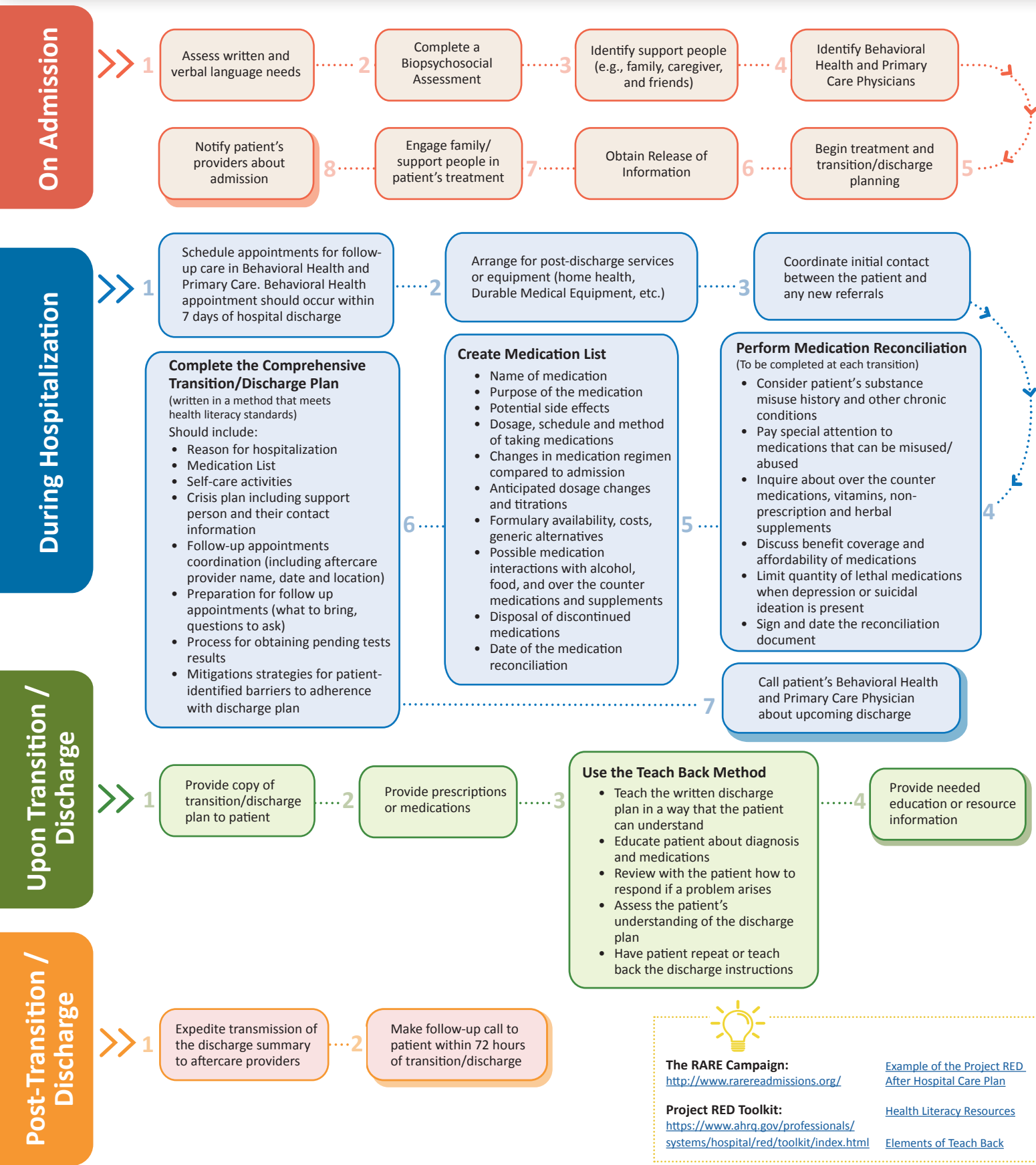


Care Transitions Workflow

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

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):

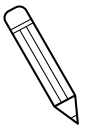
Notify patient's providers about admission

Engage family/support people in patient's treatment

Obtain Release of Information

Begin treatment and transition/discharge planning

Team Member Name(s):



NOTES



RESOURCES

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
- Mitigations strategies for patient-identified barriers to adherence with discharge plan

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

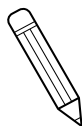
Perform Medication Reconciliation

(To be completed at each transition)

- Consider patient's substance misuse history and other chronic conditions
- 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



NOTES

Team Member Name(s):



RESOURCES

Post-Transition/Discharge

WORKSHEET



ASSIGN ROLES FOR EACH STEP



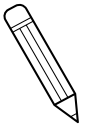
Expedite transmission of the discharge summary to aftercare providers



Make follow-up call to patient within 72 hours of transition/discharge

Team Member Name(s):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



NOTES



RESOURCES