26th Annual National Case Management and Transitions of Care Conference & 20th Annual ACMA Meeting

APLCM | Association for Physician Leadership in Care Management
Physician Advisors Training & Education

April 13-17, 2019
Seattle, WA | Washington State Convention Center
casemanagementconference.com | #ACMAnational

BROCHURE LAST UPDATED FEBRUARY 20, 2019. FOR THE MOST CURRENT INFORMATION, VISIT ACMAWEB.ORG/NATIONAL
Dear Members and Supporting Organizations:

Twenty years ago this May 2019, ACMA, became a reality. Through this twenty year span we have many firsts and while ACMA has already created a Legacy of accomplishments — we are not DONE!

Our professional practice continues to be challenged. The demand for Case Management increases with every Administration’s attempt at change, increase in regulation and new focused outcome measurements. You will continue to see ACMA advocate for your needs and strive to provide what is needed for the practice.

In light of our 20-year Anniversary Celebration, ACMA will be honoring a professional who left a Legacy mark on the practice of Case Management — Dr. Sharon Mass. Dr. Mass will be presented with ACMA’s first Legacy Award recognizing not just her impact on ACMA as one of the seven founding board members — but even more her impact of an astounding 39 year career within the practices of Social Work and Case Management, and the core of what drove her career — people in need like our patients and families. The first ACMA Legacy Award will be presented at our ACMA Legacy Gala — please join us; it will be a celebration of ACMA’s twenty years and Dr. Mass’ Legacy.

What started as seven individuals willing to support an association “idea” has resulted in ACMA building services, advocacy and education to support our ever-growing complex Case Management and Transitions of Care practice. My first ACMA letter in 1999 welcomed individuals to be founding members that would collaboratively define the practice and build tools and educational content to support Case Management practitioners. Over 200 professionals took a leap of faith and joined an organization with no name recognition and few member benefits.

The founding members and Founding Board’s passion resulted in the lists of “firsts” ACMA has been able to accomplish — and they along with the many members who have joined since then have created the largest Case Management association in the U.S. — both in Total Members and Revenue. We accomplished this feat five years ago, but our continued growth validates a shared vision and purpose in the support of case management practitioners and now transitions of care.

We have many reasons to celebrate our 20-year anniversary — but our work is far from done. Be part of the largest Case Management and Transition of Care association; join us in Seattle and in our ongoing mission — to be THE Association for Health Care Delivery System Case Management and Transitions of Care (TOC) Professionals.

Regards,

L. Greg Cunningham
Founder and CEO

ACCOMPLISHMENTS

First Collaborative Case Management publication
First set of Health System Case Management Standards of Practice
The first 95% confidence level National Case Management Practice Research Data
First case management listserv
First case management app
The first national database of avoidable delays
The first Physician Advisor conference
The first case management certification testing the application of knowledge through simulation
The first case management educational tool available online 24/7 — COMPASS
The first Physician Advisor educational tool available online 24/7
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Welcome to Seattle

It seems only fitting that the ACMA’s 2019 National Conference takes place in the remarkable venue of Seattle which represents a rich and vibrant region known for its innovation, diversity and philanthropy. ACMA ventures west for an unforgettable networking, educational, community and member event as we celebrate the 20th Anniversary. You will join more than 2,000 of your peers from case management and transitions of care from April 14-17 at the Washington State Convention Center in downtown Seattle.

Also, we encourage you to make this year’s conference a destination for visiting and seeing the beautiful city of Seattle. Whether visiting the famous Space Needle, Mt. Rainier or the gorgeous evergreen behind the nickname “The Emerald City,” ACMA 2019 attendees have options for satisfaction beyond the professional takeaways and memories of this gathering of ACMA members, affiliates, industry partners and associates who seek to advance patient care across all settings.

SEATTLE MUST SEE ATTRACTIONS

- Space Needle
- Pacific Science Center
- Museum of Pop Culture
- Seattle Aquarium
- Ballard Locks (Hiram H. Chittenden Locks)
- Argosy Cruises Harbor Tour
- Chihuly Garden and Glass
- Woodland Park Zoo
- Pike Place Market
- Olympic Sculpture Park
- Pioneer Square
- Paramount Theatre
- Seattle Great Wheel

Welcome to Seattle
Venue & Travel

CONFERENCE CENTER
Washington State Convention Center
705 Pike Street | Seattle, WA 98101

HOTEL ACCOMMODATIONS
Official Conference Hotel: The Sheraton Grand Seattle
1400 6th Avenue | Seattle, WA 98101

Discounted Room Rate: $239/night Discounted group rates are applicable during conference dates (April 14 – April 17, 2019) until all guest rooms in the room block have been reserved or until the hotel reservation deadline of March 21, 2019, whichever comes first. A limited number of rooms are available at the group rate for nights before and after the conference, so we encourage you to make your reservations early!

Make Hotel Reservations
Telephone: 888-627-7056 (Identify yourself as part of ACMA) | Online: Bit.ly/acma-seattle

CONFERENCE OBJECTIVES: After attending this conference, you will be able to:
1. Identify barriers and apply approaches to engage physicians, case managers and interdisciplinary team members to effect health care change.
2. Recognize opportunities and apply care coordination strategies to successfully prevent unplanned readmissions.
3. Use case management tools and implement approaches to promote patient engagement and self-management.
4. Recognize common barriers & apply strategies to manage complex relationships between healthcare stakeholders, patients, families and providers.
5. Apply documentation review standards to consistently validate and justify medical necessity, appropriateness of level of care and resource utilization.

Who should attend?
The 2019 ACMA National Conference in Seattle offers a remarkable opportunity to connect with the association case managers, to learn and grow professionally and to network among a devoted community. Your colleagues attending the ACMA National Conference are the best and brightest with tenured successful careers, which have played a part in our legacy over the last 20 years.

Who Should Attend?
• Allied Health Professionals • Case Management Leaders • Case Managers • Nurses • Physicians
• Physician Advisors • Social Workers • Students • TOC Professionals

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 often run scams designed to obtain your personal details and credit card information.

HOTEL DEADLINE — MARCH 21, 2019
As the first female U.S. Navy F-14 Tomcat fighter pilot, Carey Lohrenz knows what it takes to succeed in one of the most demanding, extreme environments imaginable: the cockpit at Mach 2. As a former combat-mission-ready U.S. Navy pilot, Lohrenz is an expert at working in fast-moving, dynamic environments, where inconsistent execution can generate catastrophic results.

By seamlessly translating the lessons she learned to challenges in business, she provides applicable insight on market change, customer evolution and the importance of adaptability. Author of the Wall Street Journal bestselling book, Fearless Leadership: High-Performance Lessons from the Flight Deck, she outlines her experiences and advice on how to supercharge performance in today’s competitive business environments. Praised by top business leaders, from Fortune 500 executives to middle managers, her book provides insight on the importance of setting a bold vision to bring the team together and stay resilient through hard times.
General Session

Martin Makary, M.D., M.P.H., F.A.C.S.

Topic: The Future of Health Care
Tuesday, April 16 | 8:00 am – 9:15 am
Participant Level — Intermediate 1 CE

Dr. Martin Makary is a surgeon, New York Times bestselling author and Johns Hopkins health policy expert. He is the author of Unaccountable and The Price We Pay, creator of the Surgery Checklist and former leader of the W.H.O. work-group to create global measures of surgical quality. Makary has written for The Wall Street Journal, TIME, Newsweek, and appears as a medical commentator on NBC, CNN and Fox News.

A leading voice on patient safety and quality, Dr. Makary describes the current health care marketplace and new trends that represent a disruption in the industry and the hope of a more patient-centered, value base with accountable care. Finding the best care and navigating the system can be a challenge, even for the most educated consumer. In his presentation, he describes a new movement as American health care seeks to make medical care safer, more transparent and patient-centric.

Closing Session

Erik C. Wahl

Topic: The Art of Vision in Health Care
Tuesday, April 16 | 4:00 pm – 5:00 pm
Participant Level — Intermediate 1 CE

Back by popular demand, Erik Wahl will be joining us for his third ACMA Conference. Wahl is an internationally recognized artist, TED speaker, and No. 1 bestselling author. His breakthrough experience as an artist and entrepreneur has translated into making him one of the most sought-after corporate speakers.

In his presentation, Wahl provides an entertaining and highly practical program that uncovers new ways to make your health care organization more creative and — ultimately — more productive.

Wahl will also be joining us at the Closing Party where he will be on hand to sign his book Unchain The Elephant.
Conference Schedule

SATURDAY, APRIL 13, 2019 – EARLY CONFERENCE DAY

1:00 pm – 5:00 pm  ACMA Chapter President’s Meeting

6:00 pm – 9:00 pm  ACM™ VIP Event (Invitation Only)

SUNDAY, APRIL 14, 2019 – PRE-CONFERENCE EVENT

8:00 am – 12:30 pm  Pre-Conference Intensives (Select One)
  Volume to Value: Population Health Intensive
  Health Care Landscape: Strategic Planning Intensive
  Foundations for Physician Advisors

12:30 pm – 2:00 pm  Lunch on Your Own

2:00 pm – 3:45 pm  Afternoon Pre-Con Breakout Sessions (Select One)
  Advance Care Planning and Palliative Care: Discussions through Simulation Training
  Case Management and Physician Partnerships: Innovations and Outcomes
  Assuring Excellence in the Case Manager Role Across the Continuum

2:00 pm – 6:00 pm  Opening Reception with Sponsors & Exhibitors

6:30 pm – 9:30 pm  ACMA Legacy Gala (Ticket Required)

MONDAY, APRIL 15, 2019 – MAIN CONFERENCE DAY 1

8:00 am – 9:30 am  Welcome and Keynote Address: Lessons in Leadership, Carey Lohrenz

9:45 am – 10:45 am  A BREAKOUT SESSIONS: 1A – 8A

11:00 am – 12:00 pm  B BREAKOUT SESSIONS: 1B – 8B

12:00 pm – 2:00 pm  Lunch, Exhibition & Win the Wheels

1:00 pm – 2:00 pm  Rapid Cycle Learning: Interactive Poster Review

2:00 pm – 3:00 pm  C BREAKOUT SESSIONS: 1C – 8C

3:15 pm – 4:15 pm  D BREAKOUT SESSIONS: 1D – 8D

4:30 pm – 5:30 pm  E BREAKOUT SESSIONS: 1E – 8E

5:00 pm – 7:00 pm  Exhibition & Win the Wheels
### TUESDAY, APRIL 16, 2019 – MAIN CONFERENCE DAY 2

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>6:45 am – 7:45 am</td>
<td>Sunrise Breakout Sessions</td>
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<tr>
<td>8:00 am – 9:15 am</td>
<td>General Session: The Future of Health Care, Dr. Martin Makary</td>
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<tr>
<td>9:30 am – 10:30 am</td>
<td>F BREAKOUT SESSIONS (PLATINUM SESSIONS 1F – 11F)</td>
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<tr>
<td>10:45 am – 11:45 am</td>
<td>ACMA Annual Meeting (ACMA Member Only Event)</td>
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<td>11:00 am – 1:15 pm</td>
<td>Lunch &amp; Win the Wheels Car Giveaway</td>
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<tr>
<td>12:45 pm – 1:15 pm</td>
<td>Car Giveaway: Must be Present to Win</td>
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<tr>
<td>1:30 pm – 2:30 pm</td>
<td>General Session: TOC Standards of Practice, Deb McElroy</td>
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<tr>
<td>2:45 pm – 3:45 pm</td>
<td>G BREAKOUT SESSIONS: 1G – 8G</td>
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<tr>
<td>4:00 pm – 5:00 pm</td>
<td>Closing General Session: How to Deal with Fear in the Creative Process, Erik Wahl</td>
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<tr>
<td>5:00 pm – 6:30 pm</td>
<td>Closing Party</td>
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### WEDNESDAY, APRIL 17, 2019 - POST CONFERENCE

<table>
<thead>
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<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>7:00 am – 8:00 am</td>
<td>Registration and Continental Breakfast</td>
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<tr>
<td>8:00 am – 3:30 pm</td>
<td>ACM™ Certification Review: Case Management Process and Practice</td>
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<tr>
<td>8:00 am – 3:30 pm</td>
<td>ACM™ Certification Review: Case Management Process and Practice</td>
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Attendees will select from the Population Health or Strategic Planning Intensive for their Pre-Conference experience. This program combines self-assessment, assigned prework, lecture, discussion and interactive experiences to advance case management and Transitions of Care emerging and established leader development. Educational intensives within population health and strategic planning domains provide essential information to equip leaders with operational concepts, skills and vision to ignite transformative change within their health care settings.

**OPTION ONE**

**VOLUME TO VALUE: POPULATION HEALTH INTENSIVE**

**Sunday, April 14 | 8:00 am – 3:45 pm**

Attendees will complete a short assessment and review reference materials as prework for the Population Health Intensive. Population Health sessions offer 5.5 hours of lecture and interactive learning.

**Faculty:**

James Whitfill, MD, Chief Medical Officer, Innovation Care Partners
Karen Vanaskie, DNP, MSN, RN, Chief Clinical Officer, Innovation Care Partners
Ann Greiner, MCP, President and CEO, Patient-Centered Primary Care Collaborative
Kathleen Ferket, MSN, APN-BC, Senior Consultant, Transitions of Care and Simulation Programs

**Focus Areas:**

Aggregating data and analytics, outcomes and reporting, defining at-risk populations, care management frameworks and touch points, incentives and reimbursement, longitudinal care approaches and primary care partnerships.

**Objectives:**

1. Review population health management systems and frameworks
2. Define population health metrics with a focus on at-risk populations
3. Apply best practices to leverage advanced primary care models and align incentives
4. Explore strategies to structure effective longitudinal care management

**OPTION ONE – MORNING SCHEDULE**

**8:00 am – 9:00 am | Road from Volume to Value: Population Health Primer**

James Whitfill, MD; Karen Vanaskie, DNP, MSN, RN
Participant Level — Intermediate 1 CE

Over the past decade healthcare in America has seen a steep increase in the focus on value-based care where payments are impacted by provider cost and quality metrics. Making this transition is challenging for organizations who are used to a fee for service model. Key tools required to function in a population health environment include robust analytics, care coordination across the spectrum of care and provider engagement. This session will cover both macro trends in health policy as well as real-world experience from a Clinically Integrated Network with a proven track record of success.

**9:10 am – 10:10 am | Partnering with Primary Care**

Ann Greiner, MCP
Participant Level — Intermediate 1 CE

As healthcare delivery in the US continues to transform, the primary care medical home (PCMH) has become a foundational concept. This session will provide a current state assessment of how healthcare systems, ACOs and health plans are leveraging advanced primary care models such as the PCMH to enhance value. Key legislative and environmental changes that are shaping how and where primary care is being delivered will also be reviewed with an eye towards what the future may hold for patients and clinicians.

**10:10 am – 10:30 am | Break**

For complete session details within each option, visit acmaweb.org/national/sessions.
## OPTION ONE – MORNING SCHEDULE (CONTINUED)

<table>
<thead>
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<tbody>
<tr>
<td>10:30 am – 11:30 am</td>
<td>Operationalizing a Longitudinal Approach to Care Management</td>
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<tr>
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<td>Kathleen Ferket, MSN, APN-BC</td>
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<td>Participant Level – Intermediate 1 CE</td>
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<td>Poorly managed care transitions translate to billions of lost dollars annually. This session will discuss strategies health systems can implement when moving from an episodic model of care coordination to the new model of longitudinal accountability for patients across the care continuum.</td>
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<tr>
<td>11:30 am – 12:30 pm</td>
<td>Roundtable Discussion: Comprehensive Approaches &amp; Success Strategies</td>
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<td>Participant Level – Intermediate 1 CE</td>
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<tr>
<td>12:30 pm – 2:00 pm</td>
<td>Lunch (on your own) and Networking</td>
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<tr>
<td>2:00 pm – 3:45 pm</td>
<td>Afternoon Breakout Sessions (Select from three options starting on next page.)</td>
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## OPTION TWO

**HEALTH CARE LANDSCAPE: STRATEGIC PLANNING INTENSIVE**

**Sunday, April 14 | 8:00 am – 3:45 pm**

Attendees will complete a short assessment and review reference materials as prework for the Strategic Planning Intensive. Strategic Planning sessions offer 5.5 hours of lecture and interactive learning.

**Faculty:**
- Michael Gao, MD, Assistant Professor, Medicine and NYP Transformation, NYP Weill Cornell
- Debra McElroy, MPH, RN, Senior Vice President for Practice Development and Education, ACMA
- Julie Mirkin, DNP, MA RN Wharton Fellow, Chief Nursing Officer, Stony Brook Medicine
- Mary Beth Pace, RN, BSN, MBA, ACM-RN, CMAC, Vice President, Care Management Trinity Health Systems
- Colleen Fitzgerald, RN, MSN, CCM, ACM-RN, CMAC, System Director, Care Management, Trinity Health Systems

**Focus Areas**
Case management trends and future implications, predictive analytics and tools, strategic partnerships to achieve outcomes, value-driven health system innovations and redesign.

**Objectives:**
1. Increase awareness of case management trends to anticipate and prepare for the future
2. Apply performance improvement and analytics to redesign processes and operations to deliver the best possible care at the best price
3. Review strategic partnership applications and potential value within your setting
4. Discuss multi-site system volume to value redesign and identify transferable concepts

## OPTION TWO – MORNING SCHEDULE

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<tr>
<th>Time</th>
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<tr>
<td>8:00 am – 9:00 am</td>
<td>Strategic Planning: Creating A Foundation for Success</td>
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<td>Debra McElroy, MPH, RN; Julie Mirkin, DNP, MA, RN, Wharton Fellow</td>
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<td>Participant Level – Intermediate 1 CE</td>
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<td>Case Management Practice in Today’s Health Care Environment: This session will present findings and analysis from the 2018 ACMA National Survey</td>
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<td>Strategic Planning Tools and Approaches: Successful strategic initiatives are the result of thoughtful analysis, collective problem solving and directed plans. Essential components, tools and approaches will be discussed. (continued on page 12)</td>
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For complete session details within each option, visit acmaweb.org/national/sessions.
**OPTION TWO — MORNING SCHEDULE (CONTINUED)**

**9:10 am – 10:10 am | Partnering with Physicians & IT to Create a Strategic Planning Roadmap**  
Julie Mirkin, DNP, MA, RN, Wharton Fellow; Michael Gao, MD  
Participant Level — Intermediate 1 CE

Case management leader’s problem solving, and collaborative abilities drive strategic plans within health care settings. Executing a successful strategic plan at this health system required partnering with Information Technology Services and physicians. Technology was leveraged to mine data and create meaningful reports. Engaging physician champions led to developing best practices aligned across the health care system.

**10:10 am – 10:30 am | Break**

**10:30 am – 11:30 am | Assuring Value with Innovation: Integrating Care Delivery**  
Colleen Fitzgerald, RN, MSN, CCM, ACM-RN, CMAC; Mary Beth Pace, RN, BSN, MBA, ACM-RN, CMAC  
Participant Level — Intermediate 1 CE

Case Management has earned a seat at the table to plan, lead, and execute system-wide initiatives and organizational change. Over the past year this system began moving from Volume to Value which required a change from traditional case management to an integrated delivery system across 22 states. This session will review the strategic planning assessment, preparation and process steps to embark on the transformational change.

**11:30 am – 12:30 pm | Roundtable Discussion: Your Roadmap for Success**  
Participant Level — Intermediate 1 CE

**12:30 pm – 2:00 pm | Lunch (on your own) and Networking**

**2:00 pm – 3:45 pm | Afternoon Breakout Sessions (Select from three options starting below.)**

**AFTERNOON PRE-CONFERENCE BREAKOUT SESSIONS**

All Pre-Conference Intensive participants are automatically registered to attend and select from among three afternoon breakout sessions. If desired, persons not attending the Intensives can register to attend only the Afternoon Pre-Conference Breakout Session component and select one of three sessions.

**2:00 pm – 3:45 pm | The afternoon offers a choice of three sessions:**

1. Advance Care Planning and Palliative Care: Discussions through Simulation Training  
2. Case Management and Physician Partnerships: Innovations and Outcomes  
3. Assuring Excellence in the Case Manager Role Across the Continuum

**Faculty:**

Christopher Oates, LCSW, MPA, Social Work Manager, NYU Langone Health  
Sharre Thompson, MSN, RN, Care Coordinator Educator, NYU Langone Health  
Antonia Ferrer, MPA, BSN, RN, Assistant Director, Supportive Care Program, NYU Langone Health  
Robert Grant, MD, MSc, FACS, Physician Advisor and Chairman Utilization Management Committee, New York-Presbyterian  
Steven McGaffigan, LCSW, ACM-SW, Administrative Director, Transition Management Administration, Vanderbilt University Medical Center  
Karen Nelson, MSW, MBA, Director, Social Work and Case Management, Stanford Healthcare  
Annita Paolucci, MA, CCC/SLP, CCM, Director, Case Management Educator, The Ohio State University Wexner Medical Center  
Amy Singer, MSN, RN, Educator-Patient Care Resource Management, OSU James Cancer Hospital and Solove Research Institute  
Stacy Galik, LMHC, CCM, Director, Hospital Care Coordination, BayCare Health System  
Pamela E. Andrews, RN, MSW, MBA, CCM, ACM-RN, AVP Inova Health System Case Management  

For complete session details within each option, visit acmaweb.org/national/sessions.
Advance Care Planning and Palliative Care: Discussions through Simulation Training
Antonia Ferrer, MPA, BSN, RN; Christopher Oates, LCSW, MPA; Sharre Thompson, MSN, RN
Participant Level — Intermediate 1.5 CEs

When patients and their families have an increased understanding of advance care planning, diagnoses, prognoses, and palliative or hospice options, they are more able to make informed end-of-life decisions. Providing clinicians with educational opportunities to participate in simulations of difficult patient discussions, allows them to practice therapeutic communication skills in a safe environment. Their ability to facilitate these important conversations improves. Targeted activities develop the skills required to successfully explore patients’ and families’ understanding of a patient’s diagnosis and prognosis. This presentation will share two case scenarios, crafted to explore patients’ personal values, preferences, goals of care, help clinicians assess a patient’s care goals and the develop a discharge plan that honors those goals.

Case Management and Physician Partnerships: Innovations & Outcomes
Robert T. Grant, MD, MSc, FACS
Participant Level — Intermediate 1.5 CEs

Synergies created with physician-case management partnerships led to advancements in operations and clinical practice within this multi-site health care system. Providing infrastructure, training, tools, data mining and outcome monitoring were integral components in developing a team of physician champions. During this interactive session, panelists will provide case examples to illustrate key factors leading to process improvements and innovations. Successful outcomes were realized with Care Traffic Control Boards tracking pre-admission-discharge flow and proactively addressing barriers to care within adult and Pediatric care.

Assuring Excellence in the Case Manager Role Across the Continuum
Steven McGaffigan, LCSW, ACM-SW; Karen Nelson, MSW, MBA; Annita Paolucci, MA, CCC/SLP, CCM
Amy Singer, MSN, RN; Stacy Galik, LMHC, CCM; Pamela E. Andrews, RN, MSW, MBA, CCM, ACM-RN
Participant Level — Intermediate 1.5 CEs

Providing orientation to the case management role, and supporting ongoing professional development, is critical in the case management role as systems continue to expand their care delivery continuum. Often the default for orientation, shadowing with an experienced care manager/social worker may offer positive observation of an experienced coworker but may also perpetuate non-evidenced-based practice or modeling of entrenched attitudes. Standardize, comprehensive training and ongoing professional development for the case management role have become increasingly important. ACMA engaged key organizations to beta test the addition of experiential learning to the educational journey of new and seasoned professionals. Hear strategies from leading health systems on how they are working to expand and standardize orientation, assess competency and reduce variation in practice in the case management role.

For complete session details within each option, visit acmaweb.org/national/sessions.
With the formation of the APLCM, ACMA seeks to broaden its support for the integrated case management team and specifically physician leaders in care management and those in the physician advisor role.

The ACMA provides thought-leadership and expertise including education, training and certification for Case Management and Transitions of Care professionals. Since its inception in 1999, ACMA has promoted a collaborative practice model and has led to the establishment of standards for the case management practice. Foundational to all ACMA activity is the principle that case management is not the domain of one clinical discipline but rather demands the blend of multiple disciplines to assure that patients receive high-quality, cost-effective and accessible care in their transitions across the healthcare continuum.

Physician engagement, roles and leadership in case management are increasingly visible in evolving organizational structures and models of care management. ACMA has always included physicians in its membership, although the percentage of participants has been smaller compared to nurses and social workers. With its commitment to providing support, education, training and networking to all case management professionals, ACMA has historically included physician developed content in its publications and developed a physician advisor course library in its Compass online learning system that teaches and tests solid foundational knowledge in case management and physician advisory practices.

### INTENSIVE

**FOUNDATIONS FOR PHYSICIAN ADVISORS**

**Faculty Moderator:** Bruce Ermann, MD, IPAS Physician Advisor, CHI IPAS Compliance Lead  
**Participant Level — Intermediate 1 CE**

This session offers 5.5 hours of lecture and interactive learning and will equip new Physician Advisors with the knowledge required to perform effectively and for case management directors or chief medical officers looking to improve their Physician Advisor function. The session will include an interactive session engaging participants to physician leaders in care management and those in the physician advisor role.

**Objectives:**

1. Describe the role, responsibilities and success characteristics for Physician Advisors  
2. Review and identify the CMS Utilization Management Conditions of Participation and the Physician Advisor role in the UM process  
3. Describe foundational areas of knowledge, skill and abilities related to Physician Advisor work, including regulatory, utilization management and workflow considerations  
4. Decide the resolution of complex case studies in an interactive group discussion

**Attention NJ Social Workers:** This session is not applicable for CEs.

**SCHEDULE:**

- **8:00 am – 12:30 am | Morning Session**
- **12:30 pm – 2:00 pm | Lunch (on your own) and Networking**
- **2:00 pm – 3:45 pm | Afternoon Breakout Sessions (Select from three options starting on page 12.)**
20th Anniversary Legacy Gala

Sunday, April 14  |  6:30 pm – 9:30 pm

NEW THIS YEAR! The 20th Anniversary Legacy Award Gala will be THE social event of the conference. The gala will be our first formal black-tie event and will include dinner, live music and the inaugural ACMA Legacy Award.

Join us for an evening celebrating Dr. Sharon Mass — the first recipient of the ACMA Legacy Award. Dr. Mass has an astounding 39-year career that has left a legacy. She will be recognized not only for her impact on ACMA as one of the seven founding board members, but also for her impact on the practices of social work and case management, her influence on colleagues and students and the core of what drove her career — people in need, such as our patients and families. Her mark on Case Management has left a legacy and inspires others.

The ACMA Legacy Award represents an individual who has demonstrated a career of serving the greater good of patients and their families, positively impacted health care outcomes and made a significant contribution to the practice of case management and transitions of care. Dr. Mass embodies these characteristics.

The event will require an additional $150 registration fee and limited seating is available. The celebration will take place at the Sheraton Grand Seattle on Sunday, April 14, 6:30 - 9:30 pm. Make your plans now to arrive a little earlier and spend the evening celebrating ACMA’s 20 years and honoring Dr. Mass’s legacy.

ACM™ VIP Reception

Saturday, April 13  |  6:00 pm – 9:00 pm

Attention ACM™ candidates and credentialed professionals — you are cordially invited to attend the ACM™ VIP Party! To honor and celebrate the Accredited Case Manager achievement and the future success of certification candidates, ACMA is hosting a by-invitation-only reception at Pike Brewing Company on Saturday, April 13, 6:00 - 9:00 pm, located at 1415 First Avenue (between Pike & Union in downtown Seattle’s Pike Place Market neighborhood).

Founded in 1989 and becoming the third microbrewery in Seattle, the brewery was state of the art for the time, with a four-barrel copper kettle custom made by Seattle’s Alaska Copper and Brass Company. Home to one of the world’s most extensive collections of beer memorabilia showcasing 9,000 years of brewing history and with a full view of Pike’s working brew kettle, The Pike Pub will be the gathering place on Saturday night!

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 take the exam. Held in conjunction every year with the National Conference, the ACM™ VIP party is a must-attend event you won’t want to miss!
Registration Dates

REGISTRATION/RESERVATION DEADLINES

<table>
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<th>Date</th>
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<tr>
<td>20th Anniversary Special Registration: Until January 7, 2019</td>
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<td>Early Registration: January 8, 2018 - February 8, 2019</td>
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Conference Dates

Pre-Conference: . . . . . . . . . . . . . . . . . . . . . . . April 14, 2019
Main Conference: . . . . . . . . . . . . . . . . . . . . . . . April 15-16, 2019
Post-Conference: ACM™ Certification Review: . . . . . . . . April 17, 2019

Exhibit Hall Hours

<table>
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<tr>
<td>April 14, Sunday</td>
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<td>April 15, Monday</td>
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<td></td>
<td>5:00 pm – 7:00 pm</td>
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<tr>
<td>April 16, Tuesday</td>
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Win the Wheels

Win the Wheels has become one of the most highly anticipated events at the ACMA National Conference drawing huge crowds and excitement. In 2018, our winner left with the keys to a brand new 2018 Ford Mustang. For the ninth year in a row, one ACMA 2019 attendee will again leave with a brand-new car!

Visit casemanagementconference.com for official rules.

Poster Presentation

After much success last year, ACMA continues its rapid-cycle learning sessions where attendees select from 40+ interactive presentations showcasing innovative ideas, best practices and advancements in health care to apply within their work settings and improve practices.
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 CE 50-MIN</th>
<th>RN CE 60-MIN</th>
<th>SW CE 60-MIN</th>
<th>ACM™ CE 60-MIN</th>
<th>CME 60-MIN</th>
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**MAXIMUM AVAILABLE CES**

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

### Legend

Look for these icons throughout the Breakout Session sections to gain insight into session topics and subject matter relevant to practice settings.

- **Acute Care**
- **Ambulatory**
- **Home Health & Hospice**
- **Long Term and Skilled Care**
- **Pediatric**
- **Primary Care**
- **Physician Advisor/Medical Director**
- **Rehabilitation**

### Get Social

Stay informed and connect with other attendees by using #ACMAnational on social media.

- Facebook: TheACMA
- Twitter: @TheACMA
- YouTube: ACMACaseMgmt
- LinkedIn: ACMAnational

### Don’t Miss Out

**ACM Conference App** — The ACMA conference app will be available to download and use during the pre, main and post-conference activities. Keep up with announcements and have the latest information at your fingertips.
A1 ED Transitions: Using Social Determinants of Health to Reduce Re-visit Rates 
Lene Hudson, MSN, RN, CCM, CCDS; Sondra King, MSN, ACM-RN
Participant Level – Beginner 1 CE

Patients who present to the ED with chronic medical and behavioral health needs, in conjunction with two or more adverse social determinants of health, are at risk for high ED re-visit rates. This program focuses on establishing care in the appropriate post-ED setting through coordinating the required outpatient resources to support those patients who are ready for discharge but at high risk of a 30-day re-visit to the emergency department as evaluated by the social determinants of health screening. The outcomes of ED Transitions-360 Transitional Care Program are: a reduction of the 30-day ED revisit rate, and an increase in plans to address patients’ social determinants of health that negatively impact the current episode of care.

A2 Business Case for Cross-Continuum Care Management: An ACO Solution 
Nancy Turner, BSN, ACM-RN
Participant Level – Beginner 1 CE

This presentation will provide a toolkit for selling and implementing a Cross-Continuum Care Management Model. This model has demonstrated results with high risk/high needs patients for five years. The model includes inpatient, ambulatory and community care management components as well as a high-risk clinic for the top 3% high utilizing patients who account for 50% of the annual healthcare spend. The inpatient team works to transition patients to the appropriate level of care. The ambulatory team is focused on high-risk patients to prevent readmissions, close gaps in care and engage patients in self-care. The community care managers support the Preferred Provider Skilled Nursing Network, working to reduce readmissions and length of stay. Results are positive on all metrics, including $4M cost savings for Medicare Share Savings patients and a nearly 50% reduction in readmissions rates.

A3 Negotiating with Patients: Overcoming Resistance to Home Services 
Lee Lindquist, MD, MPH, MBA; Annie Seltzer, LCSW, CSW-G 
Participant Level – Intermediate 1 CE

Older adults who need support in the home will sometimes refuse it even when it is the best strategy to allow them to safely age in place. Research with 68 older adults from multiple rural, suburban and urban sites revealed what is often behind the reluctance and insights to overcome resistance. This presentation will connect these insights with business school-taught negotiation tactics, demonstrating a practical means to achieve acceptance of home services. These Refusal of Care (ROC) negotiation techniques have been taught to nurses, social workers, case managers and providers. Case studies to illustrate how ROC negotiation techniques were successfully used in discharging patients from the hospital, in ambulatory/outpatient care, and home settings will be shared.

A4 Building Resilience and Gratitude in Case Management Practice 
Joan Brueggeman, RN, BSN, ACM-RN
Participant Level – Intermediate 1 CE

Case management professionals work in a rapidly changing and evolving health care environment. Personal attributes and skills are necessary to navigate change successfully. The use of disciplined rather than default behaviors during stressful interactions and techniques of resilience that are relevant to case management practice will be reviewed. Interactive exercises will build upon strengths and weaknesses that each individual can contribute to moving the team forward. The session will conclude with a discussion and exercise on gratitude that will enhance self-care and fulfillment.
Pediatric Care Coordination: Best Practices to Avoid Readmissions  
Cyndi Fisher, RN, MSN, CPNP, ACM-RN  
Participant Level – Intermediate 1 CE  

This children’s hospital required a strategy to reduce seven-day readmission rates by 10% over the course of a year. Evidence-based interventions known to lower readmission rates include identification of at-risk patients, clinician feedback, scheduling follow-up appointments and evaluation of the efficiency of discharge planning. This session will provide an overview of focused improvements that resulted in a 13.7% reduction in the seven-day readmission rate rolling average. Case management surveys in the emergency department, garnering and sharing feedback on quality of discharge plans, technical improvements in arranging follow-up appointments and follow-up calls have proven to be effective interventions.

High Demand Session (Repeated)  
You asked, and we listened. Based on feedback from attendees one high demand session will be repeated during the conference.

Improving Outcomes and Experiences with Palliative Care Skills  
Ruth MacIntosh, BS, RN, CCM; Allison Silvers, MBA  
Participant Level – Beginner 1 CE  

Participants in this session will be introduced to a new set of skills — drawn from the field of palliative care that impact patient quality-of-life, satisfaction and avoidable utilization. These skills include: clarifying patient’s values and goals; assessing symptom burden, emotional and spiritual needs, and caregiver burden; and communicating with the care team to align treatment with what is most important to the patient. The session will describe how this skill training was implemented in a health plan, accountable care organization (ACO) and hospital transitions program. After a didactic presentation, there will be brief role play to illustrate these skills in action, and then participants will learn about resources available for skill training and assessment tools. An interactive Q & A will conclude the session.

Combatting the Opioid Epidemic and Drug Misuse  
Darren E. Totty, Pharm.D., APh  
Participant Level – Intermediate 1 CE  

Prescription opioid misuse results in 115 deaths each day in the United States and is growing. Strategies are needed in outpatient settings to bring a creative approach to addressing the growing opioid crisis. The speaker will present multifaceted, integrated approaches to combating this particular crisis, spanning various settings and applying techniques to demonstrate a positive impact.
Integrating Episodic and Longitudinal Care Management: A 30-Day Transition Model
Stephanie Kleier, RN; Verda Weston, LSSBB
Participant Level — Beginner 1 CE
A transition of care phone call after discharge from an inpatient hospital stay is critical, but it is only the beginning. To lower risk of readmission, improve patient quality of life and integrate self-care and preventive care into a patient’s post-discharge routine, a comprehensive Transition of Care Management program is required. Hospitals and ambulatory clinics can provide more cohesive transitions between care settings. The session will detail a model that incorporates the relationship between transition of care nurses that work alongside case managers on the hospital floors and care managers who are embedded into the primary care clinics, showcasing how that relationship can provide better management of the patient through complex post-discharge transitions.

Centralized Authorizations, Denials & Appeals: A Model for a Multi-Hospital System
Michael McEntire, RN, ACM-RN, CRCR, IQCI; Deborah Werner, RN, CCM, CRCR, IQCI
Participant Level — Intermediate 1 CE
One multi-hospital region of Adventist Health System introduced a centralized model for authorizations, denials and appeals rather than a centralized utilization review function and achieved a decrease in claims denials from $95 million in 2015 to $24 million in 2017. Expanding on this success, a new pilot program this year will broaden the department’s scope past the initial focus of inpatient and observation authorizations by adding elective surgical procedures, working to pre-authorize 100% by collaborating with coders, physicians and payers to obtain authorizations for all potential CPTs. This year, other regions adopted this model and results from all regions will be presented, including what has worked well and what has not.

Intersection of Human Trafficking and Healthcare
Tejal S. Patel, Esq.; Karen B. Silva, PhD, MFN, MSN, RN-BC; Divina E. Franco, LCSW, MPH, ACM-SW
Participant Level — Intermediate 1 CE
A 2017 survey from the Coalition to Abolish Slavery & Trafficking (CAST) of labor and sex trafficking victims, shows nearly 50% of human trafficking victims reported at least one healthcare encounter during victimization and 97% received no information about human trafficking. Medical care providers are often unprepared to identify and appropriately respond to trafficked persons. Less than .01% of the more than 5,500 hospitals in the U.S. have a plan in place for treating trafficked patients. Cedars-Sinai Medical Center’s Human Trafficking Task Force, made up of social workers, nurses, PhDs, a forensic nurse-educator and an attorney-risk manager, educates healthcare providers about the physical, emotional and behavioral symptoms of a potential victim. An action plan involving a trauma-informed approach and a sample conversation/template for clinicians is part of the training.

Pathway Home: Bridging Behavioral Inpatient Stays with Community Services
Mark Graham, LCSW; Barry Granek, LMHC
Participant Level — Intermediate 1 CE
Traditional Behavioral Health Care Management services offered to Medicaid recipients in New York City often lack the scope and expertise to address the complex needs of individuals with serious mental illness (SMI). The challenges faced after being discharged from long inpatient stays at psychiatric hospital facilities are unique. CBC Pathway Home (PH) is designed to bridge the post-discharge period when individuals are most vulnerable and face significant challenges engaging with community-based services. Multidisciplinary teams offer community-based time-limited intensive support to adults with SMI returning to the community. The audience will learn how the PH teams engage this reluctant population and address clinical and social determinants of health and improved health outcomes.
Pediatric Case Management and Outpatient Service Coordination in the Emergency Department  
Mary Daymont, RN, MSN, CCM, FAAN  
Participant Level – Beginner 1 CE  

Emergency department and urgent care utilization by the pediatric patient population can create challenges for any health system. On-site care coordination and case management services along with increased awareness and availability of community resources are imperative. These capabilities enhance emergency department efficiency and promote patient and caregiver satisfaction, especially for pediatric clients. This session will provide examples of services provided within healthcare settings to achieve improved efficiency and patient satisfaction results.

Improved Hospital/SNF Partnerships: Expediting Transfer of Complex Patients  
Mona Chambers, BSN, RN, ACM-RN  
Participant Level – Intermediate 1 CE  

Faced with high census, high daily boarder-patient counts and increasing length of stay, Harborview Medical Center’s Bed Readiness Program partners with three local skilled-nursing facilities to expedite the discharge of clinically and socially complex patients. The program provides financial incentives for the skilled-nursing facility, as well as care coordination support and collaboration. This helps the hospital with patient throughput, which improves the hospital’s ability to serve more patients in the community.

Non-Medical Home Care: How It’s Accessed/Funded  
Gavin Ward, BS, Certified in Readmission Prevention and Bundled Payments; Maricris Tengco, RN, BSN, MHCA  
Participant Level – Beginner 1 CE  

This presentation will discuss the growing utilization of non-medical caregivers as care extenders to health care organizations throughout the country. Providing this non-medical care is demonstrated to reduce acute care episodes of those receiving the support. As many as 90% of aging adults wish to age in place, and care models are responding by delivering in-home care. Complementary non-medical home care must also become more available. In fact, 31 state Medicaid programs now provide funding for non-medical care as an alternative to nursing home placement. Attendees will learn from existing models of care that leverage the non-medical workforce and are showing some promising results with lower costs of care. A variety of funding sources will be uncovered, including grants and Medicare Advantage Plans funding.

Providing Integrated Behavioral Health Services  
Catrina C. Litzenburg, Ph.D.; Mark McGovern, Ph.D.  
Twinchit C. Salcedo-Singer, MS, LCSW  
Participant Level – Beginner 1 CE  

Accessible, affordable and available ambulatory behavioral health resources are limited in many communities. Integration of behavior health with primary care settings is important to meet the needs of patients seeking care for mental illness. This session will explore options and present community programs piloted among leading institutions to meet the care management needs of the behavioral health population.
C1 Managing Readmissions Across 28 Hospitals: A “How To” Transitions of Care Manual
Devonne Grizzle, RN, MSN, CCM; Sue Muchler, RN, MSN, MBA, FACHE
Participant Level – Intermediate 1 CE
Quorum Health Corporation is a nationwide health system with locations in non-urban markets. In January of 2017, to address the ongoing impact of CMS readmission penalties, Quorum instituted a readmissions management program that included a “how-to” manual with electronic forms, tools and resources. The focus is a transitions of care program that includes COPD, CHF and Pneumonia DRGs and is implemented at each of the 28 hospitals in the system. Each hospital operationalizes the program according to facility size and patient population served. By Q3 2017 penalty reductions in several of the facilities were below 10. Now with an ACO and with the transitions of care program in place, acute care case management will connect with a population health nurse to improve care transitions and chronic care management, improving performance further.

C2 Managing Observation Status and Reducing Denials
Susan O’Connell, RN, BSN, MPA
Participant Level – Beginner 1 CE
Management of Medicare and Medicare Advantage observation status is best accomplished with a multidisciplinary team and process. This presentation will be both a primer on the observation rules and nuances, as well as an overview of the components of a successful multidisciplinary process. The process integrates the daily observation huddle, the monthly observation data review and the escalation process for delays in service. Implementing this approach has led to a reduction from 33% to 22% in initial observation rates and a corresponding reduction in claim denials during the first half of 2018.

C3 Elder Abuse in Healthcare Settings: Early Identification and Comprehensive Assessment
Lisa Bednarz, LCSW, ACM-SW
Participant Level – Intermediate 1 CE
Elder abuse is a complex and under-reported issue associated with increased use of health care services including emergency rooms, sub-acute rehabilitation programs and long-term care facilities. These institutions are uniquely positioned to address this reporting crisis. During discharge planning, case managers assess patients’ functional status, environment and support system. This responsibility provides an opportunity and the authority to identify survivors of elder abuse and to provide prevention and intervention services. This presentation will discuss assessments of physical, financial, emotional and sexual abuses through both questionings and using medical records to identify forensic biomarkers that may point to such abuse. Case studies highlighting successful and missed interventions will be presented.

C4 Speed Learning: Case Management Innovation Showcase
Stacy Wright, LCSW, MHA, MBA, ACM-SW
Participant Level – Intermediate 1 CE
This session will feature case management innovations that have been successfully implemented in health care settings. Panelists representing four innovations will provide a ten-minute overview of project goals, implementation and outcomes. Interactive Q & A and audience participation will follow the panel presentations.
C5 **Improving Hospital Throughput Using Discharge Milestones**  
Joan Cullen, MSN, RN, CCM, CNL; Lesly Whitlow, DNP, MBA, RN, CCM  
**Participant Level — Intermediate 1 CE**

Ineffective hospital throughput contributes to decreased patient satisfaction, decreased quality of care and missed revenue opportunities. Since most children at this institution are discharged in the evening, a multidisciplinary campaign was launched to identify discharge tasks that resulted in delays. Common barriers to timely discharges include: ordering medications, arranging transportation and entering discharge orders. Interdisciplinary collaborative efforts resulted in an improved patient and family experience as well as smooth, efficient transitions.

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C6 **Post-Acute Care: Authorization and Denial Avoidance**  
Janeen Foreman, RN, BSN, MHHS, CPHQ; Karla White, MSW, LCSW  
**Participant Level — Intermediate 1 CE**

Securing authorization for services and treatment and accessing funds for underfunded patients is becoming increasingly difficult. Long-term Acute Care (LTAC) facilities, skilled facilities and acute rehab settings are increasingly scrutinized by both payers and regulatory bodies in order to certify care. In this session, successful approaches to obtain authorization for the right care at the right level and transition from acute short-term to LTAC while avoiding payment denials will be presented.

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C7 **Strategies to Improve Patient and Family Satisfaction**  
Russell Hilliard, Ph.D.  
**Participant Level — Intermediate 1 CE**

What are the keys to achieving patient and family satisfaction within the community? Does this differ from the acute care experience? During this session, case examples will highlight factors influencing patient satisfaction. Cultural sensitivity and communication styles will be explored. The presenter will discuss innovative approaches, strategies and outcome data to apply and improve performance.

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C8 **Best Practices in Population Health Management**  
James Whitfill, MD  
**Participant Level — Intermediate 1 CE**

Best practices in population health management require integration of several aspects of care delivery. This session will include a discussion of best use technologies, predictive analytics and access to electronic medical record information. Approaches to complex care planning, chronic disease management, multiple provider or setting coordination, identification of high-risk patients and patient/family navigation will all be presented.
D1 Bedside Case Managers: Using an Actionable Dashboard
Todd McClure Cook, MBA, MSW, Ed.D, FAIHQ, FABQAURP, FABC, ACM-SW
Participant Level – Intermediate 1 CE

An opportunity to bring real-time, measurable data to the bedside case manager arose as part of a training re-design process. Bedside case managers identified a need to quickly focus on the most important variances related to a patient’s stay. Importantly, these variances must respond to immediate actions with measurable and meaningful outcomes. An Actionable Dashboard (AD) was created. The AD is a real-time reporting function embedded in the institution’s EMR system. This AD facilitates the objective measurement and communication of work performance and ties dollar impact to that work. Over a nine-month period, the AD has resulted in multi-million dollar measurable contribution to the bottom line, directly related to case manager action. This has a favorable impacted case manager engagement and a positive impact on system executive perception of case management’s contribution.

D2 Clinical Documentation Improvement: Analytical Tools and Physician Education to Improve Results
Debra Scavitto Jaeger, MSN, RN
Participant Level – Intermediate 1 CE

Clinical documentation improvement will lead to improved outcomes and increase efficiency for all teams involved in documentation and coding. Analytics support the assessment of risk and identification of improvement opportunities. Assessments focused on the identification of cases requiring further evaluation, including physician documentation review. Physician chart reviews followed to determine whether the greatest impact would be process improvement or physician education. This session will highlight tools the participants can apply in their organizations to identify and prioritize cases for review and share specific examples of quality outcomes and tools used for physician education.

D3 Health System-Payer Partnership: Shared Data and Coordinated Care
Nancy Magee, RN, MSN, ACM-RN; Phyllis Rebolzo, RN, MSEd
Participant Level – Intermediate 1 CE

The merger of a health system with a major payer in our market positioned us to impact health outcomes and the cost of care within our shared population. Community partnerships were created, and primary care and chronic disease delivery models were transformed. Data transparency provided solid metrics to analyze shared data and identify at-risk populations. An assessment tool and common patient-centered interdisciplinary documentation care plans span the continuum. This session will equip you with ideas and tools to streamline processes and apply strategies within an integrated delivery system.

D4 Pediatric Case Management When Medical Child Abuse Is Suspected
Candice Ferguson, ADN, RN; Amy Munoz, LMSW
Participant Level – Intermediate 1 CE

Medical child abuse, often a result of Munchausen by Proxy behavior of the caregiver, occurs when a parent or caregiver is suspected of lying about their medical history or causing symptoms that lead to unnecessary treatments or procedures. There are no reliable statistics regarding the number of children who suffer this type of abuse. While commonly considered rare, evidence suggests this is not the case. The staff at Cook Children’s Medical Center recently identified processes to monitor, track and case manage these types of situations. Presenters will discuss the development and implementation of the Medical Child Abuse Monitoring Program (MCAMP), highlighting the importance of a multidisciplinary approach, which includes internal medical and legal teams and outside agencies such as child protective services, law enforcement, the district attorney’s office and local advocacy centers. Case scenarios will be reviewed.
**D5 Pediatric Case Management Models: A Panel Discussion**

Deborah Hill-Rodriguez, MSN, MBA-HMA, ARNP, NE-BC  
Gay Matthews, MSN, RN, CCRN-K; Susan Navarro, RN, ACM-RN  

*Participant Level – Intermediate 1 CE*

Changes in the healthcare delivery system have led to restructuring pediatric case management departments and service delivery processes. During this session, panelists will review indications for change, as well as compare the structure of case management models, role delineation, assignments, caseloads and service sites. Model strengths and challenges will be discussed. Outcomes and key performance indicators (KPIs) will be shared.

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**D6 Successful Transitions and Hand-offs to Community Providers and Facilities**

Lory Arquilla-Maltby, DNP, ANP, APRN-BC; Donna Smith, MSN, MHA, RN, CCM, CRRN  

*Participant Level – Intermediate 1 CE*

Communication is critical to ensure safe, effective care transitions to skilled, rehab and long-term care facilities. During this session, health care professionals representing various care settings will provide tips, tools and examples applied at the point of hand-off within their practice. Transitions of care standards and best practices will be presented related to the multifaceted communication process involving: preplanning and goals of care establishment, hospital-to-post acute facility communications and preparation of patient and family.

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**D7 Home Care Industry: Overview and Update**

William Dombi, Esq.  

*Participant Level – Advanced 1 CE*

Obtain insights on the expected direction within the home health and hospice arena to address upcoming industry changes and meet standards for cost-effective quality care and services. During this session updates on new regulatory requirements such as the Home Health Groupings Model (HHGM), the revised CoPs and quality initiatives such as value-based purchasing, 5-star ratings, face-to-face reviews and bundled payment models will be shared.

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**D8 Building Patient Engagement Beyond Hospital Walls**

Jeanne Fears-Wickliffe, RN, BSN, MHA, CPN; Peggy Tyndall, RN, MBA  

*Participant Level – Intermediate 1 CE*

Involving patients in care before, during and after outpatient or ambulatory services can improve outcomes and lower costs. During this session, tips, tools and best practices to provide patient-centric care will be reviewed. Identification of key strategies, performance metrics and essential components for patient engagement will be discussed.
Weekend Interdisciplinary Rounds – An Implementation Tool Kit
Lisa Bednarz, LCSW, ACM-SW; Tanya Mighty, RN, MS, BSN; Renuka Gupta, MD, FHM, FACP
Participant Level – Intermediate 1 CE

This presentation will provide an implementation toolkit with a focus on staffing models, strategic partnerships and information technology necessary to implement efficient interdisciplinary rounds on the weekends. Weekend rounding programs can lead to meaningful increases in weekend discharges and decreases in length of stay. Data will demonstrate success in increasing Saturday and Sunday discharges between 40–60% with the corresponding decrease in length of stay.

Attention NJ Social Workers: This session is not applicable for CE’s.

Leveraging Predictive Analytics to Drive Estimated Day of Discharge
Elizabeth Halbert, RN, BSN; Ginna Parker, LCSW
Participant Level – Intermediate 1 CE

Individual patient variance in healing and recovery create such uncertainties in length of stay (LOS) that providers are often reluctant to predict a specific patient’s estimated discharge date. DRG guidelines fall short of predictive value for the complex patient. Learn how an integrated academic health care delivery system improved LOS and patient outcomes by predicting estimated date of discharge (EDD) using analytics and technologies such as data mining and artificial intelligence. This presentation will share the important elements of a predictive tool, some of the challenges of implementing predictive analytics and specific outcomes. These analyses are paired with virtual interdisciplinary rounding boards and cross-department teams that address social and intra-institutional barriers to discharge.

Speed Learning: A Clinical Supervision Cohorts Model – Managing Social Workers in a Case Management Practice
Dawn St. Aubyn, MSW, LICSW
Participant Level – Intermediate .5 CE

Many case management departments include a mix of RN and MSW case managers. Often RN case managers are tenured nurses while many MSW staff members are new to case management. These MSWs work under a provisional license that includes a requirement of formalized clinical supervision. Clinical Supervision (CS) Cohorts, is a specific supervisory format designed to meet targeted clinical and professional development needs of provisionally licensed MSW case managers using a combination of didactic and practical learning in a focused, supportive environment. The presentation will introduce this format, discuss outcomes and share lessons learned. Finally, we will demonstrate how CS Cohorts can be customized to a variety of case management practice environments.

Attention NJ Social Workers: This session is not applicable for CE’s.

Speed Learning: Twenty Strategies to Reduce Inpatient Readmissions to Implement Now
Kimberly Jungkind, MPH, MBA, BSN, CCM
Participant Level – Intermediate .5 CE

As many as one in four readmissions are defined as potentially avoidable, meaning there is a 50% chance the readmission could have been avoided. This presentation will provide 20 ideas and strategies to reduce inpatient readmissions for quick implementation. Each innovative solution presented will be reviewed with examples to consider implementing right away. In addition, high risk populations will be discussed with unique ways of utilizing resources.

Attention NJ Social Workers: This session is not applicable for CE’s.
**Impact of Evidence-Based Protocols on Remote Patient Monitoring**

Karen Hercules-Doerr, MBA; Li Zhou, MD

*Participant Level – Beginner 1 CE*

Ensuring long-term patient engagement is imperative in population health and value-based care initiatives. Barriers include patients not understanding the importance of reporting key symptoms to their providers on a timely basis and the cumulative effect often experienced when multiple co-morbidities exist. Accessible technology should require low patient activation that can be used by any patient regardless of health literacy or tech savvy. Remote patient monitoring should facilitate an increased understanding of signs and symptoms related to the patient’s chronic disease so that they are more active in their health management. Evidence-based protocols presented in this session will consider patient engagement, ease of patient accessibility and impact on utilization demonstrated with verifiable clinical outcomes.

**Speed Learning: Providing Well-Coordinated Care for Pediatric Behavioral Health Patients**

Carey Spain, MSW, MBA, LCSW, LSCSW, CCM, ACM-SW

Mindy Schneider, MSW, LCSW, LMSW, ACM-SW

*Participant Level – Intermediate .5 CE*

Managing youth with complex behavioral health needs in the acute medical setting is common. To meet the growing centers for medicare and medicaid services (CMS) demands required by increased volume and limited community resources, children’s hospitals create safe spaces, policies and education programs. One children’s hospital saw a 56% increase in the number of children admitted for behavior health concerns during 2016-17. Pediatric facilities are not equipped to be safe spaces, lack staff with specialized skills and may often be overwhelmed by the demands created by these patient needs. Attendees will learn how one facility addressed this challenge.

**Attention NJ Social Workers: This session is not applicable for CE’s.**

**Speed Learning: Managing Pediatric Behavioral Health Issues**

Caroline Cortezia, M.S., CCLS III

*Participant Level – Intermediate .5 CE*

Limited financial and community resources, as well as common regulatory and legal commitment bottlenecks, pose challenges when coordinating plans for pediatric patients who have behavioral health problems. During this session, the presenter will describe one institution’s efforts to address these challenges so that children’s needs are met.

**Attention NJ Social Workers: This session is not applicable for CE’s.**
E6 A Post-Acute Network for Elderly Patients: The HOPE SNF Collaborative
Heather N. Jacobson, MHA, MS, CCC-SLP
Participant Level – Intermediate 1 CE

Value-based payment models encourage hospital systems to collaborate with post-acute care (PAC) providers to integrate resources and reduce health care spending and hospital readmission rates. There is a variety of approaches in scope and objectives as well as in financial benefit. In 2017, Duke University Health System Accountable Care Organization launched the HOPE Skilled Nursing Facility (SNF) Collaborative. It includes facilities with varied Star rankings, geographic locations and re-hospitalization rates. This presentation will review the steps involved from the initial working group to the final assembly of participants. Goals were set to improve transitional care processes and 30-day readmission rates, and five additional goals were established to focus on improving care transitions and creating infrastructure for larger strategic initiatives and integration. Specific goals and performance data will also be shared.

E7 Improving Outcomes for COPD Patients Through Clinical Consensus
Pam Foster, LCSW, MBA, ACM-SW
Participant Level – Intermediate 1 CE

COPD is a leading cause of mortality and morbidity, causing the death of more than 150,000 Americans each year. More than 20% of hospitalized patients over the age of 40 have COPD, and readmissions of COPD patients cost Medicare $475 million each year. Improving the inpatient management of COPD patients through well-designed, evidence-based care pathways can improve patient outcomes, reduce functional decline and decrease the likelihood of readmission. In addition, there are positive implications for Medicare cost per beneficiary by implementing pathways that reduce unnecessary consultations and medications. This presentation will explore one health system’s journey of bringing multiple clinical stakeholders together to build a pathway through a unique, physician-lead clinical consensus process. The pathway includes: appropriate triage, admission status, medication regimens, triggers for pulmonary consultation, vaccinations, smoking cessation, patient education and transition planning. It will explore case management’s integral role in building and executing the pathway and will share positive outcomes on the length of stay, readmissions and cost per episode.

E8 Longitudinal Care: TOC Roundtable Discussion
William Dombi, Esq.; Daren Giberson, RN, MSN, ACM-RN; Dheeraj Mahajan, MD, FACP, CMD, CIC, CHCQM
Participant Level – Advanced 1 CE

During this session common care coordination challenges encountered within various care delivery sites will be reviewed. Best practices will be shared through interactive audience group discussion providing audience members with networking opportunities and ideas to apply within their settings.
SR1 Engaging Physicians in Care Management Initiatives
Marijke (May) McAnally, RN, MS, BSN, CCM
Pat Metzger, RN, BSN, MSA, ACM-RN, FABC
Participant Level – Intermediate 1 CE

Physician partnerships are critical to facilitate efficient, effective care. The care management team must engage physician partners to coordinate care, plan for early discharge, review performance metrics and develop strategies to address areas of opportunity. During this session, panelists will share tools and strategies they successfully applied to promote early discharges, length of stay reduction and denial avoidance.

SR2 Increase Appropriate Admission Authorizations for Pediatric Short Stays
Kimberly Littell, BSN, MPA, ACM-RN
Participant Level – Intermediate 1 CE

Increasing denials on inpatient claims for short stays indicated that process changes were necessary at this pediatric hospital. Physician and case management undertook a multifaceted approach including chart review, physician education, medical necessity criteria application review and UM process updates. This co-led effort resulted in decreased denials with increased appropriate inpatient claims and an increase from 18–22% in observation status patients.

SR3 Public Policy
Max Perkins, BA; J. Suzanne Wilson, RN, MBA, ACM-RN
Participant Level – Intermediate 1 CE

ACMA Public Policy Committee strives to inform the membership of current and relevant legislation that impacts the practice of case management. This session will provide an overview of legislation that is currently being monitored for ACMA advocacy, and also give an update on the ACMA Public Policy focus and activity.

BREAKOUT SESSION F | TUESDAY, APRIL 16 | 9:30 AM – 10:30 AM

The ACMA reserves the F Sessions for current topics from industry partners that provide case management solutions. Typically, we have ten or more different sessions and we will update the content as the sessions are approved. For complete session details within each option, visit acmaweb.org/national/sessions.
TOC Standards of Practice
Debra McElroy, MPH, RN, Senior Vice President for Practice Development and Education, ACMA
Participant Level – Intermediate 1 CE
Currently the term “transitions of care” is used widely by regulators, providers, payers and community agencies — yet there is wide variability across the service components, minimal standards of service, and the skillsets of people managing care transitions. It is well understood that poorly managed transitions impact health care quality and costs. According to the Centers for Medicare and Medicaid Services (CMS), the cost of poor care transitions of Medicare patients from acute care alone is $26 billion per year as of 2016.
This session will describe standards that will bring clarity to the practice of care transitions and assist providers, payers and all health care organizations in establishing processes for seamless coordination across the entire continuum of care, with the goal of achieving the best health outcomes.

BREAKOUT SESSION G | TUESDAY, APRIL 16, 2019 | 2:45 PM – 3:45 PM

G1 Hospital and Health Plan Partnership for Discharge Planning and Transitions of Care
Stephanie Bowen, RN, MSN, ACM-RN; Yvonne Chan, RN, MSN, GCNS-BC, NE-BC, CCM
Stephanie Mahler, RN
Participant Level – Intermediate 1 CE
This session will detail a unique partnership between a community not-for-profit hospital and a local non-profit health plan for the care coordination of the managed Medicare and Medicaid patient population. The context and makeup of the partnership, keys to senior stakeholder involvement, model development and evolution will all be covered from both partners’ perspective. Pre-partnership and post-partnership results will be reviewed including avoidable days, readmission rate, length of stay and overall health care utilization, including Quality Measurement standards. Considerations and implications for replicating the model for complex patients will be discussed.

G2 Physician Advisor Workflow and Metrics
Yvette Coronado-Castellanos, BSN, RN, ACM-RN; Leah Low, MD
Participant Level – Beginner 1 CE
To remain financially secure in an ever-changing environment, an understanding of regulatory guidelines governing medical necessity and how payers define medical necessity is critical. Care management plays an instrumental role in this process, and their performance influences the revenue stream of an institution. This presentation will present a case study of UTMB Galveston’s experience responding to the need to improve. The foundation of the change was a new physician advisor program and a reorganization of care management. Barriers, challenges and strategies for success will be discussed. Attendees will learn ways to develop and implement a physician advisor program at a large, multi-center, academic, state institution serving a resource-poor region. Our improved workflows, processes and care management reorganization will be highlighted.
Providing Culturally Competent Care to LGBTQ Patients
Susan Guthrie, MSN, RN, ACM-RN
Stacy Wright, LCSW, MHA, MBA, ACM-SW
Participant Level – Beginner 1 CE

Healthcare systems, including post-acute care agencies, are not all equipped to provide culturally competent care for lesbian, gay, bisexual, transgender and queer (LGBTQ) patients. The LGBTQ community is growing and its members have unique needs often unmet by healthcare systems. The personal story of one transgender patient will demonstrate how one healthcare system creates a sense of dignity and respect for patients during an acute care stay and how collaboration with post-acute providers, such as home health and skilled nursing facilities is critical to doing so.

Applying Technology and Tools to Enhance Utilization Management
Janine Jordan, M.D.; Patricia Resnik, MJ, MBA, RRT, CPHQ, CHC, FACHE
Participant Level – Intermediate 1 CE

In this session, presenters will review utilization management processes in a large, integrated delivery system and how they leveraged technology to improve efficiency and effectiveness. The leadership team’s journey to operationalize a collaborative, interdisciplinary team approach to utilization management engaging with colleagues from patient financial services, compliance, information technology and health information management services will be discussed. Attendees will gain insight to develop proactive monitoring processes including hard stop alerts for short stay admissions and will utilize data dashboards to drive operational improvements.

Screening Pediatric Patients for Readmission Risk
Sarah Bradshaw, RN, MSN, CPN, ACM-RN
Blair Buenning, MSN, RN, CPN, ACM-RN
Participant Level – Intermediate 1 CE

Readmission reduction is a vital component of case management programs. At the core of readmission reduction is the identification of high-risk patients who may require more focused intervention by case managers. There are several risk assessment tools available to evaluate the adult population, but pediatric assessment tools are less common. During this presentation, the High Acuity Readmission Risk Pediatric Screening (HARRPS) tool and research findings will be reviewed.

Achieving the Triple Aim: Hospitals and Health Systems Align with Post-Acute Care Partners
Dheeraj Mahajan, MD, FACP, CMD, CIC, CHCQM
Participant Level – Intermediate 1 CE

Achieving the triple aim for patients transitioning to post-acute care requires multisite collaboration to provide effective patient centric care coordination. During this session, acute care and skilled facility transition planning challenges will be discussed. Strategies will be presented to overcome barriers and create a high functioning Post-Acute Network.
Closing Party

If you’ve attended an ACMA National Conference in previous years, you know we wrap up with a memorable celebration and closing event. This year is even more special as we celebrate 20 years of meeting together! Our time together will close on a high note with music, dancing, cocktails and hors d’oeuvres.

Our Closing Session speaker, Erik Wahl, will be on hand to sign his book *Unchain The Elephant*. You can purchase the book by making a donation to ACMA, but supplies will be limited.

The Closing Party is complimentary for conference attendees and exhibitors. Guest passes to the party may be purchased for $75. Make sure you schedule 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**

**Participant Level — Beginner 5 CEs**

Plan to renew or achieve your ACM™ Certification with a review course to prepare you for success based on the Accredited Case Manager Certification Study Guide.

This practical 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 by ACMA guidelines and ACM™ certification.

For complete session details within each option, visit acmaweb.org/national/sessions.
Whether you are just beginning your case management career, or have served for years in the profession, ACMA membership can help you take the next step in your career.

**Your membership with ACMA will provide you with access to:**

- An online library of CE opportunities — Earn CE credits at your convenience, included in the cost of membership.
- Timely news on health care topics impacting your profession
- National advocacy participation
- Community forums discussing and resolving challenges and obstacles commonly encountered in the health care setting
- Networking opportunities
- Resources for professional growth
- Exclusive discounts on travel and products and services in your local region
- ... and so much more.

Are you ready to take your career to the next level? We are ready to welcome you!

Join THE Association for Health Care Delivery System Case Management and Transitions of Care (TOC) Professionals today. Join ACMA.
ACMA leads the practice by introducing Advanced Care Transitions Simulation (ACTS). This simulation program will transform orientation and professional development for case management teams. ACMA has a record of success through COMPASS, and now offers interactive simulations for advanced case management learning.

ACTS is focused on improving care transitions through team assessment communication, planning and collaboration. It leverages unique, team-based simulations of patient scenarios to enhance assessments, care coordination, and critical thinking skills for your entire team.

To learn more, visit us at: acmaweb.org/acts
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*Non-member pricing includes one-year ACMA membership.

**GROUP REGISTRATION SAVINGS: After January 7th, during Early, Main and Late Registration two or more registrations from the 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 the membership status of each person at the time of registration.

***PRICE INCLUDES ACM™ STUDY GUIDE. If Study Guide already has been purchased, the fee is reduced by the cost of Study Guide.

ACMA accepts payment via credit card or check. If paying by check, 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. All check payments must be received at ACMA by March 31, 2019. 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.

Please note if you need special accommodations such as dietary restrictions and/or special accessibility needs, include this on your registration or contact ACMA at 501-907-2262.