Centers for Medicare & Medicaid Services
National Conference on Care Transitions
Friday, December 3, 2010

Cathie Berger:

Good morning. My name is Cathie Berger. I am the Director of the Area Agency on Aging at the Atlanta Regional Commission, and as you can imagine what a pleasure for us in Atlanta to be working with Piedmont Hospital and to work with a lot of direction coming from Dr. Schreiber and I don't think he knows how much his thinking of making changes within the system has influenced us at the Area Agency on Aging.

And, I want to begin to say to you that I firmly believe that care transitions provides to us a tremendous opportunity to shift and to bridge the gap that exists between the acute care and the long term care system, to address the divide, that still exists between the medical services and the provision of support of services.

In Atlanta under the leadership of Piedmont Hospital, we have created the Atlanta Care Transitions Workgroup and the workgroup brings together everybody that has a stake in care transitions that are working to the common goal of achieving such transitions and it does include hospitals, home health agencies, service provider agencies in the community.

Our hospital, Georgia Hospital Association and our QIO, And we're all working to promote the common understanding of care transitions, to share our best practices and to educate the medical, as well as the social services network, as well consumers, on what the practice of safe transitions really entail.

At the Area Agency on Aging, we are concerned about this issue. We are one of twelve Area Agencies in Georgia. There are 635 in the nation. And, as an Area Agency on Aging, we have over 40 years gained a lot of knowledge and understanding of the needs of older adults which are living in the community. We also have established a robust, Coleman community-based service network and, a network that is keeping thousands of older adults in the community.

And the way that we as a network are supporting care transitions is through our ideas, through providing information and counseling to people who are seeking information about long term care options, about what is available in the community. We provide care

management. We provide direct support services in the homes of individuals who are returning home. And, we are out there educating the consumers about what is happening in the health care system, et cetera.

Also, just to point out to you that we're not alone. We are part of a national network beginning with the Administration on Aging, 50 state units on aging, 600 plus Area Agencies on Aging and 20,000 direct service agencies.

In Atlanta, under our transitions workgroup, we have established the framework and this just shows you how we see the community on both sides of the hospital supporting transitions work.

How do we do this? How are we working with Piedmont Hospital? How are we working with other hospitals in the Atlanta region to support care transitions? Going back to our role as ADRC, as the agency that in Atlanta is receiving 70 thousand calls a year from individuals who are seeking assistance with their long term care issues that are wanting to know what is available to them.

What we have done is we've taken the care transitions approach, the care transition tools, the protocols, and incorporated that in how we do information counseling. We are – as we receive those calls from individuals who are either in the hospital, many times its families calling us or once they have transitioned out of the hospital they are back home asking for assistance. We are asking them the right questions. We are following up with the questions that were asked in the hospital, reinforcing all those points about safe transition.

We are also providing them with all the options that are available, always empowering the consumer to make the right decisions about what they need at a given point, provide information, educational materials, and we do follow up. Did you get the services? How is your transition going? Did you follow up with your physician?

In – as I've mentioned to you, we get 70 thousand calls, we have 15 certified information specialists, and we have provided them with a statewide resource database with 24,000 listings. These individuals are social workers or nurses and they are very well prepared to follow up

and to support what has happened in the hospital.

In a care management programs, we are, again, incorporating the care transition protocols. We are making sure that people understand their transition plans. That they understand their medications, that they are taking them when they should taking them, that they are watching for the red flags, and that they are – that they are making sure that they have their medical appointments right and also that they have personal health records.

What we're also doing is making sure that the services that we have put in place, those home and community-based services, are supporting the transition plan. Do we need to increase the in home personal aide who is coming in to provide assistance? We're looking at that at all times, looking at how do we support this transition process. We are tracking hospitalizations and just as the matter of interest, we implement the Georgia Medicaid Waiver Program. And looking at one year of admissions, a third of the people that we are serving in that program were hospitalized and twenty-two percent of them returned within 30 days. So we are watching those numbers and looking at how do we go back to the hospitals and how do we help to reduce the numbers there.

Also, want to quickly point out that we do have this extensive service delivery system that includes a range of services – home delivered meals, in home services, et cetera, that are supporting people as they come home. These are funded under the local, state and the Older American Tax Funding. We also are providing those services that are supported under the Medicaid Waver Program.

We need to know, that unfortunately our aging service system is often faced with long waiting lists, I think we can all talk about that. We also are charged with the responsibility to make sure that the service we do have are targeted to the right people, those in greatest need.

Now, the unintended consequences are that very often we have lengthy intake processes and we're not there immediately when the individual comes out of the hospital.

To respond to that need, we are piloting with one of our service agencies and hope to expand this to others over the next few months, a pre-arranged support package that provides the individual seven days of home delivered meals immediately, interim support six hours, two trips to medical appointments and we have now added escort to that, very often people can't go alone, and then a case manager and coaching for 30 days.

These services are being provided in this pilot at no cost to the individual and we are doing it through four participating hospitals. Our initial data, very promising, shows that it is running at $400 per package and our admission rate just looking at those for a three month period how many people went back and that was 16 percent.

Then lastly just to mention to you that as an Area Agency on Aging, we have a far reach into the community and with Piedmont Hospital's help we have developed a packet how to navigate through the health care system and through our senior volunteer program we have already trained 14 volunteers that are going out into the community, made 77 presentations to tell people before they go into the hospital, before they have an emergency room visit, what to expect, what questions to ask and how to handle the process.

I'll close by saying to you that we believe that it is critical that the community- based services system in the hospitals collaborate on the issue of care transitions to make it successful. We have to look beyond the 30 days, we have to know what are the support systems in place that will keep people out of the hospital. And I can tell you that aging network welcomes the opportunity to step up to the plate and be part of this system. Thank you.