RARE Reducing Avoidable Readmissions Effectively

Recommended Actions for Improved Care Transitions: Mental Illnesses and/or Substance Use Disorders

The transition period between care settings is the most vulnerable time for patients and their caregivers. The unique vulnerabilities for patients with mental illnesses such as depression, mania, anxiety, schizophrenia and/or substance use disorders* heighten the need for coordinated transitions and aftercare. In 2010, depression was the fourth diagnosis by volume for readmissions in Minnesota according to the Potentially Preventable Readmissions data collected by the Minnesota Hospital Association.

This document is intended for health care professionals who provide care for patients in a variety of settings. It provides basic recommendations in five key areas that are well-recognized core strategies for care transition improvement along with recommendations specific to mental health populations. These recommendations based on best practices, evidence and consensus are key practices that organizations should be working to implement. Additionally, this document identifies key recommendations that are important specifically for care transitions improvement when working with patients with new or existing mental illnesses. This document does not specifically focus on delirium or dementia but many of the recommendations will also help support the families of these patients.

This document is aimed at three types of mental health patient populations:

1. Inpatient mental health admissions and readmissions.
2. Patients who are admitted to acute care hospitals for medical/surgical conditions who also have a mental illness and/or substance use disorder.
3. Patients with acute or exacerbation of chronic medical illnesses who subsequently develop a mental illness, such as depression with congestive heart failure or anxiety with chronic obstructive pulmonary disease (COPD).

The RARE Campaign was established to focus efforts across the state to improve the quality of care for patients transitioning across care systems and to reduce avoidable readmissions by 20% by the end of 2012. For our patients this means 16,000 nights of sleep at home rather than in a hospital bed.

In preparing this document, a group of dedicated mental health stakeholders assembled to engage in dialogue regarding opportunities to improve care transitions for these patients. In addition to completing a literature review, the work group identified aspects associated with care of some mental health patients that can further challenge care transitions such as stigma associated with mental illnesses; siloed and fragmented care; barriers to involving family and/or friends; transportation challenges; health care access limitations; and medication complexities. The literature in the area of care transitions in mental health is a limited but developing body of evidence and it was used where applicable; however, many of the recommendations put forth were based on experience, organizational pilots, promising practices and group consensus.

A companion document *Recommended Actions for Improved Care Transitions* is available on the RARE website, along with comprehensive information about the RARE Campaign and other interventions to reduce avoidable readmissions.

www.RAREreadmissions.org

*Throughout this document, when the term mental illness is mentioned, it also includes substance use disorders.

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The RARE Campaign calls upon hospitals and their partners along the care continuum to focus on five key areas known to improve care and thereby reduce avoidable hospital readmissions.

The Five Key Areas

The issues that influence avoidable readmissions are many and complex. Improvement work needs to be done in each care setting and across care settings to make an impact. In analyzing the literature, local and national programs, five areas have been identified as a focus for quality improvement efforts.

#1 Patient/Family Engagement and Activation

#2 Medication Management

#3 Comprehensive Transition Planning

#4 Care Transition Support

#5 Transition Communication

#1 Patient/Family Engagement and Activation

In our culture, many patients and their families have been relegated to a passive role in their health care. Rather than assisting in developing a realistic plan for care outside the hospital, they may simply be told the plan, which may not be workable for the patient or the family. They may also feel powerless to bring up issues with health care professionals. In the case of mental illnesses, the family can be marginalized in their involvement for many reasons including misunderstood or misapplied privacy policies.

In this document we will use the term family with the understanding that the patient defines "family." Friends rather than relatives may be the patient's family in terms of support. Patients and families have wide variation in their knowledge of the health care system and their understanding of the issues that affect them. Hospitalized patients may be impaired by their illness, pain, and sedatives or simply confused by what they are experiencing. These factors, along with cultural and language issues, may prevent patients from being fully engaged in their health care and decision-making processes.

The patient and their family live daily with their condition and they need to be as engaged as possible as they make numerous decisions about their care, often in the absence of any guidance by health care professionals. Families are often an unrecognized resource in providing safe transitions for patients. Organizations working to improve in this area focus on ensuring that processes are in place to engage patients and their family, elevate the status of family caregivers as essential members of the team, and prepare the patient and family to manage care at home. (Coleman, 2011)

Recommendations for All Patients:

- Ask the patient to identify family and friends who comprise their support network. HIPAA does assume consent if the patient allows the family and friends to be present during discussions.

- Care team members are strongly encouraged to involve family in the treatment process upon admission, potentially including participating in Emergency Department evaluation, admission intake assessments and engagement of outpatient providers. Families should be invited and highly encouraged to participate in establishing the goals and plan of care, offering feedback throughout treatment, and developing the discharge plan. Consideration should be given to type, intensity and setting of care needed for the successful treatment of the patient with consideration of family involvement.
- Care team members are strongly encouraged to use the Teach Back method to assess comprehension of instructions given to the patient and family during and after transitions, including general and disease-specific information. Care providers should include family whenever possible. If Teach Back is unsuccessful or the patient is unable to perform all requirements of the care plan, the plan needs to be modified. This may be accomplished by engaging family to assist in carrying out the plan with the patient. (Project BOOST)
- Care providers must utilize health literacy standards such as the AHRQ Health Literacy Universal Precautions Toolkit to ensure that spoken language and written materials are easy to understand from the patient's and family's perspective. (DeWalt, 2010)

Recommendations for Patients with Mental Illnesses:

- Proactively obtain releases of information to include family members at each appropriate interaction. Obtain appropriate releases to engage these people in the care, planning and transition early in the hospital stay. Some inpatients on mental health units may be reluctant at first, but may be more open later in their stay to having family involved.
- Care teams are strongly encouraged to be knowledgeable of and make frequent referrals to community support services, including:
  - Mental health and/or chemical health support groups
  - Social services available through a variety of county and charitable organizations, including:
    - Financial assistance for medications
    - Transportation assistance
    - Nutritional support
    - Emergency housing
    - Assistance services such as homemaker services and behavioral aide support
    - Supported leisure options
    - Volunteering opportunities
- If the patient does not have a family support system, include a surrogate such as a Case Manager or Assertive Community Treatment (ACT) team member.

#2 Medication Management

Medications are important components of an overall strategy to manage complex acute and chronic conditions. However, the number and complexity of medication regimes and medical jargon may leave the patient and their caregivers in a quandary as to how to follow so many instructions. They may also experience difficulty in obtaining medications due to financial constraints. Patients and caregivers need support in how they can become active managers of their medication regimes, including why, how and when to take the medications. Additional improvement opportunities exist to ensure patients are prescribed only what they need and that the benefits of those medications outweigh the risks.

Recommendations for All Patients:

- Medication Reconciliation

  Medication reconciliation must be completed at each patient transition, not just as a completed task, but also as a means to ensure safety, accuracy and appropriateness of medication therapy, and to facilitate communication and shared understanding between the care team and the patient. Remember to ask about over-the-counter (OTC) medications, vitamins, herbals, other non-prescription supplements and about substance use, if any. This should be addressed with the patient and family along with outpatient primary care and behavioral health providers as part of comprehensive transition planning. (NPSG 03.06.01 TJC)

- Patient Medication List

  Reconciled medication lists should indicate the purpose of each medication and the date of completed reconciliation. Any identified discrepancies must be evaluated and resolved. (NPSG 02.06.01 TJC)

  Optimal elements in the medication list include:
  - Name of the medication
  - Purpose of the medication
  - Side effects
  - How to take the medication
  - When to take the medication
  - Future anticipated dosage changes, e.g. titrating doses
  - Current changes in the medication regime
  - Formulary availability, cost and generic alternatives
  - Possible interactions with other medications and substances such as alcohol and food

- Medication Availability

  Recognizing that medication prescribing in acute care organizations may be influenced by hospital formulary requirements, it is strongly suggested that in order to avoid unnecessary disruptions/changes in medication therapy regimes, items such as benefit coverage and affordability be discussed with the patient and family and that they be engaged in shared decision-making around medication therapy.

- Patient Agreement and Understanding

  When transitioning out of the hospital, the patient should be engaged in their plan for medications and agreement to follow that plan should be assured. Changes in the medication regime from pre-hospital medications should be made clear to the patient and family, including guidance on OTC medications and use of substances such as alcohol. Ask the patient and the family what medications are in the home and discuss the plan for their use or disposal. Teach Back is an effective strategy that should be used to elicit the level of understanding needed by the patient and family to take medications safely and as prescribed. (Project BOOST)

Recommendations for Patients with Mental Illnesses:

- Quantity of Medications

  Condition-specific consideration should be given when ordering medication supply. For example, if the patient has had suicidal issues or major depression in the past, quantities of potentially lethal medications should be limited.

- Communication of Medication Plans

  Acknowledging the complexities associated with medication therapy for mental illnesses such as required medication titration, it is imperative that the communication regarding intended plans for medications be clear to all providers caring for the patient as well as the patient and family.

- Screen For Other Co-occurring Disorders

  Screen at-risk psychiatric and medical patients with such issues as trauma, stroke, myocardial infarction, cancer and diabetes, for possible substance use disorder. When warranted, use motivational interviewing methods.

- Special Population Considerations

  Special considerations should be given for patients who are:
  - Incapacitated with respect to medical decision-making or have been deemed legally incompetent
  - Confused or experiencing cognitive deficits
  - On involuntary commitment
  - In the midst of acute psychotic episodes
  - Newly diagnosed
  - Live alone without support
  - Experiencing cognitive deficits

  For these patients, consider strategies to enhance adherence such as:
  - Direct observation of medication use
  - Depot medications – a special formulation of the medication that is given by injection and gradually released into the body over a period of time
  - Involvement of a case/care manager

Other Possible Strategies:

- Medication Therapy Management should be offered in the acute and ambulatory care settings for patients who have special challenges.
- A pharmacist should review orders at the time of transition for accuracy and necessity, potential side effects and/or interactions for high-risk patients. (Frandzel, 2012)
- For high-risk patients, consider offering a structured follow-up visit, either by phone or home visit, to reconcile the medication list with what the patient is actually taking. Consider OTC, legal and illegal substances.

#3 Comprehensive Transition Planning

The comprehensive transition plan (formerly called discharge instructions) is a guide developed collaboratively between the discharging care team and the patient and family for the tasks that are to be done by the patient and family post-hospitalization. The focus is to ensure that all of a patient's needs are considered and the information is delivered in a way that the patient and family can understand and use as a reference. Consideration should be given to any identified cognitive deficits as well as literacy and health literacy in preparing these materials. (Sheppard, 2010) (Project RED)

Recommendations for All Patients:

A written patient-centered transition plan must include the following:

- Reason for hospitalization, including information on diagnosis in terms the patient and family can understand
- Medications to be taken post-transition, including, as appropriate, resumption of pre-admission medications:
  - Purpose of medication
  - Dosage of medication
  - When to take medication
  - How to take medication
  - How to obtain medication and refills
  - Where to obtain medications
  - Instructions regarding OTC, legal and illegal substances considering the patient's prior history
- Self-care activities such as exercise and diet
- Crisis Management: Condition-specific symptom recognition and management, including:
  - Symptoms that warrant a patient response and understanding action steps and what care options are available (red flags)
  - What to do if a red flag occurs, including the urgency of the issue, who to contact, how to contact them, and what to do in an emergency and after clinic hours
- Coordination and planning for follow-up appointments
  - Appointments should be made prior to transition and usually within seven business days of transition (based on the patient's condition)
  - Involves coordination with the patient and family to ensure they will be able to get to and keep the appointment
- The transition plan must be written in easy-to-understand, plain language, using only as many words as necessary, meeting as many health literacy standards as possible. Also avoid medical jargon, abbreviations and acronyms. Teach Back may also be useful in this regard.

Recommendations for Patients with Mental Illnesses:

The transitional care plan should also include the following:

- Coping Skills
  - Sleep hygiene
  - Self-soothing
- Nutrition/Exercise
  - Diet
  - Physical activity level or limitations
  - Weight monitoring
  - Yoga, meditation
- Recovery Goal/Plan
  - Work
  - Social
  - Harm reduction
  - School
- For patients with acute or chronic medical conditions and newly diagnosed depression or anxiety, a follow-up appointment with a mental health provider in addition to their primary care provider.

- If there are physical health considerations and the patient does not have a primary care physician or clinic, help the patient obtain one for physical health issues and preventative care. Note: Research has shown that disregarding the preventive and physical needs of a mentally ill patient can put them in danger of earlier occurrence of chronic diseases. (MN 10x10)

  The following should be addressed in the primary care follow-up:
  - Preventive measures such as immunizations
  - Orientation to long-term health and lifestyle issues
  - Frequency of follow-up needed
  - Patient goals for overall health such as tobacco cessation, exercise, weight loss, etc.
  - Provide brochures, websites or phone numbers for information on topics most pertinent to the individual patient

#4 Care Transition Support

The transition period between care settings is the most vulnerable time for patients and their families. Fragmentation in the health care system often leaves the patient to navigate a complicated system without adequate knowledge and support. The objective of care transition support is to help the patient and family successfully transition from one care provider to the next.

Recommendations for Patients with Mental Illnesses:

Post-hospitalization follow-up:

- The patient should have a follow-up appointment with a provider of mental health services within seven calendar days post-hospitalization or sooner if their condition warrants, to review their progress and plan of care.
- For new referrals, facilitate the connection between the patient and the agency to which the patient is being referred to ensure a successful connection.
- The receiving mental health provider should have a system to accommodate availability for transitioned patients within seven calendar days.
- All patients with mental illnesses and chronic or acute physical problems should have an appointment scheduled with their medical provider prior to discharge from the hospital.
- An adult mental health patient who does not have a designated primary care provider should be connected to one and an appointment made within 60 days for a physical assessment and prevention interventions..
- Within 72 hours of transition, a team member with knowledge of the patient's history and plan of care should contact the patient to review the care transition plan (including medication and possible medication side-effects) and inquire as to any questions or new concerns.
- Teach Back and open-ended questions should be used to assess and ensure the patient and family understands and is able and willing to follow through on the plan of care, including attending follow-up appointments.
- Brief teaching of the patient (and family if applicable) on the content of the follow-up visit should focus on preparation, including:
  - Patient's goals for the visit, factors contributing to admission or emergency department visit and current medication regime
  - Patient's need for medication adjustment, follow-up on outstanding test results, monitoring and testing, psychosocial environmental factors, and instruction on self-management using Teach Back
  - Patient and family questions regarding warning signs and how to respond using Teach Back
  - Review crisis plan and ensure it continues to meet the needs of the patient.
  - Ask about any changes in the patient's living situation, including temporary or permanent changes in address, access to transportation or any previously unidentified concerns
  - Expect questions regarding why and how the patient's medical problems are being managed
  - Expect questions about OTC medications, vitamins, herbs, supplements, and legal or illegal substance use or abuse.
  - Expect questions about healthy lifestyle choices and support

Other Strategies:

- Care Transitions Intervention®. This intervention developed by Dr. Eric Coleman and his team at the University of Colorado uses a coach to support the patient through their transition. The coach focuses on helping the

patient and family caregiver develop skills and confidence to assert their treatment preferences and ensure that their needs are being met during transitions. It is recommended that the coach have a mental health background when providing coaching for a mental health patient. www.caretransitions.org (Coleman, 2006)

- Case or care managers have a series of regular follow-up communications with the patient to ensure that medications, meals/nutrition, transportation, appointments and other needs of the patient are in place.
- Consider an Assertive Community Treatment intervention (ACT), a service-delivery model that provides comprehensive, locally-based treatment to people with serious and persistent mental illnesses. Unlike other community-based programs, ACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation agencies or services. Rather, it provides highly individualized services directly to consumers. ACT recipients receive the multidisciplinary, round-the-clock staffing of a psychiatric unit, but within the comfort of their own home and community. To have the competencies and skills to meet a client's multiple treatment, rehabilitation, and support needs, ACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. The ACT team provides these necessary services 24 hours a day, seven days a week, 365 days a year. (http://www.namihelps.org/assets/PDFs/fact-sheets/General/Assertive-Community-Treatment.pdf)
- Critical Time Intervention (CTI) is an empirically supported, time-limited case management model designed to prevent homelessness and other adverse outcomes in people with mental illnesses following discharge from hospitals, shelters, prisons and other institutions. (http://www.criticaltime.org/model-detail/)

#5 Transition Communication

Lack of timely and adequate information between providers and sites of care contributes to discontinuity of care and the risk of readmissions for patients. Transition information may be too late, too much, not enough, or in a format that renders it suboptimal or even unusable.

Recommendations for All Patients:

- The patient's providers, including mental health, primary care, specialists and others, should be notified as soon as possible of an admission and prior to the transition out of the hospital.
- At every point during care transitions, patients, family and any caregivers must know who is responsible for care and how to contact them. Care providers must also know who is responsible at each transition.
- The transition communication responsibilities of the hospital physician should be explicitly stated in policy or in medical staff bylaws.
- Concise transfer forms with key elements as identified in the MHA Safe Transitions of Care program must be sent with the patient transferring to post-acute sites of care, such as acute rehabilitation, skilled nursing facilities or transitional care facilities (http://www.mnhospitals.org/patient-safety/current-safety-quality-initiatives/readmissions-safe-transitions-of-care).
- When a patient transfers from one facility to another, direct verbal reports between nursing staff should take place.
- Complete transition summaries should be received by the accepting facility within five business days or within adequate time to be available for the initial follow-up appointment.

Recommendations for Patients with Mental Illnesses:

- Ascertain if the patient has a county case manager, a clinic care manager or a health plan case manager and if so, notify them of the hospitalization and involve the care manager in development of the care plan and any changes to the care plan.

Other Strategies:

- Develop a universal patient care plan template that would be used by all outpatient providers and patients who may have difficulty with the widely varying formats and information.
- Utilize a patient health record that is maintained by the patient and is brought to and reviewed at all patient/provider encounters. (http://www.caretransitions.org)
- Provide access to hospital electronic health records for those facilities commonly in receipt of patients transitioned from that hospital.
- Develop as a shared resource a brief video for teaching purposes that orients the patient/family/caretaker to the need for transitions and preparation for outpatient continuing care (including both mental health and primary care providers).

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Suggested Measures

#1 Patient/Family Engagement and Activation

Percent of patients where family has been identified and releases have been obtained.

Percent of patients and/or family for whom the Teach Back method was used by care team members giving instructions on what to do during and after care transitions.

Percent of care providers who utilize health literacy standards (e.g. AHRQ Health Literacy Universal Precautions Toolkit).

#2 Medication Management

Percent of patients for whom medication reconciliation was completed on admission and discharge.

Transition plan indicates the list of active medication the patient should be taking post-transition. Medication list includes:

- Name of the medication
- Purpose of the medication
- Side effects
- How to take the medication
- When to take the medication
- Future anticipated dosage changes, i.e. titrating doses
- Current changes in the medication regime
- Possible interactions with other medications and substances such as alcohol and food

Percent of patients who successfully completed Teach Back instructions on how to take their medications and how frequently to take them.

Percent of patients whose medication plan was communicated to the next care provider(s).

Percent of patients discharged on multiple antipsychotic medications. (NQF Measure #0552)

Percent of patients discharged on multiple antipsychotic medications with justifications (three failed trials of monotherapy, plan to taper to monotherapy, augmentation of clozapine). (NQF Measure #0560)

#3 Comprehensive Transition Planning

Percent of patients who have a care plan and/or transition plan which includes the following:

- Reason for hospitalization that includes information on disease/condition in patient-friendly language (no medical jargon, acronyms or abbreviations).
- List of medications to be taken after transition (purpose, dosage, start date, frequency, how to take medication, how to obtain medication and refills).
- List of specific self-care activities (coping skills, diet, physical activity, recovery goal/plan, crisis management).
- Symptom recognition and management (symptom red flags, urgency of red flags, who to contact and what to do in an emergency).
- Follow-up appointment information (follow-up appointment scheduled within seven days of transition). (NQF Measure #0557)

Percent of patients whose care plan/transition plan was communicated to the next care provider(s). (NQF Measure #0058)

Percent of patients who have a follow-up appointment with a primary care provider within 60 days to address physical health considerations.

#4 Care Transition Support

Percent of patients who had a follow-up appointment with a provider of mental health services within seven business days post-transition.

Percent of patients who had a follow-up contact within 72 hours of transition by a care team member involved in the patient's transition.

Percent of patient who successfully completed Teach Back of instructions on how to self-manage their condition and what to do in case of warning signs.

#5 Transition Communication

Percent of patients for whom the mental health provider was notified on the same day of their admission or transition (the following morning if overnight admission).

Percent of patients for whom primary care provider was notified of their admission.

Percent of patients with a case/care manager that is notified about the hospitalization.

Percent of patients whose care plan/transition plan was communicated to the next care provider(s).

Percent of patients transferred to another facility whose information was directly communicated between care provider staff.

Authors from the RARE Mental Health Work Group

Paul Goering, MD	*Allina Health*
Chris Walker, MSN, RN, MHA	*CentraCare Health System*
Cathy Brouwer, RN	*Chippewa County Montevideo*
Kathy Knight, RN, MA	*Fairview Health Services*
Karen Lloyd, PhD	*HealthPartners*
Terry W. Crowson, MD	*HealthPartners*
Michael A. Trangle, MD	*HealthPartners*
Paul Davis, PhD, LP	*Lakewood Health System*
Jennifer McNertney, MPP	*Minnesota Hospital Association*
Sue Abderholden, MPH	*National Alliance on Mental Illness*
Nancy Houlton, LICSW	*UCare*
Kathy Cummings, BSN, MA	*Institute for Clinical Systems Improvement*
Joann Foreman, RN, BAN	*Institute for Clinical Systems Improvement*

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Eric A. Coleman, MD, MPH
Professor of Medicine, Director,
Care Transitions Program Head,
Division of Health Care Policy and Research
University of Colorado Denver Anschutz Medical Center
http://www.caretransitions.org/overview.asp

Harold Alan Pincus, MD
Professor and Vice Chair, Department of Psychiatry, College of Physicians and Surgeons
Co-Director, Irving Institute for Clinical and Translational Research, Columbia University
Director of Quality and Outcomes Research, New York-Presbyterian Hospital

Howard Epstein, MD
Chief Health Systems Officer
Institute for Clinical Systems Improvement

Gary Oftedahl, MD
Chief Knowledge Officer
Institute for Clinical Systems Improvement