**Transition Care**

**Competency**

General Information

**Transition Care**

CMS defines transition of care as, “The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.”[[1]](#footnote-1)

Transition of care management, communication, collaboration and adequate planning are crucial for all transition of care episodes. Proper planning and identified individualized needs and preferences will be instrumental in the development of a transition of care plan.

Transition of Care Planning is essential for all resident transfers. The United States government indicates:

“Improving care transitions between care settings is critical to improving individuals’ quality of care and quality of life and their outcomes. Effective care transitions:

* Prevent medical errors
* Identify issues for early intervention
* Prevent unnecessary hospitalizations and readmissions
* Support consumers preferences and choices
* Avoid duplication of processes and efforts to more effectively utilize resources”[[2]](#footnote-2)

**General Information**

Transition planning on returning to the community begins prior to admission and continues throughout the client/resident stay. The goal is to transition the client/resident to the least restrictive environment that will maintain and/or improve the level of function achieved during the skilled nursing stay. Care transition also includes comprehensive communication and collaboration from the setting prior to admission to the facility to ensure quality, person-centered care is delivered.

§483.21(c)(1) Discharge Planning Process

“The facility must develop and implement an effective discharge planning process that focuses on the resident’s discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility’s discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and—

1. Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
2. Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
3. Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
4. Consider caregiver/support person availability and the resident’s or caregiver’s/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
5. Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
6. Address the resident’s goals of care and treatment preferences.
7. Document that a resident has been asked about their interest in receiving information regarding returning to the community.

(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.

(B) Facilities must update a resident’s comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.

(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident’s goals of care and treatment preferences.

1. Document, complete on a timely basis based on the resident’s needs, and include in the clinical record, the evaluation of the resident’s discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident’s representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident’s discharge or transfer.”[[3]](#footnote-3)

F624 also addresses: “Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.”[[4]](#footnote-4)

A solid system for transition of care planning will be essential for quality of care.

**Suggestions for Resources/Data to Support the Competency**

A resource for expectations for providers for Transition Care in LTC includes AMDA Clinical Practice Guideline: Transitions of Care in the Long-Term Care Continuum and the CMS State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities-Discharge Planning Process.

Suggested competencies for staff will include:

* Licensed Nurse(s):
  + Assessment Process
  + Person-Centered Care Plan
  + Oversee Implementation
  + Discharge Planning
  + Discharge Teaching
  + Demonstration/Evaluation
  + Documentation
  + Communication
* CNA’s:
  + Implementation of person-centered care plan interventions
  + Communication
  + Implementation of care plan interventions
  + Documentation and reporting of weight/vital signs
  + Identification and reporting of change of condition
* Interdepartmental Employees per facility policy
* Documentation
* Communication

**F-Tag Reference General Information**

Examples of (Federal) F tags that could be cited during a survey inspection that are related to transition of care and discharge planning include:

* F552: Right to be Informed and Make Treatment Decisions
* F553: Participate in Care Plan
* F561: Advance Directives
* F578: Right to Refuse
* F580: Notification of Change
* F624: Orientation for Transfer or Discharge
* F644: PASARR Coordination
* F658: Professional Standards
* F659: Care Provided by Qualified Persons
* F660: Discharge Planning
* F725: Sufficient Nursing Staff
* F745: Medically Related Social Services
* F756: Drug Regimen Review
* F841: Medical Director
* F842: Resident Records
* F865: QAA/QAPI

**Link to Critical Element Pathway**

Use the Discharge Critical Element (CE) Pathway[[5]](#footnote-5), along with the interpretive guidelines when determining if the facility meets the requirements for providing care and services for a resident receiving hospice services, in accordance with professional standards of practice, and the comprehensive person-centered hospice/facility care plan.

**Resources and References**

Centers for Medicare & Medicaid Services. State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf>

Centers for Medicare & Medicaid Services. Long Term Care Critical Element Pathways: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>

Centers for Medicare and Medicaid Services, EHR Incentive Program. Transition of Care: <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/8_Transition_of_Care_Summary.pdf>

Medicaid.gov. Improving Care Transitions: <https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/care-transitions/index.html>

1. Centers for Medicare and Medicaid Services, EHR Incentive Program. Transition of Care: <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/8_Transition_of_Care_Summary.pdf> [↑](#footnote-ref-1)
2. Medicaid.gov. Improving Care Transitions: <https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/care-transitions/index.html> [↑](#footnote-ref-2)
3. ,4 Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-3)
4. [↑](#footnote-ref-4)
5. [↑](#footnote-ref-5)