Discharge Planning Implementation Tool

	- 24 months Process Initiation	- 24 months	- 3 months	After Handoff
Transition Team	✓			✓
Assess	✓			
Design	✓	✓		
Implement	✓	✓	✓	
Monitor				✓
Evaluate				✓

The following recommendations will guide your care of youth who will transition to adult health services at 18 years of age. This plan if fully implemented in your care setting will help you meet Accreditation Canada's transition standards published in Medical Services required organizational practices (ROPs) February 2015 for inclusion in 2016 accreditation surveys. Please note that while the plan identifies discrete time periods, they are a guide for activities which will in fact be iterative and on a continuum over the 24 months leading up to the patient's 18th birthday and transition to adult health services.

At an organizational level, consider the current workflow, policies and procedures, decision support analyses and IM/IT enablers which could be used, modified or developed to enable discharge planning implementation. Consider the following:

- Is there a policy or procedure in our organization regarding discharging an adolescent from paediatric care to adult services?
- Would it be possible to create a clinic visit called discharge consultation, in order to track the number of patients who were provided a formal discharge planning discussion?
- How can the information management system (electronic medical record) support the discharge summary development?
- Provide the discharge summary to the patient and or family so they can be informed and inform adult providers who may for some reason not have the discharge summary immediately available for the patient visit?
- Can we create or do we have a space within the discharge summary for patients to identify their goals for health and social development?

Guidance Timeline

Process Initiation: 24 months before transition discharge (< or = 16 years old)	
Transition team	• Although plans begin as soon as a person becomes a paediatric patient, a minimum of 24 months before the person's 18th birthday, a series of decisions must be taken: • Which program within an organization is responsible for managing the patietns transition • Who is responsible for transition within a program • Who in the regular health care team is the primary transition lead or facilitator for the patient • If the patient attends other organizations, establish a lead organization (likely the organization where the most care is received)

Assess current state and gaps	**Identify:**
	• a primary care provider (not a paediatrician)
	• primary medical supports (specialists)
	  • community supports; regional and or provincial
	• Supports
	  • financial
	  • social
	  • educational
	  • document transition assessment in chart
	  • document discussion with patient and family
	
	Determine if there are:
	• organizational transition policies are in place to guide transition processes
	• transition clinics of this diagnostic group, or general youth transition
	• If there is no transition clinic in the organization, schedule a clinic visit to discuss and the initiation of transition; every HCP needs to discuss the transition – in addition the HCP may be supported by a transition clinic
	• community services (such as CCAC, community organization coordinators) should be engaged in the process
	• have a discussion about consent and capacity; start to prep child and family for the difference between family centered and patient centered care. Begin to encourage independence / autonomy…. At this point it should be a discussion.
	
	Identify Gaps and issues between:
	▪ patient readiness[1]
	▪ family readiness
	▪ current paediatric services versus available adult services
	▪ develop a plan to address readiness gaps for patient and for family

[1] A readiness for transition tool has been developed and validated by McMaster researchers and the use of this tool, or a similarly validated readiness tool is recommended. The development of a risk assessment tool to help identify those adolescents most at risk of encountering difficulty after transitioning from paediatric services is in development and will also be made available when it is ready on the CanChild website.

<table>
<tr><th colspan="2">Process Initiation: 24 months before transition discharge (< or = 16 years old)</th></tr>
<tr><td>Design individualized state</td><td>
At every point of contact with the child and family assess readiness using readiness tools:

parent
patient

Link patient and family to resources

developmental
chronic disease

Develop a service mirror-example
<table>
<tr><th colspan="2">Paediatric</th><th colspan="2">Adult</th></tr>
<tr><td>X</td><td>Primary care MD</td><td>√</td><td>Primary care MD</td></tr>
<tr><td>√</td><td>Respirologist</td><td>X</td><td>Respirologist</td></tr>
<tr><td>√</td><td>Endocrinologist</td><td>X</td><td>Endocrinologist</td></tr>
<tr><td>√</td><td>Mental health clinician</td><td>√</td><td>Mental health clinician</td></tr>
<tr><td>√</td><td>Paediatrician</td><td>X</td><td>Paediatrician</td></tr>
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</td></tr>
<tr><td>Implement</td><td>

Help patient complete “MyHealth Passport’, an on line tool developed at SickKids to document key health information on a form that can be printed and folded into a wallet sized document; it could be used to help youth learn how to make a 3-sentence summary of their health condition
If multiple care organizations, collaborate to determine lead organization for transition preparation; most likely organization providing the most service
If patient does not have a family doctor, patient and or family supported in finding one.
Health update sent to (new) family doctor

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<tr><td>Monitor</td><td></td></tr>
<tr><td>Evaluate</td><td></td></tr>
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12 months before transition discharge (< or = 17 years old)	
Transition team	
Assess	
Design	▪ Develop "a Transition to adult health services document" that will provide an overview of the : ▪ transition process, issues and mitigation strategies ▪ social, educational, developmental status and supports ▪ a comprehensive discharge summary with standard elements provided by all disciplines currently involved in care ▪ all currently treating specialists to contribute standardized elements ▪ standard formatting recommended to improve clarity of communication for reader ▪ discharge summary sent to all adult providers and copy given to patient and/ or family (if patient gives permission to share with family). Exceptions only for components that are sensitive and have been identified as confidential ▪ Identify who will provide case management (may be primary care provider / service or may be community organization)
Implement	▪ Start sending referrals for adult services ▪ Include a comprehensive summary that includes recommended elements ▪ Document activity and confirm plans for adult services: ▪ Name of provider / service ▪ Contact information for provider / service ▪ Location address ▪ Transportation to get to provider / service
Monitor	
Evaluate	

3 months before transition discharge (< 18 years old)	
Transition team	
Assess	
Design	

Implement	▪ Primary case manager to conduct transition visit and include adult providers as appropriate and possible; if in person attendance is not possible, yet warm handover preferred, consider videoconference, or teleconference option for adult provider
	▪ Ensure written documentation of transition visit in chart and given to patient and or family
	▪ Ensure family knows of coordinator to contact if problems arise.
	▪ Give written and verbal information to patient and family confirming all adult providers and services arranged:
	  ▪ name of provider / point of contact at service
	  ▪ date and time of appointment
	  ▪ location of provider
	▪ As availability and care complexity requires, link clinician types between paediatric and adult teams: nurse to nurse, social work to social work, physician to physician (by specialty, or ensure primary care adult doctor has contact information for paediatric specialist)
	▪ Document and confirm to patient and or family where to seek care if required before first contact with adult provider

Monitor	
Evaluate	

After Handoff	
Transition team	To ensure smooth transition let the patient and family know that the pediatric providers can be contacted if problems arise prior to establishing the relationship / first visit with the adult provider
Assess	
Design	
Implement	
Monitor	▪ Contact patient within three months after discharge to confirm first visit to adult provider(s) has taken place. Based on the phone call consider whether further action is required.
Evaluate	▪ Plan to gather feedback from patients and family on transition process benefits and gaps (organization level) ▪ Further provincial evaluation activity will be considered within the context of PCMCH strategic work review and strategic planning

Links to Resources

Transition to Adult Health Services resources developed through the Provincial Council for Maternal and Child Health (www.pcmch.on.ca/transition).

Link to Readiness Assessment tool (http://www.canchild.ca/). The tool is housed on the measurement page.

HQO's QI Team Design

Accreditation Canada's Medical Services Standards published February 2015 for inclusion in January 2016 surveys
Organization that participate in accreditation will have the Standards for Medical Services—refer to the publication from February 2015 for Survey's beginning January 2016.

The Good 2 Go Transition Program provides a number of resources to support the advancement of self-management skills for children and youth throughout their development. The "Help Them Grow...so They're Good 2 Go" Timelines provides examples of activities and skills to develop, from time of diagnosis, for any child with a chronic health condition (see general Timeline). Examples of condition-specific Timelines also exist.

HQO's Quality Improvement Framework

HQO's Transitions of Care Improvement Package

Feedback

Please let us know if you use this guidance and how useful you found it.
If you are willing to provide helpful feedback to further improve the tool please send it to info@pcmch.on.ca