

# **PERSON-CENTERED TRANSITIONS OF CARE: - CHALLENGES AND SUCCESSES FOR DISCHARGE PLANNING ACROSS THE CONTINUUM**

Wednesday, September 24, 2008 • 8:00 a.m. – 4:00 p.m.  
Holiday Inn Albany, 205 Wolf Road, Albany, NY 12205 • 518-458-7264

- 8:00 - 8:30 a.m.      **Registration**
- 8:30 a.m.            **Introduction**  
Anna Colello, Esq., Director, Regulatory Compliance/OHSM  
New York State Department of Health (NYSDOH)
- 8:40 a.m.            **Welcome**  
John Morley, MD, FACP, Medical Director, OHSM  
New York State Department of Health (NYSDOH)
- 8:50 - 9:50 a.m.    **Keynote**  
**Transitional Care: Enhancing the Experiences and  
Outcomes of Chronically Ill Patients**  
Mary D. Naylor, PhD, RN, Director, New Courtland Center for Transitions and Health  
University of Pennsylvania School of Nursing
- 9:50 - 10:45 a.m.   **Partnerships and Strategies to Support Person-Centered  
Care Transitions**  
Sara Butterfield, RN, BSN, CPHQ, CCM, Director, Health Care Quality Improvement, IPRO  
Diane Nanno, RN, BSN, Transition Coach, Senior Centered Care, Crouse Hospital
- 10:45 - 11:00 a.m.   **Break**
- 11:00 - 11:45 a.m.   **Medicare Post Acute Payment Reform Initiative –  
Continuity Assessment Record and Evaluation Tool**  
Barbara Gage, PhD, Director, Post Acute Research, RTI International
- 11:45 - 12:30 a.m.   **Bringing a Guardianship to Accomplish a  
Hospital Discharge**  
Robert N. Swidler, Esq., Northeast Health
- 12:30 - 1:30 p.m.    **Lunch** (provided)

(continued)

#### **Continuing Education Credits**

**This program has been approved by the NYS Board of Examiners of Nursing Home Administrators for six (6) hours of continuing education credit for nursing home administrators.**

#### **Registration**

**Form attached, please complete and mail or fax to register.**

#### **Hotel Information**

**Registrants who want an overnight room on 9/23/08 should call 1-800-Holiday. You need to ask for the NYS Health Facilities Association, Inc. room block at \$125.00 plus 14% tax for one night. Holiday Inn, 205 Wolf Rd., Albany, N.Y. 12205 518-458-7264.**

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(continued)

1:30 - 2:15 p.m.

## **New York State Agencies and Their Community Partners**

Scott Edwards, Director of the Bureau of Housing and Shelter Services  
New York State Office of Temporary and Disability Assistance (OTDA)  
Lisa Irizarry, Director of Special Needs Policy  
New York State Division of Housing and Community Renewal (DHCR)  
Patricia Lincourt, LCSW-R, Clinical Services Unit  
New York State Office of Alcoholism and Substance Abuse Services (OASAS)  
Mike Newman, Director of Housing Development and Support  
New York State Office of Mental Health (OMH)

2:15 - 3:15 p.m.

## **Best Practices**

### **Optimizing the Role of a Nurse Practitioner in a Transitional Care Model Across Settings and Organizations**

Marina Burke, RN, MSN, Visiting Nurse Service New York

### **Success at Home: It Takes a Team**

Brenda Ko, PT, RN, Assistant Director of Patient Services  
St. Joseph's Certified Home Health Agency

Mary Anne Garafalo, RN, Coordinator  
St. Joseph's Certified Home Health Agency

### **Addressing Difficult to Place Patients at the Community Level**

Ronald Lagoe, PhD, Executive Director, Hospital Executive Council

3:15 - 3:45 p.m.

## **Nursing Home Transition and Diversion (NHTD) Waiver and Money Follows the Person (MFP) Demonstration**

Bruce Rosen, Director of NHTD Waiver and MFP Demonstration Project Director

3:45 - 4:00 p.m.

## **Wrap up**

### **SPONSORED BY:**

**New York State Department of Health (NYSDOH)**

### **IN PARTNERSHIP WITH:**

**Empire State Association of Assisted Living (ESAAL) -**

**Healthcare Association of New York State (HANYS) -**

**Home Care Association of New York State, Inc. (HCA) -**

**I PRO -**

**New York State Association of Homes & Services for the Aging (NYAHS) -**

**New York State Association of Health Care Providers, Inc. (HCP) -**

**New York State Health Facilities Association (NYSHFA) -**



STATE OF NEW YORK  
DEPARTMENT OF HEALTH

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## SEPTEMBER 24, 2008

### TO REGISTER:

**Fax this form** to (518) 431-7812  
Attn: Joan Stewart

**Mail form to:**  
Healthcare Association of New York State  
Attn: Joan Stewart  
One Empire Drive, Rensselaer, NY 12144

### FOR MORE INFORMATION:

contact Debbie LeBarron, Director,  
Continuing Care at (518) 431-7702 or  
at [dlebarro@hanys.org](mailto:dlebarro@hanys.org).

**Conference materials will be made available  
online following e-mail notification to all  
registrants after September 15.**

**CANCELLATIONS:** Substitutions are permitted and encouraged. Cancellations received less than five working days before the program are subject to a 25% service charge. Facilities that cancel the day of the program or fail to attend/participate will forfeit the registration fee. Cancellations must be in writing and directed to Joan Stewart, Registration Coordinator, HANYS, One Empire Drive, Rensselaer, NY 12144.

### GENERAL INFORMATION (Please print or type):

Facility Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Title: \_\_\_\_\_

Contact E-mail: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP Code: \_\_\_\_\_

**PLEASE NOTE:** An e-mail address is required to receive confirmation of your registration.

#### REGISTRANT #1:

Name: \_\_\_\_\_

Title: \_\_\_\_\_

E-mail: \_\_\_\_\_

Please indicate special needs for attending this conference:

mobility  hearing  sight  dietary

#### REGISTRANT #2:

Name: \_\_\_\_\_

Title: \_\_\_\_\_

E-mail: \_\_\_\_\_

Please indicate special needs for attending this conference:

mobility  hearing  sight  dietary

#### REGISTRANT #3:

Name: \_\_\_\_\_

Title: \_\_\_\_\_

E-mail: \_\_\_\_\_

Please indicate special needs for attending this conference:

mobility  hearing  sight  dietary

**TUITION: \$100 per person**

**METHOD OF PAYMENT:** Full tuition must accompany registration. HANYS only accepts credit card payments for education program registrations; we no longer accept payments by check. If you have questions about this new policy, please contact HANYS' education staff at (888) 994-4373.

**Please charge my** (CIRCLE CHOICE): Mastercard® Visa® American Express® Discover®

**Amount To Be Charged:** \$ \_\_\_\_\_

#### THE FOLLOWING INFORMATION IS REQUIRED:

Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

Name as it Appears on Card \_\_\_\_\_

Cardholder Billing Address \_\_\_\_\_

CVV # (3-4 digits found in the signature bar on the back of the card) \_\_\_\_\_

Cardholder's Signature \_\_\_\_\_