Alberta Health Services

PROCEDURE

TITLE
CARE TRANSITIONS

SCOPE
Provincial Addiction & Mental Health: Ambulatory Services; Residential Addiction Treatment and Detoxification Settings

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AMH-13-01

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Care Transitions Policy (#AMH-13)

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NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

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OBJECTIVES

- To assist **health care providers** working in Addiction & Mental Health (AMH) **ambulatory services** (including community programs), and residential addiction treatment and detoxification settings (excluding the Protection of Children Abusing Drugs program) to provide seamless services during **care transitions**.
- To address known **patient** safety concerns before the **conclusion of care**.
- To support patients, their **alternate decision-makers** (ADM) and, as appropriate, those the patient identifies as supports (herein referred to as **family**) as active partners in the patient's care.
- To outline the role of health care providers in the coordination of care transition and conclusion of care processes.

APPLICABILITY

Compliance with this document is required by all Alberta Health Services employees, members of the medical and midwifery staffs, students, volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

ELEMENTS

1. Points of Emphasis

1.1 Limits of confidentiality shall be discussed as a part of the patient's orientation to service, in accordance with applicable legislation.

1.2 The patient's and/or their ADM's consent for disclosure of information shall be discussed and documented, in accordance with the Alberta Health Services (AHS) *Collection, Access, Use and Disclosure of Information* Policy.

1.3 Health care providers shall assist patients and/or their ADM, as needed, to identify and access a **primary care provider** when they do not currently have one.

1.4 Family should be involved in transition and treatment planning, as appropriate.

2. Service Commencement

2.1 Health care providers shall consider at the time of commencement of service that the patient may require care transition(s), may choose to discontinue services or independently coordinate their care.

a) When the program and/or health care provider initiate the care transition, patients and/or their ADM should be given clear and timely explanations of the reason for the care transition.

2.2 At service commencement, as per the principles of **patient- and family-centred care**, the patient's preferences and consent regarding communication and involvement with identified family members shall be explored, obtained, respected, and documented.

a) For a patient who has been determined to lack capacity, their wishes, beliefs, and values should still be respected as much as possible, in consultation with their ADM.

3. Care Transitions

3.1 Health care providers, in accordance with their scope of practice and local processes, shall assess the patient's readiness for care transition, recognizing that care transitions are often a period of increased vulnerability for patients, and:

a) shall complete **suicide risk screening** during care transitions that are significant to the patient in accordance with the AHS *Suicide Risk Management* Procedure (AMH).

3.2 The sending health care provider shall:

a) in collaboration with the patient and/or ADM, receiving health care provider and family, as appropriate, establish the goals and objectives for transition in a written care transition plan, which shall include:

(i) the name and contact information for the sending and receiving health care providers;

(ii) any program-related expectations from the receiving health care provider;

(iii) who to contact if there is a change in the patient's situation;

(iv) reiteration of the patient's treatment goals;

(v) how to access after-hour crisis and emergency services;

(vi) any other risk assessment(s) and mitigation strategies (e.g., community based Naloxone kits, **safety plan**); and

(vii) required patient education.

b) provide the receiving health care provider with all referral information as required by the receiving service provider including:

(i) a discharge summary (refer to the AHS *Documenting Care Coordination* Procedure [AMH]); and

(ii) current assessment(s) including diagnosis (as available) and relevant history (e.g., medication and allergy history).

c) notify the primary care provider, as appropriate, of the care transition plan; and

d) collaborate with the patient and/or ADM and family, as appropriate, to explore other options and referrals, if the referral is not accepted.

3.3 The sending health care provider should, whenever possible, follow up with the receiving health care provider within seven (7) calendar days or less, commensurate with the clinical urgency of the request and take any additional action, as clinically appropriate, when a referral is made to a partner or non-AHS program.

3.4 The receiving health care provider shall:

a) acknowledge receipt of a referral commensurate with the urgency of the request, but no more than seven (7) calendar days after the referral was received (refer to the AHS *Wait Time Measurement, Management, and Reporting of Scheduled Health Services* Policy Suite);

b) review the referral documentation;

c) communicate with the sending health care provider, patient and/or ADM, as appropriate, to obtain treatment planning clarity, specifically but not limited to:

(i) the patient's care transition plan, goals, and objectives; and

(ii) the suitability of the receiving service provider to fit the patient's care plan, goals, and objectives.

d) inform the sending health care provider of the decision to accept or deny the referral commensurate with the urgency of the request, but no longer than 14 calendar days after the referral was received;

e) communicate with the sending health care provider and as appropriate, the primary care provider, the date, time and location for the patient's initial appointment or their status on a wait list; and

f) communicate with the sending health care provider and as appropriate, the primary care provider:

(i) within seven (7) calendar days, or less, commensurate with the clinical urgency of the request, if the patient does not attend the initial appointment; or

(ii) within 30 days of the patient's initial appointment, outlining the outcome of the visit.

3.5 Care transitions should include, when possible, the opportunity to meet in person, virtually or over the phone with the sending and receiving health care providers, patient and/or ADM, and family, as appropriate, to facilitate a smoother transition and address any patient concerns.

4. Conclusion of Care

4.1 The responsibility for care continues to reside with the sending health care provider until the care transition is complete. Conclusion of care for the patient's current episode of care shall not proceed until the most responsible health care provider has evaluated:

a) if the patient has met their treatment goals;

b) if alternate services have been arranged as the current treatment is no longer available or meeting the patient's and/or their ADM's needs or preferences; or

c) if the patient and/or their ADM has chosen to discontinue treatment and the patient does not meet the criteria for apprehension or certification

under the *Mental Health Act* (Alberta), including patients supervised under a Community Treatment Order (CTO).

4.2 When communication from the patient ends prior to the formal conclusion of care, the health care provider shall:

a) attempt to contact the patient in a manner consistent with the patient's regularly scheduled care, level of risk and past pattern of engagement;

b) consult with other involved health care providers, as necessary;

c) consider calling the emergency contact, ADM and/or next of kin within a reasonable timeframe; and

d) consult with the supervisor or on-call manager as required.

4.3 When the conclusion of care includes transitioning care to a partner or non-AHS environment or provider, the sending health care provider shall:

a) provide required information necessary to continue care, as identified by the receiving service provider, and in accordance with the *Health Information Act* (Alberta);

b) ensure necessary consents are in place for appropriate disclosure (refer to the AHS *Collection, Access, Use and Disclosure of Information* Policy);

c) ensure the patient and/or their ADM, and as appropriate, family has contact information for the receiving service provider; and

d) share the transition plan with the primary care provider.

4.4 When the conclusion of care includes transitioning care to a home environment without a receiving health care provider and where family or an ADM is involved in care, or when a patient coordinates their care independently, and/or declines services, the sending health care provider shall:

a) provide the patient with the following:

(i) relevant resources, including crisis supports;

(ii) the patient's medication list and instructions (as applicable);

(iii) information about how to access services if needed in the future;

(iv) other education as required (e.g., safety planning); and

b) share the transition plan with the primary care provider and/or other key clinical services.

5. Documentation

5.1 The programs' standardized documentation and communication strategies should be used by health care providers to ensure communication is accurate, timely and clear.

5.2 Documentation should reflect clinically relevant interactions with the patient, including care provision, risk mitigation and consultations with their ADM, if any, and other health care providers involved in the patient's care and treatment.

5.3 Documentation in the **health record** shall adhere to:

a) the AHS *Clinical Documentation* Directive and AHS *Clinical Documentation Process* Directive; and

b) the AHS *Documenting Care Coordination* Procedure (AMH).

5.4 Health care providers shall update any electronic and/or registration records to reflect the date and reason of file closure/discharge.

DEFINITIONS

Alternate decision-maker means a person who is authorized to make decisions with or on behalf of the patient. These may include, specific decision-maker, a minor's legal representative, a guardian, a 'nearest relative' in accordance with the *Mental Health Act* (Alberta), or an agent in accordance with a Personal Directive, or a person designated in accordance with the *Human Tissue and Organ Donation Act* (Alberta). This also includes what was previously known as the substitute decision-maker.

Ambulatory services means, for the purpose of this document, outpatient or community clinical services. Treatment in ambulatory services does not include admission to a hospital, detoxification or residential treatment facility bed, or public education services.

Care transitions means, for the purpose of this document, a change in Alberta Health Services Addiction & Mental Health Services care team membership, location, service area, and/or sectors (e.g., admission, handover, transfer, and discharge).

Conclusion of care means, for the purpose of this document, no further transition to Alberta Health Services Addiction & Mental Health Services, although care may continue with other providers within and beyond Alberta Health Services.

Family(-ies) means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends, and informal caregivers.

Health care provider means any person who provides goods or services to a patient, inclusive of health care professionals, staff, students, volunteers, and other persons acting on behalf of or in conjunction with Alberta Health Services.

Health record means the collection of all records documenting individually identifying health information in relation to a single person.

Patient means an adult or child who receives or has requested health care or services from Alberta Health Services and its health care providers or individuals authorized to act on behalf of Alberta Health Services. This term is inclusive of residents, clients, and outpatients.

Patient- and family-centred care means care provided working in partnership with patients and families by encouraging active participation of patients and families in all aspects of care, as integral members of the patient's care and support team, and as partners in planning and improving facilities and services. Patient- and family-centred care applies to patients of all ages and to all areas of health care.

Primary care provider means, for the purpose of this document, a Family Physician or Nurse Practitioner who provides initial care, treatment, and follow-up of various conditions as well as referrals to the rest of the health system when needed.

Safety plan means a plan developed with the patient and is usually summarized as a written plan for the management of increased danger of real or potential harm, and how to stay safe. Strategies, choices, moments of control, coping strategies and contact numbers that were discussed during the intervention should be included in the safety plan.

Suicide risk screening means inquiry into a patient's history of and current ideation, plans or behaviour related to suicide. Screening is intended to be non-invasive and to provide direction on whether further assessment is required.

REFERENCES

- Alberta Health Services Governance Documents:
  - *Care Transitions* Policy (Addiction & Mental Health) (#AMH-13)
  - *Clinical Documentation* Directive (#1173)
  - *Clinical Documentation Process* Directive (#1173-01)
  - *Collection, Access, Use and Disclosure of Information* Policy (#1112)
  - *Documenting Care Coordination* Procedure (Addiction & Mental Health) (#AMH-09-01)
  - *Suicide Risk Management* Procedure (Addiction & Mental Health) (#AMH-11-01)
  - *Wait Time Measurement, Management, and Reporting of Scheduled Health Services* Policy Suite (#1151)
- Non-Alberta Health Services Documents:
  - *Health Information Act* (Alberta)
  - *Mental Health Act* (Alberta)