UCare I-SNP Transition of Care Log

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 (M-F) 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 (M-F) 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 (M-F) 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**

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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 updates, 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 discharge.	____/____/____	**DATE OF APPOINTMENT** ____/____/____	
Complete a medication review and 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**	

Additional Comments/Notes: