Individual Care Transition Log Instructions
January 2011

General instructions:

- Enter each transition on a single row. For example, an admission to the hospital should have one completed row on the form. The return to the home setting should be a separate transition on the second row of the form.
- Communication timeframes: Tasks to be completed within 1 business day of notification include notify member's PCP, care plan shared, inform member/auth rep about care transition process and support person, communicate with member/auth rep about changes to health status and care plan.

Item	Instructions
Header	
1. Name	Member's name
2. MCO ID#	The member's health plan identification number
3. PMI#	The DHS assigned "Person Master Index (PMI) Number" used in MMIS, also known as Member ID or Client ID
4. MCO Name	Name of managed care organization [health plan]
5. Agency/County/Care System	The name of the Agency, County or Care System you work for.
Transition Section	
6. Date	Enter the date the Transition Log was completed.
7. Notification Date	Enter the date you or your agency was notified of transition, regardless of source of notification.
8. Notified by	Enter name of person who notified you of the transition.
9. Transition Date	Enter the date the member moved from one care setting to another, - if not knows, document on the log "unknown".
10. Transition From	Enter the care setting the member transitioned from (i.e. home, home health care, acute care, skilled nursing facility, custodial nursing facility, or rehabilitation facility).
11. Transition To	Enter the care setting the member transitioned to (i.e. home, home health care, acute care, skilled nursing facility, custodial nursing facility, or rehabilitation facility).
12. Transition Description	Indicate by selecting the appropriate box whether the transition was planned or unplanned. Include a brief note explaining why the transition occurred. - Planned transitions include elective surgery, hospitalization recommended by a physician, planned move to a skilled nursing facility, etc… - Unplanned transitions include unscheduled hospitalizations, unscheduled move to a skilled nursing facility.
13. Comments	Document the status of the member when you receive a notification of a transition after it has occurred (i.e. after the member returned to their usual care setting). - If the Care Coordinator communicated a task with someone other than who is indicated, document who the person was, the method of communication, and why you communicated the information with the person.
Communication From CC/CM Section	

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14. *Task:* PCP notification *Within 1 business day of notification of transition.*	Indicate by selecting the box if the member's PCP was notified or if the member's PCP was the admitting Physician. Enter the date that the member's PCP was notified. If the member's PCP was the admitting physician then the completed date is not applicable. - Phone call, fax, or communication via member's electronic medical record can serve as the notification.
15. *Task*: Care Plan shared with receiving setting *Within 1 business day of notification of transition.*	Indicate by selecting the box that communication was completed with the receiving setting regarding the member's current care plan. Enter the date of communication. - Care Plan is defined as a set of information about the member that facilitates communication, collaboration and continuity of care across settings. The care plan should be tailored to each member and take pertinent health status should be taken into consideration. The care plan may contain, and is not limited to, both medical and non-medical information (i.e. a current problem list, medication regimen, allergies, advance directives, baseline physical and cognitive function, contact information for all professional care providers and practitioners and informal care providers. - If you speak with providers (i.e. home health, PCA, waiver) to suspend, restart, or discontinue services during/after the transition, please document your conversation in the Comment box. - If you communicated with an "Other", complete the required documentation.
16. *Task*: Inform Member/Authorized Representative regarding the care transition process & support person available *Within 1 business day of notification of transition.*	Indicate by selecting the box that communication was completed with member/authorized representative about the care transition process and who needs to be communicated during the transition process. - The communication should cover changes – new meds, DME, services needed, etc. due to changes in condition. - If you communicated with an "Other", complete the required documentation.
17. *Task* Communicate with Member/Authorized Representative about changes to member's health status and care plan. *Within 1 business day of notification of transition.*	Indicate by selecting the box that communication was completed regarding changes to member's health status and care plan (i.e. new medications, medical equipment needs, home care services, waiver services, etc…). - During the transition, it is expected that communication should occur between the care coordinator and the member/authorized representative during the transition. Communication may occur with the individual in charge of discharge planning. Document the communication in Comments. - Member returning to their usual setting of care (i.e. home, nursing home, assisted living, etc…) is considered a care transition and all required tasks need to be completed. - If you communicated with an "Other", complete the required documentation.
18. *Task:* Education with Member/Authorization Representative about preventing future unplanned transitions.	Indicate by selecting the box that a discussion occurred with the member or authorized representative about how to prevent future care transitions (i.e. nursing home placement, hospitalization). - Discussion can include but is not limited to talking about reducing the member's fall risk, improving member's medication management, improving member's nutritional intake, additional services, etc…