**PURPOSE OF THIS FORM**

The purpose of this form is for the *I-SNP Primary Care Team* to capture key quality steps and details associated with any I-SNP member *transition* within a full ***transition episode***. A ***transition episode*** starts when the member transitions from their residence and ends when the member transfers back to their permanent place of residence.

This information will be shared with UCare Clinical Services Team for audit purposes validating that transition best practices processes are in place.

**COMPLETE TRANSITION EPISODE SUMMARY**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **TRANSITION 1** | **TRANSITION 2** | **TRANSITION 3** |
| **TRANSITION DATE** | **\_\_\_/\_\_\_/\_\_\_** | **\_\_\_/\_\_\_/\_\_\_** | **\_\_\_/\_\_\_/\_\_\_** |
| **DEPARTING FACILITY** |  |  |  |
| **ADMITTING FACILITY** |  |  |  |

**I-SNP MEMBER DEMOGRAPHICS**

|  |  |
| --- | --- |
| **Member Name** |  |
| **Member Date of Birth** |  |
| **Member ISNP Health Plan Name** |  |
| **Member ISNP Health Plan Number** |  |

**I-SNP PROVIDER DEMOGRAPHICS**

|  |  |
| --- | --- |
| **I-SNP Agency/Provider Group Name** |  |
| **Care Coordinator Name** |  |
| **Care Coordinator Contact Number** |  |
| **Primary Care Provider (PCP) Name****(e.g. MD, NP)**  |  |
| **PCP Contact Number****(e.g. MD, NP)** |  |

**TRANSITION LOGISTICS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Transition #1 Date:** | **\_\_\_\_/\_\_\_\_/\_\_\_\_** | **Notification Date:** |  | **Transition Day and Time:** |  |
| **Departing Facility**Member leaving from… |  | **Departing Facility Type\*** |  |
| **Receiving Facility**Member arriving to… |  | **Receiving Facility Type\*** |  |

\*Facility Types: Nursing Facility: **NF** Assisted Living Facility: **ALF** Hospital: **HP** Transitional Care Unit: **TCU** Other Facility: **OF**

**Was the transition planned?** [ ]  YES [ ]  NO

|  |  |  |  |
| --- | --- | --- | --- |
| **Transition, Admitting or Presumed Diagnosis** |  | **Symptoms that lead to transition** |  |

**CARE COORDINATOR TASKS**

|  |  |  |
| --- | --- | --- |
| **TASK** | **DATE DONE** | **Notes: Include NAME/TITLE OF PERSON** **SPOKEN WITH** |
| **Connect with discharging facility to gather information and assist with transition.**  | **\_\_\_\_/\_\_\_\_/\_\_\_\_** |  |
| **Contact member/representative to discuss transition, member health and plan of care.** *This must be within 1 business day of notification.*  | **\_\_\_\_/\_\_\_\_/\_\_\_\_** |  |
| **Notify PCP of hospital admission.** *This must be within 1 business day of notification.* | **\_\_\_\_/\_\_\_\_/\_\_\_\_** | [ ]  **Phone** [ ]  **EMR**[ ]  **Fax** [ ]  **Other:** |
| **Contact receiving facility (hospital, TCU, SNF etc.) to introduce yourself as CC, assert participation in discharge planning and sharing of plan of care.** *This must be within 1 business day of notification.* | **\_\_\_\_/\_\_\_\_/\_\_\_\_** |  |

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| --- | --- | --- | --- | --- | --- |
| **Transition #2 Date:** | **\_\_\_\_/\_\_\_\_/\_\_\_\_** | **Notification Date:** |  | **Transition Day and Time:** |  |
| **Departing Facility**Member leaving from… |  | **Departing Facility Type\*** |  |
| **Receiving Facility**Member arriving to… |  | **Receiving Facility Type\*** |  |

\*Facility Types: Nursing Facility: **NF** Assisted Living Facility: **ALF** Hospital: **HP** Transitional Care Unit: **TCU** Other Facility: **OF**

**Was the transition planned?** [ ]  YES [ ]  NO

**Is this the usual care setting?** [ ]  YES [ ]  NO

**CARE COORDINATOR TASKS (complete if member has *NOT*****returned to** **usual care setting)**

|  |  |  |
| --- | --- | --- |
| **TASK** | **DATE DONE** | **Notes: Include NAME/TITLE OF PERSON** **SPOKEN WITH** |
| **Contact member/representative to discuss transition, member health and plan of care.** *This must be within 1 business day of notification.*  | **\_\_\_\_/\_\_\_\_/\_\_\_\_** |  |
| **Notify PCP of admission.** *This must be within 1 business day of notification.* | **\_\_\_\_/\_\_\_\_/\_\_\_\_** | [ ]  **Phone** [ ]  **EMR**[ ]  **Fax** [ ]  **Other:** |
| **Contact receiving facility (hospital, TCU, SNF etc.) to introduce yourself as CC, assert participation in discharge planning and sharing of plan of care.** *This must be within 1 business day of notification.* | **\_\_\_\_/\_\_\_\_/\_\_\_\_** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Transition #3 Date:** | **\_\_\_\_/\_\_\_\_/\_\_\_\_** | **Notification Date:** |  | **Transition Day and Time:** |  |
| **Departing Facility**Member leaving from… |  | **Departing Facility Type\*** |  |
| **Receiving Facility**Member arriving to… |  | **Receiving Facility Type\*** |  |

\*Facility Types: Nursing Facility: **NF** Assisted Living Facility: **ALF** Hospital: **HP** Transitional Care Unit: **TCU** Other Facility: **OF**

**Was the transition planned?** [ ]  YES [ ]  NO

**Is this the usual care setting?** [ ]  YES [ ]  NO

**TRANSITION ANALYSIS**

**Do you think this transition could have been prevented?** [ ] YES [ ] NO

If yes, how? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The transition was influenced by:** [ ]  Provider Availability [ ]  Patient/Family [ ]  Off Hours [ ]  Facility issues

**CARE COORDINATOR TASKS**

* **COMPLETE WHEN MEMBER RETURNS TO USUAL CARE SETTING**

|  |  |  |  |
| --- | --- | --- | --- |
| **TASK** | **DATE DONE** |  | **NOTES** |
| **Contact member/representative. Discuss transition process, changes to member health, plan of care ,education about transitions and how to prevent unplanned transitions/readmissions.** *This must be within 1 business day of notification.* | **\_\_\_\_/\_\_\_\_/\_\_\_\_** | **Four Pillars for Optimal Transition** | *If not within 1 business day, note reason here.* |
| **Schedule/confirm the PCP follow up appointment within 7 days of discharge.** | **\_\_\_\_/\_\_\_\_/\_\_\_\_** | **DATE OF APPOINTMENT****\_\_\_\_/\_\_\_\_/\_\_\_\_** |  |
| **Schedule/confirm any recommended specialist appointments within 14 days.** | **\_\_\_\_/\_\_\_\_/\_\_\_\_** | **DATE OF APPOINTMENT****\_\_\_\_/\_\_\_\_/\_\_\_\_** |  |
| **Convene the Interdisciplinary Care Team (ICT), telephonically or in person, within 30 days of post discharge.** | **\_\_\_\_/\_\_\_\_/\_\_\_\_** | **DATE OF APPOINTMENT** **\_\_\_/\_\_\_\_/\_\_\_\_** |  |
| **Complete a medication review or reconciliation.** | **\_\_\_\_/\_\_\_\_/\_\_\_\_** |  |  |
| **Is there an appropriate medication management system in place to ensure adherence to the medication regimen?**  | **\_\_\_\_/\_\_\_\_/\_\_\_\_** | [ ]  YES [ ]  NO |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **TASK** | **DATE DONE** |  | **NOTES** |
| **Is member able to verbalize signs and symptoms (red flags) to watch for and know how to respond?** | **\_\_\_\_/\_\_\_\_/\_\_\_\_** | [ ]  YES [ ]  NO**Four Pillars for Optimal Transition** |  |
| **Does member use a personal healthcare record? If yes, review with member.** *Check “YES” if visit summary, discharge summary, and/or healthcare summary are being used as a PHR.*  | **\_\_\_\_/\_\_\_\_/\_\_\_\_** | [ ]  YES [ ]  NO**Four Pillars for Optimal Transition** |  |
| **Update the IPOC to include transition dates, changes in member’s status or goals related to change of condition as applicable**. | **\_\_\_\_/\_\_\_\_/\_\_\_\_** | [ ]  YES [ ]  NO[ ]  NA |  |

Additional Comments/Notes:

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