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8th Annual

Care Coordination Summit

May 9–11, 2016
Hilton Baltimore, MD

Methods and Models Leading the Way

Improve outcomes … manage resources … demonstrate quality

Learn new models of care and innovative processes transforming the healthcare system, and leading to improved outcomes and appropriate use of healthcare resources.

The 8th Annual Care Coordination Summit brings the interdisciplinary team together for a dynamic event that delivers updates on delivery system reform, new payment models, predictive modeling, transitions of care, successes from ACOs/Integrated Networks, and more. You will hear how the country's top leaders are implementing programs and gaining insights that are transforming the delivery and sustainability of healthcare. Join us and learn:

- Best practices for multidisciplinary interventions and predictive modeling
- Risk sharing models, bundled payments — how to create success and achieve value
- How to decrease inpatient re-admissions and length of stay
- Driving effective care coordination using a quality performance dashboard
- Health Information Exchanges: the design and the implementation from the state of Maryland
- Best practices for integrating care across facility and community locations
- How to redesign your onboarding process to improve utilization and satisfaction

CONTACT HOURS

Earn 18.0 Contact Hours when you attend both days!

10.0 contact hours for the **Care Coordination Summit**

+

8.0 contact hours for the **Care Coordination Achievement Program** or **Certificate in Hospital Patient Advocacy Workshop**

PRESENTED BY:

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Register at carecoordinationsummit.com or call toll-free 1-855-CALL-DH1 today!

TRAVEL

Hilton Baltimore on the Inner Harbor

401 W Pratt Street
Baltimore, MD 21201

Reservations: 1-443-573-8700

Rate: $199 per night

Call the hotel directly for reservations toll-free at **1-443-573-8700**; mention that you are coming to the **Care Coordination Summit** to qualify for the **special $199/night discounted room rate.** Note: Only a limited block of rooms have been reserved at this rate. To receive the discount **you must confirm your reservation by April 8, 2016** or before the block is full. Thereafter, reservations will be taken on a space- and rate-available basis only.

Airline discount

United Airlines is offering conference attendees a special discounted rate. Take advantage of savings up to 5% off published domestic fares! Visit the "Travel" tab on carecoordinationsummit.com for details.

Rental car discount

Avis Car Rental is offering conference attendees discounted rates. To take advantage of these rates, please call 1-800-331-1600 and mention AWD #T706699 to receive the discount.

AGENDA

Pre-conference Workshops

Monday, May 9, 2016

8:00 AM – 5:00 PM

Care Coordination Achievement Program: Skills and Competencies for Today's Healthcare Leader

The Care Coordination Achievement Program is a learning platform for healthcare professionals and organizations as they seek to understand the requirements of care coordination in achieving success. You'll learn the latest intelligence about care coordination, the components that define the workforce, and how to ensure all professionals recognize their responsibility and work together to coordinate care across the continuum.

- Professional Competencies for the Healthcare Workforce
- Models of Care: New Opportunities for High-Quality Delivery
- Communication Advances Enabling Care Coordination
- Technology and Its Role in Care Coordination
- Barriers to Care Coordination
- The Consumer's Role in Care Coordination
- Transition of Care
- Ethics of Healthcare
- Behavioral Health: Where It Fits In

8:00 AM – 5:00 PM

Certificate in Hospital Patient Advocacy Workshop

This workshop is a comprehensive education program designed to enhance training for all involved in the highly specialized field of hospital patient advocacy. The workshop focuses on the core concepts of hospital patient advocacy, and best practices for improving the patient and family experience. Attend this workshop and learn how to help patients and their families have a safe and empowered inpatient stay.

- Current healthcare trends
- Communication skills
- Patient illness narratives
- Healthcare law
- A unified process model
- Complaint/grievance resolution and emergency management
- Issues in the healthcare delivery system
- Medical ethics and death, dying and bereavement
- Case studies

8:00 AM – 8:15 AM
Welcome

8:15 AM – 9:15 AM
OPENING KEYNOTE

Delivery System Reform: Where Are We Now, Where Are We Headed?

Jean Moody Williams, *RN, MPP, Deputy Director, CMS Center for Clinical Standards and Quality*

Join us for this critical update from the CMS to get an understanding of where the U. S. healthcare delivery system is now that quality metrics and financial reforms have been put into place. Ms. Williams will share what has been learned to date, the current gaps that still exist, and what we can we expect in the future. At this keynote presentation you will learn:

- Current CMS initiatives driving Health System Reform
- Implications for care coordination
- Where the gaps are in quality initiatives and the next steps

9:30 AM - 10:30 AM
BREAKOUT SESSIONS

Track 1 | Secrets for Creating a Highly Effective Care Coordination Team

Cathy Bryan, *MHA, BSN, RN, Director of Care Coordination, Utah Southwestern ACO*

ACOs are awash in data, but all too often we underuse data to inform and direct our care coordination activities. UT Southwestern Accountable Care Network has succeeded in using both administrative and clinical data, in combination, to provide direction for where we need to focus our efforts to support providers in a variety of settings to achieve the overarching goals of the ACO – decrease unnecessary spending while increasing the quality and consistency of care. Discover the 5 key initiatives implemented that have been instrumental in driving success as a Care Coordination department. You will learn:

- Innovative ways to use claims and clinical data to guide Care Coordination activities and impact ACO objectives and goals
- How to increase provider engagement through value based offerings
- Factors to consider in determining and deploying innovative staff models

Track 2 | Driving Effective Care Coordination Using a Quality Performance Dashboard

Amanda Nenaber, *DNP, APRN, CCNS, ACNS-BC, Heart Failure Program Manager, Cardiac & Vascular Center, University of Colorado Hospital*

Chronic disease management (CDM) teams are vital to move healthcare delivery forward to improve health and healthcare for patients. Discover the impact of a collaborative multidisciplinary CDM team in driving improved performance of heart failure specific Joint Commission quality measures. This session will demonstrate how the CDM team aligned with organizational goals and strategically implemented quality improvement strategies using a systemic approach with findings well above national benchmarks. You will learn:

- The impact of a chronic disease management team in driving quality performance
- Effective methods for presenting and disseminating data to a multidisciplinary team
- How to use quality measures to motivate, engage, and focus the team on continued performance improvement

10:30 AM – 11:00 AM
Morning Break

11:00 AM - 12:00 PM
BREAKOUT SESSIONS

Track 1 | Get Your Seat at the Table: Aligning with ACOs to Optimize Patient Care, Improve Outcomes and Satisfaction Scores

Hilary Forman, *PT, RAC-CT, Senior Vice President, Clinical Strategies, Rehabilitation;* ***Marie Rosenthal,*** *RN, MSN, LNHA, Administrator, Jewish Home LifeCare – Manhattan Division*

In light of healthcare reform, communities across the continuum of care must fortify their chance of securing a seat at the table when it comes to ACO/partnership networking. Learn specifics of how to implement key initiatives to enhance patient outcomes and improve patient/family satisfaction scores. In turn, these positive results must be leveraged within the community of referral sources and potential network partners. Learn how to:

- Establish clinical niche opportunities as a strategy to effectively optimize patient care/satisfaction and align with ACO network partnerships
- Create systems to track, manage and leverage outcomes data to measure success, encourage referrals and strengthen upstream and downstream provider relationships
- Put processes in place to manage parameters that impact financial success/sustainability

Track 2 | Redesigning the Onboarding Process to Improve Utilization and Satisfaction among D-SNP Enrollees

From University of Arizona Health Plans with Banner Health: ***Thomas Ball,*** *MD, MPH, Medical Director of Population Health and* ***Susan Wortman,*** *RN, BS, Director of Medical Management*

Successful population health management requires close alignment between multiple components of a healthcare system. For example, population-based care management interventions must be timely, well-targeted, and effective in order to demonstrate efficacy and generate a positive return. The University of Arizona

Health Plans initiated a multipronged process improvement intervention that included a reengineered on-boarding process for new enrollees that increased the speed of outreach and initiation of care management interventions. Learn:

- How to describe the critical linkage between clinical analytics and interventions to meet population health goals
- How to clarify the disparate, but complementary, uses of the health risk assessment tools in both population health management and personalized care management
- The value of behavioral health integration into medical case management to effectively manage high risk populations

12:00 PM – 2:00 PM

Lunch in the Exhibit Hall

2:00 PM - 3:30 PM

BREAKOUT SESSIONS

Track 1 | Using Multidisciplinary Interventions and Predictive Modeling for Clinically Challenged and Medicaid Populations

Expert Panel

This session brings together experts from various settings who will examine and explore the problems and treatments across high costs and high intervention patient needs. A panel of experts will discuss best practice in managing patients with HIV/AIDS and Sickle Cell disease. You'll learn key program components that demonstrate how multidisciplinary interventions reduce hospitalizations, lengths of stay and overall costs of treatment will improve health status. You will learn:

- Use of predictive modeling in order to target interventions
- Methods to increase member adherence to established treatment plan
- The clinical complexity of sickle cell disease, its treatment and secondary complications
- Policies and practices to improve the health status of members with HIV/AIDS

Track 2 | Decrease Inpatient Readmissions and Length of Stay through Combined Care Coordination

Expert Panel

This panel session will address the challenges of inpatient lengths of stay and readmissions rates from the perspective of payers, facilities and community programs. These experts will cite successful programs in both mental health facilities and acute care settings. In addition, you will hear from an outpatient care team that will discuss the challenges faced when there is a need to help patients in the community find appropriate medical and specialty services. Find out the impact of the implementation of a continuum of care process and learn how to:

- Increase communication between the physician, the social worker and the discharge director
- Decrease inpatient readmissions and length of stay
- Evaluate for success and opportunity

3:30 PM - 4:30 PM

BREAKOUT SESSIONS

Track 1 | Institute of Medicine Core Competencies for Health Professionals: Foundation for Care Coordination in Practice

Lorraine Bormann, *PhD, RN, MHA, CPHQ, FACHE, Assistant Professor, Western Kentucky University School of Nursing*

A strategy for successful care coordination includes an understanding and implementation of the core competencies for all healthcare professionals as described by the Institute of Medicine to include: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, and informatics. The Quality and Safety Education in Nursing (QSEN) model added the safety competency, which emphasizes competence to protect patient safety, defines the most current trends in nursing practice, and employs an integrative paradigm in defining "nursing practice." You will learn:

- Methods to use for staff education when care coordination is expected and required
- Resources for teaching QSEN in the practice setting
- Improved care coordination by assimilating the information, gaining a deeper level of understanding, and increasing motivation for learning

Track 2 | In Pursuit of Value: Maximizing Bundled Payments to Achieve the Triple Aim

From Dignity Health: ***Regina Mudd,*** *RN, BSN, ONC, System Director, BPCI Operations and* ***Barbara Harding,*** *RN, MPA, PAHM, CCM, Senior Director, Post-Acute Care*

Learn about key strategies implemented when re-engineering a model of care utilizing bundled payments as the key impetus of change. Despite the challenges of a diverse population, difficulties with data extraction from varied sources, and skeptical providers, the participant will come away with a better understanding of the resources, tools and technology needed for success. This session will:

- Describe key components of a high-value care delivery model: Bundled Payment Care Improvement (BPCI) program
- Identify opportunities for improved care utilizing care coordination and case management in partnership with the provider and patient for the provision of patient centered quality care
- Define key data elements and methodology for evaluation that contribute to sustainability of the model

4:30 PM – 6:30 PM

Networking Reception in Exhibit Hall

8:00 AM - 9:00 AM

GENERAL SESSION

The Positive Impact of Patient Centered Medical Homes from the Grass Roots to the Big Picture

Jennifer Baldwin, *RN, MPA, CareFirst, Inc., Patient-Centered Medical Home (PCMH)*

As care coordination has grown from a vague concept in the provider setting to clarity and success in the PCMH world, Ms. Baldwin will address the critical skills needed for effective and meaningful care coordination. What is the impact of quality care coordination for employers, the community and the patient? Find out what metrics were used and the results of the CareFirst PCMH program. You will learn:

- Components of building successful PCMH programs
- Key economic impact of PCMH
- Skills needed for care coordination in the PCMH environment

9:15 AM - 10:15 AM

BREAKOUT SESSIONS

Track 1 | State of Patient Engagement: Advocacy, Empowerment and Policy

From The MITRE Corporation: ***Kristina Sheridan,*** *MS, Department Head, Enterprise Transition Planning and Execution and* ***Keara McKenna,*** *International Strategy Analyst*

There remains a gap in patient-facing capabilities to support patients and caregivers in their daily care between appointments and to enable patients to bring their voice into the clinical setting. This session will describe how mobile health has advanced patient engagement and how it can progress further. Learn how strategy, policy, regulation, law and implementation impact patient engagement and how it can be enhanced to increase levels of patient engagement beyond the clinical setting. You will:

- Learn the current state, implementation challenges and opportunities to enhance active patient engagement through mobile health
- Infuse patient engagement concepts into strategy, policy, regulation, law and implementation
- Understand how patient engagement is currently used in policy and which areas need improvement

Track 2 | Palliative Care Coordination: Appropriate Patient Identification and Community Partnerships

From Napa Valley Hospice: ***Carol Williams,*** *RN, MS, Director of Outreach & Access and* ***Angela Fontana,*** *RN, BSN, CHPN;* ***Kathryn B. Troupe,*** *DNP, RN, ANP-BC, CHRN, Coordinator of Heart Failure Program and Nurse Practitioner in Care Transitions Team, Frederick Memorial Hospital*

The World Health Organization describes palliative care as complex care focused on improving quality of life through the prevention and relief of suffering. Integration of palliative care screening criteria into the admission assessment of the electronic health record performed by case managers facilitates a recommendation to the provider for palliative care referral. Learn about the components of a pilot community based palliative care program including eligibility, data collection, and payment model. This session will highlight the community collaboration and relationship essential to its deployment and success. You will learn to:

- Differentiate between palliative and hospice care and identify components of outpatient palliative care programs
- Identify the unique role of case managers in assessing palliative care needs in end stage patients
- Describe the impact of care coordination on palliative care strategies in population health and explore opportunities for care coordination in a community based program

10:15 AM – 10:45 AM

Morning Break

10:45 AM - 12:00 PM

BREAKOUT SESSIONS

Track 1 | The Impact of Care Coordination in Maternal/Child Programs in Multiple Settings

Expert Panel

Health Plans are continuously challenged in providing care coordination services for children and pregnant members in care delivery, coordination, schools, high cost admissions, and length of stay. Outreach and coordination with obstetric providers has had a significant impact with an addiction in pregnancy program. Children with complex conditions often require a multifaceted approach to care with significant family support, primary care provider engagement, the school community and a multi-coordinated specialized care plan. In this panel, several models of care coordination will be presented by both payers and care providers. You will learn:

- Differentiators to factor into program design and strategy when working with complex pediatric population
- Methods to develop member-centric self-management/monitoring plan unique to the physical, behavioral and social needs of the complex child
- Programs that reduce ER utilization and Inpatient stays including reductions in intensive neo-natal care days

Track 2 | Integrating Care Across Facility and Community Locations: Improving Quality of Care and Quality of Life

Novella Tascoe, *JD, Executive Director, Keswick Multi-Care Center;* ***Andrey Ostrovsky,*** *MD, CEO, Care at Hand*

Keswick Multi-Care Center has invested in a unique delivery model to provide transition of care across all levels from hospital to community, while assuring patient safety and patient choice. The project is a 2015 quality improvement initiative involving

patients receiving care after being discharged from a hospital to a SNF then to their homes under the Maryland capitated reimbursement system. This presentation will cover qualitative and quantitative results demonstrating the improvements achieved by the project interventions. Attendees will learn:

- How integrating care across facility and community locations improves quality of care and quality of life
- The technology enhancements used to support patients during transitions
- Descriptive and quantitative measures captured in this program such as participants by diagnosis, types of active issues, early disease identification, better outcome, and results achieved

12:00 PM – 1:30 PM

Lunch in the Exhibit Hall

1:30 PM - 3:00 PM

GENERAL SESSION

Health Information Exchanges: the Design and the Implementation

Expert Panel

Hear from an expert panel that will provide unique insight into the Chesapeake Regional Information System for our Patients (CRISP), Maryland's state-designated health information exchange from a variety of perspectives, which was created to promote information sharing among providers across many settings to improve care coordination. After successfully connecting with hospitals and inpatient care providers, CRISP saw the need to diversify its network by extending connectivity to ambulatory care providers in physician practices, skilled nursing facilities and other care settings. Learn how CRISP data, tools and services improved care coordination in Maryland. You will:

- Gain insight into the CRISP Integrated Care Network and the impact of a functional HIE
- Hear a working example of how HIEs can be involved in care coordination and learn ACO practice and provider scorecards
- Discuss methods to leverage the Integrated Care Network to continue to improve care coordination and health outcomes

3:00 PM - 4:00 PM

BREAKOUT SESSIONS

Track 1 | Telehealth Solutions to Promote Patient Health and Facilitate Care Coordination

Stewart Levy, *R.Ph, Health Promotions Solutions*

Learn the value of using telemedicine to diagnose, manage and treat patients while keeping the care team informed. See how telemedicine technologies, including high-resolution video conferencing integrated with medical instruments and cloud-based EHR systems can be used to create a medical record. Understand the process of medical diagnosis, physician referrals and counseling via telepresence communications. You'll also hear case studies on managing care among high risk patients using telehealth. You will:

- Understand the difference between telehealth, telemedicine, and telepresence and how each can be used to promote health and wellness through a variety of devices
- Learn about successful case studies of telemedicine and the opportunities for telehealth to improve healthcare access and health outcomes
- Learn how telepresence technology can be used to integrate care among the medical staff

Track 2 | Primary Care Physicians and a Community Organization Create a Personalized Care Management Model: Healthier Life Rx

From Central Florida YMCA: ***Beth Boyer Kollas,*** *MS, MDiv, PhD, CAAP, CPCP, Executive Director and* ***Kelly Prather,*** *MHSE*

Built on true collaboration with physicians, Healthier Life Rx connects physicians and their patients to a personalized lifestyle manager and to appropriate health and prevention programs in the community. This unique delivery model of care coordination in a lower cost community-based setting achieves the desired outcomes envisioned by the referring physician and demonstrates an improved patient and physician experience. Ultimately, Healthier Life Rx is positioned to improve the overall health of these populations which should subsequently reduce the per capita cost of their care. You will learn:

- Differences between health coaching, care coordination and lifestyle management and the roles they play in healthcare
- How behavioral modification in lifestyle management and can be used to meet health goals
- Opportunities for community based programs to become a part of the patient-centered medical neighborhood

4:00 P.M.

Conference Adjourns

REGISTRATION

REGISTER BY MARCH 11 & SAVE UP TO **$595** per person!

☑ *YES!* Sign me up for the 8th Annual Care Coordination Summit!

CHOOSE YOUR PROGRAM	EARLY BIRD RATE* (Through March 11, 2016)	REGULAR RATE
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**Early registration price expires on March 11, 2016. Not to be combined with any other discount or offer.*

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Cancellations must be received in writing no later than 14 days prior to the event. If you cancel within 14 days of the conference or after materials have been distributed your registration will not be refunded. Registrants who do not cancel and do not attend are liable for the full registration fee. Transfers/substitutions of conference attendees are permitted at any time. However, for administrative purposes, please notify the conference registrar at 1-855-CALL-DH1 as soon as changes are made. Email customer@decisionhealth.com for cancellations. Phone cancellations are not accepted.

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