Palliative Care Networking Group:
Bridging the Gap Toward Smoother Care Transitions

Presented by [Darla Waldner, Executive Director of the Land of the Dancing Sky Area Agency on Aging]
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Janelle Shearer: Hi everyone, I’d like to welcome you to the Palliative Care Networking Group. Our speaker today is Darla Waldner. She’s presenting on the topic: Bridging the Gap Toward Smoother Care Transitions.

She is Exec Director of the area Agency on Aging and has worked for the Land of the Dancing Sky Area Agency on Aging for the past 9 years in the area of agency program developer. The primary focus of her role is to develop critical home and community based services that have a high impact on older adults and their caregivers, that are affordable and accessible.

Darla has over 20 years experience as a social worker in the field of aging. She has held both clinical and administrative roles, including: social services director in a long-term care facility, director of home and community based services and case manager. Darla is passionate about creating communities that last a lifetime and support older adults and their families in remaining independent and living in the home of their choice.

In February of 2013, she was promoted to Executive Director of the Land of the Dancing Sky Area Agency on Aging. I love that name. The agency services residents in a 21 county planning and service area. She and her husband and three children, are planning to relocate to the northern part of Minnesota to be closer to the administrative offices located at the Northwest Regional Development Commission.

Everyone should have received an email from me with a handout and FAQs.

Darla, it’s nice to have you with us today. I’m going to turn the program over to you now.

Darla Waldner: Good morning everybody. I’m excited to be here today for both professional and personal reasons. I want to let you know that I’ve been a big champion of rural palliative care for personal reasons. Five years ago I went through a serious cancer and there was a team of doctors, social workers, and a chaplain that supported me and my family through that process.

It stressed the importance early on of documenting my health care preferences and making my choices about health care, as well as making sure that I’m empowered and that I’m the one that makes those decisions. I was very excited when I heard about Stratis Health’s grant opportunity and the chance to work with partners out in our community.

Many of them are on the phone with us, so that’s exciting.
For professional reasons, at the Land of the Dancing Sky and with my counterparts across the state, what we’ve all been trying to accomplish in the field of health care is designing a system that supports older adults in our case and young adults as well. But for older adults living independently in their home and giving them tools to be able to manage the illness and age in place.

We can’t do that alone, so we learned early on that collaboration is a successful model for being able to provide that safety network.

The Land of the Dancing Sky has 21 counties and we’re all in the northwest side of Minnesota. It’s 385 sq. miles in that service area and sometimes that’s a daunting task. We talk about rural palliative care in our 21 counties, all of them with the exception of the community of Moorhead, according to the state demographic society are considered rural. So this really speaks to our language.

We talk about bridging the gap for older adults. We talk about putting that safety net around them and before we do that we have to understand some of the demographics in our state and together how can we accomplish that task.

I’m sure many of you are aware of the silver tsunami statistics or the dot in the age wave that is facing many of our communities. The reality is that between 2005 and 2035, people 55+ will double from 600k to 1.3 million older adults in our state. Eighty-five plus population will nearly double to 163k, and what do we know about that? As older adults age, their disease progresses and that impacts all of us in this room and our impacts our ability to provide for those diverse needs.

By 2020 there will be more people 65+ than school age children. What does that say about the amount of caregivers that will be available to meet these needs?

The next slide is a good visual about the growth we’ve seen in the 85+ population, starting in 1990 when we were below the 80k mark and slowly going towards the top. It basically says that we’ll be overwhelmed by this population and that we need to be ready as communities to serve them.

Income diminishes as one ages, which puts yet another stressor on the system. The poverty rate for 65+ is 8.3% in the state of Minnesota and a poverty rate for 75+ increases to 10.3%. Elders of color have a higher poverty rate. What’s known as a staging for older adults in the state of Minnesota is the medical assistance program. Currently the program serves the long-term care needs of just over 5% of Minnesota seniors, a relatively small population.

Minnesota’s relatively modest medium income level results in a large number of older adults, who will need support outside that safety net. Because of the impact that a small percentage of seniors will be eligible for medical assistance, will be critical for us to build bridges so these people are able to cross multiple health care settings with pathways that can be created through rural palliative care and bridge through senior linkage line and the areas agency on aging as well as other home and community based partners.

One of the key roles that the Area Agency on Aging plays is in the area of development of home and community based partners that are critical access services.

**What do we know?** We know the vast majority of long-term care starts at home. Minnesota has had a strong network of service providers that deliver low cost, high impact services, chores, homemakers, grocery shopping, meals and transportation are all just examples of that.

The thing I love about working with our rural partners is that collaboration isn’t something that’s new to us.
The foundation of all the organizations we work with were built on the successful model of collaboration, so I feel it’s a skillset we’ve been born into. Other things we need to be aware of within the field of home and community based services I can’t stress the importance enough that we can’t do this without the family and friends providing assistance to older adults.

Even a 1% reduction in family assistance equates to $30 million increases in the state budget. That's huge, that's not small change. Increasing the supply and the types of caregiver support services and activating informal networks is critical. At the areas agency on aging we have taken a strong role in the area of caregiver services and we provide funding for several programs as well as caregiver coaching. A lot of care giving isn't just a six month span of life, it can be a long journey and we know that often caregivers end up becoming sicker than the folks they’re caring for.

So it's critical to have this caregiver coaching program that can walk hand-in-hand with them. Sometimes they aren't ready to have care because coming into their homes seems huge to them. So having the caregiver that can be a resource to them, support them and provide them with the tools to manage, this practice is critically important.

Let's talk about Area Agency on Aging elder care development partnership. When Janelle said I worked for the Area Agency on Aging for nine years it's actually been in this role that I worked in prior to February of this year. It's something I've been very passionate about. For the past 20 years the Area Agency on Aging partnership has played a critical role in developing home and community based options.

The reality is that in rural northwest Minnesota and parts across our state, we don't have multiple providers. We have providers, might be one wearing multiple hats, because that's what they need to be in the community's they serve. We've worked with many of our local partners to identify and develop the gap analysis process as well as needs assessments and what the things are that are lacking in those communities and pulling the partners together.

We're doing some pretty incredible things on $20k budgets in a lot of these organizations, which are very much volunteer driven and have a huge impact. They're saving a lot of money, but most importantly all their adults are allowed to remain in their homes.

One of the areas that we work with is with local aging resource centers. The Area Agency on Aging, that was created under the Older Americans Act, has a statewide home and community based network that develops and delivers non-medical services to help older adults remain in independence at their homes.

When we talk about the designs of Minnesota's aging network what we’re talking about is that it's designated by the Minnesota Board on Aging. There are six regional area agencies on aging and one tribal Area Agency on Aging. Some of the roles they play are stewards of federal and state funds. They are experts on community services, care giving, volunteer support, housing options, Medicare and public benefits.

More importantly, I can tell you that I know many of these individuals on a personal level and they truly care about the elder adults they're serving. They help organizations for local vendor networks as well.

Let's discuss how the Areas Agency on Aging impact the care transition process. One of the areas that we can have an impact and have been successful in is consulting one to one with older adults and their families about services, housing choices, caregiver support, Medicare benefits and county services. That’s a daunting task but it’s providing them with long-term care option counseling that encompasses from finding someone to clean their home to helping them understand long-term care insurance.
It helps older adults transition across care settings. We take a big role in advocacy in that area as well. Identifying needs and distribute federal and state resources to fund services for seniors and caregivers. In that role we are a grant administrator for Older Americans Act dollars that provide services to entities on a funding formula. Some of those services are in the community's served so we fund Meals on Wheels, Caregiver and other services, homemaker chores, transportation programs, as well as legal services and evidence based programs such as a Matter of Balance and trying to be self managed in living with a chronic condition.

We are also partnered to develop effective services and programs. A lot of what we’ve done under that umbrella is during these economic times everyone is getting cuts in funding that the high cost of inflation is impacting to many of these programs that are driving huge distances. Their travel time and mileage is no news, I’m speaking to the choir on this subject, it’s eating up budgets that are already thin.

So a key role we’ve taken on is helping these organizations sustain themselves and helping them figure out what that pathway is beyond their walls and who needs to sit at their table so that together they can merge and address the issues.

One of the things we’ve been most excited about as a state is our senior linkage line, which is a toll free information assistance line, a consultation by telephone, a web chat or at home. The computer systems and technology that they use for this is remarkable. They can do live chats, transfers when an older adult calls. It’s not like Medicare or Social Security where it’s push one button and you’re transferred with lovely elevator music and you’re on the line for 20 minutes, oops you were disconnected.

That’s frustrating for me and I have adequate hearing and I’m very assertive with my needs, but imagine an older adult that can’t hear well and might be dealing with memory loss issues where trying to use a telephone system is huge. Through the linkage line they’re able to evaluate complex living situations, connect to housing options and services such as homemaker meals and transportation, medication management, home modification and wellness programs. They also answer Medicare and insurance questions.

Some of the tools for older adults to figure out are on the web. What do we know about older adults? That the 85+ population very seldom even know how to turn a computer on, although we are making gains. I think the baby boomers will change that dynamic in our lives. A lot of those tools again are web based, so the senior linkage line is key and the good thing is that it’s unbiased so they aren’t linked to a financial source, they’re just helping them understand the sources that are available out there.

Also, follow up is very much part of the senior linkage line. When an older adult or a family member accesses the line and go through the process of reviewing the options, there is follow up afterwards to make sure the process and their needs were met and see if there are any further needs to be met in the process.

The senior linkage line was created for one stop for answers on aging. I can’t tell you how many times I sit across the table from older adults and they’re tired and worn out and we ask them their story and they say do you realize you’re the 8th person this week I told my story to? How frustrating is that? They have to tell their story when they sign up for home health. They have to tell their story when they go to the physical therapist. They have to tell their story when the homemaker and chores services show up. This is their answer, one stop for answering on aging.

It is the information assistance line, Monday through Friday 8:00 to 4:30 and yes I recognize that not all problems occur during those days and times, but the options are there and available.
If you'd like more information on the Minnesota Area Agency’s on Aging I'm providing you with all the information, including all the AAA across our planning and service area. I also wanted to bring attention to the other handout we provided, which was developed by M4A as a service for seniors in-service network. In the boxes you can see some of the programs that are supported both informal and formal networks across the planning and service areas.

This is actually a good tool and handout to give to older adults when they’re trying to understand the services that are there. I can't stress enough the importance of the collaboration between the Area Agency on Aging and the palliative care networks. With the things that are going on in federal and state with healthcare home process and models as well as the hospitals with the readmission rates and some things that are going on with the projects across our states, it's where the formal and informal healthcare systems have to come together and create a system that’s seamless for these older adults as they transition across healthcare settings.

I know the Area Agency on Aging is a small piece of that pie but we feel it’s necessary to be at that table and help put these collaborations and bridges together.

Let’s open up for questions…

**Janelle Shearer:** I've heard of Meals on Wheels and Area Agency on Aging, but now that the regulation for hospitals to call the senior linkage line is when someone is at risk. It's like a well kept secret.

**How does it really work and are these services free for people?**

I know Meals on Wheels isn't because my parents had that and had to pay for their meals, but if you could tell us how it works for folks who need things.

**Darla Waldner:** I agree it’s one of the best kept secrets, so that was a nice way of putting it. We receive referrals from multiple points of entry in the system and hospital and discharge planners are key referral sources for that. Now it’s even being mandated that that partnership be strengthened.

How it works is that we have a wide variety of home and community based service providers, some of which are grantees of the Older Americans Act dollars that we fund through all our Area Agency on Aging. Some are partners that we provide technical assistance to through grant writing and community service development grants as well as private foundations and other local funding opportunities.

Under the Older Americans Act, it's based on people's ability to pay and nobody is denied services, regardless of their ability to pay. We do emphasize with our community based partners that they provide the opportunity for older adults to share in their services and I think that's something collectively that we all need to get that message across is that services can't be provided for free and that whatever ability to pay for services that should be allowed the opportunity to contribute.

Many of our rural partners were built upon faith based initiatives or have been built on volunteer networks, so sometimes they struggle with how we encourage people to donate and does that impact our mission? We're trying to work with them on saying you can build your capacity by allowing the opportunity for cost sharing of those services and many of these organizations are dependent upon grants, but they are decreasing also. They have to find some multi-diverse funding sources which is critical.

**Janelle Shearer:** So, is it folks that are down to the level of medical assistance?
Darla Waldner: Absolutely not. We have access and provide services from people that are on the elderly to alternative care programs, on up to providing services to Donald Trump if need be. The Older Americans Act is more targeted to those individuals that are just above qualifying for medical services that in between group that’s struggling with high healthcare costs and just meets the needs of that population, but the services we provide encompass all different economic groups.

Janelle Shearer: So, when they call the senior linkage line if they determine they need housekeeping and laundry services, then does senior linkage line refer them to an agency that provides those services?

Darla Waldner: Absolutely. We have a wonderful web based tool that I want to promote called MinnesotaHealth.info that everyone has access to. By the way, I want to encourage you as organizations to get on there and check your own link on there. It’s free advertising for everyone. Make sure you have all the programs you’re utilizing on there because what happens especially in our rural community, their children aren’t living next door anymore they’re living in St. Paul, Bloomington or the California daughter or Texas son so them getting access to services, unlike the 85+ population is very much web based. Having your links up on information and referral is key to those individuals.

Janelle Shearer: All your organizations are on there?

Darla Waldner: There is a toggle on the website where you can go in as a provider and update your information. There’s a search button so if you’re home health you can put that in, as well as the community you’re in and it should pop up, if you’re a registered service or licensed through the state of Minnesota, you can almost guarantee you’ll be on there somewhere.

It’s important. We promote Minnesota Health, but we can’t make those changes for all organizations as well as update them.

Janelle Shearer: Is that what the folks at senior linkage line use when they’re providing information?

Darla Waldner: They’re looking on the web but a lot of times informal providers, not just the larger organizations, sometimes in some of our rural parts its Jim Jones that lives by the grocery store that you know you can call and they’ll shovel grandpa’s driveway. Sometimes it’s informal like that and that’s how it is in our region very often.

A lot of our communities have resource directories as well that have been put together by local providers, which are also handy tools.

Guest: So you get referrals from multiple entry points. At Crane West all of our seniors have had the assessment to know their placement is appropriate or so we hope and then appropriate referrals many served by the waiver or not.

If you get a referral from someone who doesn’t have that luxury do you then make referrals for the county assessment?

Darla Waldner: Absolutely. That’s very much a part of our intake process. They have specific protocols that they follow on the senior linkage line that gets to the heart of that and if that’s the direction they need than a referral is made. The exciting thing is that they can be on the phone with the older adult, identify the problems and needs and do a three-way call to the county with the adults on there to make that transfer and get to the right person. Then once they get on the line senior linkage can get off and has made that smooth connection.
Janelle Shearer: I would expect once that referral is made than those people are the ones who make referrals for all the other services. You don't need to individually refer them for all the services that case managers can do?

Darla Waldner: Correct, but sometimes the older adult or caregiver doesn’t even know what services, they don't know if they're in the system or not or some of those things. The staff is good about saying, can you get out your card and tell me what's on the card to understand where they are. So a lot of times we do make referrals.

Janelle Shearer: So all the calls go through the linkage line?

Darla Waldner: They do. How the linkage line works is that all the area agency's on aging have call centers so, depending on where you call in part of the state it will be initially routed to the call center in that region, but when things are busy you want to give access to older adults in a timely fashion so then someone from an office call center could take a call from there. Typically, from Hover County north it goes to the Warren office and the other part of the region is routed another way, so there is similar capability across the state.

Sherry Dale: You made a comment about some of the funding things and one of those was respite, does Area Agency on Aging help fund respite or do they just help find ways for people to help fund their respite?

That's a big need we see that’s hard to get funded or even to find people to do the respite.

Darla Waldner: Each of the Area Agency’s on Aging do have their Older Americans Act dollars and specifically the title of dollars we’re talking about is Title 3E, do have providers that fund respite care. Traditionally it is a non-medical respite care and that is where the caregiver would need four-six hours out of the home to do something.

I think the gap in service what is needed is the overnight and weekend respite care, because those tend to be things our providers have done on a case by case basis, but it's a real struggle when you're doing a volunteer non-medical model to fit that niche. So to answer your question yes we do, we fund that as well as link them to programs.

Sherry Dale: Thank you.

Janelle Shearer: This is a national program right?

Darla Waldner: Yes.

Janelle Shearer: Does it look different in different states what services are provided to the Area Agency on Aging?

Darla Waldner: One of the things that’s unique to our area is the senior linkage line and it’s the shining cap of Minnesota. Other than that the administration on aging sets key initiatives that need to be accomplished and that's the Development of Critical Access Services and critical access around nutrition, caregiver respite and support, homemaker chore and transportation services and personal emergency response systems.

That's a big piece of the puzzle, as well as our Title 3E funds are targeted towards evidence based programs. I think of any area of program development we have seen huge explosion across our state is in the area of evidence based programs such as a Matter of Balance.

Fall prevention is huge. In the state of Minnesota it's the third leading cause of death and some of us can say okay we just experienced the longest winter of our life and that could have some factor in it, but I believe Florida and Arizona are the two states ahead of us with larger concentrations of older adult population.
It's the number one reason for nursing home placement, a fall. It hugely impacts people's lives and one of the programs we've developed is a Matter of Balance, which is an evidence based program, but not only do older adults learn key exercises to develop flexibility and work on their core body and strength, but it also addresses those fears of falling. It's the older adults sitting in the recliners with their Reader's Digest and balls of yarn that are all toppled over that are paralyzed from fear of falling.

This causes them to isolate themselves in their homes and ironically the number one place you fall is in home. That program has been really successful in getting people out of their recliners and starting them back into some type of exercise program. The piece I love about it is that it also does a comprehensive home safety checklist. These aren't PTOT assessments, but it helps them to identify the common things in their home because much of what we've found in our planning and service area, one of the biggest items for being at risk for falls happens to be their durable medical equipment.

I chuckle because we're brilliant out here as healthcare systems but the majority of oxygen cords are see through and older adults can't see through them. So hearing what some of the older adult population are very creative. They're blackening it with markers and doing all kinds of things to address that because it ends up being a fall hazard, as well as not using your equipment properly. So Matter of Balance has been huge with physical therapists and it's been the first program that I haven't been begging people to do, people have been calling us to do it.

The other thing is Living Well with Chronic Conditions, which is a six week workshop that actually helps people become their own self managers. Core skills that they're learning is how to have those conversations with your doctor and healthcare professionals? How do you plan for agency in place as your disease progresses? Have you documented those preferences on a healthcare document or what is appropriate?

We talk about how the pain affects them, fatigue and medications, all of those pieces are involved so it's been a huge program. Our strategy in the Area Agency on Aging is looking within the health system to recruit volunteers to lead these classes and it's been a successful model. Now we're starting tai chi and I'm excited about that.

I'm happy to be wrong. When I first said Matter of Balance jumpstarts you into fitness, but it's not like bone builders or some of the programs you see at the Y where it's ongoing. Tai chi is ongoing and when my staff first brought it up I said we are not getting these northern Scandinavians to participate in this and they looked at me and said you wait. I just had an attendance sheet from Lake Park and there were 17-18 people on there.

**Janelle Shearer:** So the Living Well with Chronic Conditions is a six week class where people come to a classroom setting and learn about things. **What about Matter of Balance?**

**Darla Waldner:** It can be an eight week class and these are two and a half hours with the Living Well with Chronic Conditions class and sometimes people do it for four weeks twice a week or eight weeks once a week. We do have Land of the Dancing Sky has master trainers in these curriculum and evidence basically means there's been a long study by some medical model that's been good data collection and researched base.

We provide the train the trainer classes throughout our planning and service area and we also provide fidelity monitoring, because evidence based means you have to have two trainers teaching the curriculum. You teach the curriculum as is, so sometimes as a social worker I might have other knowledge about family systems and those pieces, but you really have to focus on the curriculum and teach it as is, and nurses sometimes struggle with that.

They have a whole section on orthostatic hypotension, so you have a whole other knowledge, but the monitoring is that you teach what's there.
Janelle Shearer: And you said there was an in home component where there’s a home assessment.

Is that a one-time thing?

Darla Waldner: Yes. I want to clarify they are either doing it themselves. We encourage them to bring their families or whatever their support network is and prioritize these. There are a lot of things that can be fixed. We do a good job of putting lights in our bathrooms, but our long hallways in older adult homes aren’t necessarily up to code as we know and some of those things are inexpensive to fix.

I think the most difficult thing is getting them to let go of their pretty rugs. We encourage it to be family oriented. The kitchen is one of the main areas other than the bathroom where people fall because things are out of their reach, it’s not safe, so if you’re doing it with your support system they can help put the bread maker up high and organize the kitchen a little.

Janelle Shearer: If somebody in any community throughout Minnesota called senior linkage line and said I’m afraid of falling, then they can get hooked up with the Matter of Balance program?

Darla Waldner: Absolutely.

Janelle Shearer: So every community has that available?

Darla Waldner: I wouldn’t say every community. In our 21 counties I would say that 15-16 of them have one or more of these services, but some they do twice a year, some only once and that kind of thing. If you call us than we can get you in touch with a local program. There’s also a website called MinnesotaHealthyAging.org that has these classes listed, so you can go there to find out when a class is happening.

Janelle Shearer: So even if you lived in the southeast part of the state you should be able to find a program like that?

Darla Waldner: Absolutely.

Janelle Shearer: Is this done by your staff? You mentioned volunteers but I’m sure it’s not all run by volunteers.

Is it done by your staff or are you partnering homecare agencies and other people and partners in your community, how does it work?

Darla Waldner: There are multiple partners. We do have some staff that teach classes from time to time, but our role is more train the trainer model and we build collaborations. One of the exciting collaborations we just finished is with the Northland Technical Community College where I had the pleasure of being one of the facilitators of that session and we trained OT students to do Matter of Balance.

It’s huge for their learning curve long-term and understanding the needs of the older adult population and they did a joint Matter of Balance class in east Grand Forks that was successful. It really depends upon who the entity in the community is. Sometimes we partner with hospitals, which has been a lot of our strategy. Sanford Hospital itself has actually been doing Living Well for a number of years.

Janelle Shearer: Tell us how, I think it was October 2012, where the Minnesota State Legislation came through that when there’s a high risk patient being discharged that someone from the hospital needs to call the senior linkage line.

Who is considered high risk?

How does that work?
Darla Waldner: It sounds so huge, but October 1st legislation was made that mandated for hospitals to make referrals to the senior linkage line on all individuals that were 60+ that were deemed to be at risk for nursing home placement. So there’s an actual screening tool with like seven questions that the discharge planners go through and then there’s a fax referral component to the senior linkage line.

It’s offered but that doesn’t mean that every older adult wants to engage in that process, but it’s certain offered for those that are at risk. It has increased referrals into our organization.

I don’t know if all hospitals yet are aware that that piece of legislation exists. Through one of our integrative systems grants we have a staff member that has gone from hospital to hospital educating them on this process and the reasons why. Our role is important in bringing those home and community based services to the formal hospital systems and support them.

That’s been a better part of 18 months where we’ve been going to hospitals to start those conversations and build that bridge.

Janelle Shearer: So the discharge planner would do the assessment where someone is at risk for nursing home placement and then they offer senior linkage line to that patient or they call senior linkage line?

Darla Waldner: They make a referral. They can call. There’s a fax referral which has a protocol in place for that. It can be both hard copy and then online to the senior linkage line and then that person would follow up with a phone call to the patient or their family.

Janelle Shearer: Whether they go home or to a nursing home.

Darla Waldner: Yes. There’s a different process when they go to a nursing home because there’s a pre-admission screening process and all that. There’s a process they go through with the county and long-term care expansion.

Janelle Shearer: Has anyone with us today had experience with the senior linkage line or making those referrals?

Guest: Are they mandated regardless of the patient’s services or does that assessment determine if they have community services or support that’s already in place which would decrease their risk? So even if you already know they have Meals on Wheels and have someone that checks on them, have you seen the questions of the assessment what do they encompass?

Darla Waldner: There are questions about risk of falls, about chronic illness and things like that. So yes based on those questions regardless of services they would be referred to us.

Guest: So it might be as simple as that referral, them touching base with the patient or family?

Darla Waldner: Yes. One thing to let you know of is that senior linkage line has access to MMIS which is the county system so for those who are medical assistance eligible they would have knowledge of the services being provided with that population.

Sherry Dale: What we run into is that our hospitals will refer everybody to Area Agency on Aging regardless; our discharge planner has been doing that. Our homecare clients will get calls from Area Agency on Aging asking about all these different services which most often they have in place, but then they’re confused as to what Area Agency on Aging is or why they’re getting a phone call.

Darla Waldner: That’s feedback I’ve heard and it is a relatively new process.
A lot of work through integrative systems grant is trying to educate the people about the process and the reasons why, so thank you for that comment. What ends up happening is a lot of this information comes out in the form of an IM that could sit on someone’s desk and be read or not, so we’re doing our best to try and get the message out there.

**Janelle Shearer:** Do you think regardless of someone’s age the care transition, I think we have so many initiatives trying to make it better that sometimes you get eight phone calls, different people like a transition coordinator, care coordinator, case manager and then there are others who get none at all. It’s almost like a double edge sword, we either do too much or we don’t do enough.

**Darla Waldner:** Hospitals are daunting too as well as Minnesota Area Agency on Aging. Often we don’t know what the person is doing across the cubicle from us and sometimes we’re trying to accomplish the same goals. We need to get better at communications and having one central place.

One of the rural palliative groups I work with I have to give a plug to out of the Sanford Center, in sitting in meetings with them and their counterparts they have lots going on and I look at them and say what we’re talking about is care coordination, regardless of the initiative it’s the same thing. We need to find a way where we’re all sitting at the same table. I’m also excited because this group was selected to do a presentation at Age Odyssey this year and they’ve done some good work and I’m proud of them.

**Janelle Shearer:** Thank you Darla for your presentation today.

If you have questions about this webinar, please contact Stratis Health at info@stratishealth.org.

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