



Enhancing concurrent capability:
A toolkit for managers and staff

Transitions in care

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Introduction

How was this toolkit chapter created?

The content for this chapter was developed following a literature review and discussions within the organization to establish what resources were available and what needed to be included for Addiction and Mental Health (AMH) related to transitions in care. This chapter is one of eight in the Enhanced Concurrent Capability (ECC) Toolkit. A number of relevant websites were reviewed related to specific addiction and mental health associations and organizations. Content was validated with a variety of stakeholders who were part of a provincial working group and AMH Strategic Clinical Network (SCN). Representation on these committees was inclusive of the various zones and sectors representing Addiction and Mental Health in Alberta Health Services.

We would like to acknowledge the work of the participants who helped create this resource and are grateful for their valuable contributions.

We are committed to matching the toolkit content to the needs of the people who will be using it. We welcome any feedback, questions, or suggestions for content additions or revisions. We wish to learn from the experiences at the front line, so please let us know how well this toolkit works for you by emailing us at concurrent.disorders@ahs.ca

What you will learn in this chapter

This chapter will highlight and discuss transitions in care for persons with concurrent disorders. Topics that will be focused on will include the key considerations for transitioning someone from one level of care to another, when and where transitions take place, how transitions should occur and how to work collaboratively with all members of the team to ensure successful transitions in care.

As with other chapters in this toolkit, we have tried to keep the main part of the chapter brief. There is detailed information available in the Appendices where you can read about topics of further interest to you. Throughout the chapter and in the Appendices you will find additional information on resources on transitions in care, specifically Appendix A provides a variety of vignettes that can be used in some of the exercises in the chapter, or for other illustrative purposes through the document when you need to provide an example.

The following topics are covered in this chapter

- When and where transitions in care happen
- How transitions in care happen
- Planning for transitions in care
- The care plan and required documentation
- Patient experiences with transitions

Terms and definitions

For the purposes of this chapter, the following terms and definitions will be used:

Care team: team of people who work collaboratively with the individual, their family and other health care providers to ensure the individual receives the support needed to achieve goals in their recovery journey (may include family physician, elder, community counsellor, probation officer, psychiatrist, addiction worker, mental health clinician, peer support worker, housing support worker, outreach worker, teachers, etc.)

Co-occurring disorders/concurrent disorders: for the purposes of this document refers to a combination of mental health disorders and either substance use disorders or problem gambling.

Family: for the purposes of this document, “family” refers to persons who the individual considers as being part of their support system, including immediate relatives, extended family, partners, friends, advocates, cultural supports, guardians, etc.

Individual or person: “individual” or “person” refers to the person, patient, or client in question who has a concurrent disorder and is working with clinicians, family and/or others on recovery, treatment or care. These two terms will be used interchangeably.

Informed consent: consent provided by the individual, or their family as appropriate, to allow their provider to release information and/or agree to treatment after the individual, the family as appropriate, and their care team understand the benefits and risks of all options.

Integrated treatment planning: recovery planning that includes the individual, their family and the care team to support them in setting goals for their recovery, and where there is shared responsibility to develop a single recovery plan addressing both addiction and mental health issues.

Keep and consult: when health care providers ‘keep’ working with individuals with concurrent disorders to minimize transitions and reduce the frequency of individuals moving between services by ‘consulting’ with other clinicians, colleagues, and services when questions arise about diagnoses or questions about working with the individual in which they may require additional expertise.

Navigator: a person or role within the healthcare system who support seamless transitions across the continuum of care and assist individuals and families to access services as needed.

Service coordination: services are focused on the individuals needs and strengths and may include basic needs (housing, food, financial, legal, medications, crisis, etc.), as well as addiction and mental health concerns by advocating for the individual and/or their family.

Safety plan: a plan developed with the patient/individual and is usually summarized as a written plan for the management of increased danger of suicide or non-suicidal self-injury (self-harm), and how to stay safe in and out of hospital. Strategies, choices, moments of control, coping strategies and contact numbers that were discussed during the intervention should be included in the safety plan. (Alberta Health Services, 2011, p7).

Treatment/intervention: specific strategies or therapeutic techniques for concurrent disorders, diagnoses or symptoms of the diagnoses. Synonyms for the term treatment include therapy, intervention, help, counselling and care. Treatments can be acute interventions to establish safety, short or long term interventions towards recovery goals, and strategies to support socio-economic factors that impact the recovery journey. For the purposes of this document we will also use the term ‘intervention’ interchangeably with treatment.

Recovery: recovery is an individual journey and the goals of the individual may include living a satisfying, hopeful, and contributing life, even when health problems and illnesses cause ongoing limitations. Implementing recovery-oriented practices that will enhance health outcomes and quality of life for people with lived experience and their families.¹

Recovery journey: a process of change through which an individual can improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Transitions in care: this term refers to the ‘movement of patients of all age groups between health care providers, services, and/or sectors’ (Alberta Health Services, 2017, p12).

Warm handoff: for the purposes of this document refers to a transfer of care between two members of the health care team, where the handoff involves the patient and family. This transparent handoff of care allows patients and families to hear what is said and engages patients and families in communication, giving them the opportunity to clarify or correct information or ask questions about their care.

¹ Adapted from the Mental Health Commission of Canada definitions <http://www.mental-healthcommission.ca/English/focus-areas/recovery>

Care transitions

What are transitions in care?

Transitions in care mean ‘the movement of any patient [person receiving care] between health care providers, services and/or sectors’ (Alberta Health Services, 2017, p12).

It has also been defined as, ‘a series of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location’ (Alberta Health Services, 2015, p 24).

Transitions in care can take place between units, services, facilities, providers, sites and zones. Essentially, every time an individual’s care is undertaken by a new person or service, and communication about the care plan is required, there is a transition. The overall experience of an individual in transition can be a difficult time and are often periods of increased stress and suicide risk.

Patient First Strategy

Alberta Health Services Patient First Strategy can be applied to working with individuals with concurrent disorders. The strategy is about strengthening AHS’ culture and practices to fully embrace patient-and-family centred care (PFCC) at AHS.

One of four sub-themes of the strategy is to Improve Transitions in Care by (Alberta Health Services, 2015):

- Facilitating the development of a standardized, provincial transition process that recognizes the uniqueness of patients and families in order to provide the highest quality of care, and
- Establishing shared accountability between care providers for discharge and transitions.

CoACT

In aligning with the Four Foundational Strategies, the CoACT Collaborative Care Design supports three principles: Patients First, High-Performing Teams, and a Quality Culture focused on integrated care and safe care transitions. Within Collaborative Care, patients and families work closely with their care providers, and providers work closely with each other. In caring together, all involved use evidence to inform decisions about clinical care content, process, outcomes and next steps.

(Collaborative Care Resource Guide, Alberta Health Services, 2018, p12)

Collaborative care is where providers collaborate more closely with each other, patients and their families which helps improve patient experience and outcomes, provider experience, and the delivery of high-quality health care.

The CoACT program helps to establish high-functioning teams and uses quality processes and measures to ensure patient-centred, collaborative care and smooth transitions between levels of care.

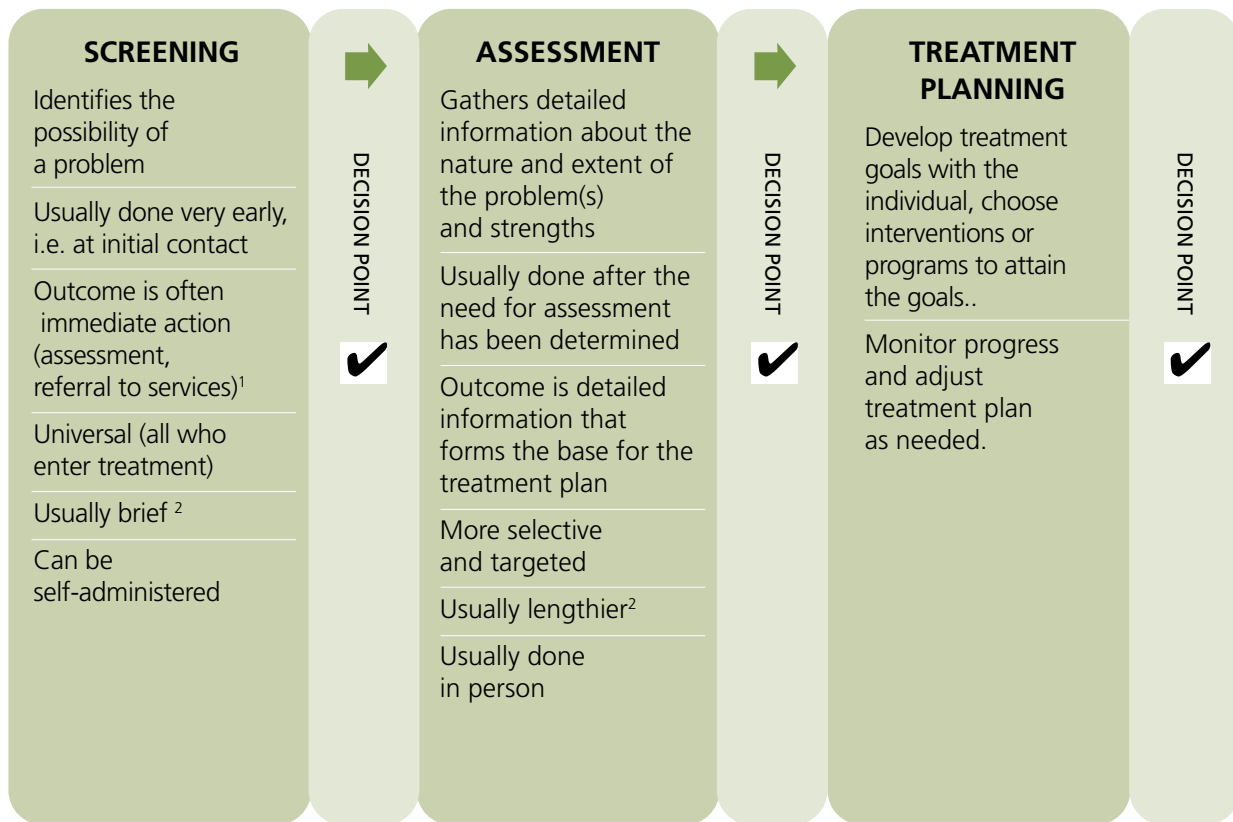
Check out Appendix B for AHS-specific examples and infographics related to CoACT.

Clinical decision making: Transitions in care

As discussed in previous chapters, screening, assessment and treatment planning can overlap, yet they have unique qualities and follow a progressive timeline. The sequencing of the three activities makes sense – each process builds on the other process as shown below. Between each process is a decision point where the treatment team, in collaboration with the individual, and/or family, decide what to do next.

Transitions in care happen throughout a person’s care, at and between each touchpoint in the decision-making process.

Clinical Decision-Making Process



¹ While the assessment may identify immediate needs, it is usually more concerned with longer-term treatment planning and service coordination.

² Some assessment tools may actually be briefer than some screening tools if the assessment tool focuses only on specific disorders, and the screening tool is multidimensional in its coverage.

The standard approach to concurrent capable practice

While this chapter will focus on transitions in care, it is a good time to review concurrent capable practices in general. As discussed in previous chapters, The Standard Approach to Concurrent Capable Practice algorithm outlines a process for concurrent capable practice as outlined in the Figure below. Selecting the right combination of interventions with and for the person seeking treatment is done as part of this process. It is important to recognize that even though the process has certain steps, it is also cyclical in nature and is a process of ongoing re-assessment and continuous care that changes as goals are met and priorities shift.

A Standard Approach to Concurrent Capable Practice

First contact with person

EVERY DOOR IS THE RIGHT DOOR...

Concurrent Capable
Addiction Services

Concurrent Enhanced Programs
Integrated AMH Teams

Concurrent Capable
Mental Health Services

WELCOME AND ENGAGE

Observe and gather information on appearance, behaviour and cognition (ABC) and review history, while establishing rapport and engaging individual/family

SCREEN FOR CONCURRENT DISORDERS

Using a reliable tool (GAIN-SS, DSM-V CC, etc.) identify the presence of a mental health, addiction or concurrent disorder

BRIEF INTERVENTION

- Solution focused
- Single session or more (5-10)
- Crisis intervention

WARM HANDOFF

- Mental Health
- Addictions
- Concurrent Enhanced Service
- Community supports

KEEP AND CONSULT

Consultation, collaboration and coordination with other service (addiction or mental health) and other involved service providers

COMPREHENSIVE ASSESSMENT

- Recovery oriented, collaborative process that is person-centred, trauma informed and strengths based
- Involves person/family and other services providers in care coordination
- Reassessment is ongoing throughout the recovery journey with shifts in treatment planning as needed

INTEGRATED TREATMENT PLANNING

COMPREHENSIVE INTERVENTIONS

TRANSITIONS IN CARE

Transitions in care: An integral part of your practice

Transitions in care recognize that the individual receiving care is part of the care team and may have multiple needs. Collaborative teams work with the individual to ensure that transitions in care between services, facilities and providers are coordinated and match the individual's recovery goals (Adapted from Alberta Health Services, 2017, p8).

Just like in Integrated Treatment Planning, transitions in care should be recovery-focused, and trauma informed to ensure the most appropriate care is being provided to match with the individual's recovery goals.

Transitions in care happen all of the time and in many different ways. Transitions in care can be challenging and many different terms and names are used to describe it or aspects of it including discharge planning, collaborative care, and case management. Transitions in care are all of those things, and more.

Transitions in care can be done with a 'warm handoff', and should:

- Be seamless, coordinated and comprehensive
- Be person-centered
- Be inclusive of the person receiving treatment, the person's family members as appropriate, and the providers and/or care, teams, to which care is transitioning to and from
- Be carried out in a culturally appropriate way for the individual
- Be trauma informed
- Be recovery focused
- Consider each person's diversity
- Include a 'coordinated, [multi-provider], multi-agency approach' (Young Minds, 2012)

As part of the concurrent capable care algorithm, the term 'warm handoff' is mentioned. This part of the process should take place across the continuum of care and especially during transitions in care.

What is a 'warm handoff'?

There are several definitions of a 'warm handoff' including:

- An approach in which the [care provider] does a face-to-face introduction of a patient to the [provider/service] to which he or she is being referred

(Center for Integrated Health Solutions (CIHS) as cited in Care Compass Network, 2016)

- A novel approach to care transitions in which health care providers directly link patients with specialists, using face-to-face or phone transfer.

(Richter, 2012)

- A warm handoff is a transfer of care between two members of the health care team, where the handoff occurs in front of the patient and family. This transparent handoff of care allows patients and families to hear what is said and engages patients and families in communication, giving them the opportunity to clarify or correct information or ask questions about their care.

(Agency for Healthcare Research and Quality, 2017)



Transitions in care can often be the points where care can be interrupted, lost or fragmented. Individuals may be at risk during transition of experiencing more mental or emotional stress due to extra challenges, changes and disruption (RARE, 2015). A ‘warm handoff’ helps to reduce or eliminate these issues and can provide the individual with an additional level of comfort and trust in transitioning to a new provider or service.

When the transition involves more than one provider, continuity can be improved when providers assist and accompany people, and provide relevant information. In this way, individuals and families are introduced to a new provider and don’t have to tell their stories all over again.

A **navigator** or peer can be part of a ‘warm handoff’ to guide individuals and families and ensure seamless transitions (Conte, 2018).

The provider usually has enormous influence on how the individuals will perceive and respond to the new services and care. With a ‘warm hand-off’, the care provider directly introduces the individual to the new service and providers at the time of the individual’s first visit or pre-visit. The ‘warm hand-off’ establishes an initial face-to-face contact between the individual and the new care provider and confers the trust and rapport the individual has developed with the previous provider to the new one. (Adapted from reference <https://ccalac.org/wordpress/wp-content/uploads/St-Johns-Warm-Hand-Off-PP.pdf>)

A warm handoff is more than sending a referral. Here are some tips to make it more successful:

- Meet face to face with the referral agency and the person and their family
- Invite the person to meet at the new office next time
- Develop a collaborative relationship with internal and external community partners
- Call the referral agency and discuss the referral prior to sending the referral package
- Continue to support the person until their initial visit with the referral agency

For more information on warm handoffs, refer to:

Implementation Quick Start Guide to Warm Handoffs by the Agency for Healthcare Research and Quality (AHRQ) at <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfepprimarycare/warm-handoff-qsg-brochure.pdf>

Alberta Health Services care transitions policies and procedures

Alberta Health Services has a set of policies and procedures related to transitions in care for patients that clearly outline some of the steps that need to be taken to ensure safe, timely and seamless services during transitions of care.

These policies and procedures specifically focus on health care providers in ambulatory and residential Addiction and Mental Health programs and ensure that patients and families are active partners in their care.

Where do transitions in care happen?

Transitions take place between facilities, between people and providers, levels of care, across the continuum of care, and between programs.

Transitions may be from inpatient to outpatient services; from one setting to another such as hospitals, emergency departments, nursing facilities, the person's home, primary care or physicians' offices, recovery housing or long-term care facilities; from detox units or corrections facilities to community settings; and between health care providers.

Transitions in care can happen at various levels of care, within settings and from one level of care to another, between geographical locations, from acute, corrections, or residential to community, from urban to rural settings, and so on. For all transitions, it is important to consider where the individual is transitioning from and where they are transitioning to and to connect them with local services and providers as appropriate.



When should transitions in care happen?

Transitions in care should be considered and occur to ensure that the individual is receiving the most appropriate care in a timely manner resulting in improved health outcomes.

Each individual will transition at a different time, to a different place and for different reasons. This is a very individualized plan and should take into consideration the individual's recovery goals.

How should transitions in care happen?

The process of transitioning care has some key components to help ensure that all care team members are involved in the transition, and that coordination of care is provided through sharing of information and informed consent.

Paper copies of plans and health information can be provided to all involved team members, including the individual and family, as appropriate.

Alberta Health Services has developed Concurrent Capable Standards for AMH Services

A Handbook for Individuals and Families outlines what a person or their family can expect when accessing addiction and mental health services. One of the standards is Transitions in Care – see Appendix C for a quick reference of the Standard.

Questions about who you can share information with?

Check out the Health Information Act.

‘The Health Information Act (HIA) sets out the rules for the collection, use, disclosure and protection of health information that is in the custody or under the control of a custodian. Examples of custodians include Alberta Health, Alberta Health Services, Covenant Health, physicians, pharmacists, registered nurses, and dentists.

The HIA strikes a balance between the protection of privacy and enabling the appropriate amount of information sharing to provide health services and manage the health system.’ (Alberta Health, 2018)

For more information about HIA check out <https://www.alberta.ca/health-information-act.aspx>

What do patients say about transitions in care?

As part of AHS consultations on patient- and family-centred care, ‘participants discussed the challenges of transitions in care as being:

- lack of communication systems to facilitate seamless transitions, and
- lack of processes to safeguard transitions

They also linked poor transitions of care to poor health outcomes. Patients, families and health care providers want to improve the ways providers share information with patients during transitions, such as checking assumptions, providing both written and verbal information, and ensuring patients know who to contact, when, and for what reasons. Patients, families and health care providers also want improved communication between providers at transitions of care.’ (Patient First Strategy Consultation Report, Alberta Health Services, 2015, p25)

Patient Experience Quarterly Report on Transitions in Care, 2017 stated:

‘We know that poorly coordinated transfers and discharges can cause anxiety and frustration, leading to a poor patient and family experience. Lack of discharge preparation increases the likelihood of emergency department visits and unplanned readmissions and can affect patient outcomes.’ (Alberta Health Services, 2017, p4)

Key elements for successful transitions in care

- All team members, including the individual, and/or their family members, are included in the transition plan
- Planning for transition is undertaken, including opportunities for family and individuals to ask questions about next steps
- Information transfer to the individual and their family; and between and among service providers.
- Follow-up with the individual transitioning to new services or providers is completed
- For instance, when an individual is introduced to an outreach worker prior to transition and has a follow-up date/time/place with this person.

{ Ensuring a seamless transition in care' is essential in providing quality health care... }

(Alberta Health Services, 2015, p 24)

Planning transitions in care

With transitions in care, many parts of an individual's care need to be considered. Planning should involve all members of the care team, including the individual receiving care, providers or family members, as appropriate.

Planning requires careful consideration of many aspects that could impact their recovery and transition to a new provider, service, setting or level of care. Consideration should be given to:

- Financial support and/or needs
- Transportation needs for work, activities, appointments etc.
- Cultural needs and considerations of the individual
- Language needs
- Medication reconciliation – access, administration, assertive outreach
- Participation in community activities
- Supportive community members like family or friends

- Legal processing requirements (i.e., Trustee, power of attorney, guardian)
- Ability to arrange appointments

Some transitions take time; usually longer stays in one setting require more time for a transition to a new setting or level of care. Ensure you start planning for transitions with enough time to make them successful.

Exercise: The complexity of transitions in care

Below is a scenario that requires careful consideration when planning for transitions in care. Consider the complexity of what might be needed for the following:

exercise

An individual has been an inpatient on an addiction and mental health acute adult unit for 6 weeks. He has been off work, he is in need of new housing, and he has community follow up appointments upon discharge.

How can the person and their family be included in the transition planning process?

Consider the need for follow up phone call after discharge to check mental status and remind of appointment.

Information transfer

Not only should the transition care plan be provided to the individual and/or their family members, but it should also be provided to the new team or service working with the individual.

Ensuring that all of the appropriate information is transitioned to the new team or service, in a timely manner, is critical to ensuring transitions in care are successful.



A Required Operational Practice (ROP) Tip Sheet for Information Transfer at Care Transitions (2016) states:

- The team transfers information relevant to the care of patients among service providers during care transition.
- Information is transferred accurately where clients experience a change in team membership or location: admission, handover, transfer, and discharge and is documented.
- Use standardized tools to transfer information.
- Give clients and families the information that they need to make decisions and support their own care during care transitions.

These practices are assessed regularly as part of an accreditation process.

Follow-up after transition

Follow-up after a transition is a key step in the continuum of care to ensure that an individual receives the care or services required and that the transition of services is as seamless as possible.

What does follow-up look like?

Follow-up requires planning ahead of time so that the individual knows the person, place, date and time of the follow-up appointment or phone call.

This also means that the health care provider who is leading the transition should be in touch with the follow-up service or provider, ensuring that they have the transition plan and any other relevant information required.

For example:

- Brad will meet with Fred at the Addiction and Mental Health Services office in Red Deer on Friday, June 1, at 10:00 am.
- Sally from a community outreach program will phone Jane at 2:00 pm on Monday, June 4, to follow-up.

What happens during a follow-up call or appointment?

Follow-up with an individual is to ensure that they are on track with their new service or provider, answer any questions that have come

up since transitioning, and to assess the individual to ensure they are not in crisis.

Checking in with the individual is part of the overall care plan and helps to make sure transitions are going as planned.

Best practice suggests that once the follow-up contact has been made with the individual that the follow-up provider connects back to the originating provider to let them know how the individual is doing.

See Appendix D for a sample follow-up call process.

What happens after follow-up when someone is in crisis?

If the follow-up call or appointment indicates that the individual may be in crisis, the follow-up provider must act to determine their risks, needs and required supports and interventions. This may range from contacting the individual's emergency contact list on the transition plan, to de-escalation where the individual does not require follow-up, to calling police services or crisis teams.

What happens when the follow-up doesn't happen?

If the follow-up phone call or appointment doesn't occur, this requires further investigation to ensure that the individual is okay or if they need to rebook their follow-up call.

Attempts should continue to be made to connect with the individual if they missed the planned follow-up call or appointment and to reschedule another one.

If contact is lost with the person, communication lines between the transitioning and receiving providers should be open to plan next steps and consider if the individual may be in crisis and at-risk.

The transitions in care plan

A transitions in care plan should include a document that the team, including the individual receiving treatment, can use to help guide the next steps in recovery no matter what level or type of service they are participating in. The plan also helps the next provider or support worker understand the next steps the individual will be taking in recovery, as well as what they have succeeded at in the past.



A transitions in care plan should be co-created with the sending provider, the individual and/or family as appropriate, and the receiving provider or service to ‘identify and manage risks to the [individual] while care is being transferred.’ (Policy, Alberta Health Services, 2016, p2)

A patient-centred transition plan should list:

- Name and contact information of the health care provider coordinating services
- Name and contact information of the new service or health care provider
- How to access essential and urgent services for the individual receiving care, including 24-hour crisis and emergency services
- The individual’s goals for recovery
- Steps the individual is to take if they need help or are in crisis
- Relevant personal information

The individual can take this plan with them whether they are in community, hospital or rehabilitation settings.

Ensuring that a transitions in care plan is effectively developed means more than just filling out a piece of paper. It requires careful thought and collaboration with the person and their family, as well as other team members, agencies, programs and services.

The role of the sending and receiving provider

The roles and responsibilities of the sending and receiving care team and responsible health care provider ensure transitions are communicated in a patient centred manner. Below is an overview of both roles.

If you are working with an individual to transition them to a new provider, team or program, you should:

- Establish goals for the transition with the individual and family
- Assess the individual for readiness for transition
- Co-create a care transition plan with the individual, family and receiving service or provider
- Provide all referral information to the receiving provider, and individual
- Ensure that the individual is informed about what the transition might look like
- Connect with the new provider, team or program and ensure that they have all of the correct and up to date information about the individual's plan for care and recovery, and answer any questions they might have
- Help to coordinate the transition from one service, unit, facility etc. to another
- Notify the primary care physician, as appropriate, of the care transition plan.

As the receiver of transition information, you should:

- Ensure you receive all relevant transition and recovery plan information for the individual coming to your area
- Acknowledge receipt of the referral
- Correspond with the transitioning team and/or individual involved about any questions or clarification required to do with the transition plan
- Confirm a date, time and location for the individuals first meeting or appointment with you



- Communicate with the sending provider, and/or primary care physician, if the individual does not attend their initial appointment
- Meet with the individual to welcome them and introduce them to the new facility, unit, service and team
- Follow-up with an individual to see if they have any questions about the new service

Transitions from youth to adult services

Special consideration has been given to the transition of individuals who are part of child and adolescent services into adult services at a prescribed age. The Mental Health Commission of Canada (MHCC) calls these individuals ‘emerging adults’ and note that these individuals tend to ‘disengage from service at a higher rate than others’ (MHCC, 2015, p5.)

For more specific information about transitions from youth to adult services check out the following resources:

Taking the Next Step Forward: Building a Responsive Mental Health and Addictions System for Emerging Adults, Mental Health Commission of Canada, 2015

Transitioning from Youth to Adult Mental Health Services, Canadian Mental Health Association, Ontario

Young Minds The voice for young people’s mental health and wellbeing, Young Minds, United Kingdom

Is a transitions in care plan the same as a discharge plan?

No. A hospital discharge plan typically follows the patient record or chart, and clinicians have access to the information included on this plan for clinical assessment needs. A typical discharge plan is not always shared with the patient or individual.

While discharge plans are often medically focused, it is important that the individual receiving care and treatment also receives a copy of relevant information that is understandable and in plain language. A transitions in care document can provide individuals with an outline of their goals, including key information and contact numbers, medication information, a checklist on self-care and warning signs to watch for, as well as information about their next steps.

Your role as a care team member

A key component of ensuring appropriate care transitions is realizing that as a care team member, you can build relationships with others to help support an individual in their care and transitions. You can do this by:

- Cultivating partnerships and referral sources across various levels of care, and developing partnerships with other providers, services, community organizations and other agencies or programs that enhance support and treatment (e.g., peer support groups, community agencies).
- Facilitating the use of community resources for the individual, i.e., recreational, spiritual, medical, social, and housing.
- Supporting the person in navigating these systems and advising them of available options. To do this, you yourself need to establish relationships with other people, areas and services to ensure you can provide the best options to the individual.
- Help set up the person for success, using reminders, outreach, and follow up, involving the family where appropriate.
- Knowing when to “keep and consult”, and when to provide a warm handoff to more appropriate services to ensure continuity of care.

Successful transitions in care

What makes a transition successful? One of the major indicators is that individuals have exited treatment and are not returning, or not being readmitted to that level of care; as well as that there is no interruption in care.

Successful transitions in care require:

- Timely and accurate communication of information between and among health care providers, services and individuals to minimize misunderstanding or gaps in service
- Including the individual, their family and care team, along with the new service provider in the transition planning
- Comprehensive planning for the transition that allows enough time for a warm handoff
- Standardized procedure and forms for transition
- Timely follow-up with the individual, service and health care providers involved

We know that if transitions in care are not well planned, problems can occur such as:

- Individual needs are not met
- Individual withdraws from services, program, housing etc.
- Increased readmission
- Programs and services do not know to follow-up with an individual
- Poor care coordination or lack of resources
- Increased likelihood of suicidality, destabilization, substance use and/or readmission
- Poor use of health care resources and personnel

Inadequate or impaired communication can result in poor care, poor transitions and unnecessary duplication of care

(Alberta Health Services, 2015, p21)

For successful transitions, one person should lead the transition, to ensure planning, information transfer and follow-up are all considered and completed. The following tips will also help with successful transitions in care:

- Communication of the correct and appropriate information, in a timely manner, with the right people
- Shared accountability and responsibilities among all team members, including the person receiving care, family members as appropriate, health care providers, and new members of the care team
- A written plan, with copies for each member of the care team, family members as appropriate, and the team members to which the care is being transitioned
- The readiness of the individual to transition; this includes a screen for risk of self harm
- Allowing enough time to plan the transition
- Use of volunteer or peer support workers can help individuals and their families navigate the AMH system to ensure that they are connected with appropriate community services (e.g., housing, finance, legal, education, recreation)

The **RARE1 campaign (Reducing Avoidable Readmissions Effectively), provides five key areas of recommended actions for improved care transitions.**

They are:

- Patient/family engagement
- Medication management
- Comprehensive transition planning
- Care transition support
- Transition communication

For more detailed outlines of recommendations and strategies in each of these areas, check out the report Recommended Action for Improved Care Transitions: Mental Illnesses and/or Substance Use Disorders at http://www.rarereadmissions.org/documents/Recommended_Actions_Mental_Health.pdf

Exercise: Planning transitions in care

Select a vignette from Appendix A and read with a partner. Discuss what could be done to successfully transition the individual to a new setting or service and use the questions outlined below as a guide. Discuss your findings and considerations as a group.

Review the following list of questions as a starting place for consideration when working with an individual who will be experiencing a transition in care:

1. Where will you live?
2. Will you work/volunteer? Do you have a job to go back to? Do you have to look for employment/volunteer positions? What support do you need to enable this?
3. Who will help you?
4. How will they get to appointments?
Obtain medications?
5. What type of transportation do you have to get to appointments? Pick up medications?
6. What will you do in case of emergency or if you need help?
7. Do you need language services to help
8. What cultural practices will you participate in?
Will any of these interfere with your recovery goals?
9. What is the best way to reach you for follow-up connections? Phone number, text, email?

exercise

Conclusion

We hope you have found this chapter to be helpful. If you have any questions, comments or stories to share, please contact concurrent.disorders@ahs.ca.

Want more information on transitions in care?

While this chapter highlights transitions in care in general, here are some resources that provide more specific details:

Registered Nurses' Association of Ontario (2014). Care Transitions Guidelines. Toronto, ON: Registered Nurses' Association of Ontario.

http://rnao.ca/sites/rnao-ca/files/Care_Transitions_BPG.pdf

Consensus Statement on Improving Mental Health Transitions, Institute of Health Economics Consensus Statement, Volume 7, November 2014

<https://www.ihe.ca/publications/consensus-statement-on-improving-mental-health-transitions>

For Alberta Health Services employees check out InSite for specific policies and procedures related to transitions in care.

□ note section

APPENDIX A

Vignettes and examples for exercises

The following vignettes provided can be used in some of the exercises in the chapter, or for other illustrative purposes through the document when you need to provide an example.

Adult-focused Vignettes

Vignette 1: Paula is a 29 year old woman who uses crack cocaine and experiences persecutory voices and paranoid ideation. She is frequently arrested for panhandling and aggressive behavior. She has been referred to services two times in the past ten months, but she lives with various acquaintances or on the street, so the assigned clinician has never been able to make contact with her. She has only ever met with crisis workers in the community, usually when the police call because of a disturbance.

Transitions

- Form 10 to psychiatric emergency
- Transition to inpatient psychiatry x 4 weeks; awaiting rehab bed
- Transition to 4 week residential treatment program
- Transition to bridging housing sober living facility x 3-6 months
- Transition to single independent housing; AISH (Alberta Income for the Severely Handicapped); addiction services drop in group weekly
- Transition to community including recreation group with peer support worker weekly

Vignette 2: Jim Bob is a 42 year old man diagnosed as having bipolar disorder. He was referred to the services of the community AMH four months ago due to a DUI. He had been stopped for reckless driving and tested with a BAC of .21; however, upon initially coming to services, he denied to his clinician that he'd ever had a problem with drinking. He now meets with his clinician every Tuesday, and he admits that he sometimes feels his drinking has interfered with his

goal of being a good father. Jim Bob normally drinks on weekends, and for the past three weekends he has participated in sober activities with his family. This has cut down his intake of alcohol, though he still tends to get drunk on Saturday nights.

Transitions

- Transition to court ordered diversion services;
- Transition to forensic assessment community program; psychoeducational programs; budgeting
- Referral to addiction counsellor; opportunity to attend concurrent disorder group
- Transition to community 12 Step group

Vignette 3: Wendy is a 49 year old woman diagnosed with schizoaffective disorder. She has a long history of using methamphetamine, and her two closest friends also use meth. She keeps in close contact with her clinician whom she considers an important support. She indicates that she wants to stop using meth because she wants to “have a better life” (which includes keeping her mental health symptoms under control, finding a job involving kids or animals, and being able to afford a piano someday). Wendy’s friends are aware of her desire to stop using, and one friend is willing to engage in sober activities with her during the daytime. Wendy has not used meth in 9 weeks, though she states she’s often “bored” and tempted to use.

Transitions

- Referral from AMH clinician to CD residential treatment program
- Transition to Concurrent Disorder residential treatment program for 3 months
- Transition to women’s only supportive housing
 - Transition to addiction services; concurrent disorder group weekly
 - Transition to 12 step group in community like Narcotics Anonymous

- Transition to employment services; supported employment if needed
- Transition to recreation group with peer support worker; increase healthy social support

Vignette 4: John, a single young man who has been diagnosed in the past with schizophrenia, occasionally shows up at the community AMH and demands to see someone. He knows he has a clinician but cannot remember his name. He last saw his clinician one month ago when he wanted to get fuel assistance. His contacts with staff are infrequent and he usually wants money, food or cigarettes. He smokes marijuana on a daily basis but does not speak with his clinician about it.

Transitions

- Transition to psychiatric emergency
- Transition to In-patient psychiatry stay x 4 weeks; assist with AISH application
- Transition to community housing for 6–12 months
 - Transitions to peer support worker to attend recreation group and appointments
 - Transitions to addiction services; attend concurrent disorder group
 - Transitions to assertive outreach team; consider depot injection therapy

Vignette 5: Fred has been a client of the community AMH for many years. He was a long-time resident of the hospital before coming to the community AMH. He drinks at least a quart of wine daily and is not taking his prescribed medication. He does meet weekly with his clinician and sometimes calls when in crisis. Fred states that using alcohol helps him forget his troubles; when asked about any downsides of drinking, he notes that his apartment manager “picks on me” for being loud or angry when drunk.

Transitions

- Evicted from apartment
- Transition homeless drop in shelter with bags of belongings

- Transition to community
 - Transitions to referral to addiction counsellor for motivational interviewing; concurrent disorder group
 - Transitions to supported employment worker
 - Transitions to support group with peer support worker in community

Vignette 6: Crystal is a grandmother with years of polysubstance abuse. Her psychiatric symptoms are controlled with medication that she receives every other week from the community AMH nurse. She sees her clinician at least twice per month. A month ago, she went on a binge of drinking and smoked crack. She was out of control and was brought to the ER. She scared her daughter and two grandchildren. Since that incident, she successfully managed to avoid crack use and is trying to cut down on her drinking. She wants to be able to still drink in a controlled manner but if this does not work then she states that she would have abstinence as a goal.

Transitions

- Argues with daughter regarding seeing grandkids; uses crack again; calls mobile crisis unit
- Transition with mobile crisis unit clinician to psych ER
- Transition to short stay crisis unit
- Transition to women only program residential treatment centre for 3 months
- Transition to daily outpatient recovery support group
- Attend weekly concurrent disorder group; see addiction counsellor and/or nurse
- Transition to 12 step CA in community or Seniors Sobriety group

APPENDIX B

CoACT resources

Standard Transition Process

Integrated Assessment → Integrated Plan of Care → Standard Transition Process

How?

- Process occurs without deviation seven days per week.
- Standard written communication with receiving care team.
- Standard spoken communication with receiving care team.
- Standard follow-up check in (e.g. follow-up phone call).
- Standard patient experience review.

For every patient, safe transition checklist is completed.

For Acute Care:

- Repatriation candidates identified on admission
- Schedule time of departure for every patient
- Standard check-out process

“All discharges are transitions. Not all transitions are discharges”

©AHS CoACT D: May 15, 2014 R: Feb. 17, 2017

Transition Rounds

When? A daily, standard time

Who? Subset of the Collaborative Care Team

Daily commitment to review patients with an ADOT of today or tomorrow, or have complex transition needs.

Seven days per week

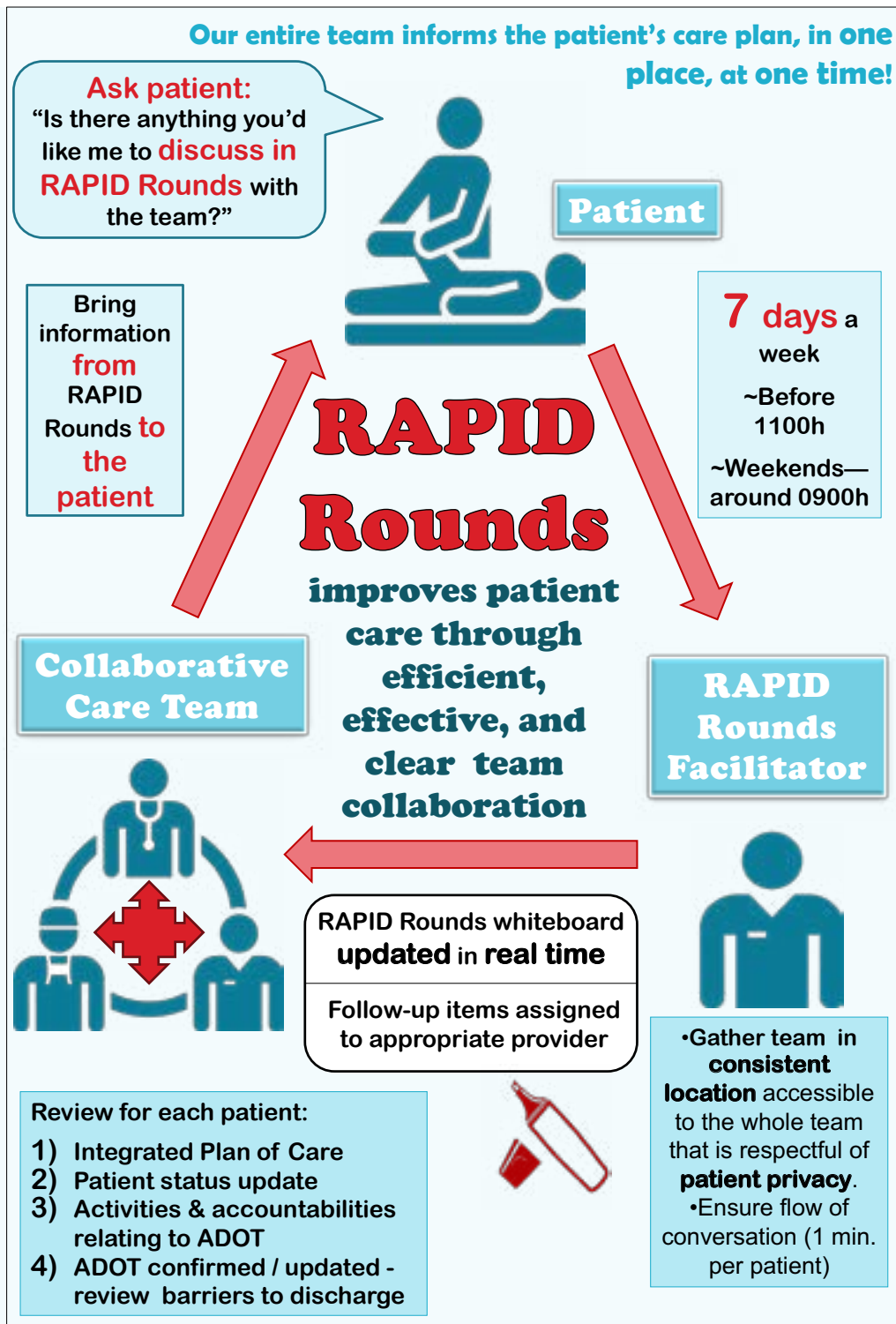
Discuss with the patient and family

“I know what has to happen so I can leave the hospital!”

4 Steps:

1. Review all patients with a focus on **transition**.
“Who is leaving and when?”
2. Update: 1.) **Safe Transition Checklist**
2.) **Integrated Plan of Care**
3.) **RAPID Rounds communication tool**
3. Update whether barriers to discharge have been addressed. & Assign **accountabilities** to the appropriate provider.
4. Four questions for **each patient**:
I. Are complex transition needs identified and addressed?
II. Is the transition destination clearly identified?
III. If transitioning today, are plans on track?
IV. If transitioning tomorrow, are plans on track?

©AHS O: May 7, 2014 R: Jan. 20, 2017



APPENDIX C

Transitions in Care Standard Quick Reference



Transitions in Care

The six Concurrent Capable Standards are written from the perspective of a patient and their family and explains what a client or family member, can expect of AMH staff and other service providers as established by provincial, national, and international best practices.

These standards and key indicators are intended to support clients and their family as they receive care related to mental health concerns, addictions issues and concurrent disorders. Let's review each standard and consider their implications for your practice, service and team.

You are part of a team that recognizes you may have multiple needs, and works together to ensure the services you receive are coordinated and match your goals for recovery. The team recognizes that each person recovers at his/her own pace, which means some individuals may require longer-term supports than others.

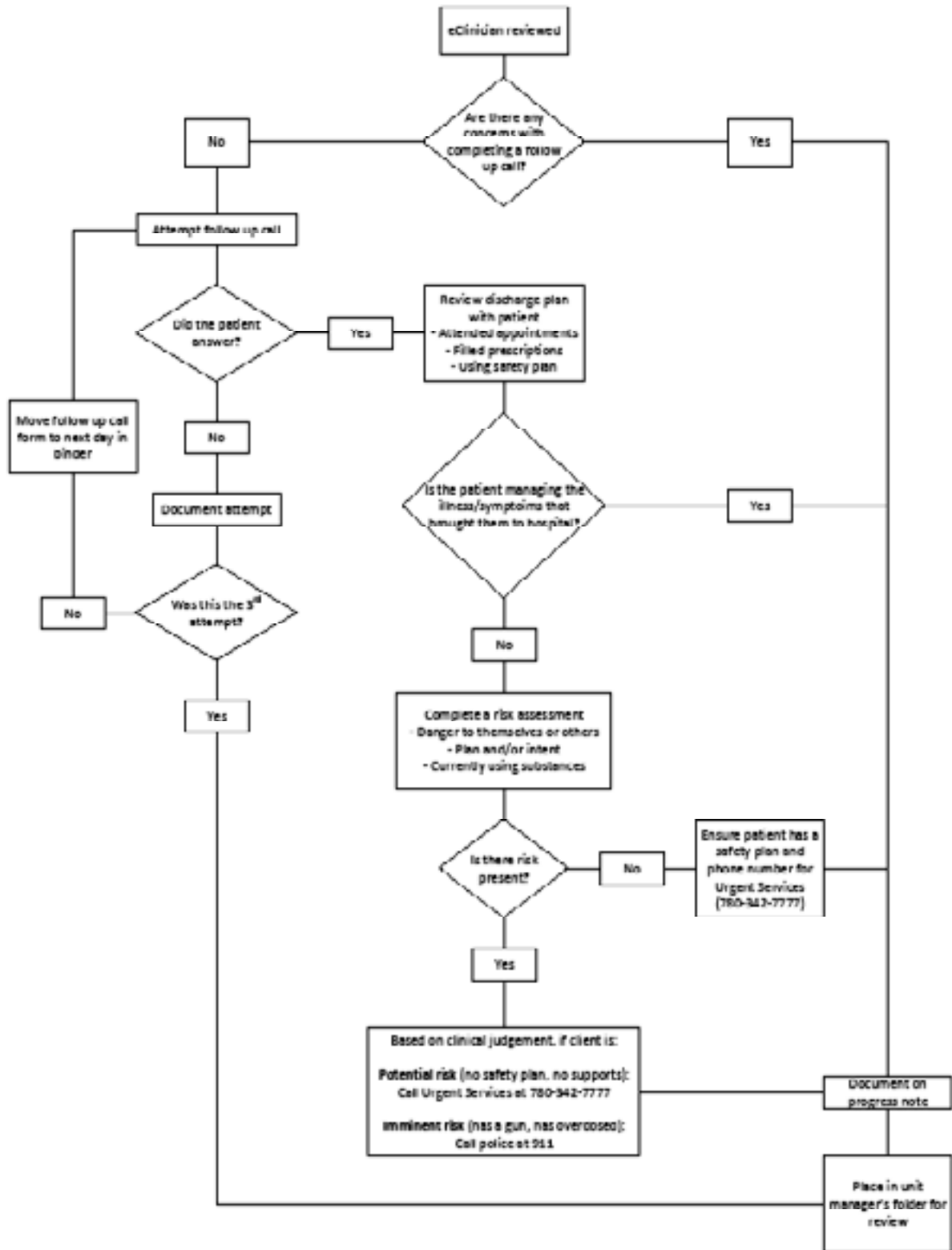
Key Indicators

- Your provider recognizes that your goals may benefit from a multidisciplinary team approach and supports you by matching your needs to other care providers as required to achieve this, and builds on your strengths to assist you in meeting your goals.
- Your provider helps you navigate the system to ensure you are connected with community services as required (e.g., housing, finance, legal, education).
- Your family and care team are your advocates, working collaboratively to ensure the services you receive are coordinated.
- You, your family and your care team make sure you have satisfactory supports in place to help you achieve your recovery goals at all stages, and give you a written list of community resources as needed.
- You, your family and your care team help you manage your recovery by using your strengths and the skills you have learned in our service.
- Your provider tells you how to re-engage with services, if needed.
- With your consent, information regarding your care and progress is shared with the rest of your care team.
- You and your family provide feedback on your experience so we can continue to improve.

APPENDIX D

Sample follow-up call process (Alberta Health Services, 2018)

FOLLOW-UP AFTER DISCHARGE



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