



Care Transitions: What Does It Really Look Like?

Thursday, June 5, 2014 • Des Moines, Washington

Highlights



- 160 attendees
- Workshops:
- 70 organizations
- 1. Discharge Planning From Day One
- 2. Frequent Flyers: Developing Community-based Strategies to Serve Frequent ER Visitors
- 3. Home and Beyond: Long-term Services & Supports
- 4. Managing Depression, Anxiety and other Psychiatric Symptoms While Making Healthy Transitions
- 5. Medication Challenges in Care Transitions: Issues Faced by Patients, Providers & Community Professionals
- Communication
- Collaboration
- Connections

"The most moving and important part of the day was hearing from the 'live' experiences of family caregivers. We need more of this truth telling!"

— Participant comment

Report

Aging and Disability Services—the Area Agency on Aging for King County—convened Care Transitions: What Does It Really Look Like?, a one-day conference on Thursday, June 5, 2014 at Wesley Homes, a nonprofit continuing care retirement community in Des Moines, Washington. The conference focused on reducing unnecessary hospitalizations (especially re-hospitalizations) in south King County.

The [conference webpage](#) provided background information and pre-reading materials about hospital readmissions and community-based care transitions models. For the conference program, with agenda, [click here](#).

Care Transitions: What Does It Really Look Like?

In the opening general session, Selena Bolotin shared progress made in south King County over the past three years:

- The readmission rate has improved—dropping from 18.3 percent in 2010 to 16.2 percent in 2013.¹
- While the south King County readmission rate is still higher than the state average, improvement in this geographic area has exceeded improvement statewide.
- South King County experienced increases in ED and Observation visits but a significant decrease in Nursing Home readmits in 2013.

Prior to the conference, participants received a link to Qualis Health's [Community Performance Report: Improving Care Transitions and Reducing Hospital Readmissions](#) (South King County data thru 12/31/2013, created 5/29/14).

Ms. Bolotin then moderated a panel presentation on key strategies for successful care transitions related to standardizing processes, improving communications and patient and family engagement.

Bruce Rehm discussed how the Kitsap County Cross Continuum of Care Transitions Project got started two years ago. He outlined the following:

- Mission, purpose, vision, strategies, goals, scope, structure, responsibilities and deliverables of the project.
- SMART (specific, measureable, attainable, relevant, time-bound) goals.
- Start small and involve stakeholders.
- Let data drive activity.
- Ensure that meetings are well-managed.

Nikole Jay discussed strategies for improving health care and patient experience at a lower cost, including:

- Provision of sub-acute services outside of hospital setting.
- Transitional support.

Opening Session Panelists:

- Selena Bolotin, LICSW, Director, Washington Care Transitions and Patient Safety, Qualis Health (moderator)
- Bruce Rehm, Manager, Operational Improvement, Harrison Medical Center
- Nikole L. Jay, Executive Director, Judson Park
- Andy Barrett and Mary Dunlap, family caregivers



Bruce Rehm, Harrison Medical Center, described the genesis of the Kitsap County Cross Continuum of Care Transitions Project.

¹ The non-dual (Medicare only) readmit rate is 14.2 percent while the dual (Medicare-Medicaid) readmit rate is 21.1 percent.

- Risk assessment.
- Short-stay orientation.
- Holistic wellbeing focus in discharge planning.
- Integration of Interact tools with electronic medical records.
- Patient and family education.
- Follow-up with primary care providers and specialists.

Mary Dunlap and Andy Barrett shared their loved one Donna's experience over eight months of care. Highlights included:

- Eight hospital stays (four different hospitals).
- Twenty-one medications upon discharge.
- Stays at four skilled nursing facilities.
- Twenty doctors and "countless" nurses.

"What happens to patients without family?"

—Mary Dunlap and Andy Barrett,
family caregivers

They recounted incidents where healthcare workers were restricted by health care system rules, lack of access to medical records, lack of coordination with Donna's primary care provider, and fragmented transition.

A combined Powerpoint for this session is available online ([click here](#)).

Collective Wisdom: Case Studies in Care Transitions

Kathleen Moisio, Ph(C), RN, BSN, Clinical Assistant Professor of Nursing and Comprehensive Gerontologic Education Partnership Coordinator, Pacific Lutheran University, led an interactive case study exercise in which conference participants discussed community resources for community-based recovery and wellness.

Participants sat at tables by role:

- Emergency Department/EMS
- Home Health/Home Care
- Hospice/Palliative Care
- PCPs/Clinicians/Clinics
- SNF/Residential Care
- Hospital/Health System-based Care Management
- Community-based Case Management/Care Coordination
- Community-based Programs/Resources/Support Services
- Programs, Systems Operations, Quality Improvement)



Participants who work in Community-based Case Management & Care Coordination considered the most appropriate response to two complex cases.

Discussion reinforced the notion that none of us can do this work alone and all of us have a role to play in improving community-based recovery and reducing hospital readmissions. To read the case studies, [click here](#). A brief PowerPoint presentation is available [online](#).

Concurrent Workshops

Two sets of concurrent 90-minute workshops were held (morning and afternoon). Following is a synopsis and key learnings from each workshop:

Discharge Planning From Day One

Healthcare organizations have come to recognize that making decisions regarding next levels of care and giving discharge instructions to patients in the last few hours before their discharge is not effective. Transition to health requires more than hospital care. Hospitals are just one part of the care continuum. Follow-up care coordination is critically important and hospital personnel must understand care needs outside of the hospital.

In this session, representatives from Franciscan and Multicare healthcare systems discussed strategies for assessing risk and planning for discharge and follow-up care, even before a patient is admitted.

Key messages:

- Recognize importance of quality vs. quantity (cost). Change system to get reimbursed for quality care.
- Have champions to drive the work, keep the ball rolling from within the ranks—someone who believes in the process.
- Deconstruct the process in order to reconstruct it.
- Define who's responsible for which parts of the process. Hardwire process improvement.
- Develop strategies using evidenced-based practices.
- Always pilot new programs and process changes.
- Allow sufficient time. Change doesn't happen overnight.
- Discharge planning and transition is everyone's job, including bedside staff. Plan early—change the discharge process to involve the bedside people from the time they enter the hospital. Make sure timelines are realistic.
- Illness progression planning is important (personally and professionally).
- Be sure staff know about Older Americans Act, Medicare and Medicaid limitations.
- Help staff learn what programs/services are available within the community, how to help patients and family members navigate systems and how to connect with available resources, including equipment that is medically necessary.
- Develop patient communication and education strategies that include patient contact prior to stay, daily contact regarding discharge, and follow-up care coordination. Include community resources at each stage of contact.
- Encourage patients and family members to use a whiteboard.
- Caregivers may not ask for help. Some don't identify themselves as caregivers. Look at informal supports. Include family members as much as possible.

Discharge Planning From Day One

Speakers:

- Carol Higgins, OTR (Ret.), CPHQ, Quality Improvement Consultant, Care Transitions Lead & Certified INTERACT® Educator, Qualis Health (moderator)
- Kim Barwell, System Manager, Care Management, Franciscan Health System
- Stephanie Mudd, RN Case Management Manager, MultiCare Health System

- [National Alliance of Professional Geriatric Care Managers](#) is an online resource for private pay patients.
- Referral numbers for Medicaid eligibility screening are available on the ADS website: www.agingkingcounty.org/docs/southcountyservices.pdf

The combined PowerPoint presentation for this session is available online ([click here](#)).

Frequent Flyers: Developing Community-based Strategies to Serve Frequent ER Visitors

Patients seen frequently in the ER have a huge impact on Medicaid, Medicare, and fire/EMS costs, and they miss receiving the coordinated care that family doctors and internists provide. Many have a mental health diagnosis or substance abuse disorder. This workshop focused on preventive and interventional strategies in use in south King County that help patients get primary care and other services and support in the community, as well as special considerations for individuals with developmental disabilities.

Elaine Thurnhofer reported good progress in reducing frequent ER visitors:

- Between June 2012 and June 2013, the rate of ED visits by Medicaid recipients declined by 9.9 percent.
- The rate of visits by frequent utilizers (5+ visits per year) declined by 10.7 percent.
- The rate of visits resulting in scheduled drug prescription fell by 24 percent.
- The rate of visits for low-acuity diagnoses declined by 14.2 percent.

Frequent Flyers: Developing Community-based Strategies to Serve Frequent ER Visitors

Speakers:

- Elaine Thurnhofer, RN, MS, CPHQ, VP Quality Services, UW Medicine/Valley Medical Center (moderator)
- Andrea Bloom, MSW, ED Case Manager, Valley Medical Center
- Dan Peterson, Mental Health Resource Manager, Developmental Disabilities Administration, Department of Social and Health Services
- Mitch Snyder, Battalion Chief, Kent Fire Department RFA, EMS/FD CARES

Key messages:

- [Kent FD CARES](#) has had remarkable success in improving the health outcomes of individuals in need of non-emergency services.
 - Firefighter EMTs and RNs determine the underlying cause of a 911 request and determine the most appropriate solution to the problem, including education, advocacy and medical systems navigation (but not case management).
 - Four other departments in Washington state have adopted FD CARES (Olympia, South King-Federal Way-DesMoines, Kitsap, Tacoma)

- High utilizers of 911 and ED services, callers with pneumonia, CHF, Acute MI, COPD, and older residents at risk of falls receive extra support to help avoid unnecessary readmissions.
 - FD CARES also maintains a non-emergent number, which avoids costly unnecessary aid responses.
 - Data (patient information and identification, and more) is a critical component in prioritizing patients and workload. Whenever possible, FD CARES tracks home care and health care provider information, and can call agencies on a patient's behalf.
- Valley Medical Center serves Public Hospital District No. 1 of King County (doing business as UW Medicine/Valley Medical Center).
 - The hospital adheres to seven best practices for reducing preventable ER visits by Medicaid clients:
 1. Electronic Health Information
 2. Patient Education
 3. Patient Review and Coordination (PRC) Clients
 4. PRC Client Care Plans
 5. Narcotic Prescription Guidelines
 6. Prescription Monitoring
 7. Use of Feedback Information
 - Critical components for success are teamwork, patient education, and patient advocacy.
- Individuals with Developmental Disabilities (DD) have complex medical needs, often undiagnosed, and have twice the rate of complex mental health symptoms than what is found in the general population. Care must be taken to look at the cause of symptoms—genetic, neurological, TBI, FAES, and pain due to medical conditions.
 - Individuals with DD who live in the community may receive a variety of supports, but in King County, roughly one-third who qualify are actually enrolled. Of those enrolled, about two-thirds receive some sort of DDA funding.
 - Individuals with DD receive both formal and informal supports, including government, family, church community, transportation, schools, community colleges, mental health enrollment, medical care, and emergency services.
- Smart 911 and 911 text options are coming.
 - In general, the more information a caller can provide to dispatch (for medical or law enforcement response), the better the response by first responders.
 - Have brief and to the point information ready for first responders. Communicate whether patient/client has problems with touch, providing appropriate response to directions, sequencing events, or communication in general.
- Resilience starts with supporting families and service providers to access competent medical and psychiatric care, and behavior support planning.



Kent Fire Battalion Chief Mitch Snyder described how Kent FD CARES reduces need for non-emergency services and avoids unnecessary readmissions.

- For high utilizers of the 911 system we first attempt to improve information to first responders at the time of the call.
- Develop cross-system crisis plans to improve collaboration around challenging individuals.

The combined PowerPoint presentation for this session is available online ([click here](#)).

Home and Beyond: Long-term Services & Supports

Knowing what services are available and how systems work together across the continuum of settings is essential in planning for transitions of care. This workshop provided an overview of essential services and supports available via community partners, within as well as beyond Seattle and King County.

1-888-4ELDERS is an easy recall number for Senior Information & Assistance, which is the “front door” to Aging Network services funded by the federal Older Americans Act and state Senior Citizens Services Act. This includes Adult Day Services, Case Management, Chronic Care Management, Care Transitions, Elder Abuse Prevention and Survivors Support, Family Caregiver Support, Health Promotion, Home Care/Personal Care, Information and Assistance, Legal Services, Ombudsman, Nutrition, Senior Centers (Seattle only), and Volunteer Transportation. Aging and Disability Services—the Area Agency on Aging for Seattle-King County—administers the funds countywide.

Key messages:

- Caseloads are quite high, due to insufficient funding.
- Case managers are frustrated when they are not informed that a client is hospitalized. Also, it's difficult to know who to call if no supports were given at discharge.
- Electronic health records have yet to provide the kind of information needed for community-based care coordination.
- HIPPA gets in the way
- Conversations about long-term care options need to start earlier. An outside person can help but more funding is needed to provide that kind of service. May need a “conversation starter kit.”
- Patients/clients need more time.
- Need more safety net services. Not a lot of options for the homeless population. Besides housing, transportation options are limited. Telephone connection may not be possible (no phone or limited minutes). Psych/social issues present challenges.

Home and Beyond: Long-term Services & Supports

Speakers:

- Maureen Linehan, Interim Director, Aging and Disability Services (moderator)
- Bernie Dorsey, Director of Outreach, Wesley Homes Retirement Communities and Health Services
- Flanna Perkins, Director of Operations/General Manager, ResCare Home Care
- Bonni Stratton, MSW, Manager of Business Development, Franciscan Hospice and Palliative Care

- Insurance companies can't make referrals unless they get the right information from the hospital.
- Patients need more discharge support, especially with medical equipment in home.
- Need to standardize processes.
- Staff development is important.
- Some patients fear hospital employees.
- The perception of some hospital employees is that they think everything is fine, as long as the patient as a home and Medicaid. Some hospital staff seem reluctant to give referrals.
- Hospital personnel should ask the patient if they want to go home, if they really want to be at home, and who will take responsibility for medications and their overall care.
- Hospice is a viable option for many. People who leave the hospital with hospice have fewer hospital readmissions. Options include routine hospice care, continuous care, respite care, and general inpatient care.
- Client data can be shared for the benefit of the client, if an agreement is in place



Maureen Linehan, Flanna Perkins, Bernie Dorsey and Bonni Stratton discuss long-term services and supports.

Maureen Linehan's PowerPoint presentation, [Navigating Social Services for Seniors](#), is available online.

Managing Depression, Anxiety and other Psychiatric Symptoms While Making Healthy Transitions

Transitions among care settings are especially difficult for people with mental health conditions. Appropriate mental health care is an important factor when addressing avoidable hospital admissions and readmissions.

Key messages:

- One in three families have experienced a major mental health problem. Some issues don't emerge until older adulthood. Even a person with a urinary tract infection (physical) can experience delusions, hallucinations, and sudden changes in behavior (mental health manifestations that can be resolved with a medical assessment).
- One of the biggest problems we face is high-volume caseloads impede transition coordination. Follow-up is difficult. Despite an increase in caseload, staffings have decreased.

Managing Depression, Anxiety and other Psychiatric Symptoms While Making Healthy Transitions

Speakers:

- David M. Johnson, EdD, LMHC, CEO, Navos Mental Health Solutions (moderator)
- George Dicks, BA, GMHS, RCMHP, Geriatric Psychiatric Services, Harborview (PM only)
- Ken Ryan, MC-GMHS, Older Adult Services, Navos Mental Health Solutions
- Allen Tacke, MA, LMHC, GMHS, Navos Health Services
- Karin E. Taifour, MA LMHC GMHS, Crisis Case Manager, Geriatric Regional Assessment Team, Evergreen Health (AM only)

- One strategy for coping with high caseloads (learned from some doctors and interns): Give full attention to one patient each day, to remember why you do what you do and to feel good about work; otherwise, you lose your passion and burn out.
- One way mental health counseling can help is to explain deficits and perspectives. Example: A female nursing home patient had deficits following removal of brain tumors. She wanted a divorce so she wouldn't be a burden to her husband. He sought counseling. The mental health counselor spoke with each person privately and then helped each one understand that memory loss caused the patient to not track how long or how often her husband visited. She was better able to understand his continuing devotion.
- Examine:
 - Consistency of flow (i.e., we should have access to medical records and shouldn't have to reinvent the wheel).
 - Simplicity (e.g., one booklet of forms to sign, plain English, no acronyms or medical terminology, every patient knows who they can call).
 - Compatibility (between primary care and mental health systems)
 - Templates (personalize care using forms that are malleable—patients aren't widgets).
- Cultural competency is very important. Language barriers include not having mental health illness definitions available in print (even in dictionaries). There is a shortage of materials than can explain. Champions and trusted advocates can help.
- It's important to support—not scandalize—a person. Example: comfort rooms, not straps.
- Traditionally, primary care and mental health are separate. We need parity. Gains have been made in the past 10 years but not enough.
- Clients listen to their doctors, and primary care providers need a better handle on mental health issues.
- Focus on and work with patients' strengths, skills and interests. Reminiscence is powerful—help patients recall their strengths. Focus on what's positive. Problem-solving is important, using something that is motivational to the patient (e.g., a patient who needs more exercise may be motivated to walk with a grandchild who is important to him or her).
- Respect the complexity of the individual. They are not their illness or occupation. Interaction is meaningful. Being present normalizes. This is a collaborative process—involve the patient and give them choices. The more we respect the patient, the better the results.
- It's good to know the relationship between the patient and his or her caregiver.



David Johnson, Navos Mental Health Solutions, moderated the panel and discussion on behavioral health.

“Respect people’s resilience rather than focusing on pathology.”—

Participant take-away attributed to the behavioral health workshop

- A national standardized tool that can be used across systems is in the works, needed to determine capacity. A tool used in independent living is called OASIS.

Karin Taifour's PowerPoint presentation on Evergreen Health's Geriatric Regional Assessment Team is available online ([click here](#)).

Medication Challenges in Care Transitions: Issues Faced by Patients, Providers & Community Professionals

The human cost from adverse drug events is high each year:

- Drugs cost \$170 billion in morbidity and mortality.
- 88 percent of the cost of transition.
- 700,000 ER visits related to adverse drug events
- Drugs causing the highest number of ER visits were Warfarin and insulin.
- Hospital admissions carry a 36 percent medication error rate.
- Medication errors at and following hospital discharge exceed 72 percent (some hospital error and a great deal of patient misunderstanding).
- 20 percent of Medicare hospital readmissions within 30 days are due to adverse drug reactions, costing \$25 billion.

Kelley-Ross pharmacists led an interactive session that illustrated the important role of medication management in reducing hospital readmissions. First, participants critiqued a discharge summary. Flaws included:

- Several doctors were listed without explanation of who does what.
- Patient instructions were vague or non-existent.
- Medications and dosages were changed between intake and discharge, and there was little consistency between the two lists. (Different unfamiliar packaging can lead to improper dosages.)
- Patients who are ill are not going to read all the pages, and may not be health literate.
- Follow-up appointments lacked consistency. Two visits—with two different doctors—carried no explanation.
- One page had “gobbledygook” printing.

Other messages included:

- Patients take comfort in “zip lock bags” of medications.
- Some physicians do not return phone calls or communicate with other providers.
- Medication changes happen quickly—sometimes weekly.
- Multiple prescribers means more room for error.

Medication Challenges in Care Transitions: Issues Faced by Patients, Providers & Community Professionals

Speakers:

- Mary Pat O'Leary, RN, BSN, Aging and Disability Services (moderator)
- Josh Akers, PharmD, RPh, Community Operations Manager, Kelley-Ross Pharmacy
- Geoffrey Meer, PharmD, RPh Consultant Pharmacist, Kelley-Ross Pharmacy
- Shanna O'Connor, PharmD, BCPS University of Washington School of Pharmacy Faculty Fellow

- A number of medical reconciliation models are available (e.g., Johns Hopkins, University of Kansas, Duke University).

Various studies highlight medication issues at home:

1. Medications are located throughout the home.
2. Medications are older than three months.
3. Patients use multiple pharmacies (no coordination).
4. Bottles are dirty.
5. Medications are mixed together.
6. Patients receive multiple strengths of the same medications.
7. Patients have more than one bottle of the same medication.
8. Drug interactions include over-the-counter and herbal and OTC medications.
9. A common drug-related adverse reaction is dry mouth, which affects dental health—a precursor to other health problems.
10. Medications are not stored properly.



Kelley-Ross pharmacists led an interactive workshop on medication challenges faced by patients and caregivers.

How to improve the process at facilities:

1. Use in-house pharmacy or understand how to use the pharmacy well.
2. High risk sheet.
3. Right medication at the right time.
4. Communicate with the doctor and pharmacy, ask patient to bring medications when admitted (including herbal and OTC).
5. Find out where patients buy medications. Call the pharmacy to request a fax list.
6. Ask the patient why they no longer take medications.
7. Time-intensive: use a technician.
8. Determine how to streamline process.

Clinic visits: Patients may be reluctant to bring meds if they have health conditions that affect mobility and limited transportation options. For example it would be difficult for someone with a walker taking the bus to bring medications. Instead call the pharmacy.

Pharmacy review is time intensive. Focus on those most at risk. Reward patients for following their regime. Build relationships so patients look forward to the visit

Measurements of success that may attract partners and funders:

1. Number of patients.
2. Time interactions (patient visits) with patient. Expect the amount of time will go down for patient consults.
3. Readmission rate.
4. Number of ER visits.
5. Number of medications per patient.
6. Patient understanding.
7. Number of problems resolved (MRP=Medical Retention Process).

Take-aways included:

1. Look at issues from patient perspective

2. Provide value to the patients
3. Begin the conversation/relationships
4. Share with others
5. Focus on high flyers
6. Use multifaceted solutions
7. Look at funders perspective - To get funded show that it is working

The Kelley-Ross Pharmacy presentation ([Medication Challenges in Care Transitions: Issues Faced by Patients, Providers & Community Professionals](#)) is available online.

Continuing the Conversation

[Continuing the Conversation](#), the final general session, was facilitated by Carol Higgins and Kathleen Moisio (referenced above). Conference participants discussed major learnings from conference sessions, emerging trends, and potential new partnerships to improve coordination of care and prevent avoidable hospital readmissions.

- Ms. Moisio shared some of the measurable success of Pierce County's "Together We Care" initiative, which she facilitates.
- Final comments included:
 - "Warm handover" has been perceived as an "extra thing" when it should be a part of our core service.
 - We all collect data. How can we share data?
 - We need to turn barriers into opportunities.
 - We need to continue to look at factors that affect readmissions.
 - Information must be disseminated to target populations, including individuals with limited or no English.
 - Professional education is important.
 - We need to focus on two to three areas to make a difference.
 - Continue to listen to patients and caregivers—ask what works, what doesn't work, and what's one thing you would change, if you could, in healthcare?

The conference closed with a short video: [Impossible Made Possible](#), an inspiring story of a Thailand football club that started off in a little floating village with no football grounds.

Appreciation

Aging and Disability Services thanks Wesley Homes for hosting the June 5, 2014 conference and the following sponsors for their generous support:

- Aging and Disability Services (ADS)
- Asian Counseling and Referral Service
- Developmental Disabilities Administration, DSHS
- Family Resource Home Care
- Franciscan Hospice and Palliative Care
- Full Life Care
- Home Care Referral Registry of Washington State
- Professional Registry of Nursing, Inc.
- ResCare Home Care
- Senior Services
- Qualis Health
- Washington Dental Service Foundation
- Wesley Homes



The individuals who served on the conference planning team, and the organizations they represented, provided guidance in numerous ways over six months leading up to the conference. Special thanks to:

- Lauren Bertagna, Developmental Disabilities Administration, DSHS
- Dave Budd, Full Life Care
- Janet Ceballos, Alzheimer's Association of Western and Central Washington
- Jay Crosby, Professional Registry of Nursing, Inc.
- Bernie Dorsey, Wesley Homes
- Carol Higgins, Qualis Health
- Katheryn Howell, Wesley Homes
- Stephen Lam, Chinese Information and Service Center
- Mary Pat O'Leary, Aging and Disability Services
- Irene Stewart, Aging and Disability Services
- Bonni Stratton, Franciscan Hospice and Palliative Care
- Gary Tang, Asian Counseling and Referral Service

Feedback

ADS requested feedback from participants in two ways—feedback forms at the event, and an electronic survey approximately one week later (which was open until the end of June). All of the feedback will be considered by the conference planning team in designing the next conference.

Eighty-five (85) people responded to the online survey. Ninety-six percent (96%) of respondents gave the conference a positive (excellent or good) rating. Favorable ratings were given for each program component, with particularly high marks for the opening panel presentation and the personal stories of two family/patient representatives. Other highlights were networking, learning more about community-based resources, and inclusion of mental/behavioral health in two workshops.

The survey solicited suggestions for improvements and gauged interest in specific topics for future conferences. Following is what the planning team learned:

Logistics: Suggestions for Improvements

- Indicate actual program start time in advance
- Ensure sufficient restroom capacity
- Improve signage:
 - Event signage (general)
 - Post signs at each entrance that indicate where to pick up registration packets
 - Provide better campus signage
 - Provide consistent signage for parking options
- Assign a greeter to each entrance
- Ensure AC/temperature controls

- Schedule a shorter day (end by 4 p.m. to avoid traffic) was mentioned by several people; however at least one participant said “more time!”
- Improve sound quality (difficult to hear speakers and audience questions in auditorium)
- Double-check accuracy of map and driving and parking directions
- Include session locations in program (not just on screen)
- Shorter breaks, especially in the afternoon (longer break in morning, with exhibits, is good)
- Include notes pages in program or blank notes in packet
- Provide more/fewer workshops, with greater variety, 45 minutes (instead of 90)
- Provide a participant list
- Provide more space between tables to make circulation a bit easier
- Reduce imposition on residents by ensuring they know about the event well in advance
- Less competition with adjacent dining hall
- Meals:
 - Improve vegetarian meal options
 - Make lunch less carbohydrate heavy (sleep inducing)
- Larger facility needed
- Provide more audio/visual support
- Presenters:
 - Give more direction to panelists about the focus of the panel, whether PowerPoint or handouts are expected, time, tools, etc.
 - Specific deadlines for slides, handouts, registration
 - Information about the workshop space
- Expand to Seattle, east side, general

Program: Suggestions for Improvements

- Cultural competency/representation of diverse communities:
 - Include special needs of minority elders, immigrants and refugees, LGBTs
 - Include workshops about beliefs, strengths and impacts of culture, language, ethnicity
- Include a few advanced workshop sessions
- Plan more intentional, structured networking and “mixing” opportunities (e.g., activities that get participants working together)

Key Words in the Online Survey

Advocate/point-person
 Behavioral/mental health issues
 Care coordination
 Caseloads (high)
 Collaboration
 Communication
 Community
 Compassion fatigue
 Complexity
 Connections
 Contact (human-to-human)
 Data
 Depression
 Discharge planning
 Family
 Funding (lack)
 Handoff/handover
 Medication reconciliation
 Multidisciplinary approach
 Networking/relationships
 Patient/client
 Quality improvement
 Red flags
 Resilience
 Resources
 Respect
 Roles
 Safety net
 Standardized care
 Teamwork
 Tools

- Need more concrete tools/solutions/pilot program for seamless transitions of care
- Design patient/client-centered programs
 - Include client/patient presentations or testimonials
 - Impact of stereotyping, stigmatizing, revolving ER door and hospitalizations
 - Include both positive/successful and unsuccessful experiences and outcomes
 - Ask for feedback to improve seamless transitions
- Hear how providers improved communication
- Ensure each session has a take-away: specific strategies or tools related to transitions among care settings
- Case studies:
 - Include specific care transitions case studies—how it happened, what worked, what didn't
 - Expand case studies from “information and referral” to “bridging the gap” strategies that result in a smoother handover.
 - Ensure that case study discussion remains realistic (not hopeful but doable)
- Focus on evidence-based transition models, strategies and interventions
- More time for questions and answers, especially with higher level hospital representatives who may not be accessible at other times
- Closing session may not be necessary (redundant)
- Consider presentation from front-line case managers on how care transitions coaching affects case loads
- Needed better explanation of what was expected by work groups (outcome, time commitment, etc.)
- Include quality improvement and patient-centered approaches rather than just cost savings
- Consider convening one work group for collaborative action.

Attendance: Suggestions for Improvements

- Include more skilled nursing providers, community mental health providers (especially mental health professionals who do home visits), and hospital representatives, including C-suite hospital leaders.

Next Conference

- All day is the preferred length of time.
- Emphasize speakers, panel presentations and skills-based workshops
- Interests (highest response):
 1. Behavioral health (73)
 2. Health literacy & communications (72)
 3. Patient education & activation (71)
 4. Patient transfer/hand-over (71)
 5. Primary care provider communication (70)
 6. Partnership communication (70)
 7. Case studies (care transitions programs) (69)
 8. Local supportive services (69)
 9. Chronic disease self-management (68)
 10. Caregiver support (67)

- 11. Hospice services (67)
- 12. Palliative care (66)
- 13. Networking (66)
- 14. Medicare and dual-eligibles (66)
- 15. Medication reconciliation (65)
- 16. Area Agency on Aging (AAA) programs (65)
- Other potential topics:
 - Discharge planning
 - Making CT work in the ED
 - Nutrition programs
 - Integration of mental health services with medical care
 - Helping patients manage multiple care coordinators
 - Strategies for addressing barriers for low-income/immigrant/LGBT communities
 - Warm handoff/handover
 - Special populations (e.g., dialysis, MS)
 - Younger adults (under age 65) with disabilities

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