TRANSITION OF CARE (TOC) SCENARIOS		
SCENARIO	TOC LOG YES/NO	NOTES
The Care Coordinator (CC) notified of the member's hospitalization on 12/1 via MnEAS/DAR on 12/3.	Yes	The notification date is 12/3. TOC activities are initiated within 1 business day of the notification date.
On 12/4, the member contacted the CC about being sent home from the hospital on 12/3. This is the CC's first notification of this hospitalization.	Yes	The date of notification is 12/4. The notification receiving setting may be NA. All other steps of the 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 with multiple ER visits or poorly managed conditions.
CC was notified of the member's admission to the hospital on 12/3, then transferred to the nursing home on 12/6, then returned 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 an outpatient procedure. CC reviews MnEAS/DAR and sees the member's outpatient status noted.	No	CC should be involved in member care needs as part of care coordination. TOC log not required.
A member shares a discharge plan to move to Intensive Residential Treatment Services (IRTS) post-inpatient mental health hospitalization.	Yes	Complete the final TOC lob with 4 pillars when going to IRTS. Care Coordinator to support members when they return home to ensure their needs are met. Document in member record CC activities.
Member is admitted to a 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 (i.e.: 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 is recommended.
The member is on UCare [MSC+ / Connect] and was admitted to the hospital on 2/1 and discharged to home on 2/4.	Optional	MSC+ and Connect do not require the use of the TOC log. CC is required to follow up with the member upon the member's return to the usual care setting to assist as needed and ensure a smooth transfer home. See the requirements grid.
Member moves from one assisted living to new assisted living with memory care.	No	CC support is recommended.
Member moves from Intensive Care Unit (ICU) to Medical Surgery Unit within the same hospital care system.	No	The TOC log is not required within the same hospital setting, except for the Swing Bed transition (see the example below).

The member is in the hospital and has been transitioned to a Swing bed (TCU in the 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 the 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 is recommended.
The member completes rehabilitation and is discharged from the Transitional Care Unit (TCU) and transferred to a long-term care setting or nursing home bed in the 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 judgment.
Member moves from TCU to long-term care setting/nursing home in a different facility.	Yes	Complete the 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/communication with the 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 is recommended.
Member moves from one assisted living home to a new assisted living home.	No	No prior hospitalization. Care coordination support is recommended.
Member is seen in the ER and then admitted to the 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 judgment. Document in member's record.
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" a TOC log is required. If noted as "observation/outpatient", CC support is recommended.
The member goes from home (aka the usual setting) to the hospital. The CC reviews MnEAS/DAR and is notified of the member's outpatient status.	No	A TOC log is not required, but CC support is recommended. Based on the member's situation, use clinical judgment on follow-up.