Centers for Medicare & Medicaid Services
National Conference on Care Transitions
Speaker Biographies

Cathie Berger is the Director of the Area Agency on Aging at the Atlanta Regional Commission. She is responsible for planning and administering the delivery of aging services provided through federal, state, local and private funding sources in the ten-county Atlanta Region. Ms. Berger oversees the 25 plus aging services contracts and multiple programs including the Atlanta Regional Commission's new Lifelong Communities Initiative designed to prepare local communities for the dramatic increase in the Region's older population. She has been with the Atlanta Regional Commission for the past 28 years. She received her Bachelor's Degree in Social Work in South Africa and her Master's Degree in Social Work from the University of Georgia.

Donald M. Berwick, MD, MPP, is the Administrator for the Centers for Medicare and Medicaid Services (CMS). As Administrator, Dr. Berwick oversees the Medicare, Medicaid, and Children's Health Insurance Program (CHIP). Together, these programs provide care to nearly one in three Americans. Before assuming leadership of CMS, Dr. Berwick was President and Chief Executive Officer of the Institute for Healthcare Improvement, Clinical Professor of Pediatrics and Health Care Policy at the Harvard Medical School, and Professor of Health Policy and Management at the Harvard School of Public Health. He also is a pediatrician, adjunct staff in the Department of Medicine at Boston's Children's Hospital and a consultant in pediatrics at Massachusetts General Hospital. Dr. Berwick has served as Chair of the National Advisory Council of the Agency for Healthcare Research and Quality, and as an elected member of the Institute of Medicine (IOM). He also served on the IOM's governing Council from 2002 to 2007. In 1997 and 1998, he was appointed by President Clinton to serve on the Advisory Commission on Consumer Protection and Quality in the Healthcare Industry. Dr. Berwick is the recipient of numerous awards and honors for his work, including the 1999 Ernest A. Codman Award, the 2001 Alfred I. DuPont Award for excellence in children's health care from Nemours, the 2002 American Hospital Association's Award of Honor, the 2006 John M. Eisenberg Patient Safety and Quality Award for Individual Achievement from the National Quality Forum and the Joint Commission on Accreditation of Healthcare Organizations, the 2007 William B. Graham Prize for Health Services Research, and the 2007 Heinz Award for Public Policy from the Heinz Family Foundation. A summa cum laude graduate of Harvard College, Dr. Berwick holds a Master in Public Policy degree from the John F. Kennedy School of Government. He received his medical degree from Harvard Medical School, where he graduated cum laude.

Jane Brock, MD, MSPH, is the Chief Medical Officer for the Colorado Foundation for Medical Care (CFMC), the Medicare Quality Improvement Organization (QIO) for Colorado. She spent 25 years in clinical practice in urgent care and occupational medicine. Dr. Brock received her MD from The University of Kansas, her MSPH and Preventive Medicine training from The University of Colorado, and a Bronze-level LEAN certification from the Society of Manufacturing Engineers. She is the Chief Medical Officer for the Care Transitions QIO Support Contractor. The Care Transitions theme is a 3-year project funded by the Centers for Medicare and Medicaid Services (CMS) which aims to improve the quality of care transitions and to reduce 30-day readmissions among Medicare beneficiaries residing in the 14 communities.

Sara Butterfield, RN, BSN, CPHQ, CCM, is IPRO's Senior Director of Health Care Quality Improvement and serves as the Care Transitions Theme Lead for the Centers for Medicare & Medicaid Services' (CMS) 9th Scope of Work. Ms. Butterfield is responsible for facilitating and managing quality improvement initiatives addressing the National Quality Improvement Priorities for Medicare beneficiaries, as identified by CMS. Since joining IPRO in July 1998, Ms. Butterfield has coordinated collaborative partnerships with acute care hospitals, private physician practices and health care providers on a multidisciplinary level to facilitate performance improvement initiatives in support of CMS' project objectives. Ms. Butterfield holds a Bachelor's of Science Degree in Nursing from Russell Sage College, Troy, NY. She received the Certified Case Manager credential from the Commission for Case Manager Certification and is a Certified Professional in Healthcare Quality, through the national Healthcare Quality Certification Board.

Louis G. Colbert, MSW, LSW, is the Director of the Delaware County Office of Services for the Aging (COSA). In this capacity he is responsible for administering an office of county government and the AAA that provides direct and contracted community services to in excess of 15,000 elderly residents. Louis has been a member of the American Society on Aging (ASA) board of directors since 2003 and recently was elected Chair Elect of the board. He chairs the PA Department of Aging's Cultural Diversity Advisory Council and has taught gerontology courses at both Lincoln and Widener Universities. Louis sits on various hospital committees such as the Crozer Keystone Health System Care Coordination Committee, CK Heart Failure Transition Team, and the CK Village Steering Committee. He is a trained Alzheimer support group facilitator and has run a caregiver support group at his church for the past 5 years. Louis has a BA degree from Morehouse College in Atlanta, GA and his MSW is from Temple University in Philadelphia, PA.

Eric A. Coleman, MD, MPH, is Professor of Medicine within the Divisions of Health Care Policy and Research and Geriatric Medicine at the University of Colorado Denver. Dr. Coleman is the Director of the Care Transitions Program, aimed at improving quality and safety during times of care "hand-offs". Dr. Coleman received his medical degree from University of California San Francisco and his public health degree from University of California Berkeley. He completed his residency in primary care internal medicine, fellowship in Geriatric Medicine, and fellowship in the Robert Wood Johnson Foundation Clinical Scholars program all at the University of Washington in Seattle. Dr. Coleman bridges innovation and practice through: (1) enhancing the role of patients and caregivers in improving the quality of their care transitions across acute and post-acute settings; (2) measuring quality of care transitions from the perspective of patients and caregivers; (3) implementing system-level practice improvement interventions and (4) using health information technology to promote safe and effective care transitions. Dr. Coleman developed the Care Transitions Intervention that has been shared with over 350 leading health organizations nationwide. He participated in the drafting of Section 3026 of the Affordable Care Act. For more information please go to http://www.caretransitions.org.

Jeff Critchfield, MD, is an Associate Professor in the Department of Medicine, at the University of California, San Francisco (UCSF). He serves as the Chief of the Division of Hospital Medicine and the Medical Director of Risk Management at San Francisco General Hospital (SFGH). Dr. Critchfield attended college at Stanford University where he received a BAS degree for work in Biology and Classical Studies. He received his medical degree from UCSF and stayed on to complete a residency in internal medicine and a fellowship in Rheumatology. Dr. Critchfield joined the UCSF faculty in 2001, serving as Director of Inpatient Medicine at SFGH. In 2003, he was named the Vice-Chief of the Medical Service and from 2007 through 2009 he served as the Chief of the Medical Staff at SFGH. As Director of Inpatient Medicine, Dr. Critchfield developed programs to enhance planning for placement, housing and connection to psychiatric and drug treatment programs for patients transitioning from the hospital. In 2008, he was named Co-Principal Investigator on a grant from the Gordon and Betty Moor Foundation to establish the Support from Hospital to Home for Elders (SHHE) project. The grant supports the adaption and implementation of the Project RED transition program to meet the needs of elderly patients at SFGH who speak English, Spanish, Cantonese or Mandarin. SHHE is conducting a randomized controlled trial comparing the SHHE intervention + usual care to usual care alone, with the intent to evaluate impact on readmission rates among seniors of diverse cultural and socioeconomic backgrounds.

Ray DuCoeur has served as the Administrator for the Westmoreland County Area Agency on Aging since April of 1986. That was following his work as the Agency's Administrative Officer beginning in March of 1981 and his start as a caseworker with the Agency in May of 1977. During his tenure, the Agency has received numerous awards and honors for innovative service programs including honors from the National Association of Counties, The Southwestern PA Partnership on Aging and the Faith in Action Program. He organized and implemented several statewide training conferences, presented papers at national, regional and statewide conferences and had served by the appointment of the Secretary of Aging on the Statewide Training Advisory Council. Mr. DuCoeur holds a Master's Degree in Psychology from Duquesne University (1974) and completed 48 credit hours of Doctoral work in clinical-systematic psychology. He resides in West Newton, Pennsylvania, with his wife Georgia and their two children at home, Mary and Lucy.

Alicia Goroski, MPH, is the Care Transitions Project Director at CFMC. Alicia received her Master in Public Health from Rollins School of Public Health at Emory University in 1997 and has worked in public health and quality improvement for 12 years. Alicia's public health work focused primarily in the area of injury research and prevention. She has worked for the Centers for Disease Control and Prevention, the Louisiana State Health Department, the University of Alabama, and the Alabama Department of Public Health. She has managed a variety of CMS-funded projects, including aspects of the HeartCare QIO Support Contract and special studies related to Transitions of Care and Geographic Variation in Healthcare Utilization. Alicia is now directing the Care Transitions activities at CFMC, including the Care Transitions QIO Support Contract, the local Care Transitions project in NW Denver, and a Geographic Variation special study.

Kathy Greenlee was appointed by President Barack Obama as the fourth Assistant Secretary for Aging at the U.S. Department of Health and Human Services and confirmed by the Senate in June 2009. Ms. Greenlee brings over 10 years of experience advancing the health and independence of older persons and their families. Prior to becoming Assistant Secretary, Ms. Greenlee served as Secretary of Aging for the state of Kansas. In that capacity, she led a cabinet-level agency with 192 full-time staff members and a total budget of $495 million. Her department oversaw the state's Older Americans Act programs, the distribution of Medicaid long term care payments and regulation of nursing home licensure and survey processes. She also served on the board of the National Association of State Units on Aging. Before her tenure as the Secretary of Aging, Ms. Greenlee served as State Long Term Care Ombudsman in Kansas, and the state's Assistant Secretary of Aging. Ms. Greenlee also served as general counsel at the Kansas Insurance Department. During her tenure there, she led the team of regulators who evaluated the proposed sale of Blue Cross/Blue Shield of Kansas, and oversaw the Senior Health Insurance Counseling for Kansas program. Greenlee also served as Chief of Staff and Chief of Operations for then Governor Kathleen Sebelius. Ms. Greenlee is a graduate of the University of Kansas with degrees in business administration and law.

Naomi Hauser, RN, MPA, CLNC, has more than 30 years of long term care experience, including clinical, administrative and regulatory skill sets. She is a Director of Healthcare Quality for Quality Insights of Pennsylvania, The QIO in Pennsylvania in King of Prussia (2005-present). She directed the CMS Nursing Home Quality Initiative in PA from 2002-2008. She lead a team that partnered with over 400 LTC providers to improve the quality of care and quality of life for the residents and staff through the continuous quality improvement process. She is presently the Director of the CMS Care Transitions Project for Pennsylvania which is being conducted in the Western Pittsburgh area since July 2008. Fourteen other states are participating in this cross setting community focused project. She received her RN from Beth Israel Medical Center in New York City, a Bachelor's Degree in Health Care Administration from St Josephs in Wyndham Maine and Master's Degree in Public Administration from New York State University at Brockport. She is a Certified Legal Nurse Consultant. She was a Long Term Care Nurse Surveyor with the New York State Department of Health. This skill set gives her a perspective from both the provider and regulatory viewpoint of long term care.

Robin Jones, RN, has over sixteen years of experience in the hospital setting and is a Quality Improvement Coordinator at Valley Baptist Medical Center in Brownsville, Texas. Ms. Jones is the lead Care Transitions project facilitator at VBMC-B. She led the Hospital's implementation of Project RED components resulting in a 3.6% reduction in all cause readmission rates and a final rate that exceeds the national average. As a Quality Improvement Coordinator, Ms. Jones oversees VBMC-B's Joint Commission (JC) re-accreditation for the hospital and lab and re-certification stroke program. Additional projects include a Six Sigma Greenbelt Certification, Change Agent Training and initiative on anticoagulation. She graduated with an Associate Degree in Nursing from the University of Texas-Brownsville.

Tim Landrin has worked with the Southwestern Pennsylvania Area Agency on Aging (AAA) for 33 years. He began his career in aging as a medical caseworker for the agency's Mobile Services to the Aging Program. He also was the Supervisor of the Domiciliary Care Program for 6 years. He has been in his current position as Director of the Home and Community-Based Long Term Care Division for the AAA for the past 25 years. Mr. Landrin holds a Bachelor's degree in Sociology from St. Vincent College and a Master's degree in Public Administration from the University of Pittsburgh Graduate School of Public and International Affairs. He has also taught courses in Gerontology at California University of Pennsylvania and Washington & Jefferson College.

Barbara Alexis Looby, MSW, MSWAC, LSW, is the Administrative Director of Senior Health Services for Crozer-Keystone Health System and is responsible for the health system's geriatric product line. Ms Looby has developed and implemented senior specific programs across the continuum of care. She created the Department of Senior Health Services and launched the Senior Support Line to provide ease of access for older adults, their families and their health care providers. More recently Ms. Looby spearheaded an initiative to provide better care coordination for older at risk adults and has partnered with the Area Agency on Aging to meet the needs of this population in Delaware County, Pennsylvania. Ms Looby has also developed a village model within a health system and to date Crozer-Keystone is the only health system in the country that owns and operates a village modeled program. Ms. Looby is a member of several organizations, including The National Council on Aging, The Long Term Care Council for The Hospital & Healthsystem Association of Pennsylvania, and The American Society on Aging (ASA) and is on the Leadership Council of ASA's Healthcare and Aging Network. Throughout her career Ms. Looby has received several recognitions for her work.

Linda Magno directs the Medicare Demonstrations Program Group at CMS. Her group is responsible for developing, implementing, and managing Medicare demonstrations of new models of health care delivery for the nation's 40 million Medicare beneficiaries. Medicare demonstrations have historically tested the impacts, feasibility and desirability of new benefits, payment methodologies, and delivery system alternatives, before they were incorporated into the Medicare program on a permanent basis. Ms. Magno previously served as Managing Director for Policy Development and Director of Regulatory Affairs at the American Hospital Association in Washington, DC. She started her career at CMS' predecessor agency, the Health Care Financing Administration (HCFA). In her first tour at HCFA, she was responsible for implementing and refining the prospective payment system for hospitals. Ms. Magno has a Master's degree in Public Affairs from Princeton University and a Bachelor's degree in Political Science from the University of California at Berkeley.

Jennifer Markley, RN, BSN, is the Senior Director of Medicare Quality Improvement and Director of the Texas Care Transitions Project for TMF Health Quality Institute in Austin, Texas. Ms. Markley has over 33 years of experience as a Nurse, Manager and Healthcare Administrator in the ICU, home health and quality improvement fields. She has been overseeing health care quality improvement projects at TMF for the past seven years. Ms. Markley is a graduate of Baylor University in Waco, Texas.

Andrew Miller, MD, MPH, is the Director of Physician Services for Healthcare Quality Strategies, Inc. (HQSI), a nonprofit organization based in East Brunswick, NJ, which is the federally-designated Medicare quality improvement organization for New Jersey. He is the co-leader of HQSI's New Jersey Care Transitions Project, the goal of which is to improve transitions of care and reduce preventable hospital readmissions for Medicare recipients residing in Southwestern New Jersey. This project is part of a CMS Care Transitions theme being undertaken by 14 state quality improvement organizations in the 9th Scope of Work. Before joining Healthcare Quality Strategies, Dr. Miller worked at the New Jersey Department of Health for 14 years. Dr. Miller, who is board certified in Public Health and General Preventive Medicine, is a graduate of Columbia University's College of Physicians and Surgeons and earned his MPH at the Harvard School of Public Health.

Mary D. Naylor, PhD, RN, FAAN, is the Marian S. Ware Professor in Gerontology and Director of the NewCourtland Center for Transitions and Health at the University of Pennsylvania School of Nursing. Since 1989, Dr. Naylor has led an interdisciplinary program of research designed to improve the quality of care, decrease unnecessary hospitalizations, and reduce health care costs for vulnerable community-based elders. Dr. Naylor is also the National Program Director for the Robert Wood Johnson Foundation program, Interdisciplinary Nursing Quality Research Initiative, aimed at generating, disseminating, and translating research to understand how nurses contribute to quality patient care. She was elected to the National Academy of Sciences, Institute of Medicine in 2005. She also is a member of the RAND Health Board, the National Quality Forum Board of Directors and chairs the Board of the Long Term Quality Alliance. She was recently appointed to the Medicare Payment Advisory Commission. Dr. Naylor received her MSN and PhD from the University of Pennsylvania and her BS in Nursing from Villanova University.

Robert W. Pryor, MD, MBA, age 59, is President & Chief Executive Officer designee of Scott & White Healthcare. He has been Chief Operating Officer of Scott & White since 2007 and was Chief Medical Officer from 2005 – 2010. Dr. Pryor is certified in Lean Healthcare from the University of Michigan, College of Engineering, Center for Professional Development. Prior to joining Scott & White, Dr. Pryor served as Chief Medical Officer at St. Joseph's Hospital and Medical Center in Phoenix, Arizona. Board Certified by the American Board of Pediatrics, Dr. Pryor is also a Fellow of the American College of Chest Physicians and The American College of Critical Care Medicine. He is a graduate of Baylor University in Waco, and received his medical degree from The University of Texas Medical Branch at Galveston. Dr. Pryor completed a Pediatric Internship and Residency at The University of Oklahoma Health Sciences Center, and a pediatric intensive care medicine fellowship at Baylor College of Medicine in Houston. He earned an MBA from Arizona State University and is a member of The American College of Physician Executives.

Dianne M. Richmond, RN, MSN, APN, is a Women's Health Nurse Practitioner by training and has over twenty years of clinical experience in nursing and fifteen years in nurse leadership roles. Past roles include provision of care in long term care, home care, hospice and acute care settings. Nurse leader roles include Nurse Manager, Care Coordinator, Director of Regulatory Affairs and Vice President of Patient Safety and Quality. Together these experiences provide a triangulated understanding of the healthcare delivery process across care settings which include clinical, operations and regulatory processes. She has worked on an international HIV/AIDS project in Zambia that was funded by the U.S. State Department and sub-awarded by the Elizabeth Glaser Pediatric AIDS Foundation providing administrative oversight to a project that partnered with the Government of Zambia to provide HIV/AIDS Care to the citizens of Zambia. During the first year of the project over 15,000 patients were enrolled in HIV/AIDS care. She is a Theme Lead for Alabama's Quality Improvement Organization providing administrative oversight for the implementation of all activities in the CMS Ninth Statement of Work related to the Patient Safety and Care Transitions Projects. She is currently pursuing her PhD in Nursing from the University of Alabama at Birmingham.

Laurie Robinson, RN, CPE, CPUR, has served as Director of Quality for eQHealth Solutions, the Medicare Quality Improvement Organization (QIO) for Louisiana, since 2006. In her current role, she manages the new Care Transitions pilot and Beneficiary Protection portions of the QIO's contract with CMS. Prior to joining eQHealth, Ms. Robinson served as Director of Medical Management for Calais Health, LLC in Baton Rouge from 2002 – 2006 and in the same role with Our Lady of the Lake Regional Medical Center in Baton Rouge from 1997 – 2002. Her major focus has most recently been on case and disease management, quality improvement and utilization review. Ms. Robinson is a graduate of Our Lady of the Lake College of Nursing and is a Certified Patient Educator and an InterQual® Certified Professional in Utilization Review.

Matthew J. Schreiber, MD, is the Vice President and Chief Medical Officer at Piedmont Hospital—a 481 bed acute care facility in Atlanta. He attended Stanford University for his undergraduate degree in International Relations. He went to medical school at the Sackler School of Medicine at the University of Tel Aviv. He attended a combined internal medicine and pediatrics residency program at University of California San Diego. After completing his training he worked as a rural primary care physician providing inpatient and outpatient care to both pediatric and adult patients. He subsequently transitioned into the hospital environment when he joined the Piedmont Hospitalist Physicians group in 2004. He assumed the Medical Directorship for Hospitalist Services throughout Piedmont Healthcare in 2006. Securing safe discharges has always been a passion of his. Piedmont Hospital was selected by the Society of Hospital Medicine to be among the first 6 pilot sites for project BOOST approximately 2 years ago. Since that time, he has been championing transitions of care for Piedmont patients. Today, he will describe his experiences for us.

Alan B. Stevens, PhD, holds the Vernon D. Holleman-Lewis M. Rampy Centennial Chair in Gerontology at Scott & White Healthcare and is a Professor of Medicine and Public Health at the Texas A&M University System Health Science Center. He is the Director of the newly created Center for Applied Health Research (CAHR) a joint endeavor of Scott & White Healthcare, Texas A&M College of Medicine and the Central Texas Veterans Health Care System to promote collaborative research across six translational and outcomes research units. Dr. Stevens' Program on Aging and Care, which develops and implements evidence based clinical interventions for older adults and their caregivers, and his NIH-funded Community Research Center for Senior Health, are core research units within CAHR. In this administrative leadership role within the Scott & White Division of Research, Dr. Stevens Chairs the Scott & White Research Grants Program and serves as Scott & White's representative to HMO Research Network (HMORN) Board of Governors. Dr. Stevens completed his graduate training at the University of New Orleans, earning a Master's degree and a Doctorate of Philosophy in Applied Developmental Psychology. Prior to joining Scott & White Healthcare and Texas A&M in 2005, he was an Associate Professor of Medicine at the University of Alabama at Birmingham.

Denise V. Stewart, MSW, is the Deputy Director of Long Term Care at the Delaware County Office of Services for the Aging (COSA). She is a graduate of West Chester University and holds a Master's Degree of Social Work Administration from Temple University. She has been active in the field of aging for over 30 years. Her work experience over the past 30 years her includes working as a Care Manager for COSA, at a Home Care agency as a Home Care Department Manager, Admissions Director and Social Work Director at an area nursing home, Social Worker at an area hospital, Supervisor and Home and Community Based Services Program Director at COSA prior to her becoming the Deputy Director in 2001. Fifteen years ago, COSA partnered with Crozer Chester Medical Center for five years to provide transitional care services. In February 2010, COSA partnered with Crozer Keystone Hospital System, Senior Health Services to do a pilot Care Transition project in Delaware County, PA.

Juliana Tiongson, MPH, serves as the team lead for the Medicare Community-Based Care Transitions Program. Ms. Tiongson has 15 years of experience working in the public health arena predominantly in the nonprofit and public service sectors. She has worked in the fields of psychiatric rehabilitation, psychiatric research, stem cell research, and most recently research on the Medicare population. Over the past 6 years she has worked as a Social Science Research Analyst at the Centers for Medicare and Medicaid Services. In this role, her research has focused on care coordination, disease management, and case management for Medicare fee-for-service beneficiaries. She has served as Project Officer for the BIPA Disease Management Demonstration, the LifeMasters Dual Eligible Disease Management Demonstration, the Care Management for High Cost Beneficiaries Demonstration, the Home Health Third Party Liability Demonstration, and the Medicare Coordinated Care Practice Research Network. She is versed in Medicare policy and procedures, operations related to the Medicare demonstration programs, and quality improvement. Prior to her work at the Centers for Medicare and Medicaid Services, she served as a research associate in The Center for the Study of Traumatic Stress at the Uniformed Services University of the Health Sciences. There her research focused on the biological basis of Acute Stress Disorder and Posttraumatic Stress Disorder. Ms. Tiongson is an active member of the Society for Public Health Education.

Mark V. Williams, MD, FACP, FHM, is Professor and Chief of the Division of Hospital Medicine at Northwestern University Feinberg School of Medicine. Dr. Williams graduated summa cum laude from Emory University School of Medicine and completed a residency in Internal Medicine at Massachusetts General Hospital. He also completed a faculty development fellowship in General Medicine at the University of North Carolina-Chapel Hill, the Woodruff Leadership Academy at Emory, the Program in Palliative Care Education and Practice at Harvard, and the Advance Training Program in Health Care Delivery Improvement sponsored by Intermountain Healthcare's Institute for Health Care Delivery Research. A Past President of the Society of Hospital Medicine and Editor-in-Chief of the Journal of Hospital Medicine, he actively promotes the role of hospitalists as leaders in delivery of health care to hospitalized patients. Dr. Williams was Principal Investigator on the Hartford Foundation-funded, $1.4 million, 3-year Project BOOST "Better Outcomes for Older adults through Safe Transitions." In 2009 he served as a Co-Chair for the AMA Physician Consortium for Performance Improvement (PCPI) Transitions of Care Work Group which developed measures for the hospital discharge transition that have been approved by the National Quality Forum, and was named to Technical Expert Panels on Care Transition Measures for CMS and the Medicare Payment Advisory Committee (MedPAC).