# Transition of Care (TOC) Log Instructions

**General Instructions:**

- This log can be used to document up to 4 transitions.
- Care Coordinators (CC) are required to follow up *directly with the member or designated representative* during each phase of a transition or document why this did not occur in comments section .
- All outreach attempts to the member/designated representative, receiving facility, and/or providers need to be documented.
- Communication tasks are to be completed by the CC regardless of the setting (i.e., nursing home)
- Communication tasks are to be completed by the CC within one (1) business day of notification of each transition.
    - For situations when the CC is notified of the discharge back to the usual care setting *prior to* the date of discharge, the CC must follow up with the member or designated representative to confirm that discharge actually occurred and discuss TOC discharge to "usual setting" tasks outlined in #18 through #26 below.
- In the date fields, document date of completion or date of first attempt. If attempted and not completed, address in comment sections.
- Planned transitions—If CC is involved in pre-planning for a scheduled hospitalization, the TOC tasks outlined below are still required throughout the transitions.
- If CC finds out about the transition 15 days or more after the member has returned to their usual care setting, no log is required. However, CC should reach out to the member to discuss the transition process, potential changes to the member's health status and plan of care, and document it in their case notes.

| Item | Instructions/Care Coordinator Considerations |
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| **Demographics** | |
| 1. Member Name | • Enter member's full name. |
| 2. Care Coordinator | • Enter the care coordinator name. |
| 3. MCO/Health Plan Member ID# | • Enter the member number used within the health plan. |
| 4. Product | • Enter the product in which the member is enrolled (e.g. MSHO, MSC+, ISNBC, SNBC) |
| 5. Agency/County/Care System | • Enter the care coordinator's agency, county, or care system. |
| **Transition #1 Information & Care Coordinator Tasks** | |
| 6. Notification Date | • Enter the date you or your agency was notified of the transition. (This may be from the Daily Admission Report, Member/Responsible Party, or Provider) |
| 7. Transition Date | • Enter the date the member moved from one care setting to another. If date not known, document "unknown" for this item. |

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| 8. Transition From | • Enter the type of care setting the member transitioned from: e.g. Home, Acute Care Hospital, Skilled Nursing Facility, Custodial Nursing Facility, Swing Bed/TCU/Inpatient Rehabilitation Facility, Residential Services, Outpatient/Ambulatory Care Facility, Inpatient Psychiatric Hospital, Mental Health or Substance Use Disorder Residential Treatment. Check the appropriate box to indicate whether this is the member's usual care setting. |
| 9. Transition To | • Enter the type of care setting the member transitioned to: e.g. Home, Acute Care Hospital, Skilled Nursing Facility, Custodial Nursing Facility, Swing Bed/TCU/Inpatient Rehabilitation Facility, Residential Services, Outpatient/Ambulatory Care Facility, Inpatient Psychiatric Hospital, Mental Health or Substance Use Disorder Residential Treatment. |
| 10. Transition Type | • Check the appropriate box to indicate whether the transition was planned or unplanned. Planned transitions may include elective surgery, planned move to a SNF, etc. Unplanned transitions include an unscheduled hospitalization, an unscheduled move to a SNF, etc. |
| 11. Reason for Admission | • Include a brief note explaining the reason for admission: e.g. hospital admission due to [reason]; change in current health status. |
| 12. Contact member/responsible party to offer assistance with transition | • Enter the date of the discussion with the member/designated representative about the transition process and changes to the member's health status and care plan.<br>• 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.<br>• 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.<br>• Provide education related to prevention of readmission and future unplanned care transitions: e.g. readmission to a nursing home, rehospitalization.<br>• Discussion can include but is not limited to talking about reducing fall risk, improving medication management, improving nutritional intake, additional services, advance care planning, discharge planning, identifying barriers to successful transition, etc. |
| 13. Shared CC contact info, care plan with receiving setting, or if applicable, home care agency. | • Receiving setting includes: e.g. Home, Acute Care Hospital, Skilled Nursing Facility, Custodial Nursing Facility, Swing Bed/TCU/Inpatient Rehabilitation Facility, Residential Services, Outpatient/Ambulatory Care Facility, Inpatient Psychiatric Hospital, Mental Health or Substance Use Disorder Residential Treatment. Enter the date care plan was shared with the receiving setting. The care plan may include the Collaborative Care Plan (CCP) or summary, the hospital/SNF discharge instructions, etc.<br>• If CC finds out about the transitions after they have already discharged from that setting, document N/A in this date field with a brief explanation in the comments section. If the transition is a return to |

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| 14. Name & title of receiving setting contact | the usual care setting with no services, document N/A in this date field with a brief explanation in the comments section.<br>• Relevant information (current services, informal supports, advance directives, medication regimen, CC contact information, etc.) may be communicated via phone, fax, electronic medical record (EMR), and secure e-mail or in person.<br>• Enter the name and title of the individual you spoke with at the receiving setting. |
| 15. Notified primary care provider (PCP) of transition.<br><br>16. Name of PCP<br><br>17. Method of PCP Contact | • Enter the date the member's PCP was notified of the transition<br>• Enter the name of the PCP<br>• Check the box as to the method of notification: e.g. fax, phone call, secure e-mail or communication via electronic medical record (EMR).<br>• Check PCP was admitting physician if that is how notification occurred. |
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| **Transition #2, #3, #4 , if applicable**<br><br>**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 within one (1) business day of notification of each transition.<br>• Enter the information as outlined in steps 6-17.<br>• Complete tasks as outlined in steps 12-17.<br>• *Asterisks' indicates that there are additional tasks required when the transition is a return to the usual care setting. If so, complete tasks as outlined in steps 18-26. 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)<br>• 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 only when the member discharges <u>TO</u> 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 discharge and discuss TOC tasks outlined below. This includes situations where it may be a 'new' usual care*** | |

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| ***setting for the member. (i.e., a community member who decides upon permanent nursing home placement)*** | |
| **Discharge to "Usual Setting" Discussion with Member/Responsible Party** | |
| 18. Does the member have a follow-up appointment scheduled with primary care or specialist? | • Determine if a follow-up appointment has been scheduled.<br>• Indicate whether member has a scheduled follow-up appointment, ideally within fifteen (15) days of discharge for a medical hospitalization. If hospitalized for mental health, the follow-up appt needs to be with a mental health provider and within 7 days.<br>• Suggested questions include:<br>✓ When is your follow-up appointment?<br>✓ Who is your follow-up appointment with?<br>✓ How are you getting to your appointment?<br>• Assist with making the appointment if necessary.<br>• Stress the importance of keeping appointment and address potential barriers.<br>• Assess need for referral for additional services/supports (arranging transportation) |
| 19. Has a medication review been completed with member? | • Determine if a medication review has been completed with the member.<br>• Suggested questions include:<br>✓ Has someone reviewed your medications with you since your discharge?<br>• Assist member in contacting pharmacist or PCP<br>• Encourage members to bring in ALL meds to PCP visits<br>• Assess need for referral to home health services for initiation of home care nurse or Medication Therapy Management Services (MTMS), if eligible |
| 20. Can the member manage their medications or is there a system in place to manage medications? | • Determine whether member/designated representative have an understanding of current medication regimen.<br>• Suggested questions include:<br>✓ Do you have all of your current medications?<br>✓ What changes were made to your medications? Do you have new medications?<br>✓ How do you get your medication from the pharmacy? Have you picked up your medications from the pharmacy? |

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| | ✓ How do you remember to take your medications?<br>✓ Do you need help with setting up or taking your medications?<br>✓ What questions do you have about your medications?<br>• Utilize "Teach Back Method" to determine level of member understanding.<br>• Assess need for referral to Medication Therapy Management Services (MTMS), if eligible.<br>• Assess need for referral for additional services/supports (home health services, DME companies, etc.) |
| 21. Can the member verbalize warning signs and symptoms to watch for and how to respond? | • Determine whether the member/designated representative are aware of symptoms that indicate problems with healing or recovery.<br>• Suggested questions include:<br>✓ What are the warning signs that might indicate you are having a problem with healing or recovery?<br>✓ What should you do if these symptoms appear?<br>✓ Who do you call if you have questions or concerns?<br>✓ Do you have those phone numbers readily available?<br>• Utilize "Teach Back Method" to determine level of member understanding.<br>• Rehearse with the member what they will do if?<br>• Refer to Transition of Care Hospital Readmission Prevention Resource Guide.<br>• Educate when to call 911.<br>• Assess need for referral for additional supports/services (home health services, DME companies, etc.) |
| 22. Does the member have a copy of and understand their discharge instructions? | • Determine if the member/designated representative has a copy of the discharge instructions. Determine if the member/designated representative understand the discharge instructions.<br>• Suggested questions include:<br>✓ Do you have a copy of your discharge instructions?<br>✓ What are your discharge instructions?<br>✓ Do you have any questions about your discharge instructions?<br>✓ Do you need assistance in following your discharge instructions?<br>• Assist member in reviewing discharge instructions and determine level of understanding (example: fluid restrictions, dietary restrictions, reporting weights)<br>• Utilize "Teach Back Method" to determine level of member understanding.<br>• Assist member in contacting provider to address questions about hospitalization & discharge instructions.<br>• Encourage member to make proactive decisions and positive choices about their health.<br>• Encourage member to write down questions for their health care team. |

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| | • Assess need for referral for additional services/supports (home health services, DME companies, etc.) |
| 23. Does the member have adequate food, housing and transportation? | • Determine if the member has access to food, housing, and transportation.<br>• Suggested questions include:<br>✓ Do you like where you live? If no, what would you change?<br>✓ Would you like to continue to live where you are now or is there somewhere else you would prefer to live?<br>✓ Do you have access to transportation to access areas outside of walking distance?<br>✓ Are you able to buy enough food for yourself each month?<br>✓ Do you have any concerns about nutrition? (food preparation, shopping access, nutrition information, need for food assistance, need for weight loss or weight gain)<br>• Assess need for referral for additional services/supports (home health services, assistance with grocery shopping, managing mail, paying bills, home delivered meals, relocation services, companion etc.)<br>• Assess need for referral for "Readmission Prevention Benefit" (MSHO members, refer to benefit guideline) |
| 24. Is the member safe in their home? | • Determine if the member feels safe in their home.<br>• Suggested questions include:<br>✓ Do you have any concerns about safety in your home? In your neighborhood?<br>✓ What are your concerns?<br>✓ Do you think you are able to evacuate safely if there was an emergency (e.g. fire)<br>✓ Are you able to get help in case of an emergency?<br>✓ Do you find yourself leaving the stove on, leaving the doors unlocked, leaving candles or cigarettes burning or anything else which may put you in danger?<br>• Provide immediate education re: addressing safety concerns.<br>• Call 911 if you have identified an emergency that requires immediate assistance from law enforcement, fire department or an ambulance<br>• Assess need for referral for services/supports (e.g. PT, OT, ST, DME to improve safety, medical alert systems, continence supplies, home modifications) |
| 25. Are there any concerns of vulnerability, abuse, or neglect? | • Determine if there are concerns of vulnerability, abuse, or neglect.<br>• Suggested questions include:<br>✓ Does someone manage your money? Do you have any concerns about mismanagement?<br>✓ Is there anyone hurting you physically?<br>✓ Is someone touching you in a way that makes you uncomfortable?<br>✓ Is someone being emotionally or psychologically abusive to you? |

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| | • Assess if there is evidence of neglect by paid provider or informal caregiver. (Evidence may include chronic hygiene, malnutrition, sores, etc.)<br>• Assess if member is at risk for: financial exploitation, physical abuse, mental abuse, emotional abuse, sexual abuse, or risk that an informal caregiver who has assumed responsibility for all or a portion of care cannot or will not provide food, shelter, clothing, healthcare, or supervision necessary to maintain the person's physical or mental health.<br>• Assess for evidence of neglect (alcohol, behaviors, dehydration/,malnutrition, hygiene, orientation impairment, inability to manage funds, inability to manage medications/treatments, unsafe living conditions, other)<br>• Assess need for referral for services/supports<br>• Call 911 if you have identified an emergency that requires immediate assistance from law enforcement, fire department or an ambulance.<br>• Report suspected vulnerable adult abuse, neglect, or financial exploitation to the Minnesota Abuse Reporting Center @ https://mn.gov/dhs/assets/Vulnerable-adults-maltreatment-reporting-and-internal-review-policy_tcm1053-354967.pdf |
| **Update the members care plan** | |
| 26. Care Plan Update | • Care plans are living documents and need to be updated following each transition.<br>• If the member resides in an institutional care setting and the care plan is updated by staff at the institutional care setting (such as nursing home, ICF, etc.), document this in the comments. It is still the Care Coordinator's responsibility to review the facility care plan to ensure identified needs are being addressed and updates occur following transitions.<br>• Be sensitive to the member's concerns and goals. Incorporate them into the care plan when possible.<br>• Add new diagnosis, medications, treatments, goals and interventions, as applicable. Consider: impacts on sleep, side effects of new medications, impacts on nutritional status, weakness from prolonged bed rest. |

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| **1 Member Name:** | | **2 Care Coordinator:** | **3 MCO/Health Plan Member ID#:** |
| **4 Product:** | **5 Agency/County/Care System:** | | |
| **Transition Communication Actions from Care Management Contact** | | | |
| **Transition #1** | | | |
| **6 Notification Date:** | **7 Transition Date:** | 8 Transition From: (Type of care setting)<br><br>Is this the member's usual care setting? ☐ Yes ☐ No | 9 Transition To: (Type of care setting) |
| **10 Transition Type:** ☐ **Planned** ☐ **Unplanned**<br>**11 Reason for Admission/Comments:** | | | |

**12** Contact member/responsible party to offer assistance with Transition: Date completed:

**13** Shared CC contact info, care plan/services with receiving setting—Date completed:

**14** Name and title of receiving setting contact:

**15** Notified PCP of transition—Date completed: **16** Name of PCP:

**17** Method of PCP contact: ☐ Fax ☐ Phone ☐ EMR ☐ Secure e-mail (OR) ☐ Member's PCP was the Admitting Physician

**Transition #2 - #4**

**6** Notification Date:

**9** Transition To: (Type of care setting)*

**7** Transition Date: _____ **10**Transition Type: ☐ Planned ☐ Unplanned

**15** Notified PCP—Date completed: _____ **16** Name of PCP:

**13** Shared CC contact info, care plan/services with receiving setting or, if applicable, home care agency—Date completed: _____

**14** Name and Title of receiving setting contact:

*Complete additional tasks below, if this transition is a return to usual care setting. **18 through 26**

**Comments**:

***Complete tasks below 18 through 26** 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).*

**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.*

**18** ☐ Yes ☐ No Does the member have a follow-up appointment scheduled with primary 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

**19** ☐ Yes ☐ No Has a medication review been completed with member? *If no, refer to PCP, home care nurse, MTM, pharmacist*

**20** ☐ Yes ☐ No Can the member manage their medications or is there a system in place to manage medications? *(e.g. home care set-up)*

**21** ☐ Yes ☐ No Can the member verbalize warning signs and symptoms to watch for and how to respond?

**22** ☐ 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.*

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| **23** ☐ **Yes** ☐ **No** **Does the member have adequate food, housing and transportation*? If no, add goal and discuss additional supports available to the member***<br>**24** ☐ **Yes** ☐ **No** **Is the member safe in their home?** ***If no, document needs and support provided***<br>**25** ☐ **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***<br><br>**26** ☐ **Yes** ☐ **No** **Have you updated the member's care plan? Add new diagnosis, medications, treatments, goals & interventions, as applicable. If No, provide explanation in comments. <u>Comments</u>:** |
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