



## **Coordination, Collaboration, Communication & Care Transitions**

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Report on the South King County Community Meeting on Effective Care Transitions

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Aging and Disability Services (ADS) convened the South King County Community Meeting on Effective Care Transitions on Tuesday, April 17, 2012 at Tukwila Community Center. Co-sponsors included ADS, Highline Medical Center, Highline Medical Services Organization, Valley Medical Center, and Qualis Health. One hundred twenty-eight (128) individuals, representing 63 organizations, attended the half-day meeting.

The [meeting invitation](#) and [ADS website](#) provided pre-reading materials about hospital readmissions and community-based care transitions models.

Participants arrived at the meeting at or before 8:30 a.m. and participated in information sharing and networking. During this time, participants had multiple opportunities to view a 7-minute [video](#), "Getting Home from the Hospital" (Qualis Health, 2012).

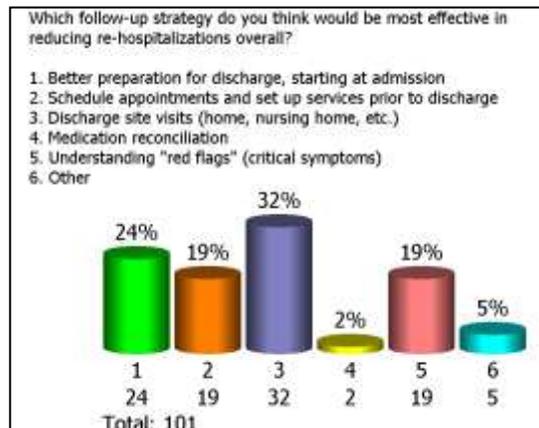
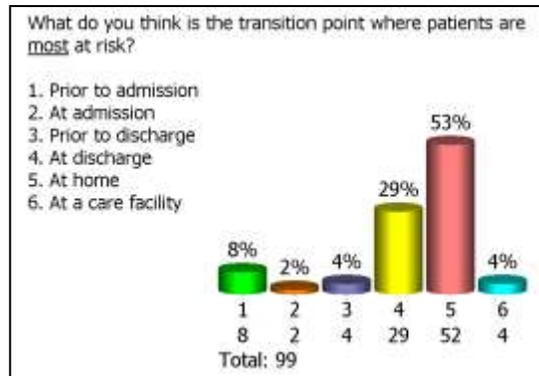
Jesse Eller, director of Aging and Disability Services, the Area Agency on Aging for King County, welcomed participants at 9:15 a.m. and served as master of ceremonies.

### **Audience Response Survey**

An audience response survey produced the following information about meeting participants. A separate report is available [online](#).

- 83 percent had helped care for a chronically or seriously ill family member or friend.
- 77 percent had experienced (or someone close had experienced) a care transition—from hospital to home or to a nursing facility—that could have been handled better.
- 64 percent had experienced (or someone close had experienced) a care transition that was handled very well.
- 89 percent perceived a problem with patients being able to access a Primary Care Provider (PCP).

- When they call a physician’s office, a plurality (35 percent) usually had to wait one to two weeks for the appointment. Nineteen percent usually have to wait more than two weeks.
- 86 percent felt that transportation to healthcare appointments and other essential destinations is a problem for clients or patients.
- 92 percent felt that clients or patients experience cultural or language barriers on at least an occasional basis.
- A majority (53 percent) felt that the transition point where patients are most at risk is at home. Another 29 percent felt patients are most at risk at discharge.
- A plurality (32 percent) felt that discharge site visits (home, nursing home, etc.) would be the most effective follow-up strategy for reducing re-hospitalizations. Another 24 percent preferred better preparation for discharge, starting at admission, and equal numbers (19%) preferred to see appointments and services scheduled prior to discharge or better understanding of “red flags” (critical symptoms).
- The vast majority (99 percent) felt that community partnerships could have some or significant impact in improving care coordination.



### Keynote Presentation

Keynote speaker Selena Bolotin, LICSW (director of Washington Care Transitions & Patient Safety at Qualis Health, the Medicare quality improvement organization for Washington and Idaho) defined care transitions, discussed drivers of poor transitions, and explained the importance of developing community solutions for prevention of unnecessary hospital readmissions. Ms. Bolotin provided examples of successful community-based care transitions programs and encouraged similar collaboration in south King County. Her presentation is available [online](#).

### Collaborative Charter

Participants were encouraged to sign a South King County Care Transitions 2012 Collaborative Charter. Over the course of the morning, the charter gained [48 signatures](#).

## **Focus Groups & Feedback Forms**

Fifteen table groups, each with a facilitator and recorder, discussed the following three questions:

1. What do you see as the biggest problem with current care coordination in King County?
2. In your opinion, what are the most serious problems that chronically and seriously ill patients face when they return home from a hospital or other care facility?
3. What ideas or solutions do you have for improving care coordination in our community?

Rich discussion ensued. Approximately half of the groups reported out at the meeting. The most common themes were the need for better coordination, collaboration, and communication. These and other themes are summarized below.

In addition, participants were invited to complete written forms describing their organization's involvement in care coordination, any additional ways that their organization could improve care coordination, and suggestions for involvement of other organizations or stakeholders. Participants were also asked whether they would participate in care coordination discussions in the future.

All written materials—focus group notes and feedback forms—were transcribed and synthesized, and are summarized in the pages that follow. Problem statements and possible solutions are reported for each question—the same way that the information was contributed.

This report and supporting materials are posted on the Aging King County (ADS) website at [www.agingkingcounty.org/healthcarereform/](http://www.agingkingcounty.org/healthcarereform/).

The meeting adjourned at 12 noon.

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## **Summary of Focus Group Discussions**

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### **What do you see as the biggest problem with current care coordination in King County?**

#### **The Problems**

The health care infrastructure has caused providers to work in silos. Until recently, there has been little understanding of this shared problem. Providers often work in isolation while patients use services across the network.

Patients do not receive holistic health care and systems lack a patient center. It is too easy to assume that another agency or provider has or will take care of secondary problems. Hospitals, other health care providers, and community-based organizations (CBOs) that address social determinants of health have begun to collaborate, but much more collaboration is needed.

Hospital personnel and others indicate they don't know enough about community-based resources for patients. Discharge planners may lack knowledge of what skilled nursing facilities do and what services are provided at assisted living facilities.

Hospital personnel may not recognize home environment issues that prevent successful convalescence at home. If a patient is unable to provide for themselves, it is important to coordinate services providers. Is there enough food in the refrigerator? Are there stairs leading into the house? Are there interior stairs? Can a family member stay with the patient? If not, who can? Does a neighbor know the patient's emergency contact numbers? A treatment plan should consider basic needs like housing and other background issues.

Home- and community-based care providers often lack the patient/health care context because discharge instructions have not been shared. HIPAA presents barriers to sharing information.

"Hand off" from acute care to community-based providers is inconsistent, and so is follow-up care. No systems are in place for care coordination. Patients often don't know who to go to for services.

Communication among hospitals, pharmacies, aging network services, and primary case manager needs improvement. Established case managers may not know that a client has been hospitalized because their clients and their paid caregivers are reluctant to disclose the hospitalization if the caregiver will receive less pay, even though the case manager can arrange for extra services and authorize extra hours for the caregiver once the client returns home.

Patients who receive medications from multiple sources risk overdose and drug interactions. Patients may not see their PCP regularly and they and the hospitals may not inform the PCP of the hospitalization. Patients may receive confusing or conflicting information from different providers. Frequently these situations result in crisis care.

Patients are not always the most reliable source for telling their own story. People remember and/or disclose things in different ways. Health literacy varies considerably, given each individual's ability to understand and internalize health information and cope with health, social, and financial issues. It is critically important to involve family members, neighbors, or other caregivers.

Patients, family members, and caregivers must learn what "yellow flags" (indicators) and "red flags" (critical symptoms) to watch out for. Some patients are stoic by nature while others want to be a "good patient" and not complain, when there is indication that medical care is needed. Attention to yellow and red flags can help a patient avoid re-hospitalization.

Family relationships vary considerably and "sufficient family support" means different things to different people. Patients must have more than a ride home from the hospital. It is important to explore the type of supports each patient will need when they return home or enter a nursing facility.

Cultural competence is vitally important to serving our increasingly diverse population. Materials should be standardized and made available in different languages, ensuring that every patient receives consistent information, no matter which medical or care facility or provider they visit.

Many health care providers are reluctant to have end-of-life conversations; however, these conversations allow patients, caregivers, and advocates to make informed health care choices. End-of-life conversations should occur between doctor and patient (where care is most patient-centric) prior to discharge to a skilled nursing facility. Patients should have realistic expectations and choices in directing their own care. In communicating to or about a patient, the patient must be "kept in the room" (figuratively, if not literally).

Unreliable transportation is frequently to blame for missed appointments. Transportation options are plentiful for some people and less so for others, depending on where they live.

Patients and family members who do not understand health care financial issues (e.g., what Medicaid/Medicare pays for) may need additional counseling.

Many patients have mental illness, which may need to be assessed in the hospital.

## **Possible Solutions**

1. Perform internal analyses of organizational strengths and weaknesses, from patients' perspectives, and address weaknesses.

2. Develop consistent basic training—across facilities, care providers, and CBOs.
  - a. Community-based resources
  - b. Motivational Interviewing—ask patients more questions, empower them to speak up
  - c. “Teach back”
  - d. Cultural competencies
    - i. Translation protocols
    - ii. Family and social considerations
3. Address technology and policy solutions for collection and dissemination of information:
  - a. Electronic Health/Medical Records (EHRs/EMRs)
  - b. Ensure HIPAA compliance
    - i. Educate providers on how to share information appropriately.
4. Collaborate on development of community health education plan(s), especially self-management of chronic conditions.
5. Design a meaningful, easy-to-understand “service map” for patients to take home, which will help them navigate the health care system:
  - a. List care providers, case managers, etc., with contact information
  - b. List medications/dosage
  - c. List follow-up services, with contact information
  - d. Clarify who to call when a yellow or red flag is present.
  - e. Providers “log on” when services are rendered (who, what, when, and with what instructions)
6. Develop system for sharing information among medical provider(s) and CBOs, including assisted living facilities.
7. Develop or expand volunteer programs for chronic disease care.
8. Explore ways to provide 24/7 access to medical advice.
9. Develop a patient-centered discharge process:
  - a. Identify high-risk patients prior to discharge.
  - b. Initiate communication with PCPs, CBOs (e.g., case managers, home care agencies, housing managers), and family members/caregivers immediately so that they can be involved in discharge planning, identify and resolve safety risks, etc.
  - c. Schedule pre-discharge mental health, palliative care, hospice, and end-of-life care discussions as necessary.
  - d. Ensure that nursing facility and other referrals have current capacity.
  - e. Schedule post-discharge appointments prior to discharge.
  - f. Explore transportation options—both home from the hospital and to follow-up appointments.
  - g. Educate patients, family members, and other caregivers about “red flags” (critical symptoms) that may occur.
  - h. Agree on expectations at “hand off” from one provider to the next.
  - i. Coordinate follow-up

### **Other Issues**

- We need to better define successful “aging in place.” We need language that everybody understands.

- Currently, we do not have access to care for all (e.g., homeless, underfunded)
- We have numerous funding constraints. The medical system set up to make money. Many people have difficulty finding doctors who accept Medicaid. Medicaid may work better than private pay because case managers provide continuity. There is no universal return on investment but we need to show savings. Funding issues affect care, especially for mental health resources. Our focus is on the center of bell curve; the fringe costs more. We lack money to hire more case managers and social workers to accommodate increasing caseloads and staff workload. Resources are misaligned—we need more resources for transportation, translation, and other supports.

## **In your opinion, what are the most serious problems that chronically and seriously ill patients face when they return home from a hospital or other care facility?**

### The Problems

Patients may not understand their discharge plan or the yellow or red flags that indicate when medical attention is necessary. Sometimes discharge plans are not specific enough. Knowing when to contact a health care professional, and who to call, is important. Patients experience challenges contacting an emergency room physician if they have a simple follow-up question. Home care workers may not be trained to recognize or manage certain conditions. Without basic guidance—in writing—about what to do when they get home, patients frequently call 911 and then end up back at the hospital. Other times, patients may not call for help, even when a red flag is present, because they don't want to return to the hospital.

Patients lack knowledge of community-based resources and lack family or social supports. 911 sometimes transports people without medical needs because that person has no other personal support.

Many patients lack a supportive home environment. Even if they have an informal caregiver (family, friend or neighbor) who helped them before they were hospitalized, they need more help when they return home—help the patient and caregiver may not anticipate or understand.

Patients may misrepresent the support they do have at home, resulting in authorization of fewer home health visits. Family members may not be able to provide enough care. Family dynamics vary widely.

A patient's limited financial resources and limited knowledge of family, friend, church, and community resources are significant. In addition, older individuals who have been hospitalized and/or are living with chronic conditions are more vulnerable to financial exploitation and other forms of abuse. Patients need an advocate at home.

Some patients lack sufficient food and/or transportation options when they return home from the hospital. Some patients who utilize paratransit services face challenges when a long commute requires them to be out of bed and/or away from a toilet for too long. If a patient travels on paratransit without a caregiver, the patient may need to be accompanied to/from vehicle, into medical appointment, from appointment, back to vehicle, and vehicle back to home or living facility.

Sometimes patients return home to insufficient food or food that is no longer fit to eat, and they do not have the ability to shop for groceries or necessary support from caregivers. Medical appointments and transportation schedules may cause a patient to miss a meal at a skilled nursing or other facility.

Referrals to PCPs to create a follow-up plan can lead to a delay in follow-up care. Patients may not have a regular PCP, or may not have visited the PCP regularly, and may have difficulty scheduling a timely appointment. Often, PCPs don't know that a patient has been admitted. When they see the patient, they may be uncomfortable providing follow-up care because they haven't seen the patient many months or years. The PCP may receive insufficient information from the hospital. HIPAA regulations present challenges for technology-based solutions.

The ability of chronically ill patients to care for themselves must be assessed accurately. Conversations about self-care competency, palliative care, hospice, and end-of-life issues should be discussed in the hospital, as necessary.

Discharged patients frequently take medications home from the hospital. Patients may become mixed up with medications already present in the home. It is difficult for a layperson (patient or caregiver) to recognize potential adverse effects. Explanation of medications should take place before the patient leaves the hospital. Some patients do not have someone at home to supervise taking of medications. Medication reconciliation at home should be incorporated into every care transition plan.

Language barriers, lack of translated discharge instructions, few multilingual health care providers, low reading comprehension, and limited understanding of their own health are significant issues. The public receives intermittent health education information. Sometimes bilingual family members choose not to translate correctly or they paraphrase some words (e.g., cancer) so that patients do not receive accurate information, indicating the need for more medical interpreters.

Many patients are overwhelmed with information at discharge. Doctors don't always sign prescriptions personally. Discharge planners and other hospital personnel may be rushed. Staff doesn't have time to properly explain medications, procedures, etc. Patients often need help remembering and someone to facilitate their recovery at home.

## **Possible Solutions**

1. Analyze the root cause of patients utilizing 911 for readmissions.
2. Increase use of technology.

- a. Identify SHA, KCHA, SHAG, and other senior residence addresses and create a “pop up” from health records.
  - b. When case management services are already established, have the case manager’s contact information “pop up” on patient records.
  - c. Consider teleconferencing opportunities with health care professionals.
3. Develop and disseminate consistent public health messages.
4. Institute discharge huddles at admission.
5. Create a cheat sheet of the top issues faced by patients post-discharge and then provide them with steps for what to do if they have certain signs/symptoms/flags (e.g., secondary infection, UTI, pneumonia, diabetes management, bowel obstruction, hydration).
  - a. Use predictive data to tailor this information.
  - b. Share the information with the patient, family members, other caregivers, housing providers, and service coordinators, as appropriate, before the patient leaves the hospital.
6. Assign one coach, advocate, or community point person who can follow the patient while in hospital through discharge and follow up at home for up to six months.
  - a. Assess self-care competency:
    - i. Inquire about self-sufficiency (e.g., food, housing, home environment, transportation, etc.)
    - ii. Perform a home safety check (e.g., reduce tripping hazards, address housekeeping issues).
    - iii. Review consent forms and discharge instructions with all members of the family/caregiver team.
  - b. Ensure that follow-up visits are made in a timely manner.
  - c. Monitor medications, diet, and at-home care.
  - d. Check in daily, by phone or in person.
7. In addition to written instructions, utilize “teach back” to ensure that patients understand their discharge instructions.

## **What ideas or solutions do you have for improving care coordination in our community?**

### **Increase Access**

1. Promote early access to a PCP.
2. Explore “hospital at home” concept as an alternative to in-patient acute care.
3. Explore ways to increase PCP home visits.
4. Set goal of same-day PCP follow-up.
5. Improve transportation options for health care appointments.
6. Promote wraparound services involving community providers that already have a relationship with the patient (e.g., neighbors, senior center, 7-11, etc.).

### **Increase Collaboration**

1. Build relationships and trust among agencies.
  - a. Develop and maximize partnerships.
    - i. Set clear roles and expectations.
    - ii. Know who to call.

- iii. Share contact info updates in a timely manner.
    - iv. Identify “hot spots” and convene local providers to discuss coordination.
  - b. Recognize distrust of the medical community (e.g., among some communities of color).
  - c. Recognize distrust of younger doctors.
- 2. Develop strategies for “warm handoff.”
- 3. Develop coaching role and responsibilities:
  - a. Coordinate care and follow-up for the patient for six months.
  - b. Take responsibility for “the big picture.”
  - c. Help people become “health care ready”—coaching for success

### Improve Communication

1. Improve communication, coordination, and follow-up among physicians, other health care providers, CBOs, patients, family members, and caregivers.
  - a. Explore SBAR (Situation-Background-Assessment-Recommendation) to standardize communication about a patient's condition among members of a patient’s health care team and with family and caregivers.
  - b. Explore Interact (Interventions to Reduce Acute Care Transfers) tools for early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities.
  - c. Explore EDIE (Emergency Department Information Exchange), a Web application that identifies patients who present at multiple ERs and facilitates multidisciplinary care across participating facilities, and intervene to provide a lower level of care at lower cost.
  - d. Develop a centralized information source (and also in-person forums) for sharing what each provider offers.
  - e. Share best practices without using jargon (e.g., the ADS evidence-based [care transitions model matrix](#)).
2. Develop a central data bank (integrated electronic health records).
  - a. Develop HIPAA-compliant data sharing agreements.
  - b. Track, trend, and evaluate outcomes.
3. Emphasize clinics as appropriate place for PCP services, not ERs.
4. Create an action plan template (1–2 pages), easy to understand (e.g., green, yellow, and red codes, with what to do/who to call at each level).
  - a. Cover the continuum of care.
  - b. Require patient accountability (e.g., assign a case manager to follow-up with the patient and instruct the patient to contact the case manager if code red).
  - c. Incorporate factors such as groceries and transportation options, as illness may change requirements in these areas.
  - d. Set an aggressive timeline for creating the template, pilot it for 6–12 months, and then revise before rolling out to a larger audience.
  - e. Possible project for UW Public Health.
5. Develop a social norm marketing campaign (e.g., “just say no to drugs”) to address patient readmission.
  - a. “Take your pills when you leave the hospital.”
  - b. “Plan now for your future care needs.”
  - c. Keep it simple, and not Web-based.

6. Expand programs like FDCARES to all fire service districts in King County.
  - a. Place follow up calls to people who have called 911 and assist in coordination of care.
  - b. Train callers to use a non-emergency number instead of 911 (reducing calls to 911 ambulance transports).
7. Engage patients in their own care:
  - a. Develop patient, family, and caregiver/advocate education materials.
  - b. Systemically teach and reinforce.
  - c. Target businesses frequented by high utilizers (e.g., beauty salons?), churches, etc.
  - d. Help patients and family members understand the benefits of hospice services.
8. Increase promotion of reliable Web resources.
9. Consider what form of communication is most effective for each patient (e.g., phone calls are not always the most effective).
10. Develop patient care and identification materials:
  - a. "Hospitalization planning" guide for patients prior to hospitalization.
  - b. Booklet and/or fridge map that identifies personal supports, contacts, etc. that can also be taken to PCP appointments.
  - c. Questionnaires for patient and/or caregiver to answer when at hospital.
  - d. Log sheet to determine who has contact with an individual.
11. Improve consent forms.
12. Continue to convene community meetings to discuss care transitions issues and share information (1–2 times annually).
13. Develop a "package of services" to meet patient needs.

### **Consider Social Determinants of Health**

1. Develop resources for homeless individuals who present at the ER for care and food.
2. King County Care Partners model targets homeless and mentally ill, partners nurse and mental health professionals
3. Mental health care requirements (patients seen by a licensed mental health professional) increases cost of care.

### **Policy & Funding**

1. Care is a multidimensional topic, driven by many things, especially ability to pay.
2. Recognize what is feasible given current funding and/or advocate for increased funding:
  - a. "Better care" may require more time and more funding.
  - b. Find money to do a pilot involving all the partners.
  - c. Bridge funding between medical and community services.
  - d. Many doctors will not take Medicaid.
3. Make consequences for predatory sales of plans.
4. Potentially need a single payer environment.
5. Bridge policy and practice more effectively.
6. Compare other countries' systems

**Research Issues**

1. Determine why the PACE (Program of All-Inclusive Care for the Elderly) model hasn't taken hold.
2. Pilot test different supports to determine the best outcomes.
3. Research and implement technologies that can make a home and home care safer.

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## Summary of Feedback Forms

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### What does your organization already do to improve care coordination?

The following responses reflect only the written input of individuals attending the care transitions community meeting:

- **Aging and Disability Services (ADS)** and south King County hospitals have partnered to develop a community-based care transitions program. ADS provides in-home case management and chronic care management services. ADS case managers contact hospitals and skilled nursing facilities when they are aware that clients are there, prior to discharge, and visit status post-discharge to ensure that they are doing what they should be doing (e.g., going to their medical appointments). RN case managers may accompany clients to doctor's appointments. Case managers oversee in-home caregiver programs, proactively coordinate care among various providers, and communicate with clients, family members, and caregivers. ADS partners with Public Health, including jail health, as well as other health care professionals working with high utilizers of health care and human services in King County.
- **Aging Services of Washington** helps members become aware of partnerships forming in their area.
- **Asian Counseling and Referral Service (ACRS)** case managers have taken the initiative to coordinate services for vulnerable elders and adults with disabilities when they are admitted to and when they are discharged from hospitals, long-term care facilities, and rehab centers. ACRS also coordinates with mental health, drug and substance abuse, and senior lunch program service providers to meet clients' service needs. ACRS participates in larger networks (e.g., Health Aging Partnership, Health Promotion Research Center).
- **Avalon Care Center-Federal Way** utilizes Interact; SBAR; flu calls; 7-day/8-hour day MDs in-house; follow-up calls at 24 hours, 72 hours, and 7 days; BOOST program; involvement with St. Francis Hospital; created care coordination position with established goals upon admission; schedules follow-up PCP appointments; arranges transportation; tracking of flu home health visits and outcomes. Tracking and trending outcomes with rehospitalizations. Increased palliative care conversation with resident and family to decrease back-and-forth to hospital.
- **Burien Nursing and Rehab Center** tries to receive as much information as possible from discharge planners before they admit a resident, ensuring that the patient is ready; delivers discharge summaries/instructions to doctors; makes appointments with doctors and specialists; participates in care planning, care conferences and discharge planning; aligns with Swedish Hospital Residential Care Team when they admit to our facilities and Sound physicians who cover a little under 40% of our patients; offers daily rounds by medical director to see his patients, often in first few days after admit; SBAR; and places calls to patients within 24 hours to check status. Physician coverage is a big key to treating in place.
- **Catholic Community Services-King County (CCSKC)** works closely with discharge planners, care managers, and social workers to assist people when they return home to remain at home. Volunteers alert their supervisors when an older adult or person

with a disability experiences a condition change, so that we can connect back with police, fire, APS, care manager, family, etc. CCSKC tries to partner with other agencies/organizations to make referrals, provide support for clients and their families. CCSKC works to get patient release of information to exchange information pertaining to care and needs.

- **City of Des Moines** provides information and referrals to agencies and services that provide care for older residents.
- **City of Kent** is learning and educating about resource, including transportation.
- **City of Renton Human Services** is trying to identify and then connect clients with other service providers.
- **City of Tukwila** convenes providers to share information, communicates across internal departments, helps individuals navigate the system, and shares information with residents.
- **Comfort Keepers** provides community education in senior centers (e.g., how to be a good advocate for yourself or a loved one).
- **Crisis Clinic** connects families and patients to resources they do not know about, conducts outreach to medical providers to raise awareness of resources, and provides temporary support while other long-term solutions are found, facilitating and providing referrals to agencies and resources for those long-term supports.
- **Evergreen Home Care Services** provides a good hospital assessment prior to discharge and good referrals to community resources such as home health.
- **Franciscan Health System Care Management** evaluates readmissions to the hospital (“where did we fail?” and “where can we improve?”), participates in a community-based care transitions program in Pierce County, networks with the community, and participates in community meetings.
- **Full Life Care** provides adult day health services and case management. Clients receive nursing care, coordination of care with their doctor, medication management, occupational therapy for management of activities of daily living, and more. Case managers communicate with and educate family members on care.
- **Hallmark Manor** social workers provide information, support and follow-up to residents and families during and after discharge from skilled nursing facility.
- **Highline Medical Center** utilizes “teach back” and offers home health, hospice, PCP, and navigator model oncology. Communication and management of each resident’s care with the different PCPs and home health care agencies and services sets the resident up for success.
- **Highline Medical Services Organization** hired a MSW to proactively visit with members (a free service to members)
- **King County Housing Authority** serves 40,000 high-risk, low-income, disabled and/or immigrant/refugee residents throughout King County, provides service coordination, and conducts community/resident outreach with in-house service coordinators (limited by 1 FTE:200 unit ratio). Staff monitor and follow up on resident health concerns, and provide service coordination, information and referrals, welfare checks, family education, advocacy, and transportation coordination.
- **Life Care Center of Federal Way** utilizes in-house physicians and provides community education.
- **Maple Valley Community Center** makes referrals to agencies with support services or higher levels of care to support aging in place.

- **Masonic Outreach Services (MOS)** provides intensive case management to folks discharging from the hospital. MOS has established a bank of rooms so that people who are not in need of skilled nursing but cannot return home (because it is not accessible or there is no one to help) can come and stay to receive intensive case management that will assist them in returning home. MOS also does comprehensive assessments and offers a full range of information and referrals.
- **Normandy Park Senior Living** meets with physicians and other health care providers.
- **Pam Piering, Consultant**, on behalf of the National Council on Aging, is interviewing AAAs and states nationwide on how to better connect evidence-based health aging programs with health funders.
- **Park Place Assisted Living** manages or coordinates care for 150+ seniors.
- **Peace of Mind Home Health** is a new home health agency (just starting up) that will provide case management to help people navigate the health care system, provide pharmacy consulting to review meds, transport clients to doctor and other appointments, and provide education on disease management and “red flags.”
- **Prince of Peace Lutheran Church** parish nurses visit people who have been discharged from the hospital to help them follow the directions they have been given, including medication instructions. Parish nurses refer people to assistance they need.
- **Providence Senior & Community Services** offers the PACE program for all-inclusive care for the elderly through Providence ElderPlace. It would be great to see this program expand further into south King County. Providence Senior & Community Services offers also offers a transitions program (free care management); home health care; hospice; home infusion; skilled nursing; assisted living; and supportive housing facilities for low-income families, with on-site managers and healthcare professionals to help residents navigate services. We have a great opportunity to better link our services.
- **Public Health—Seattle & King County EMS Division** works with nursing homes and adult family homes to better understand needs and examine better options to calling 911 for non-emergency situations. Also piloting a non-emergency response to non-acute calls to 911. Public Health also provides respite care for homeless patients who do not need to be in the hospital and links those patients with housing, medical homes, and mental health and substance abuse services.
- **SeaMar Community Services** has been partnering with adult day health care, senior centers, Providence ElderPlace, and Alzheimer’s Association.
- **Seattle Keiro Rehab & Care Center/Nikkei Concerns** participates in Medicare’s Five Star Quality Rating System program and continues to improve communication and education for patients and family. The agency has its own transportation system (free), sets up services prior to discharge from their own skilled nursing facility (e.g., home health, COPES), and contacts the community-based PCP upon patient’s admit to facility and upon discharge to another care setting or home.
- **SEIU Healthcare 775NW/SEIU Healthcare Training Partnership** trains and represents over 40,000 paid caregivers in Washington state who provide regular support services to Medicaid and dually eligible individuals in their homes and nursing homes.
- **Senior Services** provides an array of home- and community-based services, including preventative self-management services, meals on wheels, chronic disease self-management, information and assistance, and advocacy, with follow-up to ensure that clients—especially those without informal caregivers—don’t get lost in the system

and have their needs met. Gatekeepers make referrals to case management for community members with mental health issues, etc.

- **Sound Mental Health** is looking at placing assistance at housing facilities.
- **Sprint Healthcare Team** provides technology solutions for improved communication and patient care, in and out of health care facilities.
- **Stafford Care** works with hospitals and skilled nursing homes.
- **Stafford Health Care in Des Moines** participates in care conferences with stakeholders and educates patients, family members, and caregivers.
- **Stafford Suites-Kent** nurse tries to speak directly to discharge planners and the case manager or nurse who cared for their client, fax discharge orders to the PCP when the client returns from the hospital, ask the doctor to review the medical list, and remind the client of upcoming appointments with the PCP.
- **Valley Medical Center** brings community providers together with care coordination staff to educate regarding resources; participate in community initiatives; provides clinical pharmacy med review for inpatients. Reducing Readmission Performance Improvement has included daily review of 30 day readmitted clients. Starting efforts to ensure that all chronic heart failure patients have a follow-up scheduled.
- **Washington Care Center** has implemented tools and system for preventing rehospitalization. Staff teaching.

## **Are there additional ways that your organization could help improve care coordination?**

Prevention is key. Bolster chronic care management model with home health and self-management models with the general public. Strengthen outreach and public health messaging to teach people who to call for help, how the health system works, and where to find resources, including advocates. A change in the negative concept of aging will help. Very often, people age 50+ blame their health issues on the aging process.

Study what's working and get more creative about expanding programs:

- Providence Senior and Community Services PACE (currently only serving specific zip codes) and transitions programs
- Group Health
- Pierce County care transitions collaborative

Build a collaborative discharge planning team involving hospitals, PCPs, and community-based case managers. Hospitals can bolster this work by giving organizations a better understanding of the hospital discharge planning process. Communication with hospital discharge planners and PCPs can be challenging. Develop a variety of forums (in-person and electronic) for information sharing so that all organizations can communicate their services effectively and consistently, and strengthen their roles in the continuum of care and support.

Hospital and primary care providers need more information about the many resources available to patients at home, at no cost to the patient. For example, suburban cities provide programs and services for self-management—hot lunches, transportation,

caregiver support and respite, counseling, information and referral, health and wellness programs, and socialization—for thousands of south King County residents. Continue to expand knowledge of available resources—including low-income housing—so that every provider knows how to direct family members and other caregivers. Continuing education in this arena is important.

Lines of communication must be kept open. Technology can speed up processes. Electronic health records should offer access to all providers. Investigate ways to provide universal access for care transitions purposes.

Utilize clinical liaisons or gatekeepers at each hospital to support timely access to PCPs, home health, home care, hospice, skilled nursing, adult family homes, therapy, mental health, and health promotion activities outside the home. This person could be available to educate the patient and answer questions about next steps during their hospital stay as well as what they may experience at a skilled nursing facility, so that patients are better prepared.

Liaisons/coaches/gatekeepers/advocates should be trained to reconcile medications at home. This person can ensure that PCP appointments are made and kept. Liaisons could expand to provide case management on a 30-, 60- or 90-day basis. Resources that allow case managers to make more in-home and acute care setting visits should be increased so that more intensive follow-up and advocacy can occur. Referrals back to a skilled nursing facility could keep more people out of the hospital.

Physicians should see patients within three days of discharge. Physicians should also make a point of communicating with the patient's family.

Paid caregivers can play a much bigger role in care coordination and in improving health outcomes for those they support. Home care aides are currently an underutilized part of the health care system. In addition, some organizations can consider involving volunteers or increasing use of volunteers.

Become more deliberate about process improvement. Develop feedback loops between hospitals and primary care clinics to show who is doing what, including what the patient is doing to manage their own health. Communicate discharge instructions and track discharged patients, coordinating patient goals with PCP, hospital, and nursing facilities. Explore data sharing agreements among partnering organizations. Utilize SBAR and Interact tools. Convene a "hot spots" meeting to focus our efforts as a community.

Additional barriers include availability of short-term rehab for patients with mental health issues.

## **What other organizations or stakeholders should join community efforts to improve care coordination?**

Responses are ranked first by number of individual responses, and then alphabetically. Some entities listed were represented at the meeting.

- Hospital personnel (10)—discharge planners are very key players
- Home care agencies (9)
- Fire departments, EMS/911 and police departments (7)
- Home health (7)
- PCPs and other clinic medical providers (6)
- Assisted living facilities (4)
- Faith communities, parish nurses (4)
- Housing/apartment managers, including King County Housing Authority and SHAG (4)
- Senior Information & Assistance and other professional advocates for seniors and adults with disabilities (4)
- Transportation providers (4)
- Higher education (3)—includes medical schools, nursing schools, and community college programs for health care workers
- Senior centers (4): be more inclusive with center directors—they provide information and referrals; they know the community and they talk with each other.
- Adult day care/health (2)
- Adult family homes (2)
- Insurance providers (2)
- Mental health providers (2)
- Providence ElderPlace and other facilities (2)—all are interested in being part of the solution; ElderPlace program has extensive social involvement—easy to figure out who to talk to
- Lisa Doyle, CayCare, Inc. (placement and care management) and other referral agencies (2)
- Veterans Administration (2)
- AARP (1)
- Adult Protective Service (1)
- Area Agency on Aging (1)
- Caregivers (1)
- Catholic Community Services (1)
- CMS (1)
- Elder care facilitators (1)
- Every agency available (1)
- Family members (1)
- Feeding program leaders (1)
- Full Life (1)
- HMOs (1)
- Home and Community Services (1)
- Homelessness prevention agencies (1)
- Immigrant/refugee groups, including ReWA, Somali Association (1)
- Jewish Family Services (1)
- Medicare Five Star Quality Rating System program (1)
- Neighborhood Watch groups (1)
- Neighbors (1)
- Patients/consumers (1)
- Pharmacists (1)
- Public Health—Seattle & King County (1)
- Senators (1)
- Skilled Nursing Facilities/nursing homes (1)
- United Way of King County (1)
- Urgent care (1)
- Volunteer programs (1)
- WSMO (1)
- Washington State LTC Ombudsman Program (1)
- Washington State Residential Care Coalition—Adult Family Home Collective Bargaining Unit (1)

## **Would you like to participate in care coordination discussions and planning in the future?**

*The following individuals (listed alphabetically by last name) answered Yes:*

- Kevin Bail, Aging and Disability Services
- Lynda Baldwin, Burien Nursing & Rehab Center
- Bonnie Blachly, Aging Services of Washington
- Evie Boykan, City of Tukwila
- Sarah Cameron, Providence Senior & Community Services
- Marie Casanova, Aging and Disability Services
- Mary Craves-Hollands, Masonic Outreach Services
- Hilary Cross, Aging and Disability Services
- Nancy Dapper, SEIU Healthcare Training Partnership
- Thomas de Oro, Life Care Center of Federal Way
- Cindy Diller, Stafford Suites-Kent
- Gail Dubin, Catholic Community Services—King County
- Jesse Eller, Aging and Disability Services
- Jerry Fireman, Aging and Disability Services
- Carol Foltz, Park Place Assisted Living
- Dave Foltz, Stafford Care/Adult Day Health Association
- Bill Gingerich, Sprint Healthcare Team
- Sandra Hayes, Peace of Mind Home Health
- Amy Holland, Aging and Disability Services
- Buffy Tyroum Howard, Avalon Care Center-Federal Way
- Helen Huang, Washington Care Center
- Patricia Hunter, Washington State LTC Ombudsman Program
- Stacie Joyce-Young, Aging and Disability Services
- Suzanne Kenyon, Aging and Disability Services
- Dyanne Lane, Highline Medical Center
- Cara Lauer, Senior Services
- Tim Lawless, City of Renton Human Services
- Maureen Linehan, Aging and Disability Services
- Elaine Lobdell, Valley Medical Center
- Jill Marsden, Public Health—Seattle & King County (consultant)
- Jill Martin, Highline Medical Center/Des Moines Senior Advisory Council
- Megan Mattas, Crisis Clinic
- Kara Mayeda, Seattle Keiro Rehab & Care Center/Nikkei Concerns
- Kevin McNamara, Stafford Healthcare in Des Moines
- Kaylene Moon, former ADS Advisory Council member
- Patricia M. DeVol Nadon, Providence Senior & Community Services
- Micaela O'Brien, Aging and Disability Services
- Mary Pat O'Leary, Aging and Disability Services
- Katie Olson, Burien Nursing & Rehabilitation
- Kristin Ott, Full Life Care
- Sue Padden, City of Des Moines
- Deborah Parks, Sound Mental Health
- Kim Parks, Normandy Park Senior Living
- Pam Piering, Consultant
- Michele Plorde, EMS Division, Public Health—Seattle & King County
- Ninfa Quiroz, SeaMar

- Elaine Rasnack, Catholic Community Services—King County
- Laura Rexford, Aging and Disability Services
- Johneta Rowsey, City of Kent
- Denise Reinke, Prince of Peace Lutheran Church
- Ruben Rivera-Jackman, King County Housing Authority
- Monique Ruyle, Evergreen Home Care Services
- Randi Saeter, Seattle Keiro Rehab & Care Center/Nikkei Concerns
- Allison Scott, Maple Valley Community Center
- Shreya Sharma, Aging and Disability Services
- Irene Stewart, Aging and Disability Services
- Gerry Stone, Highline Medical Services Organization
- Gary Tang, Asian Counseling and Referral Service
- Bryan Tapia, Hallmark Manor
- Lauren Tomich, Franciscan Health System Care Management
- Thuy Vo, Highline Medical Center
- Linda Weedman, King County Housing Authority
- Misha Werschkul, SEIU Healthcare 775NW
- Karen Young, Valley Medical Center