What is Care Transitions?

Nevada Senior Services (NSS) Care Transitions is a free 30 day program for individuals with memory loss who are being discharged from the hospital to their homes. The goal of Care Transitions is to reduce hospital re-admissions by assisting adults with memory loss and their caregivers in accessing resources in the community, establishing a strong connection to their primary care physician, identifying barriers to a healthy living, acquiring caregiver support, and coordinating patient's needs to ensure his/her health and social needs are met.

Role of Care Transitions Specialist

1. Connect to programs and services in the community
2. Provide information, referrals, and caregiver support
3. Help to find solutions to issues that could lead to hospital re-admissions
4. Inform and educate about care options and develop care plan based on individual needs
5. Advocate on behalf of patient and caregiver
6. Support patient and caregiver to navigate and understand care plans
7. Assist to understand confusing discharge plans
8. Find solutions to medication management issues
9. Support connection with primary care physician
10. Help in accessing programs such as food stamp/SNAP, ADSD waiver programs, home maker programs, respite programs, home health agencies, home modifications etc.

You should call your **doctor** if you see any **sudden and unusual changes** **in the way your love one is thinking or acting, or has a medical condition that is getting worse**.

For questions or referral:

Please contact Justine Perez, Care Transitions Specialist at 702-331-5415 or email jperez@nevadaseniorservices.org

Hours: Monday to Friday 8:00 am – 4:30 pm