CASE MANAGEMENT AND TRANSITIONS OF CARE CONFERENCE

American Case Management Association
casemanagementconference.com | #ACMANational
APRIL 24-27

casemanagementconference.com | #ACMANational
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IMPORTANT DATES
Early Registration: February 8
Hotel Discount: March 30
Late Registration Begins: March 26
Pre-Conference: April 24
Main Conference: April 25-26
Post-Conference (ACM™ Certification Review): April 27

EXHIBITS
Tuesday 4:00 pm – 7:00 pm
Wednesday 12:00 pm – 2:00 pm
5:30 pm – 7:00 pm
Thursday 11:45 am – 1:45 pm

GET SOCIAL!
Stay informed and connect with other attendees by using #ACMAational on social media.

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Everything is bigger in Texas—and the 2018 ACMA National Conference in Houston will be no exception! Join more than 2,000 of your peers in case management and transitions of care, April 24–27, at the George R. Brown Convention Center for high-quality education, networking and an investment in your future.

In addition to the conference, Houston has a lot to offer. Experience the Houston Space Center, arts, hotels, shopping and nightlife. When the conference day is over, grab a bite from one of Houston’s many award-winning restaurants.

As an ACMA member, be sure to log into your member profile to take advantage of the member discount program! While you’re in Houston, you’ll have access to a number of discounts and savings, including City Pass, spas, and a variety of local restaurants.

Make the most of your time in Houston – check out the top 10 reasons to attend the conference on page 18!

Venue & Travel

CONFERENCE CENTER
George R. Brown Convention Center
1001 Avenida De Las Americas | Houston, TX 77010

HOTEL ACCOMMODATIONS
Marriott Marquis Houston
1777 Walker Street | Houston, TX 77010
Special ACMA Conference Rate – $259/night. Discounted group rate is applicable during April 23–26 until all guest rooms in the room block have been reserved or until March 30 (hotel reservation deadline) – whichever comes first. To make your reservation, call Marriott reservations at 800-228-9290 and reference the American Case Management Association group rate to receive the discount.

Important Booking Information
ACMA does not utilize a housing service nor employ travel agencies and/or other discount travel related organizations. If you are contacted by any company claiming to represent ACMA and/or our conference, please ask for the company name and phone number and report the incident immediately to ACMA by calling (501) 907-2262. Be aware that these companies are often running scams that are designed to obtain your personal details and credit card information. We recommend that you do not give these companies your credit card number, personal information, and/or any details about your hotel reservation.
KEYNOTE ADDRESS

The Future of Health and Medicine: Where Can Technology Take Us?

Daniel Kraft, MD

Dr. Daniel Kraft, a Stanford and Harvard trained physician-scientist, inventor and entrepreneur, will share his clinical and biomedical perspective on technology and its future impact on health care. Daniel is the founder of IntelliMedicine focused on enabling connected, data-driven and integrated personalized health and medicine and was recognized as one of the top 50 individuals and organizations for making exceptional progress in driving resources, attention and innovation toward a better health care system.

Given the demands placed on Case Management and Transitions of Care professionals practicing in various settings—who receive information from multiple sources and influence the care delivery for optimal outcomes—technology is a requisite partner. Daniel will examine the rapidly emerging, game changing and convergent technology trends, and how they are and will be leveraged to change the face of health care and the practice of medicine in the next decade.

GENERAL SESSION

Overcoming Injury: Lessons in Motivation from an Olympic Gold Medalist

Amy Van Dyken-Rouen

Amy Van Dyken-Rouen is a six-time Olympic Gold Medalist.

The prolific U.S. swimmer competed in the 1996 and 2000 Summer Games, and is the first American woman to earn four gold medals in a single Olympics. In 2014, Amy was paralyzed from the waist down in an ATV accident. She works every day to push the physical boundaries of her “new normal,” and encourages others to push through obstacles in their own lives to achieve their goals. Amy’s positive attitude and determination is motivational and her strategies for personal growth and happiness are inspirational.

EDUCATIONAL UNDERWRITER:
Angel MedFlight
WORLDWIDE AIR AMBULANCE

CLOSING SESSION

Collaboration: The Art of a Common Cause

Eric Whitacre

Grammy-winning composer and conductor Eric Whitacre will discuss his success in bringing together a user-generated choir with singers from around the world. With their common love of music, they overcame technological, personal and access barriers to achieve a synchronized Virtual Choir. From the first choir of 185 singers to more than 8,400 contributors from 101 countries to his most recent Virtual Choir 4, Eric will share his story of believing in something that had not been done and using the spirit of collaboration around a common cause—the love of music—to achieve it.

Eric is a Juilliard School of Music graduate and has spoken for Apple, Google, the United Nations and is a repeat TED speaker. More than a message, Eric will close our conference with a performance!
### Pre-Conference
**Tuesday, April 24**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>7:00 am</td>
<td>Adult Acute Care Pre-Conference Event (additional fee required; includes Pre-Conference Afternoon Sessions)</td>
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<tr>
<td>7:00 am</td>
<td>Pediatrics Pre-Conference Event (additional fee required; includes Pre-Conference Afternoon Sessions)</td>
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<tr>
<td>1:00 pm</td>
<td>Pre-Conference General Session</td>
</tr>
<tr>
<td>2:10 pm</td>
<td>Pre-Conference Breakout Sessions – 1</td>
</tr>
<tr>
<td>3:20 pm</td>
<td>Pre-Conference Breakout Sessions – 2</td>
</tr>
<tr>
<td>4:00 pm</td>
<td>Welcome Reception</td>
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<tr>
<td>6:30 pm</td>
<td>ACM™ VIP Reception</td>
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<tr>
<td>6:30 pm</td>
<td>ACM™ VIP Reception (By Invitation Only)</td>
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### Main Conference: Day 1
**Wednesday, April 25**

<table>
<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>8:00 am</td>
<td>Welcome &amp; Keynote Address: Daniel Kraft, MD</td>
</tr>
<tr>
<td>9:45 am</td>
<td>BREAKOUT SESSIONS – A</td>
</tr>
<tr>
<td>11:00 am</td>
<td>BREAKOUT SESSIONS – B</td>
</tr>
<tr>
<td>12:00 pm</td>
<td>Lunch &amp; Exhibition/ Win the Wheels</td>
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<tr>
<td>1:00 pm</td>
<td>Rapid-Cycle Learning Poster Review</td>
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<tr>
<td>2:00 pm</td>
<td>BREAKOUT SESSIONS – C</td>
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<tr>
<td>3:15 pm</td>
<td>BREAKOUT SESSIONS – D</td>
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<tr>
<td>4:30 pm</td>
<td>BREAKOUT SESSIONS – E</td>
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<tr>
<td>5:30 pm</td>
<td>Networking Reception</td>
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<tr>
<td>7:30 pm</td>
<td>SUNSET SESSION: Heath Care Documentary Film &amp; Discussion</td>
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### Main Conference: Day 2
**Thursday, April 26**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>6:45 am</td>
<td>SUNRISE BREAKOUT SESSIONS</td>
</tr>
<tr>
<td>8:00 am</td>
<td>ACMA Annual Meeting (ACMA Member-Only Event)</td>
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<tr>
<td>9:30 am</td>
<td>General Session: Amy Van Dyken-Rouen</td>
</tr>
<tr>
<td>10:45 am</td>
<td>BREAKOUT SESSIONS – F (Platinum Sponsor Educational Presentations)</td>
</tr>
<tr>
<td>11:45 am</td>
<td>Lunch, Exhibition &amp; Win the Wheels Car Giveaway (must be present to win)</td>
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<tr>
<td>11:45 am</td>
<td>Poster Presentations</td>
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<tr>
<td>2:00 pm</td>
<td>General Session: Public Policy</td>
</tr>
<tr>
<td>3:15 pm</td>
<td>BREAKOUT SESSIONS – G</td>
</tr>
<tr>
<td>4:30 pm</td>
<td>Closing General Session: Eric Whitacre</td>
</tr>
<tr>
<td>6:00 pm</td>
<td>Closing Party</td>
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### Post-Conference
**Friday, April 27**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>8:00 am</td>
<td>ACM™ Certification Review</td>
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PRE-CONFERENCE

NEW THIS YEAR! On-Site Hospital Pre-Conference Options
Adult or Pediatric Hospital Live Tours & Education Followed by Afternoon Breakout Sessions
Take advantage of this year’s conference location by starting your 2018 ACMA National Conference with one of two options within a comprehensive Pre-Conference educational experience.
Select either: Adult Acute Care Experience at Memorial Hermann and Texas Institute for Rehabilitation & Research (TIRR) or Pediatric Care Experience at Texas Children’s and Shriners Hospital for Children

Comprehensive Pre-Conference Experience
Part 1: On-site Hospital Live Tour and Educational Sessions
Adult Acute On-Site Experience: Limited to 120 Participants
• During this setting-based learning experience, attendees will be transported to Memorial Hermann, Texas Medical Center (TMC)—the largest medical complex in the world—and will also visit TIRR
• This unique Adult Acute Care interactive learning experience includes: Memorial Hermann—TMC, Red Duke Trauma Institute, Helipad, Command Central & Transport Center & TIRR (Acute Rehab)

Pediatric On-Site Experience: Limited to 90 Participants
• During this setting-based learning experience, attendees will be transported to Texas Children’s and Shriners Hospital for Children
• This unique Pediatric Care tour/education experience includes: Texas Children’s and Shriner’s Hospital facility tours, rehabilitation services, care coordination, intake, nerve center and throughput hub

Comprehensive Pre-Conference Experience
Schedule of Events (Part 1 & 2)
All participants of the Pediatric and Adult Acute Care experiences are automatically registered for the General and Breakout Sessions. If desired, attendees can register only for Afternoon General and Breakout Sessions (Part 2)

Part 1 – On-site Experience
6:00 am – 7:00 am Registration, Grab-and-Go Breakfast
7:00 am – 7:45 am Motor Coaches Depart for Hospital Sites
7:45 am – 9:25 am Site Visit and Educational Sessions (Adult or Pediatric Sites)
9:25 am – 9:45 am Motor Coaches Depart to Second Location
9:45 am – 11:25 am Site Visit and Educational Sessions (Adult or Pediatric Sites)
11:25 am – 11:45 am Motor Coaches Return to National Conference Site
11:45 am – 12:45 pm Networking Lunch

Part 2: Breakout Sessions at National Conference Site
1:00 pm – 2:00 pm General Session: Disaster Planning and Recovery: Lessons Learned
2:10 pm – 3:10 pm Pre-Conference Breakout Sessions – 1 (Select one)
Caring for Underserved Populations
Cancer Rehabilitation: An Essential Component for Cancer Survivorship

3:20 pm – 4:20 pm Pre-Conference Breakout Sessions – 2 (Select one)
Interdisciplinary Patient Care Rounds
Pediatric Care Coordination Across the Continuum

For complete information about the Pre-Conference program, including session abstract, speaker information and registration, visit casemanagementconference.com.
**Welcome Reception: Kick Things Off!**

No other organization offers access to more Case Management, Transitions of Care and Physician Advisor professionals in one location. During the Welcome Reception, more than 2,000 case management and transitions of care professionals will come together to network with others in the field, learn from a host of knowledgeable speakers and plan their time in Houston.

**NEW THIS YEAR! Poster Presentations Interactive Rapid-Cycle Learning Session & Poster Review**

During rapid-cycle learning sessions attendees will select from 40+ interactive presentations showcasing innovative ideas, best practices and advancements in health care to apply within their work settings and improve practices.

**ACM™ VIP Reception**

Attention ACM™ candidates and credentialed professionals—here’s your exclusive invitation to the ACM™ VIP Party! To honor and celebrate Accredited Case Manager achievement and the future success of certification candidates, ACMA is hosting a by-invitation-only reception at the House of Blues, Tuesday, April 24, 6:30 pm – 9:00 pm Located within walking distance of the convention center, this exclusive event will be a celebration of prestigious achievement for current ACM™ credentialed professionals, as well as recognition for those candidates currently signed up to sit for the exam. Held in conjunction every year with ACMA’s National Conference, the ACM™ VIP party is a must-attend event you won’t want to miss!

**Win the Wheels**

Win The Wheels has become one of the most highly anticipated events at the ACMA National Conference drawing huge crowds and roaring excitement. At last year’s conference in Washington, D.C., our winner left with the keys to a brand new 2017 Mazda Miata! For the eighth year in a row, one attendee will again leave with a brand new car! Visit casemanagementconference.com for official rules.
CONTINUING EDUCATION

You will have the opportunity to earn up to the following number of CEs:

<table>
<thead>
<tr>
<th>Day</th>
<th>Event</th>
<th>RN CEs 50-min</th>
<th>RN CEs 60-min</th>
<th>SW CEs 60-min</th>
<th>ACM™ CEs 60-min</th>
<th>CME 60-min</th>
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<tr>
<td>Wednesday, April 25</td>
<td>Main Conference</td>
<td>10.2</td>
<td>8.5</td>
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<tr>
<td>Thursday, April 26</td>
<td>Main Conference</td>
<td>7.2</td>
<td>6.0</td>
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<tr>
<td>Friday, April 27</td>
<td>ACM™ Certification Review</td>
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<td>5.0</td>
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Maximum Available CEs: 30.6 25.5 25.5 25.5 25.5

For complete information about approving organizations, visit casemanagementconference.com.

NEW THIS YEAR!

Texas Medical Center Onsite Education — Page 6
Interactive Rapid Cycle Learning Session & Poster Review — Page 7
Educational Movie Night! Documentary & Discussion — Page 14

You Asked — We Listened

Last year’s attendees and our planning committee picked topics and speakers with the following content in mind:

- CMS Regulatory Requirements
- Denial Management
- Population Health
- Reducing Length of Stay
- Managing Readmissions
- Discharge Planning
- Community Programs
- Palliative Care
- Pediatrics
- Ambulatory Care
- Collaboration/Communication
- Primary Care
- Current Issues and Key Challenges Case Managers Will Face in 2018

Legend

Look for these icons throughout this brochure to gain insight into session topics and subject matter to be addressed by session speakers.

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1A | **Patient Centered Medical Home: A Strategy to Reduce ED Utilization**

Overuse of emergency department visits in the United States is responsible for $38 billion in wasteful spending annually. This presentation will review patterns of emergency room utilization, the design of the care management model in the Patient Centered Medical Home, and the action plan used by the care managers to successfully reduce ED visits.

2A | **Physician Advisors: Change Agents to Transform Hospital Performance**

Physician advisors historically served on the Utilization Review Committee for medical necessity determinations and denials management. Expanding the role of the physician advisor to optimize observation utilization and drive unit-based multidisciplinary rounds not only impacts patient throughput but also staff engagement. Physician advisors are able to serve as stewards of organizational quality and patient safety initiatives at the hospital unit level.

3A | **Lost and Found: EC Navigation**

Trends indicate that emergency departments (EDs) are over utilized for non-emergent care. According to the Becker’s Hospital Review 2016 data, 136.3 million emergency department visits occur annually, and 71% of ED visits are unnecessary and avoidable. The Patient Navigation Program serves to connect the under insured with more appropriate outpatient resources. In this session, you will learn how the EC Navigation program deters this high-risk population from inappropriate utilization of emergency department services.

4A | **Substance Abuse PICC Program: Collaborative Solution for a Complex Population**

Patients with a history of substance abuse and IV drug use often have severe infections requiring long term IV antibiotic treatment. As a result, this complex patient population presents discharge coordination challenges as well as high treatment costs and readmission rates. This session focuses on positive outcomes and decreased readmission rates achieved by one organization through their collaborative approach of partnering with a drug treatment facility where patients concurrently receive IV therapy and substance abuse counseling and treatment.

5A | **The Homeless: Bridge to Safety Net**

This session reviews the collaborative approach taken by one organization to reduce the 30 day readmission rate for the homeless population in their community. The program, Bridge to Safety Net, utilizes a collaborative between the acute hospital setting, a street medicine program for the homeless, and a primary care office to reduce the health care costs of the chronically homeless by improving population health and the patient experience which ultimately reduce health care cost and readmission back into the acute care setting.

6A | **7 Day CM Revolution**

A major challenge facing today’s hospice operations is how to balance serving patient/families’ needs efficiently and effectively after “traditional” business hours with the physical and mental stress placed on the Clinical staff. The Clinical staff traditionally covers on-call support and after-hours dispatch. This session presents an innovative solution that provides both enhanced quality of care and significantly improves staff satisfaction in work/life balance and stress reduction.

7A | **Communication Matters-The Importance of Effective Transitions**

Effective transitions in Pediatric care occurs when health care professionals, patients, families and individuals responsible for providing care at home communicate properly. The handoffs between specialists and primary care physicians are critical and care management helps ensure success. It’s not just up to the physicians to treat the patient, care continues at home with the parent or guardian and their abilities need taken into consideration. Poor communication or limited ability by the parents and guardians can result in poor outcomes and higher readmissions. Parents and guardians need to be informed on what is and is not an emergency and where they should go for care.
<table>
<thead>
<tr>
<th>Session</th>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1B</td>
<td>A Complex Case Management Practice Model</td>
<td>Patients with extended stays or multiple readmissions generally have comorbidities, multiple providers, and complex psycho-social systems which often result in throughput and care transition challenges. This session will describe how one organization saved hospital days, avoided admissions and reduced ED visits by creating a Complex Case Management Practice (CCMP) model. Metrics, strategies and patient stories will be shared.</td>
</tr>
<tr>
<td>2B</td>
<td>Centralized Utilization Review: Improved Productivity &amp; System Outcomes</td>
<td>To reduce practice variation and improve outcomes, Utilization Management developed a plan to centralize and integrate functions within a large academic health system. Goals included standardizing language and methodology of review, collaboration with payers and promoting value-based care. Successful integration of 10 out of 14 facilities resulted in improved initial review timeliness, capture of inpatient-only procedures, as well as improved efficiency, productivity, and quality outcomes.</td>
</tr>
<tr>
<td>3B</td>
<td>Mobile Integrated Health Program: A Partnership to Reduce Readmissions</td>
<td>Mobile integrated health (MIH) programs bridge the gap that patients experience when transitioning from the hospital. This program offers services to patients provided by a community paramedic. This session will cover one hospital’s experience in implementing a MIH program. Goals of the program include improving care coordination and follow-up for patients, while aiming to decrease hospital readmissions. Outcome measures associated with this program will be discussed as well as elements for consideration when planning and implementing a MIH program.</td>
</tr>
<tr>
<td>4B</td>
<td>Understanding Social Determinants of Health and the Impact on Length of Stay</td>
<td>A case manager’s ability to understand the complex psychosocial factors impacting every patient’s unique health experience is critical, particularly with patients at risk of a long length of stay. These patients can become de-prioritized on the case manager’s caseload because of the perceived difficulty and multiple barriers to transitioning smoothly and efficiently back to the community. This presentation will review successful strategies utilized by one a large teaching hospital.</td>
</tr>
<tr>
<td>5B</td>
<td>Care Giver Support</td>
<td>Caregivers play a key role in creating effective patient-centric care plans for veterans. A major initiative has been underway within the Veteran’s Affairs to examine and implement strategies to best include and support veteran caregivers. During this session, resources, tips and tools will be shared that can be applied to meet patient’s needs and support caregivers.</td>
</tr>
<tr>
<td>6B</td>
<td>Models for Managing Adolescent Behavior Health Events</td>
<td>During this session, referral and assessment processes to coordinate adolescent behavioral health services will be reviewed. Presenters will describe care management options within various care settings for adolescent Medical and Psychiatric disorders. Strategies to enhance collaboration between Medical Case Managers and Psychiatry Services will be presented.</td>
</tr>
<tr>
<td>7B</td>
<td>Regional Collaboration to Provide Care in the Community</td>
<td>The advantage to supporting population health models is clear, and understanding what population health means to a health system, all working parts of the community and the patient’s continuum of care is key. This session will help case managers identify key stakeholders in the community and lay the ground work for developing a formal setting for collaboration. Forums for providers, vendors, community resources and supports provide opportunities to share best practices for providing care to the community, educating consumers and developing plans to combat epidemic issues.</td>
</tr>
<tr>
<td>8B</td>
<td>Creating Access with Virtual Social Workers</td>
<td>With the creation of an Ambulatory Care Management department, a gap was identified related to the social needs of the patient population. As a result, a Virtual Social Worker role was created to work with practices within the Medicare patient population. The role of the Virtual Social worker is to connect with patients who need assistance with navigating their health and social needs. During this session, tips and tools will be provided for attendees to apply in their settings.</td>
</tr>
</tbody>
</table>
1C | Cross-Sector Partnerships: Enhancing Community Based Care Management

This session will encourage attendees to think differently on how to provide community based case management services to complex patient populations through the development of cross-sector collaborations. Attendees will be guided through the details of successfully navigating the investigation, preparation and implementation phases. A real-world example will be highlighted, providing tangible experiences and reflection from a community organization currently engaged in such an agreement.

3C | Mental Health Integration in Primary Care Setting

Mental Health Integration (MHI) using a Team Based Care Model has been shown to be an effective model for sustainable population health management that focuses on doing the right thing for the patient. This session will provide information on how the model was applied in the primary care setting using Primary Care Providers, staff, care managers and mental health specialists to implement individualized strategies for patients and their families for improved health outcomes.

5C | Speed Learning – Back-to-Back 30-Minute Sessions

Part 1: IP versus OP: Managing Denials
Embark on a concise, but thorough journey to learn about a Children’s hospital’s rules of engagement with payers to win denial appeals.

Part 2: Status Tips and Job Aids to Get It Right from the Start
During Part 2, a Children’s teaching hospital will share best practices to proactively manage LOC status, decrease rework and avoid denials.

7C | Speed Learning: Social Determinants of Health & Outpatient Medical Care

This session identifies an effective intervention tool implemented within primary care that screens patients for additional service needs, based upon self-reported perception of burden in health care treatment and health determinants. Participants will learn about the ICAN tool and its utilization as a means to identify relevant patient stressors that are impacting patient health management. Participants will have access to the tool and discuss ways it can improve patient outcomes and satisfaction.

Part 2: AIMS model in OP SW
This session will discuss the use of the AIMS (Ambulatory Integration of Medical and Social) intervention in outpatient medical care, including assessment, care planning and unique engagement techniques.

2C | Reducing Readmissions: A New Approach to Transitional Care Planning

This session will provide information about one organization’s approach of reducing readmissions through community partnerships and the creation of a readmission initiative.

4C | Home Care, Hospice and Palliative Care: Educating Patients, Families, & Providers on the ‘Best Fit’

Providing patients with the best care while managing utilization, length of stay and readmission starts with care education of the care team, patients and families. Home care, hospice and palliative care have overlapping areas to a degree, but there are key differences as well. Keeping a patient in the least restrictive and appropriate setting is reliant on the care team helping patients and families select the best fit for their needs on the front end while taking into consideration the care plan, end of life wishes, cultural issues and insurance coverage/benefits.

6C | Speed Learning – Back-to-Back 30-Minute Sessions

Part 1: Role of the Navigator
This session will review best practices for patient navigators in various settings and their role in providing patient education, coordinating care and physician referrals.

Part 2: Managing Patients Along the Continuum in Referral-Based, Post-Acute Settings
Part 2 will present the evolving role of the field liaison to provide the right level of care at the right time, identify barriers to care and collaborate with community partners.
1D | **Geriatric Emergency Department: Improving Transitions to the Community**

Hospitals are challenged with improving care for the vulnerable older adult population. Learn how a hospital Emergency Department (ED) innovatively changed its approach to better transition patients back into the community. Partnering with geriatric physicians, participating in an ED Boot Camp and implementing a consistent assessment/referral process are key factors that have resulted in positive outcomes, including improved patient satisfaction and reduced ED readmissions.

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2D | **CMS Two Midnight Rule: Team Approach to Accurate Admission Orders**

The CMS Two Midnight Rule challenges all hospitals to ensure patients are assigned the appropriate level of care. A series of multidisciplinary, individualized interventions were developed to ensure compliance with the Two Midnight Rule and to reduce avoidable write-offs. Workflows were created with financial services, medical teams and case management to prospectively and retrospectively review at-risk accounts. The result of these efforts was an 80% reduction in avoidable write-offs.

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3D | **Community Partnerships: Patient Centered Transitions**

Partnerships with community agencies are increasingly significant to achieving quality outcomes and in providing efficient, effective transitions of care. This presentation outlines ways in which hospitals can partner with each other and develop key strategic partnerships with agencies that can help close the gap that may exist with patient transitions. Examples such as connections with free clinics to promote access to services, partnerships with the Agency on Aging, and service providers for underinsured patients will be showcased. Skilled nursing facility capabilities lists and standardized tools will be shared.

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4D | **Ethics for Case Management**

This presentation will include a review of ethical standards for case management practice, application of the standards, addressing ethical dilemmas and methods for remaining ethically fit. Case examples including conflicts between advance directives and caregiver directives, the role of behavioral health integration for Huntington’s Chorea or other conditions not commonly supported by the mental health community, and conflicts that arise when practitioners create dual relationships with co-workers or patients will be discussed.

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5D | **Shared Risk Contracts: Enhanced Communications Between Providers & Payers**

Sharing information and ensuring a level of accountability is essential for a sound payer/provider relationship. This session will describe how to build collaborative relationships with case managers of insurance companies. Tips and tools will be provided to explore implications of payer risk contracts, improve communication, and improve utilization usage.

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6D | **Transgender Youth**

In 2013, the Gender & Sex Development Program was developed to provide comprehensive and affirming care to gender non-conforming and transgender youth. This session will outline the program as well as the institutional initiatives that were necessary to transform the care environment and fully support patients and families. The Gender Program identified the need for institutional commitments beyond the original clinical scope of the program. In addition to reviewing the multidisciplinary care model of the Gender Program, the Program Manager will review three key initiatives that were institutionally implemented in support of gender inclusion within the organization.

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7D | **Case Management: What to Know About Living Wills, DNR & POLST**

Emerging research suggests ethical and safety concerns related to utilization of advance directives and Physician Orders for Life Sustaining Treatment (POLST). This session will equip case managers and health care providers with tools to assess institutional practices, implement education/safeguards and minimize patient safety risks and medical errors. Operational efficiencies gained by utilizing resuscitation safety checklists and patient-to-clinician video testimonial in advance care planning will be discussed.
1E | Critical Care Partnerships for Improved Throughput
Critical care departments at academic tertiary hospitals are commonly driven by a medical model that focuses on stabilization and transfers to the next level of care. At this institution, the Complex Case Management Practice Team (CCMP) noted referral delays until after a patient reached outlier status or until it was too late to establish a relationship that could have influenced throughput. An interdisciplinary process flow was created to promote a more timely referral process for transition planning. This collaborative strategy was essential in improving consultant usage efficiency as well as patient throughput and length of stay.

2E | Data Driven Performance with Dashboards
Organizations are data rich but can be limited in their ability to translate data into actionable information. A dashboard format allows data users the ability to quickly identify patterns and trends. This session will discuss a data-driven approach to monitor and improve key case management performance indicators. The dashboard is designed to use the organization’s existing data sources and widely available software programs to provide accessible information about care management performance.

3E | Value Based Bundling in Post-Acute Care
Has your organization taken the necessary steps to breakdown organizational silos, invested time making connections and improving communication with skilled nursing facility (SNF) provider’s to improve patient outcomes? This session is designed to provide an overview of the journey and successes achieved when a multidisciplinary team aligns to support one another to effectively meet patient needs across the continuum. Insights and outcomes will be shared on two unique pilot programs that fostered improved communication, best practice sharing, reduced clinical variation, and maximized the utilization of electronic medical record technology that impacted skilled nursing facility length of stay and reduction in readmissions.

4E | The Millennial Case Manager
Millennials have different workplace expectations, behaviors and desires that must be effectively managed in order to engage and retain them as employees. As a result, organizational leaders will need to enhance their skills and communication styles to handle generational differences between Baby Boomers, Generation Xers and Millennials. This presentation provides insight on how one hospital system has been successful in developing strategies to lead a case management workforce made up primarily of Millennial nurses and social workers.

5E | Denial Prevention: Managing Financial Risk
Learn how an Academic Medical Center (AMC) re-evaluated it’s denial management processes while in the midst of a new electronic medical record (EMR) implementation and contract renegotiation with a major payer. Collaboration between Case Management, physician offices, physician advisors, Patient Access, and the business office staff was key for this successful transformation. During this session, presenters will navigate the audience through a checklist the organization utilized to help transform processes with insightful data used to inform executives and influence decisions.

6E | Pediatric CM Forum: Roundtable Discussion
During this interactive forum, panelists will discuss challenges and innovations within Pediatric Case Management and Care Transition coordination. Interactive audience participation will be encouraged to facilitate sharing of approaches and best practices.

7E | Community Facilities (SNF LTAC Rehab) Roundtable Discussion
During this interactive forum, panelists will discuss challenges and innovations within Skilled Facility, Long Term Acute Care and Acute Rehabilitation Case Management and Care Transition Coordination. Interactive audience participation will be encouraged to facilitate sharing of approaches and best practices.

8E | Ambulatory/ Outpatient Services (VA, HH, Hospice and Ambulatory Care) Roundtable discussion
During this interactive forum, panelists will discuss challenges and innovations within Ambulatory and Outpatient Service case management and care transition coordination. Interactive audience participation will be encouraged to facilitate sharing of approaches and best practices related to outpatient services such as Home Health, Hospice, Veteran’s Administration Services and Ambulatory clinics.
**SUNRISE BREAKOUT SESSIONS**

**SUNRISE 1 | Leveraging Rideshare Apps to Expedite Patient Discharge**

RideWith24™ is an innovative partnership that utilizes technology available to Uber’s beta partners, allowing for simultaneous rides and the use of UberASSIST. UberASSIST was developed to train highly rated, experienced Uber drivers on assisting patients with disabilities and providing door-to-door transportation solutions. The program has provided over 1,100 rides from both inpatient and outpatient settings.

**SUNRISE 2 | Speed Learning: Using Patient Simulation for Case Management Education**

**Part 1: Using Standardized Patient Simulation for Case Manager Education**

Using Standardized Patient (SP) Encounters in a cutting-edge simulation center provided an innovative, high-tech approach to the training of new case managers. This presentation will provide information on how this training method provided opportunities for learners to prioritize clients’ needs from record review, demonstrated focused assessments and completed transition plans in a time-sensitive environment.

**Part 2: Applying Simulation to Case Management**

Applying Simulation to Case Management Simulation is on the cutting edge of health care. This presentation will show you how to incorporate it into case management practice. Simulation allows new employees the opportunity to practice skills they need to be successful in the often high stress situations our careers demand. It gives more experienced employees a chance to experiment, learn from coworkers and hone their skills.

**SUNRISE 3 | Speed Learning: Interdisciplinary Partnerships**

**Part 1: Interdisciplinary Partnership: Breaking Down Silos for Senior Care**

This session provides information about a program that proactively targets the high-risk and most frail aging populations in order to create impact across the patient, organization and system levels while also aligning strategically with new models of accountable and value-based care. The community based program includes an interdisciplinary team of four staff disciplines: Resource Coordinator (socioeconomic needs), Transitional Care Nurse (medical needs), Alzheimer’s and Dementia Specialist (cognitive needs) and a Geriatric Care Manager who provide care coordination for at-risk seniors. During this presentation, outcomes will be reviewed and a community resource toolkit for seniors will be shared.

**Part 2: Developing a Multidisciplinary Complex Discharge Team**

In an urban, academic medical center less than 2% of patients accounted for more than 10% of bed days annually. These medically and psycho-socially complex patients required unique transitional plans for hospital discharge. In this session, learn how the organization achieved a reduction in length of stay and outlier patient volume by using lean six sigma principles and developing a multi-disciplinary complex discharge team.
NEW THIS YEAR!

SUNSET FILM DISCUSSION

Documentary and Discussion: The Waiting Room
Wednesday, April 25 | 7:30 pm – 9:00 pm

During this session, care coordination, access and throughput issues as experienced from ER patients, families and health care team perspectives will be reviewed and discussed. The audience will watch the award-winning documentary, The Waiting Room.

An interactive audience discussion will follow the viewing, focusing on themes presented in the film and potential strategies to meet challenges in providing care for vulnerable populations.

The Waiting Room is a character-driven documentary film that uses extraordinary access to go behind the doors of an American public hospital struggling to care for a community of largely uninsured patients. The film—using a blend of cinema verité and characters’ voiceover—offers a raw, intimate and even uplifting look at how patients, staff and caregivers each cope with disease, bureaucracy and difficult choices.

BREAKOUT SESSIONS – F

Thursday, April 26 | 10:45 am – 11:45 am

We reserve the F Sessions for current topics from industry partners that provide case management solutions. Typically, we have 10 or more different sessions and we will update the content as the sessions are approved.

GENERAL SESSION: PUBLIC POLICY

Planning Ahead
Thursday, April 26 | 2:00 pm – 3:00 pm

Given the uncertainty within the current political and regulatory landscape, health care systems and providers continue to evaluate the efficacy of internal approaches to deliver cost effective quality care. During this session, an expert panel will review public policy updates and the implications within their practice settings.

SOLUTIONS CENTER

Make your conference experience complete with a visit to the ACMA Solutions Center. Whether you are just beginning your case management career or have practiced for years in the profession, ACMA has tools and resources to help you take the next step in your career. Learn more about your member resources—stop by and visit us in the exhibit hall!
1G | **Case Management Education & Training: A System’s TEAM Approach**

In the midst of an evolving health and regulatory environment, it is increasingly important to periodically assess care coordination training and education to ensure practices are current, standardized, and evidence based. This session will present the Training and Education Alignment Mission (TEAM), an initiative at a large health care system used to explore the current state and identify gaps in inpatient staff education and training. TEAM model design, lessons learned and redefined care management roles and responsibilities will be reviewed.

3G | **Intellectual & Developmental Disabilities: Successful Partnerships to Improve Patient Care**

Patients with Intellectual and Developmental Disabilities are recognized as an under-served population. They experience significant health disparities and lack adequate access to care. This session will focus on hospital to residential setting partnerships, leading to reduced readmissions, lower lengths of stay, increased appropriate palliative care consults, improved communication, and increased staff satisfaction.

5G | **Addressing IV Drug Use in the Hospitalized Patient**

Our country is facing an opioid crisis. These patients present with serious medical conditions and substance use disorders. The Code Outreach Special Team (COST) is a multi-disciplinary approach that borrows from outpatient substance abuse models to treat this population. It ensures consistent and supportive care during a prolonged hospital admission and connects patients to necessary services once their antibiotic therapy has ended.

2G | **OMEGA Project: Ending Avoidable Days**

Our Trauma I acute care facility identified a significant number of Long Length of Stay (LLOS) patients remaining in the hospital beyond the time clinically stable for discharge, resulting in 6030 medical/surgical avoidable bed days. A three-prong approach was developed to transition medically stable patients more efficiently, reducing the average length of stay for a subset of patients with discharge barriers. Needs assessments drove pilot strategies for three identified populations.

4G | **Standardized Discharge Screening Decision Tool**

Ensuring that patients transition to the appropriate next level of care is essential in the current health care climate. Process standardization and implementation of the Discharge Screening Decision Tool improves placements in the appropriate level of care. Outcome metrics demonstrate a decrease in skilled nursing facility placements and an increase in home care/outpatient services.

6G | **Leading Students into the Future and Across the Care Continuum**

This session will highlight a program that has been created to mentor last semester social work and nursing students in caring for complex patients across the care continuum. The program was designed to introduce students to transitional care by identifying patients that are at high-risk for readmission and then following their progression from hospitalization to home and back to the outpatient setting. Within the educational experience, students learn about patient opportunities, potential vulnerabilities and successes during care transition.
CLOSING PARTY

If you’ve attended an ACMA National Conference in previous years, you know that we like to go out in style with a fun and entertaining Closing Party. Music, dancing, cocktails and hors d’oeuvres close out the conference on a high note. But wait, we’re just getting started! The ACMA Closing Party has become a highly-anticipated conference benefit. The Closing Party is complimentary for conference attendees; guest passes to attend may be purchased for $75. Book your shuttles and flights a little later in the day and join us for the fun!

POST-CONFERENCE

ACM™ Certification Review: Case Management Process and Practice

Based on the Accredited Case Manager Certification Study Guide

The scope of services and standards of practice provide Nurse and Social Work Case Managers with a guide by which they can engage in the practice of case management. Understanding the parameters within which the case manager practices ensures a uniformity of services delivered to patients in need to promote quality care and assists the case manager in performing the duties required within health care delivery systems to promote wellness and improve patient outcomes. This workshop will provide intensives for focused review in four domains of Case Management practice: Screening and Assessment, Planning, Care Coordination/ Intervention/ Transitions and Evaluation. Discipline-specific clinical and psycho-social scenarios will be presented in an interactive format, allowing attendees to apply information gathering, assessment, decision-making and problem solving skills. The workshop will also provide the practicing health delivery system case manager with a review of case management practice standards in accordance with ACMA guidelines and ACM™ certification.

CONTINUE YOUR LEARNING

Compass

Does your organization struggle with maintaining annual competency validation or onboarding new hires? Keeping up with federal regulations and national standards that impact your practice is vitally important. We invite you to join the over 1,000 hospitals and the 25,000 case managers they represent that are currently staying up-to-date using Compass Directional Training.

acmaweb.org/compass

Membership

As an ACMA member you have access to an expansive free CE library that contains more than 30 contact hours of video webinars and ACMA publications.

Members of ACMA also have access to learning link—ACMA’s community forum and daily list serve where you will receive updates on the latest happenings in health care.

acmaweb.org/membership
TOP 10 REASONS TO ATTEND

1. **Earn up to 30.6 CEs.** Improve your knowledge and skills with high-quality professional development and hands-on learning. A variety of sessions (more than 50 to choose from!) will provide tools to help you make the connections that you can take back and implement into your health care setting.

2. **Gain fresh ideas and get inspired.** Keynote speakers and leaders in case management and transitions of care will inspire you and stimulate your passion to provide exceptional care. Featured session speakers will include a trained physician-scientist, a Grammy-winning composer and conductor and a six-time Olympic Gold Medalist!

3. **New this year!** Exciting opportunities this year will include Texas Medical Center on-site education, interactive rapid-cycle session and poster review and a sunset film documentary and discussion.

4. **All breakout sessions will address unique topic strands:** Ambulatory, primary care, pediatric, home health, long-term and skilled care, rehabilitation, acute care and physician advisor/medical director. This will help you plan and make the most out of your conference time based on your focus and goals.

5. **Expand your professional network.** You’ll have the opportunity to connect with knowledgeable speakers and session leaders as well as experience exceptional peer-to-peer networking opportunities where you’ll learn from others and grow your network.

6. **Learn about new advances and technologies.** Talking with our industry partners can be a great way to access expert knowledge and learn about new products and health care resources. Tour a lively exhibit hall and experience the latest health care resources during the 8.5 hours of dedicated exhibit time!

7. **Texas Medical Center—the largest medical complex in the world**—will host part of the comprehensive Pre-Conference. Options include either an adult acute care or pediatric care setting-based learning experience.

8. **Attend the Post-Conference ACM™ Certification Review**—an interactive workshop that will provide intensives for focused review in four domains of case management: Screening and assessment, planning, care coordination/intervention/transitions and evaluation.

9. **Stay on top of current and future trends in case management.** Hot topics will include length of stay reduction, transitional care planning, payment models, complex discharges, social determinants of health and public policy—just to name a few!

10. **Investment in your future.** Bring information back to your hospital or facility; session handouts are posted and available on the conference app after the event. You’ll be able to support the investment of time and budget dollars by setting up training sessions or sending out information on your return. Use the Justification Toolkit at casemanagementconference.com/justify to communicate conference benefits to your colleagues and supervisor.
## Registration

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<tr>
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**Non-member pricing includes one-year ACMA membership.

** Price includes ACM™ Study Guide. If Study Guide has already been purchased, fee is reduced by cost of Study Guide. ACMA accepts payment via credit card or check. If paying by check, simply complete an online registration form, select check as payment option, print invoice and mail with check to:

American Case Management Association | 11701 West 36th Street | Little Rock, AR 72211

### NEW THIS YEAR! GROUP REGISTRATION SAVINGS

*** Two or more registrants from same organization receive $50 off main conference registration fees for each individual. Online registration for groups must be completed at the same time. Group discount savings may not be combined with other discount offers and applicable member/non-member rates apply based on membership status of each person at time of registration.

All check payments must be received at ACMA by April 9. After that date, only credit card payments will be accepted. For more information about registration, fees, cancellations, guest rates and registration policies, visit casemanagementconference.com.