Care Transitions Workflow

The Care Transitions Workflow is a set of recommendations primarily from two evidence-based programs proven to reduce hospital readmissions: Project RED (Re-Engineered Discharge) and the RARE Campaign of Minnesota. This workflow provides staff members of inpatient psychiatric facilities an outline of key steps and considerations for assisting patients in successfully transitioning from inpatient care to outpatient support.

On Admission

1. Assess written and verbal language needs
2. Complete a Biopsychosocial Assessment
3. Identify support people (e.g., family, caregiver, and friends)
4. Identify Behavioral Health and Primary Care Physicians
5. Begin treatment and transition/discharge planning
6. Obtain Release of Information
7. Engage family/ support people in patient's treatment
8. Notify patient's providers about admission

During Hospitalization

1. Schedule appointments for follow-up care in Behavioral Health and Primary Care. Behavioral Health appointment should occur within 7 days of hospital discharge
2. Arrange for post-discharge services or equipment (home health, Durable Medical Equipment, etc.)
3. Coordinate initial contact between the patient and any new referrals
4. **Perform Medication Reconciliation**
   (To be completed at each transition)
   - Consider patient's substance use history
   - Pay special attention to medications that can be misused/ abused
   - Inquire about over the counter medications, vitamins, non-prescription and herbal supplements
   - Discuss benefit coverage and affordability of medications
   - Limit quantity of lethal medications when depression or suicidal ideation is present
   - Sign and date the reconciliation document
5. **Create Medication List**
   - Name of medication
   - Purpose of the medication
   - Potential side effects
   - Dosage, schedule and method of taking medications
   - Changes in medication regimen compared to admission
   - Anticipated dosage changes and titrations
   - Formulary availability, costs, generic alternatives
   - Possible medication interactions with alcohol, food, and over the counter medications and supplements
   - Disposal of discontinued medications
   - Date of the medication reconciliation
6. **Complete the Comprehensive Transition/Discharge Plan**
   (written in a method that meets health literacy standards)
   Should include:
   - Reason for hospitalization
   - Medication List
   - Self-care activities
   - Crisis plan including support person and their contact information
   - Follow-up appointments coordination (including aftercare provider name, date and location)
   - Preparation for follow up appointments (what to bring, questions to ask)
   - Process for obtaining pending tests results
   - Offer wide array of resources
7. Call patient's Behavioral Health and Primary Care Physician about upcoming discharge

Upon Transition / Discharge

1. Provide copy of transition/discharge plan to patient
2. Provide prescriptions or medications
3. **Use the Teach Back Method**
   - Teach the written discharge plan in a way that the patient can understand
   - Educate patient about diagnosis and medications
   - Review with the patient how to respond if a problem arises
   - Assess the patient's understanding of the discharge plan
   - Have patient repeat or teach back the discharge instructions
4. Provide needed education or resource information

Post-Transition / Discharge

1. Expedite transmission of the discharge summary to aftercare providers
2. Make follow-up call to patient within 72 hours of transition/discharge

The RARE Campaign:
http://www.rarereadmissions.org/

Project RED Toolkit:
https://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html

Example of the Project RED After Hospital Care Plan

Health Literacy Resources

Elements of Teach Back

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

ALLIANT QUALITY

This material was prepared by Alliant Health Solutions, for Alliant Quality, the Medicare Quality Innovation Network – Quality Improvement Organization for Georgia and North Carolina, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. 11SOW-AHSQIN-G1-19-03

www.alliantquality.org

On Admission
WORKSHEET

ASSIGN ROLES FOR EACH STEP

Assess written and verbal language needs	Complete a Biopsychosocial Assessment	Identify support people (e.g., family, caregiver, and friends)	Identify Behavioral Health and Primary Care Physicians
Team Member Name(s):			

Notify patient's providers about admission	Engage family/support people in patient's treatment	Obtain Release of Information	Begin treatment and transition/discharge planning
Team Member Name(s):			

NOTES

RESOURCES

This material was prepared by Alliant Health Solutions, for Alliant Quality, the Medicare Quality Innovation Network – Quality Improvement Organization for Georgia and North Carolina, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. 11SOW-AHSQIN-G1-19-03

www.alliantquality.org

During Hospitalization
WORKSHEET

ASSIGN ROLES FOR EACH STEP

Schedule appointments for follow-up care in Behavioral Health and Primary Care. Behavioral Health appointment should occur within 7 days of hospital discharge

Arrange for post-discharge services or equipment (home health, Durable Medical Equipment, etc.)

Coordinate initial contact between the patient and any new referrals

Team Member Name(s):

Complete the Comprehensive Transition/Discharge Plan
(written in a method that meets health literacy standards)

Should include:

- Reason for hospitalization
- Medication List
- Self-care activities
- Crisis plan including support person and their contact information
- Follow-up appointments coordination (including aftercare provider name, date and location)
- Preparation for follow up appointments (what to bring, questions to ask)
- Process for obtaining pending tests results
- Offer wide array of resources

Create Medication List

- Name of medication
- Purpose of the medication
- Potential side effects
- Dosage, schedule and method of taking medications
- Changes in medication regimen compared to admission
- Anticipated dosage changes and titrations
- Formulary availability, costs, generic alternatives
- Possible medication interactions with alcohol, food, and over the counter medications and supplements
- Disposal of discontinued medications
- Date of the medication reconciliation

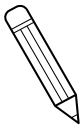
Perform Medication Reconciliation
(To be completed at each transition)

- Consider patient's substance use history
- Pay special attention to medications that can be misused/abused
- Inquire about over the counter medications, vitamins, non-prescription and herbal supplements
- Discuss benefit coverage and affordability of medications
- Limit quantity of lethal medications when depression or suicidal ideation is present
- Sign and date the reconciliation document

Team Member Name(s):

Call patient's Behavioral Health and Primary Care Physician about upcoming discharge

Team Member Name(s)



NOTES

RESOURCES

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

ALLIANT QUALITY

This material was prepared by Alliant Health Solutions, for Alliant Quality, the Medicare Quality Innovation Network – Quality Improvement Organization for Georgia and North Carolina, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. 11SOW-AHSQIN-G1-19-03

www.alliantquality.org

Upon Transition/Discharge

WORKSHEET

ASSIGN ROLES FOR EACH STEP

Provide copy of transition/discharge plan to patient

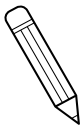
Provide prescriptions or medications

Use the Teach Back Method

- Teach the written discharge plan in a way that the patient can understand
- Educate patient about diagnosis and medications
- Review with the patient how to respond if a problem arises
- Assess the patient's understanding of the discharge plan
- Have patient repeat or teach back the discharge instructions

Provide needed education or resource information

Team Member Name(s):



NOTES

RESOURCES

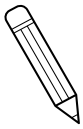
This material was prepared by Alliant Health Solutions, for Alliant Quality, the Medicare Quality Innovation Network – Quality Improvement Organization for Georgia and North Carolina, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. 11SOW-AHSQIN-G1-19-03

Post-Transition/Discharge
WORKSHEET

ASSIGN ROLES FOR EACH STEP

Expedite transmission of the discharge summary to aftercare providers → Make follow-up call to patient within 72 hours of transition/discharge

Team Member Name(s):



NOTES

RESOURCES

This material was prepared by Alliant Health Solutions, for Alliant Quality, the Medicare Quality Innovation Network – Quality Improvement Organization for Georgia and North Carolina, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. 11SOW-AHSQIN-G1-19-03