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About the Conference

Business Research Intelligence Network's Care Management & Transitional Care Summit brings together care management directors, transitional care coordinators, care managers and healthcare executives building programs that improve patient outcomes while managing costs. This conference addresses the real challenges facing care management teams including building departments from scratch, retaining experienced staff in competitive markets, integrating AI and EHR tools that actually help rather than create more work and reducing health disparities through targeted interventions.

You'll hear from care management leaders who've successfully built sustainable programs, implemented value-based care strategies that align with payer requirements, leveraged social determinants of health data to address inequities and created capacity management approaches that improve patient access. The agenda covers critical topics including staffing models that work, technology integration that improves efficiency, quality metric partnerships with payers and strategies for managing the financial complexity of modern healthcare delivery.

This conference delivers practical approaches to strengthening care management effectiveness, improving transitions of care and demonstrating value to executive leadership and payer partners. If you're building care management programs, struggling with retention, trying to prove ROI or working to reduce disparities in your patient population, this summit provides the strategies and connections you need.

Agenda

Day One – Thursday, January 28, 2027

7:15am – 8:00am
Conference Registration & Networking Breakfast

8:00am – 8:15am
Chairperson's Opening Remarks

8:15am – 9:00am
Praveen Mital, MD, MBA, FACEP
ED Adult Medical Director
UF Health Jacksonville

9:00am – 9:45am
From Discharge to Stability: Building an Integrated Care Model for Complex Patients with Medical and Social Needs
Patients with multiple chronic conditions, frequent healthcare utilization, and significant social determinants of health challenges require more than traditional transitional care interventions. This session explores how one health system developed an integrated care model that combines risk-stratified discharge planning, a Transition Clinic, Heart Failure Clinic, High Needs Medical Program, High-Risk Nurse Navigation team, chronic disease education, and a donor-supported Community Care Fund to reduce readmissions and improve outcomes. Attendees will learn how high-risk patients are identified, connected to the appropriate level of care, and supported through both medical and social barriers. The presentation will highlight program development, lessons learned, interventions that failed, and strategies that produced meaningful results while reviewing outcome data, utilization trends, and readmission reduction efforts.
Jessica Sanchez
Manager, Transition Clinic
United Regional Health Care System

9:45am – 10:15am
Networking & Refreshments Break

10:15am – 11:00am
Physician Advisors in Case Management
Length of stay is the hospital's most expensive challenge, and case management absorbs most of it. Case managers work discharge barriers relentlessly, but a case manager cannot adjudicate a clinical disagreement between services, compel an attending to make a disposition decision, or name a treatment plan that is deviating from the standard of care. The physician advisor can. The gap is not effort; it is authority. This session shows how to close it, and gives attendees two machines they can run: multidisciplinary rounds that produce a defensible discharge date, one named barrier owner per patient, and written escalation triggers; and the regulatory toolkit that converts a payer stall into a dated, appealable event, including the 2026 authorization clocks, physician standing under 42 CFR § 422.584, the appointment of representative, and the SNF, IRF, and LTCH standards. Attendees leave with a rounding script, a barrier taxonomy, a 90-day build plan, and five things to change Monday morning.
Ryan Greiner, MD, ACPA-C

System Medical Director and Physician Advisor
North Memorial Health

11:00am – 11:45am
Optimizing Your Care Team for Enhanced Throughput and Efficiency
When the normal flow of patient throughput crashes headlong into significant barriers to next care transitions, a well-organized team of savvy staff are needed to tear down these impediments. Recruiting and organizing this team should be a priority focus for any hospital.

Carissa J. Tyo, MD, FACEP
Medical Director, Clinical Decision Unit
Medical Director, Care Management and Physician Advisors
University of Illinois Hospital & Health Sciences System

11:45am – 12:30pm
Building Access: Coordinating Clinical and Operational Solutions
Transitions of care from the inpatient environment to outpatient or post-acute care can be complex, creating discharge barriers for patients and a lack of adequate access to appropriate high quality care. Novel solutions and adequate resources are needed to ensure appropriate follow up care to reduce readmissions, length of stay and comorbidities of patients. Care management is part of a multidisciplinary team that can smooth the transition to outpatient high-quality care.
Nicholas Mains, DO, FACP, FAAP
Associate Professor of Medicine and Pediatrics
Associate Chief Quality Officer, Medicine
Medical Director of Access
West Virginia University
West Virginia University Health System

12:30pm – 1:30pm
Luncheon

1:30pm – 2:15pm
Connecting 'Z' Dots: Building Sustainable Health Equity
A missed follow-up appointment. An uncontrolled chronic condition. A patient who doesn't follow the plan of care. What's really going on? The answer may lie beyond the exam room. Through innovative pilots and data-driven findings, this session explores how social drivers of health shape outcomes, how Z codes make those challenges visible, and how care teams can translate insight into action while laying the foundation for sustainable approaches to advancing health equity, one encounter at a time.

- Recognize how social drivers of health contribute to health equity, patient outcomes and healthcare utilization.
- Describe the role of screening, documenting, and communicating social drivers of health to support patient-centered care.

- Community Health Worker training and workflows for social needs intervention
- Building community resource networks and ensuring referral follow-through
- Define strategies to leverage social risk data and Z codes to support sustainable, value-based approaches for advancing health equity.

Mallory Callahan, MPAS, PA-C
Vice President, Value-Based Care
Nebraska Health Network

Kelly Mand
Population Health Coordinator
Nebraska Health Network

2:15pm – 3:15pm
Panel: Removing Barriers to Care: Aligning Clinical Authority, Access and Social Needs
Patients get stuck for different reasons: a clinical disagreement no one has authority to resolve, an access bottleneck no one owns or a social barrier no one caught in time. This panel will discuss who owns these gaps and how their organizations get clinical, operational and social teams working together to close them.
Panelists:
Sarah Reardon, MSN, RN
System Director Capacity Command Center
Bronson Healthcare

Ryan Greiner, MD, ACPA-C
System Medical Director and Physician Advisor
North Memorial Health

Nancy C. Rush, RN, BSN, CCM
Barrow Neurovascular Care Coordinator
BNI-Advanced Practice Nursing
Barrow Neurological Institute
Dignity Health I St. Joseph's Hospital and Medical Center

3:15pm – 3:45pm
Networking & Refreshments Break

3:45pm – 4:30pm
Capacity Management and Patient Access
Care managers often find themselves managing capacity challenges when patients can't get appointments, surgeries are delayed or post-acute care placement takes days. While capacity management isn't traditionally a care management function, these delays directly impact patient outcomes and satisfaction. This session explores how care management teams are working with operations to improve patient access including facilitating urgent appointments, coordinating surgical scheduling, expediting post-acute placement and addressing capacity

bottlenecks. You'll learn about effective collaboration between care management and operations, tools for tracking access delays and interventions that actually improve capacity.
Sarah Reardon, MSN, RN
System Director Capacity Command Center
Bronson Healthcare

4:30pm – 5:15pm
Beyond Discharge: The Patient Experience Advantage in Care Management and Transitional Care
What if one of the most powerful tools for reducing care gaps and improving outcomes isn't clinical at all? Patients don't remember our care plans, they remember how we made them feel. Successful care transitions require more than coordination, they require connection. This session explores how patient experience influences engagement, adherence, readmissions, and outcomes. Learn practical strategies to strengthen communication, build trust, and create seamless transitions that improve both patient outcomes and care management success.
Paul S. Kuzmickas, JD
Enterprise Director | Clinical and Operational Improvement
Cleveland Clinic

5:15pm
End of Day One

Day Two – Friday, January 29, 2027

7:15am – 8:00am
Networking Breakfast

8:00am – 8:15am
Chairperson's Remarks

8:15am – 9:00am
Transitions of Care: Reducing Readmissions and Improving Continuity
Hospital readmissions often result from breakdowns during transitions—medication errors, missed follow-up appointments, lack of post-discharge support or failure to communicate with outpatient providers. Effective transitional care requires coordination across settings, timely communication and ensuring patients understand their post-discharge care plans. This session examines evidence-based transitional care interventions including pre-discharge planning, medication reconciliation, timely follow-up calls, outpatient appointment scheduling and post-acute care coordination. You'll learn which interventions deliver the best readmission reduction, how to structure transitional care teams and measuring program effectiveness.
Tori Eide, MSN
Mayo Clinic

Anthony J. Narr, DPN, RN

Mayo Clinic

9:00am – 9:45am
EHR and AI Integration: Technology That Helps Instead of Hinders
The integration of artificial intelligence (AI) with electronic health records (EHRs) presents an opportunity to improve healthcare delivery while reducing administrative burdens on care managers and clinicians. Technologies such as ambient documentation, care gap identification, risk stratification, and clinical decision support can streamline workflows and allow healthcare professionals to spend more time engaging with patients. However, AI should help rather than hinder clinical practice by minimizing complexity, alert fatigue, duplicate documentation, and workflow disruption. Staying ahead of the curve requires healthcare organizations to continuously evaluate emerging AI technologies, invest in research, and implement evidence-based innovations that demonstrate measurable value. Successful integration also requires attention to interoperability, cybersecurity, privacy, ethical considerations, workforce education, and vendor evaluation. Organizations that proactively embrace responsible AI innovation will be better positioned to adapt to the rapidly evolving healthcare environment. Ultimately, the goal is not simply to adopt the newest technology, but to integrate AI thoughtfully into EHR workflows to improve efficiency, support informed decision-making, enhance care coordination, and preserve patient-centered care.
Anu Banerjee, PhD
Chief Operating Officer
Mohawk Valley Health System

9:45am – 10:15am
Networking & Refreshments Break

10:15am – 11:00am
Avoiding Preventable ED Admissions to Restore Hospital Capacity
Emergency department boarding and hospital capacity constraints are often approached as throughput problems, with efforts focused on reducing length of stay, accelerating discharge, and improving bed turnover. These efforts are essential, but focusing on throughput alone fails to recognize the full scope of the system that creates and consumes hospital capacity. While throughput interventions may reduce length of stay by 10 to 20%, safely avoiding an unnecessary admission represents a 100% reduction in inpatient length of stay for that encounter, making admission avoidance a high-leverage opportunity within a broader capacity strategy. UCLA Health applied improvement science methods, including a high-level aim, driver diagram, system-level measurement, and individual case review, to identify variation in admission decisions and barriers to alternative dispositions. Direct care manager intervention helped translate this learning into enhancements to existing workflows, stronger clinical and operational relationships, and better use of community resources and partnerships with other hospitals. This session will demonstrate how case-level learning and iterative improvement can make admission avoidance a high-leverage component of a comprehensive system strategy to improve patient flow, preserve capacity, and connect patients with the right care in the right setting.

Scott Jahnke
Patient Flow Command Center Director
UCLA Health

Gabriella Garza, DNP, MSN, FNP-BC, CMGT-BC, IQCI
Senior Manager, Medicine and Emergency Department
Care Coordination & Clinical Social Work
UCLA Health

11:00am – 11:45am
Optimizing ED Flow: Data-Driven Strategies to Reduce Avoidable Visits and Costs
This session demonstrates how our health system leveraged data analytics to reduce low-acuity ED visits , decrease ED-attributed costs, and improve patient satisfaction through targeted interventions. Healthcare leaders, ED administrators, population health managers, and analytics professionals will gain actionable strategies to optimize emergency services and enhance performance in value-based care models.
Patrice Callagy, RN, MPA, MSN, CEN
VP-Chief Nursing Officer, Stanford Emergency Services
Stanford Health Care

Shashank Ravi, MD, MBA
Medical Director of Health Plans and Value Based Care
Stanford Health Care

11:45am – 12:30pm
Staffing and Retention: Keeping Experienced Care Managers
Care management departments lose experienced staff to better-paying hospital roles, less stressful positions or burnout from impossible caseloads. Building stable teams requires more than competitive salaries when budgets are constrained. This session examines what actually keeps care managers engaged including manageable caseload ratios, career development opportunities, work-from-home flexibility, meaningful recognition and addressing the factors that drive burnout. You'll explore recruitment strategies when you can't match hospital compensation, onboarding programs that set new hires up for success and retention initiatives that don't require large budget increases.

- Caseload benchmarks and workload management strategies
- Career ladder development for care manager advancement
- Flexible work arrangements that improve retention without compromising care
- Recognition programs and culture changes that reduce turnover

Phil Hatfield DNP, MBA, RN, NEA-BC, FACHE
Vice President Patient Care Services
Main Line Health

12:30pm
Conference Concludes

12:45pm – 2:45pm

Workshop: Post-Acute Care Coordination and SNF Partnerships

Delays in post-acute care placement extend hospital stays, increase costs and frustrate patients and families. Building effective relationships with skilled nursing facilities, home health agencies and rehabilitation centers improves placement speed and quality. This workshop examines strategies for post-acute care coordination including facility partnerships, quality assessment beyond star ratings, placement protocols that balance patient preference with appropriate level of care and tracking post-acute outcomes. You'll learn about common post-acute placement barriers, facility relationship building and ensuring successful transitions.

Charles Ross
Chief Strategy Officer / Partner
TCM Consulting & Management

Michelle Stuercke
Chief Clinical Officer
TCM Consulting & Management