Sunday, March 9: Registration

10:00 AM - 6:00 PM

Reg1: Registration

Potomac Ballroom : Potomac A Foyer

Sunday, March 9: Minicourse

12:00 PM - 5:30 PM

M1: ACO Data-Driven Primary Care Population Strategies

Chesapeake Conference Rooms : Chesapeake H-I

States are increasingly contracting with data analytic companies to supply primary care practices with population data stratified by payer. This presentation will review a partnership between a data analytics contractor and Colorado’s accountable care organizations (ACOs) around key performance indicators and describe the primary care strategies they have jointly developed to improve the cost of care, including health assessment risk scores, shared patient–health care team treatment plans, and targeted interventions such as alternative visit types, transitions of care strategies, and intensive care team interventions.

After this presentation, participants will be able to:

• Work from state ACO data to identify populations that disproportionately utilize health care resources
• Identify tools for assessing health risks
• Describe key opportunities for reducing preventable events as well as two strategies for decreasing potentially preventable emergency room visits

Presenters: Wheeler, J., MD, VP of Clinical Services, Clinica Family Health Services; Moore, L., MD, Chief Medical Officer, Treo Solutions

M2: Build Physician Engagement to Transform Care

Chesapeake Conference Rooms : Chesapeake 4

To ensure that improvements in practice do not remain just a series of projects but evolve into a way of life, it is critical that change agents engage physicians’ hearts and minds. This session will provide a framework for building sustainable physician commitment and engagement and share a case example of what one organization achieved by adopting this model.

After this presentation, participants will be able to:

• Describe how urgency, shared vision, change sponsorship, a compact (reciprocal expectations between doctors and their organization), and a comprehensive method facilitate physician engagement in improvement
• Address the loss of autonomy or the challenge to professional identity that often blocks physician engagement
• Draw lessons from the case example that can be applied in their own organization

Presenters: Silversin, J., DMD, DrPH, President, Amicus, Inc.; Long, G., MD, Chief Medical Officer, ThedaCare
M3: Caring for Patients with Complex Needs

Participants in this minicourse will be immersed in a team-based, patient-centered approach to the evaluation and support of the “hot-spot” population: the 10% of patients who incur 50% of the expenses in any given year. With patient-advisors leading the way, participants will learn how to manage care for patients with multiple chronic conditions while also supporting them via a patient activation strategy.

After this presentation, participants will be able to:

- Design a service for providing care to complex patients via human-centered strategies and with the ongoing support of patient-advisors
- Assess both clinical and financial risk for patients to stratify care to meet their needs
- Customize a patient-centered approach to an individual patient that is based on reliable assessment tools, cross-references the patient’s activation level with the challenges he or she faces, and focuses on the patient’s goals via “real-playing” exercises
- Implement team care via protocols and therapeutic relationships to promote patient activation

Presenters: Glaseroff, A., MD, Co-Director, Stanford Coordinated Care, Stanford University Medical Center; Valcourt, S., RN, CNS, Clinical Nurse Specialist, Stanford Coordinated Care; Coleman, D., CMA, Patient Care Coordinator, Stanford University Medical Center; Travers, C., LCSW, Licensed Clinical Social Worker, Stanford Coordinated Care; Michelson, S., Manager of Perioperative Education/Patient, Stanford Hospital and Clinics; Lindsay, A., Co-Director Stanford Coordinated Care, Stanford University

M4: Care Management in the PCMH: Results from a Two-Year Pilot and Care Manager Training and Practice Integration

This session will present evaluation results from a two-year pilot program that tested provider-delivered care management (PDCM) in patient-centered medical home (PCMH) practices among over 250 Michigan providers. The PDCM pilot led to the Multi-payer Advanced Primary Care Practice (MAPCP) demonstration (currently in progress)—a full PDCM program conducted in conjunction with a three-year project supported by the Centers for Medicare & Medicaid Services (CMS) and based on the award-winning PCMH program in Michigan.

After this presentation, participants will be able to:

- Disseminate evaluation results from an innovative two-year pilot testing a PDCM model in a clinical setting
- Outline the process of expanding this pilot to a statewide program
- Utilize the lessons learned to provide practical tips and instruction on implementing similar PDCM programs in provider practices

Presenters: Mason, M., MHSA, Enhancing Health Care Value Business Consultant, Blue Cross Blue Shield of Michigan; Malouin, J., MD MPH, Associate Medical Director, Faculty Group Practice, University of Michigan Health System; Rajt, L., MSW, Senior Health Care Analyst, Blue Cross Blue Shield of Michigan; Beisel, M., RN, MSN, Project Manager, University of Michigan Health System; Tao, M., Director, Clinical Epidemiology and Biostatistics, Blue Cross Blue Shield of Michigan; Taylor, K., Site Medical Director, Integrated Health Associates
M5: PCMH Toolkit: Creating Effective Teams, Population Health, Patient Partnerships, and Workforce Systems for Success

Chesapeake Conference Rooms: Chesapeake J-L

Since 2009, Cambridge Health Alliance (CHA) has been on a journey to transform a safety net system into an accountable care organization (ACO) with a patient-centered medical home (PCMH) model of care, and its efforts have been nationally recognized by Robert Wood Johnson Foundation, IHI, and the US Department of Health and Human Services. Members of the CHA transformation team will present a PCMH “starter kit” that introduces participants to the three elements of a core infrastructure on which they can build their own transformation initiative: (1) high-functioning teams to achieve population health, (2) care management, and (3) patient engagement in redesign. The CHA transformation team will share change strategies, tool kits, lessons learned, and initial results and invite participants to design their own transformations.

After this presentation, participants will be able to:

- Identify the strategies required to develop high-functioning teams, using models from the business school literature and the lessons learned at CHA
- Develop a robust improvement framework for the workforce strategies needed to create high-functioning teams
- Implement chronic disease and complex care management in a team-based care system
- Integrate patients into practice improvement teams

Presenters: Stout, S., MD, VP of Patient Centered Medical Home Development, Cambridge Health Alliance; Meisinger, K., MD, Medical Director, Cambridge Health Alliance; Margolius, D., MD, Internal Medicine Resident, University of California San Francisco; Frank, A., MSW, MPH, Program Manager for PCMH Development, Cambridge Health Alliance; Mann, Z., MA, Patient Lead, Cambridge Health Alliance; Watt, G., Director of Care Management, Cambridge Health Alliance; Chamberlin, M., Clinical instructor, Cambridge Health Alliance; Santiago, O., Performance Improvement, Cambridge Health Alliance; Jordan, D., MS, Assistant Cooperative Education Coordinator, Northeastern University

M6: Cultivating Frontline Improvement Capabilities

Chesapeake Conference Rooms: Chesapeake 5

Health care improvement has proven not to be an easy undertaking. With a variety of improvement methodologies having produced a variety of outcomes, we now know that the achievement of desired improvements is not a predictable process. This all-day session will focus on specific structures, processes, and designs that can cultivate the improvement capability of all staff at the front line of care. Participants will have an opportunity to explore the possibilities of applied microsystem theory, including clear measures, leadership support, and team coaching, for devising more predictable improvement plans for their organizations.

After this presentation, participants will be able to:

- Describe the essential supportive infrastructures, including leadership, required for frontline teams to develop their improvement capabilities
- Design an improvement strategy, from the vision to the ways in which the frontline teams will be supported within the organization
- Detail the ways in which team coaching can cultivate improvement capabilities

Presenters: Harrison, S., Service Improvement Manager, Sheffield Teaching Hospitals; Geary, U., MBBCh BAO, FRCP, FRCSEd, FCEM, Consultant in Emergency Medicine, St. James's Hospital; Hess, A., NP, MSN, MS, President, Clinical Performance Management Inc; Anderson, D., Community Health Center; McIntosh, I., Program Director, Healthcare, Cystic Fibrosis Canada; Godfrey, M., PhD, MS, BSN, Co-Director, The Microsystem Academy Instructor, The Dartmouth Institute for Health Policy and Clinical Practice; Oliver, B., PhD, MS, MPH, APRN-BC, Assistant Professor, Massachusetts General Hospital Institute of Health Professions
Building on Intermountain’s Mental Health Integration (MHI), IHI’s Triple Aim, and integrated care for Medicare-Medicaid beneficiaries, this minicourse will address the upstream determinants of health for high-needs populations, integrating efficient, evidence-based financial incentives to engage patients, families, and communities. As they learn how to design community centers of health that produce consumer value and reward primary care team relationships, participants will also be instructed in creating population measurement tools that fit their local delivery transformations.

After this presentation, participants will be able to:

• Identify and learn integration strategies to address social conditions that impact individuals’ health
• Create a set of values and outcomes that make the most difference in the lives of individuals and communities
• Design an idealized community-based center that operationalizes these values into a viable health enterprise

Presenters: Reiss-Brennan, B., PhD, APRN, CS, Mental Health Integration Director, Intermountain Healthcare; Boudreau, K., MD, Chief Medical Officer, BMC HealthNet Plan; Laderman, M., MSPH, Research Associate, Institute for Healthcare Improvement

Participants in this Minicourse will have an opportunity to address all that goes into providing excellent, efficient services for the last years of long lives marked by multiple chronic conditions, progressive disability, high costs, and fragile balance with the environment. Specifically, this session will discuss how to identify and enroll frail persons, adapt services to match needs, develop and optimize individual care plans, integrate social services and health care, and monitor and manage the local care system. Besides offering demonstrations, resources, and toolkits, the session will address production system redesign and advocacy and provide practical examples.

After this presentation, participants will be able to:

• Test the best tools and strategies for identifying and serving frail elders
• Construct monitors of quality and cost relevant to this population
• Discuss the business models and policy changes that could enable improvement
• Apply insights to build a plan for better serving high-needs patients in their own community, at lower cost

Presenters: Lynn, J., MD, MA, MS, Director, Center for Elder Care and Advanced Illness, Altarum Institute; Stanley, H., MD, Physician, Altarum Institute; Montgomery, A., Senior Analyst, Altarum Institute

This interactive Minicourse will focus on the principles and skills of Motivational Interviewing (MI), which can be applied by an entire health care team, even a team pressed for time. Through discussion and practice, participants will be able to understand and experience a variety of techniques to support behavior change and gain the confidence to use them in practice. The session will also explore how to build these approaches into daily routines and continue to build skills beyond this introductory experience.

After this presentation, participants will be able to:

• Apply the MI spirit in conversations about behavior change
M10: The Courage to Lead in Uncertain Times

Chesapeake Conference Rooms: Chesapeake 8-9

Today’s leaders must bring more than technical skills to meeting current challenges. They must be open, authentic, and courageous as they lead others in solving complex issues and generative in managing the inevitable tension in this work. This session uses the Center for Courage & Renewal’s Circle of Trust® approach and Parker Palmer’s Habits of the Heart to help participants access their inner resources to deepen their leadership skills, stay resilient, and engage others in working constructively in the midst of change.

After this presentation, participants will be able to:

- Practice guidelines that foster relational trust in groups
- Demonstrate the use of inquiry and reflection as tools for advancing leadership skills and addressing change
- Experience the courage, integrity, and compassion of leading from within

Presenters: Sherman, H., MD, FAAP, Program Director, Health Care, Center for Courage & Renewal; Lewis, M., MD, Independent educator, No Organization

M11: Training for the Practice-Based Care Manager

Chesapeake Conference Rooms: Chesapeake 10

This Minicourse will prepare practice-based care managers to proactively identify and coordinate the care of their practice’s highest-risk patients. Key topics to be covered include identifying patients for care management, tracking patients via a high-risk registry, setting up a transitional care support system, developing and maintaining shared care plans, and providing disease management and self-management support. By staying ahead of emerging issues, care managers can help prevent costly complications and improve patients’ quality of life.

After this presentation, participants will be able to:

- Understand the roles and responsibilities of practice-based care managers, as well as the basics of disease management, self-management support, and transitional care support
- Assess patient risk, identify patients for care management services, and stratify interventions based on risk
- Set up and use a high-risk patient registry
- Develop and maintain shared care plans, embedding care management within the care team
- Coordinate transitional care support systems between multidisciplinary teams
- Identify how to embed care management within the care team.
- Learn how to coordinate transitional care support systems between multi-disciplinary teams.

Presenters: Edwards-Abbotts, J., Quality Improvement Coach, HealthTeamWorks; Gabbay, R., MD, PHD, FACP, Chief Medical Officer, Joslin Diabetes Center; Bricker, P., MBA, Research Coordinator, Penn State Hershey Medical Center
M12: What an Office Practice Can Do to Improve Care Transitions

Chesapeake Conference Rooms: Chesapeake 11

This Minicourse will address important questions for those who handle care transitions in their practice. Do they know when one of their patients has been discharged from the hospital? Are they prepared for that first post-discharge visit? Do they know how to use the electronic health record (EHR) to care for those patients transitioning from the hospital to a skilled nursing facility? This minicourse will identify the key steps in caring for and supporting patients as they transition across settings.

After this presentation, participants will be able to:

- Identify the key steps an office practice must take to improve care transitions
- Communicate and coordinate with their patients and with other care providers
- Apply lessons from the case presentations to their own practice

Presenters: Schall, M., MA, Senior Director, Institute for Healthcare Improvement; Bergeson, S., MD, Medical Director Quality, Allina Health System; Holly, J., MD, CEO, Southeast Texas Medical Associates; Wendt, L., RN, BA, CPHQ, System Director of Quality, UnityPoint Health; Tumilty, S., Senior Project Manager-Quality, UnityPoint Clinic; Barnes, C., PT, DPT, GCS, Executive Program Consultant, Kaiser Permanente

Sunday, March 9: Receptions and Meals

1:45 PM - 2:00 PM
- MCBk1: Minicourse Break 1
  Chesapeake Conference Rooms: Chesapeake Foyer

4:00 PM - 4:15 PM
- MCBk2: Minicourse Break 2
  Chesapeake Conference Rooms: Chesapeake Foyer

Monday, March 10: Receptions and Meals

6:30 AM - 8:30 AM
- ACB1: Attendee Continental Breakfast
  Potomac Ballroom: Potomac AC Foyer

9:00 AM - 9:30 AM
- GCB1: General Conference AM Break

10:30 AM - 11:00 AM
- LLAM: Learning Lab AM Break

12:30 PM - 1:30 PM
- GCL1: General Conference Lunch
  Prince George Exhibit Hall D
Monday, March 10: Keynotes
8:00 AM - 9:00 AM
Key1: Keynote One: Derek Feeley
Potomac Ballroom : Potomac Ballroom A/B

Derek Feeley joined IHI as Executive Vice President in September 2013. At IHI, Derek has executive level responsibility for driving IHI’s strategy across five core focus areas; Patient Safety; Patient and Family Centred Care; Quality, Cost and Value; Population Health; and Improvement Capability. His work is international in scope, guiding work to deliver IHI’s mission to improve health and care across the world. Prior to taking up his current role, Derek had been Director General (DG) Health and Chief Executive of the National Health Service (NHS) in Scotland since November 2010. From January 2011, the DG role was extended to cover Health and Social Care. He was the principal adviser to Scottish Ministers on health and care issues and he provided direction to the work of NHS Boards in ensuring the delivery of high quality healthcare. Derek has had a varied background in policy analysis during thirty years in public service. From 2002 to 2004, he spent two years as Principal Private Secretary to Scotland's First Minister. Thereafter, Derek moved on to work on developing a framework for service redesign in the NHS. He was a 2005-06 Harkness/Health Foundation Fellow in Health Care Policy and spent a year in the United States working with Kaiser Permanente and the Veteran's Health Administration. Derek was appointed as Director of Healthcare Policy and Strategy on his return. In that role he was responsible for advising the Scottish Government on all healthcare quality issues, including patient safety, and he also led on healthcare information technology.

Presenters: **Feeley, D.**, Chief Executive, Scottish Government Health Department
Primary care was in decline in the early part of this millennium. Staff burnout was on the increase while incomes were stagnant or declining, and medical students were flocking to other specialties. Two developments have improved the outlook. The Patient-centered Medical Home model offers a new vision for a more effective and sustainable primary care, and ties that vision to payment reform. And the Affordable Care Act explicitly identifies a robust primary care sector as the foundation of a more effective and affordable American care system. Whether a transformed primary care sector can impact health care spending will depend on its ability to effectively manage the growing number of patients with complex, chronic illness. In this session, we will describe the practice characteristics and capabilities that influence primary care's capacity to manage complex illness and coordinate care. We will also consider current trends in primary care transformation and organization (e.g., ACOs), and their impact on chronic care.

After this presentation, participants will be able to:

• Analyze the impact of transformation to Patient-centered Medical Homes on health outcomes, especially for patients with complex chronic illness, and health care costs
• Describe the organizational and care delivery characteristics of primary care practices that provide superb chronic care at relatively low total cost
• Discuss the potential impacts of different payment strategies and organizational arrangements on primary care’s ability to transform and provide excellent chronic care

Presenters: Wagner, E., MD, MPH, FACP, Director, Group Health Cooperative

Coastal Medical provides predominantly primary care to 105,000 patients, roughly 10% of the Rhode Island population, in 20 sites across the state. Coastal is rapidly evolving from a traditional physician-owned group practice to a primary care–driven accountable care organization (ACO). The majority of Coastal patients are now covered by one of five shared savings contracts. This learning lab will cover Coastal’s organizational strategy, contracting, operations, infrastructure development, financing, analytics, and communications, as well as specific clinical programs.

After this presentation, participants will be able to:

• Identify core competencies for provision of accountable care by a primary care-driven ACO
• Develop specific strategies for transforming a primary care group practice to an ACO, including infrastructure development, quality improvement, payment reform, patient engagement, customer service, and specific clinical programs

Presenters: McGookin, E., Chief Medical Officer, Coastal Medical; Moss, M., COO, Coastal Medical; Kempner, S., MD, Internal Medicine Medical Director, Coastal Medical, Inc; McHale, K., Director, Marketing & Communication, Coastal Medical; Kurose, A., MD, President & CEO, Coastal Medical
L2: Driving Primary Care Excellence to Enhance Performance and Value

Chesapeake Conference Rooms : Chesapeake 4-6

Primary care is the foundation for all successful health systems. Clinical quality, cost, value, experience, and operational performance all matter. This session will offer a structured improvement approach through change concepts, a case study, and examples of results to help primary care leaders drive excellence across multiple domains and contribute to the value and business case for their primary care organizations.

After this presentation, participants will be able to:

- Describe a framework for improving operational performance and value in the primary care setting
- Identify key strategies that can be applied in a primary care practice environment to enhance performance and value

Presenters: **St. Andre, C., MHSA**, Principal, CSI Solutions, LLC; **Chaufournier, R., MHSA**, President and CEO, CSI Solutions, LLC

L3: From Firefighting to Fired Up: Creating Patient Value with Frontline Engagement

Chesapeake Conference Rooms : Chesapeake 8-9

Palo Alto Medical Foundation adopted a lean operating system to improve efficiency and reduce the cost of care. The frontline daily engagement system includes daily department huddles, weekly stand-up meetings, frontline improvement projects, Gemba walks, care design based on model lines, and reductions in clinical variation. This approach provides physicians and staff with the infrastructure to develop standardized care. Participants will learn how to implement this approach to create frontline value at their institution.

After this presentation, participants will be able to:

- Identify opportunities in their organization or department for frontline engagement
- Develop plans for frontline engagement using the lean tools presented
- Prepare an implementation plan for their organization or department

Presenters: **Falkenburg, J.**, Physician, Palo Alto Medical Foundation; **Holmes, L., MD**, Physician, Palo Alto Medical Foundation; **Shapiro, L., MD**, Foundation Managed Care Medical Director, Palo Alto Medical Foundation; **Henderson, V., RN, MBA**, Director of Primary Care, Palo Alto Medical Foundation; **Badani, R.**, Division Head Primary Care, Palo Alto Medical Foundation; **Weirich, E., MD**, Physician and Variation Reduction Physician Champion, Palo Alto Medical Foundation

L4: Getting to "Always": Using Teach-back to Maximize Patient Learning

Potomac Ballroom : Potomac 1-2

Patient learning about their care and self-care can be maximized through reliable use of teach-back. In this session, clinicians in hospitals and community settings will have an opportunity for in-depth training in the tools and processes of the Always Event Always Use teach-back for every patient and family.

After this presentation, participants will be able to:

- Maximize their use of the free, interactive learning modules at www.teachbacktraining.com to teach staff across the care continuum and assess their competence
- Form a reliable habit of using Teach-back with all patients and families in the course of their daily work, whether in hospitals, home care settings, or office practices

Presenters: **Nielsen, G., BSHCA, FAHRA**, IHI Fellow and Faculty, No Organization; **Wendt, L., RN, BA, CPHQ**, System Director of Quality, UnityPoint Health
L5: Group Medical Care: Engaging Patients and Improving Health Outcomes

Chesapeake Conference Rooms : Chesapeake 10-12

This presentation will review the nine essential elements to setting up and coordinating a sustainable group visit program. It will also demonstrate the ways to improve health outcomes by engaging patients in the group visit model of care. Participants will learn techniques and strategies to facilitate group visits and compare and contrast self-management goal-setting in a group environment. Participants will also learn how to create appropriate group content and outcomes for group care models.

After this presentation, participants will be able to:

• Demonstrate how utilizing the practice of engaging patients through facilitated groups and self management goal setting result in improved health outcomes
• Illustrate many ways in which group care can be applied across the spectrum of care to include chronic disease, prevention and acute care
• Detail the process for developing and managing groups in an integrated healthcare setting

Presenters: Troyer, J., Vice President of Operations, Clinica Campesina; Vela Brol, M., MPH, MSN, Family Nurse Practitioner, Clinica Family Health Services

L6: Having the Conversation About End-of-Life Care: Personal and Professional Experiences

Chesapeake Conference Rooms : Chesapeake 7

During this session, members of The Conversation Project and Conversation Ready teams will lead participants through the Conversation Project starter kit and The Conversation Ready principles. Participants will have opportunities to practice their responses to difficult scenarios, and session leaders will aid them in thinking about how to make their practice Conversation Ready. This interactive session will include time for participants to reflect on their own wishes for end-of-life care, share personal and professional experiences, and develop plans for having these conversations in their own settings.

After this presentation, participants will be able to:

• Describe The Conversation Project and the role of both health care providers and individuals in discussing personal wishes for end-of-life care
• Develop a conversation action-plan for both professional and personal conversations
• Identify the barriers to having end-of-life conversations and the strategies and tools available to promote them

Presenters: Warshaw, H., Executive Director, The Conversation Project; McCannon, J., MD, Assistant in Medicine, Massachusetts General Hospital

L7: Healthcare 3.0: The Nuka System of Care

Potomac Ballroom : Potomac 3-4

Southcentral Foundation, which was awarded the Malcolm Baldrige National Quality Award in 2011, has been a National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH)–Level 3 (highest level) since 2010. This session will review ways to go beyond the starting point of PCMH standards to implement Healthcare 3.0, including approaches to creating and sustaining relationships as well as recruiting, retaining, and training a workforce. Managing information, from data systems to support for the new approach will also be discussed.

After this presentation, participants will be able to:

• Review the transformational journey of an entire health care system from physician-centered to patient-centered to customer-owned
• Describe how a health care system redesigned and built from the perspective and ownership of the community has better outcomes than a faster and leaner version of the current medical system
• Review approaches to moving beyond PCMH to Healthcare 3.0, including workforce and information management and sustaining relationships

Presenters: **Tierney, S., MD**, CMIO/Medical Director Clinic Quality Improvement, Southcentral Foundation; **Gottlieb, K., MBA, DPS(hc), President and CEO, Southcentral Foundation**

### L8: Building Frontline Improvement Capability

**Chesapeake Conference Rooms : Chesapeake G-I**

Building improvement knowledge, skills, and abilities at the front lines of care requires more than technical knowledge and cannot be implemented through “plug and play” methods. Essential support of frontline staff in practicing, reflecting on, and learning improvement requires team coaching for cultural transformation. In this session, participants will learn how to adapt and use the Team Coaching Model to develop sustainable improvement capabilities in their organization.

After this presentation, participants will be able to:

• Explore resources that promote and advance improvement at the frontlines of healthcare, including the Team Coaching Model
• Describe how the Team Coaching Model has been used and adapted in several different countries to meet improvement goals

Presenters: **Godfrey, M., PhD, MS, BSN**, Co-Director, The Microsystem Academy Instructor, The Dartmouth Institute for Health Policy and Clinical Practice; **Harrison, S., Service Improvement Manager, Sheffield Teaching Hospitals; Nilsson, A., Project manager, Swedish Association of Local Authorities and Regions; Geary, U., MBBCh BAO, FRCPI, FRCSEd, FCEM, Consultant in Emergency Medicine, St. James's Hospital**

### L9: Implementing Health Coaching in a Practice

**Potomac Ballroom : Potomac 5-6**

Health coaching for patients includes making sure that they understand their chronic condition and their care plan, engaging them in action-plans for behavior change, and assisting them with medication adherence. This session will present new data from a pioneering randomized controlled trial that uses medical assistant health coaches. Participants will receive training in the fundamentals of health coaching and be engaged in discussion of the business case for health coaching. The session will also provide and invite examples of how practices can implement health coaching.

After this presentation, participants will be able to:

• Engage various audiences in discussions on implementing health coaching and describe the evidence showing that using medical assistants as health coaches can improve chronic illness outcomes
• Use health coaching skills in patient-centered collaboration to manage chronic conditions
• Draft a pilot plan to implement a health coaching program specific to their primary care practice or clinic

Presenters: **Ghorob, A., MPH**, Trainer, University of California San Francisco; **Najmabadi, A., Health Coach, University of San Francisco**
L10: Managing Conflict on Health Care Teams

Potomac Ballroom : Potomac C

Differences are inevitable in multidisciplinary teamwork, but the pressures, fast pace, and complexity of health care can escalate such differences into conflict. Although effective resolution is critical to providing the best patient care, it is all too easy for the parties involved to either stop trying to solve the problems or get stuck in intractable arguments. In this session, participants will learn principles to help them move beyond these two reactions and transform conflict into an opportunity to develop effective collaboration. Selected skills will also be practiced.

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 identifying and using emotions during conflict
• Demonstrate how to negotiate in the face of differences in authority

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

L11: Team-Based Care: Effective Innovations in Practice

Potomac Ballroom : Potomac D

Primary care is in flux. As the population ages and newly insured individuals seek care, traditional physician-centered practice will give way to team care: the involvement of nonprovider staff in the treatment and healing of patients. Although little academic attention has been given to how team membership is determined or how teams work together, innovative practices are already attempting to meet patient needs by experimenting with team structures and role definitions. Participants in this session will hear their stories.

After this presentation, participants will be able to:

• Describe the evidence showing that team-based primary care leads to better patient health outcomes
• Highlight creative and effective strategies for using primary care team members differently
• Offer real-world examples of the innovative team roles that have been played by medical assistants, nurses, and physicians in high-performing primary care practices

Presenters: Coleman, K., MSPH, Research Associate, MacColl Institute for Healthcare Innovation; Wagner, E., MD, MPH, FACP, Director, Group Health Cooperative

L12: Site Visit to The Kaiser Permanente Center for Total Health: An Interactive Tour of the Future of Health and Health Care
Join us on an tour of the interactive Kaiser Permanente Center for Total Health, and step into the future of health. Located in the heart of Washington, D.C., the 16,000 foot meeting and exhibit center is full of hands-on opportunities to explore innovations in total health and community care.

Explore Kaiser Permanente's electronic health management tools - a benefit to patients and physicians alike. Visit the "Everybody Walk" campaign wall to learn how to make the members of your community more active. See how Kaiser Permanente is experimenting with new technologies like telemedicine, wearable health tech, portable ultrasound, and more. The tour will culminate with an interactive session hosted by Ed Ellison, MD, Executive Medial Director and Chairman of the Board, Southern California Permanente Medical Group. This is your chance to pick the brain of the Medical Director of Kaiser Permanente's largest region. You'll also hear firsthand from Patient, Gilbert Salinas, about his experience with the system.

Learn, share, engage, and connect with your fellow conference attendees on this unique learning and networking experience. We'll see you in the future!

For more information on the Center and to view a 2-minute video tour, visit www.CenterForTotalHealth.org.

Presenters: Ellison, E., MD, Executive Medical Director, Kaiser Permanente; Salinas, G., MPA, Director Patient Centered Care, Rancho Los Amigos National Rehabilitation Center

Monday, March 10: General

12:30 PM - 1:30 PM

NC: Lunchtime Networking Circle: Reflecting Together on Riding the Waves

National Harbor 6-7

As leaders we often feel isolated as we face the challenge of holding on to our integrity when we are buffeted by forces around us. The more we turn to our inner leadership to know ourselves and to each other for companionship, the more able we are to stay vital and capable in our roles of shepherding change. Join us for reflection and conversation on how we can flourish and be effective in seas of change.

After this presentation, participants will be able to:

- Connect with other leaders in a safe and trustworthy conversational space
- Reflect individually and together on how to lead with courage and integrity in turbulent times

Presenters: Sherman, H., MD, FAAP, Program Director, Health Care, Center for Courage & Renewal

Monday, March 10: Workshop A

1:30 PM - 2:45 PM

A1: Primary Care Transformation in Academic Medical Centers

Potomac Ballroom : Potomac Ballroom A/B

The transformation of primary care teaching practices is critical to our efforts to recruit and train the next generation of primary care providers and leaders. In July 2012, 19 Harvard Medical School practices from six organizations began a collaborative effort to change how they taught primary care. The change model used in this academic medical center included the creation of a learning community, practice facilitation, coaching, and direct financial support to integrate education and care redesign. This session will present the approach, early findings, and lessons learned in this collaboration.

After this presentation, participants will be able to:

- Describe an approach to launching a collaborative across academic primary care practices
• Describe early findings from the work at Harvard Medical School, including findings on leadership engagement, team structures, patient and provider satisfaction, and clinical process and outcome measures
• Identify key lessons learned that others can apply in transforming primary care teaching practices in academic medical centers

Presenters: Bitton, A., MD MPH, Associate Physician, Brigham and Women's Hospital; Ellner, A., MD, Co-Director, Harvard Medical School; Sugarman, J., MD, MPH, CEO, Qualis Health; Sevin, C., RN, MSN, NP, Director, Institute for Healthcare Improvement

RFA: Rapid Fire A: Behavioral Health Integration

Potomac Ballroom : Potomac C

Presentation 1: Creating more comprehensive primary care through better mental health integration
Benjamin Miller, University of Colorado - Denver

Presentation 2: The Nuts and Bolts of Behavioral Health Integration
Rachael Bowers, The Dimock Center

Presentation 3: Lessons from Missouri’s Statewide Collaborative
Laurel Simmons, CSI Solutions, LLC

Presentation 4: Bridging a Divide: Behavioral and Primary Care
Chase Gray, HealthTeamWorks

Presenters: Simmons, L., MS, Project Director, CSI Solutions; Gray, C., RN, Regional Director, HealthTeamWorks; Bowers, R., Pediatric Social Worker, Dimock Community Health Center; Miller, B., Assistant Professor, University of Colorado School of Medicine (For GME Residents and Faculty)

A2: Learning from Scotland’s National Safety Programme in Primary Care

Chesapeake Conference Rooms : Chesapeake 1-3

Although improving safety in primary care has unique challenges, Scotland’s national approach has managed to overcome a number of them. This session covers the experience of NHS Scotland in developing the Patient Safety Programme in Primary Care, which is now being implemented using a groundbreaking “collaborative-within-a-collaborative” methodology that engages all levels of staff. The tools, techniques, and results from developing and testing this program will also be presented.

After this presentation, participants will be able to:

• Understand patient safety in primary care in terms of the evidence-based improvement tools and methodology being used within NHS Scotland
• Discuss the global applicability of the NHS Scotland method
• Appreciate the importance of the human elements needed to improve patient safety and quality of care across the board

Presenters: Gillies, J., Improvement Advisor, Healthcare Improvement Scotland; Matthews, J., Head of Safety, NHS Healthcare Improvement Scotland
A3: A Palliative Care Medical Home Model

Incorporating the tenets of a medical home model, this workshop will describe the implementation of a comprehensive palliative care program for patients with a life expectancy of one to two years or less in a 1,000-physician multispecialty group. This program has utilized a multidisciplinary team that puts patients and their families at the center of care and coordinates patients’ care as they travel in and out of unaffiliated care silos, from hospitals, nursing homes, and hospices to homes and physician offices.

After this presentation, participants will be able to:

- Identify the key components of a palliative care medical home model
- Develop palliative care process and outcome metrics that meet the Triple Aim

Presenters: Tapper, S., MD, Program Director-Palliative Care, PAMF; Morris, W., MD, Physician, Palliative Care and Supportive Services, Palo Alto Foundation Medical Group

A4: A Systematic Approach to Preventive and Chronic Care

The Southern California Permanente Medical Group (SCPMG) has developed Proactive Office Encounter (POE), an in-reach system that engages staff and physicians to proactively address both preventive and chronic care needs at each patient encounter in primary or specialty care. Since its inception, POE has contributed to sharp improvement in the Southern California region’s clinical quality performance, including double-digit improvements in colorectal cancer screening, advice to quit smoking, and blood pressure control.

After this presentation, participants will be able to:

- Identify opportunities to create a highly reliable care process that leads to improved quality and patient care experiences, fewer missed opportunities to improve preventive care and chronic disease management, and increased efficiency
- Optimize clinician support in both specialty care and primary care
- Apply similar workflows and tools that promote partnerships between physicians and health care teams and consistently support physician practice and empower and engage staff

Presenters: Kanter, M., MD, Medical Director, Quality & Clinical Analysis, Kaiser Permanente Regional Quality and Risk Management; Andrews, K., BS, Regional Proactive Care and Outreach Support Program Manager, Kaiser Permanente Regional Quality and Risk Management

A5: Project ECHO: Technology Driven Innovations in Primary Care

Lack of access to specialty care in rural and underserved areas is a disservice to patients and a source of frustration for providers. Project ECHO is a groundbreaking model of care delivery that connects primary care providers with an array of specialists via condition specific virtual clinics. The result - a burgeoning cadre of empowered primary care providers delivering high quality, cost-effective care to patients with chronic, common, and complex conditions within their own communities.

After this presentation, participants will be able to:

- Discover transformative ways in which Project ECHO has expanded the capacity of primary care providers to improve access, maintain outcomes, and reduce costs
Assess opportunities within your own organization to leverage technology to empower primary care providers and improve patient care

Presenters: Loehr, S., MD, MPH, Director, Institute for Healthcare Improvement; Arora, S., MD, FACP, FACG, Director, Project ECHO, University of New Mexico Health Sciences Center; Scott, J., Asst Prof, University Of Washington

A6: Engaging Trainees and Students in Primary Care Delivery Transformation

Chesapeake Conference Rooms : Chesapeake 7

Providers in academic primary care face daunting challenges: antiquated fee-for-service reimbursement, numerous part-time providers, and inexperience in teaching innovative models of care. Exposing trainees (resident trainees and students) to new models of primary care delivery and engaging them in the transformation process is key to encouraging this next generation to pursue a career in primary care. This session will highlight strategies that can be used in participants’ own academic practices to keep students and trainees engaged in the transformation process.

After this presentation, participants will be able to:
- Identify the challenges facing efforts to redesign primary care delivery in academic practices
- Understand the benefits of student and trainee involvement in clinical innovation efforts
- Develop a catalog of types of clinical innovation projects in which students and trainees can successfully participate
- Identify the best ways to mentor students and trainees engaged in transformation efforts

Presenters: Margolius, D., MD, Internal Medicine Resident, University of California San Francisco; Morris-Singer, A., MD, President, Primary Care Progress

A7: Implementing Team Care in a Medical Home

Potomac Ballroom : Potomac 5-6

Union Square Family Health Center has used a team-based care model for all aspects of patient care since 2005. In this environment, all team members deliver direct patient care, even receptionists. The complex conditions of the patient population served by this safety net clinic also foster a team-based approach to patient care. In this session, participants will learn why a team structure and team work flows are key to success in this setting, and they will also have a hands-on learning experience.

After this presentation, participants will be able to:
- Develop concrete work flows for team care at their site in a series of exercises based on their own clinic structure
- Implement a quality improvement structure as the basis of all of the work of their teams as they use the tools available to them

Presenters: Meisinger, K., MD, Medical Director, Cambridge Health Alliance; Rivera, N., LPN, Cambridge Health Alliance; Alves, P., Medical Assistant, union square family medicine
A8: The PCMH and the Care of Complex, High-Cost Patients

Chesapeake Conference Rooms : Chesapeake 4-6

Denver Health has worked on finding the best ways to integrate initiatives focused on high-risk, high-cost patients into an existing patient-centered medical home (PCMH) framework. In this session, we will review methodologies for identifying high-risk patients and determining the aspects of their care that can be provided in the PCMH setting and the aspects that require external resources or interventions. Using a PCMH-based, multidisciplinary case conference model, we will discuss several innovations in care delivery for this patient population.

After this presentation, participants will be able to:

• Demonstrate a model that applies PCMH requirements to high-cost, high-risk populations
• Identify practice redesign concepts to integrate the care of this high-risk population into the medical home
• Detail the ways in which a multidisciplinary case conference model is effective in addressing and managing the needs of high-cost, complex patients

Presenters: Lee, J., MHS, Medical Student, University of Colorado Anchutz Medical Center; Loomis, L., MD, MSPH, Director Family Medicine, Denver Health; Gutierrez, P., Associate Chief Operating Officer, Denver Health; Johnson-Simmons, J., MPA, Clinical Operations Coordinator, Denver Health

A9: Measure Up/Pressure Down: Improving Blood Pressure Control in Washington, DC

Chesapeake Conference Rooms : Chesapeake 10-12

The goal of the American Medical Group Association’s Measure Up/Pressure Down campaign is 80% blood pressure control in the populations of participating medical groups by 2016. Leaders from three District of Columbia–area health care systems—Mid-Atlantic Permanente Medical Group, Johns Hopkins Community Physicians, and MedStar Physician Practices—will describe their interventions, results, and community collaborations.

After this presentation, participants will be able to:

• Identify two key tactics deployed by health care systems to improve blood pressure control
• Identify two key opportunities to create community-wide quality collaboration
• Determine the aspects of an EHR that can be leveraged to better engage patients in chronic condition management

Presenters: Penso, J., MD, Chief Medical and Quality Officer, American Medical Group Association; Territo, J., MD, Associate Medical Director of Quality, Kaiser Permanente; Basch, P., MD, FACP, Medical Director, Ambulatory EHR and Health IT Policy, MedStar Health; Albert, M., MD, Regional Medical Director, Baltimore/North, Johns Hopkins Community Physicians

A10: Managing Populations to Achieve Triple Aim Outcome

Chesapeake Conference Rooms : Chesapeake J-L

This session will provide a framework for successfully managing populations and achieving Triple Aim outcomes across a variety of populations. The framework includes a driver diagram identifying the six vital factors that combined can yield Triple Aim results. Participants will be given examples of how the framework has been applied—especially by one of the top-performing pioneer accountable care organizations (ACOs)—and the results achieved for various populations. Information will be shared on how to replicate the approach across systems and populations to achieve similar results.

After this presentation, participants will be able to:

• Describe a proven framework to apply to any population to achieve Triple Aim results
A11: Meaningful Use of EHRs to Improve Patient Care

Potomac Ballroom : Potomac D

Meaningful use (MU) of electronic health records (EHRs) can be a framework to improve both the provider and patient experience in a clinical setting. Despite incentives, however, achieving MU has been challenging for community health centers (CHCs) in New York City. This presentation will explore how a regional extension center provided quality improvement support to CHCs in New York City to promote patient engagement and improve quality of care through the achievement of MU.

After this presentation, participants will be able to:

- Explain how meaningful use of EHRs can improve the health of the populations served by CHCs in New York City by allowing them to develop and track quality and health outcome measures specific to the local community.
- Discuss strategies for using EHR data to improve quality of care for patients.
- Develop work flows that promote patient engagement and support achievement of MU.

Presenters: Magno, J., MPA, Project Manager, New York City Department of Health and Mental Hygiene; Diaz, L., Clinical Quality Specialist, New York City Department of Health.

A12: Brief Action Planning: Supporting Healthy Changes

Potomac Ballroom : Potomac 3-4

Most medical care involves change: take a medicine, change a behavior or lifestyle habit, get a screening. Many practices know that supporting patients' behavioral change is important, but how do staff find the time to do so? One answer is provided by Brief Action Planning (BAP), a structured and highly efficient process based on Motivational Interviewing (MI). This session provides an overview of BAP as well as practical experience from the field.

After this presentation, participants will be able to:

- List the steps and sequencing of BAP skills.
- Describe BAP's contribution to self-management support in outpatient settings.

Presenters: Davis, C., MN, ARNP, Program Director, Geriatric Nurse Practitioner, Centre for Comprehensive Motivational Interventions; Gutnick, D., MD, Assistant Professor of Medicine and Psychiatry, Bellevue Hospital Center; Reims, K., MD, Chief Medical Officer, CSI Solutions, LLC; Southey, C., Quality Improvement Advisor, Impact BC; Miller, D., CEO, Impact BC.
3:00 PM - 4:15 PM

B1: A Paradigm Shift from Healthcare to Health

Potomac Ballroom: Potomac Ballroom A/B

As we pursue population health, we come face to face with a startling reality: although most of our improvement efforts center on improvements in health care, poor access to health care drives only 10% of premature mortality. If our goal is focused not so much on health care access as on creating health for patients and communities, a very different set of improvement activities and change strategies emerges. In this session, participants will hear the stories of communities around the world that are transforming both health care and the health of their populations.

After this presentation, participants will be able to:

• Identify the differences and the linkages between improving health care and improving health
• Describe the ways in which communities and health systems around the world are bridging the gap between health care and health
• Integrate this shift in perspective into their own improvement work

Presenters: Stout, S., MD, VP of Patient Centered Medical Home Development, Cambridge Health Alliance

RFB: Rapid Fire B: The Care Continuum

Potomac Ballroom: Potomac C

Presentation 1: IHI’s Framework for Improving Care Transitions in the Community
Gail Nielsen, Fellow and Faculty, IHI

Presentation 2: Reducing Readmissions with Transitions in Care
Beth Heinz, HealthPartners

Presentation 3: Care Coordination across the Care Continuum
Leanne Roggemann, Fairview Medical Group

Presentation 4: Improving Communication & Readmissions
Michelle Mills, Colorado Rural Health Center

Presenters: Roggemann, L., Director of Nursing Services, Fairview Medical Group; Mills, M., CEO, Colorado Rural Health Center; Heinz, B., MSW, MHA, Vice President, Operations, Chief Operating Officer, Regions Hospital; Nielsen, G., BSHCA, FAHRA, IHI Fellow and Faculty, No Organization

B2: Learning from Scotland’s National Safety Programme in Primary Care

Chesapeake Conference Rooms: Chesapeake 1-3

Although improving safety in primary care has unique challenges, Scotland’s national approach has managed to overcome a number of them. This session covers the experience of NHS Scotland in developing the Patient Safety Programme in Primary Care, which is now being implemented using a groundbreaking “collaborative-within-a-collaborative” methodology that engages all levels of staff. The tools, techniques, and results from developing and testing this program will also be presented.

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Presenters: Gillies, J., Improvement Advisor, Healthcare Improvement Scotland; Matthews, J., Head of Safety, NHS Healthcare Improvement Scotland

**B3: A Palliative Care Medical Home Model**

*Potomac Ballroom: Potomac 1-2*

Incorporating the tenets of a medical home model, this workshop will describe the implementation of a comprehensive palliative care program for patients with a life expectancy of one to two years or less in a 1,000-physician multispecialty group. This program has utilized a multidisciplinary team that puts patients and their families at the center of care and coordinates patients’ care as they travel in and out of unaffiliated care silos, from hospitals, nursing homes, and hospices to homes and physician offices.

After this presentation, participants will be able to:

• Identify the key components of a palliative care medical home model
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Presenters: Tapper, S., MD, Program Director-Palliative Care, PAMF; Morris, W., MD, Physician, Palliative Care and Supportive Services, Palo Alto Foundation Medical Group

**B4: A Systematic Approach to Preventive and Chronic Care**

*Chesapeake Conference Rooms: Chesapeake 8-9*

The Southern California Permanente Medical Group (SCPMG) has developed Proactive Office Encounter (POE), an in-reach system that engages staff and physicians to proactively address both preventive and chronic care needs at each patient encounter in primary or specialty care. Since its inception, POE has contributed to sharp improvement in the Southern California region’s clinical quality performance, including double-digit improvements in colorectal cancer screening, advice to quit smoking, and blood pressure control.

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• Optimize clinician support in both specialty care and primary care
• Apply similar work flows and tools that promote partnerships between physicians and health care teams and consistently support physician practice and empower and engage staff

Presenters: Kanter, M., MD, Medical Director, Quality & Clinical Analysis, Kaiser Permanente Regional Quality and Risk Management; Andrews, K., BS, Regional Proactive Care and Outreach Support Program Manager, Kaiser Permanente Regional Quality and Risk Management
Lack of access to specialty care in rural and underserved areas is a disservice to patients and a source of frustration for providers. Project ECHO is a groundbreaking model of care delivery that connects primary care providers with an array of specialists via condition specific virtual clinics. The result— a burgeoning cadre of empowered primary care providers delivering high quality, cost-effective care to patients with chronic, common, and complex conditions within their own communities.

After this presentation, participants will be able to:
- Discover transformative ways in which Project ECHO has expanded the capacity of primary care providers to improve access, maintain outcomes, and reduce costs
- Assess opportunities within your own organization to leverage technology to empower primary care providers and improve patient care

Presenters: Loehr, S., MD, MPH, Director, Institute for Healthcare Improvement; Arora, S., MD, FACP, FACP, Director, Project ECHO, University of New Mexico Health Sciences Center; Scott, J., Asst Prof, University Of Washington

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Presenters: Meisinger, K., MD, Medical Director, Cambridge Health Alliance; Rivera, N., LPN, Cambridge Health Alliance; Alves, P., Medical Assistant, union square family medicine

**B8: The PCMH and the Care of Complex, High-Cost Patients**

*Chesapeake Conference Rooms: Chesapeake 4-6*

Denver Health has worked on finding the best ways to integrate initiatives focused on high-risk, high-cost patients into an existing patient-centered medical home (PCMH) framework. In this session, we will review methodologies for identifying high-risk patients and determining the aspects of their care that can be provided in the PCMH setting and the aspects that require external resources or interventions. Using a PCMH-based, multidisciplinary case conference model, we will discuss several innovations in care delivery for this patient population.

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**B9: Measure Up/Pressure Down: Improving Blood Pressure Control in Washington, DC**

*Chesapeake Conference Rooms: Chesapeake 10-12*

The goal of the American Medical Group Association’s Measure Up/Pressure Down campaign is 80% blood pressure control in the populations of participating medical groups by 2016. Leaders from three District of Columbia–area health care systems—Mid-Atlantic Permanente Medical Group, Johns Hopkins Community Physicians, and MedStar Physician Practices—will describe their interventions, results, and community collaborations.

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Presenters: Penso, J., MD, Chief Medical and Quality Officer, American Medical Group Association; Territo, J., MD, Associate Medical Director of Quality, Kaiser Permanente; Basch, P., MD, FACP, Medical Director, Ambulatory EHR and Health IT Policy, MedStar Health; Albert, M., MD, Regional Medical Director, Baltimore/North, Johns Hopkins Community Physicians
B10: Managing Populations to Achieve Triple Aim Outcome

Chesapeake Conference Rooms : Chesapeake J-L

This session will provide a framework for successfully managing populations and achieving Triple Aim outcomes across a variety of populations. The framework includes a driver diagram identifying the six vital factors that combined can yield Triple Aim results. Participants will be given examples of how the framework has been applied—especially by one of the top-performing pioneer accountable care organizations (ACOs)—and the results achieved for various populations. Information will be shared on how to replicate the approach across systems and populations to achieve similar results.

After this presentation, participants will be able to:

• Describe a proven framework to apply to any population to achieve Triple Aim results
• Utilize a roadmap for building and implementing a successful Triple Aim framework

Presenters: Knox, P., MS, BS, Executive Vice President, Chief Learning and Innovation Office, Bellin Health

B11: Meaningful Use of EHRs to Improve Patient Care

Potomac Ballroom : Potomac D

Meaningful use (MU) of electronic health records (EHRs) can be a framework to improve both the provider and patient experience in a clinical setting. Despite incentives, however, achieving MU has been challenging for community health centers (CHCs) in New York City. This presentation will explore how a regional extension center provided quality improvement support to CHCs in New York City to promote patient engagement and improve quality of care through the achievement of MU.

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• Explain how meaningful use of EHRs can improve the health of the populations served by CHCs in New York City by allowing them to develop and track quality and health outcome measures specific to the local community
• Discuss strategies for using EHR data to improve quality of care for patients
• Develop work flows that promote patient engagement and support achievement of MU

Presenters: Magno, J., MPA, Project Manager, New York City Department of Health and Mental Hygiene; Diaz, L., Clinical Quality Specialist, New York City Department of Health

B12: Brief Action Planning: Supporting Healthy Changes

Potomac Ballroom : Potomac 3-4

Most medical care involves change: take a medicine, change a behavior or lifestyle habit, get a screening. Many practices know that supporting patients' behavioral change is important, but how do staff find the time to do so? One answer is provided by Brief Action Planning (BAP), a structured and highly efficient process based on Motivational Interviewing (MI). This session provides an overview of BAP as well as practical experience from the field.

After this presentation, participants will be able to:

• List the steps and sequencing of BAP skills
• Describe BAP's contribution to self-management support in outpatient settings

Presenters: Davis, C., MN, ARNP, Program Director, Geriatric Nurse Practitioner, Centre for Comprehensive Motivational Interventions; Gutnick, D., MD, Assistant Professor of Medicine and Psychiatry, Bellevue Hospital Center; Reims, K., MD, Chief Medical Officer, CSI Solutions, LLC; Southey, C., Quality Improvement Advisor, Impact BC; Miller, D., CEO, Impact BC
Tuesday, March 11: Receptions and Meals

6:30 AM - 8:30 AM
- ACB2: Attendee Continental Breakfast
  Potomac Ballroom : Potomac AC Foyer

9:00 AM - 9:30 AM
- GCB2: General Conference AM Break

12:15 PM - 1:15 PM
- GCL2: General Conference Lunch
  Prince George Exhibit Hall D

Tuesday, March 11: Registration

6:30 AM - 1:30 PM
- Reg3: Registration
  Potomac Ballroom : Potomac A Foyer

Tuesday, March 11: Special Interest Breakfasts

7:00 AM - 7:45 AM
- SIB1: Transformational Change
  Potomac Ballroom : Potomac 1-2
  Transformational change is distinguished by radical breakthroughs in paradigms, beliefs and behavior. Albert Einstein said that “problems cannot be solved by the same level of thinking that created them.” As we venture into unprecedented times in health care, the opportunities and possibilities of Transformational Change are unlimited. Join Dr. Edward Ellison, Executive Medical Director for Southern California Permanente Medical Group and Kaiser Permanente Southern California, to explore the dimensions and depths of what radical change and holistic transformation can mean. Dr. Ellison will speak in terms of the power of using a systems approach - when the heart, mind, human behaviors, social systems, technology and the structures in which they exist are attended to equally - then welcomes open conversation and dialogue.
  Presenters: Ellison, E., MD, Executive Medical Director, Kaiser Permanente

- SIB2: New Approaches to Behavioral Health Improvement
  Potomac Ballroom : Potomac 3-4
  Meet your colleagues and learn about what others in the field are doing to improve the mental health of individuals and populations. We will share IHI’s emerging work in this area both in the US and globally. Please come prepared to discuss your ideas and experience!
  Presenters: Laderman, M., MSPH, Research Associate, Institute for Healthcare Improvement

- SIB3: Decreasing Risk and Cost for Patients with Complex Needs
  Potomac Ballroom : Potomac 5-6
IHI’s Triple Aim Improvement Community has been working on how to impact quality and costs for individuals who are costly to the healthcare system. We plan to launch a Collaborative in 2014 focusing on this area. Come discuss your interest and work in this important area.

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

**SIB4: The Lay Health Worker in Today’s Health Care**

*Chesapeake Conference Rooms : Chesapeake 8-9*

Peer workers, promotoras, patient navigators, community health workers... nontraditional care providers are becoming integral in care delivery. In this workshop we will explore ways that nontraditional staff are contributing to integrated care in various settings, including mental health. We will discuss payment models and staff recruitment, such as ideal candidates' skills and life experience. Learn how to broaden your staff team in this way and the impact of these valued workers in transforming care.

After this presentation, participants will be able to:

- Learn specific ways that nontraditional workers broaden the support base for patients, families, and staff
- Identify the tasks involved in integrating nontraditional workers in your team
- Examine best practices in the mental health field

Presenters: **Lewis, N., MS**, Director, Institute for Healthcare Improvement; **Craig, C., MSW, MPA**, Independent consultant, No Organization

**SIB5: All About the IHI Open School**

*Chesapeake Conference Rooms : Chesapeake 7*

The IHI Open School includes a growing catalog of 22 online courses that teach the foundations of quality improvement, patient safety, person- and family-centered care, population health, system design, and leadership. Learn how to take advantage of the online courses and resources to earn more than 28 continuing education credits and join more than 200,000 students, faculty, and professionals from around the world in this powerful educational network. This is a great opportunity to network with your peers.

For more information about the IHI Open School, visit: [www.ihi.org/openschool](http://www.ihi.org/openschool)

Presenters: **Strang, C.,** Director of Operations, IHI Open School, Institute for Healthcare Improvement

**SIB6: Triple Approach to the Triple Aim**

*Chesapeake Conference Rooms : Chesapeake 1-3*

Join us for sharing of ideas and a lively discussion of what changes will be required of payors, providers, patients, the population (and perhaps pharma) to achieve the Triple Aim. What is the "Missing Link"?

Presenters: **McIntosh, A., MD**, Independent Consultant, McIntoshMD LLC

**SIB7: The Comprehensive Primary Care Initiative: Ohio’s Experience and Progress**

*Chesapeake Conference Rooms : Chesapeake 4-6*
Join Kettering Physician Network as they share their first-hand experience and progress over the last year as a CPC practice in the Ohio region. This is a great networking opportunity for other CPC practices, and a great learning opportunity for all.

The CMS Comprehensive Primary Care (CPC) Initiative is a four year multi-payer initiative designed to foster collaboration between public and private health care payers to strengthen primary care. Five hundred primary care practices in seven regions were selected to participate. Practices were provided prospective PMPM care management fees based on risk, as well as continued FFS reimbursement for the first two years. The PMPM payments are scheduled to be reduced as the opportunity for shared savings begins in years three and four. Practices are required to complete and report on infrastructure and care team changes, quality measures and process measure milestones. Ongoing regional and national educational and technical support have been provided to assist in practice transformation.

Presenters: **Clark, K., DO, FAAFP, CHCQM**, PCMH Task Force, Kettering Physician Network

**SIB8: Delivering Health with Mobile Health Clinics**

Chesapeake Conference Rooms : Chesapeake 10-12

Join IHI’s Diversity and Inclusion Council and leaders of mobile health clinics from Boston, New York City, and Washington D.C to celebrate the benefits mobile health clinics bring to improving health and health care in diverse communities. You will learn about a growing body of research on the unique value of mobile health clinics as well as find out how to connect with a national network of clinics that is sharing learning and best practices.

**SIB9: Community-Centered Health Homes: Advancing the Population Health Goal of the Triple Aim**

Chesapeake Conference Rooms : Chesapeake J-L

Prevention Institute's Community-Centered Health Home (CCHH) model builds upon existing practices that integrate community health and primary care, such as community oriented primary care and more recent models of the medical home and patient-centered medical home. It takes these models a step further, however, by encouraging health care institutions to take an active role in strengthening their surrounding community, in addition to improving the health of individual patients. The defining attribute of the CCHH is active involvement in community advocacy and systems change. A CCHH not only acknowledges that factors outside the health care system affect patient health outcomes, but actively participates in improving them. Come learn more about the CCHH framework and hear about activities happening around the country to advance community prevention in health care settings.

**Tuesday, March 11: Keynotes**
Healthcare professionals are challenged to chart a path forward under new payment models that reward value rather than volume. There is a dawning realization of what it truly takes to assure success and the immense challenge in getting from here to there. Achievement of the Triple Aim of better health, better healthcare and lower costs involves more than just what goes on in the hospital or the physician office. The best results are coming from activated communities where information flows freely and from new sources and there’s genuine engagement in the lives of patients as people. “Come and get it care” is a thing of the past and a new and long-overdue respect for person-reported data is emerging. For those leaders eager to embrace this future, your time has come.

After this presentation, participants will be able to:

- Discuss the importance of healthcare engaging in the lives of patients/people and how this concept differs from “engaging patients” in the delivery system.
- Describe the role of health information technology in helping providers succeed under new payment systems and create health in their communities.
- Cite examples of the value created by health information exchanges beyond simple data sharing among disparate entities.

Presenters: Adams, L., President and Chief Executive Officer, Rhode Island Quality Institute

Health care reform is prompting health system and community collaborations to achieve high-quality care that is person-centered and cost-effective. Established accountable care organizations (ACOs) increasingly view palliative care as a practical solution to ensuring reliable, effective care for high-risk patients, particularly as access to these services grows in home and community settings. This session will present examples of innovative palliative care programs being used by pioneering ACOs to achieve the Triple Aim within the US. Participants will learn about the impact of cutting-edge models of palliative care delivery on outcomes for the highest-risk, highest-cost patients.

After this presentation, participants will be able to:

- Identify those patient populations most likely to benefit from palliative care within a Medicare ACO
- Select from among clinical models for palliative care delivery to the highest-risk, highest-cost patient population
- Choose feasible and actionable metrics to assess the clinical and cost impacts of palliative care interventions

Presenters: Meier, D., MD, Director, Center to Advance Palliative Care
C2: Centering: A Model for Group Healthcare

Potomac Ballroom: Potomac 3-4

This workshop will provide an overview of the Centering model of group care which combines the three components of care: health care, interactive learning, and community building within the group space. Although the focus of the presentation will be on CenteringPregnancy and CenteringParenting, the structure of the model makes it appropriate for use with patient populations throughout the lifecycle. Research data from CenteringPregnancy shows a statistically significant reduction in preterm birth, increased breastfeeding rates, reduced rapid repeat pregnancy, and high patient satisfaction. It is an efficient and effective way to provide and to receive care.

After this presentation, participants will be able to:

• Describe the three components of the Centering model of group care including the billable health and self-assessment process that occurs within the group space
• Describe outcomes from Centering research and evaluation studies
• Define the process needed for planning and implementation of care in groups

Presenters: Rising, S., CNM, MSN, Executive Director, Centering Healthcare Institute

C3: Building Foundations to Transform Health Care: Manitoba 2015

Chesapeake Conference Rooms: Chesapeake 1-3

The Winnipeg Health Authority, in partnership with the provincial government of Manitoba, has addressed the health needs of citizens by creating the vision of “a family physician for all” and achieving the Triple Aim by 2015. It has used an evidence-informed approach to engage family physicians and teams across the province. This strategic collaborative work across health care sectors provides lessons in how a bold vision can be coupled with strategic actions and innovative partnerships to transform a health care system.

After this presentation, participants will be able to:

• Utilize the evidence and lessons learned from the Winnipeg Health Authority’s ongoing project to improve quality, access, and accountability in primary care in support of health care system transformation
• Apply lessons from Manitoba’s successes to their own primary care and network renewal efforts, regardless of payment model, and learn from the province’s difficulties in engaging physician groups
• Discuss areas for future research and partnerships across sectors

Presenters: Permack, S., MD CCFP, Family Medicine Primary Care Program Medical Director, Winnipeg Regional Health Authority

C4: The LDL Challenge: Using HIT to Drive Clinical Quality Improvement

Chesapeake Conference Rooms: Chesapeake G-I

Thousands of primary and specialty care practices now have electronic health records (EHRs) and are poised to meet the meaningful use (MU) criteria. In the LDL Challenge, sponsored by the Office of the National Coordinator for Health Information Technology (ONC), five diverse practices tried to leverage the new health information technology (HIT) functionality to affect LDL outcomes in patients with diabetes in a 16-week intervention. This session will focus on the lessons learned from the LDL Challenge on how to use HIT to drive clinical quality improvement.

After this presentation, participants will be able to:

• Describe quality improvement strategies to achieve positive outcomes in cholesterol control
• Identify how to effectively utilize HIT to support these strategies
• Detail the practice readiness strategies that create an environment conducive to HIT-driven quality improvement
• Describe a number of successful approaches to achieve change, including leadership engagement, population health, and clinical decision support

Presenters: Wilkins, T., PharmD MS PhD, Pharmacy Advisor, Office of the National Coordinator for HIT, US Department of Health and Human Services; Sevin, C., RN, MSN, NP, Director, Institute for Healthcare Improvement; Reims, K., MD, Chief Medical Officer, CSI Solutions, LLC

C5: The ER Is for Emergencies: Best Practices for Reducing Preventable ER Visits

Potomac Ballroom : Potomac C

Emergency rooms have long been used for a variety of reasons not related to emergencies. As a result, patients who could receive effective care in a physician’s office are seen in one of the costliest care settings. This session will detail the ways in which Washington State hospitals, emergency room physicians, the medical association, and the state government have tackled this problem by implementing seven best practices, including a care plan shared by all emergency rooms.

After this presentation, participants will be able to:

• Understand how an effort to curb inefficient emergency room use could be implemented in their region
• Appreciate the impact on the health care system of preventable emergency room visits
• Discuss the reasons for preventable ER visits and the role played by health care providers when patients choose such care
• Describe the seven best practices and their impact on improvements in the delivery of health care in Washington State

Presenters: Wagner, C., RN, MBA, Senior Vice President, Patient Safety, Washington State Hospital Association

C6: Health Literacy in Primary Care

Potomac Ballroom : Potomac D

Patients’ compliance and health outcomes are closely linked to their ability to understand health information. Legacy Health developed an array of training materials for staff and providers to improve communication with patients. This session will present the techniques involved in Teach-Back. Participants will learn how to use plain language, encourage questions, and apply the universal precautions approach to improve their patients’ health outcomes and understanding of health information.

After this presentation, participants will be able to:

• Develop a health literacy program
• Implement Teach-Back and plain language in communicating with patients

Presenters: Ramerman, J., Quality Improvement Consultant, Legacy Health Systems; Conklin, M., Project Manager, Legacy Health Systems
C7: Improving Western New York’s Population Health Using the Patient-Centered Medical Home

Having a positive impact on population health takes community-wide commitment and determination. In western New York, three payers, the region’s entire hospital network, and New York State worked together using the patient-centered medical home (PCMH) model of the National Committee for Quality Assurance (NCQA) to successfully journey from paper to electronic health records (EHRs) to the PCMH. This session will detail the steps taken in this western New York project and present the positive, measurable results, such as improved patient satisfaction, a heightened community focus on patient-centered care, and improved diabetic outcomes.

After this presentation, participants will be able to:

- Describe the drivers, formation, implementation, and results of the western New York PCMH initiative to provide patients with improved, comprehensive, coordinated care
- Demonstrate the ways in which PCMH principles, coupled with enhanced use of technology, were successfully applied to this community-wide effort
- Outline the challenges, pitfalls, and lessons learned at a multi-site medical group during PCMH implementation, especially the unique challenges faced by residency programs
- Identify the quality, efficiency, and overall care management results of implementing a PCMH model

Presenters: Sadiq, R., MD, President, Western NY Medical, PC; Ball, J., BSN, RN, PCMH CCE, Senior Consultant CTG Health Services, Computer Task Group

C8: Innovation and Impact: An Integrated Team Approach Provides Access for the Uninsured

This session will demonstrate how one community organization has long been thinking outside the box to provide health care to a population characterized by high poverty and poor health. For 26 years (and before the Affordable Care Act), the Church Health Center in Memphis has provided access to health care for the working uninsured. By using an integrated team approach both inside and outside the clinic walls, in its wellness facility, and in its faith community, the Church Health 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 realize improved health outcomes

Presenters: Sheehan, A., MPhil,BEd(hons),RN,DipHSM, President, Church Health Center; Bartlett-Prescott, J., MS, Clinical Services Director, Church Health Center; Robbins, J., Chief Administrative Officer, Church Health Center; Carson, L., MS, MBA, Director Wellness, Church Health Center
C9: Medication Adherence: We Didn’t Ask, They Didn’t Tell
Chesapeake Conference Rooms : Chesapeake 10-12

Alarmingly common in patients, medication non-adherence annually leads to $100 billion in preventable health care costs and accounts for approximately half of all medication-related admissions. Increasing medication adherence is essential to the work of the patient-centered medical home (PCMH) and the key to meaningfully improving public health. This highly interactive workshop, grounded in a series of brief patient video-vignettes, will engage participants in developing practical techniques for uncovering and successfully addressing patient barriers to medication adherence.

After this presentation, participants will be able to:
- Recognize the magnitude of the problem of medication adherence
- Integrate the practice of screening for medication non-adherence into daily patient encounters
- Identify common barriers to medication adherence in the interactions among patients, physicians, and the health care system
- Describe the health care team members and resources that can be implemented in appropriate interventions to improve medication adherence

Presenters: Bussell, J., MD, FACP, Clinical Professor of Feinberg School of Medicine, Northwestern Memorial Hospital

C10: Lessons from the Beacon Communities: Improving Hospital Transitions and Care Coordination Using Automated Admission, Discharge, and Transfer Alerts
Potomac Ballroom : Potomac 1-2

The Office of the National Coordinator for Health Information Technology (ONC) provided $250 million of funding through the American Recovery and Reinvestment Act of 2009 (ARRA) over three years (2010 to 2013) to 17 selected Beacon Communities throughout the United States that had already made inroads in using HIT as a foundation for local improvement and innovation. With an eye to reducing avoidable hospital readmissions and emergency department (ED) visits and improving care transitions and coordination, several Beacon Communities developed automated alerting programs based on hospital-generated admission, discharge, and transfer (ADT) feeds. This session distills the experiences and lessons learned from these Beacon Communities and other pioneering communities as they set goals, planned for implementation, constructed technical approaches, and coached practices on effective work-flow redesign to accommodate and use the new alerts to improve patient care. The session is designed for communities that have a goal to reduce avoidable ED visits, avoidable hospitalizations, and preventable readmissions. After this presentation, participants will be able to:
- Understand how an automated ADT can support community goals to improve care transitions and coordination, particularly between hospitals and ambulatory practices
- Discuss how different organizations designed their ADT alerting projects, including technical implementation, data-sharing agreements, sustainability, and ongoing measurement and monitoring of effectiveness
Identify winning strategies to transform ADT information into clinically meaningful alerts and integrate these alerts into care provider work flows

Presenters: Horrocks, D., President, CRISP; Baker, A., MPP, Project Officer, U.S. Department of Health and Human Services; Chaufournier, R., MHSA, President and CEO, CSI Solutions, LLC; Adams, L., President and Chief Executive Officer, Rhode Island Quality Institute

C11: Talking About "The Things We Cannot Fix": Patient-Centered Care at the End of Life

Chesapeake Conference Rooms: Chesapeake J-L

In our denial-of-death culture, we often resort to medical intervention rather than conversation about the “things we cannot fix.” How do we compassionately discuss end-of-life care with our patients in order to center that care on their values, hopes, and wishes? This workshop will present the program we have developed for our 400-physician clinic to promote excellent, patient-centered care at the end of life, including physician classes, patient classes, Epic tools, and community-wide conversation.

After this presentation, participants will be able to:

- Understand the elements of an end of life program in outpatient primary care and specialty practice
- Understand the array of tools for end of life conversation in the outpatient setting and necessary skill training set for organizations to offer patients and providers
- Be able to articulate a reproducible model to promote end of life care during the routine office visit, or specialty care visit

Presenters: Marshall, E., MD, MAT, FAAFP, Director, Life and Wishes Task Force, The Everett Clinic

C12: Understanding the Costs of Operating the PCMH

Chesapeake Conference Rooms: Chesapeake 4-6

A patient-centered medical home (PCMH) is characterized by expanded patient access, extensive patient education resources, and reengineered patient-staff interactions. These differences from traditional primary care practices have an irrevocable impact on financial performance and make the PCMH unlike other primary care practices. This session will use the nation’s largest medical group practice survey to describe how a PCMH differs in practice revenue, overhead, and staffing and give participants a better understanding of the true cost of patient-centered care.

After this presentation, participants will be able to:

- Describe how a PCMH differs from a traditional primary care practice in revenue, expenses, and staffing
- Discuss the financial reality of daily operations in a PCMH and the innovative reimbursement programs used by some public and private insurers to offset higher practice operational costs

Presenters: Gans, D., MSHA, FACMPE, Senior Fellow for Industry Affairs, Medical Group Management Association; Ziehler, K., MPH, Senior Manager, Medical Group Management Association
C13: New Directions in the Assessment of Community Health and Organizational Redesign

Health care analysis, segmentation, resource allocation, and even research have long been focused on traditional categories of disease, organization, and health care encounters. To create real change we need to view the process and outcomes of health care work through an entirely different lens. Southcentral Foundation has for many years changed its focus from patients to “customer-owners” as it continues to redirect health care for the people it serves. Participants in this workshop will learn how Southcentral Foundation is redefining organizational assessment and its impact on improvement.

After this presentation, participants will be able to:

- Review the traditional means of assessing health care delivery and segmenting work product and quality
- Describe new methods and approaches to assessing populations and the potential impact on quality and organizational strategy
- Discuss how to blend traditional approaches with the new perspectives driving the redesign organizational infrastructure

Presenters: Tierney, S., MD, CMIO/Medical Director Clinic Quality Improvement, Southcentral Foundation; Brinn, S., Senior VP, Dakota Worldwide

Tuesday, March 11: Workshop D
11:00 AM - 12:15 PM

D1: Community Health, Violence Prevention, and Positive Outcomes: Connecting the Dots

Violence is a widespread public health problem, and violence and the fear of violence are significant markers of disparities across populations. The pressing public health challenge of violence must be met with a fresh approach to violence prevention that involves not only community and advocacy organizations but also the health care system. More specifically, the field of public health needs a clear, bold, and innovative plan that will allow it to engage communities in new ways, forge new partnerships, and strengthen systems to build a broader movement for health. An expert in violence prevention and patient advocacy, Gilbert Salinas will inspire participants to view health care beyond the walls of their organization and will explain his personal journey.

After this presentation, participants will be able to:

- Turn their knowledge of the determinants of health into actionable strategies to increase community health and well-being
- Apply simple methods for improving the lives of patients by improving the health of their community
- Identify practical and innovative ideas for use with their own patients to achieve the best results in the continuum of care
- Identify strategic opportunities and approaches for activating local and state efforts that promote health, wellness, and violence prevention

Presenters: Salinas, G., MPA, Director Patient Centered Care, Rancho Los Amigos National Rehabilitation Center

RFD: Rapid Fire D: Engaging the Patient

Presenters:
15th Annual International Summit on Improving Patient Care in the Office Practice and the Community

Presentation 1: Meet Me Where I Am
Susan Smith, Palo Alto Medical Foundation

Presentation 2: Engaging Patients in Practice Redesign Efforts
Bethina Abrahams, Transitions in Care, Shared Care

Presentation 3: Engaging Patients in Quality Improvement through Patient Advisory Councils
Lucia Angel, Family Health Center

Presentation 4: Patient Activation: Implications and Measurement
Val Overton, Fairview Medical Group

Presenters: Smith, S., Medical Director, Palo Alto Medical Foundation; Abrahams, B., Initiative Lead, Doctors of BC; Angel, L., Quality Improvement Coordinator, University of California San Francisco; Overton, V., VP Quality and Innovation, Fairview Medical Group

D2: Personal Mastery for Transformational Leadership

Potomac Ballroom : Potomac C

Transformational change depends on how fast and how far people shift habits, role patterns, and ways of thinking and relating. Leaders must recognize that emotional tension and resistance are human and ubiquitous constraints as they tackle the difficult task of simultaneously managing their own reactions, standing firm on decisions, and engaging others with individual consideration. This workshop will present methods to enhance “personal mastery”—learning the way to achieve desired results and build creative relationships.

After this presentation, participants will be able to:

- Explain how to identify and respond effectively to reactions in both oneself and others that may interfere with progress
- Identify key elements for facilitating change in work habits and patterns
- Define ways to exercise authority that also help to preserve positive engagement

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

D3: Becoming Conversation Ready: Strategies for End-of-Life Care Discussions in Primary Care

Potomac Ballroom : Potomac 5-6

This session will answer questions for anyone who is eager to bring the Conversation Project to their organization. Faculty and staff of the Conversation Project and the Conversation Ready Health Care Community will lead participants through the lessons learned in implementing these conversations in the primary care context, offering aid in bringing this work back to their own organization.

After this presentation, participants will be able to:

- Define what it means to be conversation-ready.
- Identify practical strategies for becoming conversation-ready that can be applied in their organization.

Presenters: McCannon, J., MD, Assistant in Medicine, Massachusetts General Hospital; Freeman, G., Vice President Marketing, Institute for Healthcare Improvement
D4: Designing Effective Strategies for High-Risk, High-Cost Populations

Chesapeake Conference Rooms : Chesapeake G-I

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 in other contexts yet design services for their unique setting. This session will focus on strategies to help participants increase their understanding of their high-risk, high-cost population and design strategies for managing care that are effective in their setting.

After this presentation, participants will be able to:

- Apply segmentation strategies to identify high-risk, high-cost patients and develop action-plans to better understand their needs from a person-centered viewpoint
- Design the first set of tests to be implemented in a care redesign process, using a set of change concepts for high-risk, high-cost patients

Presenters: Sevin, C., RN, MSN, NP, Director, Institute for Healthcare Improvement; Craig, C., MSW, MPA, Independent consultant, No Organization

D5: Lessons Learned from a Statewide, Multi-Payer PCMH Implementation

Chesapeake Conference Rooms : Chesapeake 7

The Massachusetts Patient-Centered Medical Home Initiative (MA PCMH) is a three-year, statewide, multi-payer demonstration with 45 participating practices. Sponsored by the MA Office of Health and Human Services, the MA PCMH includes payment reform, technical assistance, and an evaluation of impact on quality, patient experience, and expenditures. This session will explore the lessons learned from the initiative’s impact on technical assistance, payment, and evaluation, as well as from its design, governance, and transformation approach.

After this presentation, participants will be able to:

- Identify the lessons learned from the key components of a medical home initiative: design, governance, transformation approach, technical assistance, payment model, and evaluation
- Understand the impact of these lessons on the implementation of the initiative and the transformation of primary care practices
- Utilize specific lessons in designing or implementing changes in their own medical home initiatives

Presenters: Johnson, C., Director, Transformation and QI, PCMH, Umass Medical School

D6: Partnering Primary and Specialty Care Physicians to Improve Quality and Cost of Care

Chesapeake Conference Rooms : Chesapeake 10-12

In 2011 a select group of primary care physicians (PCPs) at Kaiser Colorado began a formal partnership with specialty department physicians. This primary care liaison program has created agreements and processes between primary and specialty care to provide cost-effective care in a patient-centric manner. By defining care pathways, liaisons are able to enhance communication, embed decision support, and encourage bidirectional feedback in innovative ways. This session will highlight a partnership project in orthopedics to deliver optimal care for knee pain.

After this presentation, participants will be able to:

- Outline the process utilized for creating partnerships between primary and specialty care providers as well as between hospitalist groups and emergency rooms
- Identify quality gaps in their health care system and select gaps for actionable change
• Develop new work flows to improve performance gaps

Presenters: Ziouras, J., MD, Kaiser Permanente; Miller, A., Senior Business Manager, Kaiser Permanente

**D7: Seamless, Focused Care Management**

*Chesapeake Conference Rooms: Chesapeake J-L*

This workshop will present the results of an innovation event that used the tools of the Virginia Mason Production System to address the continuum of care needs of the pancreatitis patient. In sharing the outcomes and learnings, we will demonstrate how to redefine care management as a service line. We also discuss the impact of implementing a professional practice model for nursing even as the role of the RN care manager is further refined.

After this presentation, participants will be able to:

• Share the challenges, barriers, and lessons learned in implementing changes to the role of the RN care manager and redefining care management as a service line
• Identify the role of the RN care manager on the care team in partnership with the inpatient nursing team
• Define RN care manager competencies based on the characteristics of the patient, using the Synergy professional nursing practice model
• Understand the accountability and responsibility for the patient’s experience shared by both ambulatory and inpatient nursing leadership

Presenters: Benz, L., RN MPA, Director, Ambulatory Care Nursing, Virginia Mason Medical Center; Nelson-Peterson, D., DNP, MN, RN, NEA-BC, Administrative Director, Ambulatory Care Nursing Services, Virginia Mason Medical Center

**D8: Strategies for Managing Populations: A Platform and Portfolio Approach**

*Potomac Ballroom: Potomac 3-4*

The transition in the US health care system initiated by the Patient Protection and Affordable Care Act (ACA) from a focus on health care production to population management has led those systems to consider their needs as managers of populations. In this session, we will explore an approach to population management based on research and development work at IHI and on the eight years of knowledge gained from its work with Triple Aim partnering organizations.

After this presentation, participants will be able to:

• Describe the population management issues faced by health care providers
• Apply the IHI framework to help them manage the population for which they are responsible

Presenters: Lewis, N., MS, Director, Institute for Healthcare Improvement; Whittington, J., MD, IHI Lead Faculty, Triple Aim Initiative, Institute for Healthcare Improvement; Torres, T., MD, MSPH, FACPM, SVP, Institute for Healthcare Improvement
D9: Technology-Assisted Care Management for Diabetes

Potomac Ballroom : Potomac 1-2

Managing the health of a population requires not only predictive analytics to identify high-risk patients but technology to scale the care management process and engage patients. This workshop will explore the case of a community with high disparities that leveraged a Centers for Medicare & Medicaid Services (CMS) innovation grant to build technology-enabled PCMHs and reduce its population of uncontrolled diabetics by 30%. Clinician leaders will share a blueprint for deploying the program in practices elsewhere to improve outcomes and lower costs.

After this presentation, participants will be able to:

- Understand how to implement a comprehensive diabetes care management program using population health management technology to close care gaps and improve patient engagement
- Utilize best practices in population health management to empower and scale existing clinical and care management resources to meet the requirements of value-based care

Presenters: Ríos, A., M.D., FACP, Northeast Georgia Physicians Group; Skey, O., Dir, Medical Assisting & Practicum Coordinator, Lanier Technical College

D10: Turning Values into Action: Discovering Your Leadership Story to Create Teams and Recruit New Leaders

Chesapeake Conference Rooms : Chesapeake 1-3

In health care we tend to emphasize data to influence colleagues, ignoring the fact that decisions are strongly influenced by values and emotions. However, to build new leadership and create interprofessional teams, we must engage both the “heart” and the “head.” This interactive workshop will teach the powerful skill of public narrative: sharing anecdotes from one’s leadership experience to both create connections with others based on shared values and build new leadership capacity.

After this presentation, participants will be able to:

- Understand the role and importance of public narrative in efforts to build strong interdependent teams to transform care delivery
- Develop and share a meaningful public narrative structured around unique “choice points” from one’s personal leadership experience
- Discuss how to coach others in developing their own public narratives to use as a tool for building teams and engaging new leaders

Presenters: Morris-Singer, A., MD, President, Primary Care Progress; Smithson, S., MD, MPH, Internist, Carolina Advanced Health

D11: A Population-Based Primary Care Model

Chesapeake Conference Rooms : Chesapeake 4-6

The primary care of the future will require a population approach. This workshop will present a model used at HealthPartners that utilizes predictive modeling, patient stratification, electronic health record (EHR) tools, and care teams across the continuum to reach out to patients and coordinate care across sites and specialties. In this model, teams work to the top of their license and patients receive personalized outreach, health coaching, education, and convenient and accessible care. At HealthPartners, success can be measured in the rate of readmission, which has been reduced to 9.84%, including readmissions for behavioral health issues.

After this presentation, participants will be able to:

- Identify ways to use resources effectively and efficiently to serve high-cost or high-utilization populations
• Understand how HealthPartners has worked across its system and community to meet the mission of achieving better health, better experience, and lower cost for patients

Presenters: Averbeck, B., MD, Associate Medical Director, Primary Care, HealthPartners; Van Why, R., Senior Vice President, HealthPartners

D12: We Harm Patients Too: Ambulatory Care Patient Safety

Chesapeake Conference Rooms: Chesapeake 8-9

Half of patient harm occurs in the out-patient setting, yet efforts to improve patient safety remain focused on the hospital. This workshop will present the journey of Valley Medical Center in creating an ambulatory patient safety program that has succeeded in increasing reporting, identifying and reducing several error trends, and implementing Just Culture. We will share our experience and demonstrate why ambulatory patient safety is an important (and different!) branch of patient safety.

After this presentation, participants will be able to:

• Recognize the importance of ambulatory patient safety as a priority in their organization
• Develop an ambulatory patient safety program within their organization
• Utilize a multidisciplinary ambulatory patient safety committee to drive improvement in their organization
• Discuss the differences between inpatient and ambulatory patient safety and identify ambulatory-specific patient safety issues

Presenters: Craine, J., RN, MN, Health Promotions Manager, Valley Medical Center; Park, J., MD, Physician, Valley Medical Center

Tuesday, March 11: Workshop E

1:15 PM - 2:30 PM

E1: Improving Environmental Practices in the Doctor’s Office

Potomac Ballroom: Potomac Ballroom A/B

Around the US, an estimated 4 billion patient-hours are spent in the waiting rooms of doctors’ offices annually. Green Doctor is a program that shows offices worldwide how to save money as they adopt wise environmental practices and how to share ideas with their staffs, families, and patients. This session will review the more than 120 action steps in this peer-reviewed, free, and science-based program. Participants will learn how their office can qualify for a Green Doctor recognition certificate.

After this presentation, participants will be able to:

• Understand the environmental impacts of doctors’ offices and their potential for improving community, environmental, and general health
• Appreciate opportunities in doctors’ offices to save money through the wiser use of resources
• Identify tools for teaching environmental improvement in doctors’ offices, with an awareness of the strengths and weaknesses of web-based programs such as Green Doctor

Presenters: Sack, T., MD, FACP, Editor, My Green Doctor
E2: Personal Mastery for Transformational Leadership

Potomac Ballroom : Potomac C

Transformational change depends on how fast and how far people shift habits, role patterns, and ways of thinking and relating. Leaders must recognize that emotional tension and resistance are human and ubiquitous constraints as they tackle the difficult task of simultaneously managing their own reactions, standing firm on decisions, and engaging others with individual consideration. This workshop will present methods to enhance “personal mastery”—learning the way to achieve desired results and build creative relationships.

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

E3: Becoming Conversation Ready: Strategies for End-of-Life Care Discussions in Primary Care

Potomac Ballroom : Potomac 5-6

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E4: Designing Effective Strategies for High-Risk, High-Cost Populations

Chesapeake Conference Rooms : Chesapeake G-I

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E5: Lessons Learned from a Statewide, Multi-Payer PCMH Implementation

Chesapeake Conference Rooms : Chesapeake 7

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- Utilize specific lessons in designing or implementing changes in their own medical home initiatives

Presenters: Johnson, C., Director, Transformation and QI, PCMH, Umass Medical School

E6: Partnering Primary and Specialty Care Physicians to Improve Quality and Cost of Care

Chesapeake Conference Rooms : Chesapeake 10-12

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- Develop new work flows to improve performance gaps

Presenters: Ziouras, J., MD, Kaiser Permanente; Miller, A., Senior Business Manager, Kaiser Permanente

E7: Seamless, Focused Care Management

Chesapeake Conference Rooms : Chesapeake J-L

This workshop will present the results of an innovation event that used the tools of the Virginia Mason Production System to address the continuum of care needs of the pancreatitis patient. In sharing the outcomes and learnings, we will demonstrate how to redefine care management as a service line. We also discuss the impact of implementing a professional practice model for nursing even as the role of the RN care manager is further refined.

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Presenters: Benz, L., RN MPA, Director, Ambulatory Care Nursing, Virginia Mason Medical Center; Nelson-Peterson, D., DNP, MN, RN, NEA-BC, Administrative Director, Ambulatory Care Nursing Services, Virginia Mason Medical Center

E8: Strategies for Managing Populations: A Platform and Portfolio Approach

Potomac Ballroom : Potomac 3-4

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• Describe the population management issues faced by health care providers
• Apply the IHI framework to help them manage the population for which they are responsible

Presenters: Lewis, N., MS, Director, Institute for Healthcare Improvement; Whittington, J., MD, IHI Lead Faculty, Triple Aim Initiative, Institute for Healthcare Improvement; Torres, T., MD, MSPH, FACPM, SVP, Institute for Healthcare Improvement

E9: Technology-Assisted Care Management for Diabetes

Potomac Ballroom : Potomac 1-2

Managing the health of a population requires not only predictive analytics to identify high-risk patients but technology to scale the care management process and engage patients. This workshop will explore the case of a community with high disparities that leveraged a Centers for Medicare & Medicaid Services (CMS) innovation grant to build technology-enabled PCMHs and reduce its population of uncontrolled diabetics by 30%. Clinician leaders will share a blueprint for deploying the program in practices elsewhere to improve outcomes and lower costs.

After this presentation, participants will be able to:
• Understand how to implement a comprehensive diabetes care management program using population health management technology to close care gaps and improve patient engagement
• Utilize best practices in population health management to empower and scale existing clinical and care management resources to meet the requirements of value-based care

Presenters: Rios, A., M.D., FACP, Northeast Georgia Physicians Group; Skey, O., Dir, Medical Assisting & Practicum Coordinator, Lanier Technical College
E10: Turning Values into Action: Discovering Your Leadership Story to Create Teams and Recruit New Leaders

Chesapeake Conference Rooms : Chesapeake 1-3

In health care we tend to emphasize data to influence colleagues, ignoring the fact that decisions are strongly influenced by values and emotions. However, to build new leadership and create interprofessional teams, we must engage both the “heart” and the “head.” This interactive workshop will teach the powerful skill of public narrative: sharing anecdotes from one’s leadership experience to both create connections with others based on shared values and build new leadership capacity.

After this presentation, participants will be able to:

- Understand the role and importance of public narrative in efforts to build strong interdependent teams to transform care delivery
- Develop and share a meaningful public narrative structured around unique “choice points” from one’s personal leadership experience
- Discuss how to coach others in developing their own public narratives to use as a tool for building teams and engaging new leaders

Presenters: Morris-Singer, A., MD, President, Primary Care Progress; Smithson, S., MD, MPH, Internist, Carolina Advanced Health

E11: A Population-Based Primary Care Model

Chesapeake Conference Rooms : Chesapeake 4-6

The primary care of the future will require a population approach. This workshop will present a model used at HealthPartners that utilizes predictive modeling, patient stratification, electronic health record (EHR) tools, and care teams across the continuum to reach out to patients and coordinate care across sites and specialties. In this model, teams work to the top of their license and patients receive personalized outreach, health coaching, education, and convenient and accessible care. At HealthPartners, success can be measured in the rate of readmission, which has been reduced to 9.84%, including readmissions for behavioral health issues.

After this presentation, participants will be able to:

- Identify ways to use resources effectively and efficiently to serve high-cost or high-utilization populations
- Understand how HealthPartners has worked across its system and community to meet the mission of achieving better health, better experience, and lower cost for patients

Presenters: Averbeck, B., MD, Associate Medical Director, Primary Care, HealthPartners; Van Why, R., Senior Vice President, HealthPartners

E12: We Harm Patients Too: Ambulatory Care Patient Safety

Chesapeake Conference Rooms : Chesapeake 8-9

Half of patient harm occurs in the out-patient setting, yet efforts to improve patient safety remain focused on the hospital. This workshop will present the journey of Valley Medical Center in creating an ambulatory patient safety program that has succeeded in increasing reporting, identifying and reducing several error trends, and implementing Just Culture. We will share our experience and demonstrate why ambulatory patient safety is an important (and different!) branch of patient safety.

After this presentation, participants will be able to:

- Recognize the importance of ambulatory patient safety as a priority in their organization
- Develop an ambulatory patient safety program within their organization
• Utilize a multidisciplinary ambulatory patient safety committee to drive improvement in their organization
• Discuss the differences between inpatient and ambulatory patient safety and identify ambulatory-specific patient safety issues

Presenters: Craine, J., RN, MN, Health Promotions Manager, Valley Medical Center; Park, J., MD, Physician, Valley Medical Center

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Potomac Ballroom: Potomac D

Presentation 1: Building for Primary Care Change at Scale
Robert Flemming, CMS

Presentation 2: AHRQ PROMISES Project
Paula Griswold, Massachusetts Coalition for the Prevention of Medical Errors

Presentation 3: Ambulatory Care Redesign: Transforming Primary Care at Contra Costa Health Services
Anthony Longoria, Contra Costa Regional Medical Center

Presentation 4: National Primary Care Extension Service in the US
Robert Gabbay, Joslin Diabetes Center

Presenters: Gabbay, R., MD, PHD, FACP, Chief Medical Officer, Joslin Diabetes Center; Flemming, R., Health Insurance Specialist, Center for Medicare and Medicaid Services; Griswold, P., Executive Director, Massachusetts Coalition for the Prevention of Medical Errors; Longoria, A., BSN, FNP/PA, CCHP, Director of Detention, Emergency Department, and Ambulatory Centers -Nursing, Contra Costa Regional Medical Center