WHA Education

WISCONSIN HOSPITAL ASSOCIATION

Post-Acute Care: Working Together Across the Care Continuum for Positive Patient Outcomes

Tuesday, June 5, 2018
9:00 am - 4:15 pm *(registration begins at 8:30 am)*

Radisson Paper Valley Hotel
333 West College Avenue, Appleton, WI 54911
Phone: 920-733-8000

Program Description:

Readmission penalties, bundled payment programs and other payment and quality initiatives are making hospitals increasingly responsible for patient outcomes after they are discharged from the hospital. WHA convened a Post-Acute Care Work Group in 2017 to identify policies that may improve the ability of hospitals and health systems to provide or locate post-acute care for their patients. One of the issues the Work Group examined is how hospitals and health systems work with patients and post-acute providers to improve outcomes for discharged patients. This conference will bring together partners in the continuum of care, including hospitals, skilled nursing and assisted living facilities and home health care providers, to share best practices for transitions of patients to post-acute care settings.

Program Partners:

LeadingAge Wisconsin

LeadingChoice NETWORK

WiAHC Wisconsin Association for Home Health Care, Inc.

Who Should Attend

- Hospital CEOs
- Chief Medical Officers
- Chief Nursing Officers
- Transitional Care Directors
- Case Management Directors
- Discharge Planners
- Rehabilitation Directors
- Quality Managers
- Long-Term Care Executive Directors/CEOs
- LTC Admissions Coordinators
- Nursing Home Administrators
- Home Health Agency Directors/CEOs
- Home Health Administrators

Program Agenda

Post-Acute Care: Working Together Across the Care Continuum for Positive Patient Outcomes

8:30 am Registration

9:00 am **Feedback Loops: An Underrecognized Key to Improving Transitional Care**
Dr. Eric Coleman, MD, MPH; Professor of Medicine; Head, Division of Health Care Policy & Research, University of Colorado, Anschutz Medical Campus

Health care can learn a great deal from other industries. In particular, a key principle for ensuring quality and safety is the incorporation of feedback loops. During this opening session, Dr. Coleman will address how feedback loops can improve transitional care with illustrative examples of how this principle can be incorporated, including determining whether care needs match care setting, cross-setting communication and gauging a patient's self-care capacity. Dr. Coleman will identify the central goal of transitional care, explain how incorporating feedback loops can improve communication between health professionals and summarize how incorporating feedback loops can ensure patient understanding of what is expected of them with regard to their own self-care.

10:30 am **Hospital-Community Partnerships in Post-Acute Care**
Maria Brenny-Fitzpatrick, DNP, RN, FNP-C, GNP-BC; Director, Transitional Care and Post-Acute Services, UW Health
Diane Schuh, RN, BSN; Manager of Case Management/Social Services, Aurora Sheboygan Memorial Medical Center

Identifying the ways in which hospital partnerships with community agencies and post-acute facilities can positively impact the outcomes of vulnerable patient populations will be the focus of this session. It will include the sharing of one organization's three-part strategy for support of congestive heart failure patients discharged to the home setting and how they incorporated the Emergency Department Geriatric Guidelines into clinical practice to effectively screen and initiate community referrals for vulnerable older adults being discharged home from the hospital emergency department. This session will also examine current and future trends related to accountable care organizations, post-acute preferred provider relationships and how the utilization of Big Data is beginning to drive practices across the continuum of care. These best practices have resulted in positive outcomes, including decreased emergency department revisits and hospital readmissions, which can be integrated into any health care system.

12:00 pm Lunch (provided)

1:00 pm **Improving Care Transitions in Partnership with Senior Care Organizations**
Nellie Johnson, MSW, Nellie Johnson and Associates
Linda Joel, FACHE, CHPCA, President & CEO, LindenGrove Communities

Senior health care and housing organizations are an important partner in meeting the needs of the elderly population. This session will focus on how skilled nursing and rehabilitation providers have strengthened their post-acute care services and partnerships with hospitals to advance shared goals and ensure patients receive coordinated services. The session will address how other parts of the senior care continuum, such as assisted living communities around the country, are adapting their services to meet the needs of hospitals. Specific best practices, utilized to strengthen the care transition process across the senior care continuum to prevent unnecessary hospital readmissions and achieve cost efficiencies, will be shared. In addition, key metrics important to ensure continued focus on quality improvement will be identified.

2:45 pm **Partnering with Home Care to Improve Patient Outcomes**
Coleen Schmidt, BSN, MSN, Senior VP of Clinical Services and Chief Operating Officer, Horizon Home Care & Hospice
Lisa Kirker, RN, MSN, MBA, Director of Home Care, Hospice and Palliative Care, SSM Health – St. Agnes Hospital Home Care and Hospice Hope, Fond du Lac
Cheryl Meyer, BSN, Director, Home Health Administrator, Marquardt Village, Watertown

Exploration of the partnership between acute care and home care, in an effort to improve outcomes and reduce Medicare spending per beneficiary, will be the focus of this closing session. With the move toward value-based purchasing and bundled payments, home care is a cost-effective method to ensure our patients are cared for beyond the hospital walls. Experts from area home care agencies will partner to walk us through the qualifying criteria for home care and share best practices in transitioning patients to the home care setting. This session will also outline the requirements to qualify for home care under Medicare's Home Health benefit, describe the role home care providers play in the care transition process and provide insight on best practices in the transition of patients from acute care to home care.

4:15 pm Adjourn

Program Registration

Registration Fee:
Early Bird: $125 per person **(must register by May 5, 2018)**
Regular: $175 per person

All registrations can be made online at www.cvent.com/d/rtqb1d

After you have registered online, you will receive a receipt, which you can print out and use to submit to your organization for payment, reimbursement or credit card charge validation.

Payment Information:

- **Credit Card**: Payment accepted online via credit card - Visa or MasterCard only
- **Check**: Payment is accepted via check made payable to "Wisconsin Hospital Association." Print registration confirmation you receive by email and mail it, along with your payment, to:

Wisconsin Hospital Association, Attn: PACC
P.O. Box 259038, Madison, WI 53725-9038

Conference Cancellation Policy: Cancellations received in writing up to seven business days prior to an event will be given a full refund less a $50 processing fee. No refunds will be given for cancellations received less than seven business days prior and day-of-program no-shows. Substitutions are accepted. Please note that hotel reservation cancellations must be made directly with the conference hotel.

About the Presenter

Eric Coleman, MD, MPH

Eric A. Coleman, MD, MPH, is professor of medicine and head of the Division of Health Care Policy and Research at the University of Colorado Anschutz Medical Campus. Dr. Coleman is the director of the care transitions program, aimed at improving quality and safety during times of care "handoffs." (Visit www.caretransitions.org.)

Dr. Coleman also serves as the executive director of Practice Change Leaders, a national program to develop, support and expand the influence of organizational leaders who are committed to achieving transformative improvements in care for older adults. (Visit www.changeleaders.org.)

Dr. Coleman was recognized with a 2012 MacArthur Fellowship for his work in bridging innovation and practice through enhancing the role of patients and family caregivers in improving the quality of their care transitions.

Program Information

Special Needs: In accordance with the Americans with Disabilities Act, the Wisconsin Hospital Association seeks to make this conference accessible to all. If you require any special accommodations or have any dietary restrictions, please email your needs to Kayla Chatterton at *kchatterton@wha.org* or call 608-274-1820 at least five business days prior to the event.

Hotel Accommodations:

Radisson Paper Valley Hotel
333 West College Avenue, Appleton, WI 54911
Phone: 920-733-8000
Cut-off date: Monday, May 14, 2018

A block of rooms has been reserved for the evening of Tuesday, June 4, at the Radisson Paper Valley Hotel in Appleton. To make a reservation, call 1-920-733-8000 by May 14, 2018. When making a reservation, request a room in the Post-Acute Care Conference block. Rate is $102 per night plus tax.

Final cut-off date for a room reservation is Monday, May 14, 2018.

Hotel Cancellation Policy:

- Please confirm the hotel's cancellation policy when making your reservation.
- Hotel cancellations must be made DIRECTLY with the hotel.

Program Partners and Sponsors

Thank you to all of the program partners and sponsors of this important conference.

Program Partners: LeadingAge Wisconsin; LeadingChoice Network; WiAHC Wisconsin Association for Home Health Care, Inc.

Program Sponsors:

Quality Improvement Organizations — Sharing Knowledge. Improving Health Care. — Centers for Medicare & Medicaid Services

Lake Superior Quality Innovation Network — Michigan | Minnesota | Wisconsin

Wisconsin Association of County Homes

PointRight®

cares® Online Dementia Training — HealthCare Interactive®

WISHIN

WHA Wisconsin Hospital Association

P.O. Box 259038, Madison, WI 53725-9038
608-274-1820 / Fax 608-274-8554 / www.wha.org