

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. Good communication also helps other members of your care team understand your needs. This helps you get the health care that is right for you. This Toolkit assists you and everyone involved recognize what is important to you about your health care.

Privacy notice: *The information you enter on the pages you print, download, or save from this Toolkit is private information. Store it in a safe place with other medical information.*

Start with Definitions



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.