Supporting alternate level of care (ALC) patients with a dual diagnosis to transition from hospital to home

Executive summary of practice guidance

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Purpose

Ontario is currently facing a hospital crisis, exacerbated by staff shortages and delayed care due to the COVID-19 pandemic. Amid this crisis, there is a pressing need to address the issue of alternate level of care (ALC) patients. These are patients who no longer require hospital-level care but remain in hospital due to a lack of appropriate settings with necessary supports for discharge. People with developmental disabilities who also have a psychiatric condition, commonly referred to as a dual diagnosis, are more likely to become ALC patients. In some cases, ALC patients can spend years in hospital which can lead to negative outcomes for the ALC patient and treatment delays for other patients that require hospital care. Patients with a dual diagnosis need supports from both the health and developmental service sectors to ensure successful transitions. This requires cross-sectoral solutions to effectively meet their needs during the transition process.

This report identifies principles and core components that are necessary to successfully transition adults with a dual diagnosis, who are ALC in hospital, into the community.

Approach

A multi-disciplinary team with expertise in health and developmental services undertook this project funded by the Ontario Ministry of Health.

First, the team conducted an environmental scan of the academic and grey literature on transitioning ALC patients with a dual diagnosis out of the hospital, supplemented by broader ALC-related documents. To build on best practices, the team used the Ontario Health Quality Standards on *Transitions Between Hospital and Home* as a guiding framework.

Second, consultations were conducted with over 100 stakeholders from across Ontario including: service providers from specialty psychiatric hospitals, general hospitals, community health and developmental services; system planners; researchers; and individuals who had experienced an ALC hospitalization and their families. Based on the environmental scan and consultations, seven transition principles were identified and 10 core components were adapted from the Ontario Transition Quality Standards.

Finally, a subset of the consultation participants were invited to participate in an expert panel responsible for reviewing the full report for accuracy, completeness, relevance and clarity. After providing written feedback, the panel met to discuss their recommendations and resolve any disparities.

This work was conducted between Fall 2022 and Spring 2023.

Transition principles

- **A hospital is not a person's home**. People should be transitioned out of hospital into an appropriate community setting as soon as they no longer need hospital care.
- Adults with a dual diagnosis have the same rights as other Ontarians to be **treated with dignity and respect and to receive high quality care** while in hospital, during the transition period and while living in the community.
- **A successful transition is a process not an event**. Transition planning should begin at (or before) admission and include a graduated transition to community with a period of coordinated, overlapping care provided by both the hospital and community teams.
- **Transition planning should be person-centred, culturally sensitive and trauma-informed**. It should begin by understanding what the person, and those who know them best, think is most important to support a successful life in the community and live as independently as possible.
- **A successful transition requires clear, consistent communication and coordination** among the patient, their family and their hospital, community health, mental health and developmental service providers.
- **Health equity, anti-racism and anti-oppression should be foundational to all aspects of care**, including transitions, with particular attention to ensuring equitable access, positive service experiences and optimal outcomes for diverse individuals living with a dual diagnosis.
- A successful transition should not rely on patient, family or staff advocacy. **A standardized process is needed to ensure equitable access for all patients**, particularly for individuals facing intersecting forms of marginalization.

Transition core components

1. Ongoing information sharing

There is a process in place to support ongoing communication and information sharing between everyone involved in planning and supporting the transition. Communication begins at (or before) admission and continues throughout the patient's hospital stay and the transition period.

2. Comprehensive assessment

Patients receive a developmentally informed comprehensive assessment of their health care and support needs by trained providers, which is used to inform the transition plan and optimize the transition process. Ideally, this assessment is started early upon admission and updated regularly throughout the hospital stay and the transition period.

3. Patient and family involvement in transition planning

A person-centred, family-centred and culturally appropriate approach is used throughout the transition process. The person transitioning from hospital to community, together with those that support and know them best, are involved in planning the transition and developing a written transition plan. The patient and family are also provided support to address any anxieties, concerns or trauma related to the hospital stay and/or transition process.

4. Patient, family and community provider education, training and support

Before transitioning from hospital, the patient, their family, and the health care and developmental services providers who will be supporting them in the community are provided the information and training they need to manage the patient's physical and mental health care needs. This includes spending time with the clinical team and the patient in hospital to observe and learn these skills.

5. Transition and Community Support Plan

A written Transition and Community Support Plan is developed that identifies the most appropriate housing, developmental services and health care supports necessary for the person to live successfully in the community and outlines a graduated transition process. Transition planning begins when the person is admitted to hospital and the plan is updated regularly throughout their stay and the transition period.

6. Graduated, overlapping and coordinated transition

An identified lead from the hospital and an identified lead from the community work closely with the patient, their family, their hospital team and their community health and

developmental service providers to support a graduated, coordinated transition which includes a period of overlapping care.

7. Medication review and support

Patients have medication reviews at admission, before discharge and once they are in the community which include information regarding medication reconciliation, adherence and optimization. There is a plan in place for accessing medications in the community, ongoing medication monitoring and supporting medication administration.

8. Coordinated follow-up medical and clinical care

Appropriate health care is provided throughout the transition period and, prior to discharge, all necessary health care providers are identified and prepared to provide follow-up care in the community. All patients require a primary care provider and some may also require other providers such as psychiatrists, psychologists, behaviour therapists, social workers, nurses, occupational therapists and speech-language pathologists, as well as case-coordination. For people with complex needs, a team-based approach is required.

9. Appropriate and timely housing and community support

Housing and community services are identified that meet the patient's needs and preferences, promote a sense of belonging, and support them to feel safe and comfortable. Considerations include proximity to family, services and community; the physical environment; other residents; cultural appropriateness; and staff supports.

10. Sufficient and flexible funding

Dedicated funding is in place to support the transition period and to provide the necessary community housing and services to help individuals thrive and prevent re-hospitalization. Funding packages have flexibility to adapt to the complex and evolving needs of the individual.

Next steps

To facilitate implementation and uptake of the transition principles and core components, we recommend the following next steps:

1. *High quality, real-time data*. Improve data systems and staff training to support consistent identification of ALC patients with a dual diagnosis in datasets. This can inform proactive response, system planning and resource allocation.
2. *Clear, consistent processes and pathways*. Implement transparent and streamlined processes for accessing funding, resources and services in both health and developmental service sectors.
3. *Flexible policies to support shared/overlapping care*. Implement policies that support overlapping care during the transition period, including opportunities for community providers to get to know the patient while in the hospital and for the hospital team to provide ongoing support to the patient and new providers for a period post-discharge.
4. *Capacity and funding for housing and clinical services*. Build greater housing and clinical capacity in Ontario to ensure there are the right settings and supports to discharge people to in the community.
5. *Training*. Support training for hospital and community health care providers on dual diagnosis, for developmental service providers on health care and for patients and families on how to access supports.
6. *Tools and templates*. Develop tools and templates to operationalize the transition core components (e.g., Transition and Community Support Plan, standard comprehensive assessment package etc.).

This report identifies transition principles and core practice components that can support ALC patients with a dual diagnosis to successfully transition from the hospital to a home. Implementing these practices can support current ALC patients; however, addressing the larger issue of ALC patients in hospitals requires consideration of how to prevent patients from becoming ALC in the first place. Many of the transition principles and components described in this report, if made available prior to hospital admission as well as once hospitalized, could help avoid unnecessary hospitalizations and prevent people who are hospitalized from becoming ALC. With the right resources and systems, we can support individuals to lead safe, fulfilling lives in their communities.

To read the full report, visit the project page on the CAMH H-CARDD website.