
- Identify appropriate staff members for their QI team
• Practice teaching a new QI team the basics of Model for Improvement methodology

Presenters: Jennifer Snyder, Director of Process Improvement, Clinica Family Health Services; Amber Carlson, MS, CES, Project Manager, Clinica Family Health Services

**B9 Volume to Value: How Do We Sustain a Patient Focus?**

*Learning Format: Buzz Session*

Most definitions of value involve a ratio between quality and cost, but measuring quality in health care has been persistently problematic, often missing the mark on what matters most to patients, at times even promoting waste and causing harms. With value-based payment now upon us, what are the essential aspects of patient-centered care that should inform our drive for value? How can we incorporate these into measures of quality and value?

After this presentation, participants will be able to:

• Describe the ways in which inappropriate quality metrics cause harm to patients, primarily through opportunity costs and wasteful overtreatment
• Understand the ideal features of next-generation quality metrics and share their ideas for meaningful examples of such measures
• Identify strategies for aligning core elements of patient-centered care (respect, compassion, collaboration, etc.) with the need to provide “value” in health care

Presenters: Gregory Sawin, MD, MPH, Program Director, Cambridge Health Alliance; Ron Adler, Physician, University of Massachusetts Medical School

**B10 Creating an Inclusive Environment for LGBTQ Patients**

*Learning Format: Buzz Session*

Now that federal regulations require data collection on sexual orientation and gender identity, LGBTQ patients are increasingly visible in health care facilities. The stigma, homophobia, sexism, and transphobia present in some health care facilities, however, can have a severe impact on their health. Contra Costa LGBTQ Pride Initiative members will discuss their approach to increasing inclusion, improving staff competency, and addressing stigma and discrimination, as well as data collection, policy development, and responses to community needs.

After this presentation, participants will be able to:

• Identify inclusion strategies for data collection on LGBTQ patients and clients
• Create a more LGBTQ-welcoming environment with inclusive policies
• Utilize staff training to increase employee LGBTQ competency and overcome stigma

Presenters: Joanne Genet, Lead, LGBTQ Pride Initiative, Contra Costa Health Services; Erika Jenssen, Blue Zone, Design Director, Contra Costa Health Services

**SWB TBD**

**WBFT Workshop B Free Time**

**Friday, April 21: Keynotes**
8:00 AM - 9:00 AM

Key1 Keynote 1: Dr. Kavita Patel and Dr. Trissa Torres

4:30 PM - 5:30 PM

Key2 Keynote 2: Dr. Erika Bliss

Saturday, April 22: Special Interest Breakfasts

7:00 AM - 7:45 AM

SIB1 The Conversation Project: Preparing Personally and Professionally for End-of-Life Care Conversations

SIB2 TBD

Saturday, April 22: Keynotes

8:00 AM - 9:00 AM

Key3 Keynote 3: Maureen Bisognano

Saturday, April 22: Workshop C

9:30 AM - 10:45 AM

C1 Fostering Wellness With Person-Centered Care

*Learning Format: Lecture*

As pressures on health care providers to provide better care continue to increase, new approaches are needed that go beyond the traditional doctor-patient paradigm. This session will present Southcentral Foundation’s relationship-based care system, which emphasizes working with patients (called "customer-owners") to help them achieve overall wellness rather than just treating problems as they arise. Presenters will share insights and detail SCF’s methods for engaging people and families in their own health care.

After this presentation, participants will be able to:

- Identify the ways in which SCF engages people and families in their own health care
- Discuss the core principles of SCF’s relationship-based care system

Presenters: **Steve Tierney, MD**, CMIO/Medical Director Clinic Quality Improvement, Southcentral Foundation; Latanya Odden, Marketing Planner, Southcentral Foundation
C2 Yes, We Can: The Iora Health Experience

Learning Format: Case Study

While many primary care practices are trying to make incremental changes in their practice, Iora Health has had the good fortune to start from scratch and build a radically new, high-impact, relationship-based care model. Recognizing that most practices have no such opportunity, Iora Health presenters will discuss the many lessons learned from their journey that can help any practice striving to improve patient and team experience, improve outcomes, and lower the total cost of care.

After this presentation, participants will be able to:

- Understand Iora Health’s new high-impact, relationship-based care model and how it can lead to improvements in the Quintuple Aim
- Identify lessons from Iora Health’s journey that can be applied to any primary care practice
- Develop strategies for overcoming barriers to implementing new care models

Presenters: Rushika Fernandopulle, CEO, Iora Health

C3 Aligning Incentives to Achieve the Quadruple Aim

Learning Format: Case Study

Boulder Community Health’s strategies for incorporating the Quadruple Aim across its primary care and specialty clinics have included: creating a new provider incentive program that rewards quality and patient experience outcomes; adding patients to clinical QI teams; training providers and frontline staff in listening, empathy, and motivational interviewing; and using Choosing Wisely and variance reduction strategies to optimize value. In this session, a provider, patient, and quality team member will review the organization’s results, successes, and challenges.

After this presentation, participants will be able to:

- Discuss tools, challenges, and engagement strategies to operationalize a provider incentive program aligning with the Quadruple Aim
- Identify strategies to successfully integrate the patient voice into quality improvement efforts
- Implement a comprehensive program to educate providers, nurse care coordinators, and frontline staff in advanced customer service skills, including active listening techniques, empathy training, and motivational interviewing

Presenters: Benjamin Keidan, MD, FACP, Medical Director of Quality and Population Health, Boulder Community Hospital; Lauren Hyer, RN, MSN, Quality Improvement and Population Health Manager, Boulder Community Health; Marc Sobel, Retired, No Organization; Kristin Robson, Clinic Manager, Boulder Community Health

C4 Community Solutions to Heroin Addiction Challenges

Learning Format: Case Study

Pueblo Triple Aim has developed a unique process to bring together cross-sector actors to plan and act on preventing and treating heroin addiction in Pueblo, Colorado. The session will offer other communities a template for creating their own process to address heroin addiction by describing how different actors and sectors were brought together in Pueblo, the planning process, the action steps taken, and successes to date in tackling heroin-related issues.

After this presentation, participants will be able to:

- Identify methods for building cross-sector coalitions to address substance abuse issues that have an impact on health care entities
• Provide examples of how disparate community organizations can take concrete steps to solve complex community issues
• Describe ways to involve those directly affected by substance abuse (family and caregivers) in the planning and actions taken to improve prevention and treatment options in a community

Presenters: **Matt Guy**, Executive Director, Pueblo Triple Aim Corporation; Lindsay Reeves, Community Engagement Director, Pueblo Triple Aim Corporation

### C5 Reaching Outside Practice Walls to Improve Health

**Learning Format: Case Study**

This session will share the experience of providers who were passionate about ensuring that their patients received appropriate care according to evidence-based practices, but frustrated by patients' less-than-desirable outcomes. Only when they began systematically identifying social determinants of health (SDH) and integrating them into their care plan did both outcomes and equity start to improve. In this highly interactive session, participants will collaborate to create SDH strategies to bring home to their own communities.

After this presentation, participants will be able to:

• Develop a strategy to identify and address social determinants of health in their community
• Implement proven techniques to improve health equity
• Create a data strategy for undertaking health equity projects at their organization

Presenters: **Christina Espersen, IA**, Adjunct Instructor, Drake University

### C6 Innovative Approaches to Family-Centered Care

**Learning Format: Simulation Encounter**

Increasing family participation in pediatric care is crucial to both child and family health. This session will provide an overview of three family-centered interventions (family navigation, problem-solving education, and navigation with depressed mothers) delivered by community health workers in medical and community-based settings developed by a multidisciplinary pediatric team to improve child and family health outcomes. Participants will learn to identify the core components of successful and innovative family-centered approaches within a safety-net hospital.

After this presentation, participants will be able to:

• Identify core components of successful and innovative family-centered approaches within a pediatric setting
• Provide an overview of three family-centered interventions employed in a pediatric safety-net setting
• Develop guidelines to implement family-centered approaches in a health care practice

Presenters: **Yaminette Diaz-Linhart**, Program Director, Boston Medical Center; Ivys Fernández-Pastrana, Special Education and Policy Initiatives Coordinator, Boston Medical Center
**C7 Reducing Readmissions to 4%: A How-To Guide**

**Learning Format: Case Study**

Hospital readmissions for chronic obstructive pulmonary disease, congestive heart failure, and pneumonia continue to challenge systems of care. Using a medical home model, process improvements, basic technology, and simple statistics, presenters will describe how they used big data and relationships to improve readmission rates (from 22% to 4%) and length of stay (from 3.9 to 3.2 days) and increase revenue using transition of care visits. Participants will gain practical tips for implementing these strategies in their home institutions.

After this presentation, participants will be able to:

- Describe strategies to reduce hospital readmissions by improving hand-off communication
- Deploy data analytics and data collection to reduce readmission rates
- Implement process improvements to improve hand-offs, reduce readmissions, and improve length of stay

Presenters: **Andrew Bland, MD, MBA**, Chief Quality Officer, Hospital Sisters Health System

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**C8 IHI Open School Students Leading for Health Equity**

**Learning Format: Rapid-Fire Sessions**

Students and residents are organizing their communities to address the needs of their most vulnerable and underserved populations. In this session, IHI Open School learners will demonstrate how to apply a community organizing approach to tackling complex health needs in a local setting. Participants will learn new organizational approaches to improving the health of a community and will have the opportunity to connect with students in their own area who can add capacity to their initiatives.

After this presentation, participants will be able to:

- Describe community organizing approaches to improving the health of their local community
- Develop intervention ideas for improving the health of vulnerable populations in their local setting
- Identify local IHI Open School learners to engage in their organization’s initiatives

Presenters: **Becka DeSmidt**, Community Manager, Institute for Healthcare Improvement; **Kate Hilton, JD, MTS**, Faculty, Institute for Healthcare Improvement

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**C9 Creating New Partnerships Across the Continuum**

**Learning Format: Lecture**

The incentive structure of the New York State Delivery System Reform Incentive Payment (DSRIP) Program, a Medicaid waiver program, provides a unique opportunity to engage diverse stakeholder groups in system transformation from volume to value. Participants in this session will hear how two different systems are helping regional "competitors" collaborate to improve population health through new partnerships and new models of care, including care coordination, care transitions, and primary care behavioral health integration.

After this presentation, participants will be able to:

- Identify best practices for diverse stakeholder engagement
- Access examples of relationship-building across partners
- Describe the care models being implemented in large health care systems to improve care coordination and outcomes

Presenters: **Damara Gutnick**, Job Title not selected, Organization Name not selected; **Amanda Ascher, MD**, Chief Medical Officer, Bronx Partners for Healthy Communities, SBH Health System
C10 Improving Equity in Pregnancy Intention

**Learning Format: Case Study**

IHI has partnered with the Women-Inspired Neighborhood (WIN) Network and Henry Ford Health System to address the challenges faced by women in underserved areas of Detroit in receiving the contraceptive care they need to plan their pregnancies and achieve their goals. This session will share early results from these efforts to assess these women’s attitudes toward family planning, the barriers to care they experience, and possible interventions to support shared decision-making and family planning options.

After this presentation, participants will be able to:

- Identify the challenges in a diverse, urban setting to understanding pregnancy intention and barriers in decision-making around contraception and family planning
- Describe tools that can be used in communities to improve shared decision-making around contraception and the uptake of contraceptive counseling and planning
- Understand how innovative models of care, such as WIN’s Community Health Worker model, support and link women to health and health care services

Presenters: Deborah Bamel, MPH, Project Manager, Institute for Healthcare Improvement; Kimberlydawn Wisdom, MD, MS, Sr. VP, Comm. Health & Equity, Chief Wellness & Diversity Off., Henry Ford Health System; Jaye Clement, MPH, MPP, Director of Community Health Programs & Strategies, Henry Ford Health System; Jeffrey Rakover, Research Associate, Institute for Healthcare Improvement

**Saturday, April 22: Workshop D**

**11:00 AM - 12:15 PM**

**D1 Interoffice Collaboration to Close Referral Loops**

**Learning Format: Lecture**

Creating reliable systems for specialist referrals, patient navigation, and test tracking is a critical element of primary care. This session will offer lessons from the Harvard Medical School Academic Innovations Collaborative on challenges and solutions to developing effective and reliable closed-loop systems, as well as examples of highly effective collaboration between primary care and specialty practices. Discussion will include examples related to preventive screenings and presentation of red-flag symptoms in diverse primary care settings.

After this presentation, participants will be able to:

- Understand key change ideas for creating closed-loop systems to prevent missed or delayed diagnosis of colorectal cancer and breast cancer
- Identify the ways in which collaboration between primary care and specialty practices is a key tool for improvement at their organization

Presenters: Gordon Schiff, MD, Dir Clinical Quality Res, Brigham and Women's Hospital; Louise MacKisack, MA, Director, Ambulatory Operations, Gen. Med & Primary Care, Beth Israel Deaconess Medical Center; Scot B Sternberg, MS, Director of Quality Improvement, Department of Medicine, Beth Israel Deaconess Medical Center
D2 Navigator on Wheels: Promoting Health, Not Jail

Learning Format: Case Study

Provincetown, Massachusetts, had a choice: hire more police, or reduce emergencies due to behavioral health issues. The rural town chose Navigator on Wheels, an innovative program designed by its Federally Qualified Health Center to engage hard-to-reach individuals beyond the clinic walls, assess their needs, and connect them with services, reducing police involvement. Key to the effectiveness of the bicycle-powered Navigator are the relationships built with community partners, whether at the library or on the street.

After this presentation, participants will be able to:

- Describe how to implement an innovative, mobile community-oriented program to creatively improve access to health-related services by increasing patient engagement
- Explain how a successful rural community Navigator program identified and overcame barriers to implementation
- Discuss next steps in ensuring the sustainability of a Navigator program and its expansion to interested nearby communities

Presenters: Andrew Jorgensen, MD, Associate Medical Director, Outer Cape Health Services; L. Forest Malatesta, Community Resource Navigator, Outer Cape Health Services; Andy Lowe, Chief Strategy Officer, Outer Cape Health Services

D3 The Role of Data in Improvement and Quality Care

Learning Format: Lecture

This session will cover Southcentral Foundation’s data-handling processes and the ways in which SCF uses data to drive improvement in all areas. Information will be presented on specific data tools and measures, such as the Data Information Request Tool (DIRT) and the population-based action lists generated at SCF for care providers. We will also discuss how SCF turns data into actionable information and how that information drives organizational change.

After this presentation, participants will be able to:

- Describe the ways in which SCF collects data, converts data into actionable information, and uses data for improvement
- Identify areas for potential improvement in their own organization’s data-handling processes

Presenters: Steve Tierney, MD, CMIO/Medical Director Clinic Quality Improvement, Southcentral Foundation; Joe Ambrosio, Alaska, Data Architect, Data Services Department, Southcentral Foundation

D4 Access Defined: New Haven Speaks

Learning Format: Buzz Session

New Haven, Connecticut, engaged community members in solid community-based participatory research methodology to define what access to primary care means to them. Beyond standard metrics like the third-next-available appointment, this data set, paired with hospital utilization data, gives new insight into the impact of access on health and cost. Understanding patient definitions of access can inform efforts to reengineer primary care systems that better engage our patients and communities.

After this presentation, participants will be able to:

- Describe how their definition (as a patient) of access to health care might differ from standard payer metrics
- Develop a “back of the napkin” plan to advocate for patient-centered access in their home health system or community
Describe the impact of a more nuanced understanding of primary care access on care utilization

Presenters: Gregory Sawin, MD, MPH, Program Director, Cambridge Health Alliance; Alicia Agnoli, MD, MPH, resident physician, Cambridge Health Alliance

**D5 Exploring Alternatives to Consultant Office Visits**

*Learning Format: Buzz Session*

Addressing the growing interest from both patients and providers in alternatives to in-office consultations, this interactive workshop will focus on bringing patients and providers together to codesign strategies for developing alternative solutions to the current dependency on in-person consultation. Using an Innovation Thinking Toolkit, participants will learn about alternative consultation models and work together to generate innovative approaches to reliance on in-office visits.

After this presentation, participants will be able to:

- Identify the rationale and options for moving “beyond the walls” of the office visit
- Determine the main implementation challenges of alternative models as well as possible solutions
- Collaborate with and learn from others to generate new innovative approaches to in-office consultations

Presenters: Chris Hayes, MD, MSc, MEd, Chief Medical Information Officer, St. Joseph’s Healthcare; Neil Drimer, MHSc, BScOT, Senior Improvement Lead, Canadian Foundation for Healthcare Improvement

**D6 Supporting Pregnant Minority Women Using the Community-Centered Health Home**

*Learning Format: Case Study*

With health care shifting to address health equity and social determinants of health, MAHEC-OB, a safety-net practice in western North Carolina, is implementing the community-centered health home (CCHH) model designed by the Prevention Institute. Presenters will share results and describe how MAHEC-OB partners with women in two communities in a low-income, high-needs zip code: a public housing community with a high proportion of African Americans and another community with many Latinos.

After this presentation, participants will be able to:

- Understand how an OB primary care practice can apply the CCHH model to address health equity and social determinants of health in low-income, high-needs communities
- Identify aspects of the CCHH model that they could apply in their primary care practices and communities
- Discuss how best to engage with community partners and with individuals, based on the experiences of MAHEC-OB

Presenters: Melissa Baker, MPH, Director of Community Population Health, Mountain Area Health Education Center; Melinda Ramage, Perinatal Nurse Practitioner, Mountain Area Health Education Center; Amanda Murphy, CNM, MSN, Certified Nurse Midwife, Mountain Area Health Education Center
D7 The Triple Aim and Major Mental Illness: Integration 2.0

**Learning Format:** Lecture

Efforts to integrate behavioral health and primary care have targeted individuals with milder, highly prevalent behavioral health needs. Although integrated primary care can achieve the Triple Aim for this population, it doesn't reach the people with serious mental illnesses whose comorbidities drive higher spending and premature mortality. We describe an integrated care model for mental health clinics that immediately reduced ED visits and hospitalizations while increasing preventive screenings among several hundred people with psychosis.

After this presentation, participants will be able to:

- Identify health disparities experienced by people with serious mental illness and their key drivers
- Describe how a community-based mental health clinic established an integrated health home for people with serious mental illness
- Develop new change ideas to better address the needs of people with serious mental illness through integrated, team-based care and population management

Presenters: **Miriam Tepper**, Job Title not selected, Organization Name not selected; **Sandy Cohen**, MSW, MPH, Program Manager, Behavioral Health Home, Cambridge Health Alliance

D8 Transforming the Primary Care Teaching Clinic

**Learning Format:** Case Study

Primary care teaching clinics face unique challenges in providing both high-quality patient care and education. Through visits to 23 primary care teaching clinics nationwide, we identified six "Clinic First" principles that sites use to create high-functioning practices in which residents learn how to become primary care leaders by experiencing a high-functioning clinic and truly engaging in practice improvement. The Clinic First model provides a roadmap for transformation at primary care teaching clinics.

After this presentation, participants will be able to:

- Identify six principles for creating high-functioning primary care teaching practices using the Clinic First model
- Develop strategies to implement transformation in specific primary care teaching clinics

Presenters: **Marianna Kong, MD**, Academic Practice Transformation Liaison, UCSF Center for Excellence in Primary Care

D9 From Reactive to Proactive: Creating a Population Management Platform

**Learning Format:** Rapid-Fire Sessions

Have you been struggling to develop your own population management platform? Have you struggled learning from successful organizations because their context (resources, patients, infrastructure, etc.) is different from yours? This session is focused on addressing those two issues. A population management paradigm will be presented supported by specific examples from the Emory Healthcare Network and Brigham and Women's Primary Care Center of Excellence. Following the presentations, participants, at their tables, will apply the learning from the Emory and Brigham examples and develop a tactical plan for implementation in their local context. This exercise will be followed by a debriefing session highlighting the transformation of successful examples in a foreign context to one that could be implemented within the participants’ local constraints.

After this presentation, participants will be able to:

- Describe a general paradigm for population management.
Identify successful implementation of population management interventions.

List strategies for transforming population management interventions in a foreign context to ones that respect local constraints.

Formulate plans for implementation of successful population management interventions in the participant’s local context.

Presenters: Richard Gitomer, MD, Director, Brigham and Women's Hospital; Kristie Koch, Director of Value Management, Emory Healthcare

Saturday, April 22: Workshop E

1:15 PM - 2:30 PM

E1 Interoffice Collaboration to Close Referral Loops

Learning Format: Lecture

Creating reliable systems for specialist referrals, patient navigation, and test tracking is a critical element of primary care. This session will offer lessons from the Harvard Medical School Academic Innovations Collaborative on challenges and solutions to developing effective and reliable closed-loop systems, as well as examples of highly effective collaboration between primary care and specialty practices. Discussion will include examples related to preventive screenings and presentation of red-flag symptoms in diverse primary care settings.

After this presentation, participants will be able to:

- Understand key change ideas for creating closed-loop systems to prevent missed or delayed diagnosis of colorectal cancer and breast cancer
- Identify the ways in which collaboration between primary care and specialty practices is a key tool for improvement at their organization

Presenters: Gordon Schiff, MD, Dir Clinical Quality Res, Brigham and Women's Hospital; Louise MacKisack, MA, Director, Ambulatory Operations, Gen. Med & Primary Care, Beth Israel Deaconess Medical Center; Scot B Sternberg, MS, Director of Quality Improvement, Department of Medicine, Beth Israel Deaconess Medical Center

E2 Navigator on Wheels: Promoting Health, Not Jail

Learning Format: Case Study

Provincetown, Massachusetts, had a choice: hire more police, or reduce emergencies due to behavioral health issues. The rural town chose Navigator on Wheels, an innovative program designed by its Federally Qualified Health Center to engage hard-to-reach individuals beyond the clinic walls, assess their needs, and connect them with services, reducing police involvement. Key to the effectiveness of the bicycle-powered Navigator are the relationships built with community partners, whether at the library or on the street.

After this presentation, participants will be able to:

- Describe how to implement an innovative, mobile community-oriented program to creatively improve access to health-related services by increasing patient engagement
- Explain how a successful rural community Navigator program identified and overcame barriers to implementation
• Discuss next steps in ensuring the sustainability of a Navigator program and its expansion to interested nearby communities

Presenters: **Andrew Jorgensen, MD**, Associate Medical Director, Outer Cape Health Services; **L. Forest Malatesta**, Community Resource Navigator, Outer Cape Health Services; **Andy Lowe**, Chief Strategy Officer, Outer Cape Health Services

### E3 The Role of Data in Improvement and Quality Care

**Learning Format: Lecture**

This session will cover Southcentral Foundation’s data-handling processes and the ways in which SCF uses data to drive improvement in all areas. Information will be presented on specific data tools and measures, such as the Data Information Request Tool (DIRT) and the population-based action lists generated at SCF for care providers. We will also discuss how SCF turns data into actionable information and how that information drives organizational change.

After this presentation, participants will be able to:

• Describe the ways in which SCF collects data, converts data into actionable information, and uses data for improvement
• Identify areas for potential improvement in their own organization's data-handling processes

Presenters: **Steve Tierney, MD**, CMIO/Medical Director Clinic Quality Improvement, Southcentral Foundation; **Joe Ambrosio**, Alaska, Data Architect, Data Services Department, Southcentral Foundation

### E4 Access Defined: New Haven Speaks

**Learning Format: Buzz Session**

New Haven, Connecticut, engaged community members in solid community-based participatory research methodology to define what access to primary care means to them. Beyond standard metrics like the third-next-available appointment, this data set, paired with hospital utilization data, gives new insight into the impact of access on health and cost. Understanding patient definitions of access can inform efforts to reengineer primary care systems that better engage our patients and communities.

After this presentation, participants will be able to:

• Describe how their definition (as a patient) of access to health care might differ from standard payer metrics
• Develop a “back of the napkin” plan to advocate for patient-centered access in their home health system or community
• Describe the impact of a more nuanced understanding of primary care access on care utilization

Presenters: **Gregory Sawin, MD, MPH**, Program Director, Cambridge Health Alliance; **Alicia Agnoli, MD, MPH**, resident physician, Cambridge Health Alliance
E5 Exploring Alternatives to Consultant Office Visits

**Learning Format: Buzz Session**

Addressing the growing interest from both patients and providers in alternatives to in-office consultations, this interactive workshop will focus on bringing patients and providers together to codesign strategies for developing alternative solutions to the current dependency on in-person consultation. Using an Innovation Thinking Toolkit, participants will learn about alternative consultation models and work together to generate innovative approaches to reliance on in-office visits.

After this presentation, participants will be able to:

- Identify the rationale and options for moving “beyond the walls” of the office visit
- Determine the main implementation challenges of alternative models as well as possible solutions
- Collaborate with and learn from others to generate new innovative approaches to in-office consultations

Presenters: **Chris Hayes, MD, MSc, MEd**, Chief Medical Information Officer, St. Joseph’s Healthcare; **Neil Drimer, MHSc, BScOT**, Senior Improvement Lead, Canadian Foundation for Healthcare Improvement

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E6 Supporting Pregnant Minority Women Using the Community-Centered Health Home

**Learning Format: Case Study**

With health care shifting to address health equity and social determinants of health, MAHEC-OB, a safety-net practice in western North Carolina, is implementing the community-centered health home (CCHH) model designed by the Prevention Institute. Presenters will share results and describe how MAHEC-OB partners with women in two communities in a low-income, high-needs zip code: a public housing community with a high proportion of African Americans and another community with many Latinos.

After this presentation, participants will be able to:

- Understand how an OB primary care practice can apply the CCHH model to address health equity and social determinants of health in low-income, high-needs communities
- Identify aspects of the CCHH model that they could apply in their primary care practices and communities
- Discuss how best to engage with community partners and with individuals, based on the experiences of MAHEC-OB

Presenters: **Melissa Baker, MPH**, Director of Community Population Health, Mountain Area Health Education Center; **Melinda Ramage, Perinatal Nurse Practitioner**, Mountain Area Health Education Center; **Amanda Murphy, CNM, MSN**, Certified Nurse Midwife, Mountain Area Health Education Center

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E7 The Triple Aim and Major Mental Illness: Integration 2.0

**Learning Format: Lecture**

Efforts to integrate behavioral health and primary care have targeted individuals with milder, highly prevalent behavioral health needs. Although integrated primary care can achieve the Triple Aim for this population, it doesn’t reach the people with serious mental illnesses whose comorbidities drive higher spending and premature mortality. We describe an integrated care model for mental health clinics that immediately reduced ED visits and hospitalizations while increasing preventive screenings among several hundred people with psychosis.

After this presentation, participants will be able to:

- Identify health disparities experienced by people with serious mental illness and their key drivers
- Describe how a community-based mental health clinic established an integrated health home for people with serious mental illness
• Develop new change ideas to better address the needs of people with serious mental illness through integrated, team-based care and population management

Presenters: Miriam Tepper, Job Title not selected, Organization Name not selected; Sandy Cohen, MSW, MPH, Program Manager, Behavioral Health Home, Cambridge Health Alliance

E8 Transforming the Primary Care Teaching Clinic

Learning Format: Case Study

Primary care teaching clinics face unique challenges in providing both high-quality patient care and education. Through visits to 23 primary care teaching clinics nationwide, we identified six "Clinic First" principles that sites use to create high-functioning practices in which residents learn how to become primary care leaders by experiencing a high-functioning clinic and truly engaging in practice improvement. The Clinic First model provides a roadmap for transformation at primary care teaching clinics.

After this presentation, participants will be able to:
• Identify six principles for creating high-functioning primary care teaching practices using the Clinic First model
• Develop strategies to implement transformation in specific primary care teaching clinics

Presenters: Marianna Kong, MD, Academic Practice Transformation Liaison, UCSF Center for Excellence in Primary Care

E9 From Reactive to Proactive: Creating a Population Management Platform

Learning Format: Rapid-Fire Sessions

Have you been struggling to develop your own population management platform? Have you struggled learning from successful organizations because their context (resources, patients, infrastructure, etc.) is different from yours? This session is focused on addressing those two issues. A population management paradigm will be presented supported by specific examples from the Emory Healthcare Network and Brigham and Women’s Primary Care Center of Excellence. Following the presentations, participants, at their tables, will apply the learning from the Emory and Brigham examples and develop a tactical plan for implementation in their local context. This exercise will be followed by a debriefing session highlighting the transformation of successful examples in a foreign context to one that could be implemented within the participants’ local constraints.

After this presentation, participants will be able to:
• Describe a general paradigm for population management.
• Identify successful implementation of population management interventions.
• List strategies for transforming population management interventions in a foreign context to ones that respects local constraints.
• Formulate plans for implementation of successful population management interventions in the participant’s local context.

Presenters: Richard Gitomer, MD, Director, Brigham and Women’s Hospital; Kristie Koch, Director of Value Management, Emory Healthcare

E10 TBD