Appendix

Patient name: Joe Smith DOB: 11/25/1990 Age: 24

Patient insurance: none Telephone: 555-555-5555

Diagnostic Assessment/ Medication Management	Day: Monday Date: May 25, 2015 Time: 9:00am Your Medical Provider is: Dr. Martinez **Please arrive 30 min. before your appointment**
Counseling	Day: Tuesday Date: May 26, 2015 Time: 11:30am Provider: Dr. Roberts
Care Coordination	Tasks: 1) CAT in home program to help with medication follow through and daily structure 2) No Insurance Get CareLink 3) Help paying for medication
Long Term Planning	Service: Intake Date: TBD Time: Destination: Center for Health Care Services - Zarzamora

Referring Source: MSTH TCC Triage Staff: Dr. Velligan

TCC Start Date: May 16, 2015 End Date: August 16, 2015

☐ Check if patient declines TCC services. Please indicate reason:

_____ _____

Patient Signature Date TCC Representative Signature Date

TABLE 1. Services and funding sources of the Transitional Care Clinic (TCC)

Dimension	Description
Overview	The TCC is an outpatient clinic providing services for up to 90 days for patients referred from the emergency room or discharged from inpatient care. TCC services are provided until a warm handoff can be made to community services, which are booking months out.
Engagement	A TCC outreach worker visits hospitals daily to introduce the clinic to patients and family members who will be referred to the TCC on discharge, calls patients prior to their TCC intake appointment to remind them and help them address barriers to attending, and calls patients who miss the intake appointment in an attempt to engage them in services. The TCC recently purchased a van to provide transportation as needed.
Access Group intake	TCC procedures are designed to ensure intake as soon as the day after discharge. Inpatients are given an appointment time by hospital staff, who use a Web-based referral system. Patients who the miss the appointment can attend the Access Group on any morning. Patients in the group take turns explaining the circumstances of their hospital admission and identifying their service needs. After the group, patients wait in the waiting room while the team meets to get them appointments for the requested services on the basis of need. Patients are then checked out individually by a staff member and given a copy of a person-directed plan developed in collaboration with the patient, along with appointment times and dates.
Psychoeducational family group	Family members present on the day of the patient's Access Group intake participate in a psychoeducational family group. Group leaders gather information about the patient and provide families with access to information about coping with and understanding mental illness. No PHI is shared. An ongoing family group is also conducted weekly for support and education.
Medication management	Prescribers, including psychiatrists, advanced-practice nurses, residents, and nursing students work together to assess and treat symptoms.
Individual and group psychotherapy	Evidence-based models of cognitive-behavioral therapy, solution-focused therapy, and motivational interviewing are used to help patients cope with symptoms and move toward recovery
Cognitive adaptation training	Home visits are offered to patients who are suicidal, psychotic, or disorganized to help them adhere to medication treatment, structure their day, and move toward recovery. Cognitive adaptation training therapists may take patients to their TCC appointments and their initial intake appointments at agencies for longer-term follow-up.
Care coordination	Case managers provide care coordination to deal with the many needs of this population, including stable housing, insurance, follow-up for general medical problems, food stamps, and other services.
Shared decision-making coach and resource room	Individual sessions before medication visits assist patients in getting more out of their visit, communicating needs to their prescriber, and ensuring that their values and preferences are reflected in health care decisions.
Funding sources	115 Medicaid Waiver Program, Methodist Health Care Ministries, and Patient-Centered Outcomes Research Institute