Nevada Senior Services Inc.
in association with Nevada Hospital Association, HealthInsight Nevada, and Valley Health Systems

DEMENTIA CAPABLE CARE TRANSITIONS: BETTER CARE AND BETTER OUTCOMES

Stakeholder Planning Summit ~ January 15, 2019
YOUR PARTICIPATION IS GREATLY APPRECIATED!

Jeffrey B. Klein, FACHE
President & CEO  Nevada Senior Services Inc.
ONE CAREGIVER’S JOURNEY FROM HOSPITAL2HOME

Teri Lawrence
NEED, PROJECT, AND COLLABORATION

Marissa Shoop, MPA
Care Partner Institute Manager, Grant Project Manager
THE LANDSCAPE
Nevada Senior Services

- Collaborating with partners to provide innovative service solutions
- Adopting dementia capable evidence-based programs
- Creation of extensive caregiver supports
- Integration of the Care Connection Resource Center (formally known as Aging and Disability Resource Center for Southern Nevada)
Nevada Senior Services

- Two Adult Day Health Care Centers
- In-Home Respite
- Home Modification Program
- Geriatric Assessment Program
- Wellness Initiatives
- Care Partner Institute
NSS Evidence Based Programs & Initiatives

Care Partner Institute

Caregiver evidenced - based programs:

  RCI REACH
  Skills2Care
  BRI Care Consultation
  Caring For You, Caring For Me
  Care Transitions – Bridge Model (For Individuals with ADRD and Caregivers)

Wellness Initiatives

Aging Mastery

National Council on Aging
The Nevada Care Connection Resource Center helps individuals access long-term services and supports.

Resource and Service Navigation (formally known as Options Counseling)
  Medicare/Savings Programs
  Benefits Counseling
  Consumer Advocacy
  Caregiver Support
  Care Planning
  Eligibility and Access to Services
  Care Transitions

Nevada Senior Services serving Clark, Esmeralda, Lincoln, and Nye counties
Nevada Population by the Numbers (2018)

- # of people: 3 million+
- # age 65+: approx. 455,000+
- # age 65+ with dementia: 45,000

DID YOU KNOW?

www.census.gov
www.alz.org
Fastest Population Growth

States with fastest population growth in U.S. (2017)

1. Idaho – 2.2%
2. Nevada – 2.0%
3. Utah – 1.9%
4. Washington – 1.7%
5. Florida – 1.6%
6. Arizona – 1.6%
Increase in Adults 65+

Largest increase in adults 65+ (ACL 2005 to 2015)

1. Nevada – 55.3%
2. Colorado – 53.8%
3. Georgia – 50.2%
4. So. Carolina – 48.9%
5. Arizona – 48%
Clark County by the Numbers

# of people: 2.2 million
# age 65+: 339,390
# age 65+ with dementia: 33,500
# of Caregivers: 113,000
Dementia Complicates Things...

- 1/3 of all hospitalized persons with AD average 1.5 to 2 stays in that year
- 1 in 4 Caregivers enter the hospital or ED annually
- 40% of all under 30 day readmissions
The Problem

- 25% Hospitalized elderly may have a dementia (with or without diagnosis)
- Hospitalization rate persons with dementia 2X cognitively healthy
- ED visits & hospitalizations often triggered by
  - Challenging Behaviors
  - Chronic or Acute Illnesses
  - Falls
- Admission rate for Urinary Tract infections (UTI) & Pneumonia 80% higher in dementia population

Source: Daiello, L., et al. (2012). Dementia is associated with increased risk of hospital readmission within 30 days of discharge. Alzheimer's and Dementia, 8(4) Supplement, P564.
Hospital patients with dementia are

- significantly less likely than other older patients to regain their preadmission functional (ADL) abilities at one month, three months, and one year after discharge
- 2-4 times more likely than other older patients to be discharged to a nursing home
- 3-7 times more likely to be living in a nursing home three months after discharge
Dementia Challenges

- Dementia increases burden on acute care systems
- Creates excessive resource consumption
- Higher complication rates
- Poor outcomes increased
Grant Awarded

Nevada Aging and Disability Services Division (Pilot Program)
Administration on Community Living (Expansion Project)

- Primary Goal: Improving health outcomes & quality of life with individuals living with dementia
- Objective 1: Deliver evidenced-based care transitions model and post care transitions services within a community based dementia capable framework
- Objective 2: Offer short-term intensive respite (respite coaching) to care partners for up to 30 days following hospital discharge
- Objective 3: Provide dementia capable education and training to hospital staff to better service patients with ADRD and their care partners
Service Population

Criteria Defined by grant requirements and stakeholder input

- Currently Serving individuals
  - Living with ADRD (diagnosed or self-identified) of all ages
  - Individuals with Intellectual or Developmental Disabilities (I/DD) at high risk for ADRD
- Currently hospitalized for any medical condition
- Lives at home alone
  - OR
  
  Care Partner and Person with ADRD reside together
- Discharge from hospital to home
- Medicare fee-for-service or under insured
Service Delivery – Care Transitions

- Deliver an evidence-based Transition of Care Program – The Bridge Model, Rush University Medical Center
- Collaborate with hospitals within Valley Health System to ensure seamless continuum of health and community care across settings
- Deliver Post Care Transitions wrap around services
Care Transitions Intervention: The Bridge Model

- Person-centered, social work-led model
- Emphasizes collaboration
- Ability to incorporate enhancements of evidence based dementia education tools
- Integration of dementia specific enhancements approved
Model Enhancement: Understanding the Dyad

Patient with ADRD
- KATZ (ADL & IADL)
- Health / Physical Well-Being
- Health Care Utilization
- Patient Health Questionnaire
- MOCA (Cognitive Screen)

Caregiver
- Health / Physical Well-Being
- Health Care Utilization
- Patient Health Questionnaire
- Zarit Screen Measure of Caregiver Burden
- Desire to Institutionalize
- MOCA (Cognitive Screen)
Model Enhancement:
Post Care Transitions Service Delivery

- 30-day post assessment

- **Goal:** Supporting patient and caregiver to continue to engage in other services for continued support
  - Personalized Care Plans
  - Connection to internal and external information and referrals
Model Enhancement:
Post Care Transitions Service Delivery

Internal

- Caregiver evidenced-based programs:
  1. RCI REACH
  2. Skills2Care
  3. BRI Care Consultation
  4. Caring For You, Caring For Me

- Other supportive programs:
  1. Respite
  2. Support Groups
  3. Home modifications
  4. Wellness programs
Model Enhancement:
Post Care Transitions Service Delivery

External

- Referrals to community public and private resources
- Long term supportive resources
- Basic need programs
- Caregiver education and support services
Service Delivery – Respite

- Provide Respite Coaching – intensive service utilization
- Coaching provided to caregiver, offering a break to caregiving
Respite Coaching

- Post hospitalization increases stress and caregiver burden
- Provides a short-term intensive respite services following acute hospitalization (high utilization of service)
- Delivered for 30 days post hospitalization
- Ability to transition to standard in-home respite program
Respite Coaching

- Provided by dementia trained respite professional
- Assist in managing challenges relate to care transitions and dementia
  - Identify and support the changing needs of individuals with ADRD
  - Assist in reducing caregiver burden
  - Understand behavioral and psychological symptoms of dementia (BPSD)
Service Delivery – Education

- Deliver dementia education and innovative practices offered to the individual and care partner
- Support and provide dementia capable education and innovations with collaborative healthcare partners
Education and Training

- Dementia capable education to support healthcare providers caring for individuals with Alzheimer’s Disease and Related Dementias.

- Deliver information and best practice education to individuals and their care partners as they transition from hospital to home.
Dementia Education and Training

Dealing with Dementia

4 HOUR WORKSHOP FOR PROFESSIONAL AND FAMILY CAREGIVERS

Caregiver Education Series

TOPICS INCLUDING ACCESSING RESOURCES, FUTURE PLANNING and BRAIN HEALTH

Caring For You, Caring For Me

10 HOUR WORKSHOP FOR PROFESSIONAL AND FAMILY CAREGIVERS

Thoughtful Hospitalization®

A 90 MINUTE WORKSHOP FOR CAREGIVERS TO PREPARE FOR POSSIBLE HOSPITALIZATION AND UNDERSTANDING CAREGIVER RIGHTS

Thinking About Thinking

INFORMATIVE SEMINAR THAT ADDRESSES THE KEY ROLE THAT COGNITION PLAYS IN PATIENT SUCCESS IN THE ACUTE CARE ENVIRONMENT
Expected Outcomes

- Reduced readmission rates
- Reduced emergency department visits
- Increased health indicators
- Decreased caregiver burden
- Increased caregiver coping
- Decreased depression
- Enhanced patient and caregiver activation
Alone we can do so little, together we can do so much

- Helen Keller
Community Engagement & Partnership

- Interdisciplinary connections and staffing
- Provide wrap around services / crisis care management
- Processes made to meet the unique needs of the service population and referring organization
- Professional development and education
Community Partnerships

- Enhances service delivery
- Provides expertise and support
- Streamlines process and procedures
- Enhances collaboration and communication
- Increases engagement of patient and caregivers
- Encourages best person-centered and best practices
"COMING TOGETHER IS A BEGINNING, STAYING TOGETHER IS PROGRESS, AND WORKING TOGETHER IS SUCCESS."

~ HENRY FORD
Thank you!  Questions?
References

- United States Census Bureau Retrieved on January 8, 2019 https://www.census.gov/quickfacts/nv
- Daiello, L., et al. (2012). Dementia is associated with increased risk of hospital readmission within 30 days of discharge. Alzheimer’s and Dementia, 8(4) Supplement, P564.
CARE TRANSITIONS AND HOSPITAL READMISSIONS

Linda Griskell, MHA
Quality Improvement Director HealthInsight
Care Transitions

Care transitions is the movement of patients between one care setting or provider to another.

Transitioning patients opens several opportunities for complications and breakdowns.

Breakdowns can impact patients and families, care providers, and the health care system.
Transitioning Patients to Home

Discharge from hospital to home requires the successful transfer of information from clinicians to the patient and family to reduce adverse events and prevent readmissions.

Engaging patients and families in the discharge planning process can help make this transition in care safe and effective.

Source: Agency for Healthcare Research and Quality
Ineffective care transition processes can lead to adverse events and higher hospital readmission rates and costs.

Care transitions outcomes are typically measured by looking at hospital 30-day readmissions.
Nevada Readmission Rates

Source: Medicare FFS beneficiaries, 30-day all cause readmissions, rates are per 1,000 beneficiaries living in the area, average quarterly rate for Q2 2017 – Q1 2018. *U.S. rate is for Q1 2017.
Readmissions by Hospital

30-Day All Cause Readmission Rates

Rates range from 13.4% to 32.9%

Source: Medicare FFS beneficiaries, 30-day all cause readmissions / # of Medicare FFS live discharges; April 2017-March 2018; excludes hospitals with denominator < 25.
Readmissions Trends and Targets
East Las Vegas Community

Source: Medicare FFS beneficiaries, 30-day all cause readmissions, rates are per 1,000 beneficiaries living in the area; rates are plotted by quarter; baseline is an average quarterly rate for four quarters.

We need 134 fewer readmissions per quarter compared to baseline to reach the 12.7 target.

2014 baseline rate 14.1
10% reduction target 12.7
Q1 2018 rate 18.9
Making Sense of Quarterly Rates

77 out of 1,000 Medicare beneficiaries in your community were admitted to the hospital in Q1 2018.

19 of those patients were readmitted within 30 days.

Source: Medicare FFS beneficiaries, 30-day all cause readmissions, rates are per 1,000 beneficiaries living in the area, Q2 2017 – Q1 2018.
Readmissions by Day
East Las Vegas Community

For your community, 50% of 30-day readmissions happened within the first 10 days.

21 percent of readmitted patients return by Day 3
50 percent of readmitted patients return by Day 10

Source: Medicare FFS beneficiaries, 30-day all cause readmissions, rates are per 1,000 beneficiaries living in the area, average quarterly rate for Q2 2017 – Q1 2018.
Readmissions by Discharge Destination

- Readmissions from skilled nursing
  - 26.7 percent, 3,068 points
- Home health
  - 23.3 percent, 4,250 points
- Most patients are readmitted from “home”
  - 21.2 percent, 13,000 points

Source: Medicare FFS beneficiaries, 30-day all cause readmissions, rates are per 1,000 beneficiaries living in the area, average quarterly rate for Q2 2017 – Q1 2018.
Readmissions by Primary Diagnosis

Source: Medicare FFS beneficiaries, 30-day all cause readmissions, average quarterly rate for Q2 2017 – Q1 2018. AHRQ Clinical Classification Software (CCS) for ICD-10-CM diagnoses.

Other: A long list of other diagnoses with lower volume make up this category (e.g., oncology, infections, neurovascular, burns, substance disorders, other respiratory, etc.). There are too many to include in this chart.
Survey of Patients’ Experiences

85 percent of Nevada patients agree they were given information about what to do during home recovery.

50 percent of Nevada patients understood their care plan when they left the hospital.

Source: Hospital Compare data period 1/1/2017 - 12/31/2017; Nevada HCAHPS survey results.
It Takes a Team!

A community-based team approach with effective communication and sharing of information is essential to prevent avoidable readmissions.

Meet the Team

Hospital, primary care, specialists, skilled nursing, behavioral health, long-term care, rehab, pharmacy, home health patients and families, paramedicine and community services.
The health information exchange (HIE) is at the center of it all, to collect and share out information with the team.
QUESTIONS?

Linda Griskell, MHA
Quality Improvement Director
HealthInsight
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Thank you!
PROGRESS REPORT
HOSPITAL2HOME: DEMENTIA CAPABLE CARE TRANSITIONS

Jeffrey B. Klein, FACHE
President & CEO  Nevada Senior Services Inc.
Progress Report Highlights

Participating Organizations

January 2018  19
January 2019  39
Progress Report Highlights

Program Referrals To Date = 52

Currently Pending Discharge = 9

Program Readmission Rate = 0%
Progress Report Highlights

Program Partner Referrals

- Valley Health System
  - Desert Springs Hospital & Medical Center
  - Summerlin Hospital
  - Valley Hospital & Medical Center

Cleveland Clinic, Lou Ruvo Center for Brain Health

Southern Nevada CHIPS

Henderson Fire Department
Progress Report Highlights

- Recruited and trained an outstanding team
- Refined the model working with Cognitive Solutions and Bridge
- Developed database and analytic tools
- Presented “Thoughtful Hospitalizations” to caregiver groups
- Presented “Thinking About Thinking” to hospital, clinical, and administrative leadership
- Presentations at regional and national conferences and meetings
QUESTIONS?
Gina Pierotti-Buthman RN, MSN, ACHRN – VHS Regional Director
Care Management/Social Services/Utilization Management
Introduction

Care transitions for persons with Alzheimer's and dementia, represents daunting challenges for the individual, their family caregiver, the health care delivery system and often the communities in which the person resides. Older adults with Alzheimer’s/dementia have higher skilled nursing facility use, greater hospital and home health care utilization, and more transitions per person per year.
Cognitive Impairment in an Acute Setting

- 5.6 million
- 1/9 over age 65
- 17 million caregivers
- Low rates of formal diagnosis and disclosure
- Over 75% have one or more addition chronic illness
- Medicare beneficiaries cost 60-300% more
- People with dementia age 65+ are about 3 times more likely to be hospitalized than other people age 65+
- On average, about 25% all hospital patients age 65+ have dementia (with likely wide variation among hospitals and hospital units)
- Annually about 1/3 of people with dementia have at least one hospitalization
Cognitive Impairment in an Acute Setting

Recognition of dementia varies in different hospitals:

- One study in 3 Pennsylvania hospitals found that among people age 65+ admitted to the hospital, only 12% of those who had cognitive impairment consistent with dementia had it in their medical record.

- Non Acute Practitioners may know these patients have dementia, but the diagnosis isn’t shown in the records that came with them to the hospital.

- The number of Americans with dementia is estimated at more than 6 million.
Prevalence by State
In 2013, Nevada finalized its State Plan to address Alzheimer’s disease and established the Task Force on Alzheimer’s Disease (TFAD), created by Nevada Assembly Bill 80 from the 2013 Legislative Session.
Alzheimer’s and Related Dementia – Caregiving

These are the realities:

- The healthcare cost for Alzheimer’s and dementia caregivers in Nevada is estimated to have increased by $69 million in 2013.

- About 70 percent or 27,300 of Nevadans with Alzheimer’s disease live at home, where an estimated 80 percent of their care is delivered by family members, Alzheimer’s Association.

- Nevada has an estimated 140,000 unpaid caregivers, together providing 159 million hours of unpaid care for a loved one with dementia or Alzheimer’s disease.

- The annual economic value based on the hours of unpaid care is estimated at $1,937,000,000, or more than 1.9 billion dollars, Alzheimer’s Association.

- The caregiving tasks of those caring for persons with Alzheimer’s disease are more challenging than routine care for older adults.
Assessment Phase

Communication and Collaboration with Nevada Senior Services and VHS to review potential program foundation and structure with consideration for best standards of practice.
Integration Phase

Subject Matter Experts determined a program of Care Transitions designed to address the difficult challenges posed by patients with cognitive impairment, and their family caregivers, will help these high-risk older adults with memory concerns, transition from the hospital back to their homes, while providing the much needed respite type care necessary. The key was provision for both patient and caregivers. The final goal is to continue provision of services necessary to maintain this population within our community.
Cognitive Impairment in an Acute Setting

- Critical Population Management recognized by VHS in needs assessment.
- Clear indications supported partnering with recognized expert entity that was closely aligned with support for this population; Nevada Senior Services.
- NSS provided Administrative and resource support as part of their awarded Grant to consider and address opportunities and initiatives for this patient population. They were our Subject Matter Experts.
- Stakeholder meetings were established and research reviewed and platform organized with teams.
Key Elements of the Collaboration:

Nevada Senior Services would provide:

- Bridge Care Transitions Intervention (enhanced for dementia)
- Bridge certified interventionist to deliver care transitions services to identified VHS patients working in close coordination with the VHS team.
- Dementia specific training for VHS personnel including modified version of “Caring For You, Caring For Me”, “Thoughtful Hospitalizations”, “Thinking About Thinking” and “Delirium”.
- Outcome tracking system utilizing nationally normed scales.
- In-home respite for care transitions clients in the pilot.
Key Elements of the Collaboration:

Nevada Senior Services would provide:

- Follow-on menu of evidence-based interventions:
  - Care Consultation (telephone enabled caregiver support)
  - RCI REACH (1:1 in-home 12 session intervention for dementia caregivers)
  - Skills2Care (OT delivered 5 session in-home safety & skills building for dementia caregivers)
  - Home Safety Modifications

- Integration with network of community-based services through the Aging and Disability Resource Center
Key Elements of the Collaboration:

Valley Health System would provide:

- Participation in program implementation planning
- Participation in protocol, policy and procedure development
- Designated personnel to participate in the pilot including care management, social work and emergency department.
- Patient identification and assistance in coordination with patients, family caregivers and physicians.
Key Elements of the Collaboration:

Valley Health System would provide:

- Participation in program evaluation.
- Collaboration in developing a self-sustaining model including the potential of billing under MACRA which would enhance both physician and hospital profiles for reimbursement under Medicare.
- Development of tools and resources.
Overview of Bridge Model

The Bridge Model is an interdisciplinary transitional care model, with a focus on psychosocial and community-level factors. Bridge goals:
1. Patient engagement and self-efficacy
2. Primary care integration
3. Appropriate use of long-term community resources

Bridge Transition Program

Community-based Care Transitions Program
(Medicare demonstration project)
- 6 hospitals in Chicagoland area
  - n = 5,753

Readmission reduction (Medicare analysis):
- 30-day: 30.7%
- 60-day: 9.4%
- 90-day: 13.9%

Super-utilizer transition pilot
- Retrospective quasi-experimental pre-post study
- 6 months pre v. 6 months post Bridge intervention
  - (* all p values < .000)

SNF Readmission and Transitions project
- n = 231
- Project focused on patients discharged from a SNF with a diagnosis of Pneumonia, COPD, or both
  - Pneumonia readmission reduction = 36%
  - COPD readmission reduction = 20%

Bridge has been replicated by over 70 sites:
- Hospitals/hospital systems
- Community-based organizations
- Home Health agencies
- Skilled Nursing Facilities
- FQHCs

Bridge serves the following populations:
- Older adults and caregivers
- Medicaid
- Super-utilizers
- Patients with dementia/ADRDs

Www.Transitionalcare.org
Info@transitionalcare.org
Expected Outcomes

- Reduced readmission rates
- Reduced emergency department visits
- Increased health indicators
- Decreased caregiver burden
- Increased caregiver coping
- Decreased depression
- Enhanced patient and caregiver activation
Workflow

Placed (Internal)
- Patient enters hospital with any health condition and under observation or admitted
- Patient identification
- DSU CM reviews patient history or diagnosis of Alzheimer’s disease or related dementias
- Family caregiver identifies patient has Alzheimer’s disease or related dementias
- CG is local and available to meet in person

Identification and Inclusion Criteria
- Medicare fee-for-service
- Patient currently lives at home
- Patient is transitioning home
- Family CS lives with Patient OR
- Family CS provides assistance with ADL & IADL for 4-4+ hours a week

Referral
- DSU CM shares flyer and informs patient and family about CT Prog / Bridge
- DSU CM makes immediate referral after identification
- DSU SW prepares referral form for CT Prog / Bridge

Referral Follow-up
- Care Transition Specialist (CTS) / Social Worker (SW) will contact referral source
- CTS-SW reviews form and inclusion criteria
- CTS-SW arranges meeting time or bedside visit with Primary Contact / Family CS

Pre-Discharge
- Bedside Link: CTS-SW arrives to DSU within approx. 2-business day of receipt of referral
- CTS-SW reviews BVR / Paper Record
- Interdisciplinary:
  - Patient and family CS complete NPS participation agreement

Hospital Discharge
- DSU CM notifies CTS-SW of discharge by phone
- DSU CM sends discharge plan to CTS-SW

Post Discharge
- CTS-SW reviews discharge plan
- CTS-SW completes Bridge Assessment during home visit
- CT-SW begins to create care plan with O/C/CS

Termination
- 30 days are complete
- Notification to DSU CM or program completion

Care Transitions Program – Bridge Care Transitions Model
Desert Springs Hospital and Nevada Senior Services Collaborative
Work Flow Process
Hospital Engagement

- Post DSH Pilot of about 10 weeks, an analytic review with stakeholders on success/opportunities commenced. Based on determinations, VHS facility specific roll outs began with program review with internal Leadership and care teams. Implementation was initiated with ongoing tracking and evaluation of enhancements.

- Desert Springs Hospital (Pilot)
- Valley (Expansion)
- Summerlin (Expansion)

Upcoming:
- Spring Valley
- Centennial Hills
- Henderson
## Program Expansion and Enhancement

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<tr>
<th>Actions/Topics</th>
<th>Outcome</th>
<th>Time Frame</th>
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<tr>
<td><strong>Nevada Senior Services and Hospital team onboarding</strong></td>
<td>Leadership Meeting: Hospital CEO, NSS CEO, and Case Management Director Meeting</td>
<td>Confirm partnership agreement</td>
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<tr>
<td><strong>Hospital Orientation and Tour Team Meeting: NSS Team (CPI Manager, Care Transition Specialist, Support), Hospital Discharge Nurses, Case Management Team, Social Workers.</strong></td>
<td>Hospital Orientation and Tour Team Meeting: NSS Team (CPI Manager, Care Transition Specialist, Support), Hospital Discharge Nurses, Case Management Team, Social Workers.</td>
<td>1. Finding champion hospital support 2. NSS work space 3. Knowledge and understanding of hospital procedure and culture</td>
</tr>
<tr>
<td><strong>Credentialing</strong></td>
<td>Complete all credentialing requirements for hospital and EMR Review (Marissa, Justine)</td>
<td>Access and Process to medical records</td>
</tr>
<tr>
<td><strong>NSS Orientation for Hospital Team / Discharge / Case Management / Nursing</strong></td>
<td>Dementia Education Bridge Orientation</td>
<td>1. To streamline process of CT program 2. Relationship building</td>
</tr>
<tr>
<td><strong>Thinking about Thinking</strong></td>
<td>Hospital and Medical Staff Training – GME Group to be included.</td>
<td>1. Create dementia capability in hospital 2. Provide CEU’s</td>
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<tr>
<td><strong>Internal / External Communications</strong></td>
<td>Press release, staff email notifications, flyers etc.</td>
<td>1. Develop and disseminate program material 2. NSS and hospital staff engagement</td>
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Lessons Learned

- Communication, Communication, Communication
- Monthly Reviews of considered best practices and “tweaks” to accommodate internal facility operations. “Not all square pegs are going to fit those round holes.”
- Daily resource tools enhanced to meet daily operational needs. Forms re-educated to teams is a must.
- It takes all stakeholders commitment, starting with Leadership.
QUESTIONS?

Thank you for your Participation and Engagement
DEMENTIA CAPABLE SYSTEMS & TARGET POPULATIONS

Kate Gordon
Cognitive Solutions LLC
Dementia Capable Systems & Target Populations

- In model dementia-capable systems, programs are tailored to the unique needs of people with dementia and their caregivers.
Model Dementia-Capable HCBS System

- Identify people with possible dementia & recommend that they see a physician for a timely, accurate diagnosis
- Program eligibility and resource allocation take cognitive disabilities into account
- Staff communicate effectively with people with dementia and their caregivers
Model Dementia-Capable HCBS System (continued)

- Educate workers to identify possible dementia, and understand the symptoms of dementia and appropriate services.
- Educate the public about brain health.
- Implement quality assurance systems that measure how effectively providers serve people with dementia and their caregivers.
- Encourage development of dementia-friendly communities.
Target Populations

- People living with or those at high risk of developing Alzheimer’s disease and related dementias (ADRD)
- Informal caregivers of people living with or those at high risk of ADRD
Target Populations

- Live Alones
- Individuals with intellectual and/or developmental disabilities
- Persons at high risk of developing dementia
QUESTIONS?
Public Policy/Systems

Target Populations:
Home Alone & ID

OVERVIEW OF BREAKOUT WORKGROUPS

1:00 – 2:30pm Adjacent Ballrooms
GROUP REPORTS
ACTION PLANS/ROUND ROBIN SESSION
QUESTIONS?

Follow up information posted at: hospital2home.org

Planning Committee:
Jeff Klein
Mike Splaine
Jane Gruner
Marissa Shoop
Ellen Grossman
Paige Wilson
Kate Gordon
Shari Schwartz