# *The* Value *of* Story

**ALIGNING FORCES FOR QUALITY**
NATIONAL MEETING

Robert Wood Johnson Foundation

**Aligning Forces for Quality** | Improving Health & Health Care in Communities Across America

**NOVEMBER 7–9, 2012**
**SAN FRANCISCO, CA**

# Agenda

Robert Wood Johnson Foundation

**Aligning Forces for Quality** | Improving Health & Health Care in Communities Across America

Agenda

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**“Passwords are case sensitive”**

To connect to the **“Parc55_Conf”** wireless network:

- Please ensure your laptop is ON and it has a Wireless Card and software installed.
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- Enter the username and password code provided.

**The same codes above provide Internet access via a wired connection as well.**

**6:30 am-8 am**

Cyril Magnin Foyer
Fourth Floor

## BREAKFAST AND REGISTRATION

A hot breakfast is available for all meeting attendees.

**There are two options for enjoying it:**

### Making Local and Regional QI Connections Easier Through the National Quality Forum (NQF) Action Registry

Join a conversation about the National Quality Forum's Action Registry, a new, interactive virtual space for organizations to share their patient safety improvement activities — or "actions" — and make connections with each other. This interactive tool is designed to help organizations work together on patient safety and quality goals. Through this tool, you can tell others what you are doing and learn about effective actions by others to improve care. Before it is released, NQF would like your input on how the Action Registry can best help meet needs within your community, region, or state.

- **Jonathan Grau**, Senior Director, Stakeholder Collaboration, National Quality Forum (NQF)
- **Juliet Feldman**, Project Analyst, NQF

### Networking—What Stories Do You Want to Share?

Find a table tent that speaks to you and join your peers for casual conversation and storytelling around a variety of topics. Or choose a FIRST TIME ATTENDEE table for some casual conversation with staff from the National Program Office.

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**8 am-9:30 am**

Cyril Magnin Ballroom
Fourth Floor

## OPENING PLENARY: "THE CALL OF STORY"

*Welcome*: John Lumpkin, Senior Vice President and Director of Health Care Group, RWJF, and Bob Graham, Program Director, Aligning Forces for Quality National Program Office

**Keynote: Abraham Verghese:** Few people combine a career as physician, professor, and author as well as Abraham Verghese, who has been on the *New York Times* bestseller list with all three of his books. He was a featured speaker at TED in Edinburgh last summer, gave a Tanner Lecture in February, and lectures widely on topics that range from his experience in medicine to the patient-physician relationship and the art of storytelling.

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**9:30 am-9:45 am**

## BREAK

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## BREAKOUTS—BRINGING VALUE TO YOUR STORY: CONNECTING THE DOTS

In three concurrent, highly interactive sessions, we will dive into stories from within AF4Q and beyond, shining the light on both bright spots and struggles.

**9:45 am-11:15 am**

Powell
Third Floor

### BREAKOUT: TARGETING DEPRESSION: CONNECTING MEASUREMENT AND PAYMENT

Several Alliances are targeting depression and other mental health conditions in order to improve quality and reduce cost. The panel will focus on the intersection of QI, payment, and measurement in the context of improving care for patients and lowering health care costs. Their stories use evidence-based QI strategies to promote better health outcomes at a lower cost.

*Introduction:* Marcia Wilson, AF4Q National Program Office

*Moderator:* Jim Chase, AF4Q Minnesota

- **Paul Ponstein**, CMO, Michigan Center for Clinical Systems Improvement (MiCCSI)
- **Cally Vinz**, Vice President, Health Care Improvement and Member Relations, Institute for Clinical Systems Improvement, Minnesota
- **Sue Vos**, Program Director, MiCCSI, West Michigan
- **Henry White**, Clinical Director, Brookline Community Mental Health Center, Massachusetts



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**9:45 am-11:15 am**

Embarcadero
Third Floor

## BREAKOUT: BEYOND THE CLINIC WALLS: CONNECTING POPULATION HEALTH AND QI TO REACH VULNERABLE POPULATIONS

Equity is an essential component of quality. Yet, many of the factors that contribute to inequities in care occur outside the health care delivery system. What can be done to extend the reach of providers beyond the clinic walls to leverage community resources and improve clinical quality outcomes for vulnerable populations?

*Introduction:* Marshall Chin, Richard Parrillo Family Professor of Healthcare Ethics in the Department of Medicine, University of Chicago, and member of the AF4Q National Advisory Committee

*Moderator:* Rhonda Moore Johnson, medical director of Health Equity & Quality Services at Highmark Inc., and member of the AF4Q National Advisory Committee

- **America Bracho**, executive director of Latino Health Access
- **Mark Miller**, Behavioral Health Consultant, Swope Health Services
- **Lauren Moyer**, Director of Clinical Operations, Swope Health Services
- **Shelley Hirshberg**, AF4Q Western New York

**9:45 am-11:15 am**

Mission
Fourth Floor

## BREAKOUT: BEYOND 2015: SHOWCASING THE VALUE OF AF4Q

Alliances will share how they have developed roles and relationships with key stakeholders and how they leverage local and federal opportunities to build relationships to develop committed resources to continue to advance the AF4Q work.

*Introduction*: Robert Graham, AF4Q National Program Office

*Moderator*: Mike Painter, Robert Wood Johnson Foundation

- **Mylia Christensen**, AF4Q Oregon
- **John Gallagher,** AF4Q Puget Sound
- **Rita Horwitz**, AF4Q Cleveland
- **Melissa Kennedy**, AF4Q Cincinnati

**11:15 am-11:30 am**

## BREAK

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| **11:30 am-1 pm**<br>Cyril Magnin Ballroom<br>Fourth Floor | **LUNCHEON PLENARY: "HOW THE ELECTION RESULTS MIGHT IMPACT YOUR STORY"**<br>*Introduction:* Katherine Browne, AF4Q National Program Office<br>**Keynote: Sara Rosenbaum**, Harold and Jane Hirsh Professor and founding Chair of the Department of Health Policy at The George Washington University School of Public Health and Health Services. |
| **1 pm-1:15 pm** | **BREAK** |
| **1:15 pm-5:15 pm**<br>Cyril Magnin Foyer<br>Fourth Floor | **STORYTELLING CLINIC**<br>Teams will work together with their fellow alliance members and professional storytellers Rick Stone and Shirley Decker from I.D.E.A.S. Orlando. Teams will craft, hone, and form their strongest stories, as well as learn the craft of storytelling to wide audiences. The session will be interactive and fun, with plenty of refreshments and a few fun surprises. |
| **5:15 pm-6:15 pm**<br>Cyril Magnin Foyer<br>Fourth Floor | **NETWORKING RECEPTION**<br>We know you DEFINITELY have stories to share now! |
| **6:15 pm-** | **DINNER ON YOUR OWN**<br>Please see the AREA INFORMATION tab for nearby restaurant options and a local map. |

**6 am-7am**

Embarcadero
Third Floor

## ALIGN YOUR FORCES WITH EARLY MORNING YOGA

What better way to be active with AF4Q in San Francisco than with what is known as the official art of alignment! Join renowned yoga instructor Rosemary Garrison to begin the Friday AF4Q sessions energized. The one-hour class will be tailored to beginners, with options for advanced poses for any dedicated yogis. No fear if you have never heard the phrase "downward dog"—this class will introduce the basics of yoga, breath work, and movement, leaving you inspired and with peace of mind to conjure up your storytelling abilities! Mats will be provided.

**7 am-8:30 am**

## BREAKFAST AND REGISTRATION

A hot breakfast is available for all meeting attendees.

**There are two options for enjoying it:**

Cyril Magnin Ballroom
Fourth Floor

### 'Care About Your Care' 2013: An Overview

- **Alexis D. Levy,** Communications Officer, RWJF
- **GYMR Public Relations**
- **MSL Washington, DC**
- **Steege Thomson Communications**

Cyril Magnin Foyer
Fourth Floor

### Networking: What Stories Do You Want to Share?

Find a table tent that speaks to you and join your peers for casual conversation and storytelling around a variety of topics.

Don't forget to fill out your evaluations so we can keep what you liked and improve what you didn't!

## BREAKOUTS—BRINGING VALUE TO YOUR STORY: CONNECTING THE DOTS

In three concurrent, highly interactive sessions, we will dive into stories from within AF4Q and beyond, shining the light on both bright spots and struggles.

**8:30 am-10 am**

Market Street
Third Floor

### BREAKOUT: SHOW ME THE MONEY: CONNECTING COST AND QUALITY TO SAFELY TRANSFORM CARE DELIVERY

To affect health care cost, you need to transform its drivers. This session will bring you stories of innovative projects that are working to change how care is delivered and drive down the cost of health care in regions across the country.

*Introduction*: Susan Mende, Senior Program Officer, RWJF

*Moderator*: Arnie Milstein, Professor of Medicine, Stanford University School of Medicine, and member of the AF4Q National Advisory Committee

- **Maureen Corry**, Executive Director, Childbirth Connection
- **Valerie Klitzke**, Senior Business Planning Analyst, Meriter Health Services, Wisconsin
- **David Labby**, Chief Medical Officer, Health Share of Oregon
- **Ruth Nolan**, Vice President of Operations, Women's Health Service Line, Geisinger Health System
- **Rebecca Ramsay**, Care Support Manager, CareOregon Inc.
- **Stacey Schulz**, Manager of Contracting, Meriter Health Services, Wisconsin

**8:30 am-10 am**

Powell
Third Floor

## BREAKOUT: PROMISING RESULTS: CONNECTING PATIENT ENGAGEMENT AND QUALITY

Many alliances have successfully implemented methodologies and strategies to engage patients in improving the quality of care and the overall patient experience. They have stories of how to use patient knowledge and engagement to successfully innovate and implement quality initiatives. These programs are starting to show promising results towards improving measures. Patients can lead, transform, influence outcomes, and affect health care within their community. This session will showcase different approaches to patient engagement with each demonstrating impact and success.

*Introduction*: Catherine West, AF4Q National Program Office

*Moderator*: Melissa Jones, AF4Q Humboldt County

- **Terri Martin,** Clinical Director, Mercy Health Anderson Hospital, Ohio
- **Cheryl Magnuson-Giese**, Senior Director, Physician Services, HealthPartners Medical Group, Minneapolis, Minnesota
- **Bill Scarpaci**, Consumer Representative, Cincinnati
- **Ilene Sylvester**, Vice President of Executive and Tribal Services, South Central Foundation, Alaska

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| **8:30 am-10 am**<br>Mission<br>Fourth Floor | **BREAKOUT: BEG, BORROW, AND ADAPT: CONNECTING QUALITY IMPROVEMENT AND PAYMENT ON THE ROAD TO BIG IMPACT**<br>Connecting quality, spread, and payment: To sustain and grow the broad impact that quality improvement and payment reform efforts have on the health care delivery system in their communities, Alliances are pursuing multiple inventive ways to renew and adapt their initiatives. This session will focus on how Alliances are strategically spreading the impact of their work to new populations, communities, and settings of care.<br>*Introduction*: Katherine Browne, AF4Q National Program Office<br>*Moderator*: Keith Mandel, Vice President of Medical Affairs, Physician-Hospital Organization at Cincinnati Children's Hospital Medical Center<br>• **Christine Amy**, AF4Q South Central Pennsylvania<br>• **Kate Farley**, Executive Director, Pennsylvania Employees Benefit Trust Fund<br>• **Helena Peterson**, Program Manager, Community Care Teams, Maine Quality Counts<br>• **Angela Richards**, Project Manager, Androscoggin Home Care and Hospice, Maine |
| **10 am-10:15 am** | **BREAK** |
| **10:15 am-12:15 pm**<br>Cyril Magnin Ballroom<br>Fourth Floor | **CLOSING PLENARY: "THE POWER OF STORY TO MAKE A DIFFERENCE: EMPOWERED PATIENTS, EMPOWERED COMMUNITIES"**<br>**Anne Weiss**, RWJF<br>**Keynote: Elizabeth Cohen**, Senior Medical Correspondent for CNN's Health, Medical and Wellness unit |

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| **12:30 pm-1:30 pm** | **LUNCH**<br>All attendees are invited to stay for lunch. You may eat at the hotel and network with peers or pack your lunch to go |
| **12:30 pm-1:30 pm**<br>Market<br>Third Floor | **PRIVATE LUNCH FOR PROJECT DIRECTORS**<br>Project directors are invited to share an informal wrap-up lunch together. Lunch will be served in the room |
| **12:30 pm-1:30 pm**<br>Mission<br>Fourth Floor | **PRIVATE LUNCH FOR CONSUMER REPRESENTATIVES**<br>Consumer representatives and consumer engagement staff are invited to come back together for a final casual opportunity to debrief. Lunch will be served in the room. |

**WHAT'S NEXT?** Share your readmission and care across setting stories in February during Care About Your Care!

## There are conference calls and ideas, matrixes and charts, schedules and assignments. But you know now ... that isn't a story.

## *The story of this meeting is the people who planned and executed it.*

First, the planners. We are grateful to the November 2012 planning committee, whose vision and ideas you will see in everything from the meeting theme to the innovative storytelling session. "What really matters now," said Chris Amy on our first call, "is that we can tell our story to partners and funders and others." Their willingness to take time out of their lives to help strategize and plan is deeply appreciated.

**AF4Q November 2012 National Meeting Planning Committee:**

> **Christine Amy, Katherine Browne, Mylia Christensen, Andrea Ducas, Alan Glaseroff, Hilary Heishman, Maggie Kay, Patrick McCabe, Michael Painter, Danielle Lazar, Alexis Levy, Lissette Vaquerano, and Marcia Wilson**.

The story of the logistics is a story of chaos being woven into logic. The entire AF4Q National Program Office worked to secure and prep speakers, develop materials, stuff and pack materials, and staff sessions. Special thanks to the NPO Communications Team, who you will see in their trademark headsets running registration, tweeting sessions, writing articles for the newsletter, shooting images for the live pinterest board, and ensuring that everything from AV to food to hotel arrangements run smoothly.

The story of those who attended this meeting is the one we hope will grow and flourish. We appreciate your willingness not only to travel and take time away, but also to dive in and engage in the sessions, adding your input and experiences, taking risks with story and narrative, and both learning from your peers and letting them learn from you. Your willingness to be truly present is what makes you the hero of this story. Thank you for coming.

**Alicia Aebersold**
AF4Q National Program Office
(aaebersold@gwu.edu)

# Area Information

Area Information

Robert Wood Johnson Foundation

**Aligning Forces for Quality** | Improving Health & Health Care in Communities Across America

# **follow** the stories

*or **tweet** your own*

## use #af4q

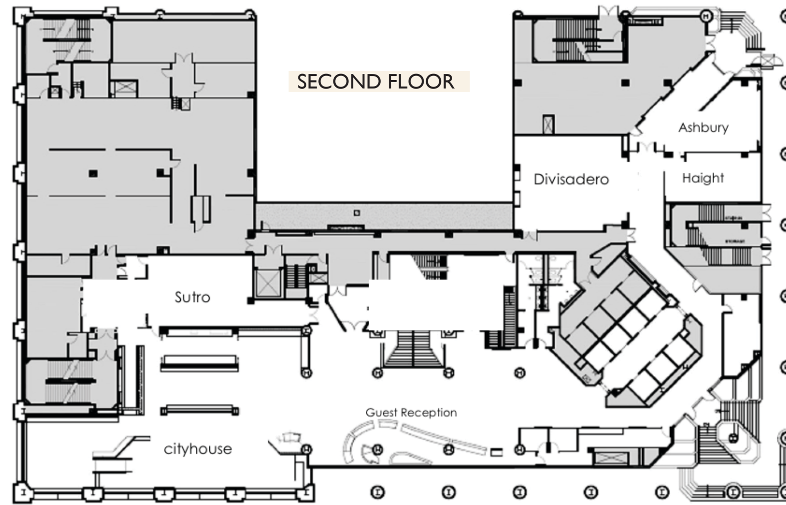
or

## @aligningforces

### want to know more about twitter?

stop by the registration desk for a twitter 101 sheet and get started today

webteam@forces4quality.org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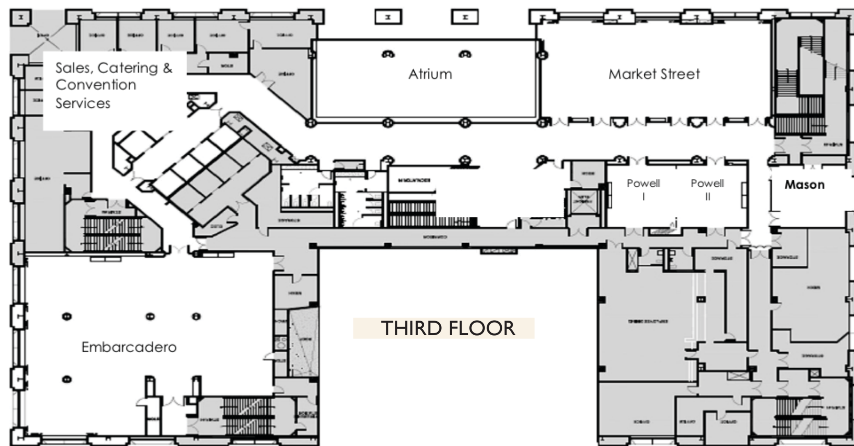
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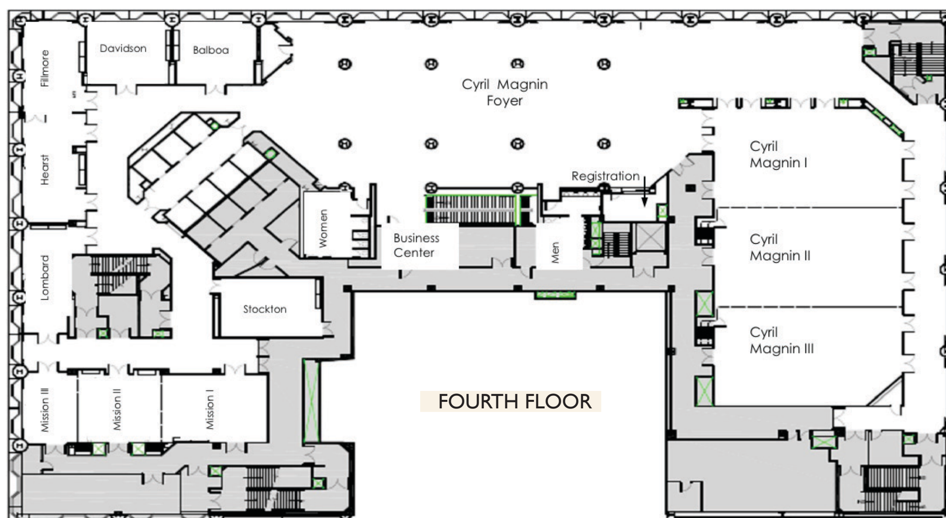
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Magnin III
FOURTH FLOOR
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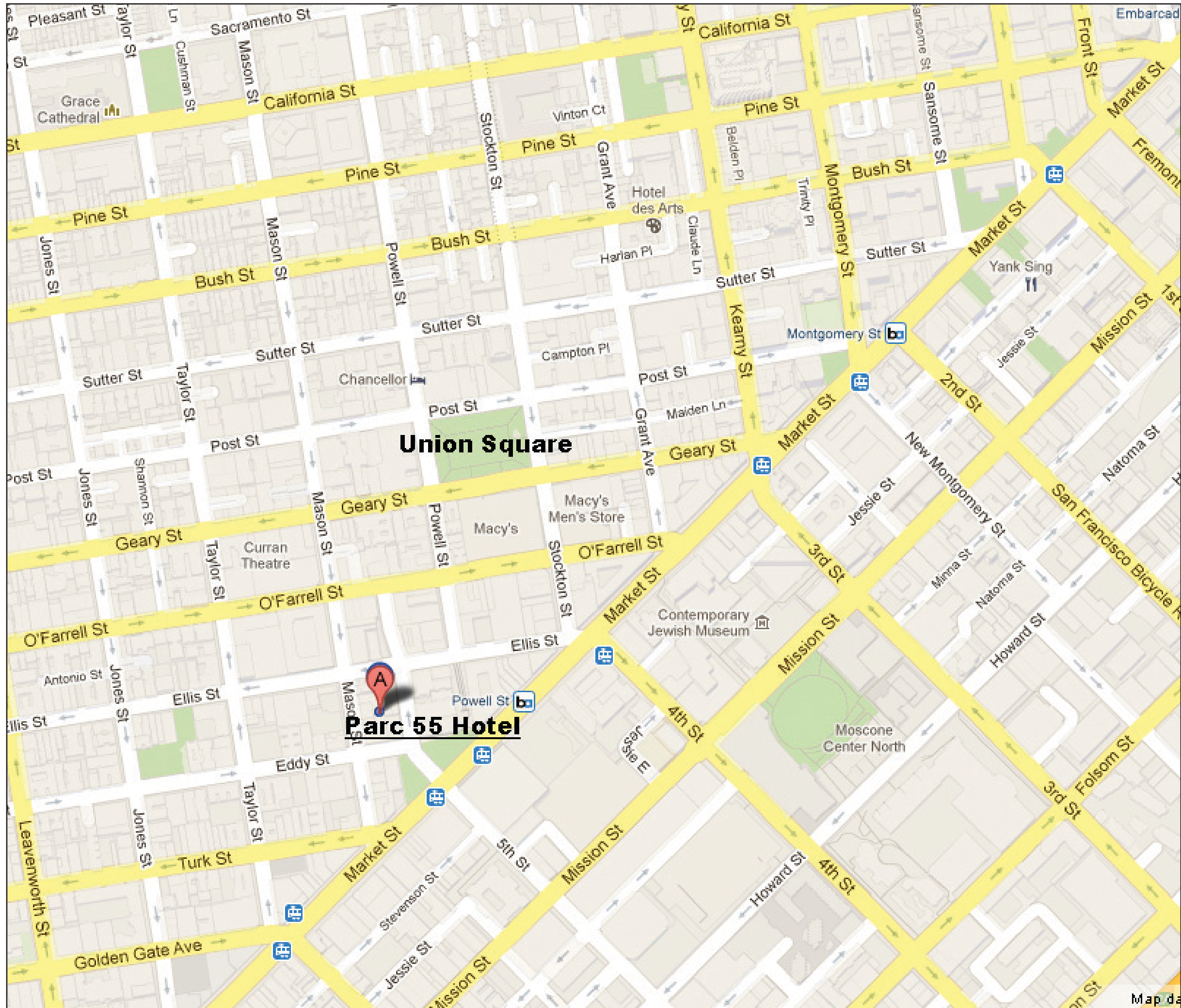
Mission II
Mission I

## HOTEL AREA MAP




## PARC 55 HOTEL

55 Cyril Magnin Street
San Francisco, CA 94102
phone: 415-392-8000

## CASUAL DINING

| Restaurant | Address | Phone | Price |
|---|---|---|---|
| **Biscuits and Blues** (American) | 401 Mason Street | (415) 292-2583 | $$ |
| **Café Mason** (American) | 320 Mason Street | (415) 544-0320 | $$ |
| **Daily Grill** (American) | 347 Geary Street | (415) 616-5000 | $$ |
| **First Crush** (American) | 101 Cyril Magnin Street | (415) 982-7882 | $$$ |
| **John's Grill (**American) | 63 Ellis Street | (415) 986-0069 | $$$ |
| **Lori's Diner** (American) | 149 Powell Street | (415) 981-1950 | $$ |
| **Roxanna Café** (American) | 570 Powell Street | (415) 989-5555 | $$ |
| **Fish & Farm** (Californian/Seafood) | 339 Taylor Street | (415) 474-3474 | $$$ |
| **Grand Café** (California) | 501 Geary Street | (415) 292-0101 | $$$ |
| **Café Espresso** (Deli) | 462 Powell Street | (415) 395-8585 | $ |
| **Café Madeleine** (Deli) | 43 O'Farrell Street | (415) 362-1713 | $$ |
| **David's** (Deli) | 474 Geary Street | (415) 440-2737 | $$ |
| **Empono Rulli Café** (Deli) | 225 Stockton Street | (415) 433-1122 | $$ |
| **Kim Thanh** (Chinese/Vietnamese) | 607 Geary Street | (415) 928-6627 | $$ |
| **Tian Sing** (Chinese-Dim Sum) | 138 Cyril Magnin Street | (415) 398-1338 | $$ |
| **La Scene** (French) | 490 Geary Street | (415) 292-6430 | $$$ |
| **Les Joulins** (French) | 44 Ellis Street | (415) 397-5397 | $$ |
| **Chutney Restaurant** (Indian) | 511 Jones Street | (415) 931-5541 | $ |
| **Borobudar** (Indonesian) | 700 Post Street | (415) 775-1512 | $$ |
| **Mela** (Indian) | 417 O'Farrell Street | (415) 447-4041 | $$ |
| **Naan "N" Curry** (Indian) | 366 O'Farrell Street | (415) 346-1443 | $ |
| **Shalimar** (Indian) | 532 Jones Street | (415) 928-0333 | $ |
| **Cesario's** (Italian) | 601 Sutter Street | (415) 441-9898 | $$ |
| **Fino** (Italian) | 624 Post Street | (415) 928-2080 | $$ |
| **Girasole** (Italian) | 480 Sutter Street | (415) 398-8900 | $$$ |
| **Kuleto's** (Italian) | 221 Powell Street | (415) 397-7720 | $$$ |
| **L'Ottavo** (Italian) | 692 Sutter Street | (415) 922-3944 | $$ |
| **Puccini and Pinetti** (Italian) | 129 Ellis Street | (415) 392-5500 | $$ |
| **Scala's Bistro** (Italian) | 432 Powell Street | (415) 395-8555 | $$$ |
| **Sakana** (Japanese) | 639 Post Street | (415) 775-7644 | $$ |

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| **Sanraku** (Japanese) | 704 Sutter Street | (415) 771-0803 | $$ |
| **Sushi Boat** (Japanese) | 389 Geary Street | (415) 781-5111 | $$ |
| **Anzu** (Japanese) | 222 Mason Street | (415) 394-1100 | $$$ |
| **Hana Zen** (Japanese) | 115 Cyril Magnin Street | (415) 421-2101 | $$$ |
| **Urban Tavern** (Mediterranean) | 333 O'Farrell Street | (415) 923-4400 | $$ |
| **Santorini** (Mediterranean) | 242 O'Farrell Street | (415) 402-0060 | $$ |
| **El Sotano** (Mexican) | 550 Powell Street | (415) 989-7131 | $$ |
| **Thai Stick** (Thai) | 698 Post Street | (415) 928-7730 | $$ |
| **Ar Roi** (Thai) | 643 Post Street | (415) 771-5146 | $$ |
| **Lefty O'Doul's** (Irish Bar) | 333 Geary Street | (415) 982-8900 | $$ |
| **Johnny Foley's** (Irish Bar) | 243 O'Farrell Street | (415) 954-0777 | $$ |
| **Farmerbrown** (Southern & Soul Food) | 25 Mason Street | (415) 409-3276 | $$ |

## FORMAL DINING

| | | | |
|---|---|---|---|
| **Campton Place** (California) | 340 Stockton Street | (415) 955-5555 | $$$$ |
| **Postrio** (California) | 545 Post Street | (415) 776-7825 | $$$$ |
| **Farallon** (Coastal) | 450 Post Street | (415) 956-6969 | $$$$ |
| **Fleur De Lys** (French) | 777 Sutter Street | (415) 673-7779 | $$$$ |
| **Jeanne D'Arc** (French) | 501 Powell Street | (415) 981-1950 | $$$ |
| **Le Colonial** (French/Vietnamese) | 20 Cosmo Place | (415) 931-3600 | $$ |
| **Marrakech** (Moraccan) | 419 O'Farrell Street | (415) 776-6717 | $$$$ |
| **Millenium** (Vegetarian) | 580 Geary Street | (415) 345-3900 | $$$ |
| **Morton's** (Steakhouse) | 400 Post Street | (415) 986-5830 | $$$$ |
| **Zingari Ristorante** (Italian) | 501 Post Street | (415) 885-8850 | $$$ |

### Pricing Guide

$ = under $10
$$= $11-$30
$$= $31-$60
$$$$= above $60

# Speakers

Robert Wood Johnson Foundation

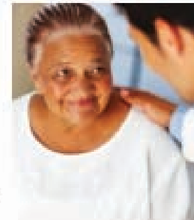
**Aligning Forces for Quality** | Improving Health & Health Care in Communities Across America

Speakers

**Aligning Forces for Quality** | Improving Health & Health Care in Communities Across America

**On the 19th of September**
Wednesday, September 19, 2012

Consumer Engagement



At first, staff at Carson City Hospital in Michigan were incredulous when quality department staff told them their scores on compliance with ideal care measures were lower than the standard the 77-bed acute care hospital had set.

"Our nurses didn't really understand what core measures were really, really all about, or what it takes to actually get in compliance with those measures," said Joan Sweet, vice president and chief quality/risk officer at Carson City Hospital.

The hospital was searching for a way to re-educate and re-energize staff members about the importance of documenting core measures. These efforts culminated in a campaign called "Because Every Patient Counts," which focuses on achieving a perfect measure of ideal care score for every patient.

# AF4Q Spotlight

*the public newsletter from the AF4Q National Program Office*
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## ABRAHAM VERGHESE, MD | KEYNOTE

Abraham Verghese, MD, renowned physician, bestselling author, and professor for the theory and practice of medicine at the Stanford University School of Medicine, has earned accolades in and out of the medical community for his advocacy on behalf of patients. He is widely regarded as having influenced the way modern medical students think about what it means to be a doctor and to treat people. Dr. Verghese has lectured widely on the importance of the doctor-patient relationship, on the Samaritan function of physicians, and on where meaning resides in a medical life.

Much of Dr. Verghese's life's work is brought to bear on his debut novel, *Cutting for Stone*, which has been celebrated by critics around the country and has spent more than 100 weeks on *The New York Times* bestseller list. *Entertainment Weekly* praised the novel as "a lovely ode to the medical profession…. The doctor in [Verghese] sees the luminous beauty of the physician's calling; the artist recognizes that there remain wounds no surgeon can mend." Dr. Verghese also has written two nonfiction books. *My Own Country*, published in 1994, is a memoir about his time treating AIDS patients in rural Tennessee. It was a finalist for the National Book Critics Circle Award and was made into a movie directed by Mira Nair (*The Namesake*). His second book, *The Tennis Partner*, about his close friendship with a drug-addicted physician, was published in 1998 and was a *New York Times* Notable Book and a national bestseller.

All of Abraham Verghese's works, fiction and nonfiction, reflect his view of medicine as a passionate pursuit and a priestly calling. Dr. Verghese was raised in Ethiopia, attended medical school in India, and came to the United States to practice. He soon became concerned about doctors losing touch with the roots of medicine and with their patients. "The patient in America is becoming invisible," observes Dr. Verghese. "It is as if the patient in the bed is merely an icon for the real patient, who exists in the computer." He has worked tirelessly to reverse the trend in his own practice and by speaking publicly. He has appeared on CBS's *60 Minutes* and on National Public Radio to discuss these issues. He has published extensively in the medical literature, and his writing has appeared in *The New Yorker, Sports Illustrated, The Atlantic, Esquire, Granta, The New York Times Magazine, The Wall Street Journal*, and elsewhere.

Before his appointment at Stanford University, from 2002 to 2007, Dr. Verghese served as the director of the Center for Medical Humanities & Ethics at the University of Texas Health Science Center, San Antonio (UTHSCSA), where he held the Dr. Joaquin G. Cigarroa Jr. Chair in Medicine and was the Marvin Forland Distinguished Professor of Ethics. He has an appointment as an adjunct professor at UTHSCSA. From 1991 to 2002, he was a professor of medicine at the Texas Tech University Health Sciences Center, El Paso, where he held the Grover E. Murray Distinguished Professorship. He is board certified in internal medicine, pulmonary diseases, and infectious diseases. He serves on the Board of Directors of the American Board of Internal Medicine.

A moving speaker, he also is acclaimed as a dedicated and inspiring teacher of medicine at the bedside and is a sought-after clinician and diagnostician.

## JIM CHASE | MODERATOR

Jim Chase is the president of MN Community Measurement, a non-profit organization whose mission is to improve the health of the community by publicly reporting information on health care quality. Mr. Chase has more than 25 years of experience in health care management, including eight years as director of health purchasing with the Minnesota Department of Human Services. He is the past chair of the Network of Regional Healthcare Improvement, a group of leading regional health initiatives working to improve the quality and value of health in their communities. He also serves on the boards of the Institute of Clinical Systems Improvement and Apple Tree Dental.

**Public Contact Information**
3433 Broadway Street NE
Suite 455
Minneapolis, MN 55413
612-454-4812
chase@mncm.org

## PAUL PONSTEIN, DO | SPEAKER

Dr. Ponstein has a long history in West Michigan of involvement with health systems, payers, physicians, and the community to improve individual health care, population health, safety, and the value of care. He is currently the executive medical director for Physician's Organization of Michigan Accountable Care Organization and CMO of the Michigan Center for Clinical System Improvement. He also serves on the Steering and Clinical Committees for the CMS Multipayer Advanced Primary Care Practice Demonstration Project (MiPCT) and the Steering Committee for the CMMI COMPASS grant. He is a strong supporter of payment redesign, information technology ,and process improvement within innovative systems of care, such as patient-centered medical homes and accountable care organizations.

### Paul's Story to Tell:

Our story is about a core group of regional primary care physician leaders from multiple health systems sharing the common dream of building a center for healthcare transformation in west Michigan. A space where providers, payers, purchasers and people come together to address problems collaboratively which they cannot solve on their own competitively. Where technical and adaptive change can occur within a patient-centric, all-patient, all-payer Medical Home environment and improvement is focused on Triple Aim metrics fostering personal and community engagement in one's own healthcare. The Michigan Center for Clinical System Improvement (MiCCSI) is now in its second year adapted from the Institute for Clinical System Improvement (ICSI) in Minnesota.

Our first initiative applies a team-based collaborative care management model in the diagnosis and treatment of major depression with emphasis on people with coexisting chronic disease. We chose to adopt the ICSI DIAMOND model and participate with ICSI in a CMS CMMI grant called COMPASS. Recruitment, training, payment redesign, and tools have been addressed, with implementation occurring in November. Today we will share our experiences on this journey, ending the session with a brief preview of things to come.

**Public Contact Information**

231-670-4799
pdponstein@gmail.com

### KEY TAKEAWAYS FROM PAUL'S STORY:

1. Physician leadership, not just engagement, is critical for success in health system redesign.
2. There are artificial barriers preventing behavioral and medical health providers from working together effectively in managing populations of people's care.
3. Effective healthcare redesign cannot occur before effective reimbursement redesign.

## CALLY VINZ, RN | SPEAKER

Cally Vinz is the Institute for Clinical Systems vice president for health care improvement and member relations, providing leadership and direction for all ICSI core programs and initiatives (guidelines, member relations, quality improvement, and strategic initiatives).

Ms. Vinz is a registered nurse and has more than 30 years of experience in clinical, administrative, and leadership roles in both ambulatory care and hospitals in large integrated systems, small rural settings in a wide variety of clinical areas, and industry. Ms. Vinz sits on several state advisory boards; directs initiatives with health care providers, health plans, and government agencies; and consults with health care stakeholders in Minnesota and across the United States on aspects of health care quality and evidence-based medicine. She has been the executive lead on health transformation projects, consulting with medical groups, providers, specialty practices, health plans, and state and national government on collaborative approaches.

### Cally's Story to Tell:

In 2008 ICSI launched the DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction) program. This program is unique as it changes how depression in primary care is delivered and paid for. It is an evidence-based, collaborative care model that improves depression treatment in primary care clinics using a care manager and consulting psychiatrist to support patient care and the PHQ-9 (Patient Health Questionnaire) for diagnosis and ongoing management of depression. Systematic patient follow-up, tracking, and monitoring is done using the PHQ-9 measurements and a patient registry to track changing PHQ-9 scores over time. The roles of care manager and consulting psychiatrist were not reimbursable, and therefore the care model was not sustainable under established payment systems. Participating health plans agreed to a payment model in which a monthly payment for a bundle of DIAMOND services is offered to participating medical groups.

More than 9,000 patients have entered the DIAMOND program at more than 62 clinics. Of the patients contacted six months after being activated in DIAMOND, 47 percent are in remission, and an additional 17 percent have seen at least a 50 percent reduction in the severity of their depression. These results are five times better than for patients with depression treated under "usual" primary care.

### KEY TAKEAWAYS FROM CALLY'S STORY:

1. Health care transformation requires both care model redesign and payment reform to make it sustainable.
2. This collaborative care model can be spread to many types of organizations beyond Minnesota and used to integrate the care of mental health and other chronic conditions.
3. The AF4Q alliance members are key to the success of care redesign and payment reform.

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## SUE VOS | SPEAKER

Sue Vos has been involved in care management and practice transformation for the past 10 years. She has helped practices achieve recognition by BCBSM PGIP and NCQA PCMH programs and has been trained in and recognized by Mi-PCT as a Master Trainer for care management. She is a key leader in care management implementation, and her extensive background provides her a clear ability to see health care from widely variable perspectives.

### Sue's Story to Tell:

Our story is about a core group of regional primary care physician leaders from multiple health systems sharing the common dream of building a center for health care transformation in West Michigan—a space where providers, payers, purchasers, and people come together to address problems collaboratively that they cannot solve on their own competitively, where technical and adaptive change can occur within a patient-centric, all-patient, all-payer medical home environment and improvement is focused on Triple Aim metrics fostering personal and community engagement in one's own health care. The Michigan Center for Clinical System Improvement (MiCCSI) is now in its second year adapted from the Institute for Clinical System Improvement (ICSI) in Minnesota.

Our first initiative applies a team-based collaborative care management model in the diagnosis and treatment of major depression, with emphasis on people with coexisting chronic disease. We chose to adopt the ICSI DIAMOND model and participate with ICSI in a CMS CMMI grant called COMPASS. Recruitment, training, payment redesign, and tools have been addressed, with implementation occurring in November. Today we will share our experiences on this journey, ending the session with a brief preview of things to come.

### KEY TAKEAWAYS FROM SUE'S STORY:

1. Value of the DIAMOND model of care delivered to the patient
2. How the DIAMOND model enhances the delivery of care management services
3. What are the patient experiences/quick returns of implementing the DIAMOND model?

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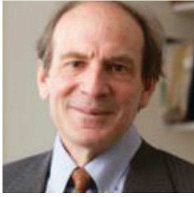

## HENRY WHITE, MD | SPEAKER

Henry White, MD, is the clinical director of the Brookline (MA) Community Mental Health Center. In addition to leading the Center's clinical services, he has successfully created and developed innovative programs for underserved populations. These include Healthy Lives, a program that integrates primary care and behavioral health services for adults with chronic medical conditions and serious mental illness, and the nationally recognized school-based program Bridge for Resilient Youth in Transition (BRYT), which provides a range of clinical, social, and academic supports to youth in transition from hospital to community. A psychiatrist, Dr. White is a clinical instructor at the Harvard Medical School.

### Henry's Story to Tell:

The Greater Boston Super-Utilizer Pilot Project is directed at a population of patients with frequent admissions or emergency department visits. It builds on the work of the Healthy Lives Program, a mobile, community-based team of nurses and case managers that has demonstrated initial success in achieving the outcomes of improved health quality and reduced cost for patients with a combination of serious mental illness and chronic physical illness. The program features a holistic approach that combines active patient engagement, care coordination, and wellness activities and integrates the behavioral health and physical medicine care of patients. The Healthy Lives team-based approach offers an individualized set of services that matches each patient's unique set of needs, preferences, strengths, and resources with a customized community support system. The Pilot Project is directed at a set of diverse neighborhoods in Boston and adjacent suburbs in which the existing system of health, social service, and community agencies is extensive but highly fragmented.

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### KEY TAKEAWAYS FROM HENRY'S STORY:

1. Community outreach and assertive engagement will transform patients from passive recipients to active participants.
2. An integrated approach to complex Quadrant IV patients will reduce costs and improve quality, but it requires staff that can bridge the two worlds of medical and behavioral care.
3. Changing payment systems creates opportunities for novel community partnerships and collaborations, leading to sustainable improvement in health delivery.

## RHONDA MOORE JOHNSON, MD, MPH | MODERATOR

Rhonda Johnson, MD, MPH, serves as medical director in the Medical Management Division of Highmark Blue Cross Blue Shield in Pittsburgh, PA. She has held similar positions with Medicaid managed credit organizations in Ohio and Pennsylvania and has more than 15 years of clinical practice experience serving children and adolescents, many of whom were children with special health care needs. Dr. Johnson is board certified in pediatrics and quality assurance and utilization review. She serves on numerous boards and advisory committees. She serves as a senior medical consultant to CHCS for the Best Clinical and Administrative Practices Workgroup on Improving Managed Care for Children with Special Needs. Dr. Johnson received her bachelor's degree in biology from Harvard University, her medical degree from the Pennsylvania State University College of Medicine, and her master's degree in public health from Ohio State University. She completed a National Health Services Corp obligation with service in Albany, GA, and Cincinnati, OH.

### Rhonda's Story to Tell:

Highmark's Health Equity & Quality Services is dedicated to reducing disparities among the health plan's increasingly diverse population of members. We are working to reduce disparities through health interventions and improvements in health literacy for members and through culturally and linguistically appropriate services across the health plan for those who serve our members. Highmark recently became the first Blue Cross and Blue Shield Plan to receive a Distinction in Multicultural Health Care (MCH) by the National Committee for Quality Assurance (NCQA). This award exemplifies the company's leadership in working to improve health care for all Americans and specifically recognizes Highmark's Commercial HMO and Medicare Advantage HMO products offered under the Keystone Health Plan West subsidiary. NCQA initiated the Distinction in MHC program to recognize health plans and other organizations in their ability to address the health care needs of minorities. Highmark was recognized for designating health care disparities reduction as a strategic goal; successfully collecting and analyzing race, ethnicity, and language data; and implementing interventions to address heart disease and diabetes among African-American members. Highmark Inc. is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

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### KEY TAKEAWAYS FROM RHONDA'S STORY:

1. A renewed commitment to improve the quality of health care for all
2. Best practice sharing
3. Individuals who feel empowered to act, lead, and innovate

## AMERICA BRACHO, MPH, CDE | SPEAKER

America Bracho is the executive director of Latino Health Access, a center for health promotion and disease prevention located in Santa Ana, CA. This center was created under her leadership to assist with the multiple health needs of Latinos in Orange County.

Latino Health Access facilitates mechanisms of empowerment for the Latino community and uses participatory approaches to community health education. The programs train community health workers as leaders of wellness and change. Ms. Bracho worked as a physician in her native Venezuela for several years, after which she came to the United States to obtain a master's degree in public health at the University of Michigan. Her public health specialty is health education and health behavior.

### America's Story to Tell:

Before 1993, a health need assessment for the Latino community in Orange County, CA, revealed the lack of access to health services and opportunities for prevention.

Since 1993, Latino Health Access (LHA) has played a consistent role in improving access to health care, promoting healthy behaviors and environments, and advocating for individuals to take charge of their health in Orange County.

LHA responds to health issues with an array of grassroots programs serving local families. Programs include healthy weight, diabetes self-management, elder care, and breast health. Services related to mental health include domestic violence/emotional health support groups, Madres a Madres (early child development), and the Children and Youth Initiative. In addition, LHA has a policy department that focuses on community engagement/organizing and advocacy. In the next three years, LHA will be proposing Health in All policies for the City of Santa Ana General Plan. In November 2013, after eight years of organizing, LHA will inaugurate the first park in a low-income area of Santa Ana.

Our success is greatly due to our community health worker (promotor) model. Interventions are led by promotores who are residents, consumers of services, recruited from the communities in which they live.

### KEY TAKEAWAYS FROM AMERICA'S STORY:

1. The importance of comprehensive health interventions addressing social determinants as a way to create health equity
2. The importance and complexity of community participation in shaping the health equity agenda
3. The importance of building a relationship with the community and creating mechanisms for participation in order to accomplish true engagement

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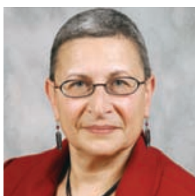

## SHELLEY HIRSHBERG | SPEAKER

Shelley B. Hirshberg is the executive director of the P2 Collaborative of Western New York and is the project director of the Robert Wood Johnson Foundation Aligning Forces for Quality (AF4Q) initiative in Western New York, one of 16 communities throughout the country.

The P2 Collaborative of Western New York, a multi-stakeholder organization with more than 270 partners, is working to improve the quality of health care by closing the gap between the quality of health care that people now receive and what the community believes the health care system is capable of delivering. In addition, the Collaborative is focused on promoting healthy lifestyles, providing health status feedback to the community, and promoting implementation of medical best practices.

Previously Ms. Hirschberg was president of Physician Advocates LLC, a consulting company involved with medical practices and non-profit organizations. She created Physician Advocates LLC in 2000 and sold the business in 2006 to a local compliance professional who has continued assisting physicians with their billing and coding compliance needs. With more than 30 years of experience in healthcare administration and non-profit management, Ms. Hirshberg served as interim CEO of Planned Parenthood of Buffalo & Erie County and in four different administrative roles at the Millard Fillmore Health System over a 10-year period. She also served as director of strategic planning for The Children's Hospital of Buffalo.

In addition to her professional accomplishments, Ms. Hirshberg has sat on more than 20 boards during the past 30 years. Her most recent volunteer accomplishment is leading the development and successful opening of Gilda's Club Western New York, a non-profit organization dedicated to providing social and emotional support for people living with cancer. She led the steering committee and the Board of Directors through a seven-year process to open the doors of this organization and complete a $3.2 million campaign.

Ms. Hirshberg has a BA from Bucknell University and an MA in health services administration from the University of Wisconsin School of Business. She also completed a fellowship program in Creating Healthier Communities from The Healthcare Forum in San Francisco and is a graduate of the Center for Entrepreneurial Leadership from the State University of New York at Buffalo School of Management.

Ms. Hirshberg's current volunteer roles include membership on the New York Diabetes Coalition, the Buffalo Clinical and Translational Research Center Governing Board, and the Network for Regional Health Improvement Executive Committee.

**(continued on following page)**

### Shelley's Story to Tell:

"Creating a Healthier Niagara Falls—A Neighborhood Empowerment Approach" is a collaborative effort designed to improve the individual health and quality of life of residents in a designated neighborhood in the city of Niagara Falls. Driven by collaboration among the city, P2 Collaborative of Western New York, and Niagara University, the effort is engaging and inspiring residents to initiate projects that will make their own neighborhood healthier, more livable, and safer. The effort was sparked by Mayor Paul Dyster's creation of a task group to "Create a Healthier Niagara Falls" in response to the area's severe health needs. The task group's charge was to create a shift from reactive, "emergent," hospital-based care, in which people access the health care system only when they are already sick, to proactive, "preventive," community-based care. In February 2010, healthcare experts Leland and Leanne Kaiser facilitated a retreat of task group participants that helped lead to the development of the collaboration. The initiative's guiding principles focus on education, outreach, organizational capacity building, and linking of residents to resources. The primary methodologies being employed are based on several respected models, in particular the asset-based community development model proposed by John P. Kretzmann and John L. McKnight. Implementation strategies are focusing on leadership training, environmental beautification, health and wellness, and disease prevention and safety. The effort will also work to alter how healthcare and human service agencies; municipal, community, and faith-based organizations; and local businesses work together to improve the community where they work and live.

### KEY TAKEAWAYS FROM SHELLEY'S STORY:

1. Importance of engaged leadership committed to the health and welfare of their community
2. Power of multi-stakeholder coalitions in establishing community needs and designing appropriate interventions
3. Building the capacity of lay adult and youth leadership to further drive engagement and change

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## BEYOND THE CLINIC WALLS: CONNECTING POPULATION HEALTH AND QI TO REACH VULNERABLE POPULATIONS

### MARK MILLER | SPEAKER

Mr. Miller is a native of Kansas City, MI. After graduating from University of Missouri in 1983 with an MS degree in community development, he held several positions within Missouri state government. The last position before his retirement in 2009 was chief operating officer of the Center for Behavioral Medicine in Kansas City. Currently, Mr. Miller serves as a behavioral health consultant to Swope Health Services of Kansas City and is a faculty member of the University of Missouri Kansas City School of Medicine Department of Psychiatry.

For several years Mr. Miller has lectured widely across the state of Missouri and the United States on mental health issues, emphasizing cultural competency. He has also served on numerous local, state, and national committees and taskforces. He helped publish a book on the history of African Americans at the University of Missouri and helped draft and edit the Missouri Department of Mental Health's plan on providing culturally competent mental health services. He has received several awards, including the University of Missouri's Distinguished Alumni Award, its Diversity Award in 1998 and 2002, and the Donald W. Howard Leadership Award by Lincoln University.

### Mark's Story to Tell:

Swope Health Services, a Federally Qualified Health Center in Kansas City, MO, like many other safety net health centers is struggling to find enough resources to provide the people they serve with good overall coordination of their medical care. In 2011 the state of Missouri became the first state in the nation to apply for and receive two state Medicaid Plan amendments, one for primary care and the other for behavioral health care. The plan amendments allowed for the creation of health homes by health care organizations throughout the state. The health home concept is to make sure clients have a regular primary care physician and get evidence-based preventive care and treatment for chronic medical conditions, along with treatment for mental illness.

The Swope Equity project took a subgroup of clients who are adult African American males and females who are diabetic and enrolled in the behavioral health/health care home. This population's diabetes treatment was reviewed based on the National Committee for Quality Assurance data measure for diabetics and compared to the general population of diabetic patients served by Swope Health Services. The ongoing review is to determine if this group has different outcomes compared to the general population of diabetic patients served by Swope. The Swope project is a partnership with the Kansas City Quality Improvement Consortium (KCQIC).

### KEY TAKEAWAYS FROM MARK'S STORY:

1. Data helps define quality, but it is not the only component.
2. Know the population as well as the systems you are working with. The details will help in creating a more comprehensive analysis of the data.
3. Don't jump to conclusions. The obvious conclusion might mask the real problem.


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## LAUREN MOYER, LCSW, LSCSW | SPEAKER

Lauren Moyer is a native change agent in Kansas City, MO. Since graduating from University of Missouri- Kansas City in 2006 with an MSW degree in social work, Ms. Moyer has held several positions within a community mental health center setting, from frontline case manager to quality improvement director. Currently, she serves as the director of clinical operations for Swope Health Services in Kansas City and assists with area grant writing for non-profits. For several years she has focused a great deal on integration of care from mental health and substance abuse to physical health. She is a member of the statewide Missouri CADRE for Co-Occurring excellence who strives to integrate all systems and levels of care.

### Lauren's Story to Tell:

Swope Heath Services of Kansas City, MO, a Federally Qualified Health Center, as many other safety net health centers, is struggling to find enough resources to provide the people they serve with good overall coordination of their medical care. In 2011 the state of Missouri became the first state in the nation to apply for and receive two state Medicaid Plan amendments, one for primary care and the other for behavioral health care. The plan amendments allowed for the creation of health homes by health care organizations throughout the state. The health home concept is to make sure clients have a regular primary care physician and get evidence-based preventive care and treatment for chronic medical conditions along with treatment for mental illness.

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### KEY TAKEAWAYS FROM LAUREN'S STORY:

1. How to create buy-in from all levels when trying to create an organizational change
2. Ways to think outside the box when trying to engage individuals in treatment services
3. How to integrate primary and behavioral health

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### MICHAEL PAINTER, JD, MD | MODERATOR

Michael Painter is a distinguished physician, attorney, health care policy advocate, 2003-2004 Robert Wood Johnson Health Policy Fellow, and senior member of the RWJF Quality/Equality Team. In 2003-2004, Dr. Painter was a Robert Wood Johnson Foundation Health Policy Fellow with the office of Senator William Frist, former majority leader. Before that he was the chief of medical staff at the Seattle Indian Health Board, a community health center serving urban American Indians and Alaska Natives. Dr. Painter earned a JD from Stanford Law School and an MD from the University of Washington. He earned a BA in economics and mathematics from Vanderbilt University.

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## MYLIA CHRISTENSEN | SPEAKER

Mylia Christensen is the executive director of the Oregon Health Care Quality Corporation, which is an independent, nonprofit organization dedicated to improving the quality and affordability of health care in Oregon by leading community collaborations and producing unbiased information. Ms. Christensen has worked in almost all facets of health care, from clinical settings to hospital and health care system management, strategic planning, and administration. She joined Quality Corp from the OHSU Center for Evidence-based Policy, where she was the project director for the Medicaid Evidence-based Decisions Project. Before joining the Center, she was a vice president at AON Employee Benefit Consulting. She also served for six years as the administrator of the state of Oregon's Public Employees' Benefit Board, responsible for Oregon's largest employee benefit program. In the early 90s, Ms. Christensen was a vice president of operations and regional director for the Oregon Health Plan enrollment broker project with Benova, Inc. Her extensive experience also includes director of program development and physician services for Legacy Portland Hospital System and the administrator of women's health services at Good Samaritan Hospital. She began her health care career in emergency services and critical care nursing.

## JOHN GALLAGHER | SPEAKER

John Gallagher is director of communication and development for the Puget Sound Health Alliance. He has 20 years experience in public relations and journalism and a background in biotechnology, physician membership organizations, and evidence-based medicine. Before joining the Alliance in January 2010, Mr. Gallagher served as the director of public relations for the American Academy of Ophthalmology, a membership organization of more than 26,000 doctors. Before that, he served as the director of corporate communications and media relations manager for Chiron Corporation, a biotechnology company. Before joining Chiron, Mr. Gallagher was a journalist for 18 years, working with prominent publications such as *The Advocate* and *Time* magazine.

### John's Story to Tell:

The Puget Sound Health Alliance produces custom reports for its self-funded purchaser members who provide data for the Alliance's Community Checkup report. The custom reports allow purchasers to compare their performance against the rest of the region, highlighting where performance exceeds the regional average and where opportunities for improvement exist. The Alliance uses the reports to engage purchasers and educate them about its quality reporting work. In addition, the reports serve as an important data point for purchasers as they develop benefit design strategies. Purchasers have used the reports to identify barriers to higher-quality care and lower-cost options, such as generics, realizing significant savings in the process.

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### KEY TAKEAWAYS FROM JOHN'S STORY:

1. The importance of engaging purchasers in quality reporting efforts
2. The need to provide data purchasers that is actionable
3. The role that coalitions can play in moving purchasers toward value-based benefit design strategies

## RITA HORWITZ, RN, BSN | SPEAKER

Rita Horwitz, RN, BSN, is director of business development for Better Health Greater Cleveland. A graduate of Ohio State University, she has held executive leadership roles in nursing, operations, and human resources in settings that include ambulatory care, occupational health, and wellness and information technology. Her most significant accomplishments at Progressive Insurance include implementing and managing several onsite primary care clinics that have integrated behavioral health and wellness programs for employees. At Better Health, she works with key stakeholders throughout Northeast Ohio to expand community relationships and facilitate value-based health care transformation. She is a member of the Society for Human Resources Management and serves on the Advisory Council for the Cuyahoga County Health Alliance.

### Rita's Story to Tell:

Since 2007, Better Health Greater Cleveland's trusted leadership in convening, data management, reporting and analysis, and quality improvement set the stage for our recent growth and expansion to new geographic areas and the startup of an innovative primary care payment reform initiative. Better Health serves the needs of the clinical providers by assisting with their practice transformation to accountable, patient-centered care and services. Of equal importance is our commitment to using trusted and actionable data to measure and report on metrics important to the purchasers investing in these practices. We are confident that the experience and outcomes of our current primary care transformation efforts will shape the path for more expansive stakeholder engagement, which in turn will enable our vision for making Northeast Ohio a healthier place to live and a better place to do business.

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### KEY TAKEAWAYS FROM RITA'S STORY:

1. The critical elements of trust and credibility in creating sustainable partnerships
2. The importance of aligning resources with stakeholder needs to provide value-added contributions
3. Focus on actions and incentives that drive measurable outcomes of the triple aim: better health, better care experience, and lower per capita costs.

## MELISSA KENNEDY, MHA | SPEAKER

Melissa Kennedy is senior director of operations for The Health Improvement Collaborative of Greater Cincinnati, where she is responsible for strategic development and oversight of programs. In that role, she also serves as project director for Cincinnati Aligning Forces for Quality and is a member of the Greater Cincinnati Beacon Community Leadership Team. Melissa received her BA in chemistry from Lake Forest College and her master's in health administration from The Ohio State University. Beforenjoining the Health Collaborative, she co-founded HealthCare Research Systems, a health care outcomes, satisfaction, and quality improvement consulting company. During her nine-year tenure as executive vice president, the company grew from a staff of two to more than 150 and successfully executed several large-scale national satisfaction and outcomes projects, including The Employee Health Care Value Survey, the NCQA HEDIS 2.0 pilot project, and Kaiser Permanente's national member satisfaction studies. After sale of the company, she joined the University of Rochester Medical Center as a strategic planner and subsequently served as a consultant to Cincinnati Children's Hospital Medical Center as part of the Robert Wood Johnson Foundation Pursuing Perfection grant.

**(Continued on following page)**

### Melissa's Story to Tell:

Formed in 1992, the Health Collaborative exists as an effective incubator for innovation to create a healthier community. We bring multiple stakeholders together in a neutral forum, enabling even competitors to become collaborators in creating sustainable health improvement initiatives. The Collaborative works to identify critical health improvement opportunities, to align diverse community stakeholders around focused health needs, to nurture and support self-sustaining initiatives to improve health, and to transfer established initiatives to community ownership. Current programs include YourHealthMatters, an innovative project using some of the most promising approaches to improving quality of care. We combine public reporting of physician practice outcomes with a consumer-friendly approach to using the information to get better care. Another is Cincinnati MD Jobs, whose mission is to assure the future of quality health care for the region by attracting and recruiting to physician talent. In 2011 alone, 32 physicians were placed through our outreach and web-based matching system. Practice Support and Development provides tools and training to support quality improvement and practice transformation. As a member of the Beacon Collaborative, the Health Collaborative provides innovative support to teams seeking meaningful ways to use IT to manage patient populations and improve patient engagement. The Health Collaborative's practice transformation program is equipping primary care groups to implement this model of care delivery designed to improve patient access and outcomes, while improving quality and reducing overall cost of care.

### KEY TAKEAWAYS FROM MELISSA'S STORY:

1. The work is never finished, but a committed group of people with a shared vision and willingness to compromise has a good chance of being successful.
2. Providing "value" can happen only by spending a lot of time listening.
3. Sustainability requires flexibility and sometimes dramatic organizational changes.

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## SARA ROSENBAUM, JD | KEYNOTE

Sara Rosenbaum, JD, is the Harold and Jane Hirsh Professor and founding Chair of the Department of Health Policy, George Washington University School of Public Health and Health Services, a unique center of learning, scholarship, and service focusing on all aspects of health policy. Professor Rosenbaum has devoted her career to issues of health law and policy affecting low-income, minority, and medically underserved populations. Between 1993 and 1994, Professor Rosenbaum worked for President Clinton, directing the legislative drafting of the Health Security Act and developing the Vaccines for Children program. Professor Rosenbaum also served on the Presidential Transition Team for President-Elect Obama. A graduate of Wesleyan University and Boston University School of Law, Professor Rosenbaum has authored more than 250 articles and studies focusing on all phases of health law and health care for medically underserved populations. She is lead author of *Law and the American Health Care System* (Foundation Press, NY), a widely used health law textbook. A holder of numerous awards for her scholarship and service, Professor Rosenbaum is the recipient of the Richard and Barbara Hansen National Health Leadership Award (University of Iowa), a Robert Wood Johnson Foundation Investigator Award in Health Policy Research, and the Oscar and Shoshanna Trachtenberg Award for Scholarship, the George Washington University's highest faculty award. In 2009, she was named one of the founding Commissioners of the Medicaid and CHIP Payment and Access Commission, which advises Congress on federal Medicaid and CHIP policy.

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## ARNOLD MILSTEIN, MD, MPH | MODERATOR

Arnold Milstein is a professor of medicine at Stanford and directs the Stanford Clinical Excellence Research Center. The Center is a collaboration of the schools of medicine, engineering, and business to design and test new health care delivery models that both lower per capita health care spending and improve clinical outcomes. His work and publications have focused on acceleration of innovations that improve the societal value of health care.

Dr. Milstein serves as the medical director of the Pacific Business Group on Health, the largest regional health care improvement coalition in the United States. He also chairs the IHA Steering Committee that directs the largest physician pay-for-performance program in the United States. Previously he co-founded the Leapfrog Group and Consumer-Purchaser Disclosure Project and served as a Congressionally appointed MedPAC commissioner.

Citing his nationally distinguished innovation in health care cost reduction and quality gains, Dr. Milstein was selected for the highest annual award of both the National Business Group on Health and the American College of Medical Quality. He was elected to the Institute of Medicine of the National Academy of Sciences and chaired the planning committee of the IOM's 2009-2010 series on best methods to lower per capita health care spending and improve clinical outcomes.

Dr. Milstein was educated at Harvard (BA, economics), Tufts (MD), and UC Berkeley (MPH, health services evaluation and planning).

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## MAUREEN CORRY, MPH | SPEAKER

Maureen Corry has served as executive director of Childbirth Connection since 1995, positioning the organization as a powerful and effective advocate for evidence-based maternity care and maternity care quality improvement. Its mission is to improve the quality and value of maternity care through health system reform and consumer engagement. She has 30 years experience as a researcher, educator, and policy analyst on maternal and newborn health issues. She is currently a member of the board of directors of the National Quality Forum and served as co-chair of the Steering Committee for its National Voluntary Consensus Standards for Perinatal Care Project (2008). She is a member of the consumer advisory council of the National Commission for Quality Assurance of the AMA/Physicians Consortium for Performance Improvement Maternity Workgroup. She is co-chair of the 2012 National Priorities Partnership/Partnership for Patients Maternity Care Action Team that is working to catalyze action to improve maternity care for mothers and babies and align public-private sector initiatives to support the National Quality Strategy. She has an MPH in health administration from Yale School of Public Health.

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### Maureen's Story to Tell:

Childbirth Connection's Transforming Maternity Care Initiative focuses on improving the quality and value of maternity care through consumer engagement and health system improvement. More than 100 leading experts helped develop two direction-setting papers, *2020 Vision for a High-Quality, High-Value Maternity Care System* and *Blueprint for Action*, which charts the pathway for how to achieve the vision through actionable strategies focused on 11 critical focus areas for change, including: performance measurement and leveraging of results; payment reform to align incentives with quality; improved functioning of the liability system; disparities in access and outcomes of maternity care; scope of covered services for maternity care; coordination of maternity care across time, settings; and disciplines; clinical controversies (elective induction, cesarean section, VBAC); decision making and consumer choice; scope, content, and availability of health professions education; workforce composition and distribution; and development and use of health IT. Many collaborative, multi-stakeholder efforts across the country are showing that rapid gains in maternity care quality, outcomes, and value are within reach.

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### KEY TAKEAWAYS FROM MAUREEN'S STORY:

1. Many women and babies in the U.S. receive poor-quality maternity care, including many procedures, drugs, and tests that are not needed, and fail to receive beneficial forms of care. Maternity care is procedure-intensive and costly, especially when it comes to the timing and method of birth. Induction and cesarean section rates have increased sharply in recent decades without improved outcomes for women and babies.

2. Rapid gains in the quality, outcomes, and value of maternity care are within reach through multi-stakeholder collaborative efforts focused on reducing elective delivery and cesarean section in low-risk women.

3. National Priorities Partnership Maternity Action Team goals and strategies are focused on reducing elective delivery and cesarean section, and Childbirth Connection and the Informed Medical Decisions Foundation are partnering to develop the First National Maternity Care Shared Decision Making Initiative to better align women's care with their preferences, reduce unwarranted practice variation, and improve the value of maternity care.

## VALERIE KLITZKE, MBA | SPEAKER

With more than 15 years of experience in market research and business analytics, Ms. Klitzke's passion is driving strategic business solutions with data. In her current role at Meriter, she works across departments to build business plans and optimize operations to position Meriter for the future health care environment and improve the patient experience.

Before joining Meriter, Ms. Klitzke worked in the environmental sector, where she conducted market assessments to measure opportunities and adjacencies for growth. Once they were identified, she built the strategic business plans and played a key role in the launch of the new platforms across operational, sales, and marketing functions.

Ms. Klitzke has an MBA in strategic management from the University of Wisconsin, Madison; Advanced Professional Certification in Internet marketing from the University of San Francisco; and certified training in sustainability from the International Register of Certificated Auditors.

### Valerie's Story to Tell:

Meriter is an independent, non-profit community hospital in Madison, WI, with a legacy of providing high-quality patient care since 1898.

Meriter recognizes that the existing fee-for-service reimbursement model lacks alignment and engagement of acute and post-acute care providers across a defined spectrum of care for patients. To solve this disconnect and to start preparing for a future of value-based reimbursements, Meriter has engaged in a collaborative effort with providers and payers as an active participant in the Partnership for Healthcare Payment Reform's Total Knee Replacement Bundled Payment pilot initiative.

For this effort, Meriter has engaged a diverse, cross-functional team of clinical and administrative professionals. The team has undertaken significant review and analysis of historical data to identify areas for improvement of care, coordination, and potential cost-saving opportunities. The team is committed to collaborating to improve the quality and affordability of care without enacting restrictions that may compromise choice or quality outcomes. A key objective is to provide tools and resources to educate patients with regard to their health care, and the ultimate goal is to incorporate best practices and evidenced-based care to improve patients' experiences and outcomes at Meriter.

### KEY TAKEAWAYS FROM VALERIE'S STORY:

1. Successfully bundling a service requires active engagement from everyone who provides a product or service that touches the patient directly and indirectly.
2. Executive engagement is required for a successful bundle initiative.
3. Tracking and reconciling data across different organizations and across different system platforms is easier said than done.

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## DAVID LABBY, MD, PHD | SPEAKER

David Labby, MD, PhD, is chief medical officer of Health Share of Oregon, one of the new coordinated care organizations (CCOs) managing a regional global budget for the physical and behavioral health care needs for Oregon's Medicaid population. Health Share currently has more than 160,000 enrollees in the TriCounty area that includes Portland and all of the major hospital and health systems, the counties, and providers, including those in safety net practices.

Before coming to Health Share, Dr. Labby was medical director for CareOregon, the state's largest Medicaid Managed Care plan. While at CareOregon, he was responsible for developing and overseeing the health plan's care management program for members with complex conditions. Since 2007, he led CareOregon's Primary Care Renewal Initiative to support key network providers in moving to a "medical home" model of care that includes integrated behavioral health. He has led a number of other plan clinical efforts, including initiatives on pediatric asthma, chronic pain, and depression. He has been part of CareOregon's participation in the IHI Triple Aim Initiative and now is part of the Triple Aim faculty. Dr. Labby practiced in primary care and was medical director of both primary care and multi-specialty settings before coming to CareOregon in 2000. He received his PhD in cultural anthropology.

### David's Story to Tell:

Oregon has challenged its Medicaid providers to fundamentally transform how they deliver care through the creation of "coordinated care organizations," new regional physical, behavioral, and dental organizations operating under a single global budget. Through integrating care and "transformation," the CCOs will allow the state to continue to maintain the number of Medicaid enrollees it covers in the face of significant budget cuts, while being held accountable for meeting defined metrics of quality and patient experience. Health Share of Oregon is the largest CCO accountable for Medicaid enrollees throughout the TriCounty area around Portland and includes the major health plans, hospitals, and health systems and providers. The presenters will share their experience and lessons learned in engaging a broad spectrum of medical, mental health, addiction, and social service providers in redesigning care delivery; they will discuss the population strategy emerging from the CCO, catalyzed by a CMMI Innovations grant award focused around better meeting the needs of the highest-acuity Medicaid members; and they will describe how they are developing new health worker models that go beyond traditional medical office practice to address social determinants driving health, quality, and cost outcomes.

### KEY TAKEAWAYS FROM DAVID'S STORY

1. An understanding of the governance model and financing structure of Health Share of Oregon (the TriCounty CCO)
2. An understanding of the initial clinical transformation plan for Health Share of Oregon
3. How a $17.3 million CMMI Innovation grant is providing a springboard for clinical transformation in the TriCounty community

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## RUTH NOLAN, PHD(c), RNC | SPEAKER

Ruth Nolan, PhD(c), RNC is the vice president of anesthesia, surgical suites, and women's health service lines for the Geisinger Health System in Danville, PA. She also serves as an adjunct faculty member for Pennsylvania College of Technology and the Thomas Jefferson University. Honors she has recently received include the 2004 Nightingale Award of Pennsylvania in Nursing Administration and selection as one of the top 100 people in business in 2005 by Pennsylvania Business Central.

Nolan holds an associate and bachelor of science in nursing degree from Pennsylvania College of Technology in Williamsport and a master of nursing from the Pennsylvania State University in State College. She is currently pursuing a doctorate in nursing from Pennsylvania State University. She is certified in inpatient obstetrics through ANCC.

Nolan also has been active within several state nursing organizations by serving on the Education Committee and as registration coordinator for the fall conference for the Pennsylvania Organization of Nursing Leaders; as member of the Board of Directors and program and awards committee for the Nightingale Association of Pennsylvania; co-coordinator of the Central Pennsylvania AWHONN chapter; as member of the Beta Sigma and Zeta Theta Chapters of Sigma Theta Tau; and as recording secretary for the Northcentral chapter of ACHE.

Experientially, most of her practice has been in perinatal and women's health nursing within acute care settings. She frequently presents at local, state, and national conferences on a variety of topics, including quality and performance improvement and health information application and management.

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## Ruth's Story to Tell:

Geisinger Health System (GHS) has applied its ProvenCare model to demonstrate that a large integrated health care delivery system, enabled by an electronic health record (EHR), could reengineer a complicated clinical process, reduce unwarranted variation, and provide evidence-based care for patients with a specified clinical condition. In 2007 GHS began to apply the model to a more complicated, longer-term condition of "wellness"—perinatal care.

The ProvenCare Perinatal initiative was more complex than the five previous ProvenCare endeavors in terms of breadth, scope, and duration. Each of the 22 sites created a process flow map to depict the current, real-time process at each location. The local practice site providers—physicians and mid-level practitioners—reached consensus on 103 unique best practice measures (BPMs), which would be tracked for every patient. These maps were then used to create a single standardized pathway that included the BPMs but also preserved some unique care offerings that reflected the needs of the local context.

A nine-phase methodology, expanded from the previous six-phase model, was implemented on schedule. Pre- to post-implementation improvement occurred for all seven BPMs or BPM bundles that were considered the most clinically relevant, with five statistically significant. In addition, the rate of primary cesarean sections decreased by 32 percent, and birth trauma remained unchanged as the number of vaginal births increased.

Preliminary experience suggests that integrating evidence/guideline-based best practices into work flows in inpatient and outpatient settings can achieve improvements in daily patient care processes and outcomes.

### KEY TAKEAWAYS FROM RUTH'S STORY

1. Reliable delivery of evidence-based medicine is the foundation of a quality program.
2. Patient activation in their care can be the difference between a successful and an unsuccessful prenatal program.
3. A focus on wellness in the prenatal period positions supports avoidance of complications in labor and after delivery.

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### REBECCA RAMSAY, BSN, MPH | SPEAKER

Rebecca Ramsay received her bachelor of science in nursing at the University of Madison, WI, and her masters in public health at Portland State University. During her nearly seven-year tenure at CareOregon, she has worked to develop and implement an innovative, nationally recognized team-based case management program that targets the plan's highest risk and costliest members. Unlike many care management programs that focus outreach and management to specific disease states, CareOregon's CareSupport Program adheres to a holistic biopsychosocial model that is rooted in population management strategies. CareOregon's case management principles have inspired numerous organizations to evolve existing programs and have been highlighted in several publications authored by the Institute for Healthcare Improvement, the Health Intelligence Network, the Association for Community Health Plans, and The Commonwealth Fund.

In addition to developing CareOregon's CareSupport Program, Ms. Ramsay has been instrumental in facilitating a primary-care-based chronic disease program that has improved clinical population outcomes across five Portland-metro-area safety net organizations. This program now is in the early process of spread within several community health centers across southern Oregon. More recently, she has developed, piloted, and implemented CareOregon's Community Care Program, which deploys specially trained, non-medical outreach workers, anchored to primary care practices, to partner with high-cost patients who suffer from multiple chronic medical conditions overlaid with mental illness or addiction. Addressing the socio-behavioral risk factors and the social determinants of health for this target population is a focus for this new program. Ms. Ramsay was instrumental in helping the TriCounty Coordinated Care Organization partners secure a $17.3 million Innovation Grant from CMS's Center of Medicaid and Medicare Innovation that will provide the means to dramatically scale up the Community Care Program, along with four other interventions that have been shown to improve care and lower cost for high-acuity Medicaid recipients.

Ms. Ramsay has been faculty for a number of regional learning collaboratives, most recently the Oregon Transitional Care Collaborative and the Oregon Health Leadership Council's High-Value Medical Home Demonstration Pilot. She is entering her third year as faculty for IHI's Triple Aim Initiative. Ms. Ramsay and colleague Dr. David Labby led IHI's ambulatory-sensitive hospitalization reduction efforts and have co-developed a risk assessment tool called the HARMS-8 that is being tested nationally. This fall she will co-lead a 10-month IHI initiative related to improving outcomes for high-cost patients.

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### Rebecca's Story to Tell:

Oregon has challenged its Medicaid providers to fundamentally transform how they deliver care through the creation of "coordinated care organizations" (CCOs), new regional physical, behavioral, and dental organizations operating under a single global budget. Through integrating care and "transformation," the CCOs will allow the state to continue to maintain the number of Medicaid enrollees it covers in the face of significant budget cuts, while being held accountable for meeting defined metrics of quality and patient experience. Health Share of Oregon is the largest CCO accountable for Medicaid enrollees throughout the TriCounty area around Portland and includes the major health plans, hospitals and health systems, and providers. The presenters will share their experience and lessons learned in engaging a broad spectrum of medical, mental health, addiction, and social service providers in redesigning care delivery; they will discuss the population strategy emerging from the CCO, catalyzed by a CMMI Innovations grant award focused around better meeting the needs of the highest-acuity Medicaid members; and they will describe how they are developing new health worker models that go beyond traditional medical office practice to address social determinants driving health, quality, and cost outcomes.

### KEY TAKEAWAYS FROM REBECCA'S STORY:

1. An understanding of the governance model and financing structure of Health Share of Oregon (the TriCounty CCO)
2. An understanding of the initial clinical transformation plan for Health Share of Oregon
3. How a $17.3 million CMMI Innovation grant is providing a springboard for clinical transformation in the TriCounty community

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## STACEY SCHULZ, MBA | SPEAKER

Stacey Schulz, MBA, has been actively engaged in the health care billing and reimbursement sector for the past 14 years. With a comprehensive focus from the provision of diverse services (e.g., clinic, facility, laboratory, durable medical equipment, home infusion, home care, etc.) through coding and claim adjudication, Ms. Schulz's area of expertise has resided with compliance and contractual analysis.

In her current role, Ms. Schulz is responsible for negotiating and analyzing third-party payer contracts for an integrated health care delivery system. In an effort to foster innovation and quality, she has engaged in research and development of innovative models of reimbursement. She has analyzed historical cost and utilization data in collaboration with acute and post-acute care providers, as well as payers, to support the development of a bundled payment for a defined episode of care.

Ms. Schulz has an MBA in finance from the University of Wisconsin, Whitewater.

### Stacey's Story to Tell:

Meriter is an independent, non-profit community hospital in Madison, WI, with a legacy of providing high-quality patient care since 1898.

Meriter recognizes that the existing fee-for-service reimbursement model lacks alignment and engagement of acute and post-acute care providers across a defined spectrum of care for patients. To solve this disconnect and to start preparing for a future of value-based reimbursements, Meriter has engaged in a collaborative effort with providers and payers as an active participant in the Partnership for Healthcare Payment Reform's Total Knee Replacement Bundled Payment pilot initiative.

For this effort, Meriter has engaged a diverse, cross-functional team of clinical and administrative professionals. The team has undertaken significant review and analysis of historical data to identify areas for improvement of care, coordination, and potential cost-saving opportunities. The team is committed to collaborating to improve the quality and affordability of care without enacting restrictions that may compromise choice or quality outcomes. A key objective is to provide tools and resources to educate patients about their healthcare, and the ultimate goal is to incorporate best practices and evidenced-based care to improve patients' experiences and outcomes at Meriter.

### KEY TAKEAWAYS FROM STACEY'S STORY:

1. Collaborative approach to payment reform must occur among providers (acute and post-acute) and payers.
2. Quality and cost must become integrated into all aspects of reimbursement and care analysis.
3. The reimbursement matrix can be revised to align cost, quality, and collaboration of care across the entire care spectrum, particularly for a defined episode of care.

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## MELISSA JONES, JD | MODERATOR

Melissa Jones is an attorney with a passion for health care reform and policy. She received her bachelor's degree in sociology from Sonoma State University and her law degree from Lewis and Clark Law School in Portland, OR. While at Lewis and Clark, she focused on health care and policy issues from a legal standpoint. In addition to her JD, she obtained a certificate in public interest law. She is a member of the California State Bar. In 2010, she started working as the health policy analyst for CCRP, and in 2012, as the Project Director for Aligning Forces Humboldt.

### Melissa's Story to Tell:

Humboldt County is a rural community in far northern California. In 2009, the IPA adopted an ambulatory quality improvement collaborative model pioneered at Care Oregon, called Primary Care Renewal (PCR). Open to primary care practices in the community, the PCR collaborative has provided a forum for medical practices to become familiar with quality improvement methodologies and gain exposure to best practices. Locally, the implementation of this work has been led by a multi-stakeholder steering team including IPA administrative leadership, consumer leadership (paid program manager of consumer engagement efforts, and volunteer lead consumer representative), and a PCR project manager. Current iteration is focused on "Advanced Access," a model based on patients getting care when they need it. The participating 10 practices meet every other month as a large group and as individual practice improvement teams at least twice a month to improve work on their office aims.

Since 2010, patients have been active participants in this project and members of office practice improvement teams. The "Patient Partners" is the name given to Aligning Forces Humboldt's effort to engage these patients in ambulatory quality improvement. Practices see the value in using the patient perspective, and many have consulted patient partners on projects like brochures or survey development.

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### TERRI MARTIN, RN, BSN, MBA | SPEAKER

Terri Martin, RN, BSN, MBA, is the director of clinical nursing services, clinical transformation and governance at Mercy Health-Anderson Hospital. Ms. Martin received her BSN from the University of Cincinnati and her MBA from the University of Phoenix. She has 22 years of acute care inpatient and outpatient operational experience. This includes Lean Six Sigma Black Belt, with participation in AF4Q Transforming Care at the Bedside (TCAB) and IHI Safety Across the System.

#### Terri's Story to Tell:

The mission of the Patient Family Council is to collaborate actively with patients and families as partners with Mercy Hospital and the TCAB unit. We strive to enhance care by providing a means of communication between families and hospital staff to improve the patient experience. The Council represents our hope for Mercy Hospital to continue to maintain and heighten the level of health care services our community has come to rely upon.

A1 is a very busy telemetry unit. Depending on census, we have the ability to fill 50 beds with close to 100 staff members, making us the second-largest unit at Anderson behind the Family Birthing Center. Our patients have several medical issues and at times complex social issues. It is here where we developed a strong bond with our volunteers, as they were a resource we tapped into frequently. It was in November 2009 we were introduced to TCAB. The impact TCAB has made on our unit speaks for itself. At any moment you can walk on the floor and see everyone wearing a smile, but most importantly you will see what collaboration and teamwork means. Our patient satisfaction scores have improved, we are committed to hourly rounding, and we have maintained zero falls with harm and greatly reduced our fall rate since implementing safety rounds. We have adopted a quiet time for our patients, biweekly meetings are conducted with our hospitalists, and patient-centered care has truly become our focus. Sarah Varney RN, clinical coordinator, developed the Patient Family Council based on this premise. The first meeting was held in February 2011.

#### KEY TAKEAWAYS FROM TERRI'S STORY:

1. Partnering with patients in our community helps our organization redesign care with a focus on patient-centered care.
2. This involvement also provides an additional patient safety checkpoint.
3. Through this forum, bedside staff and leaders are empowered to find the best way to accomplish our organizational goals and achieve desired outcomes for our patients.

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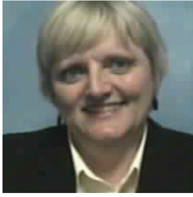

## CHERYL MAGNUSON-GIESE, MSW/MPH, SPHR | SPEAKER

Cheryl Magnuson-Giese is the senior director of physician services for HealthPartners Medical Group. Physician Services is responsible for recruitment, performance management, leadership development, and consultation for the 800 physicians and 300 advanced practice clinicians in the group.

Ms. Magnuson-Giese has served more than 20 years in leadership roles in major healthcare systems, including director of human resources and risk management for University of Minnesota Physicians, director of organization development for University of Minnesota Hospitals and Clinics, and employee relations manager of the Children's Hospitals and Clinics.

Ms. Magnuson-Giese has served on the Board of Spare Key, a non-profit agency focused on keeping families with health issues in their homes. She also served on the Nominating Committee for Clearway Minnesota, an organization focused on eliminating smoking, and as the vice president of the Board for the Ronald McDonald House. Currently, she is the chair of the Steering Committee for the Group Practice Improvement Network, a group of more 70 of the largest clinical group practices in the country.

### Cheryl's Story to Tell:

In 2010 HealthPartners physicians and other providers requested support for improving their patient satisfaction scores. As part of an initiative to improve the patient experience, the Shadow Coach Program was established, which provides feedback and suggestions to providers on how they interact with patients, with a goal of helping improve patient satisfaction with the experience of care.

Shadow coaches are non-clinical employees from across the organization who sign up to participate and complete the required training. Shadows observe providers while they are delivering care, provide feedback and suggestions throughout the day on possible improvements, and create detailed feedback reports of their observations for the providers. In the clinic setting, patient surveys are distributed and an additional data report provided.

Provider feedback has been very positive, and satisfaction scores have improved. The program has expanded from the clinic to the hospital setting and now also includes medical residents.

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### KEY TAKEAWAYS FROM CHERYL'S STORY:

1. Patients support their physician's/provider's efforts to improve their interaction skills and are open to having observers focusing on this in exam and hospital rooms.

2. Physicians and other providers find direct observation and feedback useful and can improve patient satisfaction using this information.

3. Non-clinician shadow coaches can support providers and patients in improving interactions while also gaining knowledge and understanding of the complexities of care delivery.



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## WILLIAM J. SCARPACI | SPEAKER

Mr. Scarpaci is a retired chief operations officer of a large print manufacturing company located in the greater Cincinnati, OH, area. His career in printing has spanned more than 40 years in various locales throughout the United States. Throughout his career, he has been actively involved in various professional organizations and industry steering committees, where he has received awards for his dedication to establishing innovative improvements to benefit the industry. Mr. Scarpaci now volunteers his time with several organizations in the greater Cincinnati area, including Mercy Health-Anderson Hospital.

### Bill's Story to Tell:

We are a group of volunteers who meet with patients, their families, and their visitors. We have a mission that is structured differently from the health care providers at the hospital. Our goal is to help provide information and services that are strictly non-medical. We are here not only to meet the non-medical expectations of the patient, but also to see that their families and guests receive the attention that is expected.

As patient partners we are lifting the spirits of our guests. As we visit the patient rooms, we offer the patients and their guests a wide range of services to make them more comfortable. When a patient goes home from Mercy Health-Anderson Hospital, we want them to believe that their experience and care was the very best they could have received from any hospital. Their perceptions will provide evidence that Mercy Heath-Anderson Hospital is a world-class facility. The information that is gathered from our patients and their guests is submitted to the volunteer office. The data collected is then used to identify areas that might need improvement or change.

Not only have I had the opportunity to experience Mercy Health-Anderson Hospital as a volunteer, but over the past several years my family and I have had occasion to experience exemplary care during the times we also were in need of emergency or in-hospital care. As health care customers, we noticed and believed we were receiving the highest quality care. The consistent interaction that the staff at Mercy Health-Anderson Hospital provide their patients helps enormously to relieve some of the natural anxiety that one experiences when visiting a hospital.

### KEY TAKEAWAYS FROM BILL'S STORY:

1. Better understanding of what hospital volunteers do to improve patient's experience
2. Understanding of the call light response system in each patient's room
3. A better understanding of compassion for the patients and their families

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## ILEEN SYLVESTER | SPEAKER

Ileen Sylvester, MBA, vice president for executive and tribal services at Southcentral Foundation in Anchorage, AK, has held management positions in finance and operations at the organization since 1995. She currently manages and directs the day-to-day operations of tribal relations and village initiatives for health care delivery to 55 rural villages and provides traditional healing, staffs the Seattle resource advocate office, and provides communications and public relations, planning and grants, research, contract management, and corporate office support. She works closely with the president/CEO and executive staff in the management and direction of more than 1,300 professionals in a complex health care service delivery system including primary care/outpatient services at the Alaska Native Medical Center to 46,000 Alaska Natives and American Indians residing in the Anchorage Service Unit.

### Ileen's Story to Tell:

Southcentral Foundation (SCF) is an Alaska Native owned and managed nonprofit health care system located in Anchorage, AK. We were incorporated in 1982 under the tribal authority of Cook Inlet Region Inc. (CIRI), and have grown from a small organization of fewer than 100 people and two programs to more than 1,400 employees and 65 programs.

Our Nuka System of Care is one of the nation's most innovative health care systems. Alaska Native people have earned this recognition, and we are constantly raising our expectations for what our health care will look and feel like.

SCF recognizes that health care is about people and relationships. Alaska Native people have always lived life in "community," sharing and caring for one another. And so, from the very beginning, SCF has built its health care system around the understanding that personal relationships make a difference. Relationships are the basis for SCF's operational principles and, as such, are at the core of every SCF program and service, as well as infrastructure.

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Providers are hired and trained to create trusting, accountable, long-term, relationships with customer-owners. Getting the right diagnosis and prescribing the right medications are only the beginning and only support the real work of relationship building. When there is a relationship between a provider and a customer, there is a better understanding of the context in which the customer lives. Real conversations can be had about ongoing choices and habits. And, it creates a collaborative environment in which individuals are choosing their paths to health and wellness, with support and coaching along the way.

SCF's facilities are designed to eliminate unnecessary barriers between those giving and receiving services. As much as possible, a talking room is used rather than an exam room to put the customer-owner on more equal footing with the provider. Wellness is also supported outside the clinic setting, as is the case with programs like SCF's Family Wellness Warriors Initiative, Alaska Women's Recovery Project, and many others. SCF focuses not only on treatment, but also on getting to the underlying determinants of health and wellness.

### KEY TAKEAWAYS FROM ILEEN'S STORY:

1. How the NUKA System of Care has changed the dynamics between the doctor and the patient verses the provider team and the customer/owner.
2. How long-term personal relationships with a provider team has improved health care for our customer/owners.
3. Consider how the SCF Nuka System of care might be applied in their setting.

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## BEG, BORROW, AND ADAPT: CONNECTING QUALITY IMPROVEMENT AND PAYMENT ON THE ROAD TO BIG IMPACT

### KEITH MANDEL, MD | MODERATOR

Keith Mandel, MD, is vice president of medical affairs of the Physician-Hospital Organization at Cincinnati Children's and a faculty member within the James M. Anderson Center for Health Systems Excellence. He has been on the core team driving Cincinnati Children's quality/transformation journey over the past 12 years. He leads large-scale improvement initiatives, including the Greater Cincinnati Beacon Community Program and a regional asthma initiative impacting outcomes for 13,000 children. He has experience designing innovative payer reward programs that accelerate large-scale improvement (*JAMA*, 2010).

Dr. Mandel serves as improvement advisor for national improvement initiatives, including those organized by the HHS Office of National Coordinator for Health Information Technology, RWJF, AHRQ, and AAP. He co-leads the national quality improvement advisory group for the AMA-Physician Consortium for Performance Improvement. He also serves on the Ohio Department of Health-Hospital Measures Advisory Council, representing children's hospitals across Ohio on public reporting of hospital quality measures.

Dr. Mandel was an RWJ Clinical Scholar in health policy and management at Johns Hopkins University School of Medicine. He completed his pediatric residency and chief residency at Children's Medical Center of Dallas. He holds a BA in economics from Duke University and an MD from the University of Pittsburgh School of Medicine.

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## CHRISTINE AMY | SPEAKER

Chris Amy is the project director for Aligning Forces for Quality–South Central Pennsylvania. In this role, for more than five years she has helped those who give, get, and pay for health care transform today's broken healthcare system into one that supports high-quality care at an affordable cost. She possesses 20 years' experience in consumer advocacy, public relations, and non-profit management. In prior roles, she served as the senior market director for the American Diabetes Association's nine-county Central Pennsylvania office, customer development director for the York County Chamber of Commerce, and development coordinator for rabbittransit, a local public transportation system. Ms. Amy holds a bachelor's degree in marketing from Penn State University.

### Chris' Story to Tell:

AF4Q SCPA was created in 2007 through RWJF funding to improve health and health care in two counties of Pennsylvania: Adams and York. To be sustainable, an organization must meet the needs of its customers. To this end, AF4Q SCPA is in the process of working with 10 additional counties to build a regional health improvement organization that would better match the region's media and health care payer market. This regional expansion of stakeholders has been invigorated by payment reform work being undertaken in AF4Q SCPA's PRICE Committee, which is working to facilitate the implementation of new models of payment: bundled payments for hip and knee replacement, clinics that care for high utilizers of health care, and patient-centered medical homes in primary care.

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### KEY TAKEAWAYS FROM CHRIS' STORY:

1. Small successes/projects are great from a research viewpoint, but for long-term impact, your organization's work has to meet the needs of members who will ultimately support your organization. Geography, provider service areas, and payer and media markets are important.
2. Start in an area where people have a reason to collaborate; payment reform is a big motivator.
3. You need a neutral convening body like an AF4Q organization to be successful; no one stakeholder group can serve that role.

## KATHRYN FARLEY | SPEAKER

Kate Farley serves as the executive director of the Pennsylvania Employees Benefit Trust Fund, serving 297,000 members and managing $1 billion in benefits. The Pennsylvania Employees Benefit Trust Fund (PEBTF) administers health care benefits for the current and former employees of the commonwealth, the largest employer group in Pennsylvania. Ms. Farley joined PEBTF in 2007, bringing with her more than 25 years of health care experience. Under her leadership the PEBTF has improved customer satisfaction while streamlining operations, implemented quality initiatives, reduced GASB liability by implementing Medicare Advantage Medical and Part D plans, and negotiated vendor contracts to achieve savings for the Fund. Prior to PEBTF, she held executive level positions with Independence Blue Cross with responsibility for claims, customer service, membership, pharmacy, and managed care programs. She also was employed by the Jefferson Health System. In 2007, Ms. Farley was appointed to the Pennsylvania Chronic Care Commission, which is working to improve how Pennsylvanians with chronic disease will receive health care in the future. She served as a member of the Pennsylvania Health Information Exchange Advisory Council, established in 2008. She serves on the technical advisory committee for Catalyst for Payment Reform and on the advisory board of Health Evolution Partners. She was responsible for implementing Bridges to Excellence for PEBTF in 2010. Ms. Farley also is a member of the Aligning Forces for Quality Alliance of South Central Pennsylvania. Ms. Farley is a member of the Forum of Executive Women and The American College of Health Care Executives. She graduated from Leadership Philadelphia and received the YMCA Women's Achievement Forum Award. Ms. Farley received an MBA from the Wharton School at the University of Pennsylvania.

### Kate's Story to Tell:

AF4Q SCPA was created in 2007 through RWJF funding to improve health and health care in two counties of Pennsylvania: Adams and York. To be sustainable, an organization must meet the needs of its customers. To this end, AF4Q SCPA is in the process of working with 10 additional counties to build a regional health improvement organization that would better match the region's media and health care payer market. This regional expansion of stakeholders has been invigorated by payment reform work being undertaken in AF4Q SCPA's PRICE Committee, which is working to facilitate the implementation of new models of payment: bundled payments for hip and knee replacement, clinics that care for high utilizers of health care, and patient-centered medical homes in primary care.

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### KEY TAKEAWAYS FROM KATE'S STORY:

1. Small successes/ projects are great from a research viewpoint, but for long-term impact, your organization's work has to meet the needs of members who will ultimately support your organization. Geography, provider service areas, and payer and media markets are important.
2. Start in an area where people have a reason to collaborate; payment reform is a big motivator.
3. You need a neutral convening body like an AF4Q organization to be successful; no one stakeholder group can serve that role.

### HELENA PETERSON, RN, MPH, CPHQ | SPEAKER

Helena Peterson, RN, MPH, CPHQ, is the program manager for Community Care Teams with Maine Quality Counts. Her background is in emergency and critical care nursing, hospital administration, and quality improvement. She has worked for very large and very small hospitals, including one on an island, as well as a physician practice. Moving into public health, she served for 10 years as director of a healthy community coalition before joining the effort to transform health and healthcare. She holds an AS degree in nursing from DeKalb College in Atlanta, a BSN from the University of Maine, a graduate certificate in public health from the University of New England, and an MPH from A.T. Still University. She is a certified professional in health care quality. She lives and sails in beautiful coastal Maine.

**(Continued on following page)**

### Helena's Story to Tell:

Maine Quality Counts (QC) leads Maine's AF4Q Alliance and currently supports a variety of statewide improvement programs, including the Maine Patient-Centered Medical Home (PCMH) Pilot and its Community Care Teams (CCTs), which work with medical homes to identify high-needs patients who need additional support, with the goal of reducing unnecessary ED visits and hospitalizations. Twenty-six (soon to be 76) PCMH pilot practices and eight (soon to be 10) CCTs receive prospective per-member per-month payments from Medicare, MaineCare (Medicaid), and the major commercial payers. One CCT has been selected as the "Vanguard" team to work with Dr. Jeff Brenner and the Camden (NJ) Coalition of Healthcare Providers to improve the quality of care for "superutilizer" patients with three focus areas: the acquisition and use of data for population management, use of health information technology to support individual care management (including secure email and patient portals), and strengthening connections to non-clinical resources, including faith, fitness, public health, and volunteer organizations. The Vanguard team will disseminate these new skills and knowledge through our statewide learning collaborative to the other CCTs and PCMH practices.

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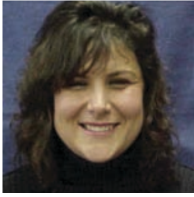
### KEY TAKEAWAYS FROM HELENA'S STORY:

1. Aligning a statewide infrastructure of PCMH practices and partner CCTs with widespread payer support for care coordination presents a compelling opportunity to improve care and provider and patient satisfaction and reduce costs of avoidable ED visits and hospitalizations.

2. The Maine PCMH pilot and CCTs' rapid development has required a delicate balance between statewide standardization and structure and the potential for innovation as a variety of organizations have stepped up to become CCTs: hospitals, home health agencies, FQHCs, and groups of independent practices, each with their own local knowledge and approach.

3. Creating new payment models and new ways to communicate across organizations for care coordination requires significant organizational and staff transformation and must be supported by a structured learning collaborative that brings in experts from all over the nation as well as multiple opportunities for peer-to-peer sharing.

## BEG, BORROW, AND ADAPT: CONNECTING QUALITY IMPROVEMENT AND PAYMENT ON THE ROAD TO BIG IMPACT



### ANGELA RICHARDS, RN, BSN | SPEAKER

Project Manager Angela Richards, RN, BSN, began working for Androscoggin Home Care & Hospice shortly after she graduated from the University of Southern Maine in 1989. For the past 22 years she has been a valued employee whose roles have ranged from visiting nurse to clinical software coordinator to providing educational support to the organizations' employees. Her work at Androscoggin Home Care & Hospice has given her more than 22 years of first-hand experience in identifying barriers to, evaluating, and implementing complex solutions for our health care organization.

Ms. Richards' role as the project lead for the Androscoggin Home Care & Hospice Community Care Team (CCT) is instrumental in the support of the participating patient-centered medical homes. The CCT coordinates and connects patients to additional health care and community resources to support their health improvement goals, achieve better health outcomes, and reduce avoidable costs. In addition to her lead with the Community Care Teams, she has taken the lead on the organizations flu clinics, MD Portal project, chronic care management program, and the M.O.D.E.L. Care initiative.

### Angela's Story to Tell:

Community Care Teams (CCTs) are key strategy for improving care and reducing avoidable costs for patients in the pilot and MAPCP demo, especially those with complex or chronic conditions. CCTs coordinate and connect patients to additional health care and community resources to support their health improvement goals, achieve better health outcomes, and reduce avoidable costs.

Androscoggin Home Care & Hospice CCT program currently works with four practices to identify patients at high risk or with high utilization who need additional support and will seek to link them to that support within the practice, in the health care environment, or in the community. AHCH CCT helps ensure effective coordination and communication across a patient's full health care team and community supports.

**(Continued on following page)**

The service AHCH CCT provides (either directly or through contracting and referral arrangements) includes:

- Medical assessments and complete community/social service needs assessments
- Nurse care management (including patient visits prior to hospital discharge, in the primary care practice, group visits, or at home)
- Case/panel management (screening, patient identification, scheduling appointments, referrals to care managers and other team members)
- Behavioral health (brief intervention, cognitive behavioral therapy, motivational interviewing, and referral)
- Substance abuse services (screening, brief treatment, and referral)
- Psychiatric assessment and coordination of follow-up services as needed
- Medication review and reconciliation (may be provided by pharmacists, pharmacy techs, or nurses)
- Pharmacy consultation for providers
- Transitional care
- Health coaching for nutrition, physical activity, tobacco cessation, diabetes, asthma, other chronic disease
- Chronic disease self-management education and skill-building, such as linking to Living Well programs
- Other non-clinical services to actively connect patients to community organizations that offer supports for self-management and healthy living, transportation assistance, housing, literacy, economic, and other assistance to meet basic needs.

The CCT program has seen significant reduction rates of ER use and hospital readmissions through connecting patients with community resources, education, and coordination with their primary care provider. The CCT staffing structure consists of one full-time CCT nurse manager, one full-time CCT LMSW, one full-time CCT coordinator assistant, and a full-time CCT director. The CCT program uses tele-health monitors and coordinates support of the diabetic nurse educator as needed.

### KEY TAKEAWAYS FROM ANGELA'S STORY:

1. The understanding of the importance of knowing the patient. Having the patient identify "their goals" and actions they want to take to improve their health and overall well-being.

2. The importance of relationship building within the practices. Understanding of how "together" we can assist patients with meeting their goals and improving their health outcomes.

3. The identification and connections with community resources and building those relationships to enhance the opportunities for the chronically ill patients.

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## CLOSING PLENARY: THE POWER OF STORY TO MAKE A DIFFERENCE: EMPOWERED PATIENTS, EMPOWERED COMMUNITIES

### ELIZABETH COHEN, CNN SENIOR MEDICAL CORRESPONDENT | KEYNOTE

As senior medical correspondent for CNN's Health, Medical, and Wellness Unit, Elizabeth Cohen has reported breaking medical news ranging from the BP oil disaster and the Haiti earthquake to Hurricane Katrina and the H1N1 influenza outbreak. Her signature digital column, *The Empowered Patient*, keeps consumers informed on how to ensure the best medical care for themselves and their families and was followed by a book, *The Empowered Patient: How to Get the Right Diagnosis, Buy the Cheapest Drugs, Beat Your Insurance Company, and Get the Best Medical Care Every Time*, published in August 2010.

Ms. Cohen's reporting on the BP scandal included a whistleblower exclusive with a fisherman's wife who was among the first to speak out about the health concerns of fishermen now working for BP as clean-up workers. In Haiti, she reported from a makeshift hospital, bringing insights to the injury triage, the complications of transporting critical patients to the United States, and the lack of medical infrastructure and resources. She added clarity to reporting on the global response to H1N1 influenza, interviewing patients and reporting on the latest prevention updates.

Ms. Cohen's report on the aftermath of the destruction of Hurricane Katrina in 2005 contributed to CNN's Peabody and Emmy Award-winning coverage through stories about airlifts of premature babies from flooded neonatal intensive care units and reports on displaced cancer patients in desperate need of treatment. She also contributed to CNN's Emmy Award-winning coverage of the 9/11 terrorist attacks, reporting with sensitivity and professionalism on the rescue and recovery at Ground Zero and the search for missing people in lower Manhattan.

Passionate about teaching others how to be advocates for themselves and their families when faced with a less than perfect medical system, Ms. Cohen speaks fluidly about patients' need to take better control of their healthcare by learning the basic skills for achieving the best medical care in her engaging keynotes.

Before joining CNN in 1991, Ms. Cohen was associate producer of Green Watch, an environmental television program on WLVI in Boston, a reporter for States News Service in Washington, DC, and a reporter for the *Times Union* newspaper in Albany, NY, where she won a Hearst Award. Her field reporting also has included coverage of the Virginia Tech student shootings, offering a detailed account of what happened from a student who claimed to be the last person shot that day.

Ms. Cohen received a Sigma Delta Chi Award from the Society of Professional Journalists and a National Headliner Award in 2006 for "A Lesson Before Dying," a feature on the medical decisions made by a Georgia man at the end of his life. In 2007, Cohen was honored by the Newswomen's Club of New York and the New York Association of Black Journalists for the feature "African Americans and Bone Marrow Transplants." The Mental Health America Media Awards honored her in 2007 for "Perfection Obsession," a feature focusing on a teen's battle against obsessive-compulsive disorder. In 2008, Cohen received a Gracie Award from American Women in Radio and Television for "Where's Molly?", a feature on a man's search for his sister nearly 50 years after she was placed in a residential mental health institution. Ms. Cohen is the recipient of the outstanding alumna award from Columbia College in New York City, where she received a bachelor's degree in history, and the Distinguished Alumni Award at Boston University where she earned a master's degree in public health.

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