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## **Eldercare Locator Announces Campaign to Encourage Discussion and Planning with Older Adults during the Holidays**

*Cost Savings and Better Health Outcomes Cited as Reasons for Older Patients and their Caregivers to Actively Plan for Hospital Stays*

Washington, DC – Returning home from a hospital stay can result in unexpected challenges for many seniors and as a result, millions of older Americans are spending billions of dollars on health care costs every year that could be avoided through simple planning and preparation prior to being admitted to the hospital. Nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days due to an injury resulting from medical management – not the underlying disease – costing over \$26 billion every year. Some studies have found that between 40 percent and 50 percent of readmissions are linked to social problems and lack of community resources.

Today, Eldercare Locator, a public service of the U.S. Administration on Aging that is administered by the National Association of Area Agencies on Aging (n4a), launched its 9th Annual Home for the Holidays campaign encouraging older adults, caregivers and their families to use their time together this holiday season to discuss potential hospital visits and start planning ahead for a smooth transition from the hospital to the home.

“As we age, the likelihood of a hospital stay increases and it is critical to plan before that time arrives,” said Kathy Greenlee, Assistant Secretary for Aging, U.S. Department of Health and Human Services. “We encourage families and caregivers to take advantage of their time with older relatives this holiday season to talk about the brochure’s important cost-saving and potentially life-saving tips.”

Eldercare Locator and the United Hospital Fund’s Next Step in Care ([www.nextstepincare.org](http://www.nextstepincare.org)) released a consumer guide that can be used by families and caregivers to lead the discussion this holiday season. The guide, which provides planning tips for pre-hospital check-in as well as post-checkout from the hospital, is available at: [www.n4a.org/pdf/HospitaltoHome.pdf](http://www.n4a.org/pdf/HospitaltoHome.pdf). Some of the questions the Eldercare Locator encourages the public to address prior to being admitted to a hospital include: What do you need to bring? If you are not going to be well enough to care for yourself when you are released, where will you go? Will you need help getting around? Will you need equipment and supplies? Will you be able to take the appropriate medications without help those first days out of the hospital? Who will assist you? How long will you need assistance?

“Often older adults underestimate their needs for assistance following a hospital stay, and family members are critically important partners in managing these transitions,” said Carol Levine, director of the United Hospital Fund’s Families and Health Care Project. “Eldercare Locator has

provided an excellent resource to guide both older adults and their families as they plan for a move from hospital to home.”

In April 2011, the Centers for Medicare and Medicaid Services (CMS) launched the Community-based Care Transitions Program to reduce preventable readmissions among patients covered by Medicare. The program is being administered through the CMS Innovation Center and provides up to \$500 million to community-based organizations that partner with eligible hospitals for care transition services that include timely, culturally, linguistically-competent post-discharge education, medication review and management, and patient-centered self-management support within 24 hours of discharge.

CMS recently announced that seven Aging Network-centered programs were selected to participate in the Community-based Care Transitions Program to help provide better coordinated, consumer-focused, quality care for Medicare beneficiaries at a lower cost. The first seven participants are Atlanta Regional Commission in Atlanta, Georgia; Akron/Canton, Ohio Area Agency on Aging; Southwest Ohio Community Care Transitions Collaborative; Southern Maine Agency on Aging/Aging and Disability Resource Center; Maricopa County in Arizona; Merrimack Valley of Massachusetts and Southern New Hampshire; and Council for Jewish Elderly (CJE SeniorLife) in Chicago, Illinois. CMS is accepting applications and enrolling participants on a rolling basis as funding permits. For more information on the Community-based Care Transitions Program, visit: <http://innovations.cms.gov/initiatives/partnership-for-patients/care-transitions.html>.

“The aging network is playing a significant role to help provide better coordinated, consumer-focused, quality care for Medicare beneficiaries at a lower cost,” said Sandy Markwood, n4a CEO. “This holiday season is an ideal time for families to get together and plan ahead so that when medical issues arise, a plan is in place.”

#### **About Eldercare Locator**

The Eldercare Locator is the first step to finding resources for older adults in any U.S. community and a free national service of the U.S. Administration on Aging (AoA) that is administered by the National Association of Area Agencies on Aging (n4a). Contact the Eldercare Locator at 800.677.1116 or [www.eldercare.gov](http://www.eldercare.gov).

#### **About Next Step in Care**

The United Hospital Fund’s Next Step in Care website ([www.nextstepincare.org](http://www.nextstepincare.org)) has guides for family caregivers on many aspects of transitions, including medication management, discharge checklists, hospice and palliative care and many others. The guides are free and available in English, Spanish, Chinese and Russian.

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