TRANSITION OF CARE (TOC) SCENARIOS		
SCENARIO	TOC LOG YES/NO	NOTES
Care Coordinator (CC) notified of member hospitalization on 12/1 via MnEAS/DAR on 12/3.	Yes	Notification date is 12/3. TOC activities are initiated in 1 business day of notification date.
On 12/4, member contacted the CC about being sent home from hospital on 12/3. This is the CC's first notification of this hospitalization.	Yes	Date of notification is 12/4. Notifying receiving setting may be NA. All other steps of TOC log are completed.
CC reviews MnEAS/DAR and sees member was in the Emergency Room (ER) on 12/3.	No	ER use does not require a TOC log. Awareness of ER use and CC intervention may benefit members who have multiple ER visits or poorly managed conditions.
CC notified of member admitted to hospital on 12/3, then transfers to nursing home on 12/6, then returns home on 12/27.	Yes	Three TOC log entries for this scenario. Home > Hospital **(1),** Hospital > SNF **(2),** SNF > Home **(3).**
Member is seen for outpatient procedure. CC reviews MnEAS/DAR and sees the members outpatient status noted.	No	CC should be involved in member care needs as part of care coordination. TOC log not required.
Member shares a discharge plan to move to Intensive Residential Treatment Services (IRTS) post inpatient mental health hospitalization.	Yes	Complete final TOC lob with 4 pillars when going to IRTS. Care Coordinator to support member when they return home to ensure needs are met. Document in member record CC activities.
Member is admitted to substance use disorder (SUD) treatment facility on 12/4.	Yes	CC will need an ROI from member to disclose SUD information to PCP. May share other medical information with PCP (ie: illness/accident/injury etc.) If no ROI on file, complete all other tasks. Post SUD treatment completion f/u with mental health provider recommended.
Member goes from home (aka usual setting) to long term care setting/nursing home.	No	This is one permanent setting to a new permanent setting. CC support recommended.
Member is on UCare [MSC+ / Connect] and is admitted to hospital on 2/1 then discharged to home 2/4.	Optional	MSC+ and Connect do not require use of the TOC log. CC is required to f/u with member upon member's return to usual care setting to assist as needed and ensure a smooth transfer home. See requirements grid.
Member moves from one assisted living to new assisted living with memory care.	No	CC support recommended.
Member moves from Intensive Care Unit (ICU) to Medical Surgery Unit within the same hospital care system.	No	TOC log not required within the same hospital setting, except for Swing Bed transition (see example below).
Member is in the hospital and is transitioned to Swing bed (TCU in hospital) in the same facility.	Yes	Because this is a TCU admission, TOC would be completed, even if within the same facility.

Member has a planned move from current home to long term care setting/nursing home or assisted living permanently.	No	Consider if a change in condition reassessment is needed. CC support recommended.
Member completes rehabilitation and is discharged from Transitional Care Unit (TCU) and transferred to long term care setting/nursing home bed in same facility.	Yes	Close out TOC by completing the 4 pillars if no plan of discharge in sight. If temporary, follow member closely and complete final log when new permanent residence is determined. Use professional judgement.
Member moves from TCU to long term care setting/nursing home in a different facility.	Yes	Complete TOC log to coordinate care transition.
Member is discharged from Hospital X and admitted to Hospital Y on the same day.	Yes	TOC log needed continue care coordination/communicate with receiving setting and other tasks.
Member plans a move from long term care setting/nursing home (current permanent residence) to community (new permanent setting).	No	No prior hospitalization. CC support recommended.
Member moves from one assisted living home to new assisted living home.	No	No prior hospitalization. Care coordination support recommended.
Member is seen in the ER then admitted to hospital.	Yes	TOC log starts with hospitalization (would consider this from home to hospital).
Member is seen in the ER and then returns home on the same day.	No	Visits to the ER that do not result in hospitalization do not require a TOC log. Care Coordinator education/support/interventions based on member needs and CC judgement. Document in chart.
Member discharged from Hospital ABC to Long Term Acute Care Hospitalization (LTACH).	Yes	Continue TOC logs until member returns to usual care setting.
Member is admitted on a 72-hour hold, then admitted to the psych unit of the hospital.	Yes	If noted as inpatient, TOC log is required. If noted as “observation/outpatient”, CC support is recommended.