Nevada Task Force on Alzheimer's Disease

State Plan Recommendations Planning Template

Recommendation #: ___11 – Hospital Transitional Care Practices____

TFAD Member Lead(s): ___Reed____

<u>Current Recommendation as Stated</u>:

Recommendation #11: Hospital Transitional Care Practices

Ensure high quality hospital-to-community (i.e., home and long-term care) care transitions programs are available to persons living with dementia and their caregivers, with key elements including: care/discharge planning, care management, information on community resources, wrap-around services and periodic follow-up check-ins and assessments. One such program specific to Alzheimer's and dementia currently available in Southern Nevada is Nevada Senior Services' Hospital-to-Home program. Another relevant resource is the Community Paramedics program (active in Humboldt County).

To explore new innovations, as well as expand and support existing efforts, the Nevada Department of Health and Human Services (DHHS) should investigate federal funding opportunities through the Centers for Medicare and Medicaid Services and the CMS Innovation Center, as well as others. Opportunities to support more widespread use of a care transitions programs should be explored by seeking and establishing key partnerships and identifying available resources.

Indicators

- Monitor the number of care transitions programs available across Nevada's counties, including those connected to rural hospitals, such as the Community Paramedics program.
- Monitor the ongoing process and impact data of the Hospital-to-Home program, with updates from Nevada Senior Services.

Potential Funding

Grants, donations and/or gifts.
Specific sources may include:

- Collaboration within DHHS, including between ADSD, Division of Health Care Financing and Policy (DHCFP), DPBH, and other appropriate State agencies;
- Federal innovations and funding opportunities.

<u>Determination</u>: Do you propose that for the 2021 State Plan this recommendation be:

1) Retained as is
2) Retired to the Appendix (it has been accomplished or is no longer relevant)
3) Revised / Updated

DRAFT

Justification: If you propose revising this recommendation, what is your rationale for your suggested changes:

- Retain recommendation as it remains relevant for support of people living with dementia statewide.
- Incorporated editorial revisions suggested by DFNV.

Suggested Revisions: Please provide the text for your suggestions on how to revise the recommendation (and be sure to include each of the following required elements):

Recommendation #11: Hospital Transitional Care Practices

Ensure high quality hospital-to-community (i.e., home and long-term care) care transitions programs are available to ~~persons~~ people living with dementia and their ~~caregivers~~family care parters, with key elements including: care/discharge planning, care management and associated tools, information on community resources, wrap-around services, ~~and~~ periodic follow-up check-ins and assessments, strategies for living well with dementia, and dementia-self-management resources. One such program specific to Alzheimer's and dementia currently available in Southern Nevada is Nevada Senior Services' Hospital-to-Home program. Another relevant resource is the Community Paramedics program (active in Humboldt County).

To explore new innovations, as well as expand and support existing efforts, the Nevada Department of Health and Human Services (DHHS) should investigate federal funding opportunities through the Centers for Medicare and Medicaid Services and the CMS Innovation Center, as well as others. Opportunities to support more widespread use of ~~a~~ care transitions programs should be explored by seeking and establishing key partnerships with Nevada's healthcare providers and systems, as well as~~nd~~ identifying available resources. New and existing programs should be evaluated to determine program accessibility, effectiveness, and impact.

Efforts should be taken to mobilize continuing education programs designed to build healthcare providers' understanding of the importance of care transition planning and their skills in convening interprofessional teams of providers to counsel and support patients at the time of discharge. Hospital-to-community care transitions programs should emphasize the essential role of family care partners and include the development of care transition plans that support family care partner health and well-being.

Indicators

- Monitor the number of care transitions programs available across Nevada's counties, including those connected to rural hospitals, such as the Community Paramedics program.
- Monitor the ongoing process and impact data of the Hospital-to-Home program, with updates from Nevada Senior Services.
- Monitor the number of continuing education programs for Nevada medical providers that discuss the importance of care transition planning.
- Receive updates on new and existing care transitions programs.

Formatted: Font: 11.5 pt
Formatted: Font: (Default) Times New Roman, 11.5 pt
Formatted: Font: (Default) Times New Roman, 11.5 pt
Formatted: Default, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers
Formatted: Font: (Default) Times New Roman, 11.5 pt
Formatted: Font: (Default) Times New Roman, 11.5 pt
Formatted: Font: (Default) Times New Roman, 11.5 pt
Formatted: Font color: Black
Formatted: Font: (Default) Times New Roman, 11.5 pt
Formatted: Font: (Default) Times New Roman
Formatted: Font: (Default) Times New Roman, 11.5 pt
Formatted: Font: 11.5 pt
Formatted: Font: (Default) Times New Roman, 11.5 pt, Font color: Custom Color(RGB(26,26,26))
Formatted: Normal, Indent: Left: 0.25", No bullets or numbering

DRAFT

Potential Funding

Grants, donations and/or gifts.
Specific sources may include:

- Collaboration within DHHS, including between ADSD, Division of Health Care Financing and Policy (DHCFP), DPBH, and other appropriate State agencies;
- Federal innovations and funding opportunities.

DRAFT