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.

Complete a **Identify Behavioral** Identify support people Assess written and Biopsychosocial Health and Primary (e.g., family, caregiver, verbal language needs Assessment Care Physicians and friends) Notify patient's Engage family/ Begin treatment and Obtain Release of support people in providers about transition/discharge Information patient's treatment admission planning Schedule appointments for follow-Arrange for post-discharge services Coordinate initial contact up care in Behavioral Health and or equipment (home health, between the patient and Primary Care. Behavioral Health Durable Medical Equipment, etc.) any new referrals appointment should occur within 7 days of hospital discharge Create Medication List

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
- Mitigations strategies for patientidentified barriers to adherence with discharge plan

- 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, nonprescription 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

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

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

Expedite transmission of the discharge summary to aftercare providers

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





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





Upon Transition/Discharge

WORKSHEET



ASSIGN ROLES FOR EACH STEP



Team Member Name(s):	Provide copy of transition/discharge plan to patient	Provide prescriptions or medications	 e the Teach Back Method Teach the written discharge plan in a way that the patient can understand Educate patient about diagnosi 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
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RESOURCES





Post-Transition/Discharge

WORKSHEET



Team Member Name(s):

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



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