Institute for Healthcare Improvement

13th Annual International Summit on

# Improving Patient Care in the Office Practice and the Community

## Rediscovering Conversations

A path to ~~patient~~ PERSON-centered care

March 18-20, 2012 | Washington, DC

**Welcome** to the 13th Annual International Summit on Improving Patient Care in the Office Practice & the Community.

# Contents



**Rapid-fire (RF) workshops** are energetic and fast-paced presentations on five subject areas. A diverse mix of presenters will have 10 minutes to share 10 slides and discuss their findings on one of the following topics:

**RFA: Transitions in Care**

**RFB: The Patient-Centered Medical Home**

**RFC: Specialty Care**

**RFD: Health Information Technology**

**RFE: Patient Safety**

Rapid-fire workshops are offered at the same time as workshops A through E and do not repeat. Rapid-fire workshop titles are listed under the workshop session information, beginning on page 10.

## About IHI

The Institute for Healthcare Improvement (www.IHI.org) is an independent not-for-profit organization that works with health care providers and leaders throughout the world to achieve safe and effective health care. IHI focuses on motivating and building the will for change, identifying and testing new models of care in partnership with both patients and health care professionals, and ensuring the broadest possible adoption of best practices and effective innovations. Based in Cambridge, Massachusetts, IHI mobilizes teams, organizations, and increasingly nations through its staff of more than 100 people and partnerships with hundreds of faculty around the world.

# Dear Colleagues,

**Welcome to the 13th Annual International Summit on Improving Patient Care in the Office Practice and the Community!**

At this year's International Summit, we'll look at "rediscovering conversations." So often, we are too busy to start real, human conversations. Too pressed for time to ask patients about their lives. Too immersed in everyday pressures to step back and remind ourselves why we are doing this work. And we may be reluctant to rock the boat by initiating conversations that challenge the status quo.

We hope to rediscover these important conversations here at the International Summit. This could mean a new way of listening to the patient, allowing us to hear the richness of a person's story rather than simply the symptoms and diagnoses captured in the medical record. It could mean internal conversations that reconnect us with our first calling. It could mean promoting new ideas to executives and board members, stimulating the will for systemic change. Each and all of these conversations can ultimately help create a higher standard of care that is not only patient-centered, but is truly person-centered.

And beyond the frontline, I'm struck by how health care reform is changing the nature of other critical conversations. Increasingly, doctors are talking with finance teams, and hospital executives are in dialogue with physician practices. Emotions can run high in these exchanges as pressure mounts to define new models of care that achieve Triple Aim results — lowering per capita costs, while improving care for individuals and the health of populations.

These conversations take courage, perseverance, and time. We need support and encouragement from our colleagues to catalyze them. Over the next few days we'll celebrate our successes, learn from each other, and rediscover the conversations that are at the heart of transformational care.

I'm so thrilled you've joined us here this week. Welcome to Washington, DC, and enjoy your time at the International Summit.

Sincerely,

Maureen Bisognano
President and CEO
Institute for Healthcare Improvement

# AgENda at-a-Glance

## Sunday, March 18
### Pre-Conference

| | | |
|---|---|---|
| 6:30 AM – 4:30 PM | Registration | Level 2 Prefunction |
| 8:30 AM – 4:00 PM | Minicourses | Conference Center Meeting Rooms |
| 12:00 PM – 1:00 PM | Attendee Lunch | Prince George's Exhibit Hall A |

## Monday, March 19
### General Conference Day One

| | | |
|---|---|---|
| 6:30 AM – 5:00 PM | Registration | Level 2 Prefunction |
| 7:00 AM – 7:45 AM | First Time Attendee Orientation | Chesapeake D-F |
| 8:00 AM – 9:00 AM | Keynote One: Maureen Bisognano | Maryland Ballroom |
| 9:30 AM – 12:30 PM | Learning Labs | Conference Center Meeting Rooms |
| 12:30 PM – 1:30 PM | Attendee Lunch | Prince George's Exhibit Hall A |
| 1:30 PM – 2:45 PM | Workshop A | Conference Center Meeting Rooms |
| 3:00 PM – 4:15 PM | Workshop B (A workshops repeated) | Conference Center Meeting Rooms |
| 4:30 PM – 5:30 PM | Keynote Two: Donald M. Berwick, MD, MPP | Maryland Ballroom |
| 5:30 PM – 7:30 PM | Storyboard and Networking Reception | Maryland Ballroom Foyer |

## Tuesday, March 20
### General Conference Day Two

| | | |
|---|---|---|
| 6:00 AM – 1:30 PM | Registration | Maryland Ballroom Foyer |
| 7:00 AM – 7:45 AM | Special Interest Breakfasts | Conference Center Meeting Rooms |
| 8:00 AM – 9:00 AM | Keynote Three: Ellen Goodman | Maryland Ballroom |
| 9:30 AM – 10:45 AM | Workshop C | Conference Center Meeting Rooms |
| 11:00 AM – 12:15 PM | Workshop D | Conference Center Meeting Rooms |
| 12:15 PM – 1:15 PM | Attendee Lunch | Prince George's Exhibit Hall A |
| 1:15 PM – 2:30 PM | Workshop E (D workshops repeated) | Conference Center Meeting Rooms |

# Hotel and Conference Information

**International Summit Videos (available via IHI TV)**
Registered attendees of the International Summit will have free access to all keynote and special interest keynote videos via IHI TV. International Summit attendees will receive an email in early April with information on how to access these videos.

**Business Center**
Photocopying, computers, Internet access, facsimiles, shipping, and other services are available at the Business Center located on Level 2 of the Convention Center.

**Business Center Phone:** (301) 965-2030
**Business Center Fax:** (301) 965-2039

**Daily Hours:** 7:00 AM – 9:00 PM

**Address where guests may receive packages:**
Guest Name
c/o Gaylord National Resort and Convention Center
201 Waterfront Street
National Harbor, MD 20745

**Check-Out**
Check-out time is 11:00 AM. Please see the hotel bell staff if you would like to store any luggage, or to arrange airport transportation.

**Emergencies**
If for any reason there is an emergency during the conference, you may dial "0" on any hotel phone to request assistance from the operator. You can always ask IHI or Gaylord staff for help.

**Safety and Security**
Please do not leave any personal belongings unattended in meeting rooms. IHI is not responsible for lost or stolen items.

**Job Postings**
International Summit participants may post job openings or positions wanted on the Job Postings board located in the Maryland Foyer.

**Guests**
We are happy to know that family and friends are accompanying many of you, but regret that meeting space can accommodate registered participants only at the keynote sessions, workshops, and meal functions. Your guests, however, are welcome to join you at the International Summit Storyboard and Networking Reception on Monday, March 19 from 5:30 PM – 7:30 PM.

**Messages and Faxes**
If you are staying at the Gaylord National, your telephone messages will go directly to your room. Urgent messages will be posted on the Message Board next to the Registration Desk in the Maryland Foyer.

**Gaylord National Resort and Convention Center Phone:** (301) 965-4000

**Name Badges**
Please wear your name badge throughout the conference. It is your ticket into keynote sessions, workshops, and meal functions.

**Session Materials**
All International Summit presentations made available to IHI by presenters before the conference will be available to participants on their customized event page at www.IHI.org. To view your session handouts, please follow these steps:

1. Go to www.IHI.org, click "Log In/ Register" at the top of the page and enter your email address and password.
2. Once you're logged in, click on "My IHI" at the top right and then "My Offerings" from the left menu.
3. Under "My Enrollments," you will see the "13th Annual International Summit" listed and below that you'll see a hyperlink titled "Materials – Handouts."
4. Click on this link to access any materials and handouts for International Summit sessions in which you are enrolled.

Paper handouts will not be provided for any sessions. If you would like paper handouts, please print your materials prior to your arrival or visit the printing kiosks located at Maryland Registration Desks A and C.

**Satisfaction Guaranteed. We Promise You'll Be Satisfied, or Your Money Back.**
If for any reason you are not completely satisfied that the 13th Annual International Summit is a valuable experience, IHI will gladly refund your enrollment fee. Please note that due to unforeseeable circumstances, last-minute changes in program titles, speakers or presentations may be unavoidable.

How can we find time (and money) for quality improvement work in busy medical practices operating on slim margins?

What's the future of primary care practices?

# Keynotes and Special Interest Keynotes

**Three inspiring and highly respected keynote speakers** will set the stage for improving patient and population health and health care across the full continuum of community care.

### Keynote One: Monday, March 19, 8:00 AM – 9:00 AM

*Maryland Ballroom*

**Maureen Bisognano,** President and CEO, Institute for Healthcare Improvement (IHI), is a prominent authority on improving health care systems, whose expertise has been recognized by her elected membership to the Institute of Medicine and by her appointment to The Commonwealth Fund's Commission on a High Performance Health System, among other distinctions. Ms. Bisognano advises health care leaders around the world, is a frequent speaker at major health care conferences on quality improvement, and is a tireless advocate for change. She is also an Instructor of Medicine at Harvard Medical School and a Research Associate in the Brigham and Women's Hospital Division of Social Medicine and Health Inequalities. Prior to joining IHI, she served as CEO of the Massachusetts Respiratory Hospital and Senior Vice President of the Juran Institute.

### Keynote Two: Monday, March 19, 4:30 PM – 5:30 PM

*Maryland Ballroom*

**Donald M. Berwick, MD, MPP,** is the former President and CEO of the Institute for Healthcare Improvement, an organization that he co-founded and led for over 20 years. In July 2010, President Obama appointed Dr. Berwick to the position of Administrator of the Centers for Medicare & Medicaid Services, a position he held until December 2011. A pediatrician by background, Dr. Berwick has served on the faculty of the Harvard Medical School and Harvard School of Public Health, and on the staffs of Boston's Children's Hospital Medical Center, Massachusetts General Hospital, and the Brigham and Women's Hospital. He has also served as Vice Chair of the US Preventive Services Task Force, the first "Independent Member" of the American Hospital Association Board of Trustees, and Chair of the National Advisory Council of the Agency for Healthcare Research and Quality. He served two terms on the Institute of Medicine's (IOM's) governing Council, was a member of the IOM's Global Health Board, and served on President Clinton's Advisory Commission on Consumer Protection and Quality in the Healthcare Industry. Recognized as a leading authority on health care quality and improvement, Dr. Berwick has received numerous awards for his contributions. In 2005, he was appointed "Honorary Knight Commander of the British Empire" by the Queen of England in recognition of his work with the British National Health Service. Dr. Berwick is the author or co-author of over 150 scientific articles and four books.

### Keynote Three: Tuesday, March 20, 8:00 AM – 9:00 AM

*Maryland Ballroom*

**Ellen Goodman** is founder of The Conversation Project, a collaboration with the Institute for Healthcare Improvement on a grassroots effort to encourage every person to have a conversation about their wishes for care at the end-of-life. Ms. Goodman is a Pulitzer Prize-winning columnist, author, speaker, and commentator who refuses to call herself a pundit. She has long been a chronicler of social change in America, especially the women's movement and its effects on our public and private lives. One of the first women to open up the op-ed pages to women's voices, she became, according to Media Watch, the most widely syndicated progressive columnist in the country. From her observation post, Ms. Goodman continues to work as a writer, speaker, and commentator. In addition to the Pulitzer Prize for Distinguished Commentary in 1980, she has been recognized by the American Society of Newspaper Editors, the Leadership Conference on Civil Rights, the National Women's Political Caucus, the Women's Research & Education Institute, and the National Society of Newspaper columnists.

## Special Interest Keynotes

All special interest keynotes will take place in the Maryland Ballroom.

### A1 How Do They Do That? Finding Joy in Practice: Experiences from the Field

**Monday, March 19**
1:30 PM – 2:45 PM

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

**Sinsky, T., MD,** Physician, Medical Associates Clinic and Health Plans

### B1 Patient-Centered Medical Home Redesign: Tools for Practice Transformation

**Monday, March 19**
3:00 PM – 4:15 PM

**Sugarman, J., MD,** CEO, Qualis Health

**Wagner, E., MD,** Director, MacColl Institute for Healthcare Innovation at the Center for Health Studies, Group Health Cooperative of Puget Sound

**Daniel, D., PhD,** Senior Quality Improvement Principal, Qualis Health

**Phillips, K.,** Director, Qualis Health

### C1 Minimally Disruptive Medicine: Achieving Patient-Centered Care

**Tuesday, March 20**
9:30 AM – 10:45 AM

**Montori, V., MD,** Director, Mayo Clinic Healthcare Delivery Research Program and Professor of Medicine, Mayo Clinic

### D1 SCF Nuka System of Care: Whole System Transformation Improves Outcomes

**Tuesday, March 20**
11:00 AM – 12:15 PM

**Eby, D., MD,** Vice President of Medical Services, Southcentral Foundation

**Aloysius, C.,** Vice President, Southcentral Foundation

### E1 Designing the Best: Engaging Stakeholders in Primary Care Transformation

**Tuesday, March 20**
1:15 PM – 2:30 PM

**Edgman-Levitan, S.,** Executive Director and IHI Fellow for Patient- and Family-Centered Care, Massachusetts General Hospital

# Events and Special Programs

### First Time Attendee Orientation
**Monday, March 19**
7:00 AM – 7:45 AM
*Chesapeake 4-6*

If you are new to the International Summit, we suggest that you attend this orientation session to help you navigate through the program and devise a personal learning plan.

### Exhibit Hall
**Monday, March 19 – Tuesday, March 20**
*Maryland Ballroom Foyer*

Learn about an array of support services and products useful in improving the quality of health care.

**Exhibit Hours**
**Monday, March 19**
7:30 AM – 9:30 AM
12:30 PM – 1:30 PM
5:30 PM – 7:30 PM

**Tuesday, March 20**
7:30 AM – 9:30 AM
12:15 PM – 1:15 PM

### Storyboard and Networking Reception
**Monday, March 19**
5:30 PM – 7:30 PM
*Maryland Ballroom*

Join us for a reception to learn about the quality improvement successes of other health care organizations. Representatives from storyboard organizations will be available to answer questions, share lessons learned, and network in an informal atmosphere. For the full storyboard listing, please see page 17.

### American Academy of Family Physicians (AAFP) Networking Lunch
**Tuesday, March 20**
12:30 PM – 1:15 PM
*Chesapeake G-I*

Grab your lunch and come hear about how a specialty organization has responded to the need to transform primary care practices.

### Special Interest Breakfasts
**Tuesday, March 20**
7:00 AM – 7:45 AM
Network with colleagues and discuss a variety of improvement topics over breakfast. Special Interest Breakfasts are group conversations led by an expert facilitator.

### SIB1 Shared Medical Appointments: 10+ Pearls for Success
*Chesapeake J-L*

Facilitated by: **Brent Jaster, MD,** Group Visit Consultant, JasterHealth, Inc., University of Colorado School of Medicine

### SIB2 Coaching/Practice Facilitation in Primary Care
*Maryland 1-2*

Facilitated by: **Cory Sevin, RN, MSN,** Director, IHI

### SIB3 The Triple Aim: Building the Future of Health Care
*Maryland 3-4*

Facilitated by: **Carol Beasley, MPPM,** Director, Strategic Projects, IHI

### SIB4 Do You Know Where Your Patients Are? Partnering to Improve Transitions in Care
*Chesapeake G-I*

Facilitated by: **Marie Schall,** Senior Director, IHI

## International Summit Co-Chairs

IHI would like to thank the International Summit Co-Chairs for their effort and commitment in developing the program* for the 13th Annual International Summit on Improving Patient Care in the Office Practice & the Community.

**Victor M. Montori, MD,**
Director, Mayo Clinic Healthcare Delivery Research Program and Professor of Medicine, Mayo Clinic

**Catherine Baase, MD,**
Global Director of Health Services, The Dow Chemical Company

**Ellen Goodman,**
Pulitzer Prize-winning columnist, author, and speaker

*All planning committee members and persons influencing the content of the International Summit program have disclosed all relevant financial relationship with any commercial interest to IHI.

# Pre-Conference

**SUNDAY**
March 18

## Minicourses

8:30 AM – 4:00 PM

Minicourses offer in-depth, hands-on learning opportunities with details about how to implement and sustain change.

### M1 Building Sustainable Physician Engagement to Transform Care

*Chesapeake 4-6*

To ensure that improvements in practice do not remain just a series of projects but evolve into a way of life, it is critical to 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 organizations.

**Silversin, J.**, President, Amicus, Inc.; **Long, G., MD**, Chief Medical Officer, ThedaCare

### M2 Change Management Skills for Practice Coaches

*Maryland 1-2*

This interactive Minicourse will offer participants an opportunity to gain new knowledge and skills to increase their effectiveness as agents of change. The selected frameworks and tools presented in this session will enable change agents and coaches to understand the organizational and group dynamics necessary for successful change. After spending much of the day working with these frameworks and tools, participants will leave with practical knowledge to use in their own change efforts.

**After this presentation, participants will be able to:**

- Identify roles and tasks for change management and alignment.
- Explain how to map a change project to diagnose the effectiveness of current change management and the state of alignment.
- Identify ways to intervene skillfully to facilitate change using an understanding of human dynamics, focusing especially on resistance and self-management.

**Sevin, C., RN**, Director, IHI; **Baker, N., MD**, Principal, Neil Baker Coaching and Consulting, LLC; **Lefebvre, A.**, Associate Director, North Carolina AHEC at UNC Chapel Hill

### M3 Engaging Patients, Families, and Communities in Health Care Improvement

*Maryland 5-6*

Involving patients and families in health system planning contributes to better health outcomes, better patient experiences, and better use of health care dollars. In a full-day interactive session, participants will develop and implement an engagement plan for patient, family, and community involvement. Case studies and examples from participants will be used to explore practical methods to include the patient voice in health system design. Tip sheets and tool kits will also be provided.

**After this presentation, participants will be able to:**

- Identify reasons, opportunities, and methods to engage patients, family members, and communities in health system planning.
- Draft plans for implementing patient, family, and community engagement in their own organizations or practices.

**Tolson, M.**, Leader, Community Engagement, Vancouver Coastal Health Authority; **Harper, C., RN**, Manager, Public Participation and Collaboration, Vancouver Island Health Authority; **Boyd, B.**, Leader, Community Engagement, Vancouver Coastal Health Authority; **Rivard, C.**, Regional Practice Support Program Leader, Impact BC

### M4 Enhancing Primary Care Value at Lower Cost to the Community

*Chesapeake 1-2*

This session will help participants design community centers of health that honor, enhance, and produce value through primary care relationships. Building on Intermountain Healthcare's successful and sustained redesign of primary care through Mental Health Integration (MHI) and IHI's Triple Aim, lessons from sustained innovations will be woven into a primary care relational framework that will create a potential approach to measurement. This framework will define value by incorporating a solid universal understanding of what really matters to patients, their families, and the communities in which they live; provide the leadership needed to deliver this value; and approaches to practical measurement of success in meeting those values. Participants will engage in a collective social network activity that will create "out of their box" designs for sustainable, local, social centers of health. Traditional financing and funding barriers will be removed to create space for defining value outcomes through the eyes of the participants.

**After this presentation, participants will be able to:**

- Create a set of values and outcomes that make the most difference in the lives of individuals and communities.
- Define the delivery system and societal costs that will measure the value of enhanced quality.
- Build a framework for enhancing the quality of primary care through relational networks.

**Reiss-Brennan, B.**, Mental Health Integration Director, Intermountain Healthcare; **Boudreau, K., MD**, Senior Vice President and Medical Director, Continuum Portfolio, IHI

### M5 Improving Access to All Ambulatory Services

*Maryland 3-4*

This session will explore the transformational work by a number of organizations to eliminate waits and delays for care and services in the medical office setting. Discussion will focus on basic strategies not only to improve access to medical appointments but also to dramatically eliminate delays for all services, including primary and specialty care, imaging, lab, and a variety of therapies. The session will demonstrate the benefits of the philosophy "there is rarely value in delays," using examples from diverse groups in the United States and Canada. For instance, participants will learn about the Saskatchewan pooled referrals project, which has redesigned the way patients access care across surgical specialties and helped surgeons and primary care physicians collaborate to quantifiably reduce wait times and increase patient, surgeon, primary care provider, and staff satisfaction.

**After this presentation, participants will be able to:**

- Identify six strategies to dramatically improve access and reduce waits for all appointments and services in the medical office settings.
- Use case studies from organizations that have committed to systemwide access improvement, including tested tools for forecasting appointment demand and supply for all services.
- Identify common access pitfalls and use strategies to avoid and remedy the access problems they have encountered in their own settings.

**Tantau, C.**, President, Tantau & Associates; **Stange, K., MD**, Surgeon, Alaska Native Medical Center; **Sherin, T.**, Senior Researcher, Health Quality Council

### M6 Improving Transitions: A Practical Approach for Primary Care and Home Care Providers

*Chesapeake G-I*

Patients all too often experience care as fragmented, confusing, and sometimes frightening, especially when being moved from one care setting to another. Primary care teams and home health care providers can address the gaps in the important transition from hospital to home by focusing on the first post-hospital interaction with patients. In this session, participants will learn practical approaches to anticipating the needs of hospitalized patients, preparing patients and care teams for the first visit or contact, ensuring that patients' needs are met during the visit, and communicating and coordinating post-visit care with patients, families, and other providers, including preparation for patient self-care. Strategies for partnering with other cross-continuum partners will also be explored.

**After this presentation, participants will be able to:**

- Use a simple diagnostic tool to identify opportunities for improving patients' transition from hospitals and other settings to home.
- Use "Teach Back" and other health literacy principles to prepare patients for self-care.
- Identify ways to partner with hospitals and other community-based providers and social service agencies to meet the needs of recently hospitalized patients.

**Schall, M.**, Senior Director, IHI; **Rutherford, P., RN,** Vice President, IHI; **Balaban, R., MD,** Associate Director of Hospital Medicine, Cambridge Health Alliance; **Noonan, L., MD,** Pediatric Faculty and Improvement Advisor, Levin Children's Hospital; **Sobolewski, S., RN,** Director of Practice Improvement, The Visiting Nurse Service of New York

## M7 It Takes a Region: Integrating Communities of Care

*Chesapeake 3*

Isolated efforts to redesign practices, payment structures, and benefit packages have had exciting but limited impacts. Since health care is local, an all-in, multifactorial, community-level approach is needed to achieve Triple Aim goals. These include the implementation of patient-centered medical home (PCMH) efforts and mechanisms to coordinate care across medical neighborhoods and accountable care organization (ACOs); health information technology; methods to engage consumers, patients, and families at various levels; methods to engage community members and resources to enhance this effort; and payment reform models to present to health care insurers and employers. This session will focus on creative ways for these multiple stakeholders to develop a shared vision with specific goals in order to achieve a high-functioning, integrated community of care.

**After this presentation, participants will be able to:**

- Identify opportunities in their own community to bring multiple stakeholders together to develop a shared vision for redesigning health care delivery and payment systems to reach a high-quality, integrated community of care.
- Develop a mock plan for integrating health care into their community, including a phase-in strategy to reach Triple Aim goals.

**Harbrecht, M., MD,** CEO, HealthTeamWorks; **Wagner, E., MD,** Director, Group Health Cooperative; **Jones, C., MD,** Executive Director, Vermont Blueprint for Health, State of Vermont Agency of Human Services; **Stanley, C., MD,** Senior Medical Director, UnitedHealthcare; **Gottsman, A.,** Executive Vice President, HealthTeamWorks

## M8 Motivational Interviewing for Busy Clinicians

*Chesapeake A*

This interactive Minicourse focuses on principles and skills of motivational interviewing (MI) that can be applied by professionals who are pressed for time. Through discussion and practice, participants will come to understand a variety of techniques to support behavior change, and they will gain the confidence to use them in their own practice. We will explore ways to incorporate MI techniques into daily routines and develop MI skills beyond this introductory experience.

**After this presentation, participants will be able to:**

- Apply the principles of motivational interviewing in conversations about behavior change.
- Demonstrate a patient-centered interaction that supports behavior change.
- Design ways to include MI approaches in daily work.

**Davis, C.,** Geriatric Nurse Practitioner, Connie L. Davis Health Services; **Gutnick, D., MD,** Assistant Professor of Medicine and Psychiatry, Bellevue Hospital Center

## M9 Solutions for Effective Care Management in a Non-Integrated System

*Chesapeake J-L*

This session will focus on the development of the infrastructure and transformation necessary for effective care management across community settings. Different roles and tasks of non-integrated community partners—hospitals, physicians, health plans, community agencies, patients—will be described. Participants will design a roadmap for the synergistic use of available resources to create effective care management in a non-integrated system. We will discuss outcome measures, tracking improvement, and their complexity and highlight critical lessons from MI-STAAR.

**After this presentation, participants will be able to:**

- Describe a conceptual model for integrating the components of care management across independent organizations.
- Describe strategies for integration and transformation across multiple community stakeholders in care management.
- Articulate the critical elements for effective community care management, including communication, information technology, and risk stratification.
- Use the tools and exercises described in the session to facilitate community collaboration among stakeholders.

**Benzik, M., MD,** Medical Director, Integrated Health Partners; **Hindmarsh, M.,** President, Hindsight Healthcare Strategies; **Clark, R., RN,** Executive Director, Integrated Health Partners

## M10 Targeting Ambulatory Care Patient Safety Priorities

*Chesapeake 10-12*

The success of interventions to improve safety in the ambulatory setting depends on several factors: agreement on a definition of harm; defect identification; systems, staffing, and support structures (which can differ widely depending on the size of the practice and the level of technology implementation); and the role of the patient. In this session, we will describe the problems in ambulatory care systems identified through research and also by participants, and we will provide examples of effective practices. Faculty will also offer practical tools to assess patient safety risks and culture in participants' own settings.

**After this presentation, participants will be able to:**

- Describe the major patient safety issues in the ambulatory care settings.
- Discuss the value of different tools to identify and address safety risks in the outpatient setting.
- Develop preliminary plans to implement at least two of the tools in their own settings.

**Federico, F., RPh,** Executive Director, Strategic Partners, IHI; **Gandhi, T., MD,** Chief Quality and Safety Officer, Partners Healthcare

## M11 Using Lean Principles to Improve Clinic Flow

*Chesapeake D-F*

This Minicourse will review basic Lean principles and applications of tools derived from the Lean Toyota Production System to improve clinic flow, productivity, and quality. Examples drawn from the transformative work at Denver Community Health Services, 2011 winner of the Shingo Prize Bronze Medallion for Operational Excellence, will demonstrate how to engage clinical teams in process improvement. In simulation exercises, participants will practice identifying and eliminating waste and improving flow.

**After this presentation, participants will be able to:**

- Identify the "wastes" in clinic processes that can interfere with flow and quality.
- Explain the application of Lean methods to redesign processes to meet medical home criteria, including empanelment, advanced access, and referral tracking.
- Describe how to adapt lessons learned from the example of the Shingo Prize winner, Denver Community Health Services.

**Loomis, L., MD,** Director of Family Medicine, Denver Health; **Kampe, F.,** Lean Facilitator, Denver Health; **Lee, J., MD,** Team Leader, Westwood Family Health Center, Denver Health Community Health Services and Assistant Professor, Department of Family Medicine, University of Colorado

## M12 Using Microsystems to Transform Practice: Fundamentals to Advanced Applications

*Chesapeake B-C*

This session will explore office practice transformation using applied clinical microsystem theory. The first part of the session will focus on the fundamentals of microsystem theory. In the second part, faculty will discuss advanced microsystems and will present participants with organization infrastructure and coaching models to consider and adapt to their own organizations.

**After this presentation, participants will be able to:**

- Adapt and apply clinical microsystem fundamentals to their own settings.
- Compare and contrast a case study from an ear, nose, and throat practice to their own contexts to develop a microsystem strategy.
- Develop their own organizational infrastructures and coach front-line staff in providing and improving care.

**Godfrey, M., RN,** Co-Director, The Microsystem Academy and Instructor, The Dartmouth Institute for Health Policy and Clinical Practice; **Leary, L., MS,** Microsystem Academy Associate, The Dartmouth Institute Microsystem Academy; **Hess, A.,** President, Clinical Performance Management, Inc.

# General Conference

**DAY 1**
**MONDAY**
March 19

## Keynote One

8:00 AM – 9:00 AM

*Maryland Ballroom*

**Maureen Bisognano,** President and CEO, Institute for Healthcare Improvement

## Learning Labs

9:30 AM – 12:30 PM

Learning Labs offer specific how-to improvement information.

### L1 Achieving the Triple Aim for High-Cost Patients

*Chesapeake J-L*

Focusing on achieving better care and lower health costs for a practice's highest-risk patients, this session will highlight strategies for integrating complex care management into primary care; demonstrate how to identify high-cost, high-risk patients who need advanced levels of care; and provide interactive exercises to train clinic personnel to be complex care managers. Participants will better understand how improved complex care management accomplishes the Triple Aim: by enhancing the care experience, improving population health, and reducing health care costs.

**After this presentation, participants will be able to:**

- Identify patients in their practice's panel who require more intensive levels of care to reduce health care costs and improve patient experience.
- Describe the nuts and bolts of deploying practice staff to meet the needs of high-risk patients in primary care.
- Train their practice staff to be complex care managers.

**Margolius, D., MD,** Internal Medicine Resident, University of California, San Francisco; **Ghorob, A.,** Trainer, University of California, San Francisco

### L2 ACO Transformation: A Community Collaborates to Improve Population Health

*Chesapeake G-I*

Sharing a vision of improving population health, Integrated Health Partners (IHP), a physician hospital organization, created a partnership with community stakeholders. Engaging these partners, including those from outside the health care continuum, Calhoun County Pathways to Health was created. In this framework, employers and health plans partner with IHP to improve employee health, and community partners collaborate to improve the experience of care across the continuum. This session will highlight one area that is critical to the success of these partnerships: attention to metrics and public reporting of outcomes data.

**After this presentation, participants will be able to:**

- Identify partners outside of the health care field for developing an accountable care organization (ACO).
- Create partnership strategies for successful ACO development.
- Better understand the complexity of calculating community health care costs and savings.

**Benzik, M., MD,** Medical Director, Integrated Health Partners; **Clark, R., RN,** Executive Director, Integrated Health Partners

### L3 Advancing Care Management Techniques and Innovations in Diabetes Care Management

*Maryland 5-6*

The first part of this two-part session will concentrate on the basics of improving chronic disease care management processes. Using workflow diagrams, participants will identify their current processes and develop an ideal state for care management in their practices. The second part of the session will review the efforts of a multidisciplinary team to improve diabetes care management across a large, integrated health care delivery system. This part will focus on strategic prioritization, staff and patient education programs, and measurement development. Also highlighted will be the establishment of diabetes care management guidelines, a real-time monitoring system, and the role of the electronic health record.

**After this presentation, participants will be able to:**

- Analyze current care management processes.
- Develop a plan or a workflow to integrate new aspects of care management into their practices, with a focus on the management of chronic disease and prevention services.
- Demonstrate a model for understanding the role of quality data in monitoring and improving diabetes care management.

**Skoch, E., RN,** Director, Systems Transformation, HealthTeamWorks; **Gray, C., RN,** Program Manager, HealthTeamWorks; **Mehta, P., MD,** Vice President, North Shore–Long Island Jewish Health System; **Besthoff, C., RN,** Director, Program Evaluation, Krasnoff Quality Management Institute, North Shore–Long Island Jewish Health System; **Frazzitta, M.,** Director, North Shore Center for Diabetes in Pregnancy, North Shore–Long Island Jewish Health System

### L4 Coaching Health Care Improvement

*Chesapeake 4-6*

A variety of coaching programs have emerged in the past five years. This session will explore a coaching model grounded in decades of experience and recent research showing that coaching can advance a health care organization's improvement strategies and results.

**After this presentation, participants will be able to:**

- Apply a three-phase coaching model to their own practices to raise the success rate of employees engaged in improvement efforts.
- Define the art as well as the science of coaching health care improvement.
- Use two coaching outcome tools to determine the effectiveness of coaching.

**Godfrey, M., RN,** Co-Director, The Microsystem Academy, and Instructor, The Dartmouth Institute for Health Policy and Clinical Practice; **Nilsson, A.,** Project leader, Qulturum; **Hvitfeldt Forsberg, H.,** Student, Karolinska Institute

### L5 Communication and Teamwork for Acute Care Practitioners

*Chesapeake B-C*

This session will present a dramatized obstetrical disaster laced with scenes of miscommunication and compromised teamwork between nurses, physician staff, and trainees. Using professionally made clinical video clips, the session will debrief participants on these clinical situations to demonstrate the adverse impact on patient care of lack of communication and teamwork.

**After this presentation, participants will be able to:**

- Identify failures in teamwork and communication within a practice.
- Articulate how these failures lead to poor patient outcomes.
- Use this understanding to develop behavioral mechanisms to improve their own communication and teamwork skills.

**Cowie, N., MD,** Anesthesiologist, University of Saskatchewan

### L6 Enhancing Comparative Effectiveness Research for Colon Cancer Screening with Human-Centered Design

*Chesapeake 3*

In this interactive session, participants will learn how IDEO's human-centered design approach is being used to advance the translation and dissemination of comparative effectiveness research (CER) for colon cancer screening. Preliminary results of the pilot testing of the "GutCheck" suite of tools will also be shared.

**After this presentation, participants will be able to:**
- Describe the human-centered design elements of the "GutCheck" suite of tools.
- Identify the successful strategies that pilot sites have employed with the "GutCheck" tools to engage patients around colon cancer screening and move them to action.
- List three tests of change that they can implement in their practices using "GutCheck."

**Sevin, C., RN,** Director, IHI; **Schwartz, A., PhD,** Healthcare Lead, IDEO; **Taylor, J.,** Improvement Advisor, IHI

## L7 Enlightening Experiences with Shared Medical Appointments

*Chesapeake 10-12*

This session will provide an overview of common shared medical appointment (SMA) models, data, implementation strategies, and physician experiences. Successful implementation stories will be shared, and role-playing will provide valuable experiential training for participants. Participants will also share their successes and challenges with SMA models in diverse settings.

**After this presentation, participants will be able to:**
- Discuss various SMA models, their key features, and supportive data.
- Illustrate the essential SMA elements: process, team, confidentiality, billing, and recruitment.
- Describe strategies for implementation from a real-world physician experience.

**Jaster, B., MD,** Group Visit Consultant, JasterHealth, Inc.; **Haney, B., MD,** Family Physician, Family Health Care of Ellensburg

## L8 Improving Safety Across Acute, Community, and Mental Health Care Settings

*Chesapeake A*

The South West Strategic Health Authority in England has led pioneering efforts to improve safety in acute settings as well as in community settings (community hospitals, district nursing, nursing homes) and mental health settings. This session will describe the journey to date of this evolving collaborative, focusing on measurement strategies, early results, success factors, and program design elements.

**After this presentation, participants will be able to:**
- Describe a whole-system approach to patient safety improvement across care settings (acute, community, and mental health).
- Identify the key success factors, especially in community and mental health care settings.
- Articulate the steps for planning, implementing, and sustaining a collaborative program that promotes safety across care settings.

**Williams, D., PhD,** Improvement Advisor, TrueSimple Consulting; **Blumgart, J., RN,** Associate Director, Quality and Patient Safety, NHS South West; **Thomas, C., RN,** Senior Clinical Advisor for Patient Safety, NHS South West

## L9 Integrating Coaching into Management to Achieve Transformation

*Maryland 3-4*

What factors enable the successful integration of coaching into management to achieve transformational change? This question will be explored in a case study of CareSouth, which integrated coaching to achieve significant improvement in quality, financial, and patient experience measures, as well as an increase from 11 to 76 percent of staff who felt that the mission of the organization "makes me feel my job is important." Participants will also look at the potential roadblocks to successful integration of coaching in their own organizations.

**After this presentation, participants will be able to:**
- Explain how CareSouth defined leadership versus management versus coaching.
- Identify the factors that enable the successful integration of coaching into management.
- Define the factors that allow accountability to be integrated with the personal engagement of staff.

**Lewis, A.,** CEO, CareSouth Carolina, Inc.; **Baker, N., MD,** Principal, Neil Baker Coaching and Consulting, LLC

## L10 Quality Improvement for Improving Care Coordination in Pediatrics

*Chesapeake 1-2*

This interactive session will build on the quality improvement (QI) model adopted in Reach Out and Read's national QI initiative, whose findings will be presented to illustrate multi-site quality improvement. Participants will apply QI principles to enhance their understanding of process flows and opportunities for improvement in care coordination in pediatric primary care practice. Using process mapping, the Plan-Do-Study-Act (PDSA) tool, and related materials, participants will make plans to measure and analyze care coordination in their own practices.

**After this presentation, participants will be able to:**
- Describe and use process mapping to identify opportunities for improvement.
- Identify and use tools to implement new processes for improving care coordination.
- Establish and implement systems to monitor and analyze the impact of process changes in their practices.

**Ducharme, B.,** Director, Training and Program Quality, Reach Out and Read, Inc.; **Roberson, R.,** Quality Improvement Program Manager, Reach Out and Read, Inc.

## L11 Transforming Meaningful Use into Meaningful Care

*Chesapeake D-F*

The University of North Carolina Health Care system aims to exceed the requirements of meaningful use (MU) to fulfill its goal of improving care delivery. Its approach to achieving MU for approximately 700 eligible professionals across more than 50 practice sites is based on collaboration among physicians, clinical staff, project coaches, system developers, trainers, and data analysts. In this session, the MU project team will discuss strategies and tools for using practice-based teams to drive process and behavior change and transform meaningful use into meaningful care.

**After this presentation, participants will be able to:**
- Develop an infrastructure to drive implementation and support sustainability.
- Design a motivational incentive distribution model.
- Engage leadership through data transparency and alignment of MU with organizational goals.

**Lord, J.,** Meaningful Use Project Manager, University of North Carolina Health Care; **Malone, R., PharmD,** Vice President, UNC P&A Practice Quality and Innovation, University of North Carolina Health System; **Thornhill, J.,** Manager, UNC P&A Practice Quality and Innovation, University of North Carolina Health System; **Nauss, N.,** Health IT Project Manager, University of North Carolina Health Care; **Spencer, D.,** Medical Director and Vice President of Ambulatory Care, University of North Carolina Health System

## L12 You Want to Build a Patient-Centered Medical Home: Are You Insane?!

*Maryland 1-2*

In this session, participants will learn how to build a patient-centered medical home (PCMH) by picking the right plan (Accreditation Association for Ambulatory Health Care [AAHC], National Committee for Quality Assurance [NCQA], Utilization Review Accreditation Commission [URAC], or The Joint Commission), picking the right contractors, and learning some basic construction techniques (tools and guidelines provided). They will see a model PCMH assembled right before their eyes, and the certificate awarded at the end of the session will attest that the participant is sane enough to build his or her own PCMH.

**After this presentation, participants will be able to:**
- Develop a PCMH plan for their organization or practice and spell out clear steps for implementing the plan.
- Identify the specific PCMH program that will work for their sites.
- Use the tools and guidelines provided in the session in their own PCMH journeys.

**Schwartz, C., RN,** Quality Improvement Coach, Pennsylvania Academy of Family Physicians; **Grajales, L.,** Vice President, Quality Initiatives, Pennsylvania Academy of Family Physicians; **Jones, J.,** Health Information Technology Facilitator, Pennsylvania Academy of Family Physicians

## Workshop A 1:30 PM – 2:45 PM

## Workshop B 3:00 PM – 4:15 PM

All A workshops repeat during B workshops, except for the special interest keynotes and rapid-fire workshops.

## Special Interest Keynotes

### A1 How Do They Do That? Finding Joy in Practice: Experiences from the Field

*Maryland Ballroom*

**Sinsky, C., MD,** Physician, Medical Associates Clinic and Health Plans; **Sinsky, T., MD,** Physician, Medical Associates Clinic and Health Plans

### B1 Patient-Centered Medical Home Redesign: Tools for Practice Transformation

*Maryland Ballroom*

**Sugarman, J., MD,** CEO, Qualis Health; **Wagner, E., MD,** Director, Group Health Cooperative; **Daniel, D., PhD,** Senior Quality Improvement Principal, Qualis Health; **Phillips, K.,** Director, Qualis Health

### A2/B2 A Triple Aim Approach to Reducing Health Inequality in England

*Chesapeake 3*

A Triple Aim program working across local agencies has reduced health inequity in a town in southeastern England. This session will discuss the National Health Service (NHS) Institute initiative in the district, "Healthy Places, Healthy Lives," which enlisted local knowledge in identifying low aspirations as the main cause of teenage pregnancy and prescribed cultural and behavioral change as the solution. The session also offers lessons from across England in using this program to engage communities and introduce tools for managing improvement projects.

**After this presentation, participants will be able to:**

- Discuss the development of the local infrastructure for community-wide population health improvement using the Triple Aim.
- Use some simple tools to manage a program of multi-agency projects aimed at improving the health of a defined population.

**Scott-Clark, A.,** Deputy Director, Public Health, Eastern and Coastal Kent Primary Care Trust; **Lucking, G.,** Senior Associate, NHS Institute for Innovation and Improvement

### A3/B3 Best Practices for Leveraging Social Media to Engage Patients

*Maryland 5-6*

Social media is revolutionizing health communication. Hospitals, health plans, public health organizations, government agencies, pharmaceutical companies, and countless start-ups are using social media—Facebook, Twitter, blogs, YouTube, eCards, and other technologies—to engage health care consumers in new ways. This session will discuss the emergence of best practices in health care organizations using social media technologies for health communication. Participants will be provided with the skills to select and use social media effectively, using best practices and case studies.

**After this presentation, participants will be able to:**

- Identify the primary types of social media and how health care organizations use them.
- Create an effective social media strategy.
- Identify the demographics of social media users.

**Gualtieri, L., PhD,** Assistant Professor, Tufts University School of Medicine

### A4/B4 Developing an Office Practice Culture of Safety

*Chesapeake 1-2*

A culture of safety is essential to improving safety in almost any setting. In this session, we will provide tools for assessing and improving the culture of safety in the office setting, whose challenges are different from those in the hospital setting.

**After this presentation, participants will be able to:**

- Discuss the relationship between a culture of safety and the incidence of harm or error.
- Describe two approaches to assessing the culture of safety in the ambulatory setting.

**Gandhi, T., MD,** Chief Quality and Safety Officer, Partners Healthcare

### A5/B5 Developing Effective Quality Improvement Leaders in Office Practices

*Chesapeake D-F*

A self-activated practice cannot develop without effective team leaders. This workshop will use the experience of transforming practices into patient-centered medical homes through performance improvement to delineate the roles of practice teams and team leaders. Participants will learn about a quality improvement (QI) team-leader training module that assesses the skills of team members and identifies and coaches the leaders.

**After this presentation, participants will be able to:**

- Identify the key elements in developing QI team leaders and resident leadership training, including program content and coach mentoring.
- Describe implementation of the QI team-leader training and resident leadership program.
- Discuss lessons learned from the program.

**Deaner, N., MSW,** Residency Project Program Manager, HealthTeamWorks; **Jortberg, B.,** Faculty, University of Colorado; **Dickinson, P., MD,** Professor, University of Colorado Health Sciences Center

### A6/B6 Essential Elements of Practice Coaching Programs

*Maryland 3-4*

This session will review the resources developed by the Aligning Forces for Quality (AF4Q) Alliances, which support coaching programs for primary care transformation. Those resources include coach training materials, skills assessment, and the "ROI Calculator." Participants will also learn about the AF4Q cross-alliance coaching network and the lessons learned through its rapid dissemination and spread.

**After this presentation, participants will be able to:**

- Articulate the essential elements of an evidence-based practice coaching program training curriculum.
- Describe how to combine a practice needs assessment tool with a practice coach skills assessment tool to tailor support and ongoing training for practice coaches.
- Describe the "ROI Calculator," a teaching tool for practices that quantifies the costs and benefits of quality improvement initiatives.

**Powell, J.,** Health Care Improvement Advisor

### A7/B7 Integrating Outpatient Care Management in the Patient-Centered Medical Home

*Chesapeake 4-6*

This session will demonstrate how 17 primary care practice sites received National Committee for Quality Assurance (NCQA) Level 3 patient-centered medical homes (PCMH) recognition. The transformation to patient-centered medical homes required that practices change their model from episodic to continuous care and redirect resources to help patients manage their care between visits and achieve self-management goals. Participants will learn how these practices developed a care management program to help patients efficiently manage their health, chronic diseases, and preventive care.

**After this presentation, participants will be able to:**

- Discuss the design and implementation of an outpatient care management program.
- Identify care management roles and responsibilities that support PCMH recognition.
- Describe how to develop and implement processes to manage patient populations.

**Russell, D., RN,** Director, Medical Management and Quality, Baystate Medical Center; **Roy, A., RN,** Manager, Clinical Integration, BayCare Health Partners

### A8/B8 Proactive Office Encounter: Systematic Preventive and Chronic Care

*Chesapeake G-I*

The Southern California Permanente Medical Group (SCPMG) has developed Proactive Office Encounter (POE), an in-reach system that engages staff and physicians to address proactively 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. In this session, we will detail the main features of these quality improvements. These include: enhancing the patient care experience; improving preventive and chronic disease management; achieving greater efficiencies; empowering and engaging staff; supporting physician practice, (both specialty and primary); and enhancing partnerships between physicians and health care teams.

**After this presentation, participants will be able to:**

- Identify opportunities to create a highly reliable, improved, and more efficient care and disease management process.
- Describe ways to empower and engage staff, optimize clinician support in specialty care and primary care, and enhance partnerships between physicians and health care teams.

**Kanter, M., MD,** Medical Director, Quality and Clinical Analysis, Kaiser Permanente Regional Quality and Risk Management; **Andrews, K.,** Proactive Care Group Leader, Kaiser Permanente Regional Quality and Risk Management

### A9/B9 Scotland's Primary Care Safety Improvement Program: Innovative Tools and Approaches

*Chesapeake A*

Improving safety in primary care isn't easy! Senior faculty will share their experience in developing Scotland's safety program for primary care. This work, funded by the Health Foundation, is now the basis for a larger program supported by the Scottish government. This session will share results and the techniques and tools developed, including structured case note review (trigger tools), improvement bundles, safety climate surveys, and patient involvement.

**After this presentation, participants will be able to:**

- Describe the importance of culture, human factors, reliability, and patient engagement in improving safety.
- Use a range of groundbreaking tools and approaches, tested with 80 primary care teams, to develop and improve patient safety in their own primary care setting.

**Houston, N., MB ChB,** Family Physician and National Clinical Lead, Patient Safety in Primary Care Program, NHS Scotland; **Gillies, J.,** National Program Manager, Patient Safety in Primary Care Program, NHS Scotland

### A10/B10 Stop Feeding the Urgent Care Clinic Monster

*Chesapeake 10-12*

Daytime urgent care clinics and walk-in clinics are well-intentioned attempts to meet today's demand for medical care. Unfortunately, they often take on a life of their own, draining resources and systematically robbing patients and providers of the opportunity to enjoy continuity and the benefits of the relationship between patients and primary care physicians. In this session, participants will learn how to slay the urgent care clinic "monster" and redeploy resources to better support continuity and access in their organization.

**After this presentation, participants will be able to:**

- Describe how urgent care and walk-in clinics create a false economy and undermine efforts to establish a primary care patient-centered medical home (PCMH).
- Identify the key steps they can take to analyze their need for urgent care.
- Make a plan to dismantle an urgent care framework and redeploy those resources to support a strong PCMH.

**Tantau, C.,** President, Tantau & Associates

### A11/B11 The Effective Patient Portal: Improving Practice Productivity and Patient Care

*Maryland 1-2*

Using the patient portal Epic, Sisters of Mercy – which covers a four-state region in the Midwest – has enrolled over 170,000 patients in two years, one of the fastest growth rates among Epic users. Epic services offered include scheduling appointments, conveying test results, refilling medications, messaging, conducting e-visits, and paying bills online. Growth and marketing, patient and physician acceptance, and information technology present new challenges to Epic users, and this session will discuss those challenges in detail. Participants will also learn how Epic helped Sisters of Mercy reach meaningful use (MU) objectives in 2011.

**After this presentation, participants will be able to:**

- Develop a plan for implementing a patient portal that adds value and helps meet MU objectives.
- Identify the impacts of a patient portal on office work flow, productivity, and improvements in patient care.
- Implement a patient portal with greater functionality.

**Faron, M., MD,** EHR Medical Director, Mercy Multispecialty Group; **Weick, R., MD,** Physician, St. John's Mercy Medical Center

### A12/B12 Transition Clinic: An Innovative Model for Increasing Primary Care Access

*Chesapeake J-L*

To address the needs of an increasing number of unattached patients, the South Calgary Primary Care Network created a transition clinic. This model allows transitioning physicians – new medical school graduates and international physicians – to work in a fully-funded clinic with an established family physician who acts as a mentor while maintaining his or her own patient panel and providing walk-in services. Transitioning physicians build a patient panel over a six-month period before moving out to their own practice in the community.

**After this presentation, participants will be able to:**

- Describe an innovative model for increasing access to primary care services.
- Articulate how to use a full complement of disciplines in their office setting and still be efficient.
- Use new techniques to work with physician students in a primary care setting.

**Benterud, E., RN,** Director of Health Promotion and Research, South Calgary Primary Care Network; **Sisodiya, M., RN,** Director of Clinical Services, South Calgary Primary Care Network

### Rapid-Fire A: Transitions in Care

*Chesapeake B-C*

**Moderated by: Schall, M.,** Senior Director, IHI

**Make the Call: Implementing a Post-Hospital/ Emergency Department Follow-Up Process**
**Ross, J.,** Project Manager, Medical Home, Legacy Health Systems

**Common Outpatient Risk Factors for Adverse Events**
**Dickerman, J., DO,** Medical Director, Mountain PACE Program and Senior Medical Director for Primary Care, Memorial Hospital

**RED Connect: Now Engaging the Community Pharmacist**
**Loughnane, J., MD,** Medical Director, Boston's Community Medical Group

**Lessons from a Community Effort to Reduce Readmissions**
**Hilger, R., MD,** Medical Director, HealthPartners

### Rapid-Fire B: The Patient-Centered Medical Home

*Chesapeake B-C*

**Moderated by: Bagley, B., MD,** Medical Director for Quality Improvement, American Academy of Family Physicians

**Redesigning a Clinic to Improve Patient Outcomes**
**Duane, M., MD,** Medical Director, Spanish Catholic Center of Catholic Charities

**Implementing the Patient-Centered Medical Home: Best Practices**
**Steiner, R., RN,** Director of Collaborative Care, MidMichigan Health Network

**Taking the Medical Home Statewide: Lessons Learned**
**Gabbay, R., MD, PhD,** Director, Institute for Diabetes and Obesity, Penn State College of Medicine

**Medical Home Delivery System Redesign**
**Fortini, R.,** Vice President and Chief Clinical Officer, Bon Secours Virginia Medical Group

## Keynote Two

4:30 PM – 5:30 PM

*Maryland Ballroom*

**Donald M. Berwick, MD, MPP,** Former Administrator, Centers for Medicare & Medicaid Services; Former President and CEO, Institute for Healthcare Improvement

## Keynote Three

8:00 AM – 9:00 AM

*Maryland Ballroom*

**Ellen Goodman,** Pulitzer Prize-winning columnist, author, and speaker

## Workshop C 9:30 AM – 10:45 AM

Workshop C does not repeat.

## Special Interest Keynote

### C1 Minimally Disruptive Medicine: Achieving Patient-Centered Care

*Maryland Ballroom*

**Montori, V., MD,** Director, Mayo Clinic Healthcare Delivery Research Program and Professor of Medicine, Mayo Clinic

## Rapid-Fire C: Specialty Care

*Chesapeake B-C*

**Moderated by: Tantau, C.,** President, Tantau & Associates

**Mobilizing the Multiple Sclerosis Patient**
**Bednar, A.,** PR Manager, Multiple Sclerosis Association of America

**Transforming the Lives of Patients with Addictions**
**Roll, D., MD,** Internist and Pediatrician, Cambridge Health Alliance

**Primary Care Model for High-Risk Patients**
**Weil, E., MD,** Associate Medical Director for Primary Care, Massachusetts General Hospital

**Diabetes: Ambulatory Team Management Approach**
**Bai, M., MD,** Assistant Medical Director, Kaiser Permanente

### C2 Advanced Medical Home Delivery System Redesign

*Maryland 3-4*

This session will delineate the necessary changes for improving care delivery, modifying patient behavior, and managing care transitions. Participants will be given a detailed look at core competencies, care team composition, and goals and objectives for effective case management, population management, and capacity and access improvement. Faculty will describe our efforts to build a team approach to patient care by embracing the medical home model and the principles of embedded panel management and case management.

**After this presentation, participants will be able to:**
- Explain a three-phase approach to reengineering care that underlies the successful execution of the patient-centered medical home (PCMH) care delivery model.
- Describe the role of electronic medical record implementation in the standardization, workflow redesign, and care coordination that drives benefits from the PCMH.
- Illustrate improvement in selected outcome metrics, including patient wait time, patient satisfaction, no-show rates, and physician productivity.

**Auer, T., MD,** CEO, Bon Secours Virginia Medical Group; **Fortini, R.,** Vice President, Chief Clinical Officer, Bon Secours Virginia Medical Group

### C3 Better Population Health: Innovative Self-Management Support

*Chesapeake J-L*

In this workshop, we will describe innovative approaches to self-management support to address the needs of a population and improve the health of a community—one leg of the Triple Aim. We will use a case study to demonstrate how the population can be segmented and staff deployed to meet the needs of different patient groups. Outcomes include improvements in patient confidence and in health indicators.

**After this presentation, participants will be able to:**
- Describe two ways of creating a plan for population management through self-management support.
- Create a stepped-care approach to self-management support.

**Davis, C.,** Geriatric Nurse Practitioner, Connie L. Davis Health Services; **Lewis, A.,** CEO, CareSouth Carolina, Inc.

### C4 Developing High-Functioning Outpatient Teams to Enhance Patient Outcomes

*Chesapeake D-F*

Fairview Medical Group has found that providing interdisciplinary outpatient teams with proximity to one another, regular, dedicated meeting times, and the tools and permission to innovate leads to higher-functioning teams and culture transformation in outpatient settings. This workshop will discuss the work of these interdisciplinary teams, which has enhanced patient outcomes and improved staff job satisfaction and overall patient satisfaction.

**After this presentation, participants will be able to:**
- Describe how one medical group tackled cultural transformation to develop high-functioning teams and how to use the same approach in their own settings.
- Apply methods for moving individuals from a manager role to a leader role in adaptive work.

**Holley-Carlson, K.,** Clinic Administrator, Fairview Health Services; **James, H.,** Clinic Administrator, Fairview Health Services; **DeRoche, K., MD,** Family Practice Physician, Fairview Health Services

### C5 Hardwiring an Office-Based Patient Safety Program

*Maryland 5-6*

Over the last five years, HealthTexas Provider Network, a physician-led organization with more than 500 members, has established an aggressive and vigorous patient safety (PS) program that has produced outcome data, process metrics, findings on role development, and an active PS committee. The program has now been hardwired in over 150 clinic sites. In this session, presenters will review these initiatives and other programs, share what worked and what did not, and discuss future challenges.

**After this presentation, participants will be able to:**
- Describe the methods and challenges involved in creating an office-based patient safety program.
- Identify role development and methods for hardwiring PS program policies and initiatives in a clinical office practice.
- Describe the different modalities involved in effectively communicating the patient safety message to their target audience.

**Casey, B., RN,** Patient Safety Manager, Health Texas Provider Network; **Felton, C., RN,** Director, Baylor Health Care System; **Tucker, S., MD,** Physician and Chair, Patient Safety Committee, Health Texas Provider Network

### C6 Lessons from the Trenches: Improving Practice in an Academic Health Center

*Chesapeake 10-12*

Transforming a practice is not for the faint of heart. This session will describe the real-world journey of one academic community health center when it set out to improve access and efficiency by becoming a patient-centered medical home. Participants will learn lessons from the trenches of this experience:

how to improve a practice through practical project management, using Plan-Do-Study-Act (PDSA) testing cycles, huddles, and team communication; how to develop multidisciplinary clinic teams; and how to improve physician and staff engagement.

**After this presentation, participants will be able to:**
- Develop a step-by-step procedure for testing, implementing, and spreading a process within practices.
- Engage physicians and staff in defining roles and building care teams.
- Identify actions that help sustain the changes being spread and develop plans for addressing the barriers.

**Boyle, E., MD,** Medical Director, Baystate Medical Center; **Delozier, G., RN,** Health Center Manager, Baystate Medical Center

## C7 Redesigning Care Services Using Public Health Data and Quality Improvement

*Chesapeake 1-2*

This session will detail the experience of a locally developed public health strategy to prevent HIV/AIDS transmission that uses public health data and quality improvement frameworks in redesigning and reorganizing services in primary and community care settings. Participants will become familiar with the critical features of this initiative, including client voice, use of public health clinical data as quality indicators, and sharing of regional patient information between multidisciplinary and cross-boundary health care teams to enhance care and coordination.

**After this presentation, participants will be able to:**
- Utilize public health strategies and data to drive local redesign of health care services to improve population health.
- Identify strategies to integrate client experience and voice into all levels of a population-based initiative that strives to improve public health and individual patient experience.
- Identify public health data sources and strategies to share patient information across providers, boundaries, and disciplines to optimize patient care and outcomes while respecting the confidentiality of patient information.

**Barrios, R., MD,** Medical Director, BC Centre for Excellence in HIV/AIDS; **Clarke, C.,** Quality Improvement Advisor, Impact BC

## C8 Structuring a Multi-Clinic EHR and E-Prescribing Conversion Process

*Chesapeake 3*

Over the past two years, more than 30 Virginia Commonwealth University Health System (VCUHS) ambulatory clinics have been converted to e-prescribing and an electronic health record (EHR) through a structured process developed by its project team. This presentation will address how key processes were identified and outline the conversion process used by the project team. Participants will learn about the importance of clinic-level champions and staff involvement and how VCUHS monitored and addressed compliance issues after implementation.

**After this presentation, participants will be able to:**
- Identify the key steps in a successful transition from a paper to an electronic workflow in complex ambulatory settings.
- Discuss how VCUHS determined the key state processes common to all of its ambulatory clinics and used these in the conversion process.
- Outline VCUHS's use of a structured 15-week meeting plan with clinics to transition workflow from the current paper state to the future electronic state.

**Van't Riet, S.,** Performance Improvement Specialist, Virginia Commonwealth University; **Burgett, D., RN,** Senior Project Manager, Virginia Commonwealth University

## C9 Team-Based Care: Redesigning Team Roles

*Chesapeake 4-5*

The Veterans Health Administration has embarked on a transformation of its primary care system into a medical home model of health care delivery. Critical to this effort has been a redesign of both the team and the work performed at the point of care. This session will demonstrate how clarifying roles, responsibilities, and functions around the new work design fosters open dialogue and enables the team to view care as team-based rather than provider-based. Although the primary care provider's relationship with the veteran patient remains key, the bond is augmented and strengthened by involving other health care staff as part of an integrated team.

**After this presentation, participants will be able to:**
- Describe the Veterans Health Administration process for redesigning the roles of staff in team-based care.
- Develop measures to track task completion in transformation efforts in their own settings.

**Shear, J.,** National Primary Care Clinical Program Manager, Department of Veterans Affairs; **Stark, R., MD,** Director of Primary Care Operations, Department of Veterans Affairs

## C10 The Path to the Shingo Prize: Building a Lean Clinic

*Chesapeake G-I*

In 2011, with over five years of experience using the Lean Toyota Production System as a framework for process improvement, Denver Community Health Services became the first health care delivery organization to win the Shingo Prize Bronze Medallion for Operational Excellence, for transformational work in its network of eight health centers. This session will review Denver Health's journey, from its first attempts at open access to its development of a systemwide culture of improvement.

**After this presentation, participants will be able to:**
- Identify the "wastes" in clinic processes that can interfere with flow and quality.
- Describe how to apply the basic tools of Lean production analysis to improve clinic flow and quality of care.
- Develop a portfolio of Lean tools, events, and projects to transform their organizations.

**Loomis, L., MD,** Director of Family Medicine, Denver Health; **Kampe, F.,** Lean Facilitator, Denver Health

## C11 You Want to Build a Patient-Centered Medical Home: Are You Insane?!

*Chesapeake A*

Picking patient-centered medical home (PCMH) teammates is not like grade school, where we all picked our favorite friends. Setting up a PCMH team is much more like drafting players in the first-round draft, whether football, basketball, or baseball. First-round picks have clear skills that are advantageous to the team doing the selecting. A PCMH team must also be selected with an eye to acquiring members with the skills that can offer the most assistance with the particular PCMH application. This workshop will provide participants with some tips, tricks, and tools that will help them achieve the biggest championship of all—becoming a patient-centered medical home.

**After this presentation, participants will be able to:**
- Determine which skills to look for in selecting members for PCMH teams.
- Describe which tools are appropriate for streamlining the organization of the PCMH team and how to use them effectively.
- Articulate how to stay on track, meet the deadlines set by the PCMH team, and make sure the chairperson is a leader and not a "I will do it all myself" person.

**Schwartz, C., RN,** Quality Improvement Coach, Pennsylvania Academy of Family Physicians; **Grajales, L.,** Vice President, Quality Initiatives, Pennsylvania Academy of Family Physicians; **Jones, J.,** Health Information Technology Facilitator, Pennsylvania Academy of Family Physicians

## C12 Building Successful Partnerships with Communities to Improve Health and Wellness

*Maryland 1-2*

Outstanding clinical outcomes, supportive care and follow up, and patient and community engagement in improvement—these can't be planned or executed in isolation, behind the four walls of our offices and clinics. It takes a community with the motivation to change, a willingness to build and share resources, and access to community expertise and experience to build a successful and healthy community. There is increasing evidence that existing community networks for care, social support and education, and the facilitation of access to care can be augmented by community health workers (CHWs) and advocates. This session will provide background on some successful approaches to collaboration between health care organizations, community workers, and other partners to benefit the health and wellness of the communities they serve.

**After this presentation, participants will be able to:**
- List examples in which integrating CHWs into primary care and mental health teams has led to improved patient health outcomes and engagement and lower health care expenditures.
- Describe the evidence, value, and impact of CHWs in preventing and managing chronic diseases such as heart disease and stroke, diabetes, and cancer.
- Begin identifying and building a successful partnership with community resources to benefit the health and wellness of the community.

**Hupke, C., RN,** Director, IHI

## Workshop D 11:00 AM – 12:15 PM
## Workshop E 1:15 PM – 2:30 PM

All D workshops repeat during E workshops, except for the special interest keynotes and rapid-fire workshops.

## Special Interest Keynotes

### D1 SCF Nuka System of Care: Whole System Transformation Improves Outcomes

*Maryland Ballroom*

**Eby, D., MD,** Vice President of Medical Services, Southcentral Foundation; **Aloysius, C.,** Vice President, Southcentral Foundation

### E1 Designing the Best: Engaging Stakeholders in Primary Care Transformation

*Maryland Ballroom*

**Edgman-Levitan, S.,** Executive Director and IHI Fellow for Patient- and Family-Centered Care, Massachusetts General Hospital

### D2/E2 A Systems-Based Approach to Redesign: Improving Preventive and Chronic Care

*Chesapeake D-F*

University of Wisconsin Health (UW Health) uses a standard framework to guide improvement work at all levels of the health system. Based on organizational and engineering models described by the Institute of Medicine (IOM), Stephen Shortell, and UW Systems Engineering Initiative for Patient Safety (SEIPS), this model has guided redesign efforts in primary care, resulting in improvements in preventive and chronic care. The framework facilitates a systems-based approach to redesign, identifying critical elements of change at each level of the health system.

**After this presentation, participants will be able to:**

- Describe an organizational framework for top-down and bottom-up improvement work that aligns and engages all levels of an organization (the patient self-care system, the microsystem, management, organization, and environment).
- Apply the health system framework to their primary care redesign initiatives.
- Discuss the role of leadership in model implementation.

**Kraft, S., MD,** Medical Director, Quality and Safety Improvement, University of Wisconsin Hospital and Clinics

### D3/E3 A Triple Aim Approach in Independent and Small Practices

*Chesapeake 3*

This session offers participants a do-it-yourself tool to achieve the Triple Aim in independent and small practices by presenting the replicable innovative work of members of a collaborative of independent practices. Establishment of a nationwide cooperative network, using free or low-cost, patient-centered, asynchronous, cutting-edge, and sustainable tools, allowed these providers—from a variety of practice settings and styles—to increase access, improve patient and provider satisfaction, and lower emergency room and hospital use costs.

**After this presentation, participants will be able to:**

- Identify methods to collaborate with other practices to improve and redesign practices.
- Implement specific actions to improve access to care and patient-centered care in any practice.
- Assimilate adult learning methods to transform practices into effective, efficient, accessible medical homes.

**Antonucci, J., MD,** Physician, Ideal Medical Practices; **Brady, J., MD,** Family Physician, The Village Doctor

### D4/E4 An Innovative Approach to Workforce Development: Improved Outcomes and Satisfaction

*Maryland 3-4*

Southcentral Foundation (SCF) in Alaska is known for its relationship-based system of care that has resulted in improved health outcomes, decreased costs, and increases in customer and employee satisfaction. Through its innovative approach to workforce development (WFD), SCF aligns individual employee performance with organizational goals and objectives in support of its mission and vision. SCF's comprehensive WFD system integrates human resources with the learning and development function, supporting employees from initial recruitment and selection, orientation and on-boarding, and performance development and management to job progression and career track and pipeline development.

**After this presentation, participants will be able to:**

- Discuss SCF's innovative approach to comprehensive workforce development.
- Identify SCF's alignment of individual employee performance with organizational goals and objectives.
- Examine a variety of WFD methodologies and evaluate how they could adapt these approaches to their organizations.

**Brenock-Leduc, K.,** Director of Learning and Development, Southcentral Foundation; **Martz, E.,** Manager, Southcentral Foundation; **Sappah, B.,** Improvement Specialist, Southcentral Foundation

### D5/E5 Effectively Reducing Readmissions: Lessons from a Community Collaboration

*Maryland 5-6*

This session will discuss how to tackle the challenge of reducing readmissions of high-risk patients through a multifaceted approach involving numerous partners with little history of collaboration. Participants will learn how health plans, community clinics, hospitals, home care agencies, and transitional care facilities can learn from each other, improve and streamline care delivery, and form strong relationships that increase the chance of success in achieving the Triple Aim.

**After this presentation, participants will be able to:**

- Implement care plans (including narcotic restriction plans) for high-risk patients to improve patient safety and reduce unnecessary readmissions.
- Demonstrate how to align hospital and outpatient or community-based services – such as nursing homes, home care, and health plan care management practices – to decrease unnecessary readmissions.
- Demonstrate how to leverage the electronic medical record within an organization to improve quality and reduce unnecessary readmissions.

**Hilger, R., MD,** Medical Director, HealthPartners; **Heinz, B.,** Vice President, Operations, Regions Hospital

### D6/E6 Improving Performance in Practice (IPIP): The Michigan Experience

*Chesapeake 1-2*

This session will share the story and results of Michigan's efforts to transform primary care practices into patient-centered medical homes. Michigan's nationally led quality improvement initiative, Improving Performance in Practice (IPIP–MI), used industry-proven QI methods and engineers, predominantly from the automotive sector, to help physicians transform and, in some cases, redesign their practices. Participants will learn how the initiative, based on MacColl Institute's Chronic Care Model and the Blue Cross Blue Shield PCMH, drove primary care practice improvements: adopting a registry or EMR with embedded clinical guidelines to identify and track care for patients with a target condition (diabetes or asthma); establishing team care through the use of role definition, protocols, and standing orders; and developing processes to provide self-management support within the practice and through referral to appropriate services in the community.

**After this presentation, participants will be able to:**

- Describe the implementation of Michigan's IPIP initiative, a nationwide project to incorporate quality improvement tools and techniques into health care, and discuss the implementation of similar programs or processes in other settings.
- Articulate the lessons learned from Michigan's IPIP efforts to provide constructive advice for the implementation efforts of others.

**Gutowsky, J.,** Lean Coach and Quality Management Specialist, IPIP Project; **Steiner, R., RN,** Director of Collaborative Care, MidMichigan Health Network

## D7/E7 Multiple Practice Transformation: Learning from the Largest Primary Care Residency Collaboratives

*Chesapeake A*

For medical, economic, and political reasons, interest in practice transformation is widespread, but accomplishing it is challenging, particularly in academic settings. Three of the largest primary care residency collaboratives have assisted practices, hospitals, and health systems in beginning or continuing a journey in multiple practice transformation, and in this session they will answer questions about those efforts. How did they do it? What worked for them, and what didn't?

**After this presentation, participants will be able to:**

- Identify the key components of efforts to assist practices in a health network or similar organization with medical home transformations.
- Delineate the optimal methods of transformation for their own settings.
- Define a framework ("blueprint") upon which to begin such a transformation, using best-practice methodology.

**Radosh, L., MD,** Program Director, Family Medicine Residency, Reading Hospital and Medical Center; **Weir, S., MD,** Clinical Associate Professor, University of North Carolina Health System; **Warning, W., MD,** Program Director, Crozer Keystone Health Systems; **Dickinson, P., MD,** Professor, University of Colorado Health Sciences Center; **Lefebvre, A., MSW,** Associate Director, North Carolina AHEC at UNC Chapel Hill

## D8/E8 Reducing Variation in the Primary Care Setting

*Chesapeake G-I*

In this session, participants will learn how to increase the value of the care they provide by removing unwarranted variation. Faculty will share key lessons from the Palo Alto Medical Foundation's successful variation reduction initiatives in the primary care setting and use of Kaizen methodology. Faculty will also provide guidance for replicating the variation reduction framework in other organizations, including strategies to engage physicians in the development of standards of practice in the primary setting.

**After this presentation, participants will be able to:**

- Identify strategies for applying the variation reduction methodology to primary care.
- Explore the use of the Kaizen methodology in the clinical settings.
- Create simple strategies to harvest data on clinical variation in their own setting.

**Knapp, W., MD,** Physician, Palo Alto Foundation Medical Group; **Trujillo, L., MD,** Medical Director of Quality, Palo Alto Medical Foundation; **Paull-Flores, L.,** Project Manager, Palo Alto Medical Group

## D9/E9 Statewide Patient-Centered Medical Home Initiatives: Results and Lessons Learned

*Chesapeake 10-12*

The patient-centered medical home is an increasingly popular approach to providing comprehensive, accessible primary care that improves coordination, accountability, and quality. This session will describe the experience of three statewide patient-centered medical home (PCMH) initiatives, in operation for more than four years in Pennsylvania, Colorado, and Michigan. Participants will learn how these initiatives convened stakeholders; were led, designed, and funded; negotiated incentives; recruited and supported practices; and measured improvement. Faculty will share outcomes and translatable lessons to assist participants in designing their own initiatives.

**After this presentation, participants will be able to:**

- Discuss the results and lessons from three statewide PCMH initiatives with respect to leadership, initiative design, practice recruitment and support, funding, and stakeholder engagement.
- Identify the keys to the success of each of these statewide initiatives.
- Develop plans for replicating the keys to success in other PCMH initiatives.

**Gabbay, R., MD, PhD,** Director, Penn State Institute for Diabetes and Obesity, Penn State College of Medicine; **Harbrecht, M., MD,** CEO, HealthTeamWorks; **Johnson, S.,** Healthcare Analyst, Blue Cross Blue Shield of Michigan

## D10/E10 Tactics to Strengthen Physician Engagement

*Chesapeake 4-5*

It is a given that physicians should be active participants in quality and safety improvement efforts. Yet a gap persists between this imperative and the extent to which physicians in most organizations are meaningfully engaged in these efforts on a daily basis. This session provides practical ways to develop and sustain the critical engagement of physicians to improve practice quality and safety.

**After this presentation, participants will be able to:**

- Describe how the bifurcation of physicians' clinical and managerial roles diminishes the urgency and responsibility they bring to the improvement imperative.
- Identify steps to strengthen the alignment of physician and organization goals in deciding what transformed care will look like and how it will be achieved.
- Articulate specific behaviors that foster physician engagement and ownership for success.

**Silversin, J.,** President, Amicus, Inc.

## D11/E11 Team-Based, Relationship-Centered Care Management for Safety Net Populations

*Maryland 1-2*

Patients who must turn to social and medical services provided by government safety net programs are at especially high risk for fragmented care and poor outcomes. This session will present a team model of ambulatory care management that has been developed as a component of PCMH transformation. This model seeks to improve outcomes for high-risk patients by utilizing the continuity relationship with the patient's primary care team nurse. The workshop will detail outcomes thus far for various categories of high-risk patients.

**After this presentation, participants will be able to:**

- Share lessons in what is needed to manage care for a safety net population with a high incidence of mental illness and social dysfunction.
- Develop a team-based, relationship-centered model of care management that strives to effectively manage the medical, social, and behavior illnesses of a safety net population of patients.

**Stout, S., MD,** Vice President of Patient-Centered Medical Home Development, Cambridge Health Alliance; **Carr, E., LICSW,** Chief, Medical Social Work, Cambridge Health Alliance; **Chevalier, A., RN,** Clinical Manager, Cambridge Health Alliance; **Elvin, D., MD,** Physician, Cambridge Health Alliance

## D12/E12 The Role of Ambulatory Staff in an Inpatient World

*Chesapeake J-L*

This workshop will introduce a new paradigm: outpatient care teams leading efforts to prevent readmissions in high-risk patient populations. Faculty will describe the benefits and impact of this paradigm for the accountable care organization model. Also explored will be concepts related to the creation of a longitudinal care system built on coordinated care transitions between outpatient and inpatient care teams: effective interventions, care coordination, and realistic goal setting. Faculty will use case studies to demonstrate how these shifts lead to successful patient experiences and better overall results.

**After this presentation, participants will be able to:**

- Describe the implementation of models of care led by outpatient care teams to prevent readmissions.
- Articulate how risk assessment, combined with intuitive knowledge of the patient relationship, can aid in a successful care plan.
- Identify strategies for including patients and caregivers in active goal setting for better quality of life and care transition outcomes.

**Loughnane, J., MD,** Medical Director, Boston's Community Medical Group

## Rapid-Fire D: Health Information Technology

*Chesapeake B-C*

**Moderated by: Boudreau, K., MD,** Senior Vice President and Medical Director, Continuum Portfolio, IHI

### Transitioning from Paper to Electronic Health Records

**Norris, L.,** Nurse Practitioner, Riverview Medical Associates

### Workflow: What's Under The Rock?

**Van't Riet, S.,** Performance Improvement Specialist, Virginia Commonwealth University

### Patient Portal: Growth and Expansion of Functionality

**Faron, M., MD,** EHR Medical Director, Mercy Multispecialty Group

### Telemedicine in Primary Care

**Corrigan, K., MD,** Physician, National Lead in Primary Care for Telehealth, James A. Haley Veterans' Hospital

## Rapid-Fire E: Patient Safety

*Chesapeake B-C*

**Moderated by: Gans, D.,** Vice President, Innovation and Research, Medical Group Management Association (MGMA)

### The B-SMART Medication Adherence Checklist

**Oyekan, E., PharmD,** Safety Leader, Pharmacy Quality and Medication, Kaiser Permanente National Offices

### Team-Based Safety Improvement Using the Physician Practice Patient Safety Assessment

**Pracilio, V.,** Project Manager for Quality Improvement, School of Population Health, Thomas Jefferson University

### Open Wide: The Safety Culture of Dentistry

**Kalendarian, E.,** Chair, Oral Health Policy and Chief of Quality, Harvard School of Dental Medicine

### PROMISES: Proactive Reduction in Outpatient Malpractice: Improving Safety Efficiency and Satisfaction

**Ling, J.,** Improvement Advisor, PROMISES

# Index by Presenter

# StoRYboArDs

Representatives from organizations with storyboards on display will be able to answer questions during the storyboard reception on:

Monday, March 19
5:30 PM – 7:30 PM
*Maryland Ballroom Foyer*

**SB1 ACE'ing Operations Improvement at UNC Health Care**
University of North Carolina Health System
Ashley Howard
ahoward@unch.unc.edu

**SB2 Communication and Satisfaction in College Health**
New York University
Kathy Gunkel
kg47@nyu.edu

**SB3 Continuity Panel Management in a Pediatric Clinic**
Carolinas HealthCare System
Maureen Walsh Koricke
maureen.walshkoricke@carolinashealthcare.org

**SB4 Conversations with Patients: Shared Action Plans**
University of Nebraska Medical Center
Teresa Barry Hultquist
tbarry@unmc.edu

**SB5 Improving Blood Pressure Control: Saving Lives!**
Kaiser Permanente of the Mid-Atlantic States
Kristen Gibson
kirsten.r.gibson@kp.org

**SB6 Innovative Field Tools for Practice Coaches**
Powell & Associates
Jennifer Powell
jenpowell.HCC@gmail.com

**SB7 Opportunities for Patient Experience Design**
Zoe Kronex
ex;it
itzoe.kron@exploreexit.com

**SB8 Rediscovering Partners' Value in Primary Care**
Ministry of Health, Singapore
Yewjern Low
low_yew_jern@moh.gov.sg

**SB9 The Significance of Health Information Exchanges**
Certify Data Systems
Steve Hulverson
shulverson@certifydatasystems.com

**SB10 Transition of Care Between Hospital & PCP Setting**
Pinnacle Health System
Barbara Emberg
bemberg@pinnaclehealth.org

**SB11 Using a Care Gap Summary to Promote Prevention**
Texas Tech University Health Sciences Center
Crystal Wilkinson
crystal.wilkinson@ttuhsc.edu

*Storyboards submitted after February 22 are not included in this list. A full list of storyboards is available at the IHI Registration Desk.*


**Which storyboard did you enjoy? Tweet it using #IHI**

# Exhibitors

Located in the Maryland Ballroom Foyer

### American Academy on Communication in Healthcare (AACH)

The American Academy on Communication in Healthcare (AACH) improves healthcare effectiveness by providing education, research and practice focused on communication and relationships for clinicians, patients, families, and healthcare teams.

1756 Riley Street
Jacksonville, FL 32250
Phone: (859) 514-9154
info@aachonline.org
www.aachonline.org
**Booth #107**

### CINA

CINA, a leader in data acquisition and standardization, works across multiple EMR platforms to provide practical and effective tools for Clinical Decision Support, Population Management, Disease Registry and Data Analytics.

One Glen Lakes
8140 Walnut Hill Lane, Suite 400
Dallas, TX 75231
Phone: (214) 550-6976
info@CINA-US.com
www.cina-us.com
**Booth #114**

### L3 Strategies LLC

L3 Strategies is a management consulting firm specializing in breakthrough transformations, and process improvement coaching utilizing the Toyota Production System or "Lean" methodologies. We specialize in supporting healthcare transformations with proven results in outpatient settings.

Phone: (616) 258-0879
office@L3strategies.com
www.L3strategies.com
**Booth #116**

### Care Team Connect

Care Team Connect's platform aligns hospitals, community providers and family, powering ACOs, readmission and PCMH care coordination programs to deliver the right care to the right patient at the right time.

1601 Sherman Avenue, Suite 500
Evanston, IL 60201
Phone: (877) 736-4631
info@careteamconnect.com
www.careteamconnect.com
**Booth #112**

### HealthStream, Inc.

More than half of US hospitals use HealthStream's research, learning, simulation, and talent management solutions to improve outcomes. Learn how we support better healthcare quality and experiences at www.healthstream.com.

209 10th Avenue South
Suite 450
Nashville, TN 37203
Phone: (615) 301-3100
www.healthstream.com
**Booth #118**

### NRC Picker

NRC Picker is passionate about patient-centered care. Our comprehensive approach to integrated research, evidenced-based best practice recommendations and quality improvement helps achieve successful patient-centered care environments. Learn more at www.nrcpicker.com.

1245 Q Street
Lincoln, NE 68508
Phone: (800) 388-4264
info@nrcpicker.com
www.nrcpicker.com
**Booth #100**

### Cautious Patient Foundation

Cautious Patient Foundation educates patients: about the risks patients face in the medical system; that patients' participation in their healthcare could be lifesaving; and how to participate for maximum benefit.

2507 Ohsfeldt
Houston, TX 77008
Phone: (713) 461-2822
info@cautiouspatient.org
www.CautiousPatient.org
**Booth #102**

### i2i Systems

i2i Systems' integrated Population Health Management software, i2iTracks, is used by over 1000 sites nationwide to create healthier populations, increase pay-for-performance revenue, improve operational efficiency, and reduce healthcare costs.

3663 N. Laughlin Road #200
Santa Rosa, CA 95403
Phone: (707) 575-7100
info@i2isys.com
www.i2isys.com
**Booth #106**

### Patient Engagement Systems®

Patient Engagement Systems® enables providers to improve treatment for patients with chronic diseases through personalized targeted patient content and guidelines-based decision support. PES demonstrated improved outcomes and reduced costs in NIH funded studies.

89 Beaumont Ave., Given Courtyard, 4 South
Burlington, VT 05405
Phone: (866) 233-2298
Fax: (802) 656-4576
contactus@ptengage.com
www.patientengagementsystems.com
**Booth #105**

## PowerDMS™

PowerDMS™ improves communication and collaboration, reduces risks, and saves time. This integrated solution also effectively addresses compliance needs in policy-and-procedure management, employee training, regulatory and accreditation standards, and much more.

200 E. Robinson St., Suite 525
Orlando, FL 32801
Phone: (800) 749-5104
marketing@powerdms.com
www.powerdms.com
**Booth #120**

## The Doctors Company

The Doctors Company is fiercely committed to defending, protecting, and rewarding doctors. With 71,000 members, we are the nation's largest insurer of physician and surgeon medical liability. Visit www.thedoctors.com.

185 Greenwood Road
Napa, CA 94558
Phone: (800) 421-2368 x1243
patientsafety@thedoctors.com
www.thedoctors.com
**Booth #101**

## URAC

URAC is a leading, third-party, independent accreditor of organizations specializing in health management, health care operations, Pharmacy Quality Management®, health information technology, and medical home.

1220 L Street NW, Suite 400
Washington DC, 20005
Phone: (202) 216-9010
businessdevelopment@urac.org
www.urac.org
**Booth #108**

## Qualis Health

Qualis Health is a national healthcare consulting organization that supports clinical practice transformation through implementation of the Patient-Centered Medical Home model. Our services include assessments, technical assistance, practice coaching, and recognition support.

10700 Meridian Avenue North, Suite 100
Seattle, WA 91833
Phone: (206) 364-9700
rfps@qualishealth.org
www.qualishealth.org
**Booth #103**

## United Allergy Services

United Allergy Services is a healthcare services organization that assists primary care and other physicians in providing comprehensive allergy testing and customized immunotherapy services to their patients.

100 NE Loop 410, Suite 250
San Antonio, TX 78216
Phone: (210) 265-3181
sales@unitedallergy.com
www.unitedallergyservices.com
**Booth #110**

## Exhibit Hours

**Monday, March 19**
7:30 AM – 9:30 AM
12:30 PM – 1:30 PM
5:30 PM – 7:30 PM

**Tuesday, March 20**
7:30 AM – 9:30 AM
12:15 PM – 1:15 PM

# Evaluations and Continuing Education

In support of improving patient care, the IHI is accredited by the American Nurses Credentialing Center (ANCC), the Accreditation Council for Pharmacy Education (ACPE), and the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing education for health care teams.

**The International Summit carries a maximum of 16.75 credits.**

During this program, participants will be able to:

- Identify cutting-edge ideas that are ready for immediate application to their practice.
- Apply new ways to engage patients, families, and communities in redesigning and delivering optimal care.
- Network with colleagues to generate ideas and build supportive relationships.
- Explore ways to build healthier communities and provide superior care to patients while containing or reducing costs.

Participants of the International Summit can earn contact hours by completing a brief evaluation before a certificate for continuing education credits can be issued. To access the evaluations, complete the brief General Evaluation that is accessible at: http://www.IHI.org/certificatecenter.

### How to Get a Continuing Education Certificate

In order to be eligible for a continuing education certificate, participants must complete the online evaluation within 30 days of the continuing education activity. If circumstances prevent you from completing the survey by the specified deadline, please email info@IHI.org before this period expires. After this time period, you will be unable to receive a certificate.

1. Go to www.IHI.org/certificatecenter. *(If you are not currently logged into the website, you will be redirected to the login screen. Once you are logged in you will be redirected back to the Certificate Center.)*
2. Click on the 13th Annual International Summit link that appears under the Create Certificate header.
3. Select the type of credits you wish to receive from the drop down list and then click the Submit button. You will be able to choose from Nursing Contact Hours, Pharmacist CPE, US Physician CME, Social Worker Contact Hours, AAFP Credits, or General Attendance.
4. Review your enrollment to confirm that the sessions you attended are selected. If not, click the "Edit Enrollment" button to choose your sessions. Once your sessions are selected, click "Proceed to Check Out." Click on the "Commit Changes" button to view your revised attendance summary. Confirm revision is correct and click the link that says "Return to the Certificate Center." To proceed, click the "Continue" button.
5. Complete the surveys associated with each session you attended, and for which you want to receive credits, by clicking the "Take Survey Now" button next to each session. If there are surveys listed that you do not wish to claim credits for, click the "Opt Out of Survey" button.

   *Note: You must either take or opt out of each survey in order to print your certificate.*
6. Once you have completed all surveys, click the "Generate Certificate" button to generate a PDF file of your certificate. You can print or save this certificate to your computer.

This program is approved by the National Association of Social Workers (approval number 886367066-9931) for Social Work Continuing Education Contact Hours.

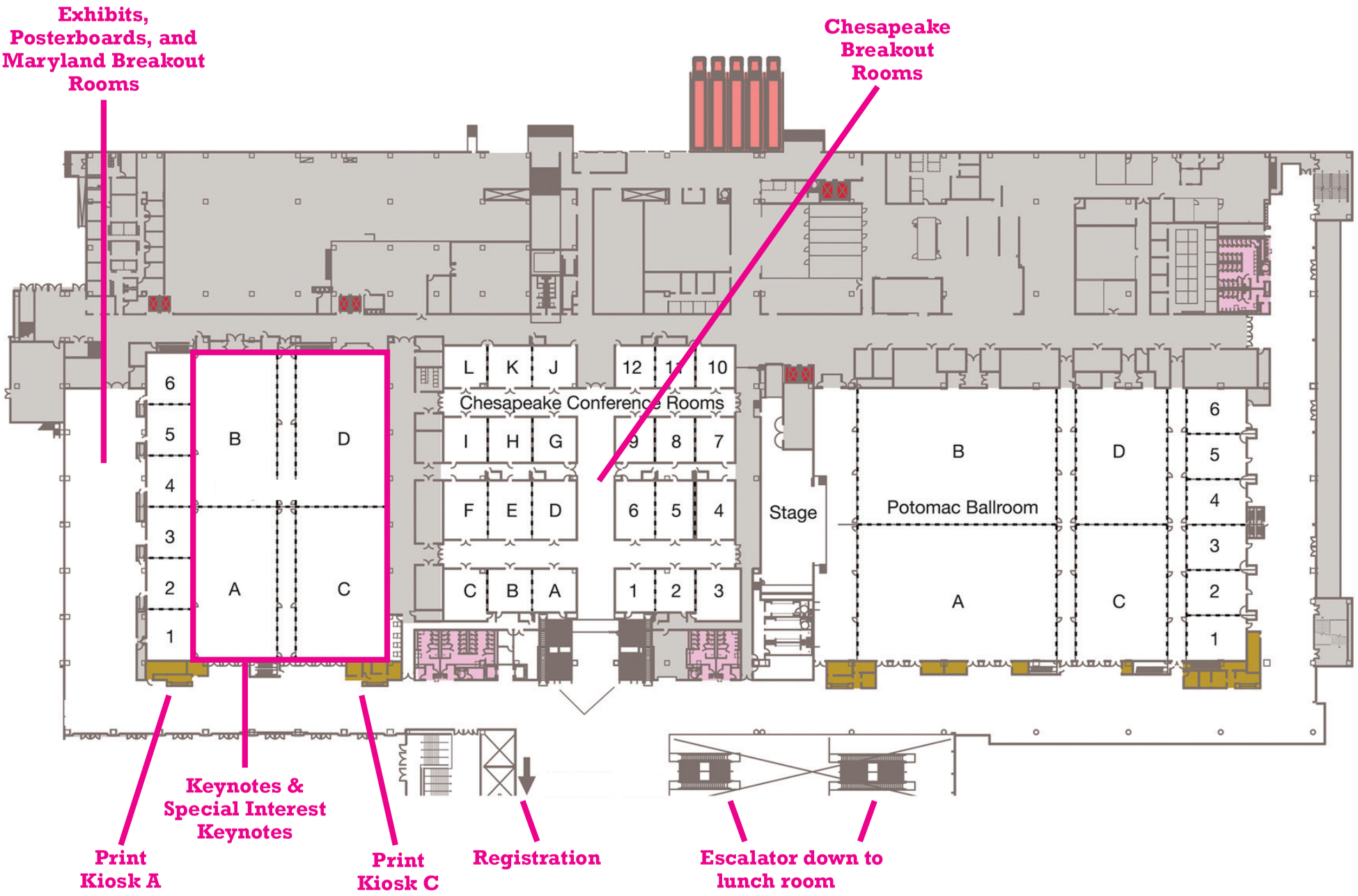
The following sessions offer NASW Contact Hours: M1, M2, M3, M6, M7, M8, M9, L1, L2, L3, L4, L7, L9, L10, A2/B2, A3/B3, A5/B5, A7/B7, A8/B8, C1, C2, C3, C4, C7, C9, C12, D1, D3/E3, D5/E5, D11/ E11, and D12/E12.

In order to be eligible to receive NASW Contact Hours, you must sign-in and out of each session onsite. Please see an IHI Staff member at the Registration Desk for more information.

This live activity, IHI's 13th Annual International Summit on Improving Patient Care in the Office Practice & the Community, with a beginning date of 03/18/2012, has been reviewed and is acceptable for up to 16.75 prescribed credits by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

## Save the Date!

Please join us next year at the 14th Annual International Summit on Improving Patient Care in the Office Practice and the Community, April 7-9, 2013, in Scottsdale, Arizona.


Exhibits, Posterboards, and Maryland Breakout Rooms
Chesapeake Breakout Rooms
Chesapeake Conference Rooms
Stage
Potomac Ballroom
Keynotes & Special Interest Keynotes
Print Kiosk A
Print Kiosk C
Registration
Escalator down to lunch room

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