Minicourses
Sunday, April 7
8:30 AM – 4:00 PM

M1: ACO Foundations—Patient-Centered Medical Homes and Microsystems
High-performing clinical microsystems, mesosystems, and patient-centered medical homes (PCMHs) build strong foundations for accountable care organizations (ACOs). A case study will demonstrate how to leverage microsystems to build the foundation and organizational improvement capacity for improving population health. Participants will be required to bring their own data to be used during the Minicourse.

After this presentation, participants will be able to:

- Analyze data to determine the strategic improvements that would move their organization toward a high-performing PCMH
- Explore the use of improvement methods within the PCMH to improve patient outcomes
- Discuss the coaching interventions that would support the development of frontline staff improvement capability

Godfrey, M., RN, Co-Director, Microsystem Academy, and Instructor, Dartmouth Institute for Health Policy and Clinical Practice; **Hess, A.,** President, Clinical Performance Management, Inc.; **Anderson, D., MD,** Director of Primary Care, VA Connecticut Health Center System

M2: Back to Basics: Quality Improvement 101
So, you can explain what the letters PDSA mean. Great! But can you run multiple PDSA (Plan-Do-Study-Act) tests in one day? Do you know when a change concept is ready for implementation? Can you sustain the improvements you achieve? This workshop will provide a refresher for those who are stalled in their quality improvement efforts and a jump-start for those who are new to this journey. Built around the Model for Improvement (MFI), the session will demonstrate how to link the three questions related to aim, measurement, and change to the sequence for success.

After this presentation, participants will be able to:

- Provide an overview of the MFI
- Describe the differences between testing, implementing, and spreading
- Identify key concepts and tools that should be part of their QI tool-kit

Taylor, J., EdD, Improvement Adviser, Institute for Healthcare Improvement (IHI); **Lloyd, R., PhD,** Executive Director, Performance Improvement, IHI

M3: Build Sustainable Physician Engagement Transformation
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 organization.

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

M4: Transformation as a Safety Net: The ACO/PCMH Model at Cambridge Health Alliance

This session will describe the cultural, infrastructural, and population health aspects of the transformation of a safety net system to an ACO-PCMH model of care triggered by health care reform in Massachusetts. Strategies for physician engagement, team development, financial transformation, leadership redesign, and care redesign will be outlined. Also shared will be the challenging lessons learned, the early outcomes, the key levers for success, and the applicability for systems undergoing national health reform.

After this presentation, participants will be able to:

- Understand the strategic priorities for transformation to an ACO-PCMH model of care, especially for safety net populations
- Identify the lessons learned in a transformation to an ACO-PCMH, especially the key success factors

Stout, S., MD, Vice President, Patient-Centered Medical Home Development, Cambridge Health Alliance (CHA); **Thompson, D.,** Chief Administrative Officer, ACO Development, CHA; **Lind, C.,** Family Leader and CHIPRA Project Associate, Federation for Children with Special Needs; **Meisinger, K., MD,** Medical Director, CHA; **Joseph, R., MD,** Director, C-L Psychiatry, CHA; **Jorgensen, A., MD,** Medical Director, CHA

M5: Change Management Skills in Primary Care

This interactive Minicourse will offer participants the opportunity to gain new knowledge and skills to increase their effectiveness as agents of change. The presenters will describe selected frameworks and tools that enable change agents and coaches to understand the organizational and group dynamics necessary for successful change. After working with these frameworks and tools, participants will have practical knowledge to bring to their change efforts.

After this presentation, participants will be able to:

- Identify roles and tasks for change management and alignment
- Map a change project to diagnose the effectiveness of current change management and the state of alignment in their organization
- Explain the human dynamics of change for both practice teams and the coach and identify skillful interventions that account for these dynamics, focusing especially on resistance and self-management

Sevin, C., RN, Director, Institute for Healthcare Improvement; **Baker, N., MD,** Principal, Neil Baker Coaching and Consulting, LLC; **Lefebvre, A., MSW, CPHQ,** Associate Director, North Carolina AHEC (Area Health Education Center) Program

M6: Enhancing Primary Care Value at Lower Cost to the Community

Building on a successful and sustained redesign of primary care through mental health integration (MHI) and IHI's Triple Aim and socially complex care, this session will demonstrate how to create a framework that moves away from simply treating volumes of patients. Participants will learn how to define value by incorporating an understanding of what matters to individuals, their families, and their communities; they will also become familiar with the leadership needed to deliver this value and the practical measurement of success in these efforts. Participants will engage in a collective social network activity that creates "out of the box" designs for sustainable, local, and social centers of health. The session will also explore innovative financing and funding opportunities that support such transformations.

After this presentation, participants will be able to:

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

Boudreau, K., MD, Chief Medical Officer, Boston Medical Center HealthNet Plan; **Cannon, W., MD,** Primary Care Clinical Program Leader, Intermountain Healthcare

M7: Motivational Interviewing for Busy Clinicians

This interactive Minicourse focuses on the principles and skills of motivational interviewing (MI), which can be applied by the entire health care team, even when pressed for time. Through discussion and practice with a variety of techniques to support behavior change, participants will gain both an understanding of these skills and principles and the confidence to use them in practice. We will explore ways to incorporate these approaches into daily routines and also ways to continue building MI skills.

After this presentation, participants will be able to:

- Apply MI principles in conversations about behavior change
- Demonstrate a patient-centered interaction that uses MI to support behavior change
- Design ways to include MI in their own daily work

Davis, C., Geriatric Nurse Practitioner, Centre for Comprehensive Motivational Interventions; **Gutnick, D., MD,** Assistant Professor of Medicine and Psychiatry, Bellevue Hospital Center; **Reims, K., MD,** Chief Medical Officer, CSI Solutions, LLC

M8: Multi-Stakeholder Partnerships and Collaboration to Achieve the IHI Triple Aim

IHI Triple Aim organizations are able to improve the health of the populations they serve, improve patients' experience of care, and lower their per capita costs. The impact of organizations focused on the Triple Aim has evolved from isolated effects within their own organization or subpopulation to a collective impact at the community level that requires multi-stakeholder collaboration. This interactive session will explore IHI's thinking on the distinctive issues and opportunities presented by Triple Aim improvement and will include high-level lessons gleaned from several Triple Aim sites working in multi-stakeholder partnerships.

After this presentation, participants will be able to:

- Understand the framework that IHI makes available to organizations and communities to accomplish the Triple Aim
- Draw lessons and strategies from IHI Triple Aim sites that can be applied to their own organization or community
- Understand the governance and collaboration structures that guide Triple Aim efforts
- Employ tools and methods for building a learning system to drive Triple Aim results

Beasley, C., Vice President, New Business Development, Institute for Healthcare Improvement; **Lewis, N.,** Director, IHI; **Brooks, K.,** Project Manager, IHI

M9: Using Story and Spirituality to End Domestic Violence, Child Sexual Abuse, and Child Neglect in the Native Community

Southcentral Foundation's award-winning Family Wellness Warriors Initiative is ending domestic violence, child abuse, and child neglect in Alaska. Recognized internationally for its innovation, this approach is thoroughly grounded in Alaska Native traditional values and strengths, including Alaska Native story and spirituality traditions. This workshop will demonstrate the power of story in identifying the root causes of behaviors and will also discuss the importance of spirituality as a cultural resiliency factor that is inseparable from the traditional belief systems that have been instrumental in historical survival.

After this presentation, participants will be able to:

- Use new strategies for working with their community to end child abuse and maltreatment
- Harness the power of story to break the silence associated with abuse and initiate a safe, healing journey
- Describe how cultural strengths can be used to address the spiritual, emotional, mental, and physical effects of abuse

Tierney, M., Vice President, Organizational Development and Innovation, Alaska Native Medical Center; **Gottlieb, K.,** President and CEO, Southcentral Foundation; **Outten, B.,** Clinical Director, Southcentral Foundation

M10: Improving Care Transitions: Successful Approaches to Building Community Partnerships

Bringing together hospitals and their cross-continuum partners has emerged as a key building block for local, state, and national initiatives to improve transitions in care. Participants in this Minicourse will learn how busy office practices can partner with hospitals, skilled nursing facilities, home health agencies, and other community service agencies to identify and meet the needs of patients at high risk for readmission; use care transition coaches to enable patients and their families to better manage their care; and leverage initiatives such as patient-centered medical homes (PCMHs) and accountable care organizations (ACOs) to build stronger cross-continuum relationships, processes, and systems of care.

After this presentation, participants will be able to:

- Apply strategies for building cross-continuum partnerships in their local setting
- Use practical approaches to engage patients and their families in developing and carrying out care plans that meet their needs
- Explore new methods for communicating and sharing information across settings

Schall, M., Senior Director, Institute for Healthcare Improvement; **McGill, D., RN,** Population Health Manager, Maine Medical Partners; **Lauridsen, C., RN,** Transition Care Coach, Shawnee Mission Medical Center; **Fay-LeBlanc, R., MD,** Primary Care Medical Director, Maine Medical Partners; **Fuller, K.,** Administrative Director, Case Management, Shawnee Mission Medical Center; **Yunes, M., MPH,** Quality Manager, Maine Medical Partners; **Wendt, L., RN,** Director of Quality, Iowa Health Physicians and Clinics; **Tumilty, S.,** Project Manager, Iowa Health Physicians and Clinics; **Wendland, M.,** Associate Director, Research and Planning, Finger Lakes Health Systems Agency

M11: The 10% Project: Delivering the Right Care in the Right Place for the Right Reason

To systematically reduce unnecessary medical treatment and operating costs, IHI has created a framework to decrease overtreatment and the overuse of high cost clinical care services by delivering the right care, in the right place, for the right reason. This framework is based on the theory that at least 10% of care currently being delivered in hospitals, specialty practices and primary care settings can be reallocated to more appropriate, less expensive, and higher quality care settings. Join leaders from the field who have been successful in reducing overtreatment to learn their strategies for success. Participants in this session will also be expected to provide feedback on the 10% framework based on their own experience in the field.

After this presentation, participants will be able to:

- Describe two examples of how this framework could be applied in their own organization.
- Understand the depth and breadth of overtreatment in the health system.
- List two strategies for measurable improvement in each focus area of the framework.

Rutherford, P., RN, MS, Vice President, Institute for Healthcare Improvement (IHI); **McCall, J.,** Project Manager, IHI

M12: Using Lean Analysis to Improve Clinic Flow

This Minicourse will review basic "Lean" principles and tools derived from the Lean Toyota Production System to improve clinic flow, productivity, and quality. Through examples drawn from the transformative work at Denver Community Health Services, 2011 winner of the Shingo Prize Bronze Medallion for Operational Excellence, the session will also 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 common wastes in clinical processes that can interfere with flow and quality of care
- Utilize simple techniques to eliminate wastes and improve clinic flow and processes

Loomis, L., MD, MSPH, Director, Family Medicine, Denver Health; **Kampe, F., MBA,** Operations Coordinator, Denver Health; **Lee, J., MD,** Team Leader, Denver Health

M13: Courage in Health Care: Leading From Within

Change calls for personal and communal courage. This program introduces current and emerging healthcare leaders (Open School students encouraged) and patient advocates to the Center for Courage & Renewal's principles and practices for leading from within. The Courage & Renewal® approach supports professional renewal and leadership integrity. Attendees will learn Parker Palmer's "Habits of the Heart," which help leaders and groups hold tension in generative ways and support building relational trust and responsible decision-making.

After this presentation, participants will be able to:

- Identify three ways to foster engaged listening and attention
- Implement protocols for reflection and connection in groups
- Name the Habits of the Heart that support relational trust in effecting positive change

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

Keynote 1
Monday, April 8
8:00 AM – 9:00 AM

Maureen Bisognano, President and CEO, Institute for Healthcare Improvement (IHI), previously served as IHI's Executive Vice President and COO for 15 years. She is a prominent authority on improving health care systems, whose expertise is 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, a Research Associate in the Brigham and Women's Hospital Division of Social Medicine and Health Inequalities, and serves on the boards of the Commonwealth Fund, ThedaCare Center for Healthcare Value, and Mayo Clinic Health System—Eau Claire. Prior to joining IHI, she served as CEO of the Massachusetts Respiratory Hospital and Senior Vice President of The Juran Institute.

Learning Labs
Monday, April 8
9:30 AM – 12:30 PM
L1 – L11

L1: 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 participants with valuable experiential training. 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, Shared Medical Appointment Consultant, JasterHealth Inc.; **Haney, B., MD,** Family Physician, Family Health Care of Ellensburg

L2: Meaningful Use to Drive Clinical Transformation
University of North Carolina (UNC) Health Care is leveraging meaningful use (MU) as a platform for clinical transformation and quality improvement. This session will demonstrate the success of this platform by exploring the collaborative approach used by UNC's 750 eligible professionals (EPs)—MU project coaches and information technology (IT) system development, business intelligence, and clinical operations staff—across 50 practice sites. Participants will also learn how this approach is being adapted to prepare for MU Stage 2.

After this presentation, participants will be able to:

- Utilize MU as a driver for meaningful operational change and enhanced care delivery while engaging providers and staff as partners in the transformation process
- Establish cross-functional, practice-based improvement teams to drive change and sustain improvements
- Identify the common elements of concurrent national quality initiatives and align organizational goals to coordinate improvement efforts

Lord, J., Meaningful Use Program Manager, UNC Health System; **Malone, R., PharmD,** Vice President, UNC Physicians and Associates (P&A) Practice Quality and Innovation, UNC Health System; **Thornhill, J.,** Manager, UNC P&A Practice Quality and Innovation, UNC Health System

L3: MSIS: Measure, Segment, Isolate (Driver Events), and Spread

Description TBD

Tierney, S., MD, Chief Medical Information Officer and Medical Director, Clinic Quality Improvement, Southcentral Foundation; **McNair, D., MD, PhD,** President, Cerner Corporation

L4: Optimizing the Primary Care Team with RN Care Management

This session will illustrate the one-year journey undertaken by Union Square Family Health Center of Cambridge Health Alliance as it sought to maximize the role of nurse care managers in chronic pain management and improve primary care delivery to patients. Participants will have an opportunity to engage in activities designed to help primary care practice leaders optimize RN care management in their own settings.

After this presentation, participants will be able to:

- Define the role of the RN care manager in caring for a primary care panel of patients
- Troubleshoot the development of this new role for their own practice
- Train their practice's RNs to be RN care managers

Meisinger, K., MD, Medical Director, Cambridge Health Alliance; **Margolius, D., MD,** Internal Medicine Resident, University of California–San Francisco

L5: Providing Disability-Competent Care

Disability-competent care is person-centered, provided by an interdisciplinary team (IDT), and focused on achieving and supporting maximum function. In this session, participants will learn from pioneer providers and health plans seeking to develop a system of disability-competent care. Participants will also have the opportunity to assess their current ability to provide disability-competent care and will receive guidance on how to move their organizations towards delivering this type of care.

After this presentation, participants will be able to:

- Understand the challenges and opportunities that providers and health plans face in providing disability-competent care
- Identify opportunities within their organizations to improve care for individuals with disabilities
- Develop an action plan to help their organizations provide disability-competent care

Boudreau, K., MD, FAAFP, Chief Medical Officer, Boston Medical Center HealthNet Plan; **C. Duff,** Executive Director, Disability Practice Institute; **Loehrer, S., MD, MPH,** Director, Institute for Healthcare Improvement;

L6: Readmission Prevention: A Community Collaborative Experience

Reducing avoidable hospital readmissions is important to efforts to improve the quality of patient care and meet anticipated changes pursuant to health care reform. The presenters will share the key elements of a community acute care hospital program that, with community collaboration, succeeded in decreasing 30-day hospital readmissions. They will also describe how to build a multidisciplinary and community collaborative effort and discuss the strategies and tools used in this program to reduce hospital readmissions.

After this presentation, participants will be able to:

- Explain the importance of readmission programs to patient care
- Identify effective strategies for developing multidisciplinary and community collaboration to improve patient care and reduce unnecessary readmissions
- Describe the role of the transition care coach in decreasing readmission rates and improving care transitions

Lauridsen, C., RN, Transition Care Coach, Shawnee Mission Medical Center; **Fuller, K.,** Administrative Director, Case Management, Shawnee Mission Medical Center; **McGill, D., RN,** Population Health Manager, Maine Medical Partners

L7: Shared Decision-Making in Clinical Practice

Everyone talks about shared decision-making, but most clinicians have not been trained in the specific communication skills required to do so effectively. To provide true patient-centered care, providers must understand the unique circumstances, values, and preferences of their patients in order to help them arrive at choices that fit their individual needs. In this workshop, participants will learn how to elicit patient preferences, communicate risks and benefits effectively, and recognize and help patients resolve decisional conflict.

After this presentation, participants will be able to:

- Describe the origins of the emphasis on shared decision-making in the clinical setting and the evidence supporting it
- Elicit patient values and demonstrate risk communication skills: understanding absolute risk, presenting balanced framing, using graphics and pictures, and checking for understanding
- Recognize and help resolve decisional conflict

Chou, C., MD, PhD, Professor of Medicine, San Francisco VA Medical Center

L8: Implementing Team Coaching to Build Staff Improvement Capability

Developing a staff's ability to provide care and improve care can be challenging in a health care setting. Team coaching is a successful intervention that has been shown to increase interprofessional staff improvement capabilities, leading to improvements in both processes and outcomes.

After this presentation, participants will be able to:

- Describe the three-stage team coaching model for health care improvement
- Design a team coaching structure within their own organization
- List three team coaching approaches to health care improvement that have proven to be successful

Godfrey, M., RN, Co-Director, Microsystem Academy, and Instructor, Dartmouth Institute for Health Policy and Clinical Practice; **Anderson, D.,** Director of Primary Care, VA Connecticut Health Center System; **Ward, D., RN,** Quality Improvement Manager, Community Health Center

L9: Triple Aim Strategies for High-Risk, High-Cost Populations

Patients with complex needs often have difficulty getting the exact services they need and use expensive, but avoidable, services, including emergency department visits and hospitalizations. Health care organizations moving to models of cost accountability need to adopt robust strategies for serving the small percentage of patients who account for the majority of health care spending. Participants will learn to apply Triple Aim change ideas and measurement strategies to get better results for their high-risk, high-cost patient segments.

After this presentation, participants will be able to:

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

Beasley, C., Vice President, New Business Development, Institute for Healthcare Improvement; **Ramsay, R.,** Director of Community Care, CareOregon; **Craig, C., MSW,** Director of Health Integration, Community Solutions

L10: Using Quality Improvement and Health IT Innovation

With funding from the Office of the National Coordinator for Health Information Technology, two community organizations in Cincinnati partnered to transform care for 186 primary care providers seeking to improve care for their patients with diabetes. This session will discuss how these organizations used a newly developed electronic alerting system as a clinical decision support tool to lead the primary care teams through practice transformation activities as they sought recognition as patient-centered medical homes (PCMHs).

After this presentation, participants will be able to:

- Understand the use of health IT tools in quality improvement work in a primary care setting
- Discuss the intersection of quality improvement and health IT in meeting the requirements of a PCMH

Bondurant, P., RN, Director, Beacon Program, HealthBridge

L11: Where is the Patient in Patient-Centered Care?

Many clinicians are so busy designing the patient-centered medical home, developing P&Ps, and running reports that it becomes all too easy to forget about the patients. After a review of how patients fit into a patient-centered medical home (PCMH), this workshop will give participants an opportunity to hear from several patients who are part of a PCMH and to ask them questions about their experiences.

After this presentation, participants will be able to:

- Demonstrate a deeper knowledge of the role of patients in their health outcomes
- Understand how to motivate patients to participate in their care
- Use the lessons learned about the dynamic between the provider and the patient to maximize patient outcomes

Schwartz, C., RN, PCMH Initiative Director, Pennsylvania Academy of Family Physicians; **Messmer, J., MD,** Medical Director, Penn State Hershey Medical Center

A/B Workshops
Monday, April 8
A Workshops 1:30 PM – 2:45 PM
B Workshops 3:00 PM – 4:15 PM

Special Interest Keynotes:

A1: Taking the IHI Triple Aim to the Next Level

In this session, presenters from HealthPartners, an innovative leader with a large portfolio of Triple Aim projects, will discuss its use of the total-cost-of-care methodology endorsed by the National Quality Forum (NQF) to prioritize the projects that have the greatest impact on improving patient health and yielding cost savings. Participants will learn how HealthPartners now operates more efficiently by having customized its projects to patients through the application of an experience lens.

After this presentation, participants will be able to:

- Implement the Triple Aim in a strategic way to get results efficiently
- Develop methods within their organization to prioritize and customize their Triple Aim projects around operational goals

McClure, N., Senior Vice President, HealthPartners; **Rank, B., MD,** Medical Director, HealthPartners

B1: Integrating Community and Public Health with Primary Care to Achieve Population Health

With the evolution of the IHI Triple Aim, delivery systems are considering their approach to population health. However, ensuring the health of the larger population will require partnerships with community and public health organizations. This session will focus on strategies for understanding the population that you serve and further the nature of public health, locally and nationally. Finally, we will review several examples of integration between public health and primary care.

After this presentation, participants will be able to:

- Identify the three core functions of public health
- Identify strategies for comparing the health of the population seen in primary care with the health of the community
- Cite examples of how primary care can integrate with community and public health to achieve population health

Hacker, K., Senior Medical Director for Public and Community Health, Cambridge Health Alliance**; Jacob, C.,** Chief Public Health Officer, Cambridge Health Alliance

Workshops

Rapid Fire A: The Conversation Project: From the Personal to the Practice

The Conversation Project (TCP), co-founded by Pulitzer Prize winner Ellen Goodman, launched a national public campaign in August 2012 with a goal that is simple and transformative: to have every person's end-of-life wishes expressed and respected. The project encourages open and honest discussions at the kitchen table among friends and families--before there is a crisis---about how they want to life at the end of life. It asks one question of everyone: Have you had the conversation? This Rapid Fire Workshop will look at ways to engage individuals and the public in having the conversation in addition to how as practitioners we can be prepared to receive the expressed wishes of our patients.

After this presentation, participants will be able to:

- Describe the importance and background of The Conversation Project
- Understand the role of primary care in respecting end of life wishes
- Apply new ways to engage patients and families in having the conversation

Hayward, M., Lead, Patient and Public Engagement, IHI; **Boudreau, K., MD,** Chief Medical Officer, Boston Medical Center HealthNet Plan

Open Space Workshop B

An opportunity for participants to propose their own topics for discussion and network with colleagues with shared interests.

A2/B2: A Successful Home-Based Palliative Care Model

Optimizing Advanced Complex Illness Support (OACIS), a home-based palliative care program for adults with advanced complex illness, collaborates with the patient's primary care provider on symptom management and advanced care planning. The program has demonstrated a 42% reduction in hospitalizations and a 56% decrease in variable costs related to hospitalizations. In this session, presenters will describe the development of the OACIS model and its clinical and operational features.

After this presentation, participants will be able to:

- Describe the operational features of a home-based palliative care service and its role in facilitating patients' utilization of health care resources
- Identify the role of a care coordinator, a nurse-practitioner, and a community-based time bank program in a home-based palliative care model

Ray, D., Chief, Section of Palliative Medicine and Hospice, Lehigh Valley Health Network; **Stevens, D.,** Program Director, OACIS, Lehigh Valley Health Network

A3/B3: Activating Community Assets for Population Health

Achieving the Triple Aim within a community or region requires the identification of stakeholders both within and outside of health care, their collaboration, and the activation of their assets. In this dynamic session, participants will explore the case of a community with high disparities, crumbling municipal infrastructure, and disconnected services. When this community activated its assets at the neighborhood level, it succeeded in uniting the work of care coordinators and community organizers, aligning government and other partners, creating jobs, and improving the health of the population.

After this presentation, participants will be able to:

- Use a framework based on social determinants of health to assess community-wide public health needs
- Describe community organizing approaches to generating public health interventions
- Identify measures to evaluate improvements in health, quality of life, and total health care costs
- Identify and employ tools to assess, map, and activate the assets within their community or region

Craig, C., MSW, Director of Health Integration, Community Solutions; **Lewis, N.,** Director, Institute for Healthcare Improvement

A4/B4: All Patients, Right Care: Redesigned Registries

Population-based management and innovative redesign are becoming critical components of comprehensive primary care, and delivering the right care to all patients now requires an evolution away from disease-focused registries. In this session, participants will learn how one community health center developed two decision support tools to transform whole patient care management and used an outreach registry and a care planning tool to provide sustainable, timely, and appropriate chronic and preventive care.

After this presentation, participants will be able to:

- Develop care gap alerts and incorporate them into effective outreach strategies
- Utilize care gap alerts to provide comprehensive care at the time of service and build patient engagement into their care

Dryden, H., Clinical Quality Manager, Clinica Family Health Services; **Kalikstein, B.,** Vice President of Strategic Support, Clinica Family Health Services; **Troyer, J.,** Clinic Director, Clinica Campesina

A5/B5: Community Collaboration: Creating a Healthier Niagara Falls

Improving clinical outcomes within the population of a community takes a community. Niagara Falls is on a journey to create a healthier community, using the technology and clinical expertise of local clinics to address health issues. In this session, participants will learn how evidence-based quality improvement systems have been combined with community-level engagement in a collaborative and ongoing community improvement effort in Niagara Falls that includes the goals of reducing the incidence of depression and the number of emergency department (ED) admissions.

After this presentation, participants will be able to:

- Demonstrate how to utilize evidence-based quality improvement tools in collaborations between primary care practices and the communities they serve
- Identify the critical conversations, agreements, and feedback loops required to create collaborations between laypeople and clinical specialists
- Describe unique methodologies that can be used to ensure that patients who float between clinics and local hospital EDs for their primary care comply with their care plans

Meeks, G., Manager, Clinical Care Coordination, P2 Collaborative of WNY; **Kee, S.,** Chief Operating Officer, Niagara Falls Memorial Medical Center

A6/B6: Scoring Roadmap for Sustainable Practice Redesign

This session will demonstrate how the Practice Transformation Roadmap has provided strategic pathways for sustainable practice transformation—including population health and chronic disease management—to primary care practices in greater Cincinnati. Participants will learn about the role in sustainable practice transformation of streamlining quality improvement efforts, gaining National Committee for Quality Assurance (NCQA) recognition of patient-centered medical homes (PCMHs), and meaningful use (MU) of health information technology (IT).

After this presentation, participants will be able to:

- Utilize a practice communication tool to engage all levels of staff in quality improvement testing and practice transformation efforts
- Use the Scoring Roadmap, which integrates stage 1 MU measures to meet NCQA PCMH 2011 requirements and achieve better coordination of Triple Aim initiatives

Christopher, R., Director, Health Partners Consulting

A7/B7: Standardizing and Simplifying Clinical Workspaces

This session will demonstrate the potential opportunities in deliberately reviewing the contents of clinical rooms in order to add value to the patient and staff experience by redesigning the workspace and removing clutter and waste. The presenters will give examples from their own office practices of using proven improvement techniques from the "Lean" tool-kit, including 5S and Kanban, to enhance the patient and staff experience, make room-stocking more reliable, and improve process flow.

After this presentation, participants will be able to:

- Identify ways to declutter, simplify, and standardize their clinical workspace to improve efficiency and effectiveness
- Improve the safety and reliability of their clinical workspace by incorporating human factors and ergonomics and utilizing 5S and Kanban improvement methods to structure the room changes and embed the culture

Jenkins, R., Group Medical Director, One Medicare, Ltd.

A8/B8: Tactics to Strengthen Physician Engagement

The need for physicians to be active participants in quality and safety improvement is a given. Yet a gap persists in most organizations between this imperative and the actual extent to which physicians are meaningfully engaged on a day-to-day basis. This session will provide practical ways to develop and sustain the critical engagement of physicians.

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.

A9/B9: Coordinated Care Management: An Integrated System

Patients with complex or chronic conditions need systematic, patient-centered, and system-wide care that recognizes their needs and risks. In this session, the presenters will describe how they provided Triple Aim care for such patients by developing a coordinated approach for patients as they moved across the system to receive primary, specialty, and hospital care. Proactive identification, supportive outreach, and care management not only improved the health and experience of these patients but drove down costs by reducing the number of unnecessary ED visits and readmissions to the hospital.

After this presentation, participants will be able to:

- Develop systems for care management that are coordinated across care teams in a variety of settings (primary care, specialty care, hospital care, home care, transitional care).
- Identify how to provide proactive not reactive care management for patients with complex and chronic conditions.

Heinz, B., MSW, Vice President, Operations, Regions Hospital; **Waterman, B., RN,** Chief Improvement Officer, HealthPartners

A10/B10: The Burning Platform for Engaging Physicians

Health care is enhanced when leaders are aligned with physicians in efforts to connect the dots between physician performance and the patient-centered experience. In this session, participants will learn how to use the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), the Clinical & Group Survey of the Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS), and value-based purchasing (VBP) to build a "burning platform" for physician engagement. Simple steps that physicians can take to create a patient care culture of "always" will also be presented.

After this presentation, participants will be able to:

- Create a burning platform for physician engagement by identifying and agreeing on behaviors and measures
- Communicate clear goals that will achieve alignment and implement and sustain accomplishments

Oleksyk, M., MD, Vice President of Medical Affairs and Chief Medical Officer, Baptist Healthcare; **Bixler, K.**, Business Development Manager, Baptist Leadership Group

A11/B11: Provider Education: Improving Health Care Cultural Humility and Care Equity

Health care workforce development that addresses cultural humility and care equity has become a priority as institutions attempt to meet the health care needs of all populations, especially the indigent and vulnerable. This presentation will demonstrate the successful implementation and evaluation of a collaborative approach to improving care equity through theater-based education for health care providers.

After this presentation, participants will be able to:

- Describe a community-based, collaborative partnership that teaches health care providers how to care for disadvantaged patients through experiential education and skill-building
- Identify the ways in which community integration creates a strong culture of change leading to continuous behavior improvement
- Improve recognized habits in health care interactions through the use of theater-based principles at the intersection of rapid cognition, behavior, thoughts, and actions

Bermingham, N., Access to Care Manager, Kaiser Permanente; **Wagenseller, T.**, Health Center Workforce Manager, Colorado Community Health Network

A12/B12: Unmasking Medication Adherence: Practical Techniques for Communicating with Patients to Overcome Barriers

Medication non-adherence annually leads to an estimated $100 billion in preventable health care costs and accounts for approximately half of all medication-related admissions. Overcoming medication non-adherence is central to the work of the patient-centered

medical home (PCMH) and key to the success of accountable care organizations (ACOs). This highly interactive workshop, grounded in a series of brief video patient vignettes, will engage participants in developing practical techniques for uncovering and successfully addressing patient barriers to medication adherence.

After this presentation, participants will be able to:

- Integrate the practice of screening for medication non-adherence into daily patient encounters
- Develop techniques to open a dialogue with patients about their medication-taking behavior and identify individual obstacles to non-adherence
- Design an individualized plan with patients to improve their medication adherence, understanding their unique perspective and rationale for their medication-taking behavior
- Utilize numerous publicly available tools to improve medication adherence

Brown, M., MD, Physician, Rush University Medical Center; **Bussell, J., MD,** Physician, Northwestern Memorial Hospital

Keynote 2
Tuesday, April 9
8:00 AM – 9:00 AM

Diane E. Meier, MD, is Director of the Center to Advance Palliative Care (CAPC), a national organization devoted to increasing the number and quality of palliative care programs in the United States. Under her leadership, the number of palliative care programs in US hospitals has more than tripled in the last 10 years. Dr. Meier is also Vice Chair for Public Policy, Professor of Geriatrics and Palliative Medicine, and Gaisman Professor of Medical Ethics at the Mount Sinai School of Medicine. In 2009–2010, she was a Health and Aging Policy Fellow in Washington, DC, and she was recognized in 2010 by HealthLeaders as one of 20 "People Who Make Healthcare Better." Dr. Meier received a MacArthur Foundation "genius award" in 2008.

C Workshops
Tuesday, April 9
9:30 AM – 10:45 AM

Special Interest Keynote:
C1: The Importance of Spirituality in Improving Health and Wellness
Description TBD
Gottlieb, K., President and CEO, Southcentral Foundation

Workshops

C2: Expanding Patient-Centered Medical Home Team Roles in Diabetes Care

The Diabetes Equity Project, a community clinic–based project, has improved diabetes care for underserved populations through the use of community health workers (CHWs) as part of the PCMH team. Over 30 months, glucose control (hemoglobin A1c < 7.0) for those enrolled increased from 43.2% to 49.9%, and mean A1c experienced a statistically significant decrease from a baseline of 8.4 to 7.1 twelve months later. In this session, the presenters will share the lessons and challenges of this care model and suggest ways to facilitate it.

After this presentation, participants will be able to:

- Identify the tools, resources, and tactics needed to implement a low-cost diabetes self-management training and advocacy program as part of a PCMH care coordination strategy
- Describe how CHWs can be utilized to bring diabetes disease management programs to underserved populations

Snead, C., RN, Program Director, Community Care Coordination, Baylor Health Care System; **Walton, J., DO,** Vice President, Network Performance, Baylor Quality Alliance, Baylor Health Care System

C3: Health Literacy: Enhancing Patient-Centered Care

According to the National Assessment of Adult Literacy, only 12% of adults have proficient health literacy and nine out of ten adults may lack the skills to manage their health and prevent disease. In addition, many health care providers, across a variety of practice settings, lack knowledge about health literacy and its consequences. This session will examine the strong relationship between low health literacy and poor health outcomes and demonstrate why improving health literacy has become a national priority and a cross-cutting issue in health care delivery and outcomes.

After this presentation, participants will be able to:

- Identify the consequences of low health literacy and its impact on patient safety and poor health outcomes
- Optimize oral and written communication within the health care setting by incorporating the culture, language, and tenets of health literacy
- Develop strategies to enhance patient-centered care and create a shame-free environment in the office practice setting
- Discuss strategies that foster partnerships between health care providers and the communities they serve

Turnier, J., RN, Coordinator, North Shore University Hospital; **Parnell, T., RN,** Vice President, Community Health, and Associate Chief Diversity and Inclusion Officer, North Shore–Long Island Jewish Health System

C4: Keeping People Healthy: A Proactive Approach to Patient Engagement

The four optimal behaviors—physical activity, nonsmoking, eating five servings of fruits and vegetables each day, and drinking alcohol only in moderation—can add up to fourteen years to the life span. In this session, participants will learn a multifaceted approach to encouraging these behaviors in patients, including health coaching to offer patients support in making changes and connect them to resources for follow-up; health assessments that

identify patients in need of support; and a variety of community-based efforts that support this work.

After this presentation, participants will be able to:

- Develop techniques to improve Triple Aim outcomes proactively, not reactively
- Implement initiatives that support their patients and community in reaching their health goals

Aebischer, S., Vice President, Customer and Member Services, HealthPartners; **Averbeck, MD, B.,** Associate Medical Director, Primary Care, HealthPartners

C5: Unintended Consequences: How Health IT Affects Patient Safety

The increase in the adoption of health information technology (IT) has had a profound impact on physicians as it changes work flow, provides rapid access to historical information, and enhances communications. Unfortunately, IT can also have a negative impact on patient care. This session will examine how IT can improve patient safety, describe the unintended consequences of relying on automated systems, and report on how various IT systems affect responses to the Physician Practice Patient Safety Assessment (PPPSA), a self-administered survey evaluating practice risk.

After this presentation, participants will be able to:

- Describe how electronic health records and other ITs can improve patient safety practices
- Provide examples of health ITs unintentionally harming patients
- Describe the impact of different health ITs on medical practices' assessments of their patient safety risks

Gans, D., Senior Fellow, Industry Affairs, MGMA-ACMPE

C6: Preventing Errors: Strategies to Improve Interprofessional Communication

This session will present an innovative program that brings together interprofessional, multidisciplinary teams to discuss the emotional impact of errors on patients, families, providers, and team members. In a mock program session, participants will engage in a facilitated discussion of a clinical case and patient voice narrative, discuss its emotional impact, probe the communication lapses, and discover interprofessional and patient-provider communication strategies and system solutions to prevent errors. The presenters will also describe program evaluation data and implementation suggestions.

After this presentation, participants will be able to:

- Describe the emotional impact of errors on patients and families and on relationships among members of interprofessional, multidisciplinary teams
- Identify common communication lapses between disciplines that compromise safe, compassionate, patient-centered care, as well as the causes of these lapses
- Discuss system solutions and communication strategies to prevent communication lapses during cross-discipline care of patients

Ship, A., Physician, Beth Israel Deaconess Medical Center; **Lown, B., MD,** Medical Director, Schwartz Center for Compassionate Healthcare

C7: Integrating the Patient Experience into Quality Improvement Efforts

Patient reported outcomes (PROs) have the potential to transform research and make evidence more relevant by integrating reliable patient-reported information into electronic clinical data. This session will provide expert perspectives and discussions of the challenges and opportunities for collecting, using, and implementing PROs in clinical care and patients' lives in a meaningful way. The presenters will draw on their existing PRO and data collection projects to share lessons they have learned.

After this presentation, participants will be able to:

- Identify and discuss the opportunities and challenges of developing, validating, and analyzing generic and disease-specific PROs in QI efforts
- Understand how lessons from current efforts to incorporate PRO into QI efforts could be applied to their unique needs

Holve, E., PhD, Director, Academy Health; **Pace, W.,** Professor, University of Colorado School of Medicine; **Devine, E., PharmD,** Research Assistant Professor, University of Washington; **Snyder, C.,** Associate Professor, Johns Hopkins University

C8: Integration of Physical and Behavioral Health Services

To provide comprehensive care for an increasingly complex patient population, more and more organizations are integrating physical and behavioral health services. In this session, participants will learn from organizations that have taken different approaches to integrated physical and behavioral health care, including behavioral health organizations that have incorporated physical health services and primary care practices that have integrated their physical health services with mental health services.

After this presentation, participants will be able to:

- Describe multiple models of integrating physical and behavioral health care
- Describe potential barriers and solutions to challenges to integrating physical and behavioral health care
- Create a plan to increase physical and behavioral health integration in their own care setting

Laderman, M., Research Associate, Institute for Healthcare Improvement; **Huberlie, M.,** Director of Project Implementation, Greater Nashua Mental Health Center; **Joseph, R., MD,** Director, C-L Psychiatry, Cambridge Health Alliance; **Cannon, W., MD,** Primary Care Clinical Program Leader, Intermountain Healthcare

C9: Leveraging Regional Health Improvement Collaborative Partnerships to Improve Care

Regional health improvement collaboratives (RHICs) play a pivotal role in convening stakeholders and mobilizing regions to improve office practices. This session will explore how a partnership of two RHICs—the Pittsburgh Regional Health Initiative and the Institute for Clinical Systems Improvement—disseminated an evidence-based behavioral and physical health care model for primary care across diverse regions with Agency for Healthcare Research and Quality (AHRQ) and Center for Medicare and Medicaid Innovation (CMMI) funding. Spread and sustainability strategies, including practice-level coaching and payment reform, will also be discussed.

After this presentation, participants will be able to:

- Explain the impact of RHICs on practice change across diverse regions
- Describe the multi-state initiatives created by two RHICs to implement collaborative behavioral and physical care models in primary care by leveraging resources and drawing on evidence-based practices

Feinstein, K., PhD, President and CEO, Jewish Healthcare Foundation; **Valenti, M.,** Project Manager and Quality Improvement Specialist, Pittsburgh Regional Health Initiative; **Jaeckels, N.,** Vice President, Member Relations and Strategic Initiatives, Institute for Clinical Systems Improvement

C10: Meaningful Contexts: Developing Patient Personas That Identify Needs and Preferences to Drive Practice Redesign

This workshop will illustrate a qualitative method to describe patient experiences and perspectives using analytical personas representing chronic kidney disease patients. This approach allows a more accurate and dynamic definition of the needs and preferences of patients with complex and chronic disease and results in portraits (applicable to other patient populations) that show where practice redesign and care interventions are needed. Design-thinking thus leads to the construction of innovative, patient-centered care.

After this presentation, participants will be able to:

- Demonstrate how persona portraits establish a context that leads to innovation in care delivery processes
- Explain how new tools to understand patient needs can be incorporated into their organizational improvement tool-kits

Zavaleta, K., Senior Health Systems Analyst and Consultant, Mayo Clinic

C11: Measure Up, Pressure Down: Achieving Breakthrough Hypertension Outcomes

Measure Up, Pressure Down is an unprecedented campaign by which the American Medical Group Foundation (AMGF), the nonprofit research and education arm of the American Medical Group Association, aims to transform the diagnosis and treatment of hypertension. The core strategy of Measure Up, Pressure Down is to mobilize medical groups to implement evidence-based care processes. This session will focus on the characteristics of breakthrough success and provide two case examples of outstanding results in hypertension management that are transferable to any practice setting.

After this presentation, participants will be able to:

- Define the difference between medical group efforts that achieve modest performance improvement and those that achieve breakthrough performance improvement
- Identify the cultural challenges associated with efforts to achieve breakthrough performance as compared to moderate performance improvement
- Identify the eight Measure Up, Pressure Down campaign planks that medical groups are being urged to adopt to achieve 80% blood pressure control rates within three years

Lubin, J., Project Director, American Medical Group Association; **Yphantides, P., MD,** Family Physician and Board Member, Sharp Rees-Stealy Medical Group

C12: Finding the Sweet Spot: Trainee Engagement in the Transformation of Primary Care Delivery

Description TBD

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

C13: Holding Tension During Change

Description TBD

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

D/E Workshops
Tuesday, April 9
D Workshops: 11:00 AM – 12:15 PM
E Workshops: 1:15 PM – 2:30 PM

Special Interest Keynotes

D1: Implementation and Spread of Patient-Centered Medical Homes in a Safety Net Setting

With over six years of experience using the Lean Toyota Production System analysis to improve clinic processes, Denver Community Health Services (DCHS) has recently been participating in the Commonwealth Fund's Safety Net Medical Home initiative at three of its eight sites. Using "Lean" as a framework, it has developed and spread the PCMH model across the network. In this session, presenters will review DCHS's experiences in the development and spread of practice transformation.

After this presentation, participants will be able to:

- Define the change concepts of the SNMHI, and how to leverage those to attain medical home status.
- Understand how to translate change concepts into standard work that can be implemented and sustained.
- Learn successful strategies for engaging teams and spreading change across a network.

Loomis, L., MD, MSPH, Director, Family Medicine, Denver Community Health Services

E1: Is Your Mom on Drugs? Overmedication of Elders

Older adults can become swamped in a medication cascade, prescribed drugs that may do more harm than good. The result can be misdiagnosis, repetitive hospital admissions, loss of function and independence, increasingly tangled medical complications, declining quality of life, and worse. This presentation examines prescribing and de-prescribing through the personal story of a daughter-in-law who intervened and the perspective of a physician who has worked with the frail elderly for decades.

After this presentation, participants will be able to:

- Describe safe prescribing and de-prescribing for older adults
- Explore the role of the family to ensure medication safety for older adults

Davis, C., Geriatric Nurse Practitioner, Centre for Comprehensive Motivational Interventions; **Trimble, J.,** Steering Committee Member, Patient Voices Network; **Sloan, J., MD,** Family Physician, University of British Columbia

Workshops

Rapid Fire D: Health Information Technology

Description TBD

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

Presenters: Tolentino, J., MD, Assistant Professor, Internal Medicine and Pediatrics, Cincinnati Children's Hospital Medical Center; TBD

Open Space Workshop E

An opportunity for participants to propose their own topics for discussion and network with colleagues with shared interests.

D2/E2: Perfecting Community Partnerships for Primary Care Practices

Perfecting Community Partnerships for Primary Care Practices (PCP2), as tested in Cincinnati's Beacon and Aligning Forces for Quality (AF4Q) region, focuses on changing the relationship between primary care and community partners. Using the patient-centered medical home (PCMH) standards of the National Committee for Quality Assurance (NCQA) as guiding principles, new connections and referral patterns have been developed, enhancing the effectiveness of referrals and improving the health and experience of qualified patients. In this session, a model of the relationship between a primary care provider and a council on aging is shared as an example that could be adapted to other community agencies, especially those with case management infrastructure.

After this presentation, participants will be able to:

- Identify standards within PCMH transformation that lead to new relationships with community partners
- Define the next steps to take with their own identified community agencies to test the lessons learned
- Utilize relevant approaches to begin the PCP2 process in their practice and community

Christopher, R., Director, Health Partners Consulting

D3/E3: Personal Mastery for Leaders: Continuous Learning to Support Transformational Change

There are limits to how fast and how far people can shift their habits, patterns, roles, ways of relating, and ways of thinking, and transformational change is subject to these same limits. Considering that emotional tension and resistance are human and ubiquitous, leaders are faced with the difficult task of standing firm on decisions while engaging others individually. In this session, participants will learn concepts and methods to enhance their "personal mastery"—that is, their ability to sustain continuous personal learning to create desired results.

After this presentation, participants will be able to:

- Define the nature of adaptive change challenges and their human dynamics and identify the key elements in facilitating changes of habits and patterns
- Explain skillful interventions to shift reactivity and resistance toward productive engagement
- Identify ways to exercise authority that also help to preserve positive engagement

Baker, N., MD, Principal, Neil Baker Coaching and Consulting, LLC

D4/E4: Pioneering an Expansive Statewide Patient-Centered Medical Home Program

In 2008, Blue Cross Blue Shield of Michigan (BCBSM) collaborated with the Michigan physician community to implement a statewide PCMH program. This partnership enabled the program to grow in four years from 670 practices considered for medical home designation to 1,136 practices. This session will focus on the BCBSM process for validating physicians' self-reported progress, highlighting the evolution of the site-visit process and the lessons that have been learned.

After this presentation, participants will be able to:

- Discuss the history of the Michigan PCMH program and provide an overview of its primary elements
- Describe a site-visit model change that captures practice transformation processes
- Demonstrate how to apply site-visit results to continuous program improvement

Johnson, S., Senior Health Care Analyst, Blue Cross Blue Shield of Michigan; **Mason, M.,** Senior Health Care Manager, Blue Cross Blue Shield of Michigan

D5/E5: Primary Care and Behavioral Health: Sharing a Health Home

Integration of behavioral health and primary care is an essential to the medical home model and whole-person care. A Missouri Medicaid initiative is creating health homes in primary care and mental health practices and involving both groups in a statewide collaborative learning experience. The practices' differing vocabulary, paradigms and delivery models are meeting each other on a common journey aimed at health home transformation. This session will share change concepts, lessons learned, and results.

After this presentation, participants will be able to:

- Describe changes that facilitate health home transformation in both primary care and behavioral health organizations
- Summarize the challenges and best practices for achieving integration of behavioral and physical health
- Explain strategies that mitigate challenges in a large health home initiative

Simmons, L., Project Director, CSI Solutions, LLC; **Chaufournier, R.,** President and CEO, CSI Solutions, LLC

D6/E6: The Proactive Office Encounter: Addressing Both Preventive and Chronic Care Needs

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

After this presentation, participants will be able to:

- Identify opportunities to create a highly reliable care process that improves quality and the patient care experience, leads to fewer missed opportunities to improve preventive care and chronic disease management, increases efficiency, and optimizes clinician support in specialty care as well as primary care
- Apply work flows and tools that create consistent support to the physician practice, empower and engage staff, 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

D7/E7: Hospitals and Public Health Agencies Collaborating to Improve Community Health

This session will highlight successful public health and hospital alliances in western North Carolina to improve population health through collaborative community health assessment and improvement activities.

After this presentation, participants will be able to:

- Discuss the factors that drive collaborative community health assessment and improvement planning
- Describe one region's community health improvement work involving multiple health care systems, public health agencies, and other partners

Cilenti, D., DrPH, Deputy Director, University of North Carolina at Chapel Hill, Gillings School of Global Public Health

D8/E8: Improving Cancer Screening Rates for Latinos: A Community Collaborative Approach

In this session, presenters will describe a coordinated plan for cancer screening and treatment across health systems to address the needs of uninsured and underinsured Latinos in Portland, Oregon. The success of the community collaborative approach used to increase screening for breast and cervical cancer among this population highlights the value of organizational engagement in community cancer screening events and in efforts to reduce costs of care through timelier diagnostic care. Participants will learn about this approach as a model for other efforts to improve access to cancer screening, both locally and throughout the US health care system.

After this presentation, participants will be able to:

- Understand a community-based collaborative model for providing cancer screening and treatment to an uninsured and underinsured population
- Report evaluation results to show the impact on screening rates and on earlier cancer detection and treatment

Hamilton, J., Director, Operations, Project Access NOW; **Timothy, T.,** Director, Cancer Projects and Outreach, Providence Cancer Center

D9/E9: Using Computer-Automated Assessments and Interventions to Improve Care and Efficiency

Health care quality and efficiency can be improved when assessments and behavior-change interventions are computer-automated. Such systems enable practices to provide more care and services with little or no increase in costs or clinician time. Research indicates that patients are more forthcoming about personal problems when communicating with a computer rather than a clinician; in fact, computers have been shown to be capable of treating depression and anxiety as successfully as clinicians. This workshop will provide an overview of this research and the available tools.

After this presentation, participants will be able to:

- Recognize the opportunities and pitfalls in implementing computer-automated assessments and evaluations in office practice
- Evaluate and compare the quality and benefits of various computer-automated assessments and evaluations

Thapliyal, A., CEO, HealthTRX, Ltd.; **Zayfert, C.,** TBD

D10/E10: Creating Work-Life Satisfaction While Achieving Patient-Centered Medical Home Standards

This session will provide participants with tools for coaching primary care teams in assessing and improving their small systems to achieve better outcomes for patients and families. The presenters will also discuss the key leadership and system supports that enhance team engagement in continuous improvement and build new habits and behaviors in daily work. Participants will learn how benchmark organizations have aimed to improve their practice performance and increase work-life satisfaction.

After this presentation, participants will be able to:

- Describe a comprehensive approach for creating team work life satisfaction while assessing and achieving a 3-5 year Patient Centered Medical Home transformation plan.
- Discuss collaborative learning and coaching models, PCMH measurement plans, and spread strategies that are supporting a MaineHealth 3-5 year transformation plan.
- Create a team action plan that aims to improve work life satisfaction and quality of patient care using PCMH standards.

Hess, A., President, Clinical Performance Management, Inc.; **Cawley, J.**, **DO,** Associate Chief Medical Officer, MaineHealth

D11/E11: Unleashing the Power of Teams and Health IT

This session will look at how care teams can be developed and health information technology (IT) leveraged to deliver more effective and efficient care. The presenters will discuss the growing proficiency of Kaiser Permanente care teams in using process improvement and technology, while including patients in care improvement projects. Through interactive exercises, participants will learn how to incorporate key principles and learnings into other kinds of organizational structures and care settings.

After this presentation, participants will be able to:

- Describe how effective care teams leverage advanced health IT
- Explain how care teams can use health IT to transform care and become more highly skilled in process improvement
- Apply the core principles and learnings of technology-supported care teams in their own organization

Compton-Phillips, A., MD, Associate Executive Director, Quality, Kaiser Permanente; **Chow, M., PhD, RN,** Vice President, National Patient Care Services, Kaiser Permanente

D12/E12: Patient Activation Strategies: Moving Patients Along the Continuum of Engagement

Educated, active patients are healthier patients, and Prochaska's Model of Change and Hibbard's Patient Activation Measure provide clinicians with support tools to identify levels of patient activation. In this session, participants will learn how two Aligning Forces for Quality (AF4Q) communities developed programs to move patients along the continuum: western New York's development of educational tools to move patients from passive to empowered, and south-central Pennsylvania's Patient Partner Program, which selected active patients to work on practice leadership teams to improve patient care.

After this presentation, participants will be able to:

- Define a theoretical model of the continuum of patient involvement in health care settings
- Identify strategies and approaches to increase patient activation in their own setting

Powell, J., Quality Improvement Coach; **Ebersole, K.,** Director, Regional Quality Improvement, P2 Collaborative of Western New York