CONSONUS
HEALTHCARE

Safe Transition Planning – Experts Driving Outcomes

DESCRIPTION

The updated regulations that occurred in November 2016 have specific requirements for long term care facilities participating in Medicare and Medicaid programs. Included in those rules are updated requirements for transfer and discharge. Facilities have long transferred and discharged residents to other nursing homes, or communities. The new updates require that a facility begin safe transfer and discharge transitions soon after admission and that those transitions be initiated through conversations with the resident and/or their responsible parties through person centered discharge goals and care planning into the community. These goals and discussions are the basis for the requirement of facilities being active partners in effective transitions, reducing hospital readmissions and providing safe post discharge care in the communities.

With a combined LTC experience of over 60 years, the presenters will review the rules of participation related to transfer and discharge. They will discuss the facilities' responsibility in person centered care plan development, documentation requirements, notice of transfer and discharge requirements to the State Ombudsman. Attendees will be provided with specific examples of facilities facing difficult transfer and discharge transitions, tools for transfer and discharge care plan, documentation practices and a review of Quality Measure data analytics driven by the IMPACT act of 2014.

LEARNING OBJECTIVES

1. Identify new discharge planning requirements of participation
2. Describe the Safe Transition Planning Patient/Family Meetings.
3. Implement a Master Transition Planning Calendar.
4. Evaluate Outcome Data for Post-Acute Care