

Transition of Care (TOC) Log Instructions

General Instructions:

- This log can be used to document multiple transitions.
- The minimum requirements for Care Coordinator (CC) follow up *directly with the member or designated representative* is upon discharge to usual care setting. However, it is best practice that the CC reach out to the member or designated representative upon notification of admission and as needed throughout the transitions to explain the general transition process, discuss changes to the member’s health status and plan of care. The only outreach attempts to the member/designated representative that needs to be documented on the TOC log is described in #15 below.
- Communication tasks should be completed by the CC regardless of the setting (i.e., nursing home)
- Communication tasks are to be completed by the Care Coordinator **within one (1) business day of notification of each transition.**
 - For situations when the Care Coordinator is notified of the discharge back to the usual care setting *prior to* the date of discharge, the Care Coordinator must follow up with the member or designated representative to confirm that discharge actually occurred and discuss TOC tasks outlined in #15 through #20 below.
- In the date fields, document date of completion or date of first attempt. If attempted and not completed, address in comment sections.
- Planned transitions—If Care Coordinator (CC) is involved in pre-planning for a scheduled hospitalization, the TOC tasks outlined below are still required throughout the transitions.
- If CC finds out about the transition 15 days or more after the member has returned to their usual care setting, no log is required. However, CC should reach out to the member to discuss the transition process, potential changes to the member’s health status and plan of care, and document it in their case notes.

Item	Instructions
Header	
1. Member Name	• Enter member’s full name.
2. MCO Name	• Enter the member’s health plan name.
3. Product	• Enter the type of plan. (e.g. MSHO, MSC+, SNBC)
4. MCO/Health Plan Member ID#	• Enter the member number used within the health plan.
5. Care Coordinator Contact	• Enter the care coordinator name.
6. Agency/County/Care System	• Enter the care coordinator’s agency, county, or care system.
Transition #1 Information	
7. Notification Date	• Enter the date you or your agency was first notified of the transition.
8. Transition Date	• Enter the date the member moved from one care setting to another. If date not known, document “unknown” for this item.

9. Transition From	<ul style="list-style-type: none"> Enter the type of care setting the member transitioned from: e.g. home, assisted living, hospital, skilled nursing facility (SNF), transitional care unit (TCU)/rehabilitation facility, mental health or chemical dependency residential treatment. Check the appropriate box to indicate whether this is the member's usual care setting.
10. Transition To	<ul style="list-style-type: none"> Enter the type of care setting the member transitioned to: e.g. hospital, SNF, TCU/rehabilitation facility, mental health or chemical dependency residential treatment.
11. Transition Type	<ul style="list-style-type: none"> Check the appropriate box to indicate whether the transition was planned or unplanned. Planned transitions include elective surgery, planned move to a SNF, etc. Unplanned transitions include an unscheduled hospitalization, an unscheduled move to a SNF, etc.
12. Reason for Admission	<ul style="list-style-type: none"> Include a brief note explaining the reason for admission: e.g. hospital admission due to [reason]; change in current health status.
Communication Tasks (To be completed by the Care Coordinator within one (1) business day of notification of transition)	
13. Share care plan with receiving setting, or if applicable, home care agency.	<ul style="list-style-type: none"> Receiving setting includes: e.g. home, assisted living, hospital, SNF, TCU/rehabilitation facility, mental health or chemical dependency residential treatment. Enter the date care plan was shared with the receiving setting. The care plan may include the Collaborative Care Plan (CCP) or summary, the hospital/SNF discharge instructions, etc. If CC finds out about the transitions after they have already discharged from that setting, document n/a in this date field with a brief explanation in the comments section. If the transition is a return to the usual care setting with no services, document N/A in this date field with a brief explanation in the comments section. Relevant information (current services, informal supports, advance directives, medication regimen, CC contact information, etc.) may be communicated via phone, fax, secure e-mail or in person.
14. Notify primary care provider (PCP).	<ul style="list-style-type: none"> Enter the date the member's PCP was notified and check the box as to the method of notification: e.g. fax, phone call, secure e-mail or communication via electronic medical record (EMR). If the member's PCP was the admitting physician, check the appropriate box and enter not applicable (N/A) for date completed.
Transition #2 and, if applicable, Transition #3 Note: Start a new log if there are additional	<p>Complete these sections for subsequent transitions within one (1) business day of notification of each transition.</p> <ul style="list-style-type: none"> Enter the information as outlined in steps 7-12. Complete communication tasks as outlined in steps 13 and 14. *Asterisks' indicates that there are additional tasks required when the transition is a return to the usual care

<p>transitions that occur before return to the usual care setting.</p>	<p>setting. If so, complete tasks as outlined in steps 15-21. This includes situations where it may be a ‘new’ usual care setting for the member. (i.e., a community member who decides upon permanent nursing home placement)</p> <ul style="list-style-type: none"> • If this transition is not a return to the usual care setting, no need to complete the additional asterisks tasks until they return to usual care setting. CC should stay involved as needed throughout the next transition(s).
--	--

****This section should be completed only when the member discharges TO their usual care setting within one (1) business day of notification. For situations where the Care Coordinator is notified of the discharge prior to the date of discharge, the Care Coordinator must follow up with the member or designated representative to confirm discharge and discuss TOC tasks outlined below. This includes situations where it may be a ‘new’ usual care setting for the member. (i.e., a community member who decides upon permanent nursing home placement)***

<p>15. Communicate with member or responsible party</p>	<ul style="list-style-type: none"> • Enter the date of the discussion with the member/designated representative about the transition process and changes to the member’s health status and care plan. • During the transition, it is expected that the care coordinator explains the transition process and provides contact information for additional support. The transition process includes identifying at-risk members, communicating and helping the member to plan and prepare for transitions, and follow-up care after the transition. • Communication should include an update of known medication changes, durable medical equipment (DME) products required, services needed, etc., resulting from a change in the member’s health status. • Provide education related to prevention of readmission and future unplanned care transitions: e.g. readmission to a nursing home, rehospitalization. • Discussion can include but is not limited to talking about reducing fall risk, improving medication management, improving nutritional intake, additional services, advance care planning, etc.
--	--

Discuss Four Pillars for Optimal Transition Check “Yes” - if the member, designated representative and/or SNF/facility staff manages the following:

<p>16. Follow-Up Appointment</p>	<ul style="list-style-type: none"> • Indicate whether member has a scheduled follow-up appointment, ideally within fifteen (15) days of discharge. Or within 7 days if hospitalized for mental health. Suggested questions include: <ul style="list-style-type: none"> ✓ When is your follow-up appointment? ✓ How are you getting to your appointment? • Assist with making the appointment if necessary. • Stress the importance of keeping appointment and address potential barriers.
----------------------------------	---

17. Medication Self-Management	<ul style="list-style-type: none"> • Determine whether member/designated representative have an understanding of current medication regimen. Suggested questions include: <ul style="list-style-type: none"> ✓ Do you have all of your current medications? ✓ What changes were made to your medications? ✓ How do you get your medication from the pharmacy? ✓ How do you remember to take them? ✓ Do you need help with setting up or taking your medications? ✓ What questions do you have about your medications? ✓ Assess need for referral to home health services or Medication Therapy Management Services (MTMS) if eligible.
18. Knowledge of Warning Signs	<ul style="list-style-type: none"> • Indicate whether the member/designated representative are aware of symptoms that indicate problems with healing or recovery. Suggested questions include: <ul style="list-style-type: none"> ✓ What are the warning signs that might indicate you are having a problem with healing or recovery? ✓ What should you do if these symptoms appear? ✓ Who do you call if you have questions or concerns? ✓ Do you have those phone numbers readily available? (Consider this a possible lead-in to the discussion about personal health care records).
19. Personal Health Care Record	<ul style="list-style-type: none"> • Indicate whether member/designated representative use a personal health care record for tracking health history and current regimens. <i>Check “Yes” if visit summary, discharge summary, and/or healthcare summary are being used as a PHR.</i> Suggested talking points include: <ul style="list-style-type: none"> ✓ Point out the advantages of having an organized account of personal health information. ✓ Explain that this is a good place to record their medical history, allergies, medications, visits, test results, immunizations and hospitalizations. ✓ Encourage member to bring this record to their provider appointments and to write down questions for their health care team.
Update the members care plan	
20. Care Plan Update	<ul style="list-style-type: none"> • Indicate whether the member’s care plan has been updated following this transition. <ul style="list-style-type: none"> ○ If yes, the changes that were made need to be documented on the care plan. ○ If no, document reason in the comments. For example; the member returned to previous level of function; or care plan is done by staff at institutional care setting (such as nursing home, ICF, etc.).

	<ul style="list-style-type: none"> • Be sensitive to the member's concerns and goals. Incorporate them into the care plan when possible. • Address newly identified medical issues. Example: increased fall risk.
--	---

1 Member Name:	2 MCO Name:	3 MCO/Health Plan Member ID#:
4 Product:	5 Care Coordinator Contact:	6 Agency/County/Care System:

Transition Communication Actions from Care Management Contact

Transition #1

7 Notification Date:	8 Transition Date:	9 Transition From: (Type of care setting) Is this the member's usual care setting? <input type="checkbox"/> Yes <input type="checkbox"/> No	10 Transition To: (Type of care setting)
-----------------------------	---------------------------	---	---

11 Transition Type: Planned Unplanned
12 Reason for Admission/Comments:

13 Shared CC contact info, care plan/services with receiving setting—Date completed:

14 Notified PCP of transition—Date completed: via Fax Phone EMR Secure e-mail (OR) Member's PCP was the Admitting Physician

Transition #2

Transition #3 (if applicable)

7 Notification Date:
10 Transition To: (Type of care setting)*
8 Transition Date: _____ **11** Transition Type: Planned Unplanned
14 Notified PCP—Date completed: _____
13 Shared CC contact info, care plan/services with receiving setting or, if applicable, home care agency—Date completed: _____
 *Complete additional tasks below, if this transition is a return to usual care setting. **15** through **20**
 Comments:

7 Notification Date:
10 Transition To: (Type of care setting)*
8 Transition Date: _____ **11** Transition Type: Planned Unplanned
14 Notified PCP—Date completed: _____
13 Shared CC contact info, care plan/services with receiving setting or, if applicable, home care agency—Date completed: _____
 *Complete additional tasks below, if this transition is a return to usual care setting. **15** through **20**
 Comments:

Complete tasks below **15 through **20** when the member is discharging TO their usual care setting within one (1) business day of notification. For situations where the Care Coordinator is notified of the discharge prior to the date of discharge, the Care Coordinator must follow up with the member or designated representative to confirm that discharge actually occurred and discuss required TOC tasks as outlined in the TOC Instructions. (This includes situations where it may be a 'new' usual care setting for the member. (i.e., a community member who decides upon permanent nursing home placement following hospitalization and rehab).*

15 Date completed: _____ Communicated with member or their designated representative about the following: care transition process; about changes to the member's health status; plan of care updates; education about transitions and how to prevent unplanned transitions/readmissions
Four Pillars for Optimal Transition:

Check "Yes" - if the member, family member and/or SNF/facility staff manages the following: If "No" provide explanation in the comments section.

16 Yes No Does the member have a **follow-up appointment** scheduled with primary care or specialist? (Mental health hospitalizations—the appt. should be w/in 7 days)

17 Yes No Can the member **manage their medications** or is there a system in place to manage medications (e.g. home care set-up)?

18 Yes No Can the member verbalize **warning signs and symptoms to watch for** and how to respond?

19 Yes No Does the member use a **Personal Health Care Record**? Check "Yes" if visit summary, discharge summary, and/or healthcare summary are being used as a PHR.

20 Yes No **Have you updated the member's care plan?** If "No" provide explanation in comments.

Comments: