

STOP 3 · PREPARE THE CONVERSATION

The CLEAR conversation

C

Context

State the facts you observed and the outcome you share.

L

Listen

Ask what the current way protects. (Stop 2, out loud.)

E

Explain

Connect the change to patients and to their day.

A

Agree

One specific next behavior, plus the support you'll bring.

R

Return

Set the date you'll review it together.

Specificity lowers the temperature.

STOP 3 · WORKED EXAMPLE

CLEAR with a skeptical department director

The goal: get the team reporting near misses again. Likely protection: **trust**.

Context	“Near-miss reports from your department have dropped to almost none this year.”
Listen	“What happens for your staff after they file a report?”
Explain	“Every near miss we hear about is a harm we get to prevent. Your team sees them first.”
Agree	“Would you try a two-minute ‘good catch’ shout-out at your Monday huddle for a month?”
Return	“Let's look at the reports together in 30 days and decide if it's worth keeping.”

STOP 3 · PAIRS, FIVE MINUTES

Build one CLEAR request. Then say it out loud.

1 MINUTE, ALONE

Prepare

Use your sticky-note person. Write your Context, Listen, and Agree lines. Keep the ask small enough to observe.

90 SECONDS EACH

Rehearse

Partner A makes the request. Partner B answers from the protection on A's sticky note. Then switch.

1 MINUTE, TOGETHER

Debrief

Which line made the request easier to answer? Which line made your partner dig in?

Listen for the moment the request gets easier to say yes to.



STOP 4 · REHEARSE WITH AI

Enter AI.

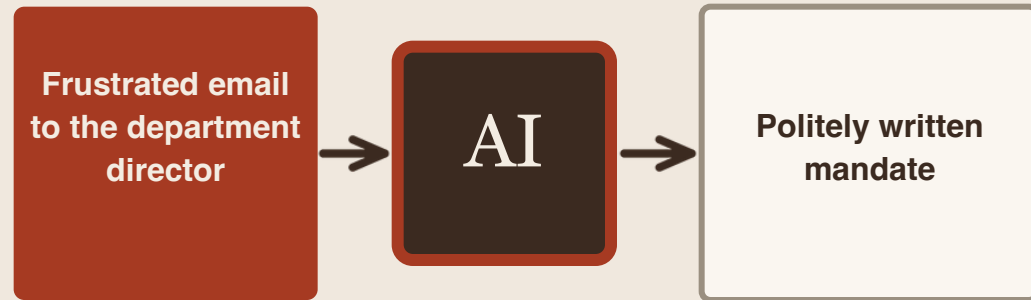
Your preparation partner. You make the call.

The AI mindset shift

From word processor to preparation partner.

THE TRAP: OLD WAY

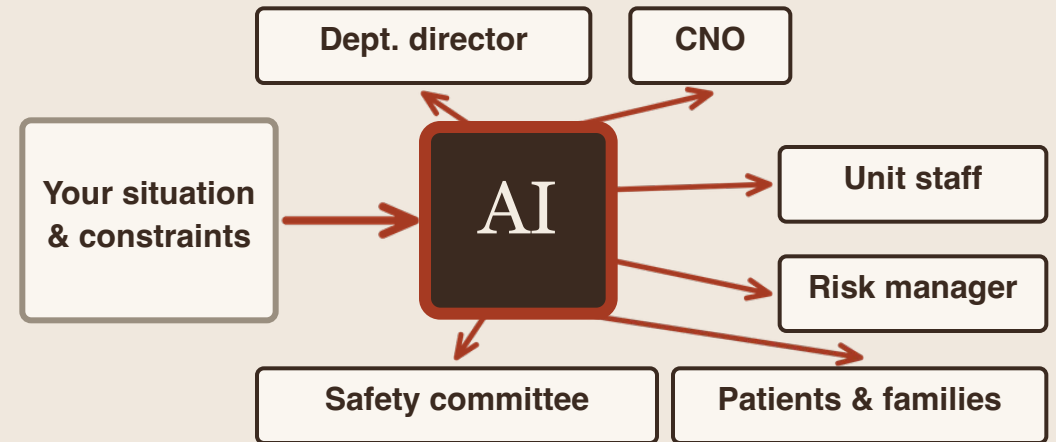
AI as a word processor



You paste in the request and say “make this better.” The us-and-them problem survives, now with better grammar.

THE SHIFT: NEW WAY

AI as a chief of staff



You give it the situation. It holds every stakeholder's view at once, and asks the questions you forgot to ask yourself.

STOP 4 · THE SAFE METHOD

Prepare with AI. Keep the judgment.

S

Strip identifiers

No names, dates, locations, record numbers, or rare case details.

Use your organization's approved tool.

A

Assign a role

First: "You're my preparation partner. Don't write anything yet."

Later: "Play the skeptical department director."

F

Frame the goal

Outcome · Person · Protection
· Evidence · Ask · Return

End with: "**Before you write anything, what questions do you have?**"

E

Evaluate

NON-NEGOTIABLE

Accuracy. Inside the facts I gave?

Assumptions. What did it invent?

Tone. Would I say this to a respected colleague?

Usefulness. A better question, a clearer ask?

STOP 4 · LIVE DEMO · STRIP, ASSIGN, FRAME

Set it up. Then let it ask.

You're my preparation partner. Don't write anything yet.

Context: I'm a quality manager at a 150-bed hospital. I don't manage anyone involved.

Outcome: one department reports near misses again, so we catch problems before they reach patients.

Person: the department director.

Protection: probably trust. If a report ever came back as blame, nobody files another.

Evidence: reports from this department dropped to almost none this year. Similar teams still report.

Ask: a two-minute 'good catch' shout-out at the Monday huddle for four weeks.

Return: review the reports together at day 30. If they say no, what smaller test would work?

Also affected: unit staff, CNO, risk manager, patient safety committee. No patient or staff names.

Before you write anything, what questions do you have?

STOP 4 · LIVE DEMO · REHEARSE AND EVALUATE

Map it. Then rehearse it.

MAP IT

Now map it. For each audience, give me what they are likely protecting, their top objection, and one sentence framing the ask for them. Then give me three questions I haven't asked myself.

REHEARSE IT

Play the department director. You're skeptical and short on time. Respond to my opening in two or three sentences, then wait. After three rounds, step out of the role and tell me where I lost you.

E · EVALUATE What would you change before this goes anywhere?

A scenic view of a lake at sunset. The sky is a mix of orange, yellow, and blue, with a faint rainbow visible. In the background, there are large, rugged mountains. On the right side, a boat named "Q VERGA" is docked at a wooden pier. The water is calm, reflecting the sky and the surrounding landscape. On the left, there's a small building and some trees. The overall atmosphere is peaceful and beautiful.

Questions?

What will you try differently on Monday?

Anna Smith · anna@wildbrushcollective.com

Owning the outcome does
not mean controlling
everyone involved.

*It means becoming more
intentional about how you
create movement when
authority is not available.*





WILDBRUSH COLLECTIVE

Take Off One Hat

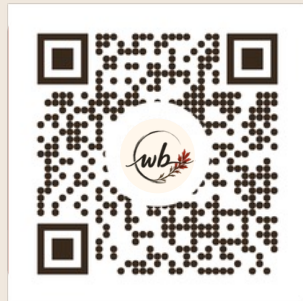
An AI Masterclass for Leaders

Date · Tuesday, October 20, 2026

Time · 12:00 PM Mountain Time

Free Webinar

with Anna Smith



Want a Copy of the Slides?

Enter your information and complete the quick survey to receive a copy of today's presentation.

Scan the QR code to get started.



BREAK

We will begin again in 15 minutes



UTAH ASSOCIATION FOR HEALTHCARE QUALITY
Commitment . Leadership . Empowerment . Integrity

Sheralee Peterson

Achieving the Quadruple Aim at Scale: Intermountain Health's cBPI Model



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Achieving the Quadruple Aim at Scale: Intermountain Health's cBPI Model

UAHQ Annual Conference
10.2.26

Sheralee Petersen, MBA, PA-C
Assistant Vice President
Clinical Programs

The Quadruple Aim in Healthcare

1.

Improving Patient Experience

Quality
Safety
Patient satisfaction

2.

Improving Population Health

Preventive Health
SDOH

3.

Reducing Per Capita Costs

Efficiency
Reduced readmissions
Value-based care

4.

Improving Provider Experience

Wellbeing
Joy in work
Mental health

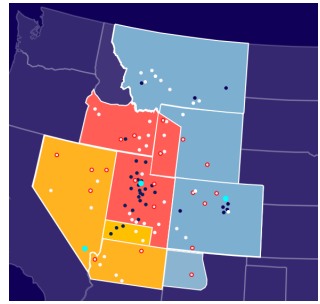
History of Quality & Safety at Intermountain Health

Clinical Programs

Behavioral Health	Primary Care
Cardiovascular	Surgical Services
Intensive Medicine	Women & Newborns
Oncology	Musculoskeletal
Pediatrics	Neurosciences

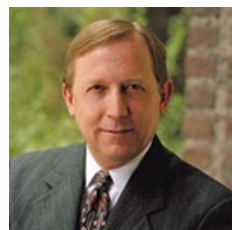
Expanding Health System

Merge with SCL Health to provide affordable, quality care to greater populations.



Healthcare Delivery Institute (HDI)

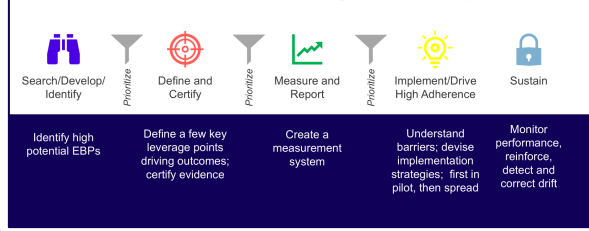
HDI launches Advanced Training Program (ATP) in Clinical Quality Improvement



Dr. Brent James

cBPI Launch

The Clinical Best Practice Integration (cBPI) Model



Clinical Integration

The work of clinical integration begins to bring alignment across the health system.

(HDI + Clinical Programs)

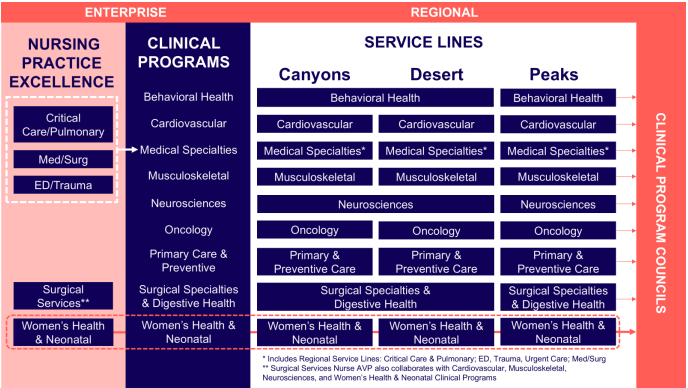
Achieving our Vision of Being a Model Health System



Intermountain Health
Service Area



cBPI Pipeline



Clinical Ecosystem



Improved Outcomes

Clinical Programs Oversight

Executive Committee

- Meets every other month
- Sets strategic priorities for enterprise alignment
- Reviews portfolios and overall performance
- Executive clinical leaders
- Strategy, ventures, health plan, finance

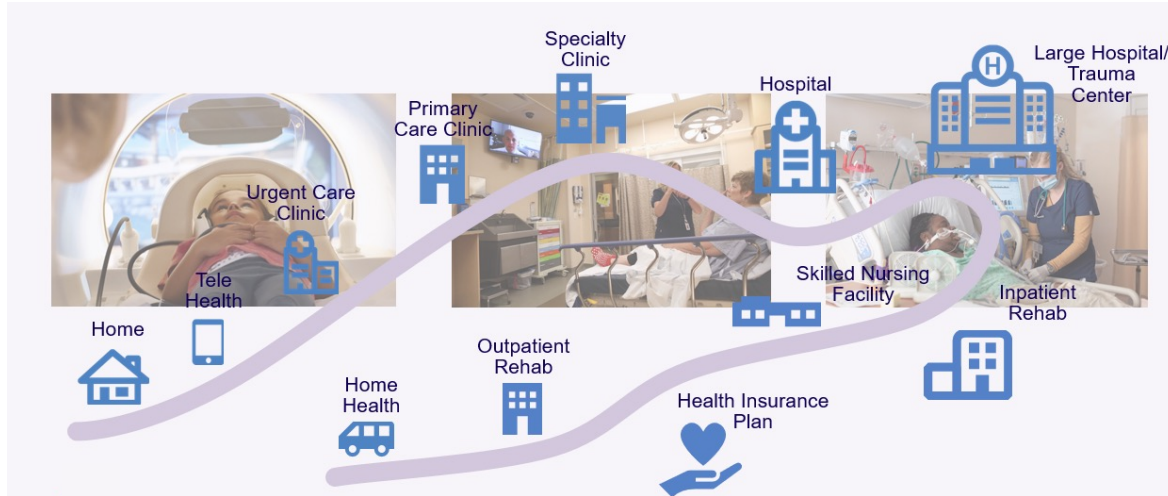
Steering Committee

- Meets monthly
- Approves pilots, tracks projects, approves scaling
- Prioritizes projects and resources
- Regional clinical leaders
- Informatics, analytics, region president, finance

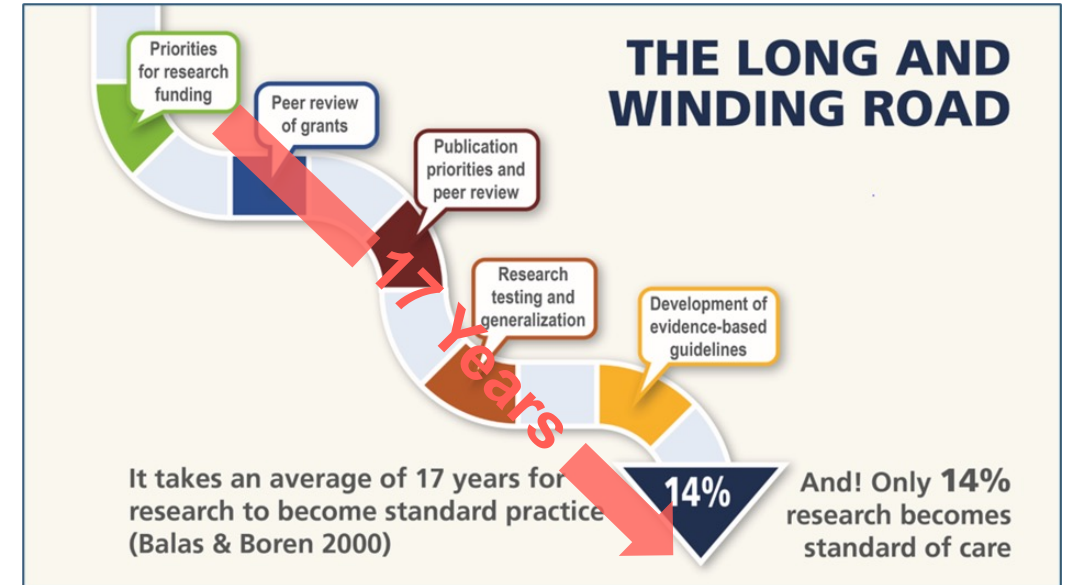
Clinical Program Councils

- Meets regularly to align Council members
- Communicate progress and performance
- Engage members for insight and guidance
- Prioritizes projects and resources
- Regional clinical leaders
- Informatics, analytics, region president, finance

The Intermountain Health Difference



+



Healthcare Delivery Institute & Clinical Programs Together

Clinical Best Practice Integration (cBPI)

Problem & Challenges

Problem:

Intermountain generally does not demonstrate high adherence to care process models (CPMs).

Urgent Challenge 2018:

Implement two CPMs with 100% high adherence to key interventions.

Long Term Challenge (ongoing):

Design and implement a systematic approach to driving high adherence to evidence-based best practice throughout Intermountain.

How Clinical Best Practice Integration (cBPI) is Different



Systematic Prioritization
at CPM & Key
Leverage Point Levels



Measure Adherence &
Focus on Adherence
Metrics

The Clinical Best Practice Integration (cBPI) Model



Search/Develop/
Identify



Prioritize



Define and
Certify



Prioritize



Measure and
Report



Prioritize



Implement/Drive
High Adherence



Sustain

Identify high
potential EBPs

Define a few key
leverage points
driving outcomes;
certify evidence

Create a
measurement
system

Understand
barriers; devise
implementation
strategies; first in
pilot, then spread

Monitor
performance,
reinforce,
detect and
correct drift

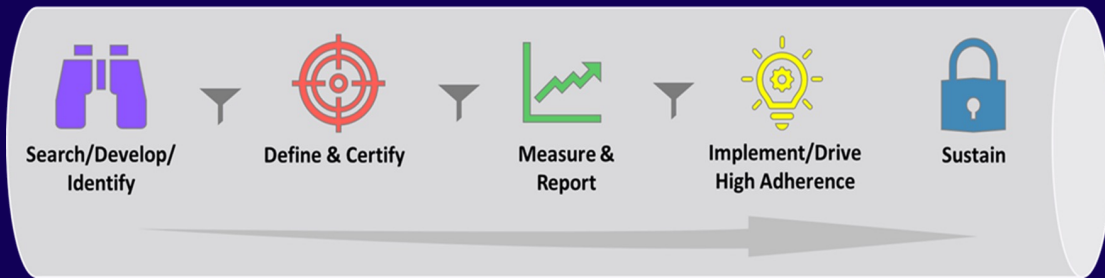
cBPI OBJECTIVES

- Shorten timeline to routine care
- Scale implementation
- Sustain adherence to EBP

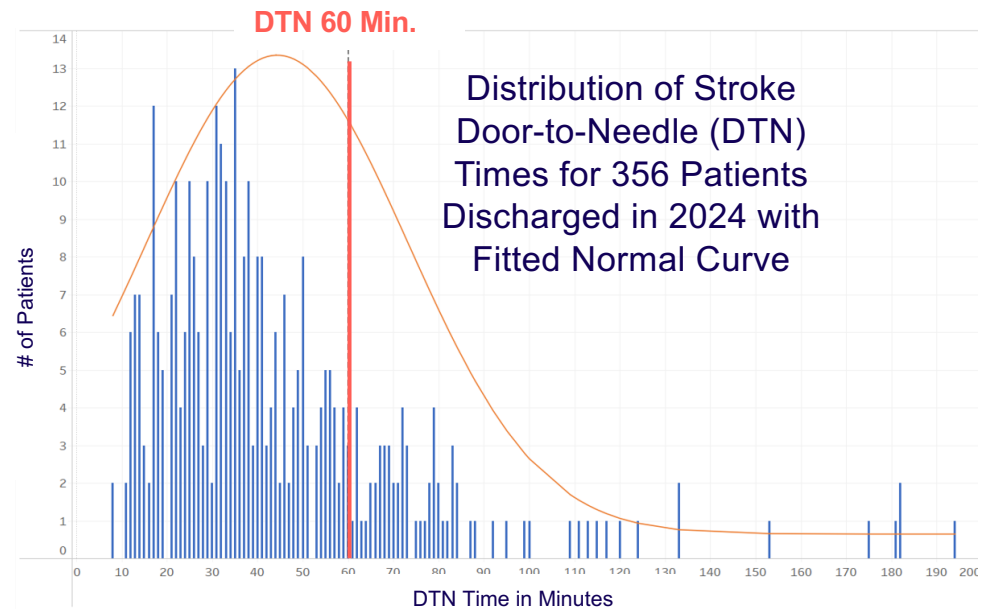
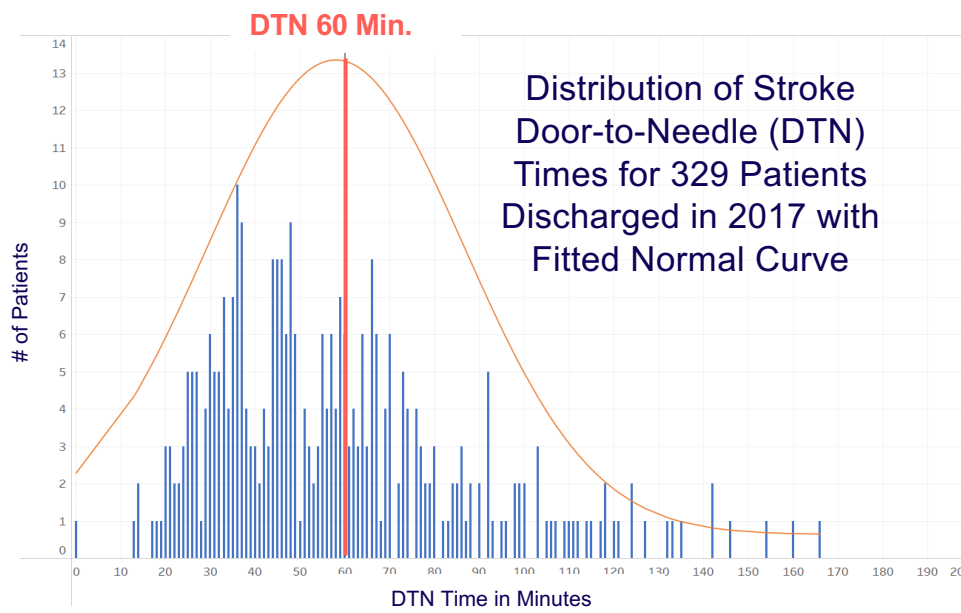
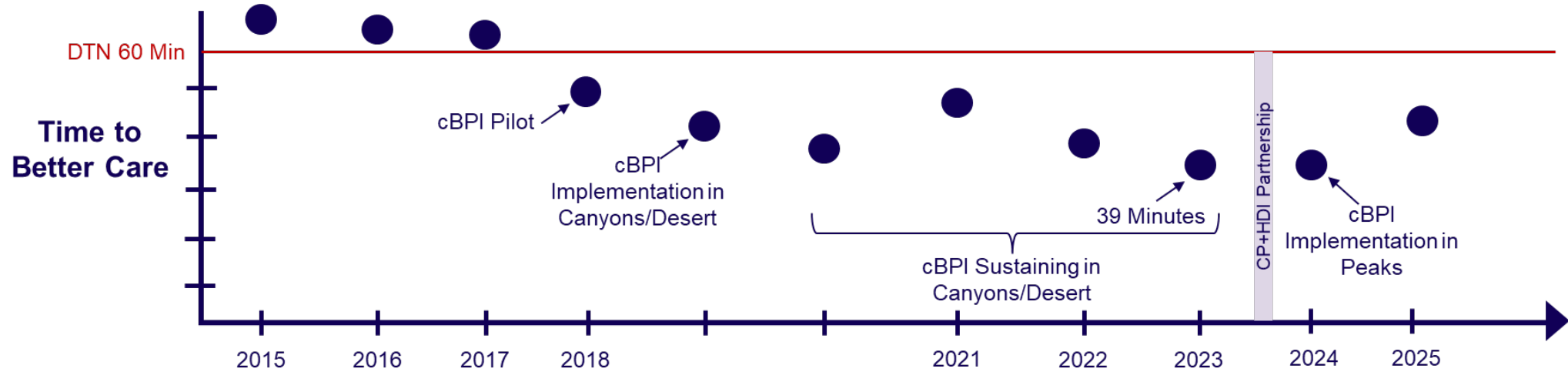


How Clinical Teams Use the cBPI Model

cBPI in Action: Adult Stroke



Stroke Door-to-Treatment Time | Canyons/Desert



Publishing The Processes and Patient Outcomes



Circulation:
Cardiovascular Quality and Outcomes

CURRENT ISSUE |

RESEARCH ARTICLE | Originally Published 3 April 2024



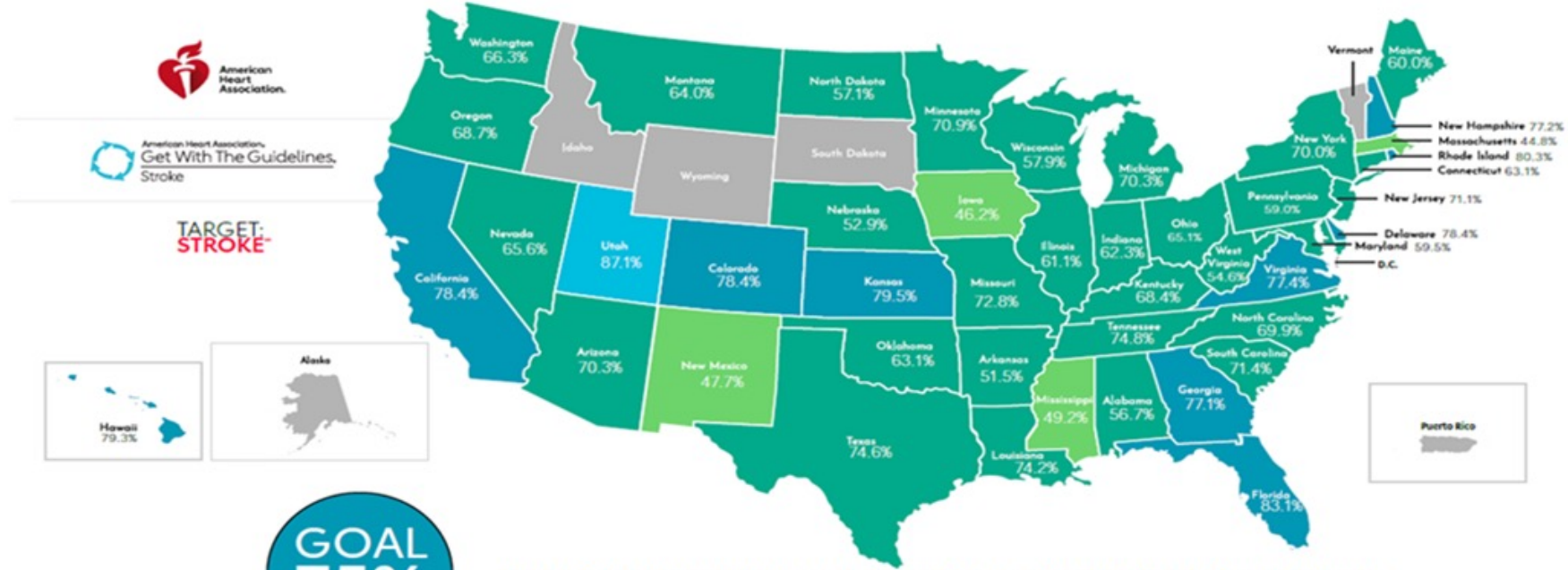
Impact of Local Tailoring on Acute Stroke Care in 21 Disparate Emergency Departments: A Prospective Stepped Wedge Type III Hybrid Effectiveness-Implementation Study

Kathleen E. McKee, MD, MPH, Andrew J. Knighton, PhD, CPA  , Kristy Veale, MSN, RN, Julie Martinez, MSN, RN , Cory McCann, MPH, MHA, RN, CCRN-K, Jonathan W. Anderson, PhD, Doug Wolfe, MBA, ... [SHOW ALL](#) ..., and Rajendu Srivastava, MD, MPH  | [AUTHOR INFO &](#)

[AFFILIATIONS](#)

Circulation: Cardiovascular Quality and Outcomes • Volume 17, Number 5 • <https://doi.org/10.1161/CIRCOUTCOMES.123.010477>

Target: Stroke[®] Phase III: Door-to-Needle within 45 Minutes



*gray states denominator too small to report

25-49%

Iowa 151/327 (30)
Massachusetts 296/661 (61)
Mississippi 209/425 (46)
New Mexico 72/151 (14)

state numerator/denominator (number of hospitals participating per state)

76-84%

California 3449/4401 (227) Rhode Island 110/137 (7)
Colorado 562/717 (33) Virginia 762/984 (44)
Delaware 171/218 (6)
Florida 3390/4081 (175)
Georgia 1138/1476 (84)
Hawaii 214/270 (13)
Kansas 210/264 (19)
New Hampshire 115/149 (12)

50-75%

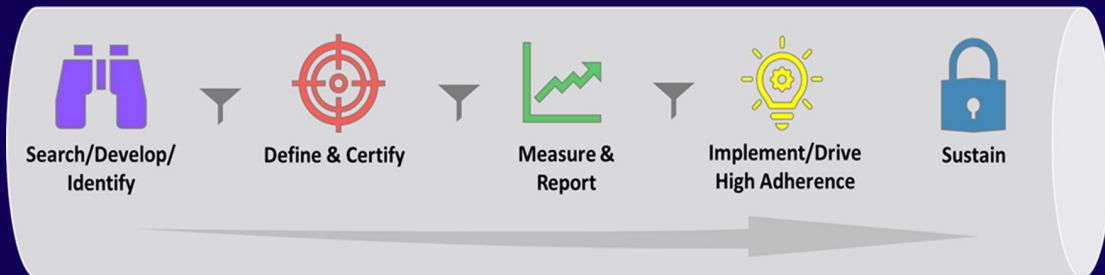
Alabama 315/556 (28) Maryland 432/726 (40) North Carolina 1080/1545 (77) Washington 536/808 (55)
Arizona 351/499 (30) Michigan 818/1163 (75) North Dakota 84/147 (22) West Virginia 125/229 (17)
Arkansas 353/686 (70) Minnesota 436/615 (31) Ohio 996/1530 (87) Wisconsin 404/698 (74)
Connecticut 245/388 (24) Missouri 889/1221 (62) Oklahoma 309/490 (24)
Illinois 810/1326 (100) Montana 80/125 (18) Oregon 408/594 (32)
Indiana 451/724 (45) Nebraska 119/225 (32) Pennsylvania 1018/1726 (120)
Kentucky 414/605 (49) Nevada 259/395 (18) South Carolina 652/913 (49)
Louisiana 482/650 (31) New Jersey 725/1019 (55) Tennessee 981/1312 (52)
Maine 75/125 (7) New York 1438/2055 (129) Texas 2683/3597 (168)

85-100%

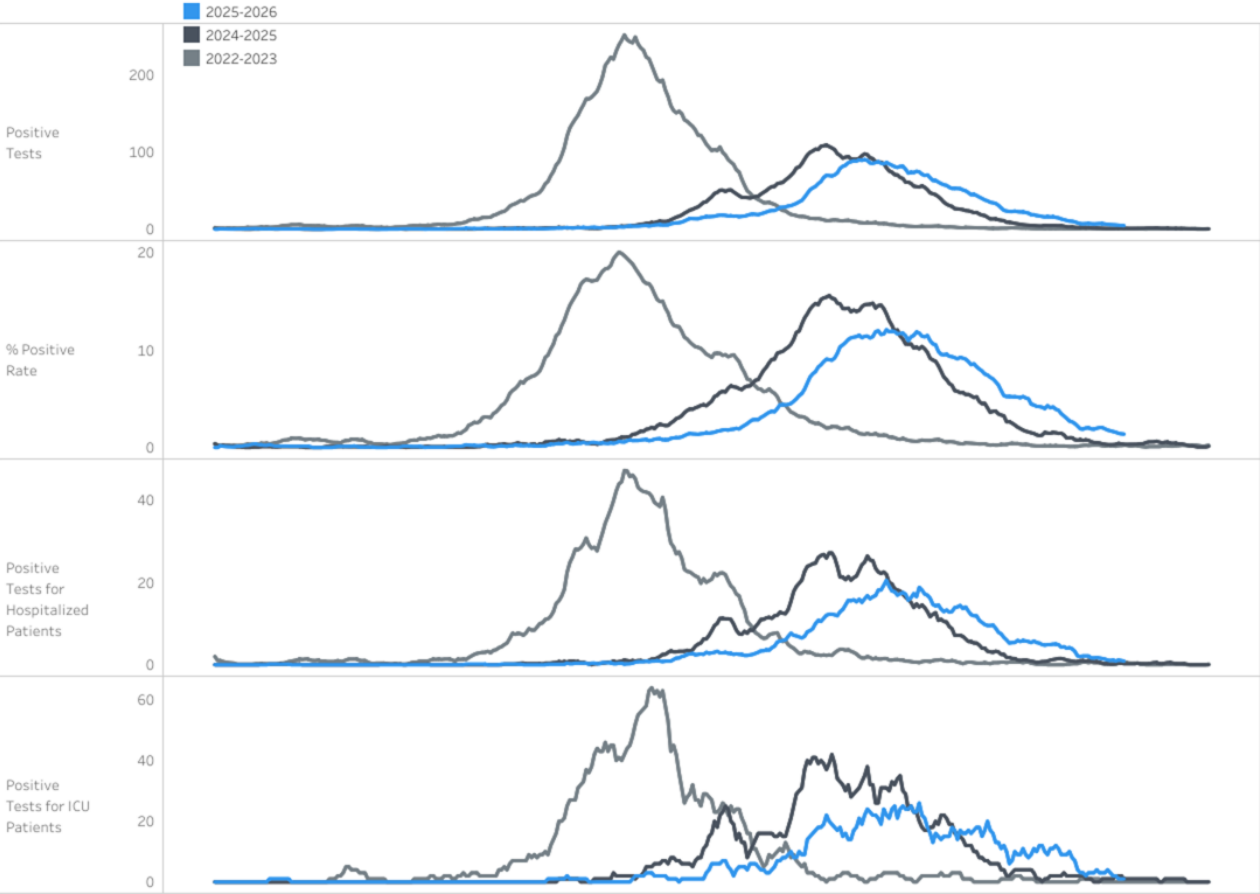
Utah 264/303 (17)

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cBPI in Action: RSV Prophylaxis



Updated: 5/30/2026

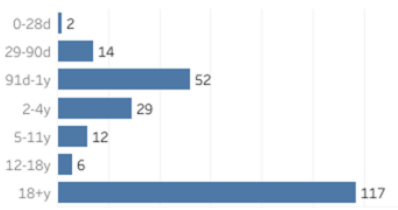


Activity

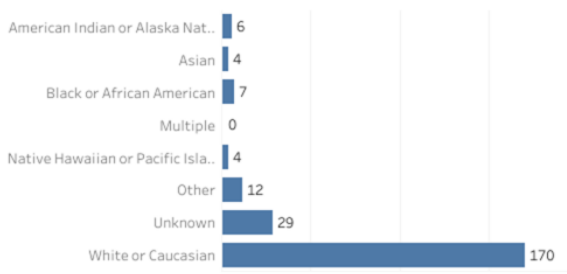
Date Range
5/1/2026 to 5/31/2026

Metric Toggle
Positive

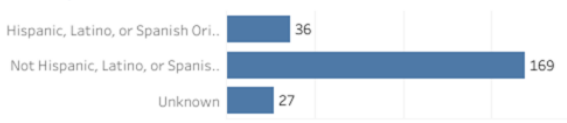
Age Group



Race



Ethnicity



Language



2024-2025 Outcomes (Nirsevimab & Abrysvo)

Children *with* protection:

9x less likely to be hospitalized

7x less likely to require the ICU

***Without* protection:**

1 in 48 children hospitalized compared to 1 in 400 protected children

RSV protection was 88% effective at preventing RSV-associated hospitalization

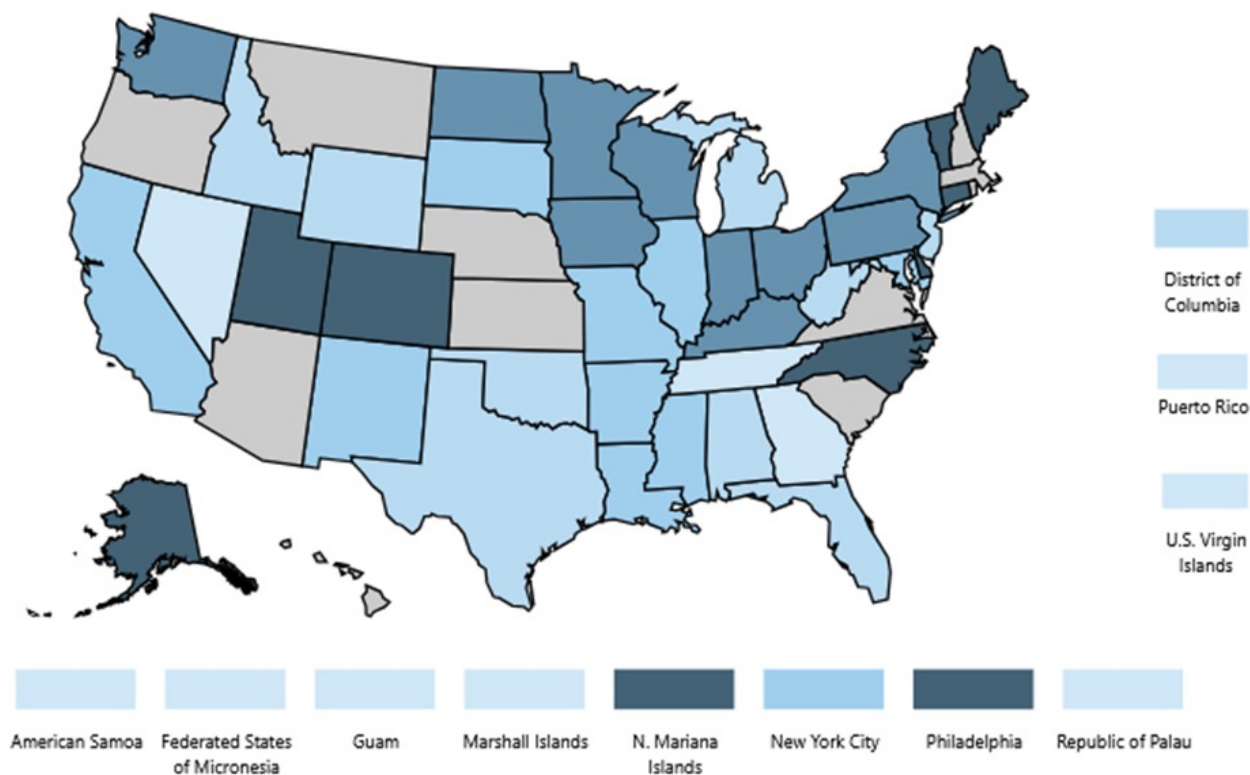
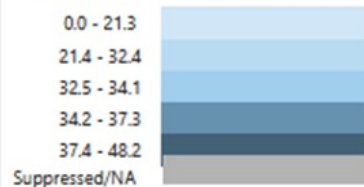
Figure 7B. Monthly Cumulative Number and Percent of Children <8 Months Who Received Nirsevimab^{*,†} by Jurisdiction, United States

Data Source: U.S. Jurisdiction Immunization Information Systems (IIS)

Current Season Month (2024-25)

March

Legend - IIS RSV Vaccination Coverage(%) for 2024-25 Season



American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN®

CONGRATULATIONS

RSV Prophylaxis Team

Children's Health Clinical Programs

**Recipient of the 2026 Pediatric Hospital Medicine
Collaborative Impact Award**

The American Academy of Pediatrics proudly recognizes your outstanding commitment, collaboration, and leadership in advancing RSV prophylaxis care for hospitalized children. Your work is making a lasting impact on the health and well-being of infants and families across our communities.



COLLABORATION
Across teams
and disciplines



IMPACT
Improving outcomes
for hospitalized
children



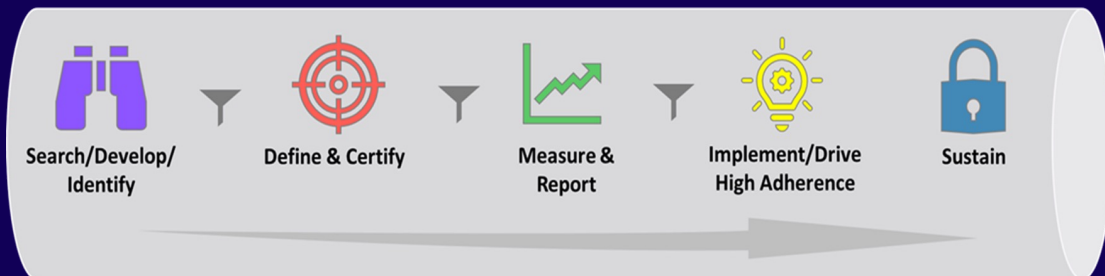
INNOVATION
Advancing best
practices in
RSV prevention



LEADERSHIP
Setting the standard
for excellence in
pediatric care

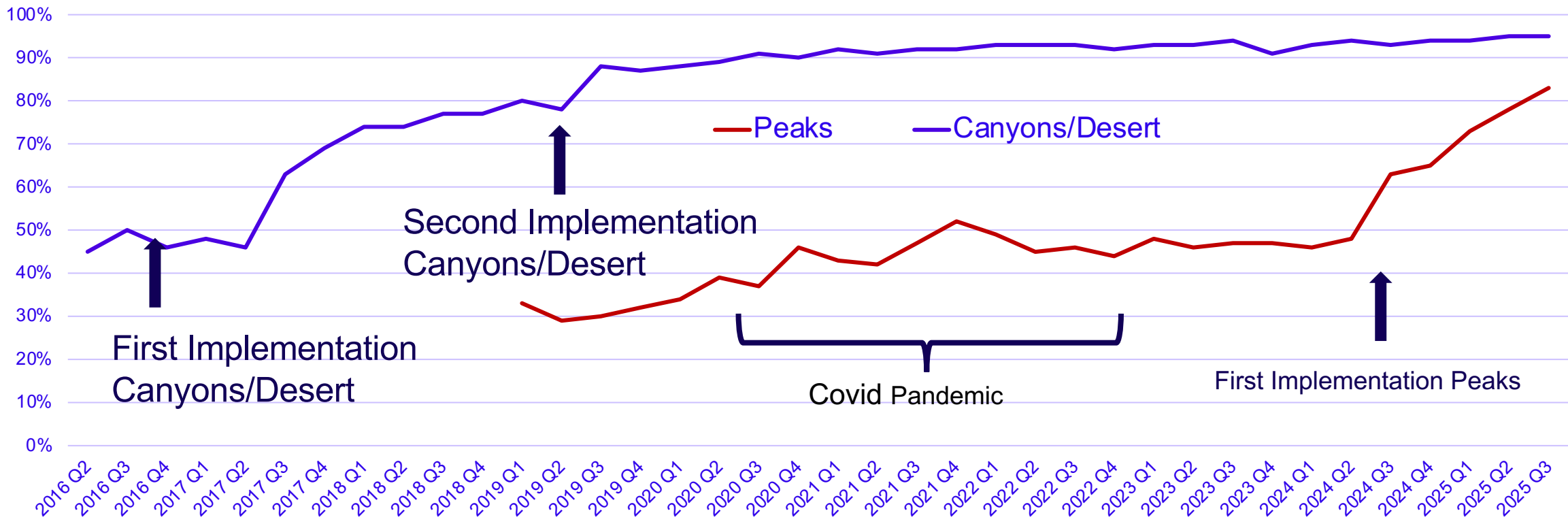
Thank you for your dedication to the health of all children.

cBPI in Action: Low Tidal Volume Ventilation



Low Tidal Volume Ventilation (LTVV) Adherence in Mechanically Ventilated Patients at Intermountain: An Evidence Based Best Practice That Improves Outcomes

LTVV Adherence in Canyons/Desert and Peaks Regions



*LTVV Adherence is defined as a tidal volume setting of ≤ 6.5 ml/Kg predicted body weight tidal volume for $>90\%$ of time on volume control ventilation not counting time on appropriate pressure support or continuous positive airway pressure. Time on non-compliant alternative modes is added to the denominator and counts against the metric.

Delivery of Lung-protective Ventilation for Acute Respiratory Distress Syndrome

A Hybrid Implementation–Effectiveness Trial

Ithan D. Peltan^{1,2}, Andrew J. Knighton³, Bradley J. Barney⁴, Doug Wolfe³, Jason R. Jacobs¹, Carolyn Klippel¹, Lauren Allen³, Michael J. Lanspa^{1,2}, Lindsay M. Leither^{1,2}, Samuel M. Brown^{1,2}, Rajendu Srivastava^{3,4}, and Colin K. Grissom^{1,2}

¹Division of Pulmonary & Critical Care Medicine, Department of Medicine, Intermountain Medical Center, Murray, Utah; ²Division of Pulmonary & Critical Care Medicine, Department of Internal Medicine and ⁴Department of Pediatrics, University of Utah School of Medicine, Salt Lake City, Utah; and ³Healthcare Delivery Institute, Intermountain Healthcare, Salt Lake City, Utah

ORCID IDs: 0000-0003-1730-234X (I.D.P.); 0000-0002-3406-0410 (J.R.J.); 0000-0003-0968-4755 (M.J.L.); 0000-0003-1206-6261 (S.M.B.).

Abstract

Rationale: Lung-protective ventilation (LPV) improves outcomes for patients with acute respiratory distress syndrome (ARDS), but adherence remains inadequate.

Objectives: To measure the process and clinical impacts of implementation of a science-based intervention to improve LPV adherence for patients with ARDS, in part by increased use of clinical decision support (CDS).

Methods: We conducted a type III hybrid implementation/effectiveness pilot trial enrolling adult patients with ARDS admitted to three hospitals before and after the launch of a multimodal implementation intervention to increase the use of mechanical ventilation CDS and improve LPV adherence. The primary outcome was patients' percentage of time adherent to low tidal volume (≤ 6.5 ml/kg predicted body weight) ventilation (LTVV). Secondary outcomes included adherence to prescribed oxygenation settings, the use of the CDS tool's independent oxygenation and ventilation components, ventilator-free days, and mortality. Analyses employed multivariable regression to compare adjusted pre- versus postintervention outcomes after the exclusion of a postintervention wash-in period. A sensitivity analysis measured process outcomes' level and trend change postintervention using segmented regression.

were similar pre- versus postintervention. The adjusted proportion of adherent time increased postintervention for LTVV (9.2%; 95% confidence interval [CI], 3.8–14.5%) and prescribed oxygenation settings (11.9%; 95% CI, 7.2–16.5%), as did the probability patients spent $\geq 90\%$ of ventilated time on LTVV (adjusted odds ratio [aOR] 2.58; 95% CI, 1.64–4.10) and use of ventilation CDS (aOR, 41.3%; 95% CI, 35.9–46.7%) and oxygenation CDS (aOR, 54.3%; 95% CI, 50.9–57.7%). Ventilator-free days (aOR, 1.15; 95% CI, 0.81–1.62) and 28-day mortality (aOR, 0.78; 95% CI, 0.50–1.20) did not change significantly after intervention. Segmented regression analysis supported a causal relationship between the intervention and improved CDS usage but suggested trends before intervention rather than the studied intervention could explain increased LPV adherence after the intervention.

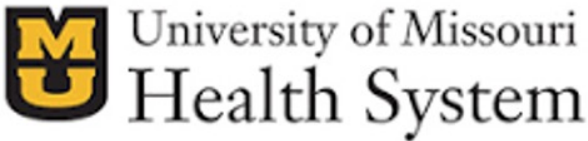
Conclusions: In this pilot trial, a multimodal implementation intervention was associated with increased use of ventilator management CDS for patients with ARDS but was not associated with differences in clinical outcomes and may not have independently caused the observed postintervention improvements in LPV adherence.

Clinical trial registered with www.clinicaltrials.gov (NCT 03984175).

How is this intended to work?



ATP Participants Since 2024



ATP: Why, When & How

Benefits of Participation

- Emphasis on leadership, people skills and rigorous technical skills involved in clinical quality improvement
- Proven QI framework for advancing high-priority projects and initiatives
- Opportunity to lead, implement & evaluate QI strategies
- Opportunity to build relationships with other committed professionals

Cohort 1 (Hybrid)

2027 Calendar - ATP

JANUARY

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

FEBRUARY

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

MARCH

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

APRIL

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

**Register
Now!**



For more information, contact natalie.soria@imail.org

The Quadruple Aim in Healthcare

1.

Improving Patient Experience

Quality
Safety
Patient satisfaction

2.

Improving Population Health

Preventive Health
SDOH

3.

Reducing Per Capita Costs

Efficiency
Reduced readmissions
Value-based care

4.

Improving Provider Experience

wellbeing
Joy in work
Mental health

Thank You!

Sheralee Petersen, MBA, PA-C
Assistant Vice President
Clinical Programs
Sheralee.Petersen@imail.org



THANK YOU!

We value your feedback!

CE Credits for CPHQ are only
available after evaluation
completion

Complete Your Evaluation Here!



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