Stakeholder Newsletter | Volume 1 | September 2018

Dementia Capable Care Transitions: Better Care and Better Outcomes

Stakeholder Newsletter

We are very excited to introduce the first issue of our newsletter about the Nevada Senior Services Dementia Capable Care Transitions initiative. Dementia Capable Care Transitions, supported by a three year grant from the Administration for Community Living, is an innovative and much needed initiative to develop and implement an evidence-based care transitions model targeting the dementia population. Addressing this critical need opens a door for families to receive critical support during their transition from hospital to home. This is very important for families with over-stressed care givers and is a model for all chronic diseases across the lifespan. We recognize that persons living alone with a dementia and persons with Intellectual or Developmental Disabilities (IDD) represent special challenges to us in developing an effective model. We also recognize that this journey will raise important public policy questions that will need to be addressed. We appreciate your participation as a key community partner and stakeholder. Your participation will make a great contribution to a successful outcome. We will use our newsletters to inform you about progress and to keep you posted on news and developments within the project. We will also use the newsletter to bring information to you about new studies, relevant data, and other projects impacting our target populations and programs. We hope you will find the newsletters informative and useful. We intend to publish the newsletter periodically. Feedback from you, as always, would be greatly appreciated.

Visit our Website

Care Transition News: Dementia Capable Care Transitions Launches

Desert Springs Hospital Medical Center becomes first Dementia Capable Care Transitions site. As part of the roll-out Cognitive Solutions LLC presented “Thinking About Thinking”, a one-day seminar for Leadership and Medical Staff, reviewing the key role that cognition plays in patient success in the acute care environment.The program presented key data, trends and evidence-based practices, about improving care for those who have or are cognitively impaired by delirium, Alzheimer’s disease or a related disorder. During the seminar enlightened approaches to caring for patients with cognitive impairment within the healthcare system were presented.

Service Spotlight: Respite Coaches

Added two Respite Coaches who receive 40 hours of training including:

- Respite and Safety Orientation
- Care Transitions Orientation
- Elder Abuse Detection
- Caring For You Caring For Me
- REST - Dealing With Dementia
- Person Centered Thinking
- Medical Emergency Preparedness

Respite Coaches participate in an additional 8 hours of job shadowing.

August Spanish Initiative

An intensive effort to enhance the capability to better serve the Spanish speaking community was made possible by ADSD funding.

The Care Transitions team will be conducting outreach in the Spanish speaking community and translating program materials into Spanish.

ADI-SSS Grant Site Visit

The project received an ADI site visit July 24-25.

The team conducted a very detailed, productive and positive review including discussions with project staff and several collaborative partners.

Partner meetings included:

- Bridge at Rush Hospital, Chicago
- Cognitive Solutions LLC
- HealthInsight
- ADSD
- Sanford Center for Aging at UNR
- Desert Springs Hospital Medical Center
- Valley Health System hosted a meeting at the hospital including senior management and case management staff.

CARE TRANSITIONS OUTCOME FACT:
SOUTHERN NEVADA READMISSION RATE = 21%
NSS CARE TRANSITIONS READMISSION RATE = 6%

Meetings and Presentations

Aging In America Conference 2018 – 90 minute presentation “Changing Dementia Service Models: Adult Day Health As An Engine for Hospital Readmission Prevention” March 28, 2018. Project team members: Jane Gruner, Mike Splaine, Walter Rosenberg, Jeffrey Klein joined by Katie Maslow.

HealthInsight Readmissions So. Nevada Community Stakeholder Conference: July 18, 2018 Attended by Jeffrey Klein.

HealthInsight/Nevada Hospital Association Readmissions Conference (Reno) Jane Gruner, Panel Participant, December 12, 2017.

HealthInsight/Nevada Hospital Association Readmissions Conference (Las Vegas) Jeffrey Klein, Panel Participant, December 14, 2017.

Nevada Hospital Association 5th Tuesday – Marissa Shoop, Presentation, March 27, 2018.

Nevada Hospital Association 5th Tuesday – Jane Gruner, Presentation, May 29, 2018.

Planning has started for Annual Stakeholder Conference in January 2019. Please look for a "Save the Date" in the near future.

Impact Factoid: Care Transitions and Dementia

Persons with an Alzheimer's diagnosis in their medical record comprise at least 40% of under 30 day readmissions back to hospital in the US population over age 65. (Readmitted for the same problem within a month.)

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.

Participating Programs Referral Sites:

Desert Springs Hospital Medical Center

Adult Day Care Center of Las Vegas

Adult Day Care Center of Henderson

Baby Boomers Activity Club

Nevada Senior Services

Dementia Capable Care Transitions Staff:

Marissa Shoop, CPI Manager / Project Manager
Pita Rizzo, Respite Coach
Ashley Martin, In-Home Respite Manager
Paige Wilson, Health Educator
Justine Perez, LSW, Care Transitions Specialist
Peggy Gutting, Lead Options Counselor

Hospital 2 Home Care Transitions is a program of Nevada Senior Services
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