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**TRANSITION OF CARE (TOC) LOG**

TOC tasks should be completed by the CC within one (1) business day of notification of each transition. **TOC Log is required for ALL products.**

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| --- | --- | --- | --- | --- | --- |
| **Member Name:** Click or tap here to enter text. | | **Care Coordinator:** Click or tap here to enter text. | | **MCO/Health Plan Member ID#:** Click or tap here to enter text. | |
| **Product:** Click or tap here to enter text. | | | **Agency/County/Care System:** Click or tap here to enter text. | | |
| **Transition #1** | | | | | |
| **Notification Date:**  Click or tap to enter a date. | **Transition Date:** Click or tap to enter a date. | **Transition From: (Type of care setting)**  Click or tap here to enter text.  **Is this the member’s usual care setting? Yes**  **No** | | **Transition To: (Type of care setting)**  Click or tap here to enter text. | |
| **Transition Type:** Planned  Unplanned **Reason for Admission/Comments:** Click or tap here to enter text. | | | | | |
| **Contact member/designated representative/guardian to offer assistance with transition:** Click or tap to enter a date.  **Shared CC contact info, care plan with receiving setting—Date completed:** Click or tap to enter a date.  **Name and title of receiving setting contact:** Click or tap here to enter text. | | | | | |
| **Notified PCP of transition—Date completed**: Click or tap to enter a date. Name of PCP: Click or tap here to enter text.  Method of PCP contact: Fax Phone  EMR  Secure e-mail **(OR)** Member’s PCP was the Admitting Physician  **Comments:** Click or tap here to enter text. | | | | | |
| **Transition #2 \*Complete additional tasks below, if this transition is a return to usual care setting.** | | | | |
| **Notification Date:** Click or tap to enter a date. **Transition To: (Type of care setting)\*** Click or tap here to enter text.  **Transition Date:** Click or tap to enter a date. **Transition Type:** Planned  Unplanned  **Contact member/designated representative/guardian to offer assistance with transition:** Click or tap to enter a date.  **Notified PCP—Date completed**: Click or tap to enter a date. Name of PCP: Click or tap here to enter text.  Method of PCP contact: Fax Phone  EMR  Secure e-mail **(OR)** Member’s PCP was the Admitting Physician  **Shared CC contact info, care plan/services with receiving setting or, if applicable, home care agency—Date completed:** Click or tap to enter a date.  **Name and Title of receiving setting contact** Click or tap here to enter text.  **Comments:** Click or tap here to enter text. | | | | |
| **Transition #3 (if applicable) \*Complete additional tasks below, if this transition is a return to usual care setting.** | | | | |
| **Notification Date:** Click or tap to enter a date. **Transition To: (Type of care setting)\*** Click or tap here to enter text.  **Transition Date:** Click or tap to enter a date. **Transition Type:** Planned  Unplanned  **Contact member/designated representative/guardian to offer assistance with transition:** Click or tap to enter a date.  **Notified PCP—Date completed**: Click or tap to enter a date. Name of PCP: Click or tap here to enter text.  Method of PCP contact: Fax Phone  EMR  Secure e-mail **(OR)** Member’s PCP was the Admitting Physician  **Shared CC contact info, care plan/services with receiving setting or, if applicable, home care agency—Date completed:** Click or tap to enter a date.  **Name and Title of receiving setting contact** Click or tap here to enter text.  **Comments:** Click or tap here to enter text. | | | | |
| **Transition #4 (if applicable) \*Complete additional tasks below, if this transition is a return to usual care setting.** | | | | |
| **Notification Date:** Click or tap to enter a date. **Transition To: (Type of care setting)\*** Click or tap here to enter text.  **Transition Date:** Click or tap to enter a date. **Transition Type:** Planned  Unplanned  **Contact member/designated representative/guardian to offer assistance with transition:** Click or tap to enter a date.  **Notified PCP—Date completed**: Click or tap to enter a date. Name of PCP: Click or tap here to enter text.  Method of PCP contact: Fax Phone  EMR  Secure e-mail **(OR)** Member’s PCP was the Admitting Physician  **Shared CC contact info, care plan/services with receiving setting or, if applicable, home care agency—Date completed:** Click or tap to enter a date.  **Name and Title of receiving setting contact** Click or tap here to enter text.  **Comments:** Click or tap here to enter text. | | | | |
| **RETURN TO USUAL CARE SETTING** \*Complete tasks below when the member is discharging TO their usual care setting*.*  *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)*.  **Discuss with Member/Responsible Party:**  ***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 Does the member have a follow-up appointment scheduled with p**rimary care or specialist? *Medical transitions-the follow up should be within 15 days of discharge. Mental health hospitalizations—the follow up appointment must be with a mental health provider within 7 days discharge***  Yes  No Has a medication review been completed with member**? *If no, refer to PCP, home care nurse, MTM, pharmacist***  Yes  No Can the member manage their m**edications or is there a system in place to manage medications? *(e.g. home care set-up)***  Yes  No Can the member verbalize warning signs and symptoms to watch for and how to respond?  Yes  No Does the member have a copy of and understand their discharge instructions? *If no, assist to obtain copy of discharge instructions, review discharge instructions, and assist to contact PCP to discuss questions about their recent hospitalization.*  Yes  No Does the member have adequate food, housing and transportation? ***If no, add goal and discuss additional supports available to the member***  Yes  No Is the member safe in their home? *If no, document needs and support provided*  Yes  No Are there any concerns of vulnerability, abuse, or neglect? *If yes, document concerns and actions taken by Care Coordinator as a mandated reporter*  Yes  No Have you updated the member’s care plan/support plan?*Add new diagnosis, medications, treatments, goals & interventions, as applicable.* ***If No, provide explanation in comments.***  **Comments:** Click or tap here to enter text. | | | | | |

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