Charting a Course to Health

Care Transitions Conference
Tuesday, May 17, 2016
IAM District 751
Seattle, Washington
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May 17, 2016

Dear Conference Participants:

Thank you for attending Charting a Course to Health, our 2016 care transitions conference. We are pleased to have community partners committed to improving health care quality and reducing hospitalizations.

In 2011, Aging and Disability Services reached out to several south King County hospitals that were particularly challenged by higher rates of chronic illness among area residents and 30-day Medicare readmission rates that exceeded the state average. Since then, our efforts have expanded to include health care providers throughout the county.

Today’s conference is our fifth related to health care quality since 2011 and we welcome local guests as well as visitors from out of state. We are grateful for sponsor support, which has kept conference registration fees low. Please see the list near the back of this program.

Aging & Disability Services—the Area Agency on Aging (AAA) for King County—is part of the Aging Network that was established under the Older Americans Act in 1973 to respond to the needs of Americans 60 and over in every local community across the nation. We are one of 13 AAAs in Washington state that provides a range of options that allow older adults to choose the home and community-based services and living arrangements that suit them best. We are also working to create communities that support people throughout their lifespan, regardless of age or ability.

We serve over 38,000 clients age 18 and up each year, through both direct and contracted services, including Medicaid care coordination, caregiver support, depression counseling, and other long- and short-term services and supports. We meet clients in their homes and in the community, and are highly aware of how the social determinants of health impact their ability to access health care services and take responsibility for their own well-being.

This year we launched a new service—Community Living Connections—that can connect you and your patients or clients with community resources and service options, when and where they are needed. Older adults, adults with disabilities, caregivers, family members, and professionals can call to get objective, confidential information at no cost: 206-962-8467 (toll-free 1-844-348-KING). Information about this service is available at the conference, and I invite you to visit www.communitylivingconnections.org.

Thank you again for attending the conference. Together we make a difference!

Sincerely,

Maureen Linehan
Director, Aging and Disability Services
The Area Agency on Aging for Seattle and King County
Charting a Course to Health
AGENDA AT A GLANCE

7:30 a.m. Conference Opens
Sign in at the registration table.
Visit the exhibit hall and posters in Hall C, enjoy a healthy breakfast, and introduce yourself to other conference participants.
Buffet breakfast includes vegetarian and gluten free options, and compostable plates, utensils, and napkins.

Where Have We Been and Where Are We Going?

Presentation descriptions are provided on pages 6–7 of this program.
If not otherwise noted, the presentation will take place in the Main Hall (labeled A/B).

8:15 a.m. Welcome
Selena Bolotin, Qualis Health
Maureen Linehan, Aging and Disability Services
Sarah Edwards, ResCare HomeCare

8:30 a.m. Keynote Session
Charting a Course to Health
Jane Brock, MD, MSPH, Telligen Medicare Quality Improvement Organization

The Promise of Collaborative Care for Addressing the CMS Triple Aim in Community Settings
Paul Ciechanowski, MD, MPH, Samepage Health

10:30 a.m. Break
Visit the Exhibit Hall and poster wall in Hall C. Poster authors will be available to answer your questions.

Tools for the Journey

10:45 a.m. Concurrent Sessions
Health Literacy: The Link between Better Communication and Better Health Outcomes
Elissa Director, MA Alki Analytics, LLC Main Hall

Balancing Cost and Quality of Care in the Least Restrictive Environment
Rhonda Steele CarePatrol Hall C
The Community Integration Model

Improving Healthcare for People with Disabilities
Michael Richardson, MPA Northwest ADA Center Conference Rooms 1 & 2
11:45 a.m.  Lunch
Buffet lunch includes vegetarian and gluten free options, and compostable plates, utensils, and napkins.

12:15 p.m.  **Chronic Disease Management with Telehealth**
Tom Edmondson, MD, CMD, AGSF, FACP, Philips Enterprise Telehealth

1 p.m.  **Poster Session**
Visit the poster wall in Hall C. Poster authors will be available to answer your questions.

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**On the Course — Promising Practices and Partnerships**

1:15 p.m.  **Innovative Transportation Strategies for Follow-Up Appointments**
Amy Conrick, National Center for Mobility Management
Francois Larrivee, Hopelink
Tod Morris, Valley Regional Transit, Boise

2:15 p.m.  **Afternoon break**
Cookies generously provided by CHI Franciscan Hospice and Palliative Care volunteers in the Main Hall.

Visit the Exhibit Hall and poster wall in Hall C. Poster authors will be available to answer your questions.

2:30 p.m.  **Community Partnerships Improve Medication Use and Overall Care Across the Continuum**
Josh Akers, PharmD, BCACP, Kelley-Ross Pharmacy Group
Jennifer L. Bacci, PharmD, MPH, BCACP, University of Washington & Kelley-Ross Pharmacy Group
Anne Casey, MS, FAACVPR, Heart Institute at Virginia Mason Medical Center
Geoffrey Meer, PharmD, Kelley-Ross Pharmacy Group

3:30 p.m.  **Conference wrap-up**

3:55 p.m.  **Gift Basket Drawing**
Must be present to win.

4 p.m.  **Conference ends**
Have a safe journey home!
Charting a Course to Health
SESSION DESCRIPTIONS

Keynote Session

Charting a Course to Health  Brock

The goals of the care transitions movement are to improve patients’ transitions from hospital to home or other care settings (and among care settings), to improve quality of care and reduce patient suffering, to reduce readmissions, and to document savings. This session will launch conference discussion about where we’ve been and how we’re doing—what’s going on nationally and what the data tells us about national and local trends. We’ll also discuss what we’ve learned about Adverse Drug Events, about neighborhood disadvantage (social determinants of health), and patient perspectives, so we can chart a better course to health for all.

The Promise of Collaborative Care for Addressing the CMS Triple Aim in Community Settings  Ciechanowski

There is an unprecedented convergence of factors in healthcare—“big data” analytics, changing reimbursement models, telehealth, team-based care—that creates exciting new opportunities to achieve higher quality care for community populations. To succeed, we need proven care models that provide the “how” to complement the data analytics “what” that sheds light on care gaps and avoidable utilization and costs. Collaborative care for chronic medical and behavioral conditions is such a model that allows systems to more effectively treat the whole person. We will discuss two decades of collaborative care evolution into its current form as a turnkey solution for addressing the CMS Triple Aim.

Concurrent Sessions

Health Literacy: The Link between Better Communication and Better Health Outcomes  Director

Poor communication between healthcare professionals and patients results in less effective management of chronic conditions, increased preventable hospitalizations, and worse overall health. Two decades of research indicate that most health information is presented in ways that most Americans cannot understand. This session will provide healthcare and social service professionals with an overview of health literacy, including several practical strategies for delivering health information in a clear and understandable way. Gain better understanding of how health literacy impacts patients, providers, and consumers and learn how a “universal precautions” approach can improve communication and health outcomes.

Improving Healthcare for People with Disabilities  Richardson

The Americans with Disabilities Act (ADA) requires full and equal access to health care services and facilities, but barriers still exist that prevent individuals with disabilities from getting routine care that can detect and treat minor issues before they turn into major and possibly life-threatening problems. This is true for individuals born with disabilities as well as those who “age into disability.” This session provides an overview of accessible exam rooms, chairs, and medical diagnostic equipment; common auxiliary aids, services and strategies to ensure effective communications; and local ADA resources for training and technical support to build professional competency on disability issues.
Balancing cost of care with the quality of care in the least restrictive environment is the goal of Medicare and well as private insurers. This session focuses on including the patient in his or her discharge plans, utilizing more community services, and reducing costs to payors while reducing readmissions and improving quality of life for the patient. Participants will learn the real cost of population health and the biggest drivers of increased cost, and be challenged with new ways of thinking about what post-acute transitions looks like when patients are actively involved in the decision-making. This session will also look at how to assess patient eligibility for benefits, and what lies ahead in The Affordable Care Act environment.

**Luncheon Presentation**

**Chronic Disease Management with Telehealth**

What is “telehealth” and how can it make a difference in our patients’ abilities to manage chronic diseases? Ingenuity and innovation has led to technologies that can improve quality of care and decrease cost of care. Dr. Edmondson will share what he hears from providers and patients about how technology and clinical process can be combined to expand access, improve outcomes, and provide a better experience for patients.

**Afternoon Sessions**

**Innovative Transportation Strategies for Follow-Up Appointments**

Preventing re-hospitalization for discharged patients rests in part on patients’ ability to get to and from primary and specialist care and therapy appointments and the pharmacy. Affordable, accessible, and reliable transportation to those destinations is essential to their ability to comply with recommended treatment and achieve expected health outcomes. This session will present case examples of health care-related transportation challenges, explore the importance of transportation as a social determinant of health, and provide transportation options and solutions, as developed by recent grantees of the National Center for Mobility Management’s health care transportation challenge grants.

**Community Partnerships Improve Medication Use and Care Across the Continuum**

One of the crucial problems that must be addressed by health care teams involves medication errors and proper medication utilization across care settings. Pharmacists are ideally suited to focus on this aspect of care through medication reconciliation and medication coaching. This session will emphasize the importance of community partnerships that allow for improved access to information and better communications and coordination. Unique partnerships with pharmacists that have had a positive impact on patient engagement and activation, readmissions, and health outcomes will be highlighted. Presenters will also provide ideas to remove barriers and further improve care transitions processes.
Josh Akers, PharmD, BCACP
Bold. Adaptive. Innovative. The Kelley-Ross Clinical Pharmacy Institute is about attaining the future of pharmacy, and managing that division is Josh Akers. Josh graduated from Washington State University in 2007, completed a residency at Virginia Mason Medical Center in 2008, and has been with Kelley-Ross ever since. Josh oversees their In-home med coaching and transitions of care programs, he serves as Manager & Residency Program Director for the Community Residency Program and is an Assistant Clinical Professor at the University of Washington.

Jennifer L. Bacci, PharmD, MPH, BCACP
Jennifer Bacci is an assistant professor and Kelley-Ross faculty fellow at the University of Washington School of Pharmacy. Dr. Bacci’s work focuses on the implementation and evaluation of innovative patient care models in the community setting. She received her PharmD and MPH from the University of Pittsburgh in 2011 and 2015, respectively.

Selena Bolotin, LICSW
Selena Bolotin manages the CMS-funded statewide initiative to improve care transitions and reduce avoidable readmissions for Medicare patients. She joined Qualis Health in 2008. Previously, she was the Program Manager for the CMS-funded Care Transitions project in Whatcom County. Selena has worked in a variety of healthcare settings including community mental health, hospital, hospice, and home care. For much of her career, she was a hospital administrator responsible for behavioral health, case management, and rehabilitation departments.

Jane Brock, MD, MSPH
Dr. Jane Brock is a medical director at Telligen, the Medicare Quality Improvement Organization (QIO) for Colorado. She is currently the medical director of the CMS QIO 10th Statement of Work Integrating Care for Populations and Communities National Coordinating Center, which provides leadership and support to 41 QIOs as they recruit communities of providers and Medicare beneficiaries to work together to reduce unwanted hospital readmissions. Dr. Brock also serves as an expert faculty member for CMS’s Community-Based Care Transitions Program technical assistance contractor.

Anne Casey, MS, FAACVPR
Anne Casey is administrative director of the Heart Institute at Virginia Mason Medical Center. She holds a Master’s Degree in Clinical Exercise Physiology and was awarded Fellow status from the American College of Cardiovascular and Pulmonary Rehabilitation for innovative work in primary and secondary prevention of heart disease.

Paul Ciechanowski, MD, MPH
“Dr. Paul” is chief medical officer and founder of Samepage Health, a Seattle-based healthcare technology and services company. He has dedicated his career to improving healthcare communication based on his blended background as a family doctor, diabetes management specialist, and psychiatrist. He has conducted national research and published extensively in top medical journals including JAMA, New England Journal of Medicine, and others. He is an international authority on case management programs, behavior change, treatment adherence, and patient-provider communication.

Amy Conrick
Amy Conrick, co-director of the National Center for Mobility Management, has 15 years of experience as a presenter, trainer, facilitator, and program director in fields of transportation and mobility management. She has been teaching and guiding teams in design thinking methodology since 2012, most recently with 16 teams working on health-care related transportation solutions.

Elissa Director, MA
Elissa Director, Alki Analytics LLC, has over 10 years’ experience providing training and consulting services to health care professionals in numerous organizations. Her clients include hospitals, healthcare systems, community based organizations and educational institutions. She has organized and led two multi-state health literacy summits and has been a featured speaker at various healthcare conferences. Elissa received her BA degree in English from Emory University and her MA degree in Teaching from Northwestern University.
Speaker Bios, continued

Tom Edmondson, MD, CMD, AGSF, FACP
Dr. Tom Edmondson is physician director of Philips Enterprise Telehealth. Tom has worked as a clinician, teacher, and physician administrator in many settings, including hospitals, post-acute and long-term care settings, and nursing home chains. As an educator, he has taught physicians in geriatric medicine fellowships and post-graduate physicians in residencies in internal medicine, family medicine, and gynecology. Tom is boarded in internal medicine, geriatric medicine, and hospice and palliative medicine, and is a Certified Medical Director. He is chair of the American Board of Post-Acute and Long-Term Care Medicine where he oversees the nation's Certified Medical Director credential. Tom serves on the Board of Directors of the Maryland Medical Directors Association as the Vice-President, the Baltimore City Medical Society as Secretary, and the State of Maryland's Board of Examiners of Nursing Home Administrators. He has been awarded Fellowship status in the American College of Physicians and the American Geriatrics Society.

Sarah Edwards
Sarah Edwards is the Executive Director for ResCare HomeCare in Seattle. With a background in social work, Sarah takes pride in leading a team that provides culturally competent, high-quality home care in eight languages.

Francois Larrivee
Francois Larrivee directs transportation programs at Hopelink, a nonprofit social services agency serving north and east King County. He has primary oversight of Hopelink’s Medicaid transportation services. Prior to joining Hopelink in 2005, Francois served a variety of operational management positions at Amazon.com. He currently serves on the City of Bellevue’s Transportation Commission.

Maureen Linehan
Maureen Linehan directs Aging and Disability Services (ADS)—the Area Agency on Aging for Seattle-King County—which serves more than 37,000 residents each year, including 13,000 Medicaid- and/or dual-eligible long-term care case management clients, with a continuum of services—from healthy aging to chronic care management. ADS has piloted and developed innovative and/or evidence-based services such as elder abuse case management, family caregiver support, PEARLS (minor depression intervention), chronic disease self-management workshops, and specialized dementia behavioral interventions.

Geoffrey Meer, PharmD
Geoffrey Meer is a clinical pharmacist in the long-term care division of Kelley-Ross Pharmacy Group. As a consultant pharmacist, he works closely with all healthcare staff at Bailey-Boushay House, a skilled nursing facility for those living with HIV/AIDS and patients needing end-of-life/palliative care. He has helped develop many processes to make transitions seamless for the entire care team.

Tod Morris
Tod Morris served as the project manager for the Rides to Wellness program in Southwest Idaho, an initiative that consists of a coordinated call system that enables patients to schedule healthcare appointments and transportation services with a single phone call. Tod is a recent graduate of Boise State’s Masters of Community and Regional Planning program. He is now a mobility planner at Valley Regional Transit in Boise, Idaho.

Michael Richardson, MPA
Michael Richardson directs the Northwest ADA Center and is responsible for coordinating the activities of the Technical Assistance Unit. He provides technical assistance, training, continuing education, and technical consultation services related to the Americans with Disabilities Act (ADA) and other federal and state disability laws.

Rhonda Steele
Rhonda Steele is the program director for CarePatrol and the Community Integration Model (CIM). A seasoned program developer, technical communicator, project manager, and corporate trainer, she streamlines processes and tailors the CIM model into sustainable solutions for hospitals and other organizations.
Transitions of Care with Kelley-Ross Pharmacy Group: Reducing Cost, Improving Lives

Kelley-Ross Pharmacy Group has been providing in-home pharmacist care and medicine coaching for more than four years. One of the leading causes of avoidable hospital readmissions is mismanaged medications, as patients are often confused, disoriented or under the impression that they simply ‘don’t really need’ to take medicine as prescribed by their physician.

This is particularly challenging for high-risk patients, such as the extremely ill geriatric patient or cardiac patient.

On average, most high-risk and severely ill geriatric patients have a 30-day readmission rate anywhere from 23 to 35 percent. Patients in our in-home medication coaching program, which focuses on these high-risk populations, have a readmission rate of only 10 percent. When you calculate the fact that Centers for Medicare & Medicaid Services (CMS) (via the Healthcare Cost Utilization Project) estimates the cost of hospital readmissions at $11,200 per patient, the potential savings quickly becomes dramatic.

Another area we can see significant savings is with high-risk/high-cost cardiac patients. In a recent pilot program called Heart to Heart, Kelley-Ross partnered with Virginia Mason to visit patients with moderate-to-severe heart failure once a month for three months after they were discharged from the hospital. Providing in-home detailed explanation of medications, thorough medication reconciliation, and patient monitoring, we integrated our recommendations directly into patients’ medical records and we saw immediate results.

Through the first eight months of the 12-month initiative, only two (6.6 percent) of the 30 patients enrolled were readmitted to the hospital within 30 days, and these were for non-cardiac issues. The national rate of unplanned 30-day readmissions for heart failure patients is about 23 percent, according to the U.S. government’s Hospital Compare website.

We’ve achieved these results by identifying more than 250 medication/therapy-related issues and performing more than 300 interventions that have enhanced care quality and patient safety. This includes providing smoking cessation support, ensuring patients are properly vaccinated, assisting with medication disposal, helping patients develop appropriate medication management systems, and providing education for patients to understand their medications and conditions.

The cost-savings associated with reduced readmission rates doesn’t just save money with high-risk admitted patients on a case-by-case basis. It saves the healthcare provider long-term as their reimbursement rates are increasingly being determined by their readmission performance. Health-systems continue to see more readmission penalties affecting their reimbursements. And it’s not just the hospitals. Readmission penalties are now affecting reimbursements for skilled nursing facilities. Payors of healthcare are no longer accepting high healthcare costs associated with readmissions, especially when they know many can be avoided.

In addition to saving healthcare providers on a patient costs associated with readmissions and protecting providers from reduced insurance reimbursements, pharmacy-led medicine coaching has many other benefits. Medicine coaching also reduces costly ER visits, and it greatly reduces initial hospitalizations for those patients who have chronic conditions and manage a complex medicine regimen. And perhaps most importantly, in-home pharmacist-led medicine coaching improves quality of life for patients and increases overall patient satisfaction.

Simply put, in-home pharmacist-led medicine management saves money and improves lives.

Kelley-Ross Pharmacy Group
Caring is in our Chemistry

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Senior Services is now Sound Generations

While the name has changed, our core mission remains the same: to promote the emotional, social, and physical well-being of older adults and those who care for them.

We continue to provide older adults and adults with disabilities with vital resources to help them thrive. We offer meals and fitness programs, free rides to medical appointments, and opportunities for meaningful engagement with others. We alleviate stress by connecting seniors and those who care about them to whatever they need to remain safe, active and healthy. We are committed to helping all people—especially those in low-income communities and communities of color—feel included and respected.

Our Community Partner Sites include:

- Ballard NW Senior Center
- Central Area Senior Center
- Shoreline/Lake Forest Park Senior Center
- Sno-Valley Senior Center
- Southeast Seattle Senior Center
- Senior Center of West Seattle

and

- LakeCitySeniors.org

If you or someone you know needs help finding just the right resources for an older adult or adult with disabilities, our Pathways Information & Assistance advocates are there to help. Call us at 206.448.3110. Information about all of our programs is available at soundgenerations.org.

*Photos by Bryan Ilyankoff*
Palliative Care Services at Valley Medical Center

The Joint Commission’s Advanced Certification Program for Palliative Care recognizes hospital inpatient programs that demonstrate exceptional patient and family-centered care and optimize the quality of life for patients with serious illness. The VMC Palliative Care team was awarded Joint Commission certification March 23, 2016 after a successful site survey.

While this is a great success for Valley and the patients and families we serve, it’s also an important achievement for the UW Medicine system. All four sites, University of Washington Medical Center, Harborview, Northwest and Valley have now attained Joint Commission Advanced Certification for Palliative Care. This makes UW Medicine the first healthcare system in the country to achieve this certification at all of its hospitals and makes for a very exciting and important accomplishment!

Why is this so important?
Palliative Care is specialized care for people with serious illnesses. It focuses on providing patients with relief from the symptoms, pain and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and their family. It is provided by a team who work together with a patient’s other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatments.

The Palliative Care team works hand-in-hand with other members of the care team to provide services that meet a patient’s specific needs including:

- **Identification of goals and wishes.** Assisting patients and their loved ones with clarifying their goals of care and helping them work towards those goals. They also assist with decisions regarding treatment options or changes in the direction of care.
- **Prevention or relief of symptoms.** Managing pain, nausea, constipation, depression and other symptoms caused by the disease or the side effects of curative treatment.
- **Emotional and spiritual care.** Providing supportive counseling for patients and families and helping identify strategies to cope with the stress of a serious illness.
- **Advance care planning.** Identifying and documenting patient’s values and preferences for future health care.
- **Information and resources.** Facilitating communication and coordinating with patients, families and the care team to encourage open dialogue so everyone has the information needed to make important decisions.

Palliative Care is appropriate for anyone with a serious, chronic, or life-threatening illness such as:

- Heart failure or advanced heart disease
- Stroke
- Kidney or liver disease
- Cancer
  
  - Alzheimer’s disease or other dementia
  - Chronic progressive lung disorders
  - Chronic and life-limiting injuries from accidents or other forms of trauma

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Are you an older adult who needs transportation? Have you signed up for utility assistance? Are you helping someone with a disability find suitable housing? Do you care for someone with dementia?

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Community Living Connections staff members are called “advocates” because they will do whatever they can to get you the help you need. Advocates have specialized training and extensive knowledge about community resources that gives them the ability to answer questions and provide you with options.

All Community Living Connections calls are free and confidential. If you or someone you know faces aging or disability issues in Seattle or anywhere in King County, call today. You may also visit [www.communitylivingconnections.org](http://www.communitylivingconnections.org) or e-mail info@communitylivingconnections.org.

[www.communitylivingconnections.org](http://www.communitylivingconnections.org)
The Home Care Referral Registry offers consumers the opportunity to choose their own pre-screened caregiver.

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- Case Manager

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Philips Telehealth Solutions enables clinicians to remotely monitor chronic patients, so they can make more timely care decisions. It also supports patient education, promoting healthy behaviors and self-care. This can lead to better clinical outcomes and reduced healthcare costs through fewer unplanned hospitalizations and ER visits.

Stop by the Philips booth for more information or contact your Territory Account Manager.

Andre Psaradelis
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andre.psaradelis@philips.com

*AutoAlert option is locally available at participating Lifeline programs. AutoAlert does not detect 100% of falls. If able, users should always push their button when they need
Poster Presentations

Posters will be displayed throughout the conference in Hall C. Poster authors are available to answer questions during the mid-day poster session.

Caring for Dying Patients in Skilled Nursing Facilities: A Hospice Train-the-Trainer Project
Latisha Newkirk, Clinical Division Manager, King County Facilities, CHI Franciscan Hospice and Palliative Care

Improving the Care of Older Adults: Northwest Geriatrics Workforce Enhancement Center
Aimee Verrall, Program Manager, Northwest Geriatrics Workforce Enhancement Center

Innovative Partnerships for Senior Health Promotion: Community-clinical Linkages between EnhanceFitness and Physical Therapy Practices
Marlana Kohn, UW Health Promotion Research Center

A Peer-engagement Intervention to Connect the Older Veterans Community to an Evidence-based Depression Care Management Program
Lesley Steinman, UW Health Promotion Research Center

Self-Management Plans for Common Chronic Conditions
Mary Pat O'Leary, RN, BSN, Aging and Disability Services

Translating Research into Practice: Lessons Learned from Providing Technical Assistance for PEARLS
Lesley Steinman, UW Health Promotion Research Center

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- Sno-Valley Senior Center
- Southeast Seattle Senior Center
- Senior Center of West Seattle
  and
- LakeCitySeniors.org

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We are a nonprofit that offers new opportunities to develop and test cross-generational solutions to the challenges facing LGBTQ midlife and older adults, building on strengths across the generations.

Using research findings from Caring and Aging with Pride and Aging with Pride, we are assessing needs and designing trainings and services for LGBTQ people, their families and communities. The goal of this partnership is to develop and test the first evidence-based trainings for providers of care to LGBTQ older adults and their families.

Additionally, the organization is creating evidence-based cross-generational support programs to reduce isolation and enhance successful aging-in-place. This project is funded by the City of Seattle.

generationswithpride@gmail.com
Valley Medical Center proudly offers a network of primary care clinics which serve as a medical home for care management. Urgent care clinics provide a safety net of after-hours care and walk-in consult and treatment, and specialty clinics provide convenient and comprehensive access throughout the district.

Primary Care: Partners for Health & Wellness
VMC’s primary care providers get to know you and your medical history, serving as personal health advocates for you and your family, and working with you to monitor and improve your health through all life’s stages.

- Cascade Clinic
- Covington Clinic
- Fairwood Clinic
- Highlands Clinic
- Kent Clinic
- Lake Sawyer Clinic
- Maple Valley Clinic
- Newcastle Clinic
- Valley Family Medicine Clinic

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- Covington Clinic
- Maple Valley Clinic
- Newcastle Clinic
- North Benson Clinic
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