Care Transitions: Whose Job Is It Anyway?

Thursday, May 30, 2013

Conference Summary

Highlights

- 115 attendees
- 61 organizations
- Keynote address by Alicia Goroski, Colorado Foundation for Medical Care
- South King County Progress Report by Selena Bolotin, Qualis Health
- Lessons Learned in Pierce County, by Kathleen Moisio, PLU Comprehensive Gerontologic Education Partnership & Together We Care
- Group discussions:
  1. The Pillars of Care Transitions Intervention: Medication self-management, patient-centered health records, primary care follow-up & educational flags
  2. Frequent Flyers: Developing community-based strategies to serve frequent ER visitors
  3. Engaging Patients in Self-Management: Motivational Interviewing, Teach Back & other best practices

"Collaboration, collaboration, collaboration!"

— Participant survey comment

Aging and Disability Services (ADS)—the Area Agency on Aging for King County--convened Care Transitions: Whose Job Is It Anyway?, a half-day conference on Thursday, May 30, 2013 at Valley Medical Center in Renton, Washington. Co-sponsors included ADS, Qualis Health, and UW Medicine/Valley Medical Center. One hundred fifteen (115) individuals, representing 61 organizations, registered at the half-day meeting. Several additional Valley Medical Center staff dropped in to hear the keynote presentation.

The conference focused on reducing unnecessary hospitalizations (especially re-hospitalizations) in south King County. This event followed up on a community meeting held in April 2012, summarized in "Coordination, Collaboration, Communication & Care Transitions: Report on the South King County Community Meeting on Effective Care Transitions. To read the 2012 report, click here. Approximately one-third of conference participants attended the 2012 community meeting.

The meeting invitation and ADS website provided background information and pre-reading materials about hospital readmissions and community-based care transitions models.

Participants arrived at the meeting at 8:30 a.m. to register, review exhibits and materials, and network.

Aging and Disability Services director Jesse Eller welcomed participants at 9:00 a.m. and served as master of ceremonies, saying "Care transitions: whose job is it anyway? It's my job, it's your job, it's everybody's job. How we define our roles, how we determine and implement strategies for reducing avoidable re-hospitalizations, and how we connect with each other and collaborate for patient success—those are the bigger questions of the day."

Aging and Disability Services—Area Agency on Aging for King County

Eller provided background on Aging and Disability Services (ADS, designated by the State of Washington as the Area Agency on Aging for King County. Area Agencies on Aging (sometimes called Triple-As) have been the backbone of the National Aging Services Network for decades but a still sometimes called "the best kept secret in town." Area Agencies on Aging provide Advocacy, Action, and Answers—and not just on aging.

ADS serves more than 10,000 long-term care case management clients throughout King County—mostly Medicaid-eligible individuals age 18 and up who have significant challenges performing Activities of Daily Living. About half live in South King County. In addition, ADS funds or administers adult day health, Alzheimer's support, caregiver support, respite, health promotion, legal, nutrition, transportation, and elder abuse services, and more.

The "front door" to most aging services is Senior Information & Assistance (1-888-4-ELDERS), which the Area Agency on Aging funds at Senior Services, as well as Community Information & Assistance services at seven agencies that specialize in linguistic and culturally appropriate services for older adults.

Overall, in 2012, ADS served 37,620 King County residents (an unduplicated count).

With decades of case management experience, ADS branched out to chronic care management a number of years ago, building partnerships with Harborview Hospital and a number of local clinics. Two years ago, the agency began to study care transitions models and to talk with south county hospitals and community-based organizations.

Care transitions coaching was a natural fit, and a number of ADS RNs and case managers were trained as care transitions coaches in 2012. Currently ADS serves Medicaid-eligible patients at high risk of re-hospitalization as well as any patients referred by CHPW—Community Health Plan of Washington. ADS collaborate with health care providers to:

- Improve transitions from hospital to home.
- Coach patients and their caregivers to follow discharge orders.
- Motivate patients to manage their health care more effectively.

UW Medicine/Valley Medical Center

Elaine Lobdell, RN, MS, CPHQ, vice-president of Quality Services, UW Medicine/Valley Medical Center, extended a welcome and shared Valley Medical Center's commitment to patient safety and successful care transitions. Valley Medical Center graciously hosted the conference.

Lobdell shared Valley Medical Center's organizational and professional values, their tremendous growth over the past decade, an overview of their specialty services, and their commitment to improving transitions for all patients, decreasing avoidable hospital readmissions, maintaining and improving quality of care, and documenting measurable savings.

Keynote Address: Alicia Goroski, Colorado Foundation for Medical Care

Alicia Goroski, MPH, associate director at Colorado Foundation for Medical Care, provided the conference keynote address, saying it takes a community, a few champions, belief in the goal over attribution, simple measures of progress, and good relationships to create an environment in which care transitions interventions work well.

The Tragedy of the Commons: When short-term selfish interests are at odds with long-term group interests

Goroski provided the history of and rationale for improving care transitions in order to reduce hospitalizations and rehospitalizations. In targeted communities, as comparison communities, care transitions intervention avoided twice as many rehospitalizations (one hospitalization for every 1,000 Medicare beneficiaries) and hospitalizations (five for every 1,000 beneficiaries).

Goroski shared "the tragedy of the commons," a reference to short-term selfish interests that are at odds with long-term group interests—in this case the interests of patients, providers and payers.

Examples of enduring Common Pool Resource management included:

Principles of CPR Management	*Grand Junction, Colorado*
Clearly defined boundaries	Geographic isolation
Local adaptation of access 'rules'	Local payer serving community needs
Participation of 'appropriators' in decision-making process	Longstanding culture of collective action
Effective monitoring by appropriators	Physician utilization comparison ranking
Graduated sanctions for those who do not respect community rules	Payment incentives, pride in ranking
Conflict resolution mechanisms that are cheap and easily accessible	IPA culture, payment incentives, social networks—"the grocery store factor"

Conditions of collective success include a common agenda and language; standard measurement system; mutually reinforcing activities; continuous communication; and backbone support organizations.

Goroski provided a national perspective of the care transitions movement, which includes 375 communities and 859 hospitals serving more than 13 million Medicare fee-for-service beneficiaries. Washington state has the third highest proportion of beneficiaries living in engaged communities, the fifth highest number of unique interventions showing improvement; is running 18th in admissions reduction (starting out with the 10th lowest admission per 1,000 rate); and 16th in readmissions reduction (started with 13th lowest readmission per 1,000 rate).

Goroski's presentation is available online.

South King County Progress Report

Selena Bolotin, LICSW, director of Washington Care Transitions & Patient Safety at Qualis Health, the Medicare quality improvement organization for Washington and Idaho, provided background on care transitions work in South King County and an update on success in reducing hospital readmissions.

When will we see state or national news highlighting South King County for leading innovation and outcomes for a diverse community?

South King County presents a significant opportunity, with readmission rates above the state average, a high number of people eligible for both Medicare and Medicaid, and a high number of residents who get care in their community.

Factors that contribute to high readmission rates include:

- Poor provider-patient interface (particularly as it concerns medication management, patient engagement, and follow up)
- Unreliable system support (including lack of standard and known processes, unreliable information transfer, and unsupported patient activation during transfers)

In addition, there is no apparent community infrastructure for achieving common goals. Bolotin shared graphic images of patient transitions, demonstrating the complex web of service providers who share patients, and outlined potential structures to further the cause. She challenged conference participants to define their community and be as inclusive as possible—hospitals (including discharge planners, case managers, pharmacists, hospitalists, quality and patient safety planners, and nurses); sub-acute providers (SNFs, home health, hospice, and primary care); community pharmacies; behavioral health; dialysis facilities; parent organizations (i.e., hospital systems); Area Agency on Aging; senior centers; community services (including transportation, EMTs, health department, parish nurses, etc.); independent and assisted living facilities; higher education (especially with nursing and pharmacy schools); patients; and family caregivers. Qualis Health remains poised to support this work.

Bolotin's call to action asked:

- When will every patient and family member have a consistently thoughtful and safe care transition?
- Who will be the catalyst for the next level of community engagement and structure to achieve common goals?
- When will we see state or national news highlighting South King County for leading innovation and outcomes for a diverse community?

Bolotin's presentation is available online, along with a 2012 Community Performance Report.

Together We Care: Lessons learned in Pierce County

Kathleen Moisio, BSN, RN, Comprehensive Gerontologic Education Partnership at Pacific Lutheran University, shared a community collaboration model in nearby Pierce County. "Together We Care" is a broad coalition of providers, stakeholders, and consumers that is working concurrent to Pierce County's 3026 Community-based Care Transitions program ("Pierce County Responsive Care Coordination") to achieve outstanding care coordination for chronically ill community members. The latter comprises the Pierce County Department of Community Connections Aging and Disability Resources (Area Agency on Aging), Franciscan Health System, MultiCare Health System, Pacific Lutheran University School of Nursing, and Comprehensive Gerontologic Education Partnership (CGEP).

Thriving on:

- **Evidence-based models with person-centered care**
- **Collective power fueled by engaged individuals**
- **Transformation to a reality not yet fully imagined**

Together We Care partners have a long history of collaboration and a willingness to share ideas, resources, and information. There is minimal focus on competition and recognition. One agency coordinates but control is shared among partners.

A frequent, open question among Together We Care partners is "What would make this partnership critical to your agency?" Steps are taken to ensure that the partnership meets everyone's needs.

Together We Care expanded upon on a model established by the CGEP. The coalition started intentionally, collaborating on a common vision, mission and goals. It created a structure and formal charter to support their goals, all outlined on a Wiki site.

Common goals include:

1. Developing Group Cohesion
2. Ensuring Physician/Provider Involvement
3. Building a Volunteer Network
4. Using Technology for Health Information Exchange
5. Developing Shared Resources/Processes
6. Building Care Coordination and Access for the Uninsured
7. Enhancing Transportation Support
8. Developing a Community System of Self-Management Education & Support

Projects within TWC's goal framework include:

- 211 integration

- State Action on Avoidable Rehospitalizations (STAAR)/Together We Care interfacility transfer order forms
- TEAMS (Together, Eating better, Actively living, Monitoring health, Self-managing risk) for Healthier Living initiative to improve health behaviors throughout the community
- Panel discussion by Individuals experiencing chronic illness and their family caregivers—who said they wanted:
    - To work together with health/community professionals
    - To have access to education to empower themselves
    - To be seen as unique individuals and treated with respect and compassion

Together We Care continues to thrive, with emphasis on:

- Evidence-based models with person-centered care
- Collective power fueled by engaged individuals
- Transformation to a reality not yet fully imagined

Moisio's presentation is available online.

Discussion Groups

Following the presentations, participants self-selected one of three discussion groups. Groups were approximately even in size. ADS staff served as discussion facilitators and recorders.

1. **The Pillars of Care Transitions Intervention: Medication self-management, patient-centered health records, primary care follow-up & educational flags**
   Facilitators: Mary Patricia O'Leary, RN, BSN, Aging and Disability Services, and Janice Nelson, ADS RN Care Manager and CT Coach

   Attendees received an overview of the four pillars of care transitions based on the Coleman model. Handouts included sample "Flags" that ADS and community partners developed collaboratively. Janice Nelson, an ADS RN Care Manager, provided an overview of how care transitions works in the current ADS client population. She cited client stories, outlined challenges and successes, and shared how Motivational Interviewing and Teach Back are used in care transitions.

   It is important that the CT coach not judge.

   Discussion and questions:

   How much does medication reconciliation play in CT? What percentage?
   - Medication reconciliation plays a huge role. RN spends at least 60% of CT time with medication reconciliation
   - Polypharmacy issues are common
   - Medication issues, e.g., not taking medications as directed, missing dosages, etc. lead to complications as well as lead to other diagnoses developing.
   - When dealing with medication adherence/compliance, it is important for the CT Coach to not judge. Need to find out reasons why medications are not taken as prescribed. Financial barriers in obtaining refills and unpleasant adverse side effects are among the issues facing clients who take multiple medications.

   Where do coach referrals come from?
   - Fire department
   - Primary care provider
   - Hospital
   - ADS case managers

   Caseload size?
   - About 50 clients per coach, though this varies.

   Where can we find tools, handouts, and more information?
   - Aging and Disability Services (King County Area Agency on Aging) website

What does the CT Coach do? Can the CT Coach help if/when client issues develop? (e.g., client asks for a change in primary care provider change, medication change, etc.)

- CT Coach attends medical appointments with the client/patient
- CT Coach completes high-risk assessment and plan of care, engaging client to take an empowerment role in his/her health.
- CT Coach can help facilitate health changes through Motivational Interviewing.
- CT Coach works with client and providers in open dialogue and relationship building. CT Coaches can help problem solve issues and when necessary help clients find a better primary care match when it is appropriate.
- CT Coach can and does improve direct relationships with medical providers, since poor alliances impact cost along with client health and well-being. The relationship extends beyond the clinic visit. CT Coach interacts with medical professionals before and after clinic visits promoting continuity of services.
- CT Coach assists with referrals to professionals, including specialists. In one example, a client was consistently told in the ER that she had pancreatitis and she should "stop drinking". This client was not drinking any alcohol. The RN CT Coach facilitated a referral to a GI specialist and the client has an intestinal issue that was the cause of her severe abdominal pain.
- CT Coaches work to decrease the unnecessary utilization of acute care treatment.
- CT involves networking with care team (primary care provider, specialist, etc. The RN CT Coach is a conduit.

What do you do if someone is selling prescription medications (provider or client)

- CT Coach makes sure the situation is safe for both client and provider.
- Paid providers cannot be under the influence of drugs and alcohol and continue to be paid by the State of Washington. Providers may be terminated if they violate their contracts.
- CT Coach would take the appropriate action to make sure the situation is safe

How do you handle interpretation?

- Hire culturally and linguistically competent staff
- Understand that information may need to be developed in low literacy format.

2. Frequent Flyers: Developing community-based strategies to serve frequent ER visitors
   Facilitator: Andrea Yip, MPA, Aging and Disability Services

What is a frequent flyer?

- Call 9-1-1 frequently, up to three times per day (Fire dept)
- Five or more visits in a year (hospitals)
- Three or more visits in a 12 month period (hospitals)
- Flip-flops – hospital to SNF to hospital (skilled nursing facilities)

Discharge planning from Day 1 …

What are the main issues with frequent flyers?

- Mental health
- Substance abuse, drug seeking

- Social isolation
- Medication mismanagement
- Uninsured, no insurance
- No in-home support or not confirming existence of in-home supports
- No PCP
- Chronic illness
- Refusal of acceptance of higher level of care
- No access to transportation
- Anxiety
- Early discharge/lack of discharge planning
- Lack of Education—
  Patients:
  - Lack of understanding of health care system, role of PCP and ER
  - Not understanding illness
  - Lack of self-management skills

  Staff:
  - Urge people to call 9-1-1
  - Skills to deal with medical situation
- Oral health/dental pain
- Cultural/language barrier
- Lack of motivation to change
- Ease of calling 9-1-1
- Family members panicking
- Fear of liability
- Care providers not wanting to take care of the patient (passing the buck)
- Pride/shame asking for help, waiting too late
- Availability of PCP to get same day appointments
- Secondary gain (hospital provides food, shelter, supports, etc)

What can we do to fix situation?

- Discharge planning from day 1, collaborate with other SNF's in South King County/Des Moines area
- Exploring transportation options to health care facilities (King County Mobility Coalition)
- Health home – primary strategy to decrease frequent flyers and reduce redundancy, care coordinators help patients navigate health care system (Sea Mar)
- Case staffing with diverse partners
- Network across entities and venues
- Using media for mass education
- Coaches work with people with chronic conditions in public housing sites and community based health centers
- Nursing care managers coordinate health care (managed care companies)
- Increasing knowledge of resources:
  - Senior I&A
  - Alzheimer's association resource for people with dementia

- 24 hour nursing line
- Congregate nutrition program (decrease social isolation)

3. **Engaging Patients in Self-Management: Motivational Interviewing, Teach Back & other best practices**
   Facilitator: Samantha Santor, MSW, Aging and Disability Services

   Keeping patients engaged and motivated to manage their health and recovery
   The group identified two primary types of barriers: those specific to the client/patient and those specific to the provider or system.

   Client/patient barriers included:
   - Overwhelmed/under-educated
   - Too ill
   - Cognitive disabilities
   - Lack of support system
   - Fix-it attitude
   - Lack of resources
   - Choice fatigue
   - Medication side effects
   - Lack of understanding re: illness
   - Passive attitude ("Tell me …")
   - Family dynamics
   - Lack of knowledge re: resources
   - Literacy/language barriers
   - Depression, anxiety, and other mental health issues
   - No clearly-identified family caregiver

   Keep the patient at the center. Meet them where they are. Use culturally appropriate interventions. Allow patient to develop own goals.

   Provider barriers included:
   - Too many hands in the pot
   - Cultural differences/lack of culturally appropriate care
   - Differing discharge practices and lack of communication
   - Lack of coordination between providers

   Specific strategies for patient empowerment
   The group identified a number of strategies for overcoming barriers to patient engagement and motivation. The primary consensus of the group was to keep the patient at the center—to meet them where they are, use culturally appropriate interventions and allow the patient to develop and identify his/her own goals. Sometimes the goals of patients do not match those of providers and that's okay. We learn to 'roll with resistance' and reserve judgment. These are keys to engaging patients in their own care planning.

   - Motivational Interviewing
     - We give clients the opportunity to develop their own goals and find out what is important to them.

    - MI uses various techniques such as Importance of confidence scales, reflections, affirmations and pros/cons
    - The spirit of MI is non-judging and curious – seeking to understand where a patient is and where they'd like to be, moving at the pace of the patient and rolling with the resistance that sometimes crops up
    - Client/patient driven goals and follow-up

- Teach Back
    - Teach-back before discharge
    - Allows staff to gauge whether a patient truly understands instructions
    - Reinforces learning by having the patient 'teach back' the information to the staff prior to discharge
    - Allows patients to get clear instructions without blaming them for not understanding. The burden is on staff to explain in a way each patient can understand.

- Other strategies included:
    - Warm hand-offs
    - Resources within community and home
    - Involve others, including providers
    - Educate clients
    - Individual planning and education
    - Consultation with family to build trust
    - Motivate individual success with coaching
    - Positive stories and messaging
    - Follow-up phone calls within three days
    - Individualized care plans
    - Conduct Chronic Disease Self Management Program (CDSMP)—sometimes called "Living Well" workshops—with peers
    - Use language re: chronic disease that people will understand
    - Set goals and help clients reach their goals

    - Motivational Interviewing resources include:
        - www.motivationalinterview.org/index.html
        - www.motivationalinterviewing.info/mi_resources.html
        - Motivational Interviewing in Health Care: Helping Patients Change Behavior by Stephen Rollnick and William Miller

    - Teach Back resources include:
        - www.teachbacktraining.com
        - www.ihconline.org/aspx/general/page.aspx?pid=107

At 11:45 a.m., participants reconvened in the auditorium to hear brief reports from each discussion group. The conference concluded at 12 noon.

Participant Surveys

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 June 12, 2013). Results follow:

Feedback Forms

1. *What is your strongest "take-away" (learning) from today's event?*

   All of the presentations were well received. Respondents were impressed by the data that shows, as one person put it, "we in the South Sound must be doing something right." Several referred to Washington state statistics that show change is occurring, and asked how this information could be shared (the May 22 performance report is available online). Others mentioned research they wanted to review.

   A large number of participants pointed at partnerships and community collaboration as keys to patient success as their most significant learning at the conference. In general, partnerships were seen as valuable for sharing strategies and resources. The Together We Care's partnership characteristics presented by Kathleen Moisio were called out, with emphasis on the five conditions of collective impact: 1) a common agenda; 2) shared measurement; 3) mutually reinforcing activities; 4) continuous communication; and 5) backbone support. Alicia Goroski's example of "The Tragedy of the Commons" also had a positive impact on participants.

   More specific to the south King County community was the notion that community providers and medical professionals could collaborate to reduce hospital readmissions. The conference provided a place to meet potential partners and to build stronger relationships.

   Participants commented on the wealth of resources already available in King County, and noted areas where there is room for improvement (e.g., education, understanding, coordination, dissemination of information), including getting the word out about the Family Caregiver Support, the role of home care agencies, and developing protocols for "warm" hand-offs.

2. *Are there additional ways that you or your organization could help improve care coordination?*

   Survey participants indicated willingness to:
   - Develop a community collaborative.
   - Developing existing partnerships, instead of starting from scratch.
   - Eliminate duplication.
   - Standardize engagement practices.
   - Streamline services.

- Support outreach to ethnic communities.

Strategies include:

- Analyze "hot spot" information (e.g., hospitalization data within housing complexes) in order to provide added services.
- Collaborate with adult day programs, fire departments, home health, hospice, and long-term care organizations, etc.
- Develop protocols for internal and external "warm" hand-offs.
- Develop relationships that reduce barriers when contacting hospital staff for transfer information (continuation of care).
- Engage insurance companies to support chronic case management programs,.
- Engage state associations to disseminate information about care transitions.
- Improve timeliness of calls to notify case managers of hospitalization and discharge.
- Increase pharmacy involvement (e.g., home visits, medication reconciliation, medication education) and creating programs to help care managers and coordinators with medication education, adherence, and medication goal setting (appropriate use).
- Improve patient education on health care system, self-management, medication management, etc.
- Notify and communicate to our residents' primary care physicians of their SNF admission and send regular updates on interdisciplinary progress
- Offer continuing education on community-based programs and services for providers and for patients.
- Organize more events to highlight care transitions.
- Place follow-up phone calls to patients.
- Provide space for community Chronic Disease Self Management Program classes.
- Reach out to primary care providers who serve residents in retirement and long-term care facilities.
- Washington Dental Service Foundation medical/dental collaborative.

3. *Yes, there are ways my organization can improve care coordination and some of those are as follows:*
   - Improved communication with primary care providers.
   - Routine clinical updates for primary care providers.
   - Increased and ongoing education for clinical staff
   - Ongoing cooperation and communication with social workers and discharge planners

Online Survey

A total of 55 people completed the follow-up survey online. Ninety-eight percent (98%) of respondents gave the conference favorable ratings (excellent or good) overall and a plurality gave excellent ratings to each of the featured speakers, with a vast majority rating the presentations as excellent or good.

The three discussion groups were rated excellent or good by most participants, with the largest number of responses fell in the "good" category for each group.

Ninety-six percent (96%) of respondents said they would attend future events related to care transitions in south King County. More than 75 percent said they would like to meet at least twice each year. The topics that respondents would you like to see addressed at future care transitions events range as follows:

General Topic	Interest
Partnership communication	55.1%
Patient transfers/hand-off	53.1%
Primary care provider communication	51.0%
Networking	49.0%
Patient education and activation	46.9%
Local supportive services	44.9%
Case studies (care transitions programs)	42.9%
Hot spots (geographic or social)	40.8%
Area Agency on Aging (AAA) programs	38.8%
Chronic disease self-management	38.8%
Long-term care options	36.7%
Medication reconciliation	34.7%
Caregiver support	32.7%
Home care services	30.6%
211 & Senior Information & Assistance	28.6%
Transportation and community mobility	28.6%
Fire/911 emergency services	22.4%
Oral health	20.4%
Skilled nursing facilities	20.4%
Hospice services	14.3%

Additional categories of interest include:

- Care transitions policy and procedure best practices
- Client registry
- DSHS assessment
- Electronic medical records
- Intersections of patient care and support (e.g., hospital-SNF, SNF-home care, home care-hospital, caregiver-PCP, caregiver-pharmacy)
- Palliative care
- Partnerships with hospitals and other community- based service providers
- Specialist and specialty offices accountability

Survey respondents expressed strong interest in skills-based workshops, networking for collaboration and activation (not marketing), and expert presentations.

Learning Opportunities	Interest
Workshops (skills based)	75.5%
Networking	69.4%
Featured speakers	63.3%
Discussion groups	49.0%
Panel presentations	49.0%
Project or work teams	42.9%

Ten respondents (from eight organizations) offered to help plan future care transitions conferences or workshops. Thirty-two of the 55 respondents offered valuable feedback on ways in which the conference could be improved, which will be considered by conference organizers. Comments centered around the event's structure, especially the need for more time in breakout sessions and for question-and-answer.

Appreciation

Aging and Disability Services thanks UW Medicine/Valley Medical Center for hosting the conference and the organizations that represented there:

Aging and Disability Services (AAA)
Andelcare
Asian Counseling and Referral Service
Burien Nursing and Rehab
Careage Home Health
Catholic Community Services HC
Chinese Information and Service Center
City of Kent
Colorado Foundation for Medical
Comfort Keepers
Community Health Plan of Washington
Cooking Gluten Free!
Crisis Clinic
DSHS-ADS Aging and Long-Term Support Administration
Franciscan Health System
Franciscan Hospice and Palliative Care
Franciscan Health System/St. Clare Hospital Emergency Department
Full Life Care
Hallmark Manor
Highline Medical Services Organization
Home Care Association of Washington
IAWW Seniors Program
International Community Health Services
Judson Park
Kelley-Ross Pharmacy
Kent Fire Department RFA
Kin On Community Health Care
Kindred Hospital
ManorCare Lynnwood
Millennia Healthcare Inc.
Multicare Auburn Medical Center
Neighborcare Health
Neighborhood House
Northwest Kidney Centers
Park West Care Center
Pierce County Aging & Disability Resources (AAA)
PLU School of Nursing, Together We Care, CGEP
PRN, Inc.
Providence Hospice of Seattle
Qualis Health
Sanofi
Sea Mar Community Health Centers
Seattle Fire Department
Seattle Pacific University
Seattle-King County Advisory Council on Aging & Disability Services
Senior Services (King County)
Senior Services of Snohomish County
Silver Planet, Inc.
Sound Mental Health
Southlake Clinic
Stafford Healthcare
Talbot Center for Rehabilitation and Healthcare
United Way of King County
UW Health Promotion Research Center
UW Medicine/Harborview Medical Center
UW Medicine/University Medical Center
UW Medicine/Valley Medical Center
Washington Association of Area Agencies on Aging
Washington Dental Service Foundation
Washington Masonic Charities
Wesley Homes
YWCA

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