Sunday, March 20: Minicourse

12:00 PM - 5:30 PM

M1 Flipping Health Care: Operationalizing What Matters Most

**Learning Format:** Flipped Classroom

How would understanding not just “what’s the matter” but “what matters” enhance partnerships with and outcomes for patients and families? Engaging patients to elicit care goals is crucial to patient-centered care at any age, particularly in primary care. In this session, participants will learn how to engage, steward, and respect their patients’ wishes. Case examples in various practice settings will demonstrate how to create a process, learn from data, and train staff.

After this presentation, participants will be able to:

- Describe how different practices operationalize “what matters” and use the results to redesign care delivery
- Identify a replicable approach to integrating “what matters” as well as “what’s the matter” into their clinical encounters
- Develop skills to engage with patients in what matters most and in advance care planning

Presenters: Digiolla, A., MD, Medical Director, University of Pittsburgh Medical Center (UPMC); Giarrusso, M., RN, BSN, MS, MBA, Director of Patient and Family Centered Care, University Of Pittsburgh; Lally, K., Director of Palliative care, Care New England Health System; Tuya Fulton, A., MD, FACP, Director of Geriatric Medicine & Butler Chief of Medicine, Care New England Health System; **Clayton, S., MIS**, Accountable Care Outcomes Specialist, PFCC Innovation Center; DeBartolo, K., National Field Manager, Institute for Healthcare Improvement; Jornsay-Hester, D., Organizational Development Consultant, University of Pittsburgh Medical Center (UPMC)

M2 We’re Bringing Joy Back! Coaching and Microsystems

**Learning Format:** Flipped Classroom

Assessing the front line of care through applied clinical microsystem theory increases the awareness of everyone involved, including patients and families, about the systems of care and the improvement possibilities. Well-intended improvement teams benefit from the support of leaders who understand how to create the context for successful improvement and from team coaching to keep the momentum of improvement within the daily delivery of care. This field-tested methodology can improve communication and relationships and sustain improvements.

After this presentation, participants will be able to:

- Assess their unit (clinical microsystem) to identify its strengths and weaknesses in current processes, communication, and relationships
- Implement simulation activities to learn improvement methodologies that are adaptable to local settings
- Identify and develop leaders with improvement knowledge and skills and describe how leaders can create the conditions for successful improvement efforts and team coaching

Presenters: **Godfrey, M., PhD, MS, BSN, FAAN**, Co-Director, The Microsystem Academy Instructor, The Dartmouth Institute; Foster, T., MD, MPH, faculty, Dartmouth Hitchcock Medical Center; Harrison, S., Head of Quality Improvement, Sheffield Teaching Hospitals; Oliver, B., PhD, MS, MPH, APRN-BC, Assistant Professor, Massachusetts General Hospital Institute of Health Professions; Messier, R., MT, MSA, Quality Improvement Consultant, The Dartmouth Institute
M3 Improving Community Health: Pathway to Pacesetter – 100 Million Healthier Lives

Learning Format: Case Study

This highly interactive minicourse will bring together Pathway to Pacesetter communities to share their journey to improving the health and well-being of their communities and the equity between them, learning how to lead from within, and leading together as well as for outcomes and for equity. All participants, not just those who are already part of Pathway to Pacesetters, will glean many lessons from this session in improving community health.

After this presentation, participants will be able to:

- Assess where they are on the journey to improving health in their community
- Develop skills to accelerate their improvement journey toward health, well-being, and equity at the community level
- Engage community members with lived experience
- Use "switch" and asset-based thinking to identify opportunities to make the improvement journey easier and more joyful

Presenters: Stout, S., MD, MS, Executive External Lead for Health Improvement, Institute for Healthcare Improvement; Mann, Z., MA, Patient Lead, Cambridge Health Alliance; Brennan, L., MSW, Principal; Co-Chair, 100 Million Healthier Lives, Community Solutions; Manchanda, R., MD MPH, Founder, HealthBegins, HealthBegins

M4 Health Equity: Linking Community and Health Systems

Learning Format: Lecture

Health equity is about eliminating health disparities and achieving optimal health for all. The Prevention Wellness Trust Fund project in Worcester, MA, is promoting health equity through community-centered systems that integrate public health, health care, and social services. This session will highlight the approaches taken to implementing an integrated model, such as improved linkage to and exchange of patient and information across systems to improve chronic disease outcomes and provide quality care to everyone.

After this presentation, participants will be able to:

- Create partnerships with public health, health care, and other community organizations to develop integrated systems
- Prepare leadership in partner organizations to support and advance quality and equitable care in these systems
- Identify additional effective methods to create and advance integrated systems and foster collaboration

Presenters: Cherala, S., MD, MPH, Assistant Professor/Senior Clinical Analyst, University of Massachusetts Medical School; Kennedy, T., Project Manager, City of Worcester Division of Public Health
M5 Complex Care Management: The Nuts and Bolts

**Learning Format: Case Study**

Health care costs for individuals with complex needs can be very high. Although new care models for this population present an opportunity to improve outcomes and costs, designing effective models can be challenging. In this session, we will take a nuts-and-bolts view of a tested design process for this population implemented in Allina’s Pioneer ACO and in the complex care management programs of the HealthPartners Health System. We will also discuss strategies to measure financial and health outcomes.

After this presentation, participants will be able to:

- Describe how Allina and Health Partners Health System identify and provide complex care management to their patients with complex needs
- Describe strategies to measure the impact on costs and outcomes of complex care management programs
- Identify two to five care management ideas to apply to their own program

Presenters: **Waterman, B., RN, MBA**, Chief Improvement Officer, HealthPartners; Bergeson, S., MD, Medical Director Care Improvement, Allina Health System; Gapstur, R., Sr. VP, COO, & CNO, HealthPartners; Tomes, K., VP Care Management & Coordination, Allina Health System; Sevin, C., RN, MSN, NP, Director, Institute for Healthcare Improvement

M6 Brief Interventions and Action Plans for Health

**Learning Format: Case Study**

Practical skills for supporting people to make healthy changes can be engaging, effective, and efficient. This interactive workshop features tested techniques that health care professionals and peers can use, individually and in groups, to support healthy choices and actions. Brief interventions can provide people with information and advice in ways that increase the chance that they will take action, and action planning structures the next steps. This person-centered approach is grounded in Motivational Interviewing.

After this presentation, participants will be able to:

- Identify actions based in Motivational Interviewing
- Demonstrate brief interventions
- Discuss ways to apply skills in real-world practice

Presenters: **Davis, C., MN, ARNP**, Co-Director, Geriatric Nurse Practitioner, Centre for Collaboration, Motivation, and Innovation; Reims, K., MD, Chief Medical Officer, CSI Solutions, LLC; Reilly, K., Nurse Care Manager (Diabetes), Palo Alto Medical Foundation

M7 Managing Conflict and Hierarchy on Teams

**Learning Format: Flipped Classroom**

Differences are inherent, even necessary, in multidisciplinary teamwork. Even under optimal circumstances, however, conflicts inevitably and frequently arise, and the complexities and hierarchies in health care often amplify the emotions roused by conflict. Without specific training in conflict management, many either engage in unpleasant confrontations or withdraw. Participants will learn and practice skills that will move them beyond these two reactions and transform conflict into an opportunity for effective collaboration.

After this presentation, participants will be able to:

- Practice building relationships and naming emotions effectively during conflict
- Identify ways to prepare for conflict situations, including differentiating between interests and positions
M8 Meeting the Access Challenge

**Learning Format:** Flipped Classroom

Meeting the recent surge in demand for primary and specialty care has added to already long waits and service delays. Besides creating ill will with patients, employers, and payer groups, appointment delays can strain a medical practice, keeping physicians and staff from important clinical work while limiting the practice's ability to absorb new patients. Participants will learn how to apply the Advanced Access model in their practices from individuals who have successfully managed this transition in their own organizations.

After this presentation, participants will be able to:

- Identify in detail the six High Leverage Changes that dramatically improve access and reduce waits for appointments and services
- Explore key metrics for access improvement, master processes for forecasting and managing appointment demand and supply, and identify common pitfalls while problem-solving existing access barriers within their organization
- Develop an Access Action Plan for systemwide access improvement to test in their organization

Presenters: **Tantau, C., BSN, MPA**, President, Tantau & Associates; **Farnitano, C., Director of Process Redesign and System Integration, Contra Costa Health Services**

M9 Primary Care Whole System Transformation: Organizational Learning, Improvement, and Integrated Care Teams

**Learning Format:** Lecture

One product of the SCF Nuka System of Care at the Southcentral Foundation (SCF) is the integrated care team (ICT), which allows customer-owners to receive same-day access to all services in one place with co-located staff. Using the ICT model as a case study, SCF subject matter experts (SMEs) will walk participants through the change steps to achieving whole system transformation and explain how to use workforce development methodologies (e.g., recruitment, on-boarding, retention, career tracks, performance development and management) and critical improvement processes and tools.

After this presentation, participants will be able to:

- Implement workforce methodologies and improvement tools to move their organization toward its whole system transformation goals
- Describe how to engage the communities served by their organization in the transformation process
- Identify the key components of an integrated care team
- Use lessons in change management learned from SCF in their organization's whole system transformation

Presenters: **Tierney, S., MD**, CMIO/Medical Director Clinic Quality Improvement, Southcentral Foundation; **McIntire, K., PHR, Director of Human Resources, Southcentral Foundation**; **Binion, M., Senior Improvement Advisor, Southcentral Foundation**
Sunday, March 20: Receptions and Meals
5:30 PM - 6:30 PM
WR Welcome Reception

Monday, March 21: Orientation
7:00 AM - 7:45 AM
GenConfOr First-Time Attendee Orientation

Monday, March 21: Learning Labs
9:30 AM - 12:30 PM
L1 Designing and Evaluating Community Improvement Programs

**Learning Format:** Case Study

In today’s complex health care environment, communities and organizations running improvement interventions need to evaluate and share their learning. Their evaluation approaches should match their improvement initiatives, adapt as the work unfolds, and be related to the readiness of the organization or community to change. This session will include examples and exercises to explore a rapid-cycle evaluation approach to designing and learning from improvement initiatives. Participants will be encouraged to discuss and apply these approaches to their improvement work.

After this presentation, participants will be able to:

- Describe the program theory of an improvement project
- Identify and understand the components and subcomponents of organizational readiness
- Outline a rapid-cycle evaluation plan for their community improvement program

Presenters: Scaccia, J., Faculty, No Organization; Parry, G., PhD, Senior Scientist, Institute for Healthcare Improvement; Reid, A., MPH, Senior Research Associate, Institute for Healthcare Improvement

L2 Team-Based Primary Care to Treat the Whole Person

**Learning Format:** Lecture

Organizations are increasingly moving toward team-based primary care that integrates behavioral health to provide “whole person” care. In response to significant barriers that limit the adoption of this approach, despite clear evidence of its benefit, IHI and the MacColl Center are running a yearlong collaborative to create integrated, high-performing primary care practices. In this interactive session, participants will learn about the content, core changes, and results of this collaborative effort to integrate behavioral health and primary care.

After this presentation, participants will be able to:

- Describe the key changes required to implement team-based primary care that integrates behavioral health
- Discuss how several diverse primary care practices have implemented the key changes required for team-based integrated care
• Identify and start to build the necessary skills to support their organization’s movement toward integrated, team-based primary care

Presenters: **Laderman, M., MSPH**, Senior Research Associate, Institute for Healthcare Improvement; Hupke, C., RN, BS, MBA, Director, Institute for Healthcare Improvement; Bradley, W., LPC, CAADC, Senior Director, Health Integration, Ampersand Health

**L3 Personal Mastery for Transformational Leadership**

**Learning Format: Case Study**

Because transformational change requires shifts in roles, tasks, and ways of thinking and relating, emotional tension and resistance are human and ubiquitous constraints that arise. Leaders are faced with the difficult task of managing their own reactions to stress and complexity while standing firm on decisions and engaging others with individual consideration. Participants will learn about and practice a method of “personal mastery” to enhance their own progress toward results and better relationships.

After this presentation, participants will be able to:

• Identify reactions in oneself and in others that may get in the way of progress
• Describe strategies for reflection and communication that facilitate moving from reactivity to motivation and commitment
• Demonstrate how to exercise authority in ways that help to preserve positive engagement

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

**L4 Complete Care: Transforming Care Delivery**

**Learning Format: Lecture**

Many health care organizations use the Chronic Care Model to guide care improvements. The Complete Care Model goes beyond the Chronic Care Model: it extends to wellness and preventive care, involves specialty care, and covers the entire continuum of care. The Complete Care Model, which was published in 2013 in the *Joint Commission Journal on Quality and Patient Safety,* has been associated with dramatic improvements in HEDIS scores for quality of care.

After this presentation, participants will be able to:

• Implement systems thinking and approaches to effect large-scale clinical improvement
• Identify key actionable strategies to improve clinical quality for chronic condition populations

Presenters: **Kanter, M., MD**, Medical Director, Quality & Clinical Analysis, Kaiser Permanente; Ahuja, A., Practice Lead - Application Development, Kaiser Permanente; Andrews, K., BS, Managing Director of Complete Care Support Programs, Kaiser Permanente
L5 Use the Power of Patients’ Voices to Enhance Care Experiences

Learning Format: Case Study

Do you want to accelerate the improvement of your patients’ experience? This session’s presenters from Clinica Family Health and UnityPoint Health will share how they engaged patients and families in closing the loop between learning about a patient’s needs and wants and responding with the needed changes to improve future experiences. They will also discuss how they built cohesive, systemwide assessment and interventions programs.

After this presentation, participants will be able to:

- Identify opportunities across the continuum to engage patients and families in improving the care delivery experience
- Aggregate and analyze information from reliable use of patient teach-back and patient experience surveys
- Implement a complete feedback loop to incorporate ideas into their practice and keep patients engaged in improvement processes

Presenters: Snyder, J., Director of Process Improvement, Clinica Family Health Services; Carlson, A., MS, CES, Project Manager, Clinica Family Health Services; Nielsen, G., BSHCA, FAHRA, IHI Fellow and Faculty, No Organization; Bradke, P., RN, Vice President Post Acute Care, UnityPoint Health – St. Luke’s Hospital

L6 Championing End-of-Life Conversations

Learning Format: Case Study

This session will introduce the Conversation Project’s tools and resources to engage patients and families in conversations about end-of-life care wishes. Participants will learn from the engagement efforts at the Orlando VA as we present scenarios for receiving, recording, and respecting end-of-life care wishes in different care and community settings. We will also discuss best practices from around the country and the prospective new Medicare reimbursements.

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 home institution or community

Presenters: DeBartolo, K., National Field Manager, Institute for Healthcare Improvement; Antoni, C., Palliative Care Coordinator, VA Medical Center

L7 Linking Health and Equity: A Learning Lab with SCALE Communities

Learning Format: Flipped Classroom

Health, social determinants, and equity are clearly interrelated. Participants in the RWJF-funded Spreading Community Accelerators through Learning and Evaluation (SCALE) Initiative learn firsthand how to use improvement science to reduce disparities and improve health in their communities. In this highly interactive workshop, we will hear their stories and learn practical skills for setting aims, using metrics, and taking creative approaches to improving equity by leading from within, leading together, leading for outcomes, and leading for equity.

After this presentation, participants will be able to:

- Take action to identify and close equity gaps in their community health efforts
L8 Defying the Myths of Aging: Engaging Seniors, Caregivers and Providers in Experience Based Co-Design

Learning Format: Lecture

This session will discuss three innovative, person-centered approaches to improving the overall health of seniors living with chronic conditions while also enhancing their access and transitions across the continuum of care. The Northumberland Partners Advancing Transitions in Healthcare, a Canadian community partnership, uses experience-based codesign methodology, and lay health care workers in Minnesota work to improve quality of life and care outcomes for individuals living at home with serious illness. Finally, CaregiverHelp.com has improved communication and reduced stress and frustration for people living with dementia and their caregivers.

After this presentation, participants will be able to:

- Describe three innovative, person-centered approaches to working with seniors and caregivers
- Understand the value of experience-based codesign in health system redesign
- Identify innovative solutions and models that provide support for seniors living at home
- Understand the causes of challenging dementia-related behaviors and identify strategies to reduce caregivers' emotional stress and improve the quality of life for individuals living with Alzheimer’s and other dementia-related diseases
- Describe the importance of building gerontology best practices into all parts of care and outline a strategy for responses to dementia-related behaviors that reduces stress for the care receiver, the caregiver, and the professional medical staff

Presenters: Sanchez, E., Speaker, Author, Co-founder CaregiverHelp.com, CaregiverHelp.com; Anderson, E., Principal Investigator, Allina Health System; Brenner, H., Vice President Patient Services and Chief Nursing Executive, Northumberland Hills hospital

L9 Integrated Health Links Model of Care in Ontario

Learning Format: Case Study

The South Simcoe and Northern York Region Health Link partners recognize the need to better integrate a vast array of specialties and services in order to coordinate the entire patient journey through the health care system, thus ensuring higher-quality care, improved access to care without duplication of services, and greater collaboration between local health care providers. Participants will learn about the development and implementation of a care model that addresses both patient and community needs.

After this presentation, participants will be able to:

- Assess patient needs and identify gaps in the health care system using a methodology that assesses challenges in the health care system and identifies the "most complex patients" (those who are vulnerable or at high risk)
• Develop a care model that addresses gaps in the health care system by identifying partners in the community and different sectors and developing a collaborative strategy
• Take steps to implement the care model and the business processes developed from it, including clearly defining the targeted patient population, piloting with community partners, seeking provider and patient feedback, and modifying the care model as required

Presenters: Gambell, R., RN BScN MN, Project Manager Health Links and Chronic Diseases, Southlake Regional Health Centre; Walko, D., Director of Seniors Services, LOFT Community Services; MacPherson, A., MAppSc, RRT, CRE, CTE, Clinical Coordinator, SSNYR Health Links, Health Quality Ontario

L10 State Expansion of an Innovative Health Care Model

Learning Format: Case Study

Involving patients directly in their health care through a group prenatal care model called CenteringPregnancy led to better birth outcomes at a busy clinic in South Carolina. We will present the steps taken by health care leaders to expand this innovative care model across the state, discuss its rationale and results, and describe the strategies that made it successful, including Medicaid payment reform, political leadership, technical support, and research partnerships.

After this presentation, participants will be able to:

• Understand the evidence of improved health outcomes and cost savings from the South Carolina statewide expansion of CenteringPregnancy, including the potential for new fields of inquiry
• Identify the methods and resources that made CenteringPregnancy implementation successful, both at the state level and within individual practices, and apply in their own community the lessons learned from South Carolina's statewide expansion of the project

Presenters: Covington-Kolb, S., Perinatal Program Coordinator, Greenville Health System; Rising, S., CNM, MSN, FACNM, Founder and President Emeritus, Centering Healthcare Institute; Picklesimer, A., Physician, Greenville Health System; Van De Griend, K., Process Evaluation Consultant, University of South Carolina Arnold School of Public Health

Monday, March 21: Receptions and Meals

12:30 PM - 1:30 PM

LT1 Lunch-Time Presentation: Bob Pozen on Productivity

Learning Format: Lecture

In this talk, Bob Pozen will show you that being more productive brings the joy back into work and reduces burnout. In addition to setting priorities and integrating them into your daily schedule, dealing quickly with the small stuff, and focusing immediately on the final product in large projects, Bob will suggest ways to become a more effective reader, writer, and presenter. He should know: Bob chaired a big asset management firm while teaching a full course load at Harvard Business School and writing the best-selling book "Extreme Productivity: Boost Your Results, Reduce Your Hours."

Presenters: Pozen, B., Executive Director, Ashurst Foundation

5:30 PM - 7:00 PM

PosRec Storyboard and Networking Reception

Monday, March 21: Workshop A
A1 Creating an Empathic Culture in Medicine

*Learning Format: Flipped Classroom*

This interactive workshop will explore barriers to empathy in medicine and provide strategies to improve clinician empathy. Prior to the conference, we will provide access to novel, evidence-based, online empathy training, which will serve as our springboard. We will also present strategies to enhance the patient experience and create culture change by implementing empathy training in organizations.

After this presentation, participants will be able to:

- Identify evidence-based medical and interpersonal benefits of empathic care
- Develop “flipped classroom” strategies to enhance empathy training
- Access a strategy for institutional transformation to humanize health care

Presenters: **Riess, H.,** Director, MGH Empathy & Relational Science Program, Massachusetts General Hospital; **Misiaszek, T.,** CEO and President, Empathetics, Inc.

SWA Storyboard Walkaround A: Team Based Care

*Learning Format: Storyboard Walkaround*

With the new "storyboard walkaround" learning format, participants can become familiar with a variety of improvement projects on a specific topic. The moderator for each session will introduce the topic and the presenters and guide the group to each storyboard. Each presenter will give a 10-12-minute overview of his or her work and then answer questions. Topics will include relational team-based care, team-based primary care, avoiding rule-breaking, and creating a personal primary care team.

Presenters: **Medeiros, L.,** Referral Management Coordinator, Cambridge Health Alliance Somerville Hospital; **John, J.,** PA-C, MHS, Chief Physician Assistant, Primary Care, union square family medicine; Ticotsky, A., RN, Cambridge Health Alliance Somerville Hospital; **Meisinger, K.,** MD, Medical Director, Cambridge Health Alliance; **Jerzak, J.,** MD, Physician, Bellin Health; Kerscher, K., BA, Team Leader -Operations, Bellin Health; **Yankle, D.,** Manager of Clinical Services, OhioHealth Physicians Group; **Hermann, C.,** Vice President, Allina Health System; **Kveton, N.,** RN, BSN, MHA, Director of Nursing and Quality, Allina Health System

A2 The Role of Specialists in Community Health

*Learning Format: Lecture*

Specialists play an important role in transforming health care by improving experiences and outcomes while decreasing cost. Participants will learn about the transformation at an orthopedic practice that set up programs on, for example, presurgical weight loss and depression, reductions in falls, and preventive bone and joint health, as well as an innovative office-based program, “What Matters to You.” This specialist practice was transformed by its focus on collaboration, coordination, prevention, and wellness.

After this presentation, participants will be able to:

- Understand the role that specialists play in transforming the health care system from volume to value
- Describe one orthopedic practice’s development of programs that focused on collaboration, coordination, prevention, and wellness and identify examples of these programs

Presenters: **Digioia, A.,** MD, Medical Director, University of Pittsburgh Medical Center (UPMC); **Clayton, S.,** Job Title not selected, Organization Name not selected
A3 Roadmap to Provider Wellness

Learning Format: Buzz Session

At Hennepin County Medical Center, we have seen a 20% relative reduction in provider burnout in the first two years of our provider wellness programs. This workshop will lay out concrete, step-by-step instructions for creating and sustaining provider wellness in any organization, provide useful tools, and discuss proven interventions that can be transferred to any clinical setting. Besides case examples, we will also share our insights, evidence base, and lessons learned.

After this presentation, participants will be able to:

- Identify the evidence base for the importance of provider wellness in a clinical setting
- Develop a provider wellness program
- Change the organizational culture and build a healthy workplace
- List evidence-based methods to prevent burnout

Presenters: Poplau, S., Office of Professional Worklife, Hennepin County Medical Center; Goelz, E., MD, Hennepin County Medical Center

A4 Transforming Care: Integrating Behavioral Health

Learning Format: Buzz Session

This session will introduce a comprehensive model for integrating behavioral health into a 90-practice, pediatric primary care network. It addresses gaps in access to care through clinical education, clinical and operational support, and psychiatric consultation. The model aims to improve the quality and reliability of behavioral health services delivered in the patient-centered medical home and the coordination of care outside the medical home while managing population health, controlling costs, and enhancing the patient and provider experience.

After this presentation, participants will be able to:

- Identify common opportunities, challenges, and barriers to integrating behavioral health into primary care
- Understand how integrating behavioral health supports quality improvement work
- Plan a quality improvement effort based on integrated care principles

Presenters: Bromberg, J., Program Manager, Pediatric Physicians Organization at Childrens; Focht, G., MD, Chief Medical Officer, Boston Children's Hospital; Goodman, E., LICSW, Manager, Integration and Clinical Support, Boston Children's Hospital; Frithsen, B., MPH, Senior QI Consultant, Boston Children’s Hospital

A5 Strategies for Working with Your Community on Improvement

Learning Format: Buzz Session

As health care becomes more people-centered in order to avoid hospitalizations and focus on the health of individuals, new and adapted models and approaches are needed to support improvement in the community. Moving beyond traditional organizational structures and into the community presents opportunities to adapt traditional improvement approaches. This interactive session will explore the unique aspects of community-wide improvement, including new approaches to building improvement capability, teaching improvement methods, working across organizations, and building creative learning systems.

After this presentation, participants will be able to:

- Explore the unique requirements of developing improvement capability across a community
- Understand key considerations, tips, and tools for teaching improvement method basics in a community
17th Annual Summit on Improving Patient Care in the Office Practice and the Community

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

Presenters: Baldoza, K., MSW, Executive Director, Institute for Healthcare Improvement; Lewis, N., MS, Executive Director, Institute for Healthcare Improvement; Gunther-Murphy, C., Executive Director, Institute for Healthcare Improvement; Martin, A., MPS, Executive Director, Proviso Leyden Council for Community Action

A6 Joy and Pain: How to Tip the Scales for Clinicians in Primary Care Practice

**Learning Format:** Buzz Session

Primary care is an increasingly challenging field, and the number of demands placed on clinicians is rising. Though health care organizations often emphasize the importance of patient satisfaction, physician experience should not be ignored. Bringing joy back to a practice is critical to sustaining a robust clinical workforce. This session will explore strategies to involve front-line clinicians in decision-making and practice transformation. Ongoing challenges, including providing patient-centered care in a volume-centered environment, will be discussed.

After this presentation, participants will be able to:

- Develop strategies for engaging clinicians in practice transformation and redesign
- Explore ways to harness resources that support clinician experience and prevent burnout
- Utilize tools to measure and track physician experience

Presenters: Worcester, J., MD, Associate Medical Director, Boston Medical Center; D’Afflitti, J., MD, MPH, Associate Medical Director, Department of GIM, Boston Medical Center; Chapman, S., Assistant Professor of Medicine, Boston Medical Center

A7 Improving Care for Transgender Patients

**Learning Format:** Lecture

Recent studies reveal disparities for transgender individuals in the health care system. Many transgender people avoid or delay seeking care because of bad experiences with health care providers. This session will highlight the key issues that can make or break a health care visit for a transgender patient, and describe strategies for making your health care organization friendlier for transgender individuals. A panel of transgender individuals will discuss their experiences.

After this presentation, participants will be able to:

- Describe four key points every health care provider needs to know before caring for a transgender patient
- Implement strategies to make their organizations more welcoming to transgender patients

Presenters: Coil, C., MD, MPH, FACEP, Chief Quality Officer, Harbor UCLA Medical Center; Buccolo, G., M.S., IBCLC, International Board Certified Lactation Consultant, Glendale Adventist Medical Center
A8 Building the Primary Care Practice of the Future

Learning Format: Lecture

All levels of the Coastal Medical organization participated in reinventing clinical programs, workflows, and care delivery systems that greatly improved patient outcomes and had a profound impact on the Coastal Medical practice in terms of quality of care, cost of care, and patient experience of care. Equally important, staff and physician satisfaction improved as well. Learn what worked--and what did not--in Coastal Medical's quest to become the primary care practice of the future.

After this presentation, participants will be able to:
- Identify when workflow and process do not support a practice's vision and strategic plan
- Discuss how to garner buy-in and participation from all levels of a practice
- Describe how to develop a plan to build a collaborative practice-wide team
- Identify gaps in process and explore solutions
- Discuss institutionalizing a culture of change in the day-to-day work of a practice

Presenters: Moss, M., Chief Operating Officer, Coastal Medical; Kurose, A., MD, MBA, FACP, President & CEO, Coastal Medical

A9 Catalyzing Students & Residents as Change Agents

Learning Format: Rapid-Fire Sessions

New, innovative approaches are urgently needed to help providers in office and community settings tackle the challenge of managing the health of populations. Organizations can leverage an underutilized resource by employing the passion and energy of students. In this session, Open School student leaders will share how to take an organizing approach to health and health care transformation and show participants how to apply these skills to their own local campaign or improvement effort.

After this presentation, participants will be able to:
- Design and implement a community, action-oriented campaign effort
- Apply organizing skills to a local population health or quality improvement effort

Presenters: Hilton, K., JD, MTS, Senior Faculty, ReThink Health & Institute for Healthcare Improvement; DeSmidt, B., Community Manager, Institute for Healthcare Improvement; Deitz, G., Community Coordinator, IHI Open School, Institute for Healthcare Improvement

A10 Improving Service Experiences When Cancer Strikes

Learning Format: Lecture

A cancer diagnosis is a fireball that turns patients' lives upside down. How can we improve the service experience of adult cancer patients and their families from diagnosis onward? Professor Leonard Berry answers this question based on his comprehensive study, including interviews with more than 350 patients, family members, oncology clinicians, and thought leaders. This session will show how the ideas presented in Berry's "5 C's of Cancer Service" framework can be acted on today.

After this presentation, participants will be able to:
- Understand the critical service shortcomings in adult cancer care and the need to improve these services
- Discuss a variety of actionable ideas for improving service quality in cancer care
Better appreciate the complex, holistic nature of the needs of cancer patients and their family members

Presenters: **Berry, L., PhD**, Distinguished Professor of Marketing, Texas A & M University

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**Monday, March 21: Workshop B**

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

**B1 Creating an Empathic Culture in Medicine**

**Learning Format: Flipped Classroom**

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After this presentation, participants will be able to:

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- Develop “flipped classroom” strategies to enhance empathy training
- Access a strategy for institutional transformation to humanize health care

Presenters: **Riess, H.,** Director, MGH Empathy & Relational Science Program, Massachusetts General Hospital; **Misiaszek, T.,** CEO and President, Empathetics, Inc.

**B2 The Role of Specialists in Community Health**

**Learning Format: Lecture**

Specialists play an important role in transforming health care by improving experiences and outcomes while decreasing cost. Participants will learn about the transformation at an orthopedic practice that set up programs on, for example, presurgical weight loss and depression, reductions in falls, and preventive bone and joint health, as well as an innovative office-based program, “What Matters to You.” This specialist practice was transformed by its focus on collaboration, coordination, prevention, and wellness.

After this presentation, participants will be able to:

- Understand the role that specialists play in transforming the health care system from volume to value
- Describe one orthopedic practice’s development of programs that focused on collaboration, coordination, prevention, and wellness and identify examples of these programs

Presenters: **Digioia, A.,** MD, Medical Director, University of Pittsburgh Medical Center (UPMC); **Clayton, S.,** Job Title not selected, Organization Name not selected
B3 Roadmap to Provider Wellness

**Learning Format: Buzz Session**

At Hennepin County Medical Center, we have seen a 20% relative reduction in provider burnout in the first two years of our provider wellness programs. This workshop will lay out concrete, step-by-step instructions for creating and sustaining provider wellness in any organization, provide useful tools, and discuss proven interventions that can be transferred to any clinical setting. Besides case examples, we will also share our insights, evidence base, and lessons learned.

After this presentation, participants will be able to:

- Identify the evidence base for the importance of provider wellness in a clinical setting
- Develop a provider wellness program
- Change the organizational culture and build a healthy workplace
- List evidence-based methods to prevent burnout

Presenters: **Poplau, S.,** Office of Professional Worklife, Hennepin County Medical Center; **Goelz, E., MD,** Hennepin County Medical Center

B4 Transforming Care: Integrating Behavioral Health

**Learning Format: Buzz Session**

This session will introduce a comprehensive model for integrating behavioral health into a 90-practice, pediatric primary care network. It addresses gaps in access to care through clinical education, clinical and operational support, and psychiatric consultation. The model aims to improve the quality and reliability of behavioral health services delivered in the patient-centered medical home and the coordination of care outside the medical home while managing population health, controlling costs, and enhancing the patient and provider experience.

After this presentation, participants will be able to:

- Identify common opportunities, challenges, and barriers to integrating behavioral health into primary care
- Understand how integrating behavioral health supports quality improvement work
- Plan a quality improvement effort based on integrated care principles

Presenters: **Bromberg, J.,** Program Manager, Pediatric Physicians Organization at Childrens; **Focht, G., MD,** Chief Medical Officer, Boston Children’s Hospital; **Goodman, E., LICSW,** Manager, Integration and Clinical Support, Boston Children’s Hospital; **Frithsen, B., MPH,** Senior QI Consultant, Boston Children’s Hospital

B5 Strategies for Working with Your Community on Improvement

**Learning Format: Buzz Session**

As health care becomes more people-centered in order to avoid hospitalizations and focus on the health of individuals, new and adapted models and approaches are needed to support improvement in the community. Moving beyond traditional organizational structures and into the community presents opportunities to adapt traditional improvement approaches. This interactive session will explore the unique aspects of community-wide improvement, including new approaches to building improvement capability, teaching improvement methods, working across organizations, and building creative learning systems.

After this presentation, participants will be able to:

- Explore the unique requirements of developing improvement capability across a community
- Understand key considerations, tips, and tools for teaching improvement method basics in a community
B6 Joy and Pain: How to Tip the Scales for Clinicians in Primary Care Practice

Learning Format: Buzz Session

Primary care is an increasingly challenging field, and the number of demands placed on clinicians is rising. Though health care organizations often emphasize the importance of patient satisfaction, physician experience should not be ignored. Bringing joy back to a practice is critical to sustaining a robust clinical workforce. This session will explore strategies to involve front-line clinicians in decision-making and practice transformation. Ongoing challenges, including providing patient-centered care in a volume-centered environment, will be discussed.

After this presentation, participants will be able to:

• Develop strategies for engaging clinicians in practice transformation and redesign
• Explore ways to harness resources that support clinician experience and prevent burnout
• Utilize tools to measure and track physician experience

Presenters: Worcester, J., MD, Associate Medical Director, Boston Medical Center; D’Afflitti, J., MD, MPH, Associate Medical Director, Department of GIM, Boston Medical Center; Chapman, S., Assistant Professor of Medicine, Boston Medical Center

B7 Improving Care for Transgender Patients

Learning Format: Lecture

Recent studies reveal disparities for transgender individuals in the health care system. Many transgender people avoid or delay seeking care because of bad experiences with health care providers. This session will highlight the key issues that can make or break a health care visit for a transgender patient, and describe strategies for making your health care organization friendlier for transgender individuals. A panel of transgender individuals will discuss their experiences.

After this presentation, participants will be able to:

• Describe four key points every health care provider needs to know before caring for a transgender patient
• Implement strategies to make their organizations more welcoming to transgender patients

Presenters: Coil, C., MD, MPH, FACEP, Chief Quality Officer, Harbor UCLA Medical Center; Buccolo, G., M.S., IBCLC, International Board Certified Lactation Consultant, Glendale Adventist Medical Center
B8 Building the Primary Care Practice of the Future

Learning Format: Lecture

All levels of the Coastal Medical organization participated in reinventing clinical programs, workflows, and care delivery systems that greatly improved patient outcomes and had a profound impact on the Coastal Medical practice in terms of quality of care, cost of care, and patient experience of care. Equally important, staff and physician satisfaction improved as well. Learn what worked—and what did not—in Coastal Medical's quest to become the primary care practice of the future.

After this presentation, participants will be able to:

- Identify when workflow and process do not support a practice's vision and strategic plan
- Discuss how to garner buy-in and participation from all levels of a practice
- Describe how to develop a plan to build a collaborative practice-wide team
- Identify gaps in process and explore solutions
- Discuss institutionalizing a culture of change in the day-to-day work of a practice

Presenters: Moss, M., Chief Operating Officer, Coastal Medical; Kurose, A., MD, MBA, FACP, President & CEO, Coastal Medical

B9 Catalyzing Students & Residents as Change Agents

Learning Format: Rapid-Fire Sessions

New, innovative approaches are urgently needed to help providers in office and community settings tackle the challenge of managing the health of populations. Organizations can leverage an underutilized resource by employing the passion and energy of students. In this session, Open School student leaders will share how to take an organizing approach to health and health care transformation and show participants how to apply these skills to their own local campaign or improvement effort.

After this presentation, participants will be able to:

- Design and implement a community, action-oriented campaign effort
- Apply organizing skills to a local population health or quality improvement effort

Presenters: Hilton, K., JD, MTS, Senior Faculty, ReThink Health & Institute for Healthcare Improvement; DeSmidt, B., Community Manager, Institute for Healthcare Improvement; Deitz, G., Community Coordinator, IHI Open School, Institute for Healthcare Improvement

B10 Improving Service Experiences When Cancer Strikes

Learning Format: Lecture

A cancer diagnosis is a fireball that turns patients' lives upside down. How can we improve the service experience of adult cancer patients and their families from diagnosis onward? Professor Leonard Berry answers this question based on his comprehensive study, including interviews with more than 350 patients, family members, oncology clinicians, and thought leaders. This session will show how the ideas presented in Berry's "5 C's of Cancer Service" framework can be acted on today.

After this presentation, participants will be able to:

- Understand the critical service shortcomings in adult cancer care and the need to improve these services
- Discuss a variety of actionable ideas for improving service quality in cancer care
• Better appreciate the complex, holistic nature of the needs of cancer patients and their family members

Presenters: Berry, L., PhD, Distinguished Professor of Marketing, Texas A & M University

**SWB Storyboard Walkaround B: Quality Improvement in Practice**

**Learning Format:** Storyboard Walkaround

With the new "storyboard walkaround" learning format, participants can become familiar with a variety of improvement projects on a specific topic. The moderator for each session will introduce the topic and the presenters and guide the group to each storyboard. Each presenter will give a 10-12-minute overview of his or her work and then answer questions. Topics will include leveraging Lean to implement and sustain improvement, unleashing the power of joy and improvement, the true cost of care in an orthopedic office setting, and the balancing act involved in leadership and staff-driven change.

Presenters: Ladonne, M., Director of Clinical Process Improvement, Signature Healthcare Brockton Hospital; Lummus, S., Executive Director Practice Innovation, MemorialCare Medical Centers; Giarrusso, M., RN, BSN, MS, MBA, Director of Patient and Family Centered Care, University Of Pittsburgh; Snyder, J., Director of Process Improvement, Clinaica Family Health Services; Lee, J., MD, MPH, FAAFP, Associate Medical Director, Practice Transformation, MemorialCare Medical Centers; Girard, K., Physician, Signature Medical Group

**Monday, March 21: Keynotes**

**8:00 AM - 9:00 AM**

**Key1 Keynote One: Derek Feeley and Trissa Torres, MD**

**Learning Format:** Lecture

Presenters: Torres, T., MD, MSPH, FACPM, SVP, Institute for Healthcare Improvement; Feeley, D., Chief Executive Officer, Institute for Healthcare Improvement

**4:30 PM - 5:30 PM**

**Key2 Keynote Two: Christine Sinsky, MD**

**Learning Format:** Lecture

Presenters: Sinsky, C., MD, Physician, Medical Associates Clinic and Health Plans

**Tuesday, March 22: Special Interest Breakf asks**

**7:00 AM - 7:45 AM**

**SIB1 End-of-Life Wishes: An Introduction to The Conversation Project**

**Learning Format:** None

The Conversation Project is dedicated to helping people talk about their wishes for end-of-life care. Too many people are dying in a way they wouldn’t choose, and too many of their loved ones are left feeling bereaved, guilty, and uncertain. Join us to learn more about our national efforts to bring this conversation to the general public (where people work, live, and pray) and health care providers

Presenters: DeBartolo, K., National Field Manager, Institute for Healthcare Improvement
Tuesday, March 22: Workshop C

9:30 AM - 10:45 AM

C1 The How and Why of Successful Culture Transformation: Lessons from South Huntington

Learning Format: Lecture

The South Huntington experience shows that the medical home can achieve Triple Aim results by designing, engineering, and implementing a culture rather than processes. In this session, we will explore explanations for the success of a culture of multidisciplinary teams based on patient engagement, continuous learning, and complete integration. In a structured discussion, participants will learn how to adapt South Huntington's specific culture-determining processes to speed up the evolution of their own practice's culture.

After this presentation, participants will be able to:

- Understand that culture is not immutable but rather is easily amenable to transformation
- Describe a few concrete processes that their practice could use to start transforming its culture
- Understand that the "why" of practice transformation is just as important as the "what" of achieving Triple Aim outcomes

Presenters: Pollack, S., MD, physician, Brigham and Womens Primary Care; Pabo, E., MD, MBA, Assistant Medical Director, Primary Care, Brigham and Women's Hospital

C2 Finding Out What Gets Between People and Outcomes

Learning Format: Case Study

All interventions ultimately depend on a person's behavior. Under initiatives to improve Medicaid outcomes and costs, Iowa uses a health risk assessment to systematically unmask the factors getting between people and optimal health outcomes. Respondents are empowered to make healthy behavior changes, and the assessment informs action planning and needs assessments for population segments at the office, state, and regional levels. Participants will learn from Iowa's experience under its State Innovation Model grant.

After this presentation, participants will be able to:

- Make informed decisions around programs to unmask the social determinants and other nonmedical factors that weigh heavily on personal and population outcomes
- Understand the value of a health risk assessment as a tool to improve population outcomes and costs
- Understand the issues and lessons learned from deploying a tool like a health risk assessment at scale (across all of a state's Medicaid providers)

Presenters: Moore, L., MD, Senior Medical Director, 3M Health Information Systems; Bussell, M., Project Manager, Iowa Foundation for Medical Care
C3 Cognitive Load Theory: Why using your EHR is so painful and how to fix it

Learning Format: Buzz Session

"Cognitive load" dramatically increases when working memory must hold questions and partial information while searching for missing information, especially when the presentation of information doesn't match the clinical "mental model" for understanding diseases or problems. Many encounter forms only add to the burden; heavy cognitive load is also associated with significant increases in errors and poor task execution. In this session, we will share the collaborative journey of a frustrated primary care doctor and a team of EHR form developers as they used Cognitive Load Theory to redesign a primary care encounter form.

After this presentation, participants will be able to:

- Understand the fundamentals of Cognitive Load Theory
- Apply Cognitive Load Theory to make improvements in their own office or organization

Presenters: Zimmerman, M., MD, Physician Owner, Temescal Creek Medicine

C4 Pathways to Population Management in Safety Net Organizations

Learning Format: Rapid-Fire Sessions

Safety net organizations are in a unique position to manage the health of populations. In this session, participants will learn a general framework for advancing population management in the safety net setting and learn how diverse safety net organizations have applied this framework to put themselves on a pathway to managing a changing health care environment.

After this presentation, participants will be able to:

- List the core components of a population management framework for a safety net organization
- Describe how safety net organizations have achieved results in managing the health of their populations

Presenters: Dorsey, C., Clinical Social Work Chief II, Rancho Los Amigos National Rehabilitation Center; Heidrick, K., PA-C, Chief Medical Officer, Yakima Valley Farm Workers Clinic

C5 Tactics to Engage Physicians

Learning Format: Lecture

Physician participation in quality and safety improvement efforts is critical. Despite growing demands for measuring and improving performance, many organizations are not succeeding in meaningfully engaging their doctors. Physician disengagement leaves administrators frustrated, physicians cynical, and the organization's capacity for improvement diminished. This session will provide practical ways to develop and sustain the essential engagement of physicians to improve practice quality and safety.

After this presentation, participants will be able to:

- Describe how the tradition of excluding physicians from responsibility for operational and financial success can diminish their willingness to engage in improvement
- Identify ways to strengthen the alignment of physician and organization goals regarding care transformation and steps to achieve them
- Articulate specific behaviors that foster physician engagement and ownership for success

Presenters: Silversin, J., DMD, DrPH, President, Amicus, Inc.
C6 LinkAges: Activating Communities for Healthy Aging

Learning Format: Lecture

Nearly half of older Americans are lonely. Lonely older adults have a 45 percent greater risk of death and a 60 percent increased rate of disability over six years. LinkAges ("link across the generations") is a modular, community-based social support system designed to help older adults successfully "age in community." The program leverages technology and cross-generational social interactions to combat loneliness and isolation and mitigate their adverse health effects.

After this presentation, participants will be able to:

- Understand the prevalence of loneliness and its adverse health effects on the well-being of older adults
- Develop successful strategies for community engagement in helping older adults age in community
- Implement sustainable, community-based interventions to address the social needs of older adults that affect their health and well-being

Presenters: Tang, P., MD, MS, VP, Chief Innovation and Technology Officer, Palo Alto Medical Foundation

C7 How Value-Based Care Can Improve Community Health

Learning Format: Case Study

The president and CEO of Nemours Children's Health System, Dr. David J. Bailey, will showcase a case study that illustrates how value-based payment can increase access, enhance care quality, and improve the health of populations while controlling costs and increasing value.

After this presentation, participants will be able to:

- Relate an experienced CEO's insights on increasing access, enhancing care quality, and improving the health of populations while controlling costs and increasing value
- Identify new approaches to care that address the lack of synchronization between innovation in care models and changes in payment systems
- Discuss the ways in which a pilot program that provided community-based care for children with asthma significantly reduced emergency room visits and hospitalizations

Presenters: Bailey, D., MD, MBA, President and CEO, The Nemours Foundation

C8 Healthcare Equity Scholars Program: Building Capacity

Learning Format: Lecture

The Healthcare Equity Scholars Program at Henry Ford Health System equips 20 employees with the tools necessary to improve clinical quality, patient satisfaction, and employee engagement. These employees learn to address the unique needs of patients from diverse cultures and backgrounds. In this yearlong program, each Equity Scholar develops an equity-focused QI project within his or her department or unit. This session will provide implementation strategies and lessons learned.

After this presentation, participants will be able to:

- Identify successful components of a training program to build organizational capacity to address disparities in health care
• Anticipate potential roadblocks to program implementation and develop approaches to circumnavigating them

Presenters: **Rowe Gorosh, M., MD, FAACH**, Clinician, Education and Org Dev, Henry Ford Health System; Wisdom, K., MD, MS, Sr. VP, Comm. Health & Equity, Chief Wellness & Diversity Off., Henry Ford Health System

**C9 Managing Populations to Achieve Triple Aim Results**

*Learning Format: Flipped Classroom*

This session will provide the drivers for successfully delivering results for all populations on a single production system platform. In addition, the session will explore the concepts of spread and scale in building a sustainable system. Participants will learn from an organizational leader whose redesigned system has produced results on several levels, from panels and conditions to employers, payer segments, and communities. Such a redesign provides the platform for the sustainable organization of the future.

After this presentation, participants will be able to:

• Build a framework for managing populations
• Conduct an assessment of current capabilities to successfully manage populations
• Create a roadmap for moving from fee for service to a value-based payment system

Presenters: **Knox, P., MS, BS**, Executive Vice President, Chief Learning and Innovation Office, Bellin Health; Hunt, J., Pharm.D., MS, Chief Population Health Officer, Enli Health Intelligence

**C10 Caring for the Homebound: The Role of the Medical Home**

*Learning Format: Lecture*

The pillars of a patient-centered medical home are timely access to care, coordination, and continuity. Providing such comprehensive care to homebound patients is difficult to achieve, however, with a traditional office-based practice. In this session, we will introduce a model of care that aims to improve care for homebound patients, and we will also discuss the challenges, successes, and outcomes associated with delivering home-based primary care as part of a patient-centered medical home.

After this presentation, participants will be able to:

• Identify the patient populations most likely to benefit from an interprofessional team providing home-based primary care and develop measures to evaluate home-based primary care
• Describe ways to help team members work to their full capacity to provide home-based primary care
• Identify community partners for optimizing home-based primary care delivery

Presenters: **Condon, A.,** Family Physician, Winnipeg Regional Health Authority; Jones, A., Intensive Case Coordinator, Winnipeg Regional Health Authority; Sawchuk, P., Family Physician, Winnipeg Regional Health Authority

**SWC Storyboard Walkaround C: Care Transitions**

*Learning Format: Storyboard Walkaround*
With the new "storyboard walkaround" learning format, participants can become familiar with a variety of improvement projects on a specific topic. The moderator for each session will introduce the topic and the presenters and guide the group to each storyboard. Each presenter will give a 10-12-minute overview of his or her work and then answer questions. Topics will include closing the quality gaps in care transitions and PCMH care transitions.

Presenters: Ladonne, M., Director of Clinical Process Improvement, Signature Healthcare Brockton Hospital; Girard, K., Physician, Signature Medical Group; Morris, A., Director of Practice Transformation, University of Massachusetts Medical School; Johnston, J., RN, Transformation Specialist, University of Massachusetts Memorial Medical Center; O'Hare, K., MD, Primary Care Innovation Fellow, Boston Children’s Hospital

Tuesday, March 22: Workshop D

11:00 AM - 12:15 PM

D1 Developing the Ideal Patient Navigator

Learning Format: Buzz Session

Patient navigation is one of the fastest-growing professions in the United States, but its role in health care organizations can vary widely. This session will illustrate the qualities of effective patient navigators based on experiences from 12 health care organizations in northeast Ohio. Participants will design an ideal job description and continuing education program for patient navigators in their own systems to help achieve the Triple Aim of better experience, improved health, and lower costs.

After this presentation, participants will be able to:

- Define the role and context of the patient navigator in a complex health system
- Build a job description for patient navigators based on optimal personal qualities and skill sets identified by managers
- Create curriculum for their staff with protected time to be patient navigators

Presenters: Margolius, D., MD, Primary Care Physician, Metro Health Systems; Ali-Matlock, W., RN, BS, MBA, FAACM, PCMH CCE, PRACTICE COACH, Better Health Greater Cleveland - Aligning Forces for Quality

SWD Storyboard Walkaround D: Metrics

Learning Format: Storyboard Walkaround

With the new "storyboard walkaround" learning format, participants can become familiar with a variety of improvement projects on a specific topic. The moderator for each session will introduce the topic and the presenters and guide the group to each storyboard. Each presenter will give a 10-12-minute overview of his or her work and then answer questions. Topics will include the opportunities and challenges in metrics design, accelerating value-based performance metrics design, and health care delivery innovation.

Presenters: Loupe, S., Director Clinical Partnerships, Blue Cross and Blue Shield of Louisiana; Murphree, P., D.O., Sc.D., Engr., Medical Director Quality, Blue Cross and Blue Shield of Louisiana; Woods, C., Quality Performance Analyst, UnityPoint Health; Scaccia, J., Faculty, No Organization; Ward, L., Director of Operations and Strategy, Dell Medical School at the University of Texas at Austin
D2 Behavioral Health Innovations to Reduce Readmissions

Learning Format: Case Study

A new model of mental health case management is the behavioral health home, which works closely with primary care practices to serve vulnerable adults and children. We will explore the work of 22 behavioral health home organizations to reduce avoidable hospital admissions and readmissions. Using a case study example and a patient-centered Integrated Health Roadmap for Care Transitions, participants will plan coordinated care for an individual and identify opportunities to improve that person's care to reduce avoidable readmission.

After this presentation, participants will be able to:

• Identify the best practices and promising strategies that a behavioral health home can use to reduce avoidable admissions and readmissions
• Explore integrated partnerships between behavioral health and primary care to improve care transitions
• Describe how to utilize key changes in quality care transitions in health care settings to guide the implementation of best practices and promising strategies to impact admissions and readmissions

Presenters: Miller, L., MPH, Project Manager, Maine Quality Counts; Beyer, M., MA, Quality Improvement Specialist, Maine Quality Counts

D3 Cultivating Ownership within Care Teams

Learning Format: Buzz Session

Team-based care is at the foundation of primary care redesign. Does it work? In this session, we will explore that question by discussing the science behind motivation and high-impact collaboration. Teams structured to promote individual team member ownership over outcomes that matter to patients are able to move from task-based work to patient-centered care. Iora Health and other organizations offer contrasting models to increase team member accountability and heighten a sense of achievement, thus fostering intrinsic motivation.

After this presentation, participants will be able to:

• Discuss emerging trends in primary care team design
• Identify the characteristics of high-functioning teams in ambulatory care
• Identify the factors that motivate health care workers to provide excellent care

Presenters: Panzer, J., MD MS, Center Medical Director, Iora Health; Khan, A., MD, MPP, Clinical Instructor in Medicine, Yale University

D4 Taking on the Triple Aim in the Safety Net

Learning Format: Rapid-Fire Sessions

In this interactive session, participants will dive into the realities of implementing the Triple Aim in a safety net setting as we discuss how we translated our vision at San Francisco Health Network Primary Care into specific goals, measures, and outcomes. We will illustrate this process through examples, such as how team-based care reduced our readmission rate from 13.0% to 10.2% and how we launched patient advisory boards in all of our clinics.

After this presentation, participants will be able to:

• Identify Triple Aim strategies that can be implemented in their organization
• Develop ideas to improve the health of high-risk populations in safety net settings
A Path To Resilience: A Nurse-Led Co-Visit Model

Learning Format: Case Study

As Americans gain access to primary care, community health clinics must meet an increased demand for services with no enhanced capacity to do so. Moreover, provider and nurse burnout exacerbate the tension between what patients need and what care teams can provide. To address this problem, Clinica Family Health has incorporated nurse-led "co-visits" into its care model. This innovation has increased same-day access as well as staff and patient satisfaction, buttressing the organization's ability to provide high-quality, affordable, relationship-centered care.

After this presentation, participants will be able to:

- Explore the benefits of utilizing primary community health care nurses to address triage issues, total visits, nurse utilization, staff and patient satisfaction, patient access, continuity of care, complex care management, and cycle time
- Discuss how to build joy into the provider, nurse, and care team experience with innovative changes in team-based primary care, including co-visits and complex care management
- Evaluate the financial and quality improvement data about such innovations in the care team model

Presenters: Davis, M., MSN, ANP-C, Director of Nursing Services and Clinical Team Development, Clinica Family Health Services; Funk, K., Vice President of Clinical Services, Clinica Family Health Services

Improving Patient Safety - Inspiration from Scotland

Learning Format: Buzz Session

In this session, participants will learn about NHS Scotland's groundbreaking Safety Program in Primary Care, the first nationwide program to reduce the harm experienced by patients receiving care in a primary care setting. This groundbreaking program uses tailor-made improvement tools and approaches to develop a positive safety culture and deliver safe and reliable care in every general medical and dental practice and community pharmacy across Scotland.

After this presentation, participants will be able to:

- Understand the range of tailor-made improvement tools and interventions used as part of the Scottish Patient Safety Program in Primary Care
- Describe the approaches used to develop, implement, and spread a primary care improvement program on a vast scale
- Adapt the tools and interventions presented to test and spread within their own primary care setting

Presenters: Gillies, J., Job Title not selected, Organization Name not selected; Matthews, J., Head of Scottish Patient Safety Programme, NHS Healthcare Improvement Scotland
D7 A Community-Centered Approach to Reducing Inappropriate ED Utilization

Learning Format: Lecture

Community paramedicine allows emergency medical personnel to fill gaps in the health care system and reduce ED visits and 911 calls. The Colorado Springs Fire Department partnered with local hospitals, a Medicaid ACO, and a private insurer to test Community Assistance Referral Education Services (CARES), a program that connects patients to a primary care medical home, a case manager, and vital community resources. For 13 Medicaid patients, the program reduced ED visits by 37.6%, decreased 30-day readmissions by 75%, and avoided an estimated $54,805 in costs. Additionally, CARES reduced non-emergency 911 calls by 55.1% for 215 CARES clients.

After this presentation, participants will be able to:

- Identify the community partners needed to create a community paramedicine program
- Describe the shared goal-setting and collaborative activities that enable partner agencies to achieve community support
- Discuss lessons learned from the CARES program

Presenters: Vivian, K., Development and Strategic Initiatives Officer, El Paso County Department of Health and Environment; Martin, J., Community & Public Health Administrator, Colorado Springs Fire Department

D8 The Triple Aim and Beyond- Partnering with Payers-Increasing Trust, Building Infrastructure, and Rethinking Partnerships

Learning Format: Case Study

Multiple stakeholders must be involved in any effort to achieve system improvements in health care for better outcomes, better patient experience, and lower costs. In this session, payers who have successfully engaged key stakeholders (providers, the community, etc.) will share how they worked collaboratively to improve patient care and quality, provide extensive data, and reduce overall costs. Case studies will be used, including an in-depth look at a successful application by a large national payer and a provider-owned payer.

After this presentation, participants will be able to:

- Understand the approaches taken by payers to successfully engage with providers and communities to improve delivery of care and patient outcomes and the keys to effective collaboration among the stakeholders
- Outline what payers can offer to provider practices to enable them to thrive in a value-based payment model, as well as the components of the Triple Aim that can be achieved in partnerships of payers with providers and their staff
- Provide data to support the momentum that fosters patient-centered care and effectively implement intervention bundles
- Identify innovative resources for population management and care coordination and tools to build community partnerships and relate success stories from providers engaged in value-based programs

Presenters: Wilson, B., Manager, Community Transformation, Anthem; Southard, D., Care Consultant Senior, Anthem; Tatum, I., RN CCM CLNC, Manager of Case Management, CommunityCare
D9 Partnering with Patients and Community Members

Learning Format: Case Study

This workshop will help practices considering partnering in improvement with patients, families, and community members develop practical tools to support their journey. Based on Cambridge Health Alliance’s experience in integrating patients into every redesign team, this workshop will help participants assess where they are in engaging patients and families and offer strategies to integrate patients into existing QI work, align that work with system priorities, nurture patient engagement in improvement, and apply lessons learned.

After this presentation, participants will be able to:

• Understand the levels of patient and community partnership and assess their engagement in improvement work
• Discuss the practical considerations and opportunities at each stage of partnership
• Create goals and an action plan to develop improved partnerships

Presenters: Mann, Z., MA, Patient Lead, Cambridge Health Alliance; Stout, S., MD, MS, Executive External Lead for Health Improvement, Institute for Healthcare Improvement; Nabisere, R., Patient Representative, Cambridge Health Alliance

D10 Shared Medical Appointments in the Care Coordination Age

Learning Format: Case Study

The care team at Orlando Health realized that, with care coordination evolving from patient-centered medical homes to accountable care organizations to, most recently, statewide clinical integration networks, physicians would have to change the paradigm of the one-on-one encounter with patients if the practice was to meet its care goals. This session will describe how Orlando Health shifted to shared medical appointments in order to reduce care gaps, optimize patient engagement, and set new standards of quality care.

After this presentation, participants will be able to:

• Identify the tools needed to take care coordination from one-on-one encounters to shared medical appointments and true population health
• Implement proven strategies to reduce care gaps and optimize ACO contract reimbursement
• Develop strategies to engage physicians and help them move toward a population health culture

Presenters: Kaplan, B., MD, MPH, FACP, Internal Medicine Physician, Orlando Health; Adkisson, T., CNS, MSN, CCNS, CCTM, Corporate Director, Population Health & Care Coordination, Orlando Health; Popeck, L., RD, LD/N, Registered Dietitian, Orlando Health

Tuesday, March 22: General

12:15 PM - 1:15 PM

LT2 Lunch-Time Presentation: Donna Cyer: A Patient Story

Learning Format: Lecture

Tuesday, March 22: Workshop E
E1 Developing the Ideal Patient Navigator

Learning Format: Buzz Session

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After this presentation, participants will be able to:

- Define the role and context of the patient navigator in a complex health system
- Build a job description for patient navigators based on optimal personal qualities and skill sets identified by managers
- Create curriculum for their staff with protected time to be patient navigators

Presenters: Margolius, D., MD, Primary Care Physician, Metro Health Systems; Ali-Matlock, W., RN, BS, MBA, FAACM, PCMH CCE, PRACTICE COACH, Better Health Greater Cleveland - Aligning Forces for Quality

E2 Behavioral Health Innovations to Reduce Readmissions

Learning Format: Case Study

A new model of mental health case management is the behavioral health home, which works closely with primary care practices to serve vulnerable adults and children. We will explore the work of 22 behavioral health home organizations to reduce avoidable hospital admissions and readmissions. Using a case study example and a patient-centered Integrated Health Roadmap for Care Transitions, participants will plan coordinated care for an individual and identify opportunities to improve that person's care to reduce avoidable readmission.

After this presentation, participants will be able to:

- Identify the best practices and promising strategies that a behavioral health home can use to reduce avoidable admissions and readmissions
- Explore integrated partnerships between behavioral health and primary care to improve care transitions
- Describe how to utilize key changes in quality care transitions in health care settings to guide the implementation of best practices and promising strategies to impact admissions and readmissions

Presenters: Miller, L., MPH, Project Manager, Maine Quality Counts; Beyer, M., MA, Quality Improvement Specialist, Maine Quality Counts

E3 Cultivating Ownership within Care Teams

Learning Format: Buzz Session

Team-based care is at the foundation of primary care redesign. Does it work? In this session, we will explore that question by discussing the science behind motivation and high-impact collaboration. Teams structured to promote individual team member ownership over outcomes that matter to patients are able to move from task-based work to patient-centered care. Iora Health and other organizations offer contrasting models to increase team member accountability and heighten a sense of achievement, thus fostering intrinsic motivation.

After this presentation, participants will be able to:

- Discuss emerging trends in primary care team design
17th Annual Summit on Improving Patient Care in the Office Practice and the Community

- Identify the characteristics of high-functioning teams in ambulatory care
- Identify the factors that motivate health care workers to provide excellent care

Presenters: Panzer, J., MD MS, Center Medical Director, Iora Health; Khan, A., MD, MPP, Clinical Instructor in Medicine, Yale University

E4 Taking on the Triple Aim in the Safety Net

**Learning Format:** Rapid-Fire Sessions

In this interactive session, participants will dive into the realities of implementing the Triple Aim in a safety net setting as we discuss how we translated our vision at San Francisco Health Network Primary Care into specific goals, measures, and outcomes. We will illustrate this process through examples, such as how team-based care reduced our readmission rate from 13.0% to 10.2% and how we launched patient advisory boards in all of our clinics.

After this presentation, participants will be able to:

- Identify Triple Aim strategies that can be implemented in their organization
- Develop ideas to improve the health of high-risk populations in safety net settings
- Detail specific approaches to improving the patient experience in safety net settings

Presenters: Davis, E., Medical Director of Care Coordination in Primary Care, San Francisco Health Network; Sansone, J., RN, MS, Director of Nursing Primary Care, San Francisco Department of Public Health; Petersen, A., MPH, Healthcare Analyst, San Francisco Department of Public Health; Albright, J., Healthcare Analyst, San Francisco Department of Public Health; Robert, A., RN, MSN, DrPH, Director of Care Coordination for Primary Care, San Francisco Health Network

E5 A Path To Resilience: A Nurse-Led Co-Visit Model

**Learning Format:** Case Study

As Americans gain access to primary care, community health clinics must meet an increased demand for services with no enhanced capacity to do so. Moreover, provider and nurse burnout exacerbate the tension between what patients need and what care teams can provide. To address this problem, Clinica Family Health has incorporated nurse-led “co-visits” into its care model. This innovation has increased same-day access as well as staff and patient satisfaction, buttressing the organization's ability to provide high-quality, affordable, relationship-centered care.

After this presentation, participants will be able to:

- Explore the benefits of utilizing primary community health care nurses to address triage issues, total visits, nurse utilization, staff and patient satisfaction, patient access, continuity of care, complex care management, and cycle time
- Discuss how to build joy into the provider, nurse, and care team experience with innovative changes in team-based primary care, including co-visits and complex care management
- Evaluate the financial and quality improvement data about such innovations in the care team model

Presenters: Davis, M., MSN, ANP-C, Director of Nursing Services and Clinical Team Development, Clinica Family Health Services; Funk, K., Vice President of Clinical Services, Clinica Family Health Services
E6 Improving Patient Safety - Inspiration from Scotland

**Learning Format: Buzz Session**

In this session, participants will learn about NHS Scotland's groundbreaking Safety Program in Primary Care, the first nationwide program to reduce the harm experienced by patients receiving care in a primary care setting. This groundbreaking program uses tailor-made improvement tools and approaches to develop a positive safety culture and deliver safe and reliable care in every general medical and dental practice and community pharmacy across Scotland.

After this presentation, participants will be able to:

- Understand the range of tailor-made improvement tools and interventions used as part of the Scottish Patient Safety Program in Primary Care
- Describe the approaches used to develop, implement, and spread a primary care improvement program on a vast scale
- Adapt the tools and interventions presented to test and spread within their own primary care setting

Presenters: **Gillies, J.**, Job Title not selected, Organization Name not selected; **Matthews, J.**, Head of Scottish Patient Safety Programme, NHS Healthcare Improvement Scotland

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E7 A Community-Centered Approach to Reducing Inappropriate ED Utilization

**Learning Format: Lecture**

Community paramedicine allows emergency medical personnel to fill gaps in the health care system and reduce ED visits and 911 calls. The Colorado Springs Fire Department partnered with local hospitals, a Medicaid ACO, and a private insurer to test Community Assistance Referral Education Services (CARES), a program that connects patients to a primary care medical home, a case manager, and vital community resources. For 13 Medicaid patients, the program reduced ED visits by 37.6%, decreased 30-day readmissions by 75%, and avoided an estimated $54,805 in costs. Additionally, CARES reduced non-emergency 911 calls by 55.1% for 215 CARES clients.

After this presentation, participants will be able to:

- Identify the community partners needed to create a community paramedicine program
- Describe the shared goal-setting and collaborative activities that enable partner agencies to achieve community support
- Discuss lessons learned from the CARES program

Presenters: **Vivian, K.**, Development and Strategic Initiatives Officer, El Paso County Department of Health and Environment; **Martin, J.**, Community & Public Health Administrator, Colorado Springs Fire Department

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E8 The Triple Aim and Beyond- Partnering with Payers-Increasing Trust, Building Infrastructure, and Rethinking Partnerships

**Learning Format: Case Study**

Multiple stakeholders must be involved in any effort to achieve system improvements in health care for better outcomes, better patient experience, and lower costs. In this session, payers who have successfully engaged key stakeholders (providers, the community, etc.) will share how they worked collaboratively to improve patient care and quality, provide extensive data, and reduce overall costs. Case studies will be used, including an in-depth look at a successful application by a large national payer and a provider-owned payer.

After this presentation, participants will be able to:

- Understand the approaches taken by payers to successfully engage with providers and communities to improve delivery of care and patient outcomes and the keys to effective collaboration among the stakeholders

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- Outline what payers can offer to provider practices to enable them to thrive in a value-based payment model, as well as the components of the Triple Aim that can be achieved in partnerships of payers with providers and their staff
- Provide data to support the momentum that fosters patient-centered care and effectively implement intervention bundles
- Identify innovative resources for population management and care coordination and tools to build community partnerships and relate success stories from providers engaged in value-based programs

Presenters: Wilson, B., Manager, Community Transformation, Anthem; Southard, D., Care Consultant Senior, Anthem; Tatum, I., RN CCM CLNC, Manager of Case Management, CommunityCare

E9 Partnering with Patients and Community Members

**Learning Format: Case Study**

This workshop will help practices considering partnering in improvement with patients, families, and community members develop practical tools to support their journey. Based on Cambridge Health Alliance’s experience in integrating patients into every redesign team, this workshop will help participants assess where they are in engaging patients and families and offer strategies to integrate patients into existing QI work, align that work with system priorities, nurture patient engagement in improvement, and apply lessons learned.

After this presentation, participants will be able to:

- Understand the levels of patient and community partnership and assess their engagement in improvement work
- Discuss the practical considerations and opportunities at each stage of partnership
- Create goals and an action plan to develop improved partnerships

Presenters: Mann, Z., MA, Patient Lead, Cambridge Health Alliance; Stout, S., MD, MS, Executive External Lead for Health Improvement, Institute for Healthcare Improvement; Nabisere, R., Patient Representative, Cambridge Health Alliance

E10 Shared Medical Appointments in the Care Coordination Age

**Learning Format: Case Study**

The care team at Orlando Health realized that, with care coordination evolving from patient-centered medical homes to accountable care organizations to, most recently, statewide clinical integration networks, physicians would have to change the paradigm of the one-on-one encounter with patients if the practice was to meet its care goals. This session will describe how Orlando Health shifted to shared medical appointments in order to reduce care gaps, optimize patient engagement, and set new standards of quality care.

After this presentation, participants will be able to:

- Identify the tools needed to take care coordination from one-on-one encounters to shared medical appointments and true population health
- Implement proven strategies to reduce care gaps and optimize ACO contract reimbursement
- Develop strategies to engage physicians and help them move toward a population health culture

Presenters: Kaplan, B., MD, MPH, FACP, Internal Medicine Physician, Orlando Health; Adkisson, T., CNS, MSN, CCNS, CCTM, Corporate Director, Population Health & Care Coordination, Orlando Health; Popeck, L., RD, LD/N, Registered Dietitian, Orlando Health

**Tuesday, March 22: Keynotes**
17th Annual Summit on Improving Patient Care in the Office Practice and the Community

8:00 AM - 9:00 AM

Key3 Keynote Three: Rishi Manchanda, MD, MPH

Learning Format: Lecture

Presenters: Manchanda, R., MD MPH, Founder, HealthBegins, HealthBegins

2:45 PM - 3:45 PM

Key4 Keynote Four: Vice Admiral (VADM) Vivek H. Murthy, MD, MBA