**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**

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|  | **TRANSITION 1** | **TRANSITION 2** | **TRANSITION 3** |
| **TRANSITION DATE** | MM/DD/YYYY  Transition Date is the date the member moved from one care setting to another. If date not known, document “unknown” for this item. |  |  |
| **DEPARTING FACILITY** | Facility Name  Departing Facility is 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 substance use disorder residential treatment. |  |  |
| **ADMITTING FACILITY** | Facility Name  Admitting Facility is the type of care setting the member transitioned to e.g., hospital, SNF, TCU/rehabilitation facility, mental health or substance use disorder residential treatment. |  |  |

**I-SNP MEMBER DEMOGRAPHICS**

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| **Member Name** |  |
| **Member Date of Birth** |  |
| **Member ISNP Health Plan Name** | Member ISNP Health Plan Name- Advocate Choice or Advocate Plus |
| **Member ISNP Health Plan Number** | Member ISNP Health Plan Number: Member number used within the health plan. |

**I-SNP PROVIDER DEMOGRAPHICS**

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| **I-SNP Agency/Provider Group Name** | I-SNP Agency/Provider Group Name = Care Coordinator’s agency. |
| **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**

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| **Transition #1 Date:** | Transition #1 Date = The date the member moved from one care setting to another. If date not known, document “unknown” for this item.  MM/DD/YYYY | | **Notification Date:** | | Notification date = The date you or your agency was first notified of the transition.  MM/DD/YYYY | **Transition Day and Time:** | | Transition Day (M-F) and Time = Day of the week and the time of day the member moved from one care setting to another. If time not known, document “unknown” for this item.  Day and Time |
| **Departing Facility**  Member leaving from… | | Departing Facility = Name of facility the member transitioned from. | | **Departing Facility Type\*** | | | The type of care setting the member transitioned from e.g., hospital, SNF, TCU/rehabilitation facility, mental health or substance use disorder residential treatment.  Facility Type =  Nursing Facility: **NF**  Assisted Living Facility: **ALF**  Hospital: **HP**  Transitional Care Unit: **TCU**  Other Facility: **OF** | |
| **Receiving Facility**  Member arriving to… | | Receiving Facility = Name of facility the member transitioned to. | | **Receiving Facility Type\*** | | | The type of care setting the member transitioned from e.g., hospital, SNF, TCU/rehabilitation facility, mental health or substance use disorder residential treatment.  Facility Type =  Nursing Facility: **NF**  Assisted Living Facility: **ALF**  Hospital: **HP**  Transitional Care Unit: **TCU**  Other Facility: **OF** | |

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

**Was the transition planned? ☐** YES  NO 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

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| **Transition, Admitting or Presumed Diagnosis** | Transition, Admitting or Presumed Diagnosis = Hospital admission due to [reason]. | **Symptoms that lead to transition** | Symptoms that lead to transition = Include notes from conversations with the member, provider, receiving and/or discharging facilities as applicable. |

**CARE COORDINATOR TASKS**

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| --- | --- | --- |
| **TASK** | **DATE COMPLETED** | **Notes: Include NAME/TITLE OF PERSON**  **SPOKEN WITH** |
| **Contact usual setting to gather information and assist with transition.** *This must be within 1 business day of notification.* | MM/DD/YY | Contact Usual Setting = what were signs or symptoms leading up to the transition, are there any concerns or requirements in returning to facility after health stabilizes |
| **Contact member/representative to discuss transition, member health and plan of care.** *This must be within 1 business day of notification.* | MM/DD/YY | Contact member/family = Enter the date of the discussion with the member/responsible party about the transition process and changes to the  member’s health status and support 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.  o 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. |
| **Notify PCP of transition.** *This must be within 1 business day of notification.* | MM/DD/YYYY  Notify PCP of transition = Enter the date the member’s PCP was notified and check the box as to the method of notification: e.g., fax, phone call, or  communication via electronic medical record (EMR).  • If the member’s PCP was the admitting physician, check "other" and make note of that. | **Phone  EMR**  **Fax  Other:** |
| **Contact receiving setting (hospital, TCU, SNF etc.) to introduce yourself as CC, assert participation in discharge planning and sharing the plan of care.** *This must be within 1 business day of notification.* | MM/DD/YYYY | Contact receiving setting = Receiving setting includes e.g., home, assisted living, hospital, SNF, TCU/rehabilitation facility, mental health or substance  use disorder residential treatment.  • Enter the date the plan of care was shared with the receiving setting.  • Plan of care 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. |

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| **Transition #2 Date:** | MM/DD/YYYY  Transition #2 = complete this section when member transitions to next location. | | **Notification Date:** | | MM/DD/YYYY | **Transition Day and Time:** | | Day & 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)**

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| --- | --- | --- |
| **TASK** | **DATE COMPLETED** | **Notes: Include NAME/TITLE OF PERSON**  **SPOKEN WITH** |
| **Contact discharging setting to gather information and assist with transition.** *must be within 1 business day of notification.* | MM/DD/YYYY | Connect with discharging setting = what were signs or symptoms leading up to the transition and concerns, reason for the transition ect. |
| **Contact member/representative to discuss transition, member health and plan of care.** *This must be within 1 business day of notification.* | MM/DD/YYYY | Contact member/family within 1 business day of discharge = Enter the date of the discussion with the member/responsible party about the transition process and changes to the member’s health status and individual plan of care.  • 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. |
| **Notify PCP of transition.** *This must be within 1 business day of notification.* | Notify PCP of transition = Enter the date the member’s PCP was notified and check the box as to the method of notification: e.g., fax, phone call, or  communication via electronic medical record (EMR).  • If the member’s PCP was the admitting physician, check "other" and make note of that.  MM/DD/YYYY | **Phone  EMR**  **Fax  Other:** |
| **Contact receiving setting (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.* | MM/DD/YYYY | Contact receiving setting = Receiving setting includes e.g., home, assisted living, hospital, SNF, TCU/rehabilitation facility, mental health or substance  use disorder residential treatment.  • Enter the date the plan of care was shared with the receiving setting.  • Plan of care 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. |

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| **Transition #3 Date:** | Transition #3 = Complete if applicable.  MM/DD/YYYY | | **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)**

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| --- | --- | --- |
| **TASK** | **DATE COMPLETED** | **Notes: Include NAME/TITLE OF PERSON**  **SPOKEN WITH** |
| **Contact discharging setting to gather information and assist with transition.** *must be within 1 business day of notification.* |  |  |
| **Contact member/representative to discuss transition, member health and plan of care.** *This must be within 1 business day of notification.* |  |  |
| **Notify PCP of transition.** *This must be within 1 business day of notification.* |  | **Phone  EMR**  **Fax  Other:** |
| **Contact receiving setting (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 ANALYSIS**

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

If yes, how? Do you think the transition could have been prevented = Answer this from Care Coordinator's perspective.

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

**\*CARE COORDINATOR TASKS**

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

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| **TASK** | **DATE COMPLETED** |  | **NOTES** |
| **Notify PCP of transition back to usual setting.** *This must be within 1 business day of notification* | MM/DD/YYYY |  | Notify PCP of hospital admission = Enter the date the member’s PCP was notified and check the box as to the method of notification: e.g., fax, phone call, or  communication via electronic medical record (EMR).  • If the member’s PCP was the admitting physician, check "other" and make note of that. |
| **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.* | MM/DD/YYYY |  | Contact member/family within 1 business day of discharge = Enter the date of the discussion with the member/responsible party about the transition process and changes to the member’s health status and individual plan of care.   * 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.   *If not within 1 business day, note reason here.* |
| **Convene the Interdisciplinary Care Team (ICT), telephonically or in person, within 30 days of post discharge to member’s usual setting.** | MM/DD/YYYY |  | Convene the ICT, via telephone or in person, within 30 days of discharge = ICT discussion to address goals, symptom management, medication management, review of monitoring schedule and engagement of involved caregivers. Update IPOC with any changes. |
| **Update the IPOC to include transition dates, changes in member’s status or goals related to change of condition as applicable**. |  | YES  NO | Update the IPOC= update existing goals that pertain to the transition. New goals may also be created |
| **Complete a medication review or reconciliation.** | MM/DD/YYYY |  | Complete a medication review and reconciliation = The CC will verify and document that the medication reconciliation has  addressed any omissions, duplications, dosing concerns, drug interactions, side  effects or compliance issues that may lead to an adverse medication event. The  CC will collaborate with the PCP for any needed adjustments. |

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| **Four Pillars for Optimal Transition** | | | |
|  | **DATE CARE COORDINATOR COMPLETED** |  | **NOTES- If answer is “No” provide an explanation here** |
| **Schedule/confirm that the member has a follow-up appointment scheduled 7 days of discharge with** p**rimary care, or a specialist within 14 days** | YES  NO  MM/DD/YYYY | **DATE OF APPOINTMENT**  MM/DD/YYYY | Schedule the PCP follow up appointment = Schedule/confirm member has a PCP follow-up appointment, ideally within 7 days (with a mental health practitioner if hospitalized for mental health). Schedule specialist appointment if necessary and if applicable.  Suggested questions include:   * 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. |
| **Is there an appropriate medication management system in place to ensure adherence to the medication regimen?** |  | YES  NO | Is there an appropriate medication management system in place to ensure adherence to the medication regimen = Yes/no and note additional details regarding medication management.  Suggested questions:   * How do you get your medications 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? |
| **Is member able to verbalize signs and symptoms (red flags) to watch for and know how to respond?** |  | YES  NO | Is member able to verbalize signs and symptoms = Yes/no and indicate whether the member/responsible party is aware of symptoms that indicate problems with healing or recovery.   * Suggested questions include: * 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 possible lead-in to the discussion about personal health care records). |
| **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 | Does member use a personal healthcare record = Indicate whether member/responsible party uses a personal health care record for tracking health history and current regimens.  Check “Yes” if visit summary, discharge summary, and/or healthcare summary are being used as a PHR.  Suggested talking points include:   * 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. |

Additional Comments/Notes:

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