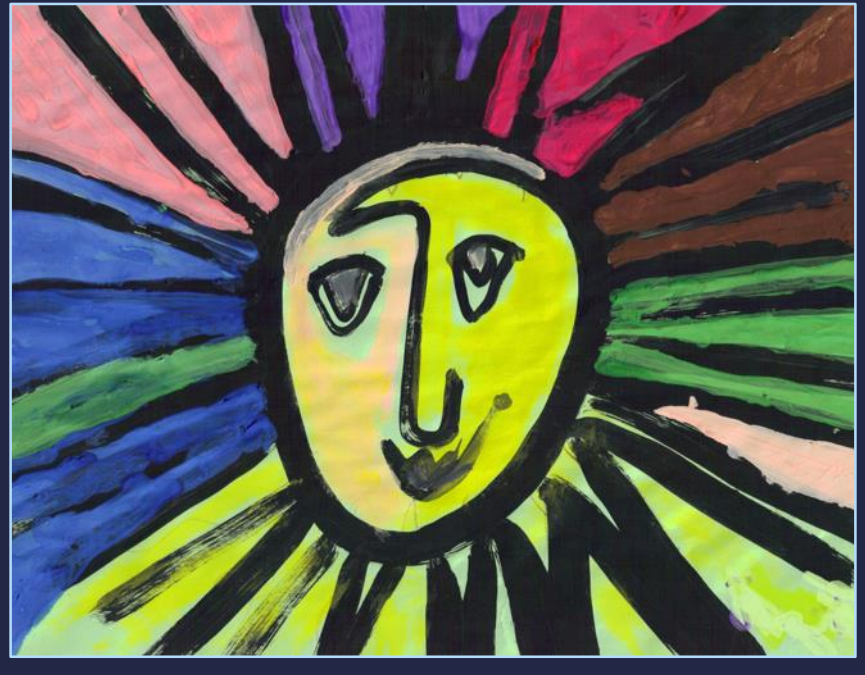
Nevada Senior Services Inc.

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!

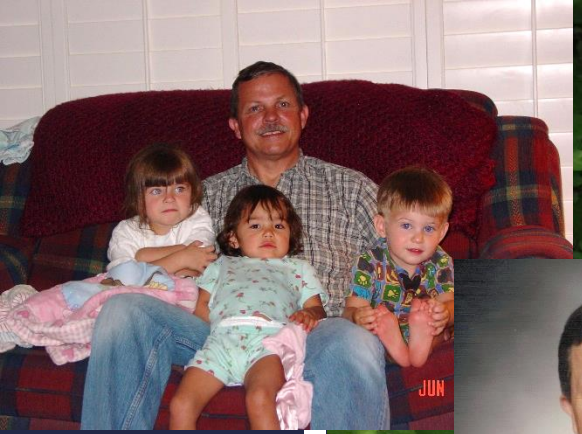
Jeffrey B. Klein, FACHE

President & CEO Nevada Senior Services Inc.

OVERVIEW

Mike Splaine

Cognitive Solutions LLC



ONE CAREGIVER'S JOURNEY FROM HOSPITAL2HOME

Teri Lawrence


ntral
LOVE


STATION CASINOS
I LOVE
PAYDAY
SUPER
PAYCHECK
BONANZA

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

AMP Aging Mastery Program®

National Council on Aging

Nevada Care Connection Resource Center

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)

DID YOU
KNOW?

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

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.

What Happens Now After Discharge

- 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
  - are 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

UNDERSTANDING THE DEMENTIA CARE TRANSITIONS PROJECT

The Bridge Model

THE HOSPITAL2HOME PROJECT

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 individual 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

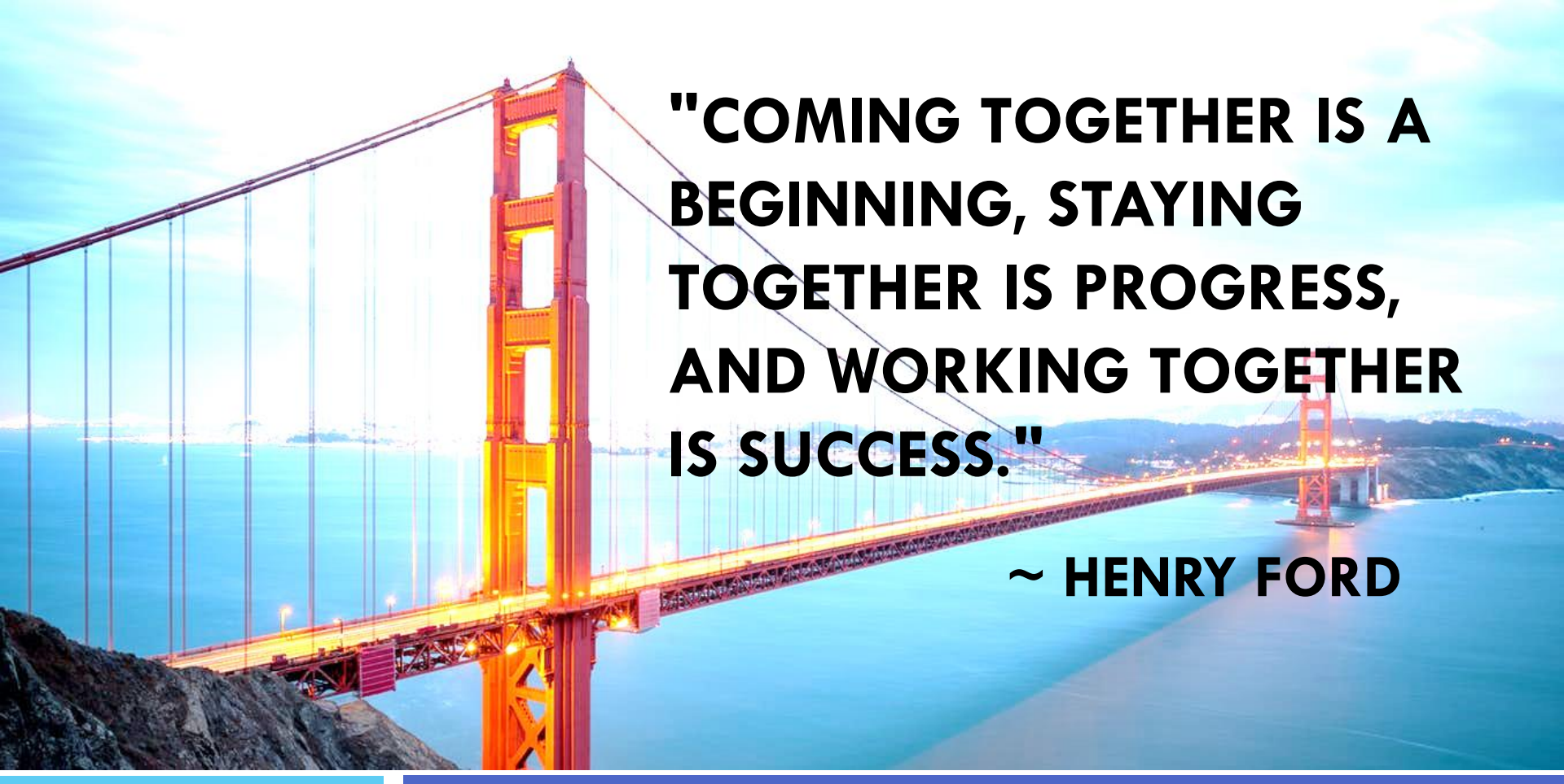
COMMUNITY ENGAGEMENT AND COLLABORATION

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

- Alzheimer's Association. (2018) 2018 Alzheimer's Disease Facts and Figures, *Alzheimer's & Dementia*. Retreived from alz.org/Nevada
- Alzheimer's Association. (2011) 2011 Alzheimer's Disease Facts and Figures, *Alzheimer's & Dementia*, *7* (2).
- Alzheimer's Association. (2012) 2012 Alzheimer's Disease Facts and Figures, *Alzheimer's & Dementia*, *8* (2).
- Alzheimer's Association. (2013) 2013 Alzheimer's Disease Facts and Figures, *Alzheimer's & Dementia*, *9* (2).
- Alzheimer's Association (2015) 2015 Alzheimer's Disease Facts and Figures; Retrieved from https://www.alz.org/facts/downloads/facts_figures_2015.pdf
- Alzheimer's Association. (2012).*The Basics: Memory Loss, Dementia and Alzheimer's Disease.* Retrieved from http://elearning.alz.org/home.aspx.
- Alzheimer's Disease International. (2011) *World Alzheimer Report 2011:The benefits of early diagnosis and intervention*. London, UK: Prince, M., Bryce, R and Ferri, C.
- 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.
- Hepburn, K., Lewis, M, Tornatore, J., Sherman, C.W., & Dolloff, J. (2012 Revision). The Savvy Caregiver Training Manual. University of Minnesota.
- Institute for Healthcare Improvement (2014). *IHI Triple Aim Initiative*. Retrieved January 30, 2014, from http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx.
- Maslow, K. and Mezey, M. (2008). Recognition of dementia in hospitalized older adults. *American Journal of Nursing*, *108*(1),40-9.
- Prada, S.I. (2013) Medicare Public Use Files and Alzheimer's disease factors in 2008 and 2010. *Alzheimer's* & Dementia, 9(4), 472-474.
- Silverstein N., & Maslow K. (2006). *Improving Hospital Care For patients with Dementia*. New York: Springer Publishing Company

CARE TRANSITIONS AND HOSPITAL READMISSIONS

Linda Griskell, MHA

Quality Improvement Director HealthInsight

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

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.

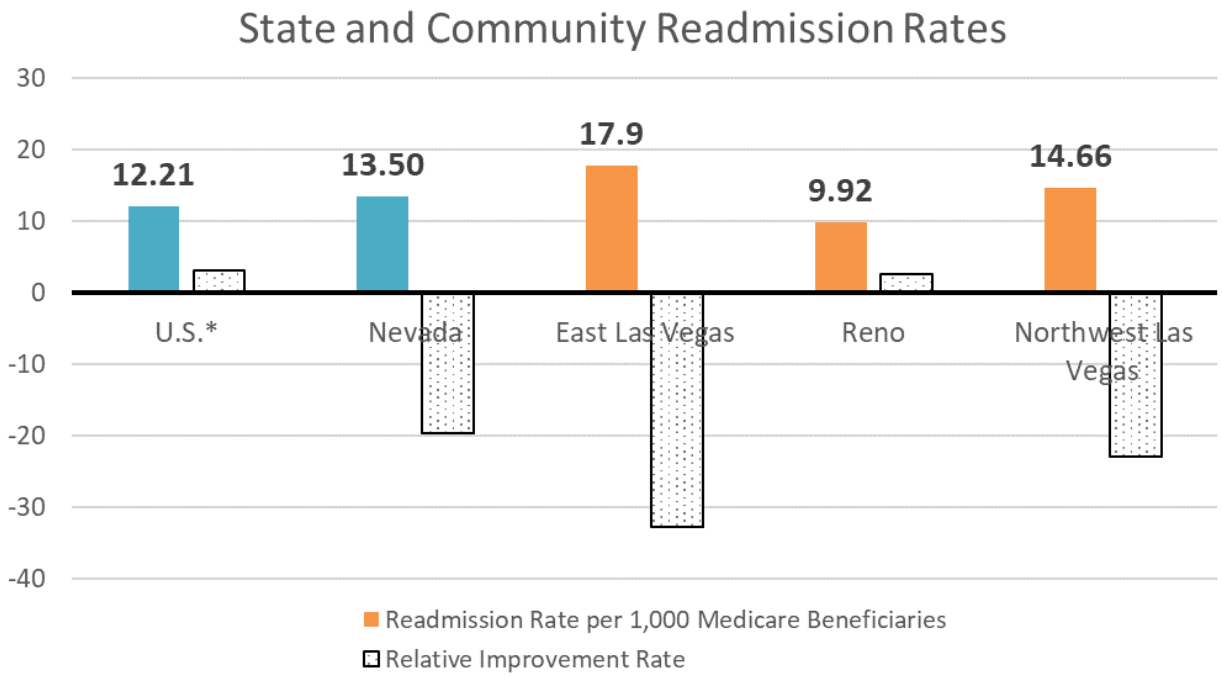
Source: Agency for Healthcare Research and Quality

Ineffective Care Transitions

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.

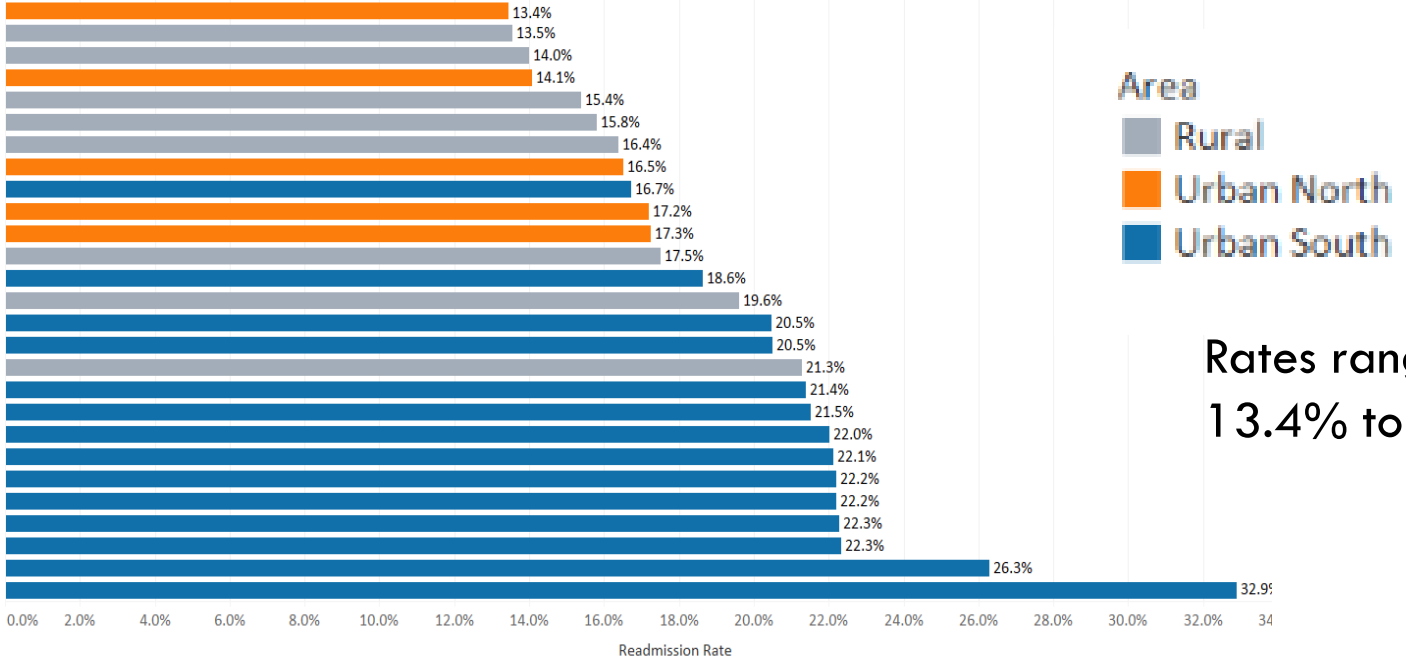
Nevada Readmission Rates



*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

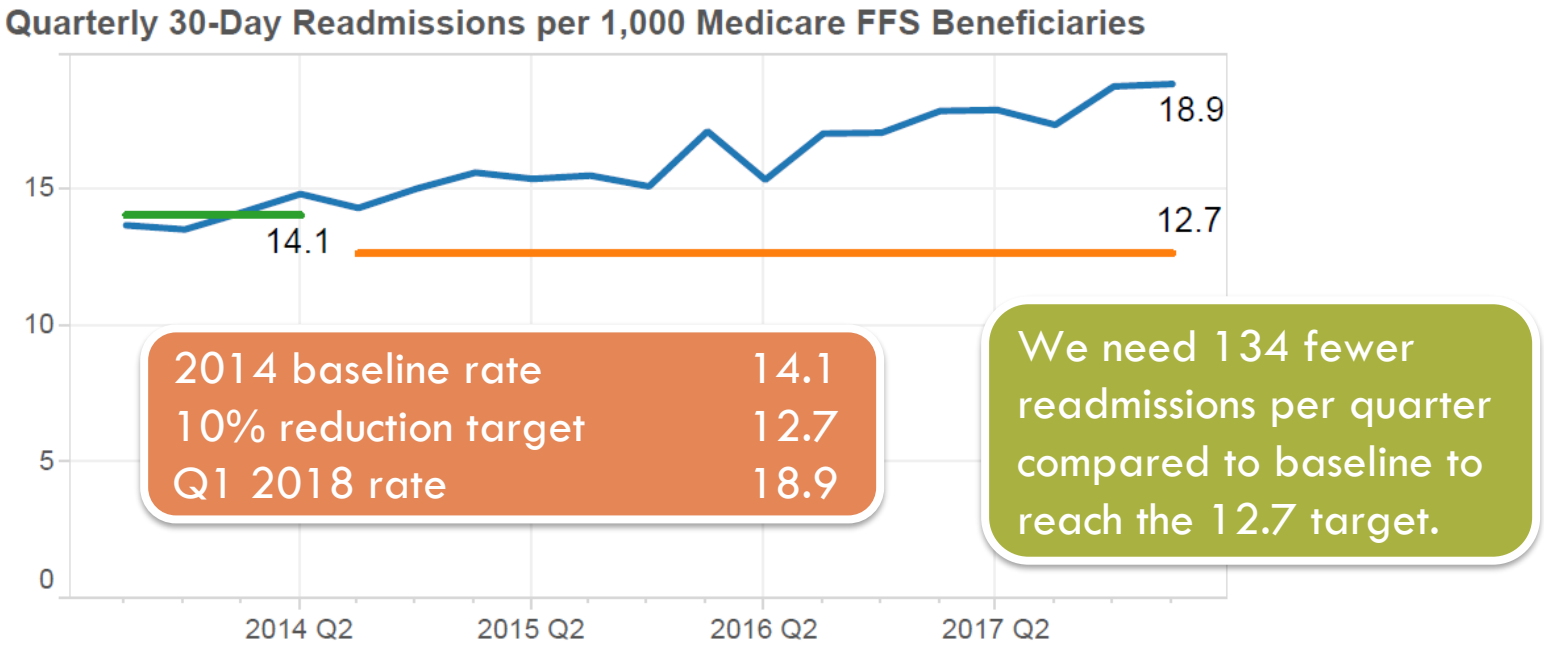


Rates range from 13.4% to 32.9%

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.

Making Sense of Quarterly Rates

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

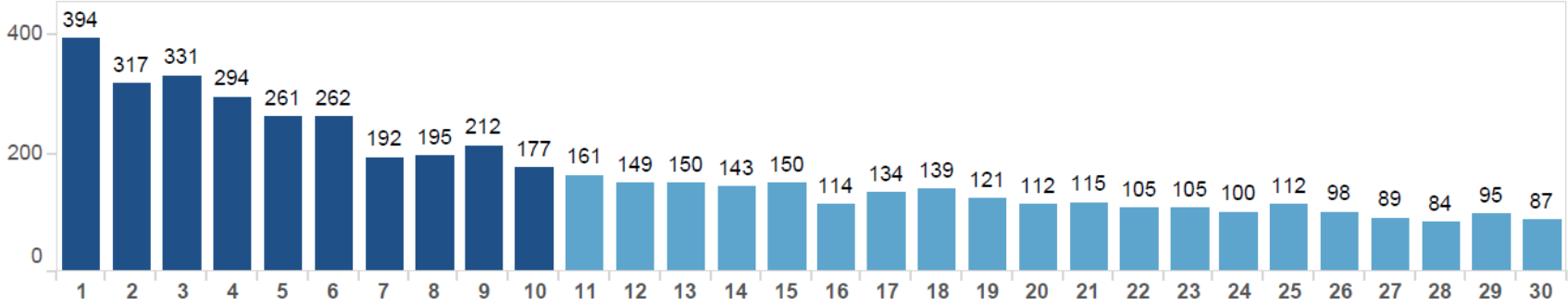
19 of those patients were readmitted within 30 days

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

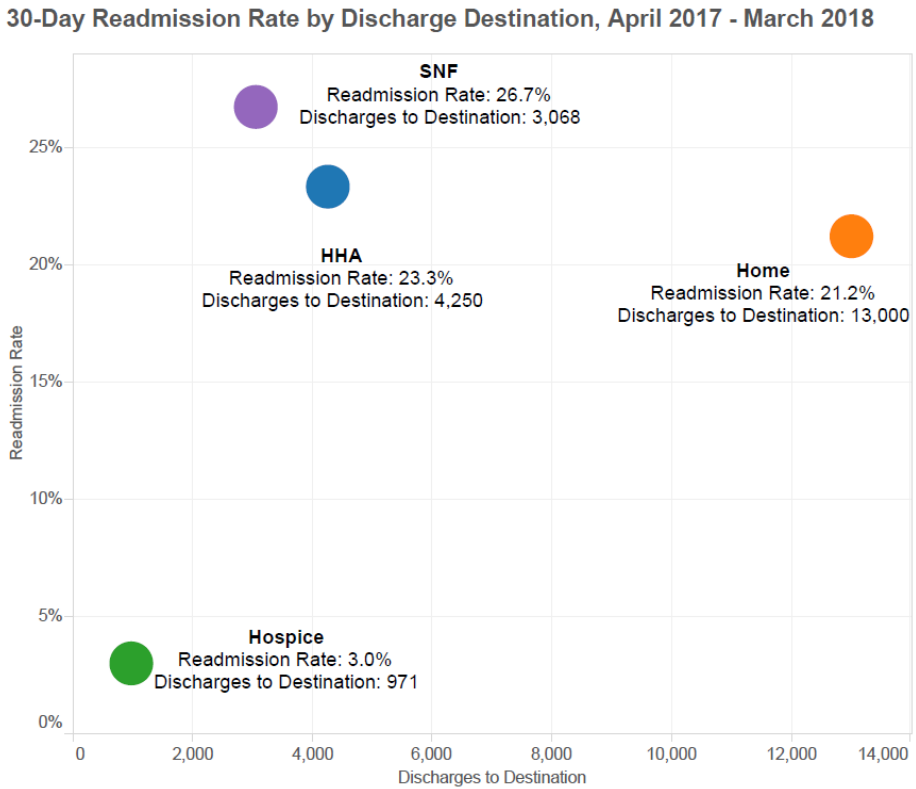
of readmitted patients return by Day 3

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.

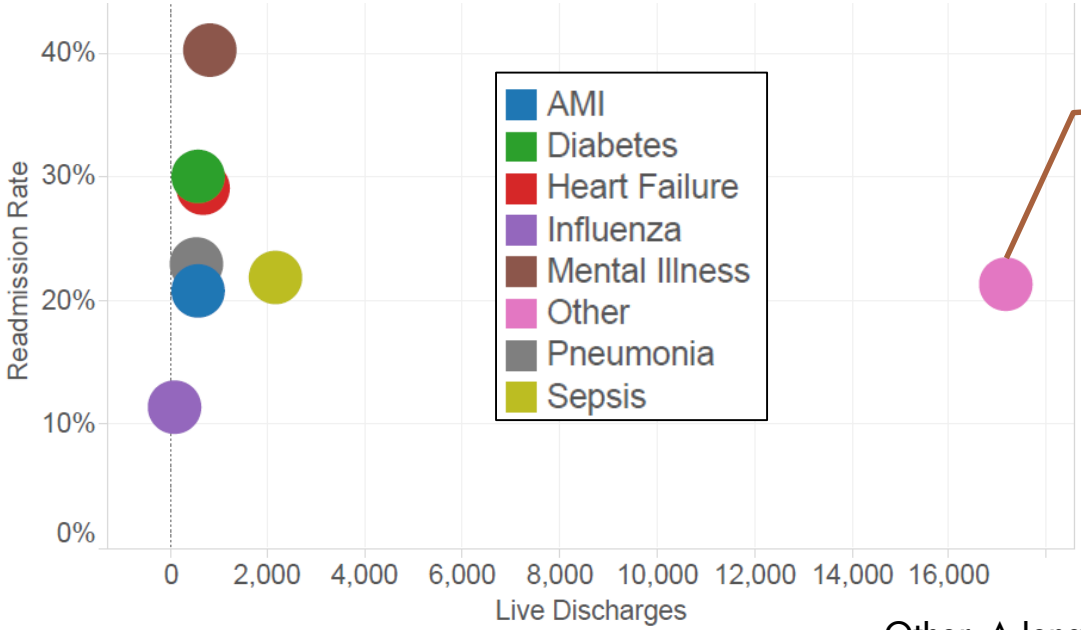
Readmissions by Discharge Destination



- 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



OTHER
17,177 live discharges (76 percent of total)
3,659 readmissions (76 percent of total)
21 percent readmission rate

	Readmissions	Live Discharges	Readmission Rate
AMI	118	566	21%
Diabetes	165	549	30%
Heart Failure	191	658	29%
Influenza	11	96	11%
Mental Illness	327	812	40%
Other	3,659	17,177	21%
Pneumonia	122	532	23%
Sepsis	473	2,164	22%

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.

Information is Key

The health information exchange (HIE) is at the center of it all, to collect and share out information with the team.

QUESTIONS?

Thank you!

Linda Griskell, MHA
Quality Improvement Director
HealthInsight
lgriskell@healthinsight.org
702-777-8372

This material was prepared by HealthInsight, the Medicare Quality Innovation Network -Quality Improvement Organization for Nevada, New Mexico, Oregon and Utah, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-C3-19-01-NV

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?

VALLEY HEALTH SYSTEM & NEVADA SENIOR SERVICES COLLABORATIVE PROGRAM – BRIDGE – ONE STAKEHOLDERS EXPERIENCE

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 ore 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

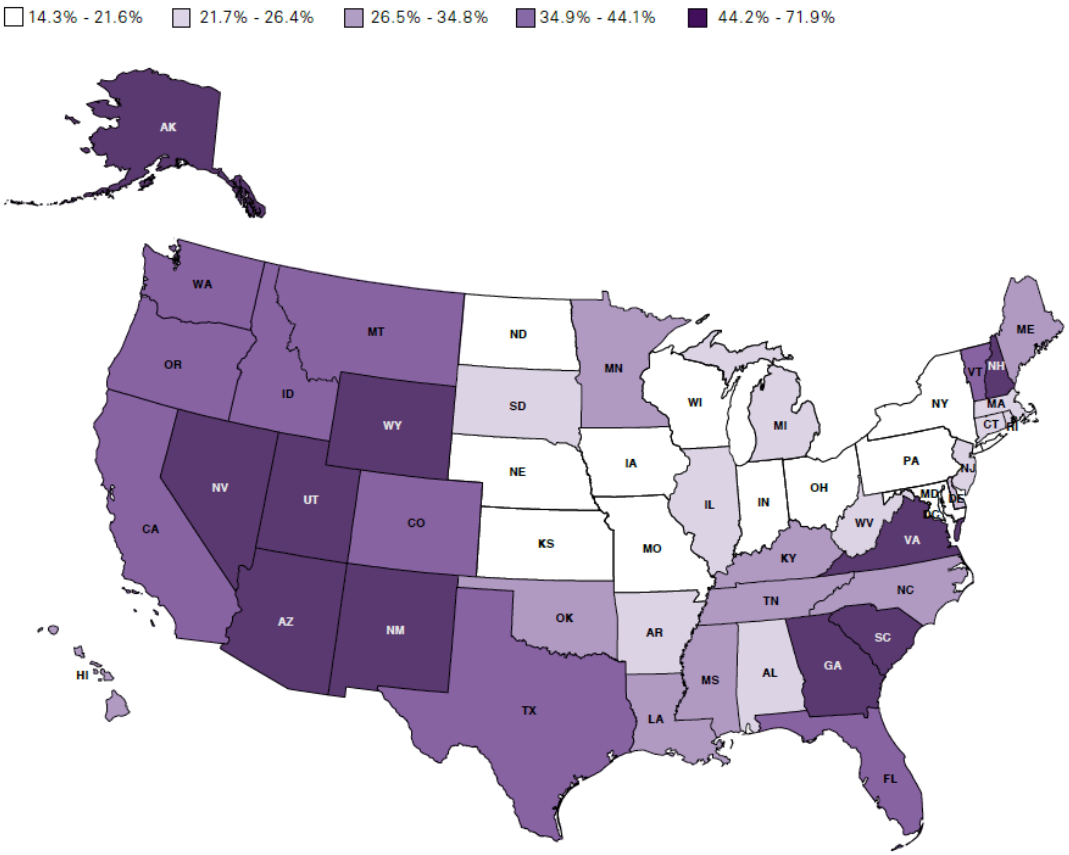
Recognition of dementia varies in different hospitals:

- 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

FIGURE 2

Projected Increases Between 2015 and 2025 in Alzheimer's Disease Prevalence by State



Change from 2015 to 2025 for Washington, D.C.: -1.1%

Created from data provided to the Alzheimer's Association by Weuve et al.[154, A7]

Alzheimer's and Related Dementia – Caregiving

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

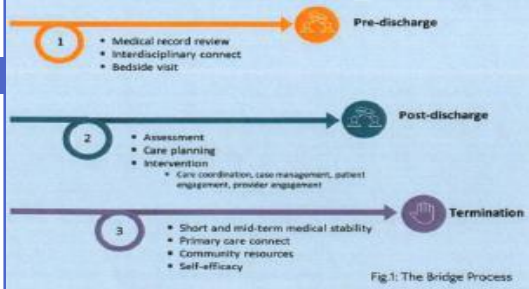


Fig.1: The Bridge Process

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

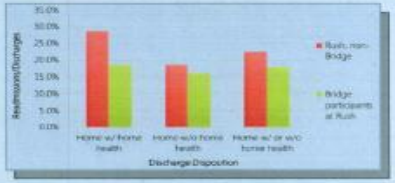
Community-based Care Transitions Program
(Medicare demonstration project)

6 hospitals in Chicagoland area
n = 5,753
Oct. 2012—Sep. 2014

Readmission reduction (Medicare analysis):

- 30-day: 30.7%
- 60-day: 9.4%
- 90-day: 13.9%

Journal of the American Geriatrics Society
n = 1,546



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

Variable	Pre-Intervention n or Mean % or ± SD n = 456	Post-Intervention n or Mean % or ± SD n = 456
# of Admissions	2.52 ± 1.79	1.25 ± 1.67
30-day Readmission Rate	29.1% ± 34.3%	11.3% ± 24.0%
# of ED visits	2.39 ± 2.64	1.52 ± 2.15
# of no-shows	4.05 ± 5.35	3.25 ± 5.11

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%

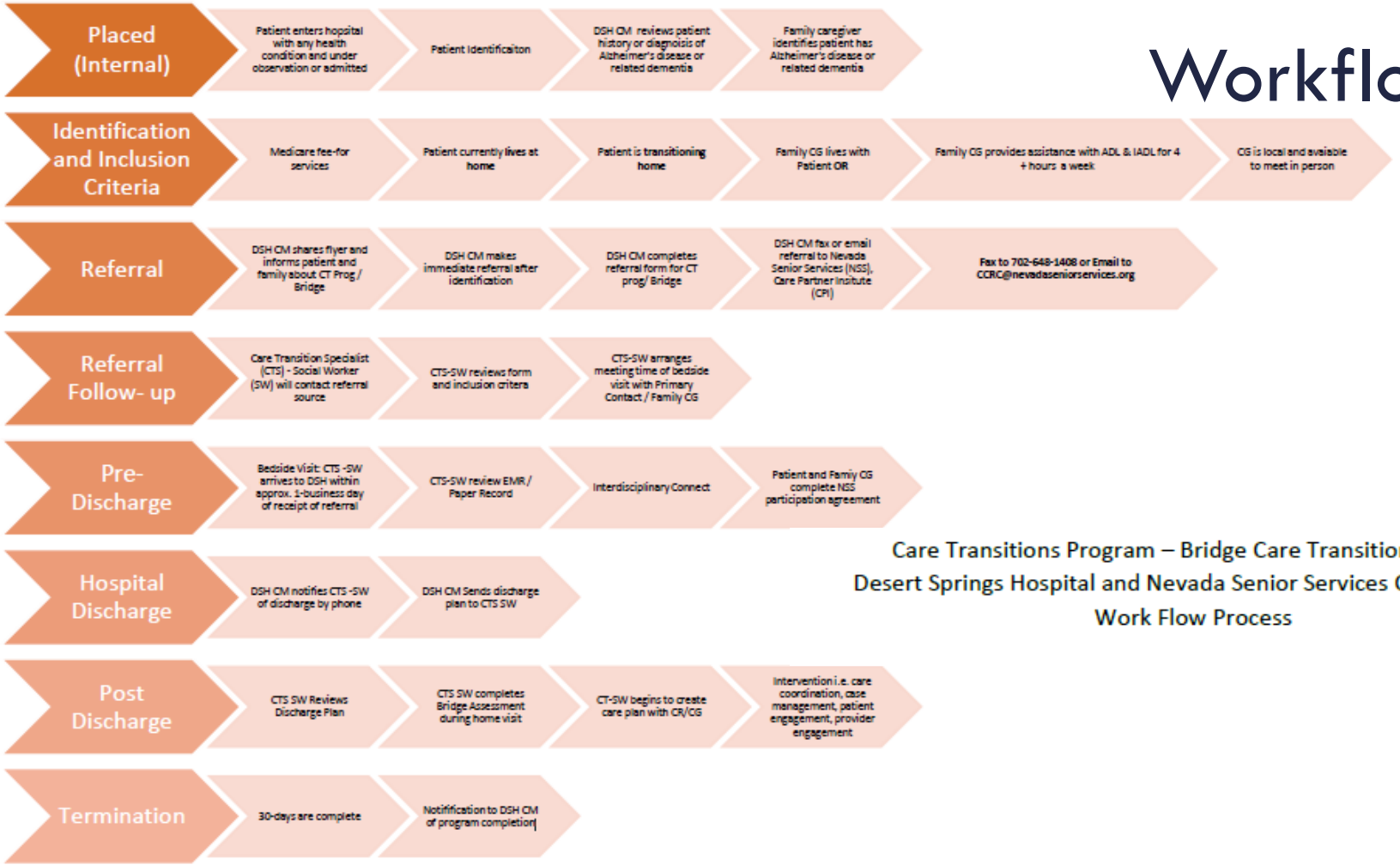
WWW.TRANSITIONALCARE.ORG
(visit for citations and training information)

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



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

Referral Tool Development

Nevada Senior Services, Inc.
Care Partner Institute
901 N. Jones Blvd. Las Vegas, NV 89108
Main Line: (702) 364-2273 Toll Free: (844) 850-5113
www.nevadaseniorservices.org

CARE TRANSITIONS REFERRAL FORM

Date: _____

Referral by: _____ **Phone #:** _____

Name of Agency: _____ **Email:** _____

Participant Information

Participant Name: _____
Hospital: _____
Patient Room Number: _____
Diagnosis: _____
Reasons for Admission: _____
☐ Check if primary contact

Family Caregiver Information

Family Caregiver (CG) Name: _____
CG Relationship to Patient: _____
CG Home Phone #: _____ CG Cell Phone #: _____
☐ Check if primary contact

Care Transitions Eligibility Criteria

1. Person with **Alzheimer's disease/dementia** is currently hospitalized for **any medical condition**.
   - Does the patient live alone? ☐ Yes ☐ No
   - Does the patient have moderate to severe dementia? ☐ Yes ☐ No
   - Does the patient with I/DD have ADRD or at high risk for dementia? ☐ Yes ☐ No
   - Does the patient / cg need assistance with behavioral symptoms? ☐ Yes ☐ No
2. Patient lives at home
3. Patient is transitioning home
4. Medicare Fee-for-Service

☐ _____ **Participant meets all criteria for Care Transitions Program**
(Staff initials)

Please fax or email to:
Nevada Senior Services
Care Partner Institute
Fax number: 702-648-1408
Email: ccrc@nevadaseniorservices.org

Nevada Senior Services is a nonprofit, 501 (c) (3) organization dedicated to improving the physical, spiritual and emotional health of individuals and families by providing a comprehensive range of health, education, and social services for those facing the challenges of chronic disease, disability and aging.

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

Hospital Engagement Schedule and Onboarding

Dementia Capable Care Transitions Program: Better Care, Better Outcomes

Time frame: **September 1, 2018 to November 1, 2018**

Actions/Topics		Outcome	Time Frame
Nevada Senior Services and Hospital team onboarding	Leadership Meeting: Hospital CEO, NSS CEO, and Case Management Director Meeting	Confirm partnership agreement	Beginning of September 2018, potential Labor Day week
	Hospital Orientation and Tour Team Meeting: NSS Team (CPI Manager, Care Transition Specialist, Support), Hospital Discharge Nurses, Case Management Team, Social Workers.	1. Finding champion hospital support 2. NSS work space 3. Knowledge and understanding of hospital procedure and culture	September 2018 Recommend Dr. Jeff Davidson or Dr. Sheik Saghir, Valley C's can also recommend during partnership meeting.
Credentialing	Complete all credentialing requirements for hospital and EMR Review (Marissa, Justine)	Access and Process to medical records	September 2018 (Once NSS Staff are credentialed, (DSH) the process will roll over to other facilities. Gina can communicate with HR)
Referral process		1.Review of work flow process 2. Review of referral process 3. Update any referral forms	September 2018
NSS Orientation for Hospital Team / Discharge / Case Management / Nursing	Dementia Education Bridge Orientation Referral Process	1. To streamline process of CT program 2. Relationship building	October 2018
Thinking about Thinking	Hospital and Medical Staff Training – GME Group to be included.	1. Create dementia capability in hospital 2. Provide CEU's	Potential dates: Oct. 16, 17 or Nov. 1, 2, 8
Internal / External Communications	Press release, staff email notifications, flyers etc.	1. Develop and disseminate program material 2. NSS and hospital staff engagment	October 2018

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