**TRANSITIONS OF CARE (TOC) LOG**

TOC tasks are completed within **one (1) business day** of notification of each transition. An ROI is required to release SUD and treatment information to providers.

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| **Member Name:** | | | **Care Coordinator:** | **UCare Member ID#:** |
| **Product:** | | **Agency/County/Care System:** | | |
| **Transition #1** | | | | |
| **Notification Date:** | **Transition Date:** | | **Transition From: (Type of care setting)**    **Is this the member’s usual care setting?**  **Yes**  **No** | **Transition To: (Type of care setting)** |
| **Transition Type:**  **Planned**   **Unplanned**  **Reason for Admission/Comments:** | | | | |
| **Contact member/responsible party to assist with transition – Date completed:** | | | | |
| **Shared CC contact info, support plan/services with receiving setting & home care agency, BHH or other case managers as applicable — Contact Name(s)/title and dates completed:** | | | | |
| **Notified PCP of transition—Date completed**:       via  Fax  Phone  EMR  Secure e-mail **(OR)**  Member’s PCP was the Admitting Physician | | | | |
| **Notes from conversation with the member, provider and receiving facility (as applicable):** | | | | |
| **Transition #2** | | | | |
| **Notification Date:**       **Transition To: (Type of care setting) \***       **Transition Date:**       **Transition Type:  Planned  Unplanned**  **Comments:** | | | | |
| **Contact member/responsible party to assist with transition – Date completed:** | | | | |
| **Shared CC contact info, support plan/services with receiving setting & home care agency, BHH or other case managers as applicable — Contact Name(s)/title and dates completed:** | | | | |
| **Notified PCP of transition—Date completed**:       via  Fax  Phone  EMR  Secure e-mail **(OR)**  Member’s PCP was the Admitting Physician | | | | |
| **Notes from conversation with the member, provider, discharging and receiving facility (as applicable):**  \**Complete additional tasks below if this transition is a return to the usual care setting.* | | | | |
| **Transition #3 (if applicable)** | | | | |
| **Notification Date:**       **Transition To: (Type of care setting) \***       **Transition Date:**       **Transition Type:**  **Planned**   **Unplanned**  **Comments:** | | | | |
| **Contact member/responsible party to assist with transition – Date completed:** | | | | |
| **Shared CC contact info, support plan/services with receiving setting & home care agency, BHH or other case managers as applicable — Contact Name(s)/title and dates completed:** | | | | |
| **Notified PCP of transition—Date completed**:       via  Fax  Phone  EMR  Secure e-mail **(OR)**  Member’s PCP was the Admitting Physician | | | | |
| **Notes from conversation with the member, provider, discharging and receiving facility (as applicable):**  \**Complete additional tasks below if this transition is a return to the usual care setting.* | | | | |
| **Transition #4 (if applicable)** | | | | |
| **Notification Date:**       **Transition To: (Type of care setting) \***       **Transition Date:**       **Transition Type:  Planned  Unplanned**  **Comments:** | | | | |
| **Contact member/responsible party to assist with transition – Date completed:** | | | | |
| **Shared CC contact info, support plan/services with receiving setting & home care agency, BHH or other case managers as applicable — Contact Name(s)/title and dates completed:** | | | | |
| **Notified PCP of transition—Date completed**:       via  Fax  Phone  EMR  Secure e-mail **(OR)**  Member’s PCP was the Admitting Physician | | | | |
| **Notes from conversation with the member, provider, discharging and receiving facility (as applicable):**  \**Complete additional tasks below if this transition is a return to the usual care setting****.*** | | | | |
| **Transition #5 (if applicable)** | | | | |
| **Notification Date:**       **Transition To: (Type of care setting) \*       Transition Date:**       **Transition Type:  Planned  Unplanned**  **Comments:** | | | | |
| **Contact member/responsible party to assist with transition – Date completed:** | | | | |
| **Shared CC contact info, support plan/services with receiving setting & home care agency, BHH or other case managers as applicable — Contact Name(s)/title and dates completed:** | | | | |
| **Notified PCP of transition—Date completed**:       via  Fax  Phone  EMR  Secure e-mail **(OR)**  Member’s PCP was the Admitting Physician | | | | |
| **Notes from conversation with the member, provider, discharging and receiving facility (as applicable):**  \**Complete additional tasks below if this transition is a return to the usual care setting.* | | | | |
| ***\*Complete tasks below when the member is discharging TO their usual care setting within one (1) business day of notification.***  If CC finds out about the transition fifteen (15) days or more after the member has returned to the usual care setting, a TOC log is not needed. However, the CC is required to follow up with the member to discuss the transition process, any changes to health status, education on preventing readmission, changes to the support plan and document the discussion in the member’s case note.  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/responsible party to confirm that discharge actually occurred and discuss required TOC tasks. This includes situations where it may be a ‘new’ usual care setting for the member. | | | | |
| **Discussion with Member/Responsible Party: Date completed:**  ***Four Pillars:***  ***To the greatest extent possible, assist members/responsible parties in ensuring the following are “YES”. If any are marked “NO” provide Comments/Notes below.***  Yes  No Does the member have afollow-up appointment scheduled within 15 days of discharge (medical) or 7 days (mental health) with p**rimary care, specialist or**  **mental health provider? *If no, assist with scheduling and ensuring that primary care is established.***  Yes  No Can the member manage their m**edications, or is there a system in place to manage medications? *If no, consider assisting with arranging support.***  Yes  No Does the member have a copy of & understand their discharge instructions? *If no, offer to assist in obtaining and contacting the PCP with questions.*  Yes  No Can the member verbalize warning signs and symptoms to watch for and how to respond? ***If no, offer to review discharge instructions with the member.***  ***Additional Discussions:***  Yes  No Has a medication review been completed with the member? *If no, consider referral to PCP, home care nurse, MTM, or pharmacist.*  Yes  No Does the member have adequate food, housing, and/or transportation? *If no, if appropriate, add a goal and offer additional supports available to the member.*  Yes  No Does the member have concerns with accessibility and/or safety in their home? *If yes, document needs and support offered.*  Yes  No Are there concerns of vulnerability, abuse, or neglect? *If yes, document concerns and actions taken by the care coordinator as a mandated reporter.*  Yes  No Education provided on preventing readmission. *Consider sharing UCare 24-hour nurse line, Mental Health Hotline, or “Where to go for Care” member handout.*  Yes  No CT+MED/MSHO: Member provided education on the benefits of LSS Healthy Transitions and anticipated outreach from program representative.  ***Support Plan Updates:***  Yes  No **Have you updated the member’s support plan?** *Add new diagnoses, medications, treatments, goals & interventions as applicable*. ***If “No,” provide an explanation in the comments.***  **Comments/Notes:** | | | | |