Feedback on Transitions from Hospital to Home: Care for People of All Ages (HQO Quality Standard)

General Comments:

- Overall, CMHO is supportive of this quality statement. Children and youth with mental health issues often experience difficult transitions as they move from the hospital back into the home/community. It is important that, given this standard is meant to apply to all ages and for all health concerns, the standard is designed to support the unique needs of children and youth with mental health concerns.
- Properly discharging a client requires involvement and connection with the community provider. For many CYMH issues, the relevant touch point for clients may not necessarily be a physician and may instead be a community mental health provider. Overall, the concept of community providers needs to be reflected in this quality standard, to the extent that this standard applies to CYMH issues.
- For many children and youth with mental health issues, intensive supports in the community and at home will be sufficient. However, particularly for inpatients, there are going to be some children and youth who require stepping down to live-in treatments (i.e. residential treatment). The protocols for this transition would be different and it is important that this is reflected in the document.
- Risk assessments should be included in the assessments.
- Transition planning should include mention of transitional safety planning.
- Important to consider the unique needs of children in care. Child welfare may need to be involved in transition planning.
- Parents/caregivers may need access to respite supports (for example, family peer support works).
- To assist in the transition, patients and families can be connected to local crisis services.
- It is important that hospitals understand wait times for community mental health services (i.e. do hospitals know how to communicate accurately about wait times for community CYMH services?)
- It is also important that hospitals understand the availability of intensive services (in home/ in patient) in the community.
- **Based on data from the Canadian Institute for Health Information (CIHI), since 2006, the number of young people making emergency department visits for mental health and substance use issues has increased by 83%; the number of who were hospitalized increased by 90%. Repeat visits, length of stay and readmission rates are also two to three times higher for children and youth with mental health and substance use issues compared to other conditions. To truly improve transitions back to the community, we need to expand the services available to children and youth in the community to ensure they are supported.**

Specific Feedback on Quality Statements

Quality Statement 1: Information-Sharing on Admission - When people are admitted to hospital, the hospital notifies their primary care and home and community care providers soon after admission via real-time electronic notification. The community-based providers then share all relevant information with the admitting team in a timely manner.

Comments:

- Need to consider issues regarding consent for sharing of information in the child and youth mental health (CYMH) sector.
- Community CYMH agencies must become connected to electronic systems to enable real-time electronic notification
- Hospitals need to have knowledge of the appropriate community CYMH providers to make appropriate referrals
- Community CYMH agencies do not have consistent access to electronic systems for information sharing and notifications
- Hospitals may not be aware of the appropriate provider (if they are referring a client to community services). There may also be significant waitlists for service

Quality Statement 2: Comprehensive Assessment - People receive a comprehensive assessment of their current and evolving health care and social support needs. This assessment is started early upon admission, and updated regularly throughout the hospital stay, to inform the transition plan and optimize the transition process.

Comments:

- Comprehensive assessment should include clinical mental health and addiction needs, and developmental concerns (e.g. ASD)
- The assessment should include something specific about risk of self-harm (within the context of "safeguarding issues")
- Depending on what assessment tool is used, it may need to be tailored to children and youth
- For consistency in tracking outcomes, a common assessment tool should be used across hospitals
- In their 2019 Provincial Priorities Report, the CYMH Lead Agencies recently recommended the inter-RAI ChYMH (mandated Common Assessment Tool) be used across the CYMH sector.

Quality Statement 3: Patient, Family, and Caregiver Involvement in Transition Planning - People transitioning from hospital to home are involved in transition planning and developing a written transition plan. If people consent to include them in their circle of care, family members and caregivers are also involved.

Comments:

- Important to consider questions related to consent for parent/caregiver involvement in care of children and youth with mental health concerns
- Need to ensure that children and youth themselves are involved in the transition process

Quality Statement 4: Patient, Family, and Caregiver Education, Training, and Support - People transitioning from hospital to home, and their families and caregivers, have the information and support they need to manage their health after the hospital stay. Before transitioning from hospital to home, they are offered education and training to manage their health care needs at home, including guidance on medications and medical equipment.

Comments:

- This should include respite services for parents/caregivers
- Hospitals may not be the best positioned to help families build their capacity to support their child or youth as they transition back into the community. Community agencies have this expertise and may be able to provide more appropriate supports to build parent/caregiver capacity.
- It's necessary to ensure that hospitals are aware of the programs that community agencies offer to provide family capacity building and support (this is an MOHLTC defined core service in the CYMH sector)

Quality Statement 5: Transition Plans - People transitioning from hospital to home are given a written transition plan (which can reside fully within the discharge summary), developed by and agreed upon in partnership with the patient, any involved caregivers, the hospital team, and the home and community care team, before leaving hospital. Transition plans are shared with primary care and home and community care providers within 48 hours of discharge.

Comments:

- This is critical. Many children and report not being provided with transition plans as they move from the hospital back to the community.
- Transition plans should be created with involvement from the community agency that will be providing care to the client after discharge from hospital
- There is a need for appropriate electronic infrastructure to ensure smooth communication of transition plans with the community agencies, primary care providers, etc.
- Important to consider how transition plans may change if the patient is moving into another live-in setting (for example, residential treatment).
- Transition plans could also outline availability of mental health crisis services in the community (i.e. walk in clinics, phone lines, mobile response units, etc).

Quality Statement 8: Coordinated Follow-Up Medical Care - People transitioning from hospital to home have follow-up medical care with their primary care provider and/or a medical specialist coordinated and booked before leaving hospital. People with no primary care provider are provided with assistance to find one.

Comments:

- In some cases, especially for children and youth with mental health concerns, their primary therapist/counsellor/case coordinator at the community agency may be the main contact for coordinated follow-up medical care. The primary care provider of course needs to be involved, but the main coordinator may be from a community agency.

Quality Statement 9: Appropriate and Timely Support for Home and Community Care - People transitioning from hospital to home are assessed for the type, amount, and appropriate timing of home care and community services they and their caregivers need. These services are arranged before people leave hospital and are in place when they return home.

Comments:

- The community care coordinator may be a staff member from a community CYMH agency
- Given capacity issues in the CYMH sector, it can be challenging to ensure timely access to mental health supports

HQO Transitions From Hospital to Home - Patient Conversation Guide

- It may be appropriate to develop a Patient Conversation Guide that is specifically designed for children, youth and caregivers
- It is important to prompt patients/families to ask about availability of (and wait times for) intensive in-home supports
- It is important to include "community service providers" when speaking about what follow up supports/appointments have been booked
    - Patients and families should be prompted to ask about the types of services they can access from their community CYMH service providers and understand the referral process
- There may be value in adding a comment around where patients/caregivers can go to access supports, if they are on a waitlist for follow-up mental health services (i.e. walk-in clinics, brief services, etc).
- It may be useful to include prompts around self-care strategies for children, youth and caregivers
- Caregivers may require more information about how to manage risk, and how to hep their child access crisis services if/when necessary