16th Annual International Summit on Improving Patient Care in the Office Practice and the Community

Sunday, March 15: Minicourse

12:00 PM - 5:30 PM

M1 Dramatically Improve Access and Reduce Waits in Primary and Specialty Care Practices

Room: Texas Ballroom : Texas Ballroom D

Learning Format: Lecture

Managing appointment delays can strain a medical practice, distracting staff, keeping them from important clinical work, and constraining the practice’s ability to absorb new patients. In this session, participants will hear from individuals who have tackled this challenge by applying the advanced access model in primary and specialty practices. Case studies will be used, including an in-depth look at a successful application at a large academic medical center, and participants will leave with an action-plan for their own organization.

After this presentation, participants will be able to:
- Identify the six high-leverage changes that dramatically improve access and reduce waits for appointments and services
- Utilize case studies from organizations that have committed to systemwide access improvement, including tested tools for forecasting appointment demand and supply for all services
- Explore common access pitfalls and coach other individuals in their organization on how to avoid and remedy the problems they have encountered on their access journey

Presenters: Tantau, C., BSN, MPA, President, Tantau & Associates; Neely, T., Chief Operating Officer, The University of Kansas Physicians

M2 True Cost and Value of Mental Health Integration: Intermountain’s Team-Based Approach

Room: San Antonio : San Antonio 4-6

Learning Format: Flipped Classroom

This session will demonstrate how Intermountain Healthcare (IH) has established value through an affordable, team-based approach that integrates screening, treatment, and management of mental health into an organized, measured process within the routine primary care encounter. We will share evidence from a retrospective longitudinal impact study that normalizing mental health mends traditional mind-body separation within the context of functioning teams and improves the quality of patient-reported outcomes and management of chronic disease while reducing unnecessary costs to the community.

After this presentation, participants will be able to:
- Identify how integrating mental health services into personalized primary care improves outcomes for patients and families managing multiple and complex conditions and determines the total cost of effective team care
- Apply the MHI team dosing measurement methodology to robust longitudinal registries (depression, diabetes, CHF, asthma) to monitor clinical and operational benchmarks for population health
- Demonstrate the greater value provided by high-performing, team-based care compared to the more traditional patient management approach, as measured by outcomes, costs, and utilization

Presenters: Reiss-Brennan, B., PhD, APRN, CS, Mental Health Integration Director, Intermountain Healthcare; Brunisholz, K., MST, statistician, University of Utah
M3 100 Million Healthier Lives: Connecting Primary Care and Community to Improve the Health of the Population

Room: Texas Ballroom : Texas Ballroom 5-6

Learning Format: Case Study

Creating health for populations and communities requires that a health care system reach beyond its walls at all points on the journey. This interactive minicourse will explore the work of leading innovators in creating pathways toward integration to address the social and behavioral determinants of health. Based on mini-case studies of multiple organizations and integration methods, participants will understand new ways of connecting primary care and community, and create a plan for mapping and activating the assets needed to make true integration happen.

After this presentation, participants will be able to:

- Explain why, in this stage of ACO and PCMH transformation, it is critical for primary care, community and public health systems to coordinate to improve the health of people, communities and populations.
- Identify new models of connecting primary care with the community.
- Describe a plan for taking the first steps to create partnerships within their own organizations and communities.
- Describe IHI’s newest initiative, 100 Million Healthier Lives, and its catalytic approaches to creating powerful linkages across stakeholders, as well as the opportunities to become a part of this catalytic global change initiative.

Presenters: Stout, S., MD, Executive External Lead, Health Improvement, Institute for Healthcare Improvement; Brennan, L., MSW, Principal, Community Solutions; Lewis, N., MS, Executive Director, Institute for Healthcare Improvement; Redding, S., MD, MPH, CEO, Care Coordination Systems

M4 Team-Based Primary Care: Effective Practices from High-Performing Organizations

Room: Texas Ballroom : Texas Ballroom C

Learning Format: Case Study

Creating more effective practice teams is the key to becoming a patient-centered medical home (PCMH), improving patient outcomes and experience, reducing staff burnout, and reducing total health care costs. This session will share lessons learned from studying 31 high-performing organizations that now use their workforce in innovative ways. Participants will also hear directly from these high-performing organizations. Participants will use a web-based primary care team guide to identify areas for changing roles, building more effective teams, and redesigning the work of patient care to become a more effective and productive practice.

After this presentation, participants will be able to:

- Assess their practice’s primary care staffing, team-building, and deployment of staff to meet important patient needs and identify opportunities for improvement
- Explore practical ideas for expanding staff roles, building and sustaining effective teamwork, and using teams to more effectively and efficiently deliver evidence-based care, self-management support, follow-up and care management, and care coordination
- Access relevant tools and other resources to support team and practice change

Presenters: Wagner, E., MD, MPH, FACP, Director Emeritus, MacColl Center for Health Care Innovation; Flinter, M., APRN, PhD, Sr. Vice President and Clinical Director, Community Health Center
M5 Designing and Redesizing Your Care Management Workforce to Support Population Management

**Room:** San Antonio : San Antonio 1-3

**Learning Format:** Lecture

With increasing responsibility for population outcomes in today’s health care environment, organizations must revamp their workforces to support the health of individuals within the health care system and the community. This session will address the key questions raised by this challenge, including how to develop diverse workforces with a broad range of competencies. Participants will hear from exemplar organizations and those in the midst of workforce redesign, and have an opportunity to share their ideas and develop an action plan to make meaningful change in their organizations.

After this presentation, participants will be able to:

• Describe various approaches to optimizing your care management workforce system to meet the needs of identified populations
• Identify some specific ideas to improve your existing care management system
• Take home some innovative ideas and approaches to improve the quality of care and reduce costs to the system through better coordination and management of patients across the care continuum

Presenters: Hupke, C., RN, BS, MBA, Director, Institute for Healthcare Improvement; Hewson, D., RN, BSN, MSPH, Sr. Vice President of Network Development and State Programs, Community Care of North Carolina; Vaccaro, N., MPH, Executive Director, Southside Coalition of Community Health Centers; Oryn, D., DO, MPH, Associate Medical Director, Petaluma Health Center; Powers, K., LCSW, Manager - Health Integration, SCHS, Saint Charles Health System

M6 Enhancing Self-Management Support by Leveraging Staff and Community Attributes

**Room:** Texas Ballroom : Texas 1

**Learning Format:** Flipped Classroom

Self-management support (SMS) is valuable, yet finding the resources to provide what patients need is a challenge. This session will guide participants to use their own practice characteristics to prioritize the SMS services that will best meet the needs of their patients. Participants will create an action-plan for implementation, leveraging the unique attributes of their staff and community. Pre-work is critical for successful participation in this interactive workshop.

After this presentation, participants will be able to:

• Understand the needs of their practice population for self-management support
• Prioritize opportunities to enhance self-management support through partnering and expanded service provision
• Create an action-plan to enhance self-management support that leverages the strength of their staff and community

Presenters: Reims, K., MD, Chief Medical Officer, CSI Solutions, LLC; Gutnick, D., MD, Associate Professor of Medicine and Psychiatry, Bellevue Hospital Center; Davis, C., MN, ARNP, Co-Director, Geriatric Nurse Practitioner, Centre for Collaboration, Motivation, and Innovation
M7 Transforming Team Conflict into Effective Collaboration

**Room:** Dallas : Dallas 5-7  
**Learning Format:** Simulation Encounter

Differences are inherent in multidisciplinary teamwork. However, the pressures, fast pace, and complexity of health care can escalate differences into conflict. Effective resolution of these conflicts is critical to optimal patient care, but it is very easy to either withdraw from problem-solving or devolve into intractable arguments. Participants will learn principles and practice skills that will help them move beyond these two reactions and transform conflict into opportunities to develop effective collaboration.

After this presentation, participants will be able to:

- Explain how to build relationships while negotiating and define the differences between interests and positions
- Identify ways to separate facts from assumptions and stories
- Practice ways to identify and use emotions during conflict and ways to negotiate in the face of differences in authority

Presenters: **Cochran, N., MD**, Associate Professor of Medicine, The Dartmouth Institute; **Baker, N., MD**, Principal, Neil Baker Consulting and Coaching; **Chou, C., MD, PhD, FAACH**, Professor of Medicine, San Francisco VA Medical Center

M8 Developing Effective Physician-Organization Compacts: An Interactive Clinic

**Room:** Texas Ballroom : Texas Ballroom 3-4  
**Learning Format:** Flipped Classroom

Interest is growing in using physician-organization compacts to align physicians and their organizations. In this highly interactive session, participants will dialogue with the leading compact authorities. Using background materials provided ahead of time, participants will be walked through a typical process and offered individual guidance in undertaking successful compact work in their own organization. They will leave with a deep appreciation of the interrelationship between compacts, shared visions, and effective leadership.

After this presentation, participants will be able to:

- Describe the potential value of an explicit, reciprocal compact in their own organizational setting
- Articulate the limitations of a compact process and the critical role of shared vision and effective leadership in compact development and implementation
- Understand how they can get executive leaders’ support for doing this work inside their own organization

Presenters: **Silversin, J., DMD, DrPH**, President, Amicus, Inc.; **Kornacki, M.**, Partner, Amicus, Inc.

M9 IHI’s Strategies to Advance Person- and Family-Centered Care

**Room:** Dallas : Dallas 1-2  
**Learning Format:** Lecture

This minicourse will explore IHI’s strategies to "Usher in a new era of partnerships between clinicians and individuals where the values, needs, and preferences of the individual are honored; the best evidence is applied; and the shared goal is optimal functional health and quality of life."

After this presentation, participants will be able to:

- Assess value of various theoretical constructs to support your own goals for improvement for the people you serve
Recognize a variety of ways to better understand the experiences of the individuals in their care, including the introduction of Always Events as a practical approach to implementing new processes and behaviors that are important to patients.

Explain how asking the question “What matters to you?” opens the door to more fully understanding the whole person.

Introduce Always Events as a practical action-oriented approach to reliably implement new processes and/or behaviors that are important to patients.

Presenters: Rutherford, P., RN, MS, Vice President, Institute for Healthcare Improvement; DeBartolo, K., National Field Manager, Institute for Healthcare Improvement; Hayward, M., Lead, Patient and Family Engagement, Institute for Healthcare Improvement

Sunday, March 15: Receptions and Meals

5:30 PM - 6:30 PM

WR Welcome Reception

Room: Center : Center Prefunction

Monday, March 16: Orientation

7:00 AM - 7:45 AM

GenConfOr First-Time Attendee Orientation

Room: Texas Ballroom : Texas Ballroom D

Learning Format: Lecture

Presenters: Lewis, N., MS, Executive Director, Institute for Healthcare Improvement

Monday, March 16: Keynotes

8:00 AM - 9:00 AM

Key1 Keynote One: Trissa Torres

Room: Texas Ballroom : Texas Ballroom A/B

Learning Format: Lecture

Trissa Torres, MD, MSPH, FACP, is a Senior Vice President at the Institute for Healthcare Improvement (IHI), where she is responsible for executing on IHI's strategy in North America: to accelerate the pace of improvement in health care and innovate and partner with organizations and communities to improve health. A preventive medicine physician by training, Dr. Torres has extensive experience in clinical preventive medicine, population management, and public, community, and population health. Prior to joining IHI, she led population health initiatives at Genesys Health System in Flint, Michigan, guiding the organization in transforming care delivery to improve the health of its community, with particular emphasis on the underserved. Over her 18-year tenure in the Flint community, Dr. Torres designed, implemented, evaluated, and evolved a novel care model anchored by "Health Navigators," individuals who serve as extensions of primary care practice teams to engage patients in healthy behaviors and their own self-management. She has been involved with IHI's Triple Aim strategy since its prototyping phase, serving initially as champion for her own organization, then as Triple Aim faculty, and now as Senior Lead for Triple Aim initiatives at IHI. Dr. Torres is committed to leveraging this unique time in history to transform health care to improve care, reduce costs, and create partnerships across the public and social sector to improve health for all.
Mary Brainerd is president and CEO of HealthPartners, Inc., the largest consumer-governed, nonprofit health care organization in the nation. Leading more than 22,000 employees in the HealthPartners integrated system, she has been with the company since 1992. Ms. Brainerd is one of the founding CEOs and the former chair of the Itasca Project, a group of 40 government, civic, and business leaders addressing issues related to long-term economic growth. She serves on several boards, including Minnesota Life/Securian, University of Minnesota Foundation, and Bremer Financial Group and formerly served on the Federal Reserve Board as a Class C Director and as Chair. Under Ms. Brainerd's leadership, HealthPartners has received numerous accolades for outstanding patient care, health plan service, and charitable community work.

Presenters: **Brainerd, M., President & CEO, HealthPartners**

Transformational change depends on how fast and to what extent people shift their roles and ways of thinking and relating, within the ubiquitous and human constraints of emotional tension and resistance. Within this context, leaders are faced with the difficult tasks of simultaneously managing their own reactions, standing firm on decisions, and engaging others with individual consideration. Through case study and practice, participants will learn how to enhance "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 reactions in oneself and 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 help to preserve positive engagement

Presenters: **Baker, N., MD**, Principal, Neil Baker Consulting and Coaching
L2 Better Quality Through Better Measurement

**Room:** San Antonio : San Antonio 4-6

**Learning Format:** Lecture

Gain practical experience with milestones in the quality measurement journey. Using exercises to practice applying the concepts and methods described, this session will provide guidance on selecting quality measures, specifying operational definitions, building data collection plans, understanding variation in data, and recommendations on linking measurement efforts to improvement strategies. An overview of control charts will be provided and participants will learn how to construct and interpret run charts. Templates and worksheets to help design a practical quality measurement system will also be provided.

After this presentation, participants will be able to:

- Describe the key milestones in the quality measurement journey (QMJ)
- Assess where they are in their QMJ and why they are measuring
- Identify, select, and define appropriate measures
- Organize data collection and analysis plans, and understand variation conceptually and statistically
- Integrate measurement principles into an overall quality improvement strategy

Presenters: **Lloyd, R., PhD**, Executive Director Performance Improvement, Institute for Healthcare Improvement

L3 The Costs of Care: Designing Value Improvement Initiatives

**Room:** Austin : Austin 5-6

**Learning Format:** Buzz Session

In this session, we will discuss best practices for combining C-suite directives with clinical insights to design and implement homegrown value improvement initiatives that achieve the Triple Aim. In particular, we will discuss strategies and opportunities for engaging clinicians in identifying improvement opportunities, as well as in finding ways around organization-specific cultural and operational barriers to high-value care.

After this presentation, participants will be able to:

- Engage clinicians in taking responsibility for providing better care at lower cost
- Describe how to apply clinician-driven insights to achieve value-based care targets
- Apply the "COST" framework to begin identifying value improvement projects at their organization

Presenters: **Shah, N., MD, MPP**, Executive Director, Costs of Care; **Moriates, C., Assistant Clinical Professor**, University of California San Francisco Medical Center

L4 Brief Clinical Interventions That Engage Patients in Their Care

**Room:** Dallas : Dallas 5-7

**Learning Format:** Case Study

Patient engagement is one strategy to improve adherence to care plans and alleviate patient frustration with treatment plans that do not fit into their lives. But who has time to pursue this strategy? Using an interactive case-study format, this session will describe evidence-based brief interventions, including ask-tell-ask, teach-back, and brief action planning designed to engage patients in their own care in the available time.

After this presentation, participants will be able to:

- Describe the spirit of motivational interviewing
- Demonstrate three types of brief interventions: ask-tell-ask, teach-back, and brief action planning
L5 Health Care, the Whole Person, and Community Engagement

Room: Texas Ballroom : Texas Ballroom 5-6

Learning Format: Lecture

A core belief of the Church Health Center in Memphis is that individuals experience life more fully when they reach their highest level of wellness. This session will demonstrate how this community organization has long been thinking outside the box to provide health care to a population characterized by high poverty, poor health, and lack of insurance. Using an integrated team approach both inside and outside the clinic, the Center has reduced hospital utilization, increased patient well-being and satisfaction, and improved health outcomes for the population it serves.

After this presentation, participants will be able to:

• Explain how an organization can lead innovative care delivery responses driven by community need
• Apply the pragmatic integrated approaches of the Church Health Center model, both clinical and community-based, to their own setting in order to provide health care and improve their patients’ health

Presenters: Sheehan, A., MPhil, BEd(hons), RN, DipHSM, President, Church Health Center; Bartlett-Prescott, J., MS, Senior Director of Integrated Health, Church Health Center

L6 Redesigning Patient-Centered Care Through Digital Health Technology and Quality Improvement

Room: Dallas : Dallas 1-2

Learning Format: Buzz Session

Big data, mobile apps, and wearables are redefining the traditional roles and relationships of providers and patients, but providers may be overwhelmed by this flood of technology available for use in clinic and community settings. This session will explore a quality improvement and design-driven approach to efficient learning about when, for what purpose, and for whom apps are appropriate to use, with the goal of improving outcomes and decreasing cost in a patient-centered way.

After this presentation, participants will be able to:

• List at least three ways in which technology is upsetting the status quo of health care delivery
• Discuss the impact of electronically enabled health and healing on the patient experience
• Explore tools and methods that organizations can use to redesign care experiences with technology

Presenters: Ostrovsky, A., MD, CEO, Care At Hand; Mascavage, G., MHA, Imaging Solutions Design Leader, General Electric Healthcare
L7 Successful Shared Medical Appointments: Improving Care with Existing Resources

**Room:** San Antonio : San Antonio 1-3

**Learning Format:** Lecture

This session will address the Cleveland Clinic's successful use of shared medical appointments (SMAs) in treating chronic conditions such as diabetes, hypertension, and obesity. Participants will learn about SMA workflow, ways to leverage resources, and the impact of SMAs on access, improved quality metrics, and patient experience. They will also formulate their own plan using the Clinic's SMA development worksheet and gain tools for SMA implementation to improve chronic disease care within their own practice.

After this presentation, participants will be able to:

- Identify ways in which SMAs can advance chronic disease care by leveraging existing resources in practices
- Review the benefits and workflow elements necessary to implement successful SMAs, whether a beginner or an experienced provider
- Share access, satisfaction, and quality data to promote the application of SMAs in chronic disease management for both those new to the concept and those with SMAs in progress

Presenters: **Sumego, M., MD**, Physician, Cleveland Clinic Health System

L8 Care Management for Complex Patients: Strategies, Tools, and Outcomes

**Room:** Fort Worth : Ft. Worth 5-7

**Learning Format:** Lecture

Patients with complex needs often use expensive services yet continue to have poor outcomes. Health care organizations moving to models of cost accountability can learn what has been successful for these patients in other contexts in order to design services for their unique context. This interactive session will focus on a rigorous approach to designing care systems for this population segment and real-world implementation of a program for a high-risk, high-cost population.

After this presentation, participants will be able to:

- Describe methods to identify and understand the needs of their own complex, high-cost population segments
- Work with other individuals to create action-plans for learning successful interventions based on a person-centered point of view
- Review outcome data and program development activities that maximize progress toward Triple Aim goals

Presenters: **Sevin, C., RN, MSN, NP**, Director, Institute for Healthcare Improvement; Elvin, D., md, Cambridge Health Alliance; Carr, E., MBA, LICSW, Senior Director, Care Integration, Cambridge Health Alliance
L9 Relational Coordination and Improvement = Success!

**Room:** Fort Worth : Ft. Worth 1-2

**Learning Format:** Flipped Classroom

Meaningful improvement in organizations can be achieved using traditional improvement methods and processes, but frequently the "people" side of improvement is not addressed or assessed. This session will describe frontline team actions that can be taken to increase individual and group accountability, mutual respect, shared purpose, shared knowledge, and communication. Participants will learn how combining a baseline assessment of microsystem-level communication and relationships can lead to sustainable cultural changes that improve team dynamics and overall improvement outcomes.

After this presentation, participants will be able to:

- Understand the link between health care improvement and relational coordination
- Explore the case study of improvement and relational coordination in the Department of Surgery at Dartmouth-Hitchcock Medical Center
- Identify key execution strategies to plan relational coordination and improvement within their organization

Presenters: **Godfrey, M., PhD, MS, BSN, FAAN**, Co-Director, The Microsystem Academy Instructor, The Dartmouth Institute for Health Policy and Clinical Practice; **Walsh, T., Vascular Surgery Nurse Clinician, Dartmouth Hitchcock Medical Center**; **Freeman, R., Chair Department of Surgery, Dartmouth Hitchcock; Foster, T., MD, MPH, physician, Dartmouth Hitchcock Medical Center**

L10 How Employers and Providers Can Work Together To Drive Health Care Reform

**Room:** Texas Ballroom : Texas 1

**Learning Format:** Case Study

This session will be an in-depth discussion of a case study in which a large employer successfully engaged with providers in their market to secure access, quality, an outstanding patient care experience, and affordability for their employees.

After this presentation, participants will be able to:

- Explain how providers and employers can drive rapid improvement in health care quality and value.
- Understand the medical conditions and quality indicators most important to employers.
- Describe how to use systems engineering to design standardized patient care pathways with employers.
- Describe how this initiative improved access, affordability, quality and the patient care experience.

Presenters: **Mecklenburg, R., MD**, Medical Director, Center for Health Care Solutions, Virginia Mason Medical Center

**Monday, March 16: Receptions and Meals**

12:30 PM - 1:30 PM

NL100 Networking Lunch: Achieving an Audacious Goal: 100 Million Healthier Lives

**Room:** Texas Ballroom : Texas Ballroom D

**Learning Format:** Buzz Session
With the audacious goal of 100 million people living healthier lives by 2020, IHI’s newest initiative is working to fundamentally transform the way the world thinks and acts to improve health. Join us for a discussion about how our members are building unprecedented collaboration to improve health.

Presenters: Freeman, G., Vice President Marketing, Institute for Healthcare Improvement; Sherman, H., MD, FAAP, Program Director, Health Care, Center for Courage & Renewal; Brennan, L., MSW, Principal, Community Solutions; Stout, S., MD, Executive External Lead, Health Improvement, Institute for Healthcare Improvement

5:30 PM - 7:00 PM
PosRec Storyboard and Networking Reception
Room: Center : Center Prefunction

Monday, March 16: Workshop A
1:30 PM - 2:45 PM
A1 Complete Care Model: Transforming Chronic and Preventive Care
Room: San Antonio : San Antonio 1-3
Learning Format: Lecture

Many health care organizations use the chronic care model to guide care improvements. The complete care model extends beyond the chronic care model to include wellness and preventive care as well as specialty care, across the entire continuum of care. Published in November 2013 in The Joint Commission Journal on Quality and Patient Safety, this model has been associated with dramatic improvements in HEDIS scores on quality of care.

After this presentation, participants will be able to:

- Understand the philosophy of the complete care model, provide key concepts of improvement of care integration, and assess whether the complete care model can be aligned with their own delivery system culture
- Distinguish between the roles of systematic care and individualized care and identify strategies and tactics to increase patient-focused care delivery
- Discuss the implementation of systematic care in a delivery system not yet delivering such care

Presenters: Kanter, M., MD, Medical Director, Quality & Clinical Analysis, Kaiser Permanente Regional Quality and Risk Management; Lindsay, G., RN, MA, Director Clinical Operations - SCPMG, Kaiser Permanente

SWA Storyboard Walk Around A: Leveraging Teams for Transformation: PCMH to ACO
Room: Texas Ballroom : Texas Prefunction
Learning Format: Storyboard Walkaround

Cambridge Health Alliance is a well-established leader in accountable care organization (ACO) system transformation with a patient-centered medical home (PCMH) model of care. Our transformation has been based on high-functioning teams with mental health and complex care integration, supported by IT infrastructure and a redesigned leadership structure for efficient decision-making. We will share our change strategies, lessons learned, and initial results to get participants started on their own system transformation.

After this presentation, participants will be able to:

- Articulate an in-depth understanding of the roles and workflows for a team-based model of primary care
• Identify the components of primary care integration with multidisciplinary teams, including behavioral health, pharmacy, and complex care
• Describe the essential elements for systemwide improvement: leadership structures, patient partnership with improvement teams, and IT infrastructure

Presenters: Budlong, L., MBA, Vice President Ambulatory Operations, Cambridge Health Alliance; Alves, P., Medical Assistant, union square family medicine; Natale, S., RN, MS, Associate Chief Nursing Officer, Cambridge Health Alliance

A2 Joy in Partnerships: Great Experiences of Care for Patients, Physicians, and the Care Team

Room: San Antonio : San Antonio 4-6

Learning Format: Case Study

Partnerships with patients can achieve joy in care for all involved and dramatically improve outcomes. An integrated approach to patient experience and partnerships not only has a significant impact on clinical outcomes but also optimizes team functioning and engagement and decreases burnout. This session will demonstrate how to use outpatient scenarios and a tested three-level framework for action to efficiently achieve great experiences of care as well as improved physician and team member engagement.

After this presentation, participants will be able to:
• Tailor a three-level framework for action to their setting based on outpatient scenarios and case studies
• Identify areas for maximum gain over a 60-day period
• Design one or two key actions to achieve gains in patient experiences and partnerships

Presenters: White, K., RN, BSN, MBA, Co-Founder, Aefina Partners

A3 Medication Optimization: It's Not a Hard Pill to Swallow

Room: Texas Ballroom : Texas 1

Learning Format: Lecture

Appropriate medication use has plagued health care for decades. Most efforts have been around improving medication adherence, which is very important, but progress on this front has been slow. This session will demonstrate how a medication optimization approach, including medication adherence, can deliver Triple Aim results, especially when pharmacists and health plans are integrated with care team approaches.

After this presentation, participants will be able to:
• Demonstrate the important role that pharmacists can play in optimizing medication use
• Describe the additional gaps in optimal medication use besides non-adherence
• Explain why medication value should not be assessed by drug costs alone but rather by its effect on total cost of care and health outcomes

Presenters: Brainerd, M., President & CEO, HealthPartners; Bruzek, R., VP Pharmacy Services, HealthPartners
A4 Building a Multi-Organizational QI Support System

Room: Texas Ballroom : Texas Ballroom 3-4

Learning Format: Buzz Session

With consolidation in health care, organizations will increasingly need to merge their quality improvement (QI) initiatives across their combined provider networks. State and federal initiatives also are encouraging collaboration across regional and statewide QI organizations. In interactive “fishbowl” discussions, participants will share lessons learned from leading collaborative QI initiatives and discuss strategies for merging content and QI approaches to develop multi-organizational collaborations to support practice transformation and continuous QI.

After this presentation, participants will be able to:

• Discuss the lessons learned and shared by other participants in leading large-scale QI initiatives
• Identify opportunities for collaboration and experiences in forming multi-organizational QI support infrastructure
• Brainstorm on methods to merge content and QI approaches as organizations come together to lead QI initiatives

Presenters: Adelman, A., MD, MS, Professor of Family and Community Medicine, Pennsylvania State University College of Medicine; Gabbay, R., MD, PHD, FACP, Chief Medical Officer, Joslin Diabetes Center

A5 Redesigning Services to Meet the Needs of the Population Served: Practical Advice from the IHI Triple Aim

Room: Texas Ballroom : Texas Ballroom 5-6

Learning Format: Case Study

IHI’s Triple Aim collaboratives have engaged over 140 organizations, coalitions, and governments seeking to fundamentally shift the way we design and manage services for the populations we serve. Now what started as a provocative idea for system change has become a part of the health care vernacular. Based on mini case studies, this dynamic session will explore learning from eight years of testing with innovative groups that have done groundbreaking work in pursuit of the Triple Aim.

After this presentation, participants will be able to:

• Explore with the IHI team the most up-to-date collective learning on the foundation and learning system needed to redesign services to better meet the needs and maximize the assets of their population
• Draw lessons and strategies from real-world Triple Aim sites to apply to the population management efforts within their organization or community
• Move from the theory and aspirations of the Triple Aim to actionable plans for execution

Presenters: Lewis, N., MS, Executive Director, Institute for Healthcare Improvement; Brooks, K., MPH, Project Manager, Triple Aim Initiatives, Institute for Healthcare Improvement; Henderson, R., PsyD, Chief Behavioral Health Officer & VP, Strategic Integration, Saint Charles Health System; Guy, M., MPA, Managing Director, Pueblo Triple Aim Corporation
A6 Early Childhood Development and Implications for Population Wellbeing

**Room:** Dallas : Dallas 1-2  
**Learning Format:** Lecture

Scientific advances across disparate fields — including neuroscience, epigenetics, economics, and others — clearly demonstrate the critical role of early childhood experiences in influencing not only subsequent physical health, but also the ability to learn and function successfully throughout the course of life. In the aggregate, the distribution of these experiences in society exacerbates class-based health disparities and leads to persistence of poverty and worsening income inequality. In this session, learn not only what health practices and systems are doing to mitigate and ameliorate these conditions — given the universality of contact with health care for families with young children — but also how communities and nations are using improvement science to address this issue and provide hope, and how you and your organization can contribute to the solution.

After this presentation, participants will be able to:

- Articulate why a focus on early childhood helps improve health, educational and occupational outcomes, and also promotes societal equity
- Describe how these insights are driving changes in policy and practice in communities in Scotland and across the US and Canada
- Identify ways to learn from and contribute to these efforts

Presenters: Burns, H., Professor of Global Health, University of Strathclyde; Homer, C., MD, MPH, CEO, National Initiative for Children's Health Quality (NICHQ)

A7 Develop and Sustain Physician Engagement in Practice Improvement and Safety

**Room:** Dallas : Dallas 5-7  
**Learning Format:** Lecture

It is a given that physicians should be active participants in quality and safety improvement efforts, but despite all the demands for measurement and performance, which depend on physicians' actions, many organizations are not succeeding in meaningfully engaging their doctors. Physician disengagement leaves administrators frustrated and physicians cynical. This session provides practical ways to develop and sustain the critical engagement of physicians to improve practice quality and safety.

After this presentation, participants will be able to:

- Explain how the tradition of separating clinical and managerial responsibilities can diminish physicians’ sense of urgency and responsibility for participating in improvement efforts
- Identify steps to strengthen the alignment of physician and organization goals regarding care transformation and ways to achieve them
- Articulate the specific behaviors that successfully foster physician engagement in and ownership of care transformation

Presenters: Silversin, J., DMD, DrPH, President, Amicus, Inc.
“The health of one person is the health of humanity.” Genuine cultural change was inspired at the Yakima Valley Farm Workers Clinic (YVFWC) when it connected its vision of a comprehensive patient self-management program with an evidence-based program to support patients with disease management outside of the provider’s office. This session will discuss YVFWC’s success in utilizing the Model for Improvement and integrated techniques such as motivational interviewing and collaborative goal-setting to maximize the impact of the self-management conversation.

After this presentation, participants will be able to:

- Describe the value of embedding evidence-based self-management into a chronic disease management program
- Guide the development of a self-management program targeted for specific chronic conditions
- Design a plan-do-study-act (PDSA) cycle to iteratively test and improve upon self-management program components

Presenters: Sandoval, B., Psy.D., Primary Care Behavioral Health Program Manager, Yakima Valley Farm Workers Clinic; Wnorowski, E., Consultant, Arcadia Solutions

A9 Improving Patient Experience in a Large Multispecialty Clinic

Room: Fort Worth : Ft. Worth 5-7

Learning Format: Lecture

After several years of stable performance, the Allina Clinics have improved from the 40th to the 70th national percentile on the measure of “willingness to recommend this clinic” (CG CAHPS). Participants in this session will learn the role played in this improvement by leadership accountability, regional collaboratives, provider improvement plans, tools to facilitate learning, and regular feedback and transparency. The session will generate specific ideas that participants can apply to their own organizations.

After this presentation, participants will be able to:

- Describe the tactics used by the Allina Clinics to improve patient experience, from regional collaboratives to feedback and transparency
- Articulate the importance of leadership accountability at all levels
- Apply lessons learned from the Allina Clinics experience to their own environment

Presenters: Bergeson, S., MD, Medical Director Care Improvement, Allina Health System; Wied, J., Director, Patient Experience and Access, Allina Health System
A10 Innovative Practice Improvements That Enhance Medical Homes for Children and Youth

**Room:** Austin : Austin 5-6

**Learning Format:** Lecture

This session will provide an overview of the development and implementation of a medical home learning collaborative (LC) that demonstrated meaningful and significant improvements in services for children and youth in primary care practices. We will share office-level innovations, spotlighting work in eight different practices. We will also describe how the practice-level findings were strategically used to inform policy-level improvements focused on metrics and scoring, patient-centered primary care homes (PCPCH) requirements, and coordinated care organizations.

After this presentation, participants will be able to:

- Describe the development of a learning curriculum and medical home collaborative improvement project meant to improve the provision of medical home services for children and youth
- Discuss the meaningful and significant practice-based improvements in care that were achieved and the innovative strategies that can be spread to other primary care practices
- Share the policy-level improvements identified through the practice-level findings and how they were used to improve policies related to metrics and scoring, patient-centered primary care home (PCPCH) requirements, and coordinated care organizations

Presenters: **Gillespie, R., M.D., M.H.P.E.**, Medical Director, Improvement Partnership, Oregon Health and Science University (OHSU); **Gallia, C., Ph.D., Senior Policy Advisor**, State of Oregon

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**Monday, March 16: Workshop B**

**3:00 PM - 4:15 PM**

**B1 Complete Care Model: Transforming Chronic and Preventive Care**

**Room:** San Antonio : San Antonio 1-3

**Learning Format:** Lecture

Many health care organizations use the chronic care model to guide care improvements. The complete care model extends beyond the chronic care model to include wellness and preventive care as well as specialty care, across the entire continuum of care. Published in November 2013 in *The Joint Commission Journal on Quality and Patient Safety,* this model has been associated with dramatic improvements in HEDIS scores on quality of care.

After this presentation, participants will be able to:

- Understand the philosophy of the complete care model, provide key concepts of improvement of care integration, and assess whether the complete care model can be aligned with their own delivery system culture
- Distinguish between the roles of systematic care and individualized care and identify strategies and tactics to increase patient-focused care delivery
- Discuss the implementation of systematic care in a delivery system not yet delivering such care

Presenters: **Kanter, M., MD**, Medical Director, Quality & Clinical Analysis, Kaiser Permanente Regional Quality and Risk Management; **Lindsay, G., RN, MA**, Director Clinical Operations - SCPMG, Kaiser Permanente
B2 Joy in Partnerships: Great Experiences of Care for Patients, Physicians, and the Care Team

Room: San Antonio : San Antonio 4-6

Learning Format: Case Study

Partnerships with patients can achieve joy in care for all involved and dramatically improve outcomes. An integrated approach to patient experience and partnerships not only has a significant impact on clinical outcomes but also optimizes team functioning and engagement and decreases burnout. This session will demonstrate how to use outpatient scenarios and a tested three-level framework for action to efficiently achieve great experiences of care as well as improved physician and team member engagement.

After this presentation, participants will be able to:

- Tailor a three-level framework for action to their setting based on outpatient scenarios and case studies
- Identify areas for maximum gain over a 60-day period
- Design one or two key actions to achieve gains in patient experiences and partnerships

Presenters: White, K., RN, BSN, MBA, Co-Founder, Aefina Partners

B3 Medication Optimization: It's Not a Hard Pill to Swallow

Room: Texas Ballroom : Texas 1

Learning Format: Lecture

Appropriate medication use has plagued health care for decades. Most efforts have been around improving medication adherence, which is very important, but progress on this front has been slow. This session will demonstrate how a medication optimization approach, including medication adherence, can deliver Triple Aim results, especially when pharmacists and health plans are integrated with care team approaches.

After this presentation, participants will be able to:

- Demonstrate the important role that pharmacists can play in optimizing medication use
- Describe the additional gaps in optimal medication use besides non-adherence
- Explain why medication value should not be assessed by drug costs alone but rather by its effect on total cost of care and health outcomes

Presenters: Brainerd, M., President & CEO, HealthPartners; Bruzek, R., VP Pharmacy Services, HealthPartners

B4 Building a Multi-Organizational QI Support System

Room: Texas Ballroom : Texas Ballroom 3-4

Learning Format: Buzz Session

With consolidation in health care, organizations will increasingly need to merge their quality improvement (QI) initiatives across their combined provider networks. State and federal initiatives also are encouraging collaboration across regional and statewide QI organizations. In interactive “fishbowl” discussions, participants will share lessons learned from leading collaborative QI initiatives and discuss strategies for merging content and QI approaches to develop multi-organizational collaborations to support practice transformation and continuous QI.

After this presentation, participants will be able to:

- Discuss the lessons learned and shared by other participants in leading large-scale QI initiatives
- Identify opportunities for collaboration and experiences in forming multi-organizational QI support infrastructure
Brainstorm on methods to merge content and QI approaches as organizations come together to lead QI initiatives

Presenters: Adelman, A., MD, MS, Professor of Family and Community Medicine, Pennsylvania State University College of Medicine; Gabbay, R., MD, PHD, FACP, Chief Medical Officer, Joslin Diabetes Center

**B5 Redesigning Services to Meet the Needs of the Population Served: Practical Advice from the IHI Triple Aim**

*Room: Texas Ballroom : Texas Ballroom 5-6*

**Learning Format: Case Study**

IHI's Triple Aim collaboratives have engaged over 140 organizations, coalitions, and governments seeking to fundamentally shift the way we design and manage services for the populations we serve. Now what started as a provocative idea for system change has become a part of the health care vernacular. Based on mini case studies, this dynamic session will explore learning from eight years of testing with innovative groups that have done groundbreaking work in pursuit of the Triple Aim.

After this presentation, participants will be able to:

- Explore with the IHI team the most up-to-date collective learning on the foundation and learning system needed to redesign services to better meet the needs and maximize the assets of their population
- Draw lessons and strategies from real-world Triple Aim sites to apply to the population management efforts within their organization or community
- Move from the theory and aspirations of the Triple Aim to actionable plans for execution

Presenters: Lewis, N., MS, Executive Director, Institute for Healthcare Improvement; Brooks, K., MPH, Project Manager, Triple Aim Initiatives, Institute for Healthcare Improvement; Henderson, R., PsyD, Chief Behavioral Health Officer & VP, Strategic Integration, Saint Charles Health System; Guy, M., MPA, Managing Director, Pueblo Triple Aim Corporation

**B6 Early Child Development and Its Implications for Population Wellbeing**

*Room: Dallas : Dallas 1-2*

**Learning Format: Lecture**

Scientific advances across disparate fields — including neuroscience, epigenetics, economics, and others — clearly demonstrate the critical role of early childhood experiences in influencing not only subsequent physical health, but also the ability to learn and function successfully throughout the course of life. In the aggregate, the distribution of these experiences in society exacerbates class-based health disparities and leads to persistence of poverty and worsening income inequality. In this session, learn not only what health practices and systems are doing to mitigate and ameliorate these conditions — given the universality of contact with health care for families with young children — but also how communities and nations are using improvement science to address this issue and provide hope, and how you and your organization can contribute to the solution.

After this presentation, participants will be able to:

- Articulate why a focus on early childhood helps improve health, educational and occupational outcomes, and also promotes societal equity
- Describe how these insights are driving changes in policy and practice in communities in Scotland and across the US and Canada
• Identify ways to learn from and contribute to these efforts

Presenters: Burns, H., Professor of Global Health, University of Strathclyde; Homer, C., MD, MPH, CEO, National Initiative for Children's Health Quality (NICHQ)

B7 Develop and Sustain Physician Engagement in Practice Improvement and Safety

Room: Dallas : Dallas 5-7

Learning Format: Lecture

It is a given that physicians should be active participants in quality and safety improvement efforts, but despite all the demands for measurement and performance, which depend on physicians' actions, many organizations are not succeeding in meaningfully engaging their doctors. Physician disengagement leaves administrators frustrated and physicians cynical. This session provides practical ways to develop and sustain the critical engagement of physicians to improve practice quality and safety.

After this presentation, participants will be able to:
• Explain how the tradition of separating clinical and managerial responsibilities can diminish physicians’ sense of urgency and responsibility for participating in improvement efforts
• Identify steps to strengthen the alignment of physician and organization goals regarding care transformation and ways to achieve them
• Articulate the specific behaviors that successfully foster physician engagement in and ownership of care transformation

Presenters: Silversin, J., DMD, DrPH, President, Amicus, Inc.

B8 Self-Management: Critical to Chronic Care

Room: Fort Worth : Ft. Worth 1-2

Learning Format: Case Study

“The health of one person is the health of humanity.” Genuine cultural change was inspired at the Yakima Valley Farm Workers Clinic (YVFWC) when it connected its vision of a comprehensive patient self-management program with an evidence-based program to support patients with disease management outside of the provider’s office. This session will discuss YVFWC's success in utilizing the Model for Improvement and integrated techniques such as motivational interviewing and collaborative goal-setting to maximize the impact of the self-management conversation.

After this presentation, participants will be able to:
• Describe the value of embedding evidence-based self-management into a chronic disease management program
• Guide the development of a self-management program targeted for specific chronic conditions
• Design a plan-do-study-act (PDSA) cycle to iteratively test and improve upon self-management program components

Presenters: Sandoval, B., Psy.D., Primary Care Behavioral Health Program Manager, Yakima Valley Farm Workers Clinic; Wnorowski, E., Consultant, Arcadia Solutions
B9 Improving Patient Experience in a large Multispecialty Clinic

Room: Fort Worth : Ft. Worth 5-7

Learning Format: Lecture

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B10 Innovative Practice Improvements That Enhance Medical Homes for Children and Youth

Room: Austin : Austin 5-6

Learning Format: Lecture

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- Share the policy-level improvements identified through the practice-level findings and how they were used to improve policies related to metrics and scoring, patient-centered primary care home (PCPCH) requirements, and coordinated care organizations

Presenters: Gillespie, R., M.D., M.H.P.E., Medical Director, Improvement Partnership, Oregon Health and Science University (OHSU); Gallia, C., Ph.D., Senior Policy Advisor, State of Oregon
Despite evidence that behavioral health integration improves health outcomes and reduces costs, multiple barriers can stymie integration. Drawing on current integration efforts at Cambridge Health Alliance, this session will encourage those planning or executing integration projects to share successful strategies and avoid common pitfalls around the key elements of integration: optimized care teams, achievable quality goals, engaged leadership, IT tracking tools and registries, and financial sustainability.

After this presentation, participants will be able to:

- Identify barriers that can foil efforts to integrate behavioral health into primary care
- Develop strategies to use quality goals, tracking tools, and team-building to sustain integration
- Integrate perspectives from primary care, psychiatric, and clinic staffs on the changes necessary to create a successful integration team

Presenters: Roll, D., MD, Internist and Pediatrician, Cambridge Health Alliance; Joseph, R., MD, Cambridge Health Alliance; Cunningham, L., RN, Cambridge Health Alliance; O’Brien, C., Psy.D., Primary Care Mental Health Assoc. Director, Cambridge Health Alliance

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**Tuesday, March 17: Special Interest Breakfasts**

7:00 AM - 7:45 AM

**SIB1 What Matters to You? A Call to Action**

*Room: Texas Ballroom : Texas Ballroom 1-2*

*Learning Format: Buzz Session*

What if every clinician, staff member, and community health worker routinely asked, “What matters to you?” — and then listened attentively at every encounter with individuals and their family members? What would we learn? How would understanding “What Matters” enhance our ability to develop genuine partnerships with individual patients? Come share your experiences and learn about how clinicians around the world are taking up the challenge of asking patients about what really matters to them.

Presenters: Rutherford, P., RN, MS, Vice President, Institute for Healthcare Improvement; Schall, M., MA, Senior Director, Institute for Healthcare Improvement

**SIB2 The Conversation Project**

*Room: Texas Ballroom : Texas Ballroom 3-4*

*Learning Format: Buzz Session*

Participants can learn more about The Conversation Project – an initiative dedicated to helping people talk about their wishes for end-of-life care.

Presenters: DeBartolo, K., National Field Manager, Institute for Healthcare Improvement

**SIB3 Better Health and Lower Costs forPatients with Complex Needs**

*Room: Texas Ballroom : Texas Ballroom 5-6*

*Learning Format: Buzz Session*
Improving care for the population of people with complex health and social needs has been an important area of focus for IHI's Triple Aim work. We invite you to join us for this informal session to learn more and find out how you can get involved.

Presenters: **Sevin, C., RN, MSN, NP**, Director, Institute for Healthcare Improvement

**SIB4 Update on the Comprehensive Primary Care Initiative: The Ohio/Kentucky Experience**

**Room:** Dallas: Dallas 1-2  
**Learning Format:** Buzz Session

This is the start of the third year of the CPCI. The Ohio/Kentucky region consists of 75 independent small and large groups and system practices in the Dayton, Cincinnati and northern Kentucky region. Ten payers, including Medicare fee for service, provided tiered levels of per member per month care management payments. Ten milestones of provided structure to CMS requirements and goals. Utilization and quality data have been provided to participating practices. Starting the third program year practices become eligible for shared saving. The presenters welcome participants from other regions to share in their experiences and other conference attendees to learn more about this innovative CMS program.

Presenters: **Clark, K., DO, FAAFP, CHCQM**, PCMH Task Force, Kettering Physician Network; **Mechley, A., Medical Director Wellness, The Christ Hospital; Miller, S., Director of Practice Transformation, The Christ Hospital**

**SIB5 Optimize Your Primary Care Team and Integrate Behavioral Health**

**Room:** Dallas: Dallas 5-7  
**Learning Format:** Buzz Session

In order to effectively treat the whole person, primary care must build high-functioning practice teams and seamlessly integrate behavioral health capacity into the team. During this breakfast we will discuss successful strategies to develop the next generation of high performing primary care teams to address patients' medical and behavioral health conditions and treat the whole person.

Presenters: **Hupke, C., RN, BS, MBA**, Director, Institute for Healthcare Improvement

**Tuesday, March 17: Keynotes**

8:00 AM - 9:00 AM

**Key3 Keynote Three: Sir Harry Burns**

**Room:** Texas Ballroom: Texas Ballroom A/B  
**Learning Format:** Lecture

Sir Harry Burns is Strathclyde’s Professor of Global Health and a leader at the International Prevention Research Institute. Appointed Honorary Consultant Surgeon and Senior Lecturer in Surgery at the Royal Infirmary in Glasgow in 1984, Dr. Burns worked with patients in the east end of Glasgow, where he gained insight into the complex interrelationships between socioeconomic status and illness. In 1994 he became greater Glasgow’s Public Health Director and later rose to prominence as a national leader in cancer prevention and care. Until recently, Dr. Burns also served as Chief Medical Officer for Scotland, with responsibilities that included public health policy. He has long focused on the importance of early childhood and co-chaired the Scottish Government’s Early Years Task Force. Dr. Burns was knighted in 2011.

Presenters: **Burns, H.,** Professor of Global Health, University of Strathclyde

**Tuesday, March 17: Workshop C**
C1 Integrating Specialty Care Services into Primary Care Safety Net Clinics

Room: San Antonio : San Antonio 1-3

Learning Format: Lecture

Traditionally, safety net providers rely on community partners for access to specialty care for uninsured or underinsured patients who require consultation for chronic medical conditions. This session will demonstrate how one public entity model federally qualified health center (FQHC), CommUnityCare, added specialty care to the scope of the services it provides in an attempt to prevent avoidable exacerbation of chronic medical conditions, reduce inappropriate ER utilization for low-acuity acute conditions, and improve quality and patient outcomes.

After this presentation, participants will be able to:

- Teach skills to establish relationships with specialist care providers
- Promote and market increased access to safety net specialty care services

Presenters: Kain, J., Project Manager, CommUnity Care; Sabella, T., RN JD, Chief Operating Officer and Chief Nursing Officer, CommUnityCare; Caldwell, D., RN Clinical Supervisor, CommUnityCare; Morris-Harris, D., Chief Medical Officer, CommUnity Care

C2 Proactive Care Transitions

Room: San Antonio : San Antonio 4-6

Learning Format: Lecture

Researchers have estimated that inadequate care coordination is responsible for $25 to $45 billion in wasteful spending each year. In 2003, the Kaiser Permanente system in Southern California implemented a proactive care strategy to improve care outcomes for its 3.7 million members that included a proactive transition bundle to improve the hand-off of patients from inpatient to outpatient care after hospitalization. Participants will learn about KP’s success in decreasing 30-day readmissions, especially the role played by multidisciplinary complex case conferences, which have significantly improved KP’s ability to address the root causes of hospital readmissions.

After this presentation, participants will be able to:

- Understand the proactive encounter aspects of transition at the time of hospital discharge
- Identify key concepts for implementing a proactive care transition bundle
- Review the process and benefits of using complex case conferences to improve care outcomes

Presenters: Kanter, M., MD, Medical Director, Quality & Clinical Analysis, Kaiser Permanente Regional Quality and Risk Management; Watson, H., MBA/HCM, Senior Consultant, Kaiser Permanente Regional Quality and Risk Management
C3 Public Engagement: Conversation Project Case Studies

Room: Texas Ballroom : Texas Ballroom 1-2

Learning Format: Case Study

Based on the successful work of the Conversation Project, this session will describe how community leaders across the country have engaged patients and families in conversations about their end-of-life wishes. Participants, whether they are focusing on end-of-life wishes or another issue that requires activation of the public, will learn how to identify and engage appropriate stakeholders using an assets-based approach to leverage community resources. We will discuss goals and field mobilization strategies and help participants determine next steps for their own project.

After this presentation, participants will be able to:

- Articulate best practices for activating a community
- Identify current community assets and partners for a similar approach in their region

Presenters: DeBartolo, K., National Field Manager, Institute for Healthcare Improvement

C4 Improving Population Health: Learning from Iowa’s Delivery System Redesign

Room: Texas Ballroom : Texas Ballroom 3-4

Learning Format: Case Study

As an accountable care organization (ACO), Wheaton–Franciscan Healthcare–Iowa has steadily improved key performance indicators to succeed in the new environment of changing payment and measurement structures in Iowa. This improvement required the development of new tools and processes to enable population health improvement. In this session, we will discuss how this changing landscape and one ACO’s adaptations pertain to other states, as well as the impact of these changes on delivery systems.

After this presentation, participants will be able to:

- Explain the delivery system implications of shifting to value-based contracting
- Describe one health system’s approach to navigating the shift to population health management

Presenters: Moore, L., MD, Senior Medical Director, 3M Health Information Systems, Inc.; Halverson, J., RPh, MBA, CMPE, VP Covenant Clinic, Covenant Medical Center

C5 Improving Clinical Workflows: Using Lean Methods to Implement Health IT

Room: Texas Ballroom : Texas Ballroom 5-6

Learning Format: Case Study

Health information technology (IT) products often fit poorly with clinical workflows. Over the past 10 years, Virginia Mason Primary Care practices have used Toyota “Lean” methods to improve care, while fully implementing an electronic medical record (EMR) and thriving in a fee-for-service environment. We will present three modules and moderate discussion around adapting “off-the-shelf” EMR tools to improve and standardize documentation, embed evidence-based best practices, and mistake-proof care.

After this presentation, participants will be able to:

- Share experiences with overcoming the constraints imposed by office EMR technology
- Understand how "Lean" methodology can be applied to integrating new IT tools into a practice
- Understand how IT departments in large institutions can be encouraged to support clinical practice more effectively

Presenters: Dipboye, K., MD, MA, Program Director, Virginia Mason Medical Center; Pittenger, K., MD, MD/primary care leadership, Virginia Mason Kirkland Clinic
C6 Patient-Centered Accountable Care: Primary Care and the Medical Neighborhood

Room: Dallas : Dallas 1-2

Learning Format: Lecture

Organizations that succeed in advancing patient-centered accountable care in the redesigned health system will be characterized by high-quality interactions among the system's various fundamental elements to form a seamless patient experience and optimal patient-oriented outcomes. This session will focus on moving toward clinical, financial, and information technology integration to get the best results for patients, using robust and capable primary care as the foundation for patient-centered accountable care.

After this presentation, participants will be able to:

- Understand the key elements and working relationships required to support accountable care
- Manage their transition strategy as they move from volume to value in accountable care
- Begin to construct a strategic roadmap for the transformation of their organization

Presenters: Bagley, B., MD, President and CEO, TransforMED

C7 Pediatrician-Driven Population Management in Action

Room: Dallas : Dallas 5-7

Learning Format: Lecture

The Children's Health Alliance, a seven-year collaboration between 100 private practice pediatricians, has been recognized for rapidly implementing quality improvements to raise the standard of pediatric care management. This session will show how the Alliance balances delivering proactive office encounters with managing the health of its pediatric populations and describe the keys to its success: meaningful, needs-based patient segmentation; actionable physician-driven measures/alerts targeting individual patient care; and clinically focused health analytics tools for managing pediatric populations.

After this presentation, participants will be able to:

- Describe a practical, multi-factor method for enabling physicians to segment their patient panels based on the level of support needed from the care team
- Discuss core competencies and operational approaches to delivering effective, office-based pediatric care management and demonstrate how to succeed at engaging providers through shared learning and through the use of rapid-cycle QI methods for development and implementation
- Explain how to use meaningful pediatric care measures and practical analytics tools to sustain high-quality patient care coordination and population health management

Presenters: Chaffin, A., MD FAAP, Physician, Children's Health Foundation; Rosenbloom, J., MD, Pediatrician & Medical Director, Children's Health Foundation
C8 Analyzing the Successful PCMH: What Is Different

**Room:** Fort Worth : Ft. Worth 1-2

**Learning Format:** Lecture

A patient-centered medical home (PCMH) differs from traditional primary care by expanding patient access and increasing the use of information technologies and team-based care. Becoming a PCMH has a significant impact on a practice’s operating costs, staffing, and revenue. This session will explore ways to improve financial performance using information from the nation’s largest medical group practice survey to describe how successful PCMHs differ in practice revenue, provider productivity, payment models, panel size, and staffing.

After this presentation, participants will be able to:

- Describe how a PCMH differs from a traditional primary care practice in panel size, level of staff support, and new forms of patient communication
- Detail the revenue impact of new payment models on PCMH and non-PCMH primary care practices
- Identify the demographic profile, staffing level, provider productivity model, and reimbursement method of PCMHs with the best financial performance

Presenters: **Gans, D., MSHA, FACMPE**, Senior Fellow for Industry Affairs, Medical Group Management Association; Carlson, A., MS, CES, Program Manager, HealthTeamWorks

C9 Building Enhanced Primary Care Teams for High-Needs Patients

**Room:** Fort Worth : Ft. Worth 5-7

**Learning Format:** Lecture

Oregon’s largest coordinated care organization used a Centers for Medicare and Medicaid Innovation (CMMI) Award to develop a regional care system for Medicaid "high utilizers" centered on enhanced primary care teams. This session will show how a deepening understanding of patient needs shaped the new care model and rallied support from both payers and the health system.

After this presentation, participants will be able to:

- Design services for a vulnerable population segment based on understanding the root causes of risk
- Mobilize a nontraditional health care workforce to meet social and behavioral needs
- Build a portfolio of measures and evidence that demonstrates sustainable value to stakeholders and funders

Presenters: Ramsay, R., BSN, MPH, Director of Community Care, CareOregon; **Labby, D., MD**, Chief Medical Officer, Health Share of Oregon
C10 The Cost-Effectiveness of "Big Bet" Programs to Address the Nonmedical and Social Needs of Individuals and Communities

Room: Austin : Austin 5-6

Learning Format: Case Study

Nonmedical and social needs influence the health of a population more than medical care, but which investments and programs to address these needs have the most impact on health outcomes and health care costs? And what is the appropriate role of the health care system? In this session, we will discuss an innovative R&D collaboration on this topic between Kaiser Permanente and IHI, including the results of worldwide scanning and evidence review, modeling, and case studies.

After this presentation, participants will be able to:

- Identify and estimate the benefits of high-leverage health system investments in social and nonmedical determinants of health
- Provide a model for health systems to use in their community

Presenters: Stiefel, M., MPA, MS, Sr Director, CMI Center For Population Health, IHI Fellow, Kaiser Permanente; Anderson, A., Research, Innov | Co-Chair, IHI Diversity/Inclusion Council, Institute for Healthcare Improvement

Tuesday, March 17: Workshop D

11:00 AM - 12:15 PM

D1 Teaching the Triple Aim to Learners at All Levels

Room: San Antonio : San Antonio 1-3

Learning Format: Simulation Encounter

Residents and clinic staff at San Francisco General Hospital are taught QI principles and methodologies organized around the Triple Aim. Medical residents receive a robust, experiential two-year curriculum, while staff learn through brief teaching sessions and team participation. This session will demonstrate to participants how to conduct mentoring projects from a QI framework and lead them through three short exercises: an ambulatory morbidity and mortality conference, a process mapping session, and a LEAN-style waste walk.

After this presentation, participants will be able to:

- Understand a basic framework for teaching QI principles and methodologies
- Introduce three specific tools to learners at their institutions
- Delineate next steps in creating a mini-QI curriculum for their staff and colleagues

Presenters: Horton, C., Medical Director, General Medicine Clinic, SFGH, University of California San Francisco Medical Center; Hammer, H., MD, Medical Director, San Francisco General Hospital; Gupta, R., MD, Assistant Professor of Medicine, University of California, San Francisco; Tse, W., QI Analyst, Kaizen Promotion Office Specialist, San Francisco Department of Public Health
**SWD Storyboard Walkaround D: Physicians Drive Down Wait Times by 85%**

**Room:** Texas Ballroom : Texas Prefunction

**Learning Format:** Storyboard Walkaround

The Central Okanagan Division of Family Practice developed a structured collaborative to create system redesign and improve access to gastroenterologists. Project work focused on referral and urgent consultation mechanisms and on enhanced communication between family physicians and specialists. Participants will learn how the new referral procedure and redesigned ambulatory care booking process reduced the number of patients waiting for GI procedures by 74% and average wait times by 85% over a 12-month period.

After this presentation, participants will be able to:

- Describe how to reduce GI endoscopy wait times and increase the accuracy of wait time information for endoscopy procedures
- Explain ways to improve the GI referral process from family physicians to GI specialists
- Discuss the enhancement of interprofessional relationships between family physicians and GI specialists achieved through the system redesign

**Presenters:** Head, T., Project Manager, Central Okanagan Division of Family Practice; Oyelese, T., Family Physician, Central Okanagan Division of Family Practice

**D2 Using Data for Improvement**

**Room:** San Antonio : San Antonio 4-6

**Learning Format:** Lecture

A health care system generates and collects data through multiple and highly variable sources. This session will explain how to turn data into information by asking the right questions and elaborate on the usefulness of this information to managers and administrators in communicating and collaborating with staff on performance levels. Health care leaders participating in this session will learn the benefits of cooperating with the workforce in utilizing a framework for improvement.

After this presentation, participants will be able to:

- Describe how the Nuka System of Care approaches and deploys the management of data
- Discuss possible responses when data shows opportunities to improve performance

**Presenters:** Tierney, S., MD, CMIO/Medical Director Clinic Quality Improvement, Southcentral Foundation

**D3 Magic in a Bottle: Making Transformation Sustainable**

**Room:** Texas Ballroom : Texas Ballroom 1-2

**Learning Format:** Lecture

When shared vision and values are brought to bear in the work of transforming care and creating new business models, the result can be an exhilarating sense of “magic in a bottle” for an organization. How can health care leaders capture and sustain the energy, creativity, and productivity of such moments? This session will explore this question and also how to make continuous learning, quality improvement, and innovation the “new normal” for staff and providers.

After this presentation, participants will be able to:

- Clarify how they can lead most effectively, using mission and values as their compass
- Develop a plan to engage staff and providers at every level to realize the shared vision of a learning organization
Identify strategies for sustaining innovation and continuous improvement within their organization

Presenters: Kurose, A., MD MBA FACP, President & CEO, Coastal Medical

**D4 Behavioral Health Integration: A Key Step Toward Achieving the Triple Aim**

*Room:* Texas Ballroom : Texas Ballroom 3-4

*Learning Format:* Lecture

Patients with comorbid medical and behavioral health issues experience poor outcomes and high health care costs owing in part to fragmented care and a lack of collaboration between providers. Integrating behavioral health care into primary care is a key area for improvement as organizations pursue the Triple Aim. Participants will learn about the benefits of integration, the core components of successful integration, and common challenges.

After this presentation, participants will be able to:

- Describe the benefits of integrating behavioral health and primary care
- Detail the core components of successful behavioral health integration
- Understand common challenges to integration and identify solutions to overcome barriers

Presenters: Hupke, C., RN, BS, MBA, Director, Institute for Healthcare Improvement; Henderson, R., PsyD, Chief Behavioral Health Officer & VP, Strategic Integration, Saint Charles Health System

**D5 Improving Together: Patients and Frontline Staff Drive PCMH Transformation**

*Room:* Texas Ballroom : Texas Ballroom 5-6

*Learning Format:* Lecture

Recognizing that frontline staff and patients are essential to improvement work, Cambridge Health Alliance’s patient-centered medical home (PCMH) transformation is driven by interdisciplinary teams of staff and patients. In this session, we will discuss the guidance from Harvard Business School that informs the design of our teams and supports their work. We will offer practical strategies for recruiting, orienting, and integrating patients into these teams, quality improvement methods, and the challenges and outcomes from this rich partnership with patients.

After this presentation, participants will be able to:

- Identify and use a range of strategies for recruiting, integrating, and supporting patients on interdisciplinary improvement teams
- Implement an approach to engaging frontline staff, patients, and leadership in improvement work, using quality improvement strategies and interdisciplinary teams
- Access a toolkit to design, launch, and support interdisciplinary teams, including strategies and resources for patient partnership

Presenters: Mann, Z., MA, Patient Lead, Cambridge Health Alliance; Chamberlin, M., MD, MBA, Medical Director of Performance Improvement for Primary Care, Cambridge Health Alliance; Stout, S., MD, Executive External Lead, Health Improvement, Institute for Healthcare Improvement
D6 Incentive Systems for High-Performing Care Teams

Room: Dallas : Dallas 1-2

Learning Format: Lecture

As primary care providers work to expand access and improve patient outcomes, they will inevitably have to give deeper consideration to the roles and incentives for non-licensed team members such as medical assistants (MA). Both financial and non-financial incentives matter a great deal in this regard, as training for new roles is crucial if staff are to work at the top of their licensure. This session will provide in-depth exploration of one or two clinics that successfully transformed their practice, in part, by leveraging the MA role.

After this presentation, participants will be able to:

• Describe and explain a range of strategies for engaging front-line primary care team members in advancing organizational goals
• Design an incentive system for frontline staff such as medical assistants that will support patient care needs while also improving job satisfaction
• Access further tools and resources for improving team cohesion and performance.

Presenters: Blash, L., Senior Research Analyst, University of California San Francisco; Strong, T., MBA, Senior Program Officer, The Hitachi Foundation; Brooke, J., Executive Director, High Plains Community Health

D7 Rapid Ambulatory Redesign for Population Health at Scale

Room: Dallas : Dallas 5-7

Learning Format: Case Study

This session will demonstrate how CHE Trinity Health, the second-largest nonprofit health system in the country, addressed the challenge of rapidly addressing population health by requiring partnership among system-level "levers" in implementing frontline innovations in more than 400 primary care practices in 20 states. Participants will learn how this health system coupled rapid deployment, utilizing a virtual learning environment, with shared accountability and measurement of value as defined by the Triple Aim.

After this presentation, participants will be able to:

• Identify key levers to accelerate large-scale care redesign
• Develop strategies to address the challenges in utilizing these levers effectively

Presenters: Benzik, M., MD, CMO Health Networks Trinity Health, Trinity Health; Tuteja, S., MHA, Director of Clinical Transformation, Trinity Health

D8 Leadership Lessons for Spread and Scale-up of Successful Improvements

Room: Fort Worth : Ft. Worth 1-2

Learning Format: Lecture

Participants in this session will learn how leaders can gain a greater understanding of their role in the spread and scale-up of key strategic initiatives. The experiences of large-scale efforts around the world will be shared, and discussion will focus on how to think about both the practice being spread and the readiness to adopt at the local level.

After this presentation, participants will be able to:

• Understand the key components of spread for both the practice and the adopting site
• Think in new ways about the leadership role in the spread and scale-up of strategic initiatives and apply this new thinking to their organization

Presenters: Feeley, D., Executive Vice President, Institute for Healthcare Improvement; Schilling, Rn, Mph, L., RN, MPH, National Vice President, Healthcare Performance Improvement, Kaiser Permanente

D9 Doing the Work – Creating a Data-Driven Approach to Improving Population Hypertension Control

Room: Fort Worth : Ft. Worth 5-7

Learning Format: Buzz Session

National statistics indicate that only 50% of patients with high blood pressure have achieved goal blood pressure. In this session, participants will form small groups to analyze population-level data from a medical group and devise an action-plan to improve hypertension control rates. The groups will share their plans and also learn about the American Medical Group Foundation’s Measure Up/Pressure Down® campaign and the most successful tactics used by participating groups to improve hypertension control.

After this presentation, participants will be able to:

• Identify at least two tactics that a medical practice can adopt to rapidly improve blood pressure control among its patients
• Create a realistic action-plan for their organization based on their population characteristics

Presenters: Penso, J., MD, MBA, Chief Medical and Quality Officer, American Medical Group Association; Cuddeback, J., MD, PhD, CMIO, American Medical Group Association

D10 An Equitable System for All: Eliminating Heath Disparities

Room: Austin : Austin 5-6

Learning Format: Case Study

Health care providers and leaders, as well as patients and families, know that inequitable health care processes and outcomes are unacceptable. As a community, we must share what we are learning to achieve a high-value, high-quality, and low-cost system for all. This session will present health equity cases to demonstrate ways to address the health equity challenge, results achieved, and what works and what does not. This engaging workshop will include small-group discussion and a Q&A.

After this presentation, participants will be able to:

• Explore ideas to move from identifying health disparities to crafting solutions
• Describe successful approaches and lessons learned in addressing health equity

Presenters: Reid, A., MPH, Senior Research Associate, Institute for Healthcare Improvement; Gallego L., A., MPH, Program Director South Carolina Health Coordinating Council, South Carolina Hospital Association; Wrenn, G., MD, Director, Division of Behavioral Health, Morehouse School Of Medicine; Farley, T., MD, Executive VP for Medical Services, Salud Family Health Centers; Redding, S., MD, MPH, CEO, Care Coordination Systems

Tuesday, March 17: Workshop E
E1 Teaching the Triple Aim to Learners at All Levels

Room: San Antonio : San Antonio 1-3

Learning Format: Simulation Encounter

Residents and clinic staff at San Francisco General Hospital are taught QI principles and methodologies organized around the Triple Aim. Medical residents receive a robust, experiential two-year curriculum, while staff learn through brief teaching sessions and team participation. This session will demonstrate to participants how to conduct mentoring projects from a QI framework and lead them through three short exercises: an ambulatory morbidity and mortality conference, a process mapping session, and a LEAN-style waste walk.

After this presentation, participants will be able to:

• Understand a basic framework for teaching QI principles and methodologies
• Introduce three specific tools to learners at their institutions
• Delineate next steps in creating a mini-QI curriculum for their staff and colleagues

Presenters: Horton, C., Medical Director, General Medicine Clinic, SFGH, University of California San Francisco Medical Center; Hammer, H., MD, Medical Director, San Francisco General Hospital; Gupta, R., MD, Assistant Professor of Medicine, University of California, San Francisco; Tse, W., QI Analyst, Kaizen Promotion Office Specialist, San Francisco Department of Public Health

E2 Using Data for Improvement

Room: San Antonio : San Antonio 4-6

Learning Format: Lecture

A health care system generates and collects data through multiple and highly variable sources. This session will explain how to turn data into information by asking the right questions and elaborate on the usefulness of this information to managers and administrators in communicating and collaborating with staff on performance levels. Health care leaders participating in this session will learn the benefits of cooperating with the workforce in utilizing a framework for improvement.

After this presentation, participants will be able to:

• Describe how the Nuka System of Care approaches and deploys the management of data
• Discuss possible responses when data shows opportunities to improve performance

Presenters: Tierney, S., MD, CMIO/Medical Director Clinic Quality Improvement, Southcentral Foundation

E3 Magic in a Bottle: Making Transformation Sustainable

Room: Texas Ballroom : Texas Ballroom 1-2

Learning Format: Lecture

When shared vision and values are brought to bear in the work of transforming care and creating new business models, the result can be an exhilarating sense of “magic in a bottle” for an organization. How can health care leaders capture and sustain the energy, creativity, and productivity of such moments? This session will explore this question and also how to make continuous learning, quality improvement, and innovation the “new normal” for staff and providers.

After this presentation, participants will be able to:

• Clarify how they can lead most effectively, using mission and values as their compass
• Develop a plan to engage staff and providers at every level to realize the shared vision of a learning organization
• Identify strategies for sustaining innovation and continuous improvement within their organization

Presenters: Kurose, A., MD MBA FACP, President & CEO, Coastal Medical

E4 Behavioral Health Integration: A Key Step Toward the Triple Aim

Room: Texas Ballroom : Texas Ballroom 3-4
Learning Format: Lecture

Patients with comorbid medical and behavioral health issues experience poor outcomes and high health care costs owing in part to fragmented care and a lack of collaboration between providers. Integrating behavioral health care into primary care is a key area for improvement as organizations pursue the Triple Aim. Participants will learn about the benefits of integration, the core components of successful integration, and common challenges.

After this presentation, participants will be able to:
• Describe the benefits of integrating behavioral health and primary care
• Detail the core components of successful behavioral health integration
• Understand common challenges to integration and identify solutions to overcome barriers

Presenters: Hupke, C., RN, BS, MBA, Director, Institute for Healthcare Improvement; Henderson, R., PsyD, Chief Behavioral Health Officer & VP, Strategic Integration, Saint Charles Health System

E5 Improving Together: Patients and Frontline Staff Drive PCMH Transformation

Room: Texas Ballroom : Texas Ballroom 5-6
Learning Format: Lecture

Recognizing that frontline staff and patients are essential to improvement work, Cambridge Health Alliance’s patient-centered medical home (PCMH) transformation is driven by interdisciplinary teams of staff and patients. In this session, we will discuss the guidance from Harvard Business School that informs the design of our teams and supports their work. We will offer practical strategies for recruiting, orienting, and integrating patients into these teams, quality improvement methods, and the challenges and outcomes from this rich partnership with patients.

After this presentation, participants will be able to:
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This presentation describes the collaborative approach taken to developing and deploying a statewide program to support primary care practices in quality improvement (QI) initiatives within the 14 community care networks of Community Care of North Carolina. Participants will be guided through a process that begins with identifying needs and progresses through plan development, implementation, evaluation, and lessons learned along the way.

After this presentation, participants will be able to:

- Describe the ways in which a QI practice support program plan serves as a guide and resource for practice engagement and facilitation
- Identify key components of an effective QI practice support program plan
- Utilize strategies and lessons learned for application in their own organization

Presenters: Barrington, R., Quality Improvement Facilitator, Community Care of North Carolina; Shastry, V., MHA, Project Manager, Clinical Programs, Community Care of North Carolina; Watkins, R., MD, MPH, FAAFP, Family Physician, Community Care of North Carolina; Halpern, D., MD, MPH, Physician Consultant, Community Care of North Carolina