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CCTC

11TH ANNUAL CARE COORDINATION AND TECHNOLOGY CONGRESS

Home Health & Post-Acute Care Track

Support High-Quality Care Beyond the Hospital

January 29–31, 2020 • Renaissance Atlanta Waverly Hotel & Convention Center • Atlanta, GA

Be Empowered to:

- Discuss the appropriate assessment and timely transition of patients out of the hospital to achieve the best outcomes
- Develop the process and criteria for selecting, evaluating, and monitoring high-performing network partners
- Assess innovative models and interventions designed to address the post-acute care needs of specific patient populations
- Collaborate with all levels of post-acute care facilities for unfunded patients with complex case needs
- Enable collaboration among multidisciplinary care team members to ensure the success of your post-acute network
- Build a centralized hub to seamlessly improve communication between inpatient and outpatient settings
- Implement efficient, cost-effective ways to age in place and address social determinants of health
- Explore the promise of the home hospital model based on current reimbursement rules as well as future policy considerations

CMS Keynote Address

Richard E. Wild, MD, JD, MBA, FACEP
Chief Medical Officer, Atlanta and Boston Regional Offices
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Featured Speakers:

Julia Crist, MHA
Vice President, Operations, Home and Community Services
ALLINA HEALTH

Denise Keefe
President
ADVOCATEAURORA POST-ACUTE DIVISION;
Executive Vice President
ADVOCATEAURORA HEALTH

Marla Riney, MSW, LMSW, MBA,
Senior Director, Post-Acute Innovation
BANNER HEALTH – BANNER INNOVATION GROUP

Patricia Anderson
Administrative Director, Post-Acute Care
PENN STATE HEALTH

Mary McLaughlin-Davis, DNP, ACNS-BC, NEA-BC, CCM
Senior Director, Care Management, Main Campus and Cleveland Clinic Akron General Hospital
CLEVELAND CLINIC

Glen Roebuck
Executive Director, Home Outpatient and Senior Services
GENESIS HEALTH SYSTEM

Cynthia Morton
Executive Vice President
NATIONAL ASSOCIATION FOR THE SUPPORT OF LONG TERM CARE

Anu Banerjee, PhD
Chief Quality & Innovation Officer
ARNOT HEALTH

Bridgette Wiefling, MD
Senior Vice President, Primary Care and Ambulatory Specialties Institute, Chief Innovation Officer
ROCHESTER REGIONAL HEALTH

Bechara Choucair, MD
Senior Vice President and Chief Community Health Officer
KAISER PERMANENTE

ONE EVENT, FIVE TRACKS

- CARE COORDINATION, TRANSITIONS & COMPLEX CARE MANAGEMENT TRACK
- HOME HEALTH & POST-ACUTE CARE TRACK
- CARE TECHNOLOGIES: RPM, ANALYTICS, & CLINICAL DECISION SUPPORT TRACK
- PAYMENT REFORM & CARE REDESIGN TRACK
- COMMUNITY HEALTH & POPULATION HEALTH MANAGEMENT TRACK

Part of:
CCTC
CARE COORDINATION AND TECHNOLOGY CONGRESS

ABOUT THE HOME HEALTH AND POST-ACUTE CARE TRACK

Hospitals and health systems that effectively coordinate care for patients and manage high-performing post-acute networks are better equipped to achieve their clinical and financial goals. This track discusses appropriate assessments and timely transitions of patients to achieve optimal outcomes; process and criteria for selecting, evaluating, and monitoring network partners for high performance; innovative models and interventions designed to address post-acute care needs of specific patient populations, and technology, to support improved communication, data sharing, and coordination of care.

WHO SHOULD ATTEND THIS TRACK?

From Hospitals, Health Systems, Home Health, and Post-Acute Care Facilities:

- Chief Nursing Officers
- Vice Presidents and Directors of:
  - Post-Acute Care
  - Home Health
  - Nursing
  - Clinical Care
  - Senior Services
  - Care Coordination
  - Care Transition
  - Care/Case Management

The Care Coordination and Technology Congress provides a comprehensive, in-depth look at:

PATIENT ENGAGEMENT

- Coordinate care for complex patient populations in communities with limited resources
- Improve health literacy and empower patients to manage their health and well-being
- Encourage discussion and shared decision-making for difficult treatment choices

VALUE-BASED CARE

- Maximize ROI for alternative payment models amid shifting requirements
- Optimize care coordination to enable expansion of value-based payment models
- Tailor shared-savings strategies to your organization's unique needs

EMERGING TECHNOLOGIES

- Deploy digital health at the hospital and in the home to increase access to care
- Leverage AI and clinical decision support to shift to prescriptive analytics
- Create seamless communication experiences for multidisciplinary care teams

POPULATION HEALTH

- Take a holistic approach to broadening the care continuum and closing care gaps
- Integrate behavioral health and primary care to deliver proactive, patient-centered care
- Shift care beyond the hospital to reduce costs and improve clinical outcomes

STRATEGIZE WITH HEALTH CARE LEADERS TO IMPROVE CARE ACROSS THE CONTINUUM

6 Keynotes

50+ Thought Leader Presentations

6+ Networking Hours

3 Days

5 Tracks

3 Workshops

> This is why this event is so important, because you need technology to get to the population. This work does not let us simply add staff to meet the growing needs of support for patients at risk; therefore, we need technology to extend our reach.
>
> **Katie Doyle, MS, RN**
> Director, Ambulatory Care Coordination
> **Northwestern Memorial Health Care**

CARE COORDINATION, TRANSITIONS, & COMPLEX CARE MANAGEMENT TRACK

This track addresses ways to ensure successful transitions, reduce readmissions, and ensure effective case management for improved care delivery.

CARE TECHNOLOGIES: RPM, ANALYTICS, & CLINICAL DECISION SUPPORT TRACK

This track provides use cases and discussions to implement tools and technologies for a more comprehensive picture of patient health, driven by data, for improved care delivery.

COMMUNITY HEALTH & POPULATION HEALTH MANAGEMENT TRACK

This track, recognizing that patient journeys do not start and stop in the hospital, examines programs and partnerships, based on data, to positively impact the clinical and social barriers affecting health outcomes.

HOME HEALTH & POST-ACUTE CARE TRACK

This track highlights successes of high-performing networks and discusses ways to overcome reimbursement challenges to ensure high-quality care is delivered in the most cost-effective setting.

PAYMENT REFORM & CARE REDESIGN TRACK

This track helps hospitals and health systems navigate complex value-based structures to achieve clinical and financial success.

DAY ONE: WEDNESDAY, JANUARY 29, 2020

11:45 am Congress Registration

1:00 pm

Congress Welcome and Opening Remarks

Anu Banerjee, PhD
Chief Quality & Innovation Officer
ARNOT HEALTH

1:15 pm

Keynote | CEO Address: Total Care from the Top Down

- Learn how leadership is driving population health initiatives and improved care delivery for patients across the continuum

2:00 pm

Keynote | CMS Address: Gain Insight into the Agency's Programs, Priorities, and Goals for Greater Care Coordination

- Gain an update on CMS priorities, requirements, and resources to help you in your efforts to improve care coordination

Richard E. Wild, MD, JD, MBA, FACEP
Chief Medical Officer, Atlanta and Boston Regional Offices
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

2:45 pm Networking and Refreshment Break

3:15 pm

Keynote | Technology Address: The Future of Virtual Care

- Review new digital approaches to expand the reach of care to patients and community members
- Delve into ways to integrate existing technologies into care coordination pathways
- Strategize how to dedicate personnel to implementing virtual care across all departments
- Incorporate analytics standards to expand the usefulness of monitoring technologies

4:00 pm

Keynote | Transformation Address: Care Beyond the Hospital Walls

- Identify avenues your organization can take to expand care reach outside of the hospital
- Establish sustainable community health goals to implement within your geographic regions
- Discuss ways to determine the effectiveness of community initiatives and develop measurable ROI objectives

Bechara Choucair, MD
Senior Vice President and Chief Community Health Officer
KAISER PERMANENTE

4:45 pm

Keynote | Innovation Address: A Holistic Approach to Improving the Health of Populations

- Identify how all aspects of the care continuum connect and affect one another
- Examine innovative ways to reduce gaps in care between different stakeholders

Bridgette Wiefling, MD
Senior Vice President, Primary Care and Ambulatory Specialties Institute,
Chief Innovation Officer
ROCHESTER REGIONAL HEALTH

5:30 pm Opening Networking and Cocktail Reception

DAY TWO: THURSDAY, JANUARY 30, 2020

7:30 am Registration and Morning Coffee

8:00 am Morning Welcome

Anu Banerjee, PhD
Chief Quality & Innovation Officer
ARNOT HEALTH

8:10 am

Keynote | CMO Address: Reducing Readmissions and Reducing Cost

- Hear how national leaders are addressing admissions and readmissions at their organization
- Understand how value-based payment models are impacting their care coordination efforts

Richard Martin, MD
Chief Medical Officer, Care Continuum Service Line, Director, Value-Based Care, Community Practice Service Line
GEISINGER

9:00 am

Mini-Intensive Workshops

A: Adapt Care Teams to Coordinated Care Models

- Examine the transition from acute case management to coordinated care
- Identify additional personnel that can aid the care team – from care navigators, to social workers, and others – for more effective and efficient care coordination
- Assess processes and patient outcomes to enable continuous improvement

Mary McLaughlin-Davis, DNP, ACNS-BC, NEA-BC, CCM
Senior Director, Care Management, Main Campus and Cleveland Clinic Akron General Hospital
CLEVELAND CLINIC

Julianna S. Sellett, DNP, MBA, RN, CPHQ, CENP
Vice President, Community Health Initiatives
CARLE HEALTH SYSTEM

Idriz Limaj, RN
Clinical Executive Director, Care Continuum Management
BRIGHAM AND WOMEN'S HOSPITALSYSTEM

B. Build a Comprehensive Care Technology Framework to Promote Population Health Initiatives

- Incorporate design thinking to promote ease of use
- Build workflows to integrate technology with population health tools
- Develop governance structure to promote seamless integration across the enterprise
- Discover how technology can be used to track quality metrics and create performance dashboards to give real-time feedback to clinicians and ultimately improve provider engagement
- Improve patient satisfaction by allowing primary care physicians and specialists access to each other's chart, and hospitals and medical groups to share records so that care managers can coordinate care between departments

Priscilla Stilwell
Executive Director, Population Health
GENESIS HEALTH SYSTEM

Angela Lappin, MBA, BSN, RN, CCM
Director, Population Health and Care Coordination
ST. LUKE'S HOSPITAL

C: Align Quality Reporting in Care Coordination to Optimize Contract Performance

- Discuss patient identification for care coordination agnostic to payer
- Explore strategies for quality reporting alignment and efficiency
- Develop care coordination process and outcome dashboards

Katie Doyle, MS, RN
Director, Ambulatory Care Coordination
NORTHWESTERN MEMORIAL HEALTH CARE

10:00 am

Concurrent Market Insights

Does your company have an innovative solution to improve care coordination across the continuum? Share your market insight with us.

Companies interested in presenting a Market Insight should contact:
Bernie Weiss at 781-939-2502 or bernie.weiss@worldcongress.com

10:45 am Networking and Refreshment Break

DAY TWO: THURSDAY, JANUARY 30, 2020

11:15 am

Home Health and Post-Acute Care Track Chairperson's Opening Remarks

Julia Crist, MHA
Vice President, Operations, Home and Community Services
ALLINA HEALTH

11:30 am

Looking Ahead: Examine the Near-Term and Long-Term Changes to Post-Acute Payment Models and the Potential Impact to Future Policy

- Review potential changes to post-acute care offerings based on new models of care
- Share the growing pains and lessons learned with transitioning to a new way to receive reimbursement for care

Cynthia Morton
Executive Vice President
NATIONAL ASSOCIATION FOR THE SUPPORT OF LONG TERM CARE

12:10 pm

Panel Discussion: Bring Together Acute and Post-Acute Care to Develop Clinical Success Criteria

- Take an inventory of what defines success for acute care and post-acute care
- Discuss the appropriate assessment and timely transition of patients to achieve best outcomes

Daniel Redman, FAAHPM
Executive Director,
Post-Acute Services
HI-DESERT MEDICAL CENTER

Michael Parmer, DO, CPE
Medical Director,
Post-Acute and
Post-Acute Services,
Palliative Care Services
MISSION HEALTH SYSTEM

Denise Keefe
President
ADVOCATEAURORA POST-ACUTE DIVISION
Executive Vice President
ADVOCATEAURORA HEALTH

12:50 pm Luncheon

2:00 pm

Geo-Networking Session: Where are you from and what population do you serve?

Participate in facilitated networking to form relationships and share insights into common challenges and opportunities faced by your peers

2:40 pm

Panel Discussion: Lessons Learned from the Development and Implementation of High-Performing, Post-Acute Care Networks

- Develop the process and criteria for selecting high-performing partners
- Determine the pertinent data to evaluate and monitor network partners
- Incorporate performance benchmarks into network contracts – Incentivize partners to meet and exceed performance benchmarks and determine what to do when they don't
- Discuss unique opportunities and challenges relating to post-acute network development given regional differences in the post-acute care landscape, patient demographics, and payment models
- Examine strategies to encourage use of preferred post-acute care networks
- Share innovative models and interventions designed to address the post-acute care needs of specific patient populations
- Understand the important role that discharge planners play in determining the success of your post-acute care network

Louise Simpson, MHA
Administrator,
Post-Acute Care
UW MEDICINE

Mackenzie Moore
Senior Business
Operations Manager,
Care Coordination
EMORY HEALTHCARE

Patricia Anderson
Administrative Director,
Post-Acute Care
PENN STATE HEALTH

DAY TWO: THURSDAY, JANUARY 30, 2020

3:20 pm Networking and Refreshment Break

3:50 pm

Discover the Future of Acute Care in the Home – Opportunities and Challenges of Implementing a Home Hospital Program

- Understand the differences between home hospital and traditional home health
- Discover the operational, technological, and strategic considerations in building a home hospital program
- Determine the clinical program scope, define the care team, and the identify biggest challenges to scale
- Explore the promise of the home hospital model and review current reimbursement considerations and future opportunities for cost savings

Gregory Goodman, MD
Associate Physician, **BRIGHAM AND WOMEN'S HOSPITAL**
Instructor of Medicine, **HARVARD MEDICAL SCHOOL**

4:40 pm

Aging in Place – Care Coordination, Technology, and Services to Support Successful Outcomes

- Discuss innovative opportunities to implement more efficient, cost-effective ways to age in place
- Identify patients who are the best candidates to receive quality geriatric care at home
- Balance personnel resources and technological applications for appropriate care delivery
- Address social determinants of health in home settings to reduce health care utilization
- Build a model of transitional care, monitoring, and resources to ensure the appropriate level of care is being delivered

Marla Riney, MSW, LMSW, MBA
Senior Director, Post Acute Innovation
BANNER HEALTH – BANNER INNOVATION (GROUP)

5:30 pm Networking and Cocktail Reception

3 EASY WAYS TO REGISTER

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Call Us
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INVEST IN YOUR TEAM.

Register 3 team members, and the 4th attends free!

DAY THREE: FRIDAY, JANUARY 31, 2020

7:30 am — Morning Coffee

8:00 am

Track Morning Remarks

Julia Crist, MHA
Vice President, Operations, Home and Community Services
ALLINA HEALTH

8:10 am

Case Study: Change the Approach to Coordinated Post-Acute Care by Expanding into New Clinical Services and Developing Relationships in Home Health and Post-Acute Care

- Examine internal capabilities for post-acute care with regards to staffing and technology before expanding into new service lines
- Develop a game plan to minimize the amount of back-end work to establish new clinical services
- Acute/Post-Acute Collaboration: Leverage bold partnership to achieve growth, reduce risk, and enhance partnership

Glen Roebuck
Executive Director, Home Outpatient and Senior Services
GENESIS HEALTH SYSTEM

8:50 am

Engage Providers to Encourage Early End-of-Life Discussions

- Develop organizational culture supportive of early end-of-life discussions
- Conduct training around the sensitive nature of end-of-life discussions to provide quality and comforting care
- Adjust clinical workflows to incorporate end-of-life discussions as a routine part of initial care
- Weigh the clinical and financial pros and cons of end-of-life decision making for patients and for the health care organization

Jenifer Hamilton, MSN, RN, CHPN
Director, Post-Acute Continuum of Care
HENRY FORD ALLEGIANCE HEALTH

9:30 am — Networking and Refreshment Break

10:00 am

Case Study: How a Central Transitional Care Management Platform Improves Outcomes for Patients in Post-Acute Care

- Proactively track patients after discharge in SNF and Home Health settings to monitor potentially catastrophic changes in health
- Build a centralized hub to seamlessly improve communication between inpatient and outpatient settings
- Develop workflows and discharge processes around a communications technology platform in order to reduce friction and achieve better results

MJ Tran, MBA
Strategic Director, Post-Acute Partnerships, **GRANGER MEDICAL CLINIC;**
Vice President, Clinical Development, **PHYSICIANS ACCOUNTABLE CARE OF UTAH**

10:40 am

Panel Discussion: Develop Post-Acute Care Strategies to Manage Patients beyond Hospital Walls

- Identify strategies to create and maintain a high-performing post-acute network
- Strengthen networks and enhance partnerships to better manage patients, particularly those with complex needs, and their care transitions
- Explore technology advancements that support improved communication, data sharing, and coordination of care
- Collaborate with all levels of post-acute care facilities for unfunded patients with complex case needs

Idriz Limaj, RN
Clinical Executive Director, Care Continuum Management
BRIGHAM AND WOMEN'S HOSPITAL

Mary McLaughlin-Davis, DNP, ACNS-BC, NEA-BC, CCM
Senior Director, Care Management, Main Campus and Cleveland Clinic Akron General Hospital
CLEVELAND CLINIC

Vanessa Roshell-Stacks, CHFP, MHA
Vice President, Clinical Documentation Improvement, Hospital Operations and Care Transitions
RUSH UNIVERSITY MEDICAL CENTER

Crissie Moody, LCSW, CCM
Complex Case Manager
DUKE UNIVERSITY HEALTH SYSTEMS

Ruby Pryor, MBA, MSN, RN
Executive Director, Care Coordination
WELLSTAR KENNESTONE HOSPITAL

11:20 am

Closing Discussion: What You Will Bring Back to Your Organization?

12:00 pm — Close of CCTC

CCTC AGENDA AT-A-GLANCE

DAY ONE: WEDNESDAY, JANUARY 29, 2020

11:45 am	Congress Registration
1:00 pm	**Welcome and Opening Remarks**
1:15 pm	**Keynote | CEO Address: Total Care from the Top Down**
2:00 pm	**Keynote | CMS Address: Gain Insight into the Agency's Programs, Priorities, and Goals for Greater Care Coordination**
2:45 pm	Networking and Refreshment Break
3:15 pm	**Keynote | Technology Address: The Future of Virtual Care**
4:00 pm	**Keynote | Transformation Address: Care Beyond the Hospital Walls**
4:45 pm	**Keynote | Innovation Address: A Holistic Approach to Improving the Health of Populations**
5:30 pm	Opening Networking and Cocktail Reception

DAY TWO: THURSDAY, JANUARY 30, 2020

7:30 am	Registration and Morning Coffee
8:00 am	Morning Welcome
8:10 am	**Keynote | CMO Address: Preventing Readmissions and Reducing Cost**
9:00 am	**Mini Intensive Workshops**

A: Adapt Care Teams to Coordinated Care Models	B: Build a Comprehensive Care Technology Framework to Promote Population Health Initiatives	C: Align Quality Reporting in Care Coordination to Optimize Contract Performance

10:00 am	**Concurrent Market Insights**
10:45 am	Networking and Refreshment Break

Concurrent Tracks

	CARE COORDINATION, TRANSITIONS & COMPLEX CARE MANAGEMENT TRACK	RPM, ANALYTICS, AND CLINICAL DECISION SUPPORT TRACK	COMMUNITY HEALTH & POPULATION HEALTH MANAGEMENT TRACK	HOME HEALTH & POST-ACUTE CARE TRACK	PAYMENT REFORM AND CARE REDESIGN TRACK
11:15 am	Track Morning Remarks	Track Morning Remarks	Track Morning Remarks	Track Morning Remarks	Track Morning Remarks
11:30 am	Optimize Ambulatory Care Workflows to Improve Patient Throughput, Decrease LOS, and Prevent Readmissions	Design a Comprehensive Care Technology Platform for Your Coordinated Care Technology Ecosystem	Leadership Perspective: Build Meaningful Partnerships to Effect Change	Looking Ahead: Examine the Near-Term and Long-Term Changes to Post-Acute Payment Models and the Potential Impact to Future Policy	Unify Clinical and Financial Incentives of Value-Based Payment Models through an Integrated Population Health Strategy
12:10 pm	Employ Utilization Review Excellence Standards to Give Patients the Right Care at the Right Time	Create a Business Case to Grow and Scale Digital Health Capabilities	Move the Crowd: 5 Strategies for Authentic Community Engagement	Panel Discussion: Bring Together Acute and Post-Acute Care to Develop Clinical Success Criteria	Leverage Analytics to Drive Clinical Redesign Strategies in Value-Based Arrangements
12:50 pm	Luncheon				
2:00 pm	Geo-Networking Session: Where Are You From and What Population Do You Serve?				
2:40 pm	Case Study: Implement Population Health Management Strategies to Reduce Readmissions and Improve Outcomes by Addressing SDOH	Case Study: Improve Overall Health and Wellness with Patient Engagement through Digital Health	Case Study: Implement Population Health Management Strategies to Reduce Readmissions and Improve Outcomes by Addressing SDOH	Panel Discussion: Lessons Learned from the Development and Implementation of High-Performing Post-Acute Care Networks	Direct Provider Contracting: Key to Transform Primary Care
3:20 pm	Networking and Refreshment Break				

CCTC AGENDA AT-A-GLANCE

DAY TWO: THURSDAY, JANUARY 30, 2020

	Concurrent Tracks				
	CARE COORDINATION, TRANSITIONS & COMPLEX CARE MANAGEMENT TRACK	RPM, ANALYTICS, AND CLINICAL DECISION SUPPORT TRACK	COMMUNITY HEALTH & POPULATION HEALTH MANAGEMENT TRACK	HOME HEALTH & POST-ACUTE CARE TRACK	PAYMENT REFORM AND CARE REDESIGN TRACK
3:50 pm	Discover the Future of Acute Care in the Home – Opportunities and Challenges of Implementing a Home Hospital Program	Discuss Logistical Barriers and Opportunities of RPM and Telehealth Deployment in Multiple Settings	Enhance SDOH Screenings and Data Collections to Improve Care Approaches for Your Population	Discover the Future of Acute Care in the Home – Opportunities and Challenges of Implementing a Home Hospital Program	Driving Performance in Population Health and Value-Based Contracts with Post-Acute Care
4:40 pm	Aging in Place – Care Coordination, Technology, Services, and Supports to Provide Seniors Appropriate Care at Home	Case Study: Synchronize Data across Multiple Platforms to Enable a Comprehensive Picture of Patient Health	Aging in Place – Care Coordination, Technology, Services, and Supports to Provide Seniors Appropriate Care at Home	Aging in Place – Care Coordination, Technology, Services, and Supports to Provide Seniors Appropriate Care at Home	Case Study: Achieve Value-Based Care Success at a Safety-Net Hospital
5:30 pm	Networking and Cocktail Reception				

DAY THREE: FRIDAY, JANUARY 31, 2020

7:30 pm	Morning Coffee				
	Concurrent Tracks				
	CARE COORDINATION, TRANSITIONS & COMPLEX CARE MANAGEMENT TRACK	RPM, ANALYTICS, AND CLINICAL DECISION SUPPORT TRACK	COMMUNITY HEALTH & POPULATION HEALTH MANAGEMENT TRACK	HOME HEALTH & POST-ACUTE CARE TRACK	PAYMENT REFORM AND CARE REDESIGN TRACK
8:00 am	Track Morning Remarks	Track Morning Remarks	Track Morning Remarks	Track Morning Remarks	Track Morning Remarks
8:10 am	Case Study: Advance Care Delivery across the Substance Use Treatment Continuum	Upgrade Your Analytics Capabilities to Build a Data-Driven Culture	Case Study: Community Transformation: Gain Insight into How the Creation of Affordable Housing and Resident Services Programs Can Address SDOH	Case Study: Change the Approach to Coordinated Post-Acute Care by Expanding into New Clinical Services and Developing Relationships in Home Health and Post-Acute Care	Case Study: Evaluate and Implement the BPCI Advanced Model for Stroke Treatment
8:50 am	Collaborate with PCPs to Deliver Coordinated Patient-Centered Care for Complex Patients	Move Toward Prescriptive Analytics through the Integration of Cognitive Computing	Collaborate with PCPs to Deliver Coordinated Patient-Centered Care for Complex Patients	Engage Providers to Encourage Early End-of-Life Discussions	Leverage Care Coordination and Contract Redesign Strategies to Expand Value-Based Care Models
9:30 am	Networking and Refreshment Break				
10:00 am	Case Study: How a Central Transitional Care Management Platform Improves Outcomes for Patients in Post-Acute Care	Case Study: How a Central Transitional Care Management Platform Improves Outcomes for Patients in Post-Acute Care	Case Study: How to Implement Results-Based Accountability to Your Community Health Needs Assessment (CHNA) Process	Case Study: How a Central Transitional Care Management Platform Improves Outcomes for Patients in Post-Acute Care	Case Study: Execute and Scale an Enterprise-Wide Care Management and Shared-Savings Strategy
10:40 am	Panel Discussion: Develop Post-Acute Care Strategies to Manage Patients Beyond Hospital Walls	Incorporate the Clinical Perspective into Clinical Decision Support Software Deployments	Panel Discussion: Develop Post-Acute Care Strategies to Manage Patients Beyond Hospital Walls	Panel Discussion: Develop Post-Acute Care Strategies to Manage Patients Beyond Hospital Walls	Oncology Episodes: Key to Curb Spending on Radiation Therapy
11:20 am	**Closing Discussion: What You Will Bring Back to Your Organization**				
12:00 pm	Close of CCTC				

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We're here to help your organization reach its goals at our conferences. That's why we tailor our offerings to the needs of our partners to ensure value and assist in building relationships with our attendees. How can we help you succeed in 2020? Pick and choose what will help your organization gain valuable return on your investment. Whether it's hosting a networking event or one of our educational sessions, together we will find the solution that best fits the needs of your organization.

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FOR CARE TECHNOLOGIES and CARE COORDINATION
Contact Ryan J. Colby: Ryan.Colby@worldcongress.com 781-939-2486

FOR COMMUNITY HEALTH, HOME HEALTH, and PAYMENT REFORM
Contact Bernie Weiss: Bernie.Weiss@worldcongress.com 781-939-2502

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