

**We are here to
HELP...**



Justine Perez, LSW
Nevada Senior Services
Care Transitions Specialist

For Information on
FREE Enrollment

Call or email
(702) 364-2273 or
toll free (844) 850-5113
ccrc@nevadaseniorservices.org

Hours:
M-F 8:00 AM—4:30 PM

Care Transitions Partners



Nevada Senior Services
**CARE
TRANSITIONS**
From Hospital to Home



We CARE ... Nevada Senior Services is here for you and your family. We offer FREE assistance, support and information. Please contact us and let us know how we can help. We are here to serve you.

NEVADASENIORSERVICES.ORG

**We are here to
HELP ...**

Care Transitions, The Bridge Model is a person-centered program providing support and care coordination for patients living with Alzheimer's and other dementias, and their caregivers, from hospital to home.

For Information & Enrollment in your area:
ccrc@nevadaseniorservices.org or call (702) 364-2273 / toll free(844) 850-5113

What is Care Transitions?

Care Transitions, The Bridge Model is designed to aid and support adults with memory loss and their caregivers during the care transition from hospital to home.

This transitional care program is delivered by social workers who provide in-person and telephone follow-up, caregiver support and short-term care coordination for recently discharged patients.



The Bridge Model, a licensed product of Rush University Medical Center, is made available through support by the State of Nevada Aging and Disability Services Division with financial assistance, in whole or in part, through a grant from the U.S. Administration for Community Living.

The Program

The Bridge Model, an evidenced– based care transitions program, provides assistance to bridge gaps in care, resolve challenges, and provide access to long-term resources.

The Care Transitions Specialist—Social Worker will engage with patients experiencing memory loss and their caregiver after the discharge process to support the transition from hospital to home.

The Benefits

- **IMPROVED** medication management
- **MEDICAL** stability—short and mid term
- **REDUCED** caregiver burden
- **ACCESS** to long term care resources
- **INCREASED** patient engagement
- **IMPROVED** health outcomes

How to Access Care Transitions

1. Upon admission, begin conversations about a discharge plan with your hospital support team (i.e. nurse, case manager or social worker).
2. Contact your hospital support team about making a referral to Care Transitions.
3. Schedule a bedside visit with your Care Transitions Specialist from Nevada Senior Services.

