Pre-Conference
Sunday, March 18

Minicourses
8:30 AM – 4:00 PM

M1 Building Sustainable Physician Engagement to Transform Care

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.

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

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

M2 Change Management Skills for Practice Coaches

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.

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

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.
- Explain the human dynamics of change for both practice teams and the coach.
- Identify ways to intervene skillfully to facilitate change using an understanding of human dynamics, focusing especially on resistance and self-management.

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

Involving patients and families in health system planning contributes to better health outcomes, better patient experience, and better use of healthcare dollars. In a full-day interactive workshop, 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.

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

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 organization or practice.

M4 Enhancing Primary Care Value at Lower Cost to the Community

This session will help participants design community centers of health that honor, enhance, and produce value through primary care relationships. Building on Intermountain Health'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; describe 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.

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

After this session, 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.

M5 Improving Access to All Ambulatory Services

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. Discussing basic strategies not only to improve access to medical appointments but 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.

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

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 setting.
- Utilize 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 setting.
- Benefit from the example of the pooled referrals project in Saskatchewan, where quantifiable improvements to reduce wait times and increase patient, surgeon, and primary care provider satisfaction were successfully implemented.

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

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.

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

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.
- Detail the roles of the care team in identifying and meeting the needs of patients as they transition out of the hospital or other care setting.
- 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.

M7 It Takes a Region: Integrating Communities of Care

Isolated efforts to redesign practices, payment structures, and benefit packages have had exciting but limited impacts. Since healthcare is local, an all-in, multifactorial, community-level approach is needed to achieve Triple Aim goals, including the implementation of: 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 healthcare 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.

Harbrecht, M., MD, Chief Executive Officer, 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

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 healthcare delivery and payment systems to reach a high-quality, integrated community of care.
- Develop a mock plan for integrating healthcare into their community, including a phase-in strategy to reach Triple Aim goals.

M8 Motivational Interviewing for Busy Clinicians

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.

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

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.

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

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 MISTA*AR.

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

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 (IT), and risk stratification.
- Convey an understanding of the complexity of measuring effective care management and outline potential solutions to measurement issues.
- Use the tools and exercises described in the session to facilitate community collaboration among stakeholders.

M10 Targeting Ambulatory Care Patient Safety Priorities

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. We will also offer practical tools to assess patient safety risks and culture in participants' own settings.

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

After this presentation, participants will be able to:
- Describe the major patient safety issues in the ambulatory care setting.
- 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 setting.

M11 Using Lean Principles to Improve Clinic Flow

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.

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

After this presentation, participants will be able to:
- Identify the "wastes" in clinic processes that can interfere with flow and quality.
- Describe the use of "Lean" tools to improve these processes.
- Understand the application of "Lean" methods to redesign processes to meet medical home criteria, including

empanelment, advanced access, and referral tracking.
- Think about how to adapt lessons learned from the example of the Shingo Prize winner, Denver Community Health Services.

M12 Using Microsystems to Transform Practice: Fundamentals to Advanced Applications

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, we will discuss advanced microsystems and present participants with organization infrastructure and coaching models to consider and adapt to their own organizations.

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. Westwood Family Health Center, Denver Health Community Health Services and Assistant Professor, Department of Family Medicine, University of Colorado

After this presentation, participants will be able to:
- Adapt and apply clinical microsystem fundamentals to their own setting.
- Compare and contrast a case study from an ear, nose, and throat practice to their own context to develop a microsystem strategy.
- Develop their own organizational infrastructure and coach frontline staff in providing and improving care.

General Conference

Day One - Monday, March 19

Keynote One

8:00 AM – 9:00 AM

Maureen Bisognano, President and CEO, IHI

Learning Labs

9:30 AM – 12:30 PM

L1 Achieving the Triple Aim for High-Cost Patients

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.

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

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 costs and improve patient experience.
- Describe the nuts and bolts of deploying practice staff to meet the needs of high-risk patients in rimary care.
- Train their practice staff to be complex care managers.

L2 ACO Transformation: A Community Collaborates to Improve Population Health

Sharing a vision of improving population health, Integrated Health Partners (IHP), a physician hospital organization (PHO), 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.

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

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.

L3 Advancing Care Management Techniques and Innovations in Diabetes Care Management

The first part of this two-part session will concentrate on the basics of improving chronic disease care management processes. Using work-flow diagrams, participants will identify their current processes and develop an ideal state for care management in their practice. The second part of the session will review the efforts of a multidisciplinary team to improve diabetes care management across a large, integrated healthcare 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.
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

After this presentation, participants will be able to:
- Analyze current care management processes.
- Develop a plan or a work flow to integrate new aspects of care management into their practice 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.

L4 Coaching Health Care Improvement

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.

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

After this presentation, participants will be able to:
- Apply a three-phase coaching model to their own practice to raise the success rate of employees engaged in improvement efforts.
- Define the art as well as the science of coaching healthcare improvement.
- Utilize two coaching outcome tools to determine the effectiveness of coaching.
- Compare two coaching case studies and discuss the research implications.

L5 Communication and Teamwork for Acute Care Practitioners

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.

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

After this presentation, participants will be able to:
- Identify failures in teamwork and communication within a practice.
- Understand how these failures lead to poor patient outcomes.

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

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.

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

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 practice using "GutCheck."

L7 Enlightening Experiences with Shared Medical Appointments

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.

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

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.

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

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.

Delgado, P., Executive Director, IHI; 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

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.

L9 Integrating Coaching into Management to Achieve Transformation

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.

Lewis, A., Chief Executive Officer, CareSouth Carolina, Inc.; Baker, N., MD, Principal, Neil Baker Coaching and Consulting, LLC;

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.
- Think through the barriers and challenges to successful integration of coaching in their own practices.

L10 Quality Improvement for Improving Care Coordination in Pediatrics

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.

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

After this presentation, participants will be able to:

- Describe and use process mapping to identify opportunities for improvement.
- Identify and utilize tools to implement new processes for improving care coordination.
- Establish and implement systems to monitor and analyze the impact of process changes in their practice.

L11 Transforming Meaningful Use into Meaningful Care

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.

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

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.
- Create effective communication mechanisms and informational tools.

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

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.

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

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 site.
- Use the tools and guidelines provided in the session in their own PCMH journey.

Rapid-Fire WORKSHOPS
10 Minutes, 10 Slides!

A mix of four diverse presenters will discuss their findings on one of the following topics:

Monday, March 19
1:30 PM – 2:45 PM
RFA: Transitions in Care
3:00 PM – 4:15 PM
RFB: The Patient-Centered Medical Home

Monday, March 19
Workshop A & B

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 special interest keynotes and Rapid-Fire workshops.

Special Interest Keynotes

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

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

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

Sugarman, J., MD, Chief Executive Officer, 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

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

Social media are 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 healthcare consumers in new ways. This session will discuss the emergence of best practices in healthcare 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.

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

After this presentation, participants will be able to:

- Identify the primary types of social media and how healthcare organizations use them.
- Create an effective social media strategy.

A4/B4 Developing an Office Practice Culture of Safety

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

A5/B5 Developing Effective Quality Improvement Leaders in Office Practices

A self-activated practice cannot develop without effective team leaders. This workshop will use the experience of transforming practices into PCMHs 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.

O'Neill, C., RD, Quality Improvement Coach, HealthTeamWorks; Deaner, N., MSW, Residency Project Program Manager, HealthTeamWorks; Jortberg, B., Faculty, University of Colorado; Dickinson, P., MD, Professor, University of Colorado Health Sciences Center

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.

A6/B6 Essential Elements of Practice Coaching Programs

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.

Powell, J., Health Care Improvement Advisor

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.
- Define the characteristics of a practice coach contract.
- Describe the "ROI Calculator," a teaching tool for practices that quantifies the costs and benefits of quality improvement (QI) initiatives.

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

This session will demonstrate how 17 primary care practice sites received National Committee for Quality Assurance (NCQA) Level 3 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.

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

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.
- Understand how to develop and implement processes to manage patient populations.

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

The Southern California Permanente Medical Group (SCPMG) has developed Proactive Office Encounter (POE), an in-reach system that engages staff and physicians to 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: 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.

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

After this presentation, participants will be able to:

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

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

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.

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

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.
- Be inspired by the example of an emerging Scottish national patient safety in primary care program.

A10/B10 Stop Feeding the Urgent Care Clinic Monster

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.

Tantau, C., President, Tantau & Associates

After this presentation, participants will be able to:

- Understand how urgent care clinics and walk-in clinics create a false economy and undermine efforts to establish a primary care 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.

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

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 (IT) 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.

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

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.

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

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.

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

After this presentation, participants will be able to:

- Describe an innovative model for increasing access to primary care services.
- Better understand how to utilize 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.

Keynote Two

4:30 PM – 5:30 PM

Donald M. Berwick, MD, MPP, Former Administrator, Centers for Medicare & Medicaid Servies; Former President and CEO, IHI

General Conference

Day Two - Tuesday, March 20

Workshop C

9:30 AM – 10:45 AM

Workshop C does not repeat.

Keynote Three

8:00 AM – 9:00 AM

Ellen Goodman, Pulitzer Prize-winning Columnist, Author, and Speaker

Special Interest Keynote

C1 Minimally Disruptive Medicine: Achieving Patient-Centered Care

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

C2 Advanced Medical Home Delivery System Redesign

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. We 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.

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

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.
- Understand the role of electronic medical record (EMR) implementation in the standardization, work-flow 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.

C3 Better Population Health: Innovative Self-Management Support

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.

Davis, C., Geriatric Nurse Practitioner, Connie L. Davis Health Services; Lewis, A., Chief Executive Officer, CareSouth Carolina, Inc.

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.

C4 Developing High-Functioning Outpatient Teams to Enhance Patient Outcomes

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.

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

After this presentation, participants will be able to:

- Understand how one medical group tackled cultural transformation to develop high-functioning teams and how to use the same approach in their own setting.
- Apply methods for moving individuals from a manager role to a leader role in adaptive work.

C5 Hardwiring an Office-Based Patient Safety Program

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, three presenters will review these initiatives and other programs, share what worked and what did not, and discuss future challenges.

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

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 the hardwiring of 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.

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

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.

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

After this presentation, participants will be able to:
- Develop a step-by-step procedure for testing, implementing, and spreading a process within a practice.
- 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.

C7 Redesigning Care Services Using Public Health Data and Quality Improvement

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

Over the past two years, more than 30 VCUHS (Virginia Commonwealth University Health System) 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.

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

After this presentation, participants will be able to:
- Identify the key steps in a successful transition from a paper to an electronic work flow in a complex ambulatory setting.
- 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 work flow from the current paper state to the future electronic state.

C9 Team-Based Care: Redesigning Team Roles

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.

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

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.

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

Loomis, L., MD, Director of Family Medicine, Denver Health; Gutierrez, P., Community Health Administrative Director, Denver Health; Melinkovich, P., MD, Director of Community Health Services, Denver Health

Rapid-Fire WORKSHOPS
10 Minutes, 10 Slides!

A mix of four diverse presenters will discuss their findings on one of the following topic:

Tuesday, March 20
9:30 AM – 10:45 AM
RFC: Specialty Care

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

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

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. 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 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.

Hupke, C., RN, Director, IHI

Workshop D & E

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

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

E1 Designing the Best: Engaging Stakeholders in Primary Care Transformation

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

University of Wisconsin Health (UW Health) utilizes 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 SEIPS (Systems Engineering Initiative for Patient Safety), 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.

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

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 UW Health primary care redesign initiatives.
- Discuss the role of leadership in model implementation.

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

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

Please note: the session title for D3/E3 is listed incorrectly in the printed brochure.

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

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.

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

- 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 own organization.

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

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, hos-

pitals, 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.

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

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 (EMR) within an organization to improve quality and reduce unnecessary readmissions.

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

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's chronic care model (CCM) 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.

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

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.

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

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?

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

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, utilizing best-practice methodology.

D8/E8 Reducing Variation in the Primary Care Setting

In this session, participants will learn how to increase the value of the care they provide by removing unwarranted variation. We 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. We 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.

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

Rapid-Fire WORKSHOPS
10 Minutes, 10 Slides!

A mix of four diverse presenters will discuss their findings on one of the following topics:

11:00 AM – 12:15 PM
RFD: Health Information Technology
1:15 PM – 2:30 PM
RFE: Patient Safety

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 setting.
- Create simple strategies to harvest data on clinical variation in their own setting.

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

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 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.

Gabbay, R., MD, PhD, Director, Penn State Institute for Diabetes and Obesity, Penn State College of Medicine; Harbrecht, M., MD, Chief Executive Officer, HealthTeamWorks; Mason, M., Senior Health Care Manager, Blue Cross Blue Shield of Michigan

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.

D10/E10 Tactics to Strengthen Physician Engagement

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.

Silversin, J., President, Amicus, Inc.

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.

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

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.

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

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.

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

This workshop will introduce a new paradigm: outpatient care teams leading efforts to prevent readmissions in high-risk patient populations. We will describe the benefits and impact of this paradigm for the accountable care organization (ACO) 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. We will use case studies to demonstrate how these shifts lead to successful patient experiences and better overall results.

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

After this presentation, participants will be able to:

- Describe the implementation of models of care led by outpatient care teams to prevent readmissions.
- Understand how risk assessment, combined with intuitive knowledge of the patient relationship, can aid in a successful care plan.

Questions?
The IHI Customer Support team is happy to help. Please call us at (617) 301-4800 or (866) 787-0831 or email us at info@IHI.org.