**Transition Care**

**Competency**

Leader’s Guide

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**Leader’s Guide**

A successful transition of care program requires a solid process, best practice systems, educated and competent staff, a robust communication structure, resident/resident representative involvement, comprehensive documentation and follow up to ensure success.

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.

The purpose of the program is to provide a successful transition of the client/resident into the community that meets his/her needs.

Oversight of the Transition of Care program involves a policies, procedures or protocols that includes the following:

1. Begin transition planning during the preadmission process. Designated facility personnel will gather the appropriate information:
	1. Prior living setting,
	2. Planned transition destination,
	3. Assistance needs after discharge from the skilled nursing facility.
2. Collect additional information upon admission
	1. Identify the residents/clients post-transition needs,
	2. Begin the process of identifying existing barriers to transition
	3. Document information about the transition needs.
3. Plan, coordinate, and implement the steps necessary to achieve goals and eliminate barriers to transition.
4. Involve the client/resident and resident representative to participate in transition planning through the participation in the interdisciplinary progress meetings.
5. Determine readiness for transition from the facility to next level of care when the client/resident has met one or more of the following criteria.

Organizational Leaders will need to ensure competency of all staff members involved with transition care/discharge planning. Adequate resources for transition care/discharge planning will need to be evaluated including:

* Staff
	+ Case Manager
	+ Licensed Nurses
	+ CNA’s
	+ Interdisciplinary Staff
* Documentation Considerations
	+ Paper vs. Electronic Health Record
	+ Assessment/documentation Forms
	+ Care Planning
	+ Hospital/Community
* Education
	+ Licensed Nurses
	+ CNA’s
	+ Interdisciplinary Staff
* Evaluation and Monitoring
	+ Identification of Responsibility
	+ System to Evaluate
	+ QAPI Considerations
* Supplies and Equipment

**References and Resources**

* 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>
* Transitions of Care in LTC Continuum [http://www.amda.com](http://www.amda.com/)