

Summary Proceedings



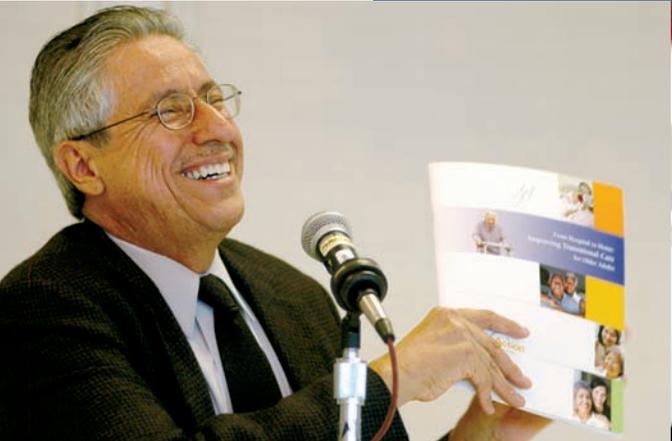
TRANSITIONAL
CARE
LEADERSHIP
SUMMIT



June 6-7, 2006

Berkeley

California



Sponsors



Gordon and Betty Moore Foundation

Established in September 2000, the Gordon and Betty Moore Foundation seeks to develop outcome-based projects that will improve the quality of life for future generations. The foundation's grantmaking is organized around large-scale initiatives in three main areas of interest: environmental conservation, science, and the San Francisco Bay Area (which includes the Betty Irene Moore Nursing Initiative). The foundation incorporates monitoring and evaluation into all of its grantmaking.



The California Endowment

The California Endowment, a private, statewide health foundation, was established in 1996 to expand access to affordable, quality health care for underserved individuals and communities, and to promote fundamental improvements in the health status of all Californians. The foundation's current priority areas are access to health, culturally competent health systems, and community health and the elimination of health disparities. The Endowment makes grants to organizations and institutions that directly benefit the health and wellbeing of the people of California.



Health Research for Action

Health Research for Action—formerly the Center for Community Wellness—is part of the School of Public Health, University of California, Berkeley. Health Research for Action works with community, government, private, and philanthropic organizations to help people make healthier choices, gain access to care, and reduce health risks in their communities. The center conducts research to produce community-driven resources, strategies, and policies that reduce health disparities and create healthier, more empowered communities. All of the center's work is conducted in partnership with the people living in these communities.

Summit Background and Goals

Following publication by Health Research for Action (HRA) of *From Hospital to Home: Improving Transitional Care for Older Adults*, HRA organized the Transitional Care Leadership Summit to identify strategies for implementing recommendations from the report and other participant suggestions. Participants included more than 50 national leaders in the field of transitional care, representing health care systems, professional associations, research institutions, transitional care programs, foundations, policy and advocacy organizations, the Centers for Medicare and Medicaid Services (CMS), the US Administration on Aging, and the California Health and Human Services Agency. Presentations and roundtable discussions highlighted transitional care innovations, barriers to implementing more widespread and effective interventions, and ways to advance transitional care policy and practice. The summit was made possible by generous support from the Gordon and Betty Moore Foundation and The California Endowment.¹

The goals of the summit were to:

- Understand the importance of improving transitions for seniors and their caregivers.
- Learn about evidence-based intervention models ready for translation, and innovative approaches being developed to meet the needs of vulnerable populations.
- Identify needed changes in policy and practice to provide effective post-acute care.
- Develop strategies for implementing recommendations in *From Hospital to Home: Improving Transitional Care for Older Adults*.

Major Summit Themes

- Transitional care is emerging as one of the most critical health issues for older adults. Each year seniors experience over 13 million transitions from acute or rehabilitative facilities to home. Many of these are poorly managed transitions resulting in a worsening of patient health, unnecessary and costly rehospitalization, and increased burdens on family and other informal caregivers. For seniors who have no caregivers, who speak little or no English, and who lack access to health care, poor transitional care puts them at very high risk.
- Transitional care must address the needs of patients and caregivers. Transitional care needs of older adults and their caregivers can differ based on race, ethnicity, education, language, literacy, legal status, cultural factors, and whether they reside in urban or rural areas. Family and community networks and resources need to be leveraged more effectively to create culturally and geographically appropriate services.
- The fragmented nature of health care delivery impedes coordination across care sites, and health insurance plans do not reimburse individual providers or health care systems for taking responsibility for the patient across settings. Effective transitional care depends on being able to monitor and meet the needs of a patient across care settings, with immediate access to up-to-date medical information by all providers and by the patient and family.
- Successful transitional care models are sustainable only if they lead to lasting systems changes—a difficult challenge. The success of each model or approach presented during the summit depended on creating new avenues of communication and points of consensus among professional disciplines, systems of care, and between practitioners and patients/caregivers. The eventual collaboration that emerged from these enhanced relationships provided the foundation for ongoing coordination and change.
- From a policy perspective, the issue of transitional care is rapidly gaining attention as increasing numbers of baby boomers and their parents encounter the limitations of current policies and practice. The models presented at the summit showed promise through cost savings in the form of reduced lengths of hospital stays, fewer readmissions, earlier and more hospice enrollments, health care screenings that identified potentially serious health problems, or improved health outcomes. Several demonstrated improved patient self-care and communication between patients and their physicians. These outcomes warrant extension into broader practice.

¹ The Hospital-to-Home Project was funded by the Gordon and Betty Moore Foundation. The study findings are available on the Health Research for Action website at www.uhealthaction.org/eldercare.html.

- The conclusion about the value of enhanced transitional care presented at the summit is a positive one: transitional care is a cost-effective intervention that provides improved care for older patients and their caregivers. While it is certainly a challenge to translate local success into state and/or national policy to eliminate barriers to transitional care, it is an achievable systems-change goal that can move forward through additional pilot projects, research, and collaboration with Medicare, Medicaid, private insurers, and philanthropists.

Presentation and Discussion Highlights

► Keynote Address

***Fernando Torres-Gil, Professor of Social Welfare and Public Policy,
University of California, Los Angeles***

Transitional care is not just an important issue, but perhaps the pivotal issue linking such disparate topics as health, disability, aging, and long-term care. Transitional care may be the missing link in the larger puzzle of health and long-term care reform and practice because it touches on the most visceral fears and insecurities of families, caregivers, and even providers. Dr. Torres-Gil described three personal examples of breakdowns in post-hospital care or planning, and discussed how effective transitional care was the critical piece that could have made the difference between neglect and continuity of care, abandonment and hope, isolation and recovery. He noted that the Hospital-to-Home report highlights the critical importance of improving care transitions, especially for our most vulnerable populations; that very few of us are prepared for the critical moment when we or a senior we are helping are released from the hospital and left to our own devices; and that we need to incorporate transitional care and effective discharge planning into provider training at all levels. Dr. Torres-Gil also noted that an increased focus on improving transitional care could be the essential bridge to improvements in acute and long-term care, especially for underserved seniors.

► Evidence-Based Models in Enhanced Discharge Planning and Transitional Care



Transition Coach Model—Eric Coleman, School of Medicine, University of Colorado

In the Transition Coach Model, nurses or nurse practitioners are trained coaches who serve as single points of contact for patients, prepare patients for what to expect and to advocate for themselves, provide tools for talking with physicians (e.g., personal health records, questions for physicians), practice or role-play the next medical encounter or visit, follow patients to the nursing facility or home, reconcile pre-and-post-hospitalization medications, and call patients following discharge. The model's focus is to help and encourage patients to do as much as they can for themselves. The results have shown fewer readmissions, patients successfully achieving self-identified goals for controlling symptoms and maintaining functionality, as well as cost savings.

***Advance Practice Nurse Model—Kathleen McCauley, School of Nursing,
University of Pennsylvania***

In this model, specially trained advance practice nurses (APNs) visit high-risk patients in the hospital, make home visits, accompany patients to physician visits, and make phone calls to the patient, caregiver, physician, and social services. The model focuses on using patient goals as a motivator; individualized assessment, interventions, teaching, and comprehension; improved self-management and access to resources; improved physician understanding of patient needs; and use of optimal evidence-based therapy. Results have shown fewer total rehospitalizations, fewer patients with multiple readmissions, lower per-patient costs for hospital care, increased time before first readmission, cost savings, and improved relationships between the APN and the patient, the APN and the physician, and between patient and physician.

Transferring Patients Across a Continuum of Care—Judy Akins, Summa Health System, Akron, Ohio

A Care Coordination Task Force led by Summa Health System Senior Services was formed to address transition problems between hospitals and nursing homes. Task force members included nursing facilities, EMT companies, and the Summa Health System. They concluded that “99.9% of the problem” between providers, providers and families, and families and caregivers involved poor communication. Interventions included a Nursing Facility Transfer Process and Referral Form, a Care Coordination Resource Manual, outpatient procedures for nursing home residents, and a universal post-acute transfer process across 17 hospitals. Results have included improved communication of patient information, fewer days of admission back-ups that result in ambulances being placed on bypass, decreased time in the hospital, and reduced readmission rates.

Advanced Illness Management (AIM) Program—Brad Stuart, Sutter VNA & Hospice, Emeryville, California

AIM is a community-based program to meet the needs of seniors with advanced chronic illness through expanded services delivered in the home and improved links between care in the home and the hospital. The program allows patients to receive concurrent disease-modifying treatment and comfort care. It is based in home care, and employs both home care and hospice nurses and social workers. The patient trajectory is from home care to AIM to hospice. Results have shown significant reductions in hospital admissions, increased utilization of hospice services, and increased family satisfaction with management of pain and other symptoms.



Discussion focused largely on similarities between the Transition Coach and APN models. Both provide one contact person for patients/caregivers after discharge; identify the patient/family as the unit of care; prepare patients to be effective agents on their own behalf; involve a shift from nurses “doing” to empowering patients and caregivers; screen for depression, which they find is a barrier to patients’ ability to be responsible for more independence and self-care; acknowledge that expertise in cultural competency is critical; emphasize working with local social services systems and Area Agencies on Aging; and recognize that nurses have to be educated and trained differently to fulfill these roles. Evaluation of another model, EverCare (in which APNs provide leadership and support to clinical practices implementing managed Medicare), shows that giving APNs responsibility for hospital and nursing home care reduces hospitalization by 50%.

▶ **Emerging Approaches to Meet the Needs of Seniors and Caregivers**

Introduction and Demographic Profile of Aging Californians—Anna Nápoles-Springer, University of California, San Francisco

- The California 65+ population in 2000 was 70% white, 13% Hispanic/Latino, 10% Asian, and 5% African American. In 2050, the 65+ population will be 31% white, 41% Hispanic/Latino, 18% Asian, and 5% African American.
- Foreign-born residents tend to be poorer than native-born residents, report being treated with disrespect and discriminated against by providers, and are less educated, with some confronting health literacy and language issues in encounters with health care providers.
- While 78% of hospitals collect information on patient race and 50% collect information on ethnicity and language, fewer than 20% of hospitals use this information to compare quality, utilization, outcomes, and satisfaction across groups.

The Community Connections Program—Joseph Sharkey, Texas A & M University

The Community Connections Program is designed to provide short-term home-delivered meals and assess needs for ancillary services after hospital discharge, and then transition older adults from in-home services to congregate nutrition and other wrap-around health services. While the grant target of 160 participants was met, the program faced numerous challenges, including resistance from hospital systems, strict criteria that excluded many participants, inability to make contact with doctors and nurses, little participation from hospital dietitians, and hospital personnel's lack of awareness about Meals on Wheels. Results showed that success is more likely if the program has a champion within the hospital, is not dependent on hospital staff, and if referral incentives are embedded into the system's structure.

Alta Bates Summit Parish Nurse Program—La'Verne McGee, Berkeley, California

The role of the Parish Nurse combines professional nursing and health ministry. Ms. McGee works with 25–30 churches and 14 senior centers. Parish nurse clients are usually members of congregations whose families and friends provide all the care. Activities include health screenings (weight, body-mass index, blood pressure, diabetes), referrals to services, educating and counseling patients and caregivers, volunteer training, and advocacy. Parish nurses can help to identify community members who need assistance in meeting transitional care needs, including making connections to local services and identifying supports for family caregivers such as respite care.

The Homecoming Services Program—Kathleen Mayeda, San Francisco, California

The Homecoming Services Program provides immediate, direct case management and support for isolated seniors transitioning from hospital to home. The program works in partnership with hospitals, community-based organizations, and public and private agencies to provide needed services. According to information collected by the program, impacts have included reduced hospital stays, reduced rehospitalizations, cost reductions, and improved health outcomes.

The Importance of Caregiver Assessment and Support—Lynn Friss Feinberg, Family Caregiver Alliance, San Francisco

In transitional care, the patient/family must be seen as the unit of care. Family caregivers are usually seen as resources to the patient rather than as individuals who need support to care for the patient, and lack of caregiver support can lead to patients' placement in institutional care. Caregiver assessment is critical to successful home-based care. Findings from the Family Caregiver Alliance's 2005 National Consensus Conference on Caregiver Assessment were released in April 2006 in two volumes, *Caregiver Assessment: Principles, Guidelines, and Strategies for Change* and *Caregiver Assessment: Voices and Views from the Field*. FCA follow-up to the Consensus Conference includes producing a toolkit on caregiver assessment for medical, health and social service professionals, and advocating for implementation of the consensus principles and guidelines as well as adoption of the identified change strategies in policy and practice.

Discussion focused on elements of success for new initiatives: the need for improved communication and information sharing among hospital and community providers about specific patient/caregiver needs as well as available community-based services; the importance of stakeholder buy-in; the need to build relationships between providers and the community as new initiatives are developed; the need for new initiatives to prove their value to existing providers; and the necessity of assessing the caregiver's risks and needs as well as the patient's.

Supporting Seniors and Caregivers During Transitions



1. Provide easy-to-understand materials to help seniors and caregivers navigate the system.
2. Implement post-discharge follow-up to seniors/caregivers. Methods could include phone calls and/or visits by multidisciplinary team members (e.g., nurses; social workers; speech, physical, occupational therapists; mental health providers; nutritionists; volunteers).
3. Improve care coordination, linkages to CBOs, and hospital staff.
4. Train and support caregivers.
5. Create care centers in hospitals where caregivers can receive education and training and be connected to community-based services.
6. Consider using peers as volunteers to provide informal support to seniors during care transitions.
7. Encourage seniors and caregivers to maintain their own personal health records, in a portable form they can carry with them.

Improving Transitional Care by Health Systems and Providers

1. Improve discharge planning and require post-discharge follow-up.
 - a) Talk about transitional “services” rather than “care” to capture a range of needs, from medical to social and community interventions. Modify language to “admit patients to home care” rather than “discharge them from the hospital” to change emphasis.
 - b) Ensure that planning for home care begins upon or before hospital admission.
2. Implement risk assessment of patients and caregivers.
3. Improve provider training, resources, and cultural competency.
 - a) Develop culturally sensitive curricula and other resources to train nurses, social workers, physicians and other health care personnel about transitional care services and supporting systems-level changes. Train hospital-based and community-based providers together.
 - b) The home-care nurse workforce is not large enough or adequately trained in family and community-centered care, which affects their ability to deliver effective transitional care.
 - c) Determine what transitional care needs to be done by an APN or RN and what can be done by social workers or other professionals, paraprofessionals, and volunteers.
 - d) Increase geriatric training of health professionals, including direct exposure to patients and caregivers in home-based programs.
4. Expand the use of electronic health records. Add an electronic discharge plan to the electronic health record.
5. Encourage the implementation and utilization of inpatient and community-based palliative care programs, with a tie-in to hospice care. These programs are multidisciplinary and are therefore integrated approaches to transition management.

Implementing Policy Changes

1. Prioritize home vs. institutional care, including for patients with chronic illness, to match the needs and preferences of seniors.
 - a) Promote long-term care integration, including uniform patient/caregiver assessment.
 - b) Increase the capacity of home and community-based services.
2. Simplify program eligibility, e.g., expand use of One-e-App, a streamlined electronic service application process being piloted in California.
3. Design and promote a transitional services benefit for Medicare and Medicaid.
4. Increase investment in and support for personal care workers and family caregivers. Informal caregivers provide three-quarters of assistance with ADLs, while only 30% of Medicaid dollars are spent on home and community-based services; this needs to be reversed. Increase wages for home-care workers to expand and retain workforce.

5. Promote information transfer and care coordination across settings.
6. Support pilot studies of enhanced transitional care and compliance with JCAHO indicators.
 - a) Focus on large-scale transitional care research and demonstration projects in fee-for-service Medicare and Medicaid. Develop evaluation measurements that assess the intervention, identify what a good transition is, include quality-of-life measures that capture the discharge goals of the patient versus the entity, and go beyond reductions in length of stay, cost, etc. Document savings to justify the incorporation of a transitional services benefit or function into the "mega-payer" programs.
 - b) Encourage development of transitional care pilot studies that include patients and/or caregivers with mental illness (beyond depression).
 - c) Promote revision of the Medicare demonstration process to more readily allow the participation of Medicare-certified agencies and systems.
 - d) Explore ways to work more strategically with the Centers for Medicare & Medicaid Services (CMS) and to be involved on the front end of CMS planning in long-term and transitional care (e.g., through participation in their stakeholder "open door" calls).
7. Remove legal/regulatory barriers that impede sharing of information between providers, and between providers, patients, and caregivers.
8. Advocate for increases in federal funds for nursing and geriatric training.
9. Promote an emphasis on transitional care by accrediting bodies such as JCAHO and NCQA.
10. Influence local, state, and national policy by increasing public awareness about transitional care needs and gaps through a public information campaign. This can mobilize people to learn from experiences, be better prepared, and raise questions that can lead to broader policy change.

Next Steps

In addition to advancing specific strategies noted above, UC Berkeley's Health Research for Action will pursue a number of summit suggestions, including:

- Convening a task force representing a spectrum of interests that can work over a period of time to identify and advance steps to implement recommendations.
- Reaching out to professional associations to disseminate recommendations regarding improved training of providers on effective discharge planning and transitional care, and advancing models of patient/caregiver education in coordination with provider training.
- Following up with organizations that have expressed interest in improving transitional care (e.g., the California Hospital Association), and to provider organizations.
- Assessing how to extend recommendations for transitional care to long-term care.
- Considering ways to redefine terminology to emphasize "admission" to home care rather than "discharge" from hospitals and other facilities, which minimizes needs following acute care.



AGENDA

Transitional Care Leadership Summit

June 6–7, 2006, Claremont Resort & Spa, Berkeley, California

Sponsored by the Gordon and Betty Moore Foundation, The California Endowment, and UC Berkeley's Health Research for Action

Tuesday, June 6

7:00–9:00 pm **Reception (Lanai 1 Room)**

Wednesday, June 7

8:00–8:30 am **Registration and Continental Breakfast (Horizon Room)**

8:30–8:50 am **Welcoming Remarks**

Linda Neuhauser, Co-Investigator, Health Research for Action and the Hospital-to-Home Project, and
Clinical Professor, School of Public Health, UC Berkeley

Edward Penhoet, President, Gordon and Betty Moore Foundation

Dianne Yamashiro-Omi, Senior Program Officer, The California Endowment

Shelley Martin, Executive Director, Health Research for Action

Holly Brown-Williams, Director of Policy and Hospital-to-Home Project Director, Health Research for Action

8:50–9:20 am **Keynote Address**

The Realities of Aging and Long-Term Care: Personal and Policy Prescriptions

Fernando Torres-Gil, Professor, Associate Dean, and Director of the Center for Policy Research on Aging,
School of Public Affairs, UCLA

9:20–9:50 am **Presentation**

Identifying the Post-Acute Care Needs of Seniors, and a Framework for Effective Transitional Care

Susan Ivey, Director of Research and Evaluation, Health Research for Action

9:50–10:05 am **Questions/Discussion**

10:05–10:15 am **Break**

10:15–11:45 am **Roundtable 1**

Evidence-Based Models in Enhanced Discharge Planning and Transitional Care

Moderator: **William Spector**, Senior Social Scientist, Agency for Healthcare Research and Quality,
US Department of Health and Human Services

Eric Coleman, Associate Professor of Medicine, University of Colorado Health Sciences Center

Kathleen McCauley, Associate Professor of Nursing, University of Pennsylvania

Judy Akins, Executive Director, Post Acute/Senior Services, Summa Health System

Brad Stuart, Senior Medical Director, Sutter VNA and Hospice

11:45–12:45 pm **Lunch (Lanai 2 Room)**

12:45–2:15 pm **Roundtable 2**

Emerging Approaches to Meet the Needs of Seniors and Caregivers

Moderator: **Anna Nápoles-Springer**, Assistant Professor of Medicine and Co-Investigator,
Center for Aging in Diverse Communities, UC San Francisco

Joseph Sharkey, Associate Professor, School of Rural Public Health and Director,
Texas Healthy Aging Research Network Center, Texas A&M University

Kathleen Mayeda, Acting Branch Director, San Francisco Senior Center

La'Verne McGee, Parish Nurse, Alta Bates Summit Medical Center

Lynn Friss Feinberg, Deputy Director, National Center on Caregiving, Family Caregiver Alliance

2:15–3:30 pm **Roundtable 3**

Policy Changes to Improve Transitional Care

Moderator: **Carol Levine**, Director, Families and Health Care Project, United Hospital Fund of New York

Jeff Flick, Regional Administrator, Centers for Medicare and Medicaid Services

Penny Hollander Feldman, Director, Center for Home Care Policy and Research, and Vice President for
Research and Evaluation, Visiting Nurse Service of New York

Sarah Steenhausen, Assistant Secretary for Long-Term Care, California Health and Human Services Agency

Charlene Harrington, Professor of Sociology and Nursing, UC San Francisco

3:30–3:40 pm **Break**

3:40–4:55 pm **Discussion**

Strategies for Change

Moderator: **Holly Brown-Williams**

4:55 pm **Closing Remarks**

Shelley Martin

5:00 pm **Adjourn**

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HOSPITAL-TO-HOME PROJECT

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