Transition of Care (TOC) Log Instructions

General Instructions:

- This log can be used to document multiple transitions.
- **Communication tasks must be completed regardless of the setting (i.e., nursing home, hospital, or treatment facility).**
- Communication tasks are completed **within 1 business day of notification of each transition.**
- In the date fields, document date of completion or date of first attempt. If attempted and not completed, address in comment sections.
- Planned transitions: When care coordination is involved in pre-planning for a scheduled hospitalization, the TOC tasks outlined below are required.
- Notifications of transitions 15 days or more after the member has returned to their usual care setting do not require a TOC log. However, the care coordinator should reach out to the member to discuss the transition process, potential changes to the member's health status and support plan, and document it in their case notes.

Item	Instructions
Header	**Enter the:**
1. Member Name	Member's full name
2. Health Plan Name	Member's health plan name
3. Product	Type of plan. (e.g., MSHO, MSC+, SNBC)
4. Health Plan Member ID#	Member number used within the health plan
5. Care Coordinator Contact	Care coordinator name
6. Agency/County/Care System	Care coordinator's agency, county, or care system
Transition #1 Information	
7. Notification Date	The date you or your agency was first notified of the transition.
8. Transition Date	The date the member moved from one care setting to another. If date not known, document "unknown" for this item.
9. Transition From	Type of care setting the member transitioned from: e.g., assisted living, hospital, skilled nursing facility (SNF), transitional care unit (TCU)/rehabilitation facility, mental health or substance use disorder residential treatment. Check the appropriate box to indicate whether this is the member's usual care setting.
10. Transition To	The type of care setting the member transitioned to e.g., hospital, SNF, TCU/rehabilitation facility, mental health or substance use disorder residential treatment.
11. Transition Type	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	Include a brief note explaining the reason for admission: e.g., hospital admission due to [reason]; change in current health status.
13. Contact member/ responsible party	Outreach to member/responsible party to provide assistance/education on CC TOC assistance – enter date completed.

Communication Tasks (To be completed by the Care Coordinator within 1 business day of notification of transition)	
14. **Share** relevant support plan information with receiving setting.	• Receiving setting includes home when home care services are in place, assisted living, hospital, SNF, TCU/rehabilitation facility, mental health or substance use disorder residential treatment. 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. • Enter the date the relevant support plan information was shared with the receiving setting. The support plan may include the support plan or summary, the hospital/SNF discharge instructions, or other relevant information. • 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.
15. Notify primary care provider (PCP).	• Enter the date the member's PCP was notified and check the box as to the method of notification: i.e., fax, phone call, 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.
16. Notes from Conversations	• Include notes from conversations with the member (or attempts to reach member), provider, receiving and/or discharging facilities as applicable.
Transition #2 and, if applicable, Transition #3, Transition #4 and Transition #5 **Note:** Start a new log if there are additional transitions that occur before return to the usual care setting.	Complete these sections for subsequent transitions. • Enter the information in steps 7-12. • Complete communication tasks in steps 13 -16. • An asterisk (*) indicates that there are additional tasks required when the transition is a return to the usual care setting. If so, complete tasks in steps 17-23. 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) • 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 when the member discharges <u>TO</u> their usual care setting. 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).	
17. Communicate with member or responsible party	• 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. ○ 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, family member and/or SNF/facility staff manages the following:*	

18. Follow-Up Appointment 18.a. – For mental health hospitalizations	• Indicate whether member has a scheduled follow-up appointment, ideally within 15 days of discharge, or within 7 days with a mental health practitioner if hospitalized for mental health. Suggested questions include: o When is your follow-up appointment? o How are you getting to your appointment? • If no, assist with making the appointment and make notes in comments/notes area of action taken.
	• Stress the importance of keeping appointment and address potential barriers.
19. Medication Self-Management	• Determine whether member/responsible party has an understanding of current medication regimen. Suggested questions include: o Do you have all your current medications? o What changes were made to your medications? o How do you get your medication from the pharmacy? o How do you remember to take them? o Do you need help with setting up or taking your medications? o What questions do you have about your medications? o Assess need for referral to home health services or Medication Therapy Management Services (MTMS) if eligible.
20. Knowledge of Warning Signs	• Indicate whether the member/responsible party are aware of symptoms that indicate problems with healing or recovery. Suggested questions include: o What are the warning signs that might indicate you are having a problem with healing or recovery? o What should you do if these symptoms appear? o Who do you call if you have questions or concerns? o Do you have those phone numbers readily available? (Consider this a possible lead-in to the discussion about personal health care records).
21. Personal Health Care Record	• Indicate whether member/responsible party use 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: o Point out the advantages of having an organized account of personal health information. o Explain that this is a good place to record their medical history, allergies, medications, visits, test results, immunizations and hospitalizations. o Encourage member to bring this record to their provider appointments and to write down questions for their health care team.
Update the member's support plan	
22. Support Plan Update	• Indicate whether the member's support plan has been updated following this transition. o If yes, the changes that were made need to be documented on the care plan. o 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.). • 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.
23. Discharge Summary Review	• Indicate whether you have reviewed the discharge summary with the member o If no, document reason in the comments • Ensure member is aware of the information in the discharge summary include any upcoming appointments

See the form on the following page.

TRANSITIONS OF CARE (TOC) LOG

TOC tasks should be completed by the CC within one (1) business day of notification of each transition. Follow up contact with member is required after return to their usual care setting. Note: If CC finds out about the transitions fifteen (15) days or more after the member has returned to their usual care setting, no TOC log is needed. However, the CC should check in with the member to discuss the transition process, any changes needed to the support plan and document it in a case note.

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? ☐ Yes ☐ No	**10.** Transition To: (Type of care setting)

11. Transition Type: ☐ Planned ☐ Unplanned

12. Reason for Admission/Comments:

13. Contact member/responsible party to assist with transition – Date completed:

14. Shared CC contact info, support plan/services with receiving setting—Date completed:

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

16. Notes from conversation with the member, provider, discharging and receiving facility (as applicable):

Transition #2,3,5,5

7. Notification Date: **10.** Transition To: (Type of care setting) * **8.** Transition Date: **11.** Transition Type: ☐ Planned ☐ Unplanned

Comments:

**Complete additional tasks below if this transition is a return to usual care setting.*

13. Contact member/responsible party to assist with transition – Date completed:

14. Shared CC contact info, support plan/services with receiving setting—Date completed:

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

16. Notes from conversation with the member, provider, discharging and receiving facility (as applicable):

Discuss Four Pillars for Optimal Transition *Check "Yes" - if the member, family member and/or SNF/facility staff manages the following:*

****Complete tasks below 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).*

17. Date completed: **Communicated with member or their designated representative about the following: care transition process; about changes to the member's health status; support plan 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.

☐ Yes ☐ No **18.** 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) For* mental health hospitalizations: ☐ Yes ☐ No **18 a.** Does the member have a **follow-up appointment** scheduled with a mental health practitioner within 7 days of discharge?