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

- Assess written and verbal language needs
- Notify patient’s providers about admission
- Schedule appointments for follow-up care in Behavioral Health and Primary Care. Behavioral Health appointment should occur within 7 days of hospital discharge

During Hospitalization

- Complete a Biopsychosocial Assessment
- Engage family/support people in patient’s treatment
- Obtain Release of Information
- Arrange for post-discharge services or equipment (home health, Durable Medical Equipment, etc.)

Upon Transition/Discharge

- Identify support people (e.g., family, caregiver, and friends)
- Develop Medication List
- Perform Medication Reconciliation (To be completed at each transition)
- Call patient’s Behavioral Health and Primary Care Physician about upcoming discharge

Post-Transition/Discharge

- Identify Behavioral Health and Primary Care Physicians
- Create Medication List
- Use the Teach Back Method
- 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

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

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

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

Example of the Project RED After Hospital Care Plan

Project RED Toolkit:

Health Literacy Resources

Elements of Teach Back

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www.alliantquality.org
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

Obtain Release of Information

Engage family/support people in patient’s treatment

Begin treatment and transition/discharge planning

NOTES

RESOURCES
**During Hospitalization WORKSHEET**

**ASSIGN ROLES FOR EACH STEP**

<table>
<thead>
<tr>
<th>Role</th>
<th>Team Member Name(s)</th>
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<tbody>
<tr>
<td>Schedule appointments for follow-up care in Behavioral Health and Primary Care. Behavioral Health appointment should occur within 7 days of hospital discharge</td>
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<td>Arrange for post-discharge services or equipment (home health, Durable Medical Equipment, etc.)</td>
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<td>Coordinate initial contact between the patient and any new referrals</td>
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**Complete the Comprehensive Transition/Discharge Plan**

(written in a method that meets health literacy standards)

- 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

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

**NOTES**

**RESOURCES**

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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

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## 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

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