Care Transition Toolkit for Persons with Mental Health & Co-Occurring Conditions

What It Is and How You Can Use It



Care Transition Toolkit for Persons with Mental Health & Co-Occurring Conditions

This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) to ensure beneficiaries enrolled in Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to Medicare-Medicaid enrollees, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar series. To learn more about current efforts and resources, visit Resources for Integrated Care (www.ResourcesForIntegratedCare.com) for more details.

Platform Overview

- Microphones are muted
- Need the slides?
  - Go to www.ResourcesForIntegratedCare.com
- Slides not advancing?
  - Press F5
- Need Closed Captioning?
  - See the “cc” icon (bottom of screen)
- Have a Question?
  - Click the Question & Answer icon (bottom of screen)
  - Engage the Operator through the phone line
  - Email RIC@lewin.com

Introductions

Gretchen Nye
Health Insurance Specialist, Medicare-Medicaid Coordination Office within the Centers for Medicare & Medicaid Services (CMS)

Erika Robbins, MA
Managing Consultant, The Lewin Group

Paolo Delvecchio, MSW
Director, Center for Mental Health Services (CMHS) within the Substance Abuse Mental Health Services Administration (SAMHSA)

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Research Consultant, The Lewin Group

Michael Hoge, Ph.D.
Professor of Psychiatry, Yale University

Meagan Alley, MPH
Research Consultant, The Lewin Group

Webinar Outline/Agenda

- Background
  - Context for the tool, why care transitions matter
- Introduce Toolkit
  - Purpose, who can use it
  - Terminology
  - Location
- Sections of the Toolkit
- Question and Answer Session (Q&A)

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Context and Background

Gretchen Nye, CMS

Paolo Delvecchio, SAMHSA



Medicare-Medicaid Coordination Office

- Capacity Building of Providers who Provide Care to Medicare-Medicaid Enrollees

- Resources for Integrated Care Website:

https://www.resourcesforintegratedcare.com/

- Acknowledgements of the developers and testers of the Care Transition Toolkit for Persons with Mental Health & Co-Occurring Conditions

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Background

The Toolkit targets individuals with mental health and co-occurring conditions receiving health care from different providers in different locations

- Critical time puts individuals at risk for disorganized care:
  - Conflict in care plans
  - Lack of follow-up care
  - Errors with medication
  - Possible duplication of services
  - Higher overall care cost
- Support during this time can improve the transition experience and health outcomes

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Coleman, E. (2003). The Care Transitions Intervention: A Patient-Centered Approach to Facilitating Effective Transfers Between Sites of Geriatric Care. Home Health Services Quarterly. 2003;22(3):1-18.

Background

- Some goals for successful care transition:
  - Communication among the individual, their care providers, and their supportive persons
  - Clear plan for follow-up appointments
  - Self-management of the individual's symptoms

- The Toolkit follows person-centered planning principles
  - Places individuals at the center of the planning process
  - Engages individuals in health care decision making
  - Empowers individuals to ask questions

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Purpose of the Toolkit

Michael Hoge, Yale University



Purpose

- Offers a way to store information about treatments, medications, appointments, etc.
- Prompts individuals to assess what they know, what they have, and what they need
- Prompts discussions between the person receiving care, their care team, and supportive individuals
- Provides information and links about resources (e.g., advance directives)

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Who Can Use the Toolkit?
Terminology
Location
How Can I Use the Toolkit?

Erika Robbins, The Lewin Group



Who Can Use the Toolkit?

- *Individuals* with mental health and co-occurring conditions who are moving from one care location to another

- *Supportive individuals* helping another person who is going through a care transition

- *Care team members* who work with individuals with mental health and co-occurring conditions

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Terminology*

What do we mean when we use certain key words?

- *Care Transition*
- *Care Team*
- *Supportive Individuals*
- *Peer Support*

*The Toolkit includes a glossary with these and additional terms

Care Transition
A care transition is when someone moves from one care provider to another. It is also when someone moves from a facility or home to another residential setting. Examples of care transitions are from home to hospital, inpatient psychiatric or residential care facility, between providers, between facilities, or facility to home.

Care Team
A care team is all the staff who assist an individual to transition between locations. It may include nurses, primary care providers, social workers, psychologists, psychiatrists, clergy, specialty counselors, peer supports, navigators, or care managers. You are the center of your care team and have the most important voice in the process. Nothing should be done to you. Everything should be done with you.

Supportive Individuals
Supportive individuals are people who care about you and reach out to you when you need support. Some examples are family members, friends, neighbors, co-workers, employers, peers, mentors, sponsors, coaches, or landlords. This Toolkit refers to these individuals as "supportive individuals."

Peer Support
A peer support is someone who offers help based on shared experiences of living with mental health issues. This peer respects and empowers another person in a similar situation. The person respects and empowers the peer too. They are part of an individual's care team and can be a supportive individual.

Poll 1

- Which option(s) describes your situation? Pick all that apply.
  - I switch between care settings as part of my own health care
  - I am a *supportive individual* for someone with mental health & co-occurring conditions who switches between care settings
  - I am part of a *care team* for individuals with mental health & co-occurring conditions who transition between care settings
  - I am a *peer support* for an individual with mental health & co-occurring conditions who transitions between care settings
  - None of these apply to me

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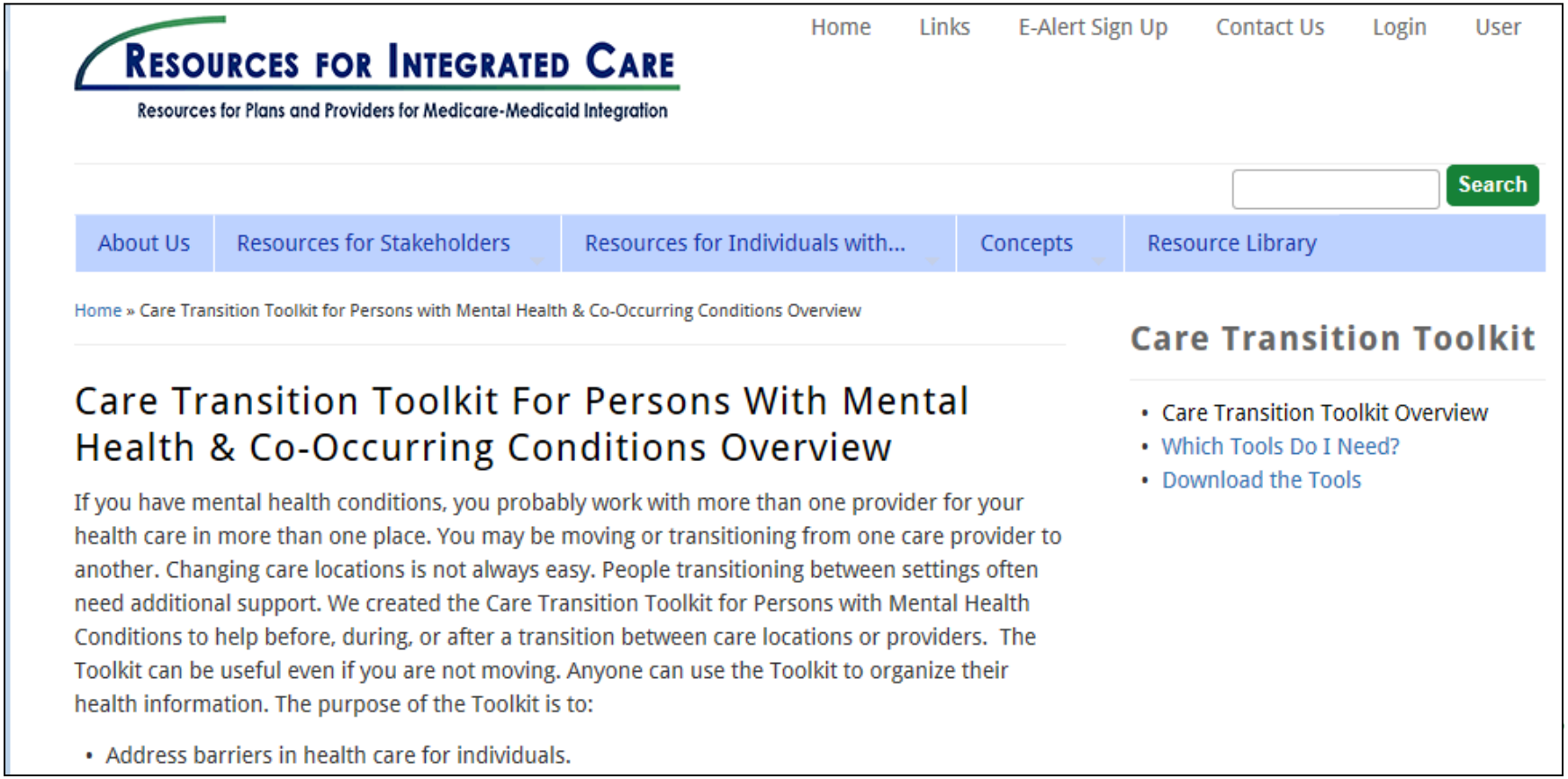
Location

The Toolkit can be found on the Resources for Integrated Care website :

https://resourcesforintegratedcare.com/care-transition-toolkit



How Can I Use the Toolkit?

Print a Paper Copy	Save an Electronic Version
Print out the different sections, fill them out, bring them to doctor's appointments, and keep them in a safe place.	Save the sections as PDF files to your personal computer, fill them out electronically. Information you enter is NOT stored on the Resources for Integrated Care website.

Use All Sections	Mix-and-Match
Users (individuals and providers) are welcome to print or download all sections of the Toolkit and fill out each one.	Users (individuals and providers) are encouraged to pick out the sections most useful to them. In this way the Toolkit can be tailored to unique individual and provider needs.

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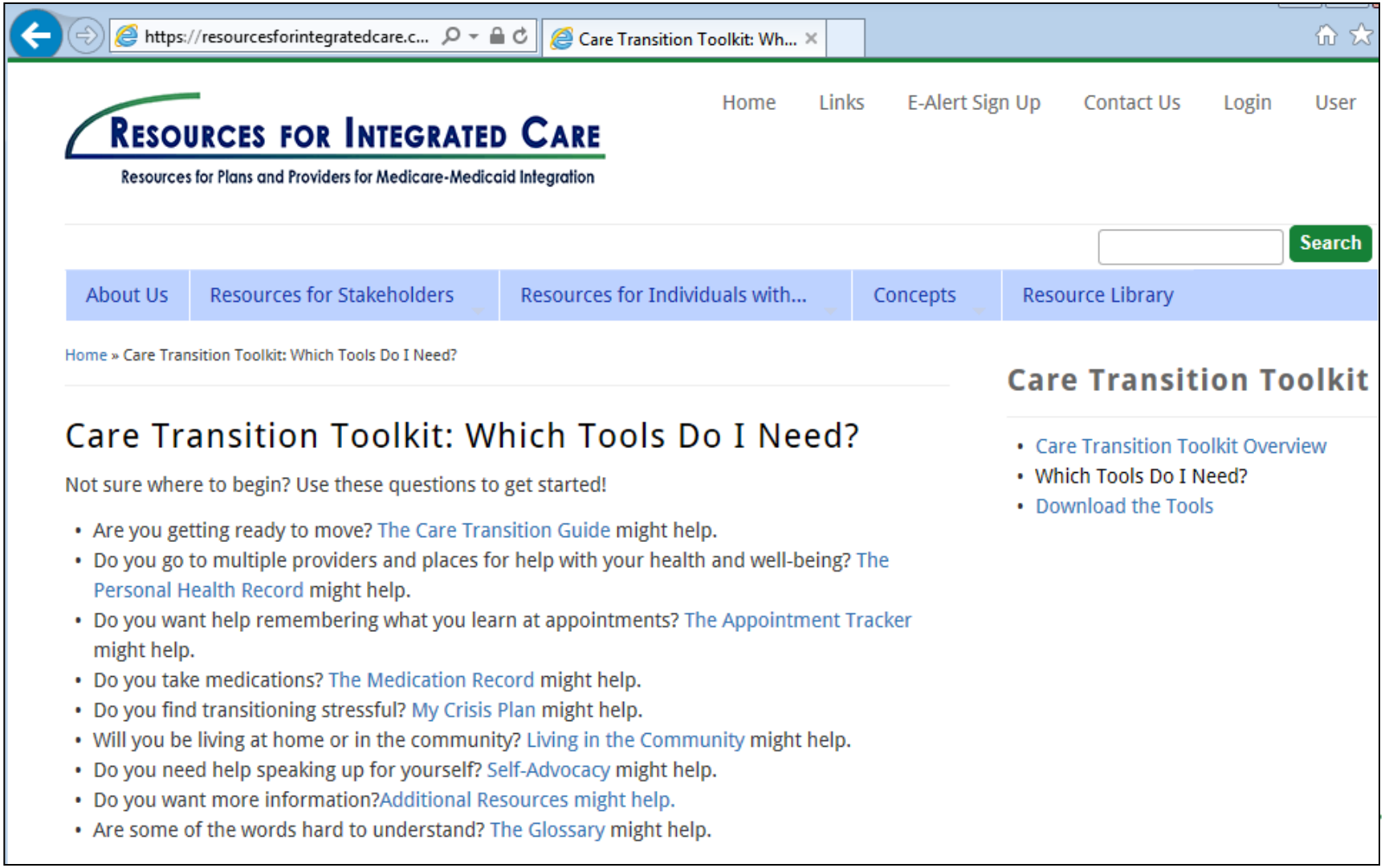
Sections of the Toolkit

Betsy Dilla and Meagan Alley,
The Lewin Group

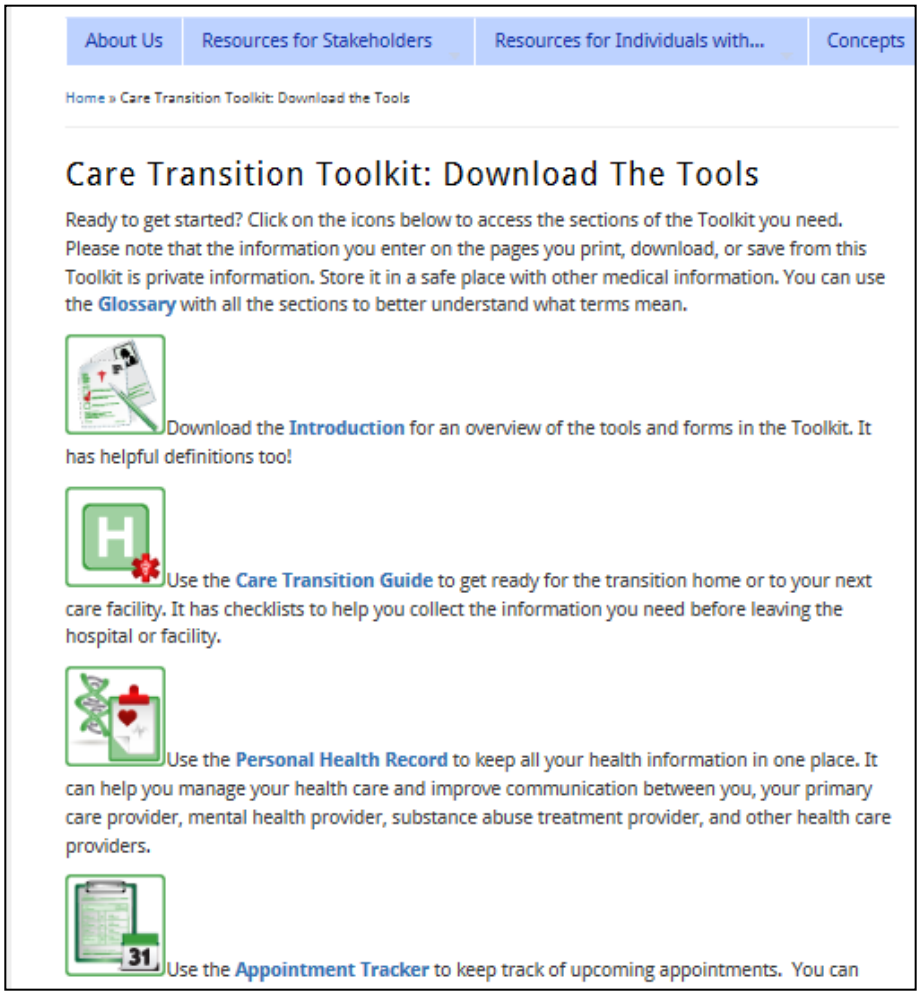


Which Tools Do I Need?



Sections by Title

0. Introduction
1. Care Transition Guide
2. Personal Health Record
3. Track Appointments
4. Medication Records
5. Crisis Planning
6. Living in the Community
7. Appendix A: Peer Support
8. Appendix B: Information about Self-Advocacy
9. Additional Resources



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Introduction

Introduction

Individuals with mental health and co-occurring conditions often receive health care from different care providers in different locations. They may be transitioning or moving between care providers or settings. Changing care locations can be a difficult process, and people moving from one place to another need more support.

The Care Transition Toolkit for Persons with Mental Health and Co-Occurring Conditions guides someone through a care transition. This tool can help before, during, or after changing between care locations or providers. This Toolkit assists individuals with mental health conditions and the individuals who support them. The Definitions box explains some terms used in this document.

The purpose of this Toolkit is to:

- Address barriers in health care for individuals.
- Improve communication when the individual transitions to a setting other than their home.
- Improve communication when the individual leaves a hospital or inpatient psychiatric care facility, nursing home, residential treatment or group living arrangement.

Build or strengthen relationships between members of the care team including the individual and his or her supportive individuals.

This Toolkit contains several tools to help individuals transitioning between care locations or providers. You can use this tool to:

- Keep track of personal health information.
- Take part in the care planning process.
- Share medical preferences with your care team.

Ask your health care team questions whenever needed.

Transitions between care locations can be confusing at times, but your care team is there to help. Good communication helps you understand what is happening.

Start with Definitions

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Care Team
A care team is all the staff who assist an individual to transition between locations. It may include nurses, primary care providers, social workers, psychologists, psychiatrists, clergy, specialty counselors, peer supports, navigators, or care managers. You are the center of your care team and have the most important voice in the process. Nothing should be done to you. Everything should be done with you.

Supportive Individuals
Supportive individuals are people who care about you and reach out to you when you need support. Some examples are family members, friends, neighbors, co-workers, employers, peers, mentors, sponsors, coaches, or landlords. This Toolkit refers to these individuals as "supportive individuals."

Peer Support
A peer support is someone who offers help based on shared experiences of living with mental health issues. This peer respects and empowers another person in a similar situation. The person respects and empowers the peer too. They are part of an individual's care team and can be a supportive individual.

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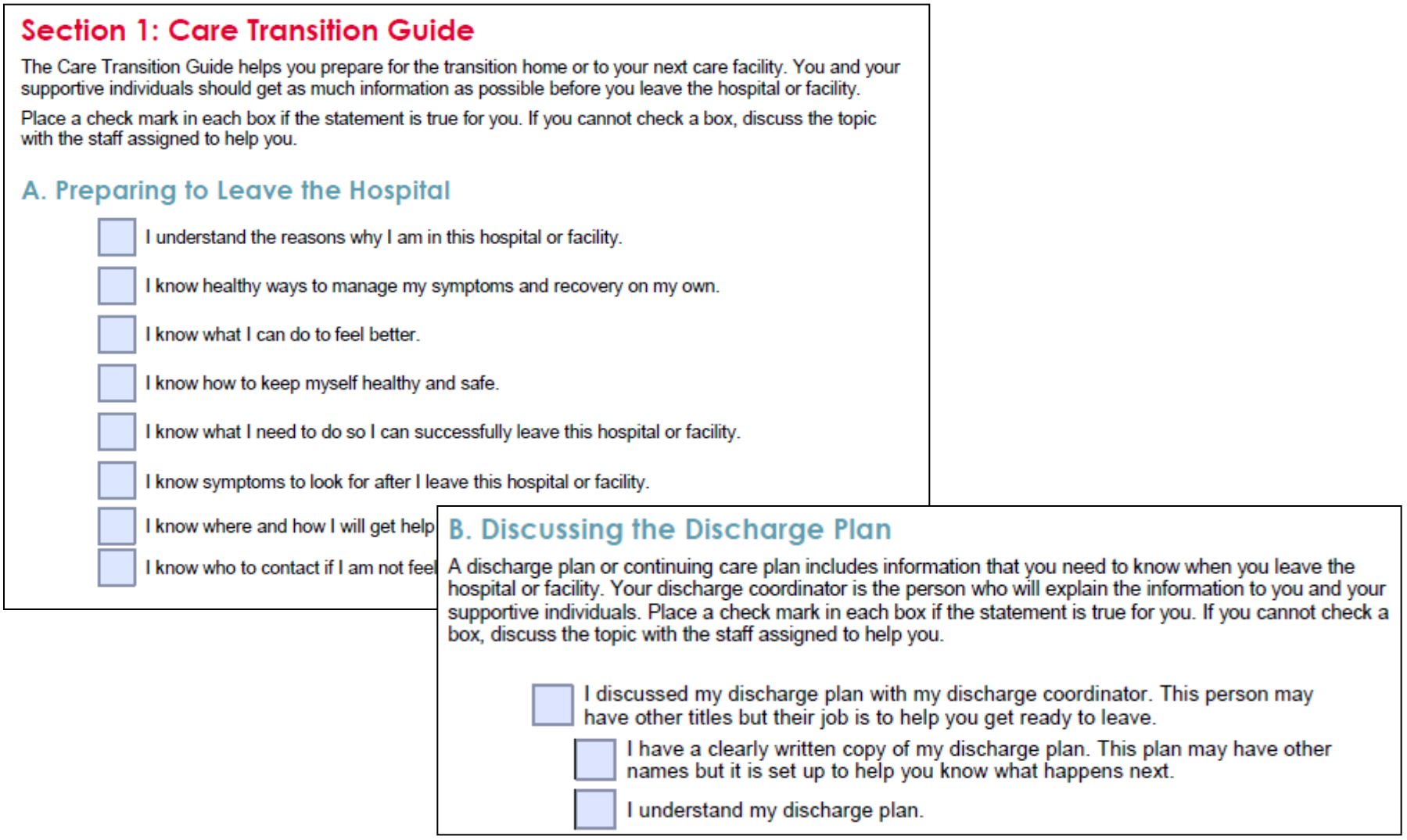
Section 1: Care Transition Guide



Section 1: Care Transition Guide

The Care Transition Guide helps you prepare for the transition home or to your next care facility. You and your supportive individuals should get as much information as possible before you leave the hospital or facility.

Place a check mark in each box if the statement is true for you. If you cannot check a box, discuss the topic with the staff assigned to help you.

A. Preparing to Leave the Hospital

- ☐ I understand the reasons why I am in this hospital or facility.
- ☐ I know healthy ways to manage my symptoms and recovery on my own.
- ☐ I know what I can do to feel better.
- ☐ I know how to keep myself healthy and safe.
- ☐ I know what I need to do so I can successfully leave this hospital or facility.
- ☐ I know symptoms to look for after I leave this hospital or facility.
- ☐ I know where and how I will get help
- ☐ I know who to contact if I am not feel

B. Discussing the Discharge Plan

A discharge plan or continuing care plan includes information that you need to know when you leave the hospital or facility. Your discharge coordinator is the person who will explain the information to you and your supportive individuals. Place a check mark in each box if the statement is true for you. If you cannot check a box, discuss the topic with the staff assigned to help you.

- ☐ I discussed my discharge plan with my discharge coordinator. This person may have other titles but their job is to help you get ready to leave.
- ☐ I have a clearly written copy of my discharge plan. This plan may have other names but it is set up to help you know what happens next.
- ☐ I understand my discharge plan.

Section 1: Care Transition Guide

C. Understanding My Medications

Place a check mark in each box if the statement is true for you. If you cannot check a box, discuss the topic with the staff assigned to help you.

- ☐ I know medication is part of my continuing care plan.
- ☐ I know what my medications are.
- ☐ I know where and how to get my medications.
- ☐ I know how and when to take my medications.
- ☐ I know what I should feel like if my medications are working.
- ☐ If I have questions about my medications or side effects, I will get help from:

Name _____

D. Preparing to Return Home

Place a check mark in each box if the statement is true for you. If you cannot check a box, discuss the topic with the staff assigned to help you.

- ☐ I have a safe and secure place to live.
- ☐ My family or supportive individuals know I am coming home.
- ☐ My family or supportive individuals will support me once I am home.
- ☐ My family or supportive individuals know what help I need when I return home.
- ☐ If needed, I have hired other personnel to help with my care.
- ☐ If needed, I already have a home care referral and physical therapy assessment.
- ☐ If needed, I have home health care when I leave the hospital or facility:

Agency Name _____

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Section 2: Personal Health Record

Section 2: Personal Health Record

The Personal Health Record includes information about you and your health. It helps you keep all your healt information in one place. You can use your Personal Health Record during your primary care and other medical treatment visits. It can help during mental health visits. Take your Personal Health Record to the hospital when you go for medical visits. Use it at home. It helps you manage your health care and improve communication between you, your primary care provider, mental health provider, substance abuse treatment provider, and other health care providers.

The Personal Health Record includes physical, mental and substance use information in all sections. Use thi tool to record all of your contact and health information in one place, including:

- Personal Information
- Additional Needs and Instructions
- Supportive Individual Contact Information
- Provider Contact Information
- Health Conditions
- Appointments
- Medication Needs and Records

Note about privacy:

Most of the information you enter on the pages you download, save, or print from this Toolkit is private information. Store it in a safe place with your other medical information.

A. My Personal Information

First Name	
Last Name	

Address	
Zip Code	State

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Section 2: Personal Health Record

B. Emergency Contacts and Supportive Individuals

As a reminder, "supportive individuals" are people who care about you. They are people you reach out to when you need help. Some examples are family members, friends, neighbors, co-workers, employers, peers, mentors, sponsors, coaches, or landlords. This Toolkit refers to these individuals as "supportive individuals."

	Primary Supportive Individual #1 Name (This is my Emergency Contact)		Phone Number
	Relationship to me		Other Phone Number

C. Provider and Clinic and Hospital Information

Use this list to keep track of your primary care, mental health, and substance abuse provider names and contact information. Also use it to record information about the primary clinics or hospitals you use.

	Primary Care Provider #1 Name		Phone Number
	Primary Care Provider #1 Address		
	Primary Care Provider #2 Name		Phone Number
	Primary Care Provider #2 Address		

Section 3: Track Appointments

Section 3: Track Appointments

You can print or download this tool to keep track of upcoming appointments. Bring this form with you to appointments to write things down during your visit. Keep it with other medical documents for future reference.

A. My Appointment Planner

	Appointment Date Month/Day/Year	HELLO my name is John Doe	Provider's Name	Phone Number
			Address	Provider Type
	Reason for Appointment			
	Questions I Want to Ask My Provider			
	Appointment Outcome *What did you hear at your appointment? Do you need to make a new appointment?*			

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Section 3: Track Appointments

B. My Appointment List

Appointment Date	Provider's Name	Reason for Appointment	Diagnosis or problem
Appointment Date	Provider's Name	Reason for Appointment	Diagnosis or problem
Appointment Date	Provider's Name	Reason for Appointment	Diagnosis or problem

C. Fellowship and Peer Support Meetings

Group Name	Meeting Location	Meeting Day and Time
Group Name	Meeting Location	Meeting Day and Time
Group Name	Meeting Location	Meeting Day and Time

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Section 4: Medication Records

Section 4: Medication Records

This section has two different medication tracking tools. Please include any over-the-counter medications or nutritional supplements you are taking. Tell your provider how your medication is working. Tell them if you experience side effects. Use this list to let all of your providers know all of the medications you are taking. This is important because some medications do not mix.

Choose the tool that will work best for you and help you keep track of your medications:

1. The first form collects lots of information about each medication you take. You will fill out one form per medication.
2. The second form lists your medications by when you need to take them during the day.

A. My Individual Medications (one form per medication)

Medication Name	What Does the Medication Look Like?
How Much to Take	**What Health Condition Does this Medication**
Call this Provider with Questions:	**Provider's Phone Number**
Call this Pharmacy with Questions:	**Pharmacy Phone Number**
Daily Schedule	**Date Started Taking Medication**
Time / Dosage	Month/Day/Year (ex: 06/23/2015)
	Date Ended Taking Medication

B. My Medications (by time of day)

Morning Medications

Drug Name	*Description Color, shape*	*Dose # Pills, puffs, shots*	*Instructions With food, water*	*Start Date*	*Stop Date*	*Provider's Name*

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Section 5: Crisis Planning

Section 5: Crisis Planning

A. My Crisis Plan[1]

Top numbers you can call:

When you are in crisis, or having thoughts about killing yourself: National Suicide Prevention Lifeline **1-800-273-TALK (8255)**	For physical emergencies or if you are attempting suicide: **911**	To call the police when it is not an emergency (local number, not 911):
For support from friends and family during a crisis (e.g. suicidal thoughts, self-harm, inability to manage feelings):	Name: Phone:	Name: Phone:

Transitioning between care settings can be stressful. It may trigger symptoms and feelings. These can lead to a crisis. After you have moved home or to another facility, you may record information in this tool. This information may help you, your supportive individuals, and your care team in case you experience a change in your symptoms or feel stressed. Taking time to record this information will help you during future care transitions.

	Please write down important strategies and thoughts that would help you in a crisis and would help others understand how best to help you:
Things I like to do when I am well that can help me stay well. These are also called self-care strategies. Examples: taking a walk, calling a friend or peer support, listening to music, exercising, eating healthy foods, attending Fellowship meeting	

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Section 6: Living in the Community

Section 6: Living in the Community

Many resources help with recovery from mental and substance use conditions. These include community involvement and/or service, access to healthcare, and a safe and stable place to live. They also include meaningful work and education opportunities and social connections. People who move to the community need community living skills. These skills make sure people know about important parts of community life. This lets them live fully integrated, successful lives and avoid isolation.

Place a check mark in each box if you have the information and support you need for each activity. If you cannot check a box, discuss the topic with the staff assigned to help you.

- ☐ I know how to ask others for things that I need.
- ☐ I know how to find and join activities in the community.
- ☐ I know how to organize or join group activities with friends and peers.
- ☐ If I want to participate, I know how to locate a Drop In or Recovery Center in the community.

  Drop In Center Name

  Phone Number

- ☐ I know how to go grocery shopping and prepare nutritious meals.

  Local Grocery Store Name and Address

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Section 6: Living in the Community

A. My Strengths and Coping Skills

In the table below, identify your strengths and coping skills that help you better manage your mental health. In the last column you can check "Yes" for any items that you would like help filling out.

STRENGTHS AND SKILLS	DESCRIPTION	I WOULD LIKE HELP WITH THIS ITEM
The times I am most at peace with myself:		◯ Yes please ◯ No thanks
My best qualities as a person:		◯ Yes please ◯ No thanks
The things I rely on to pull me through hard times:		

B. Peer Supporters Role

Peer supporters help individuals work with their healthcare team and other recovery supports to make sure that the individual's voice is heard. They also advocate for the individual's self-determined goals. Peer support is culturally sensitive. It looks for and responds to trauma. Peer support focuses on recovery. They help you know about services and supports in the community that support your recovery. From the list below, please check the box next to things that would be helpful to get from your peer support.

- ☐ Provide information about crisis resources, respite and drop in or recovery centers.
- ☐ Provide information about peer support programs and self-help groups in the community.
- ☐ Provide information and tools about Psychiatric and Medical Advance Directives (see Peer Supporters Role part of Section 6: Living in the Community).

C. Wellness

Recovery is about more than getting rid of symptoms. potential for a meaningful life in their community. Peer They can help you find ways to improve and sustain yo Dimensions of Wellness checklist below. Check the bo chosen a way to practice that dimension.

Check Box	Wellness Dimension	Description	Ways I Choose to Practice this Wellness Dimension
	Emotional	Coping effectively with my feelings and life and creating satisfying relationships.	
	Environmental	Good health by occupying pleasant environments that support well-being	
	Financial	Satisfaction with current and future financial situations	

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Appendix A: Peer Support

Appendix A: Peer Support

Peer support is practiced in different places. Many activities can be part of peer support. Both people in the relationship have experience overcoming challenges. They also both have experience living with mental health, co-occurring or substance use conditions. This creates a relationship of sharing. They support each other's healing and growth. It does not focus on deficits. Peer support does not replace needed treatment. It is rooted in kindness and respect for a person's skills, hopes, and dreams. The person and what matters to them are important. Peer support emphasizes strengths. Developing coping skills is a key part, too. Peer support also focuses on creating valued social roles in communities.

Elements of Peer Support include:

1. **Role of the Peer Supporter:** The peer supporter is part of a person's care team.

- Peer supporters help an individual communicate their needs and preferences to clinical providers. They help individuals understand their rights. They also help them advocate for their preferences.
- They help the person understand their illness. They help the person understand the treatments they are receiving. They also help them access services that may be helpful.
- The peer supporter will clearly explain to the person what services and supports they can offer. Their role has limits. They do not conduct therapy. They do not diagnose. Peer supporters are ethically bound to maintain the person's safety if they disclose plans to harm themselves or others.

2. **Peer Supporters use Strengths-Based Approaches:** Peer supporters help the person see their own abilities to cope with, and overcome, personal challenges. Then the peer supporter helps the person build on these abilities. They help the person identify and use "people, places, and things." These can help them reach their goals. Peer supporters can use their own experience to encourage hope that recovery is possible. Peer supports help people comply with and complete their treatments.
3. **Peer Supporters are Community-Based:** Effective peer support engages people in valued roles in the community. It promotes people taking part in community activities. Peer support helps people participate in their community. This lets them give back to their communities.

Recovery Support & Goal Advocate

The strengths of a peer supporter are their lived experience and understanding that recovery is an ongoing process. The peer supporter instills hope that recovery is possible. They can personally relate to the challenges of living with mental health conditions. Peer supporters also:

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Appendix B: Information about Self-Advocacy

Appendix B: Information about Self-Advocacy

This appendix on Self-Advocacy gives you tips on how to ask questions and find resources to satisfy your needs, preferences, and rights. You and your supportive individuals can refer to the tips when planning for services and supports. The tips are a way for you to stay involved and at the center of your care plan.

Sharing your needs with others will increase the chance that your needs will be met. There may be times when you feel like you need to share what is best for you. Speaking up lets others know what you want and need. There are many different ways to advocate for yourself or other people. Some ways may feel more comfortable to you. This tool provides some helpful tips and ideas about how to start. See Section 7: Additional Resources in this tool for other resources.

Tips to Advocate for Yourself

- **Tip 1: Be an active participant in your care planning.**
  One good way to advocate for your needs and preferences is to bring together the people who support you and your interests. When your care team involves you in the care planning process, make sure to use that opportunity to share your needs! First, clarify what your goals, needs, and wishes are. Second, communicate them to others. Finally, talk to your supportive individuals about your preferences for when you go home. Talk about the services and supports you need, and who you want involved in changes to your care plan or health care.

- **Tip 2: Do not be afraid to ask for help.**
  Many places can offer services to help both you and your supportive individuals. For example, transportation, housing, meals, support groups, and counseling services can support both you and your supportive individuals. The discharge planner and your community-based care team (for example, your case manager or navigator from a mental health or other agency) can help you find the support you need. One place is the Administration for Community Living's No Wrong Door (also known as the Aging & Disability Resource Centers) Program. More information is in the National Resources part of Section 7: Additional Resources in this tool.

- **Tip 3: Slow down.**
  People often make decisions in a hurry. As the person receiving care, you will have many decisions to make when you return home. It is important to start the discharge planning process early. Your family member or supportive individuals may start researching your options while you are receiving care in the hospital or facility. Upon admission, seek help from your discharge planner and get support from your community-based care team (for example, your case manager or navigator from a behavioral health or other agency).

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Additional Resources

Section 7: Additional Resources

A. General Resources

Category	Resources	Location
Help with Bills	If you need help paying crucial bills:	www.needhelppayingbills.com
	If you need help paying utility bills:	www.utilitybillassistance.com
	If you need discounted telephone services:	www.phone-bill-assistance.com
Getting a job	Every state offers vocational rehabilitation services. These services help prepare workers with mental or physical disabilities to get and stay in work. These sites have information on General Employment Supports & Tips, Career Research, Education & Training, Vocational Rehabilitation Services, and more.	State Vocational Rehabilitation Agencies Job Accommodation Network Ticket To Work (Social Security Administration) National Organization on Disability Project OPEN site, "Resources": www.peeremployment.com
Planning Your Money	This site has information on: ► Budgeting ► Social Security Benefits ► Addiction & Financial Issues ► Money Saving Tips & Resources ► And more	Money Basics site, "Resources & Info": www.money-basics.info
	This section of the National Alliance for Mental Illness website explains Special Needs Estate Planning.	www.nami.org
	U.S. Department of Housing and Urban Development: Homelessness Assistance	http://portal.hud.gov

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Poll 2

- Based on what you know of the Toolkit, which sections do you think you would use or recommend? Pick all that apply.
  - Care Transition Guide
  - Personal Health Record
  - Track Appointments
  - Medication Records
  - Crisis Planning
  - Living in the Community

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QUESTIONS

Website www.ResourcesForIntegratedCare.com

Email RIC@lewin.com

Twitter @Integrated_Care

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Survey

Thank you for joining our webinar.
Please take a moment and complete
a brief survey on the quality of the webinar.

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