Nevada Task Force on Alzheimer's Disease State Plan Recommendations Planning Template

Recommendation #: 11: Hospital Transitional Care Practices

TFAD Member Lead(s): Peter Reed

Current Recommendation as Stated:

Ensure high quality hospital-to-community (i.e., home and long-term care) care transitions programs are available to people living with dementia and their care partners, with key elements including care/discharge planning, care management and associated tools, information on community resources, wrap-around services, 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, TFAD encourages the Nevada Department of Health and Human Services (DHHS) to 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 care transitions programs may be explored by seeking and establishing key partnerships with Nevada's healthcare providers and systems, as well as 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 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 and care partners, and should include the development of care transition plans that support care partner health and well-being.

Current Status (i.e., activities/outcomes?):

The Hospital-to-Home program remains active at Nevada Senior Services with support for people living with dementia available in Southern Nevada. However, we have not received any recent updates as TFAD on the progress and outcomes of this (or other) transition programs.

Further, there has been no activity regarding the proposal that Nevada DHHS explore and promote any potential new innovations. A key next step to support this recommendation is to bring key representatives forward from Nevada Senior Services and Nevada DHHS to present on current and proposed initiatives to support effective care transitions for people living with dementia.

Determination: For the 2025 State Plan do you propose this recommendation be**:**

X **Retain as is**

☐ Retire to the Appendix (it has been accomplished or is no longer relevant)

☐ Revise / Update

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

Suggested Revisions: Please provide the text for how to revise the recommendation (please include each of the following required elements):

- **Recommendation:**

- **Indicators:**

- **Potential Funding:**