

QUALITY STANDARDS

Placemat for Supporting High-Quality Transitions Between Hospital and Home for Alternate Level of Care Patients With a Dual Diagnosis

This document is a resource for clinicians and offers guidance on how the quality standard [Transitions Between Hospital and Home](#) can be applied in supporting alternate level of care patients with a dual diagnosis to transition out of hospital. See the complete adapted guidance for this population: [Supporting Alternate Level of Care Patients With a Dual Diagnosis to Transition From Hospital to Home: Practice Guidance](#).

Information-Sharing and Assessment

Quality Statement (QS) 1: Information-Sharing on Admission

When a person is admitted to hospital, the hospital shares information about the admission with their primary care clinician, home and community care providers, and any relevant specialist clinicians soon after admission via real-time electronic notification. Community-based providers then share all relevant information with the admitting team in a timely manner.

Ensure that when a person is admitted to hospital, their community health and developmental service providers are notified of the person's admission, diagnoses, and predicted discharge date.

Ensure that community health providers and developmental service providers share relevant information with the hospital team as soon as possible.

Support regular communication with everyone involved in the transition throughout the person's hospital stay and during the transition period. This includes the patient, their family and care

partners, the hospital team, community health providers, and developmental service providers.

Ensure that communication with the patient is adapted and appropriate (e.g., speak slowly, use simple language, use visual aids).

Resource: [About My Health](#)

QS 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.

Initiate a comprehensive assessment of the patient's current and evolving health care and developmental services needs at admission to hospital. Update the assessment regularly.

Ensure that the assessment uses a strengths-based, culturally relevant, developmentally informed, trauma-informed approach. Clinicians with expertise in dual diagnosis may be needed to conduct some assessments.

Work with [Developmental Services Ontario](#) to see if the patient is eligible for provincial developmental services.

Identify risk factors for a complex or delayed transition.

Obtain additional information from family members, care partners, and community health providers to fully understand the patient's history and current needs.

Resources: [Communicate CARE](#); [HELP With Emotional and Behavioural Concerns in Adults With Intellectual and Developmental Disabilities](#)

Patient, Family, and Care Partner Involvement and Support

QS 3: Patient, Family, and Care Partner 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 care partners are also involved.

Throughout the transition planning process, use active strategies to involve the patient and the people who support them.

Ensure that patients who do not have capacity to consent to treatment are still involved in transition planning and decision-making.

Offer language interpretation as needed, and use approaches grounded in cultural safety and anti-racism.

Resource: [Decision Making in Health Care of Adults With Intellectual and Developmental Disabilities](#)

QS 4: Education, Training, and Support for Patients, Families, and Care Partners

People transitioning from hospital to home, and their families and care partners, have the information and support they need to manage their health care needs 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 community-based resources, medications, and medical equipment.

Offer information and training to the patient, their family and care partners, and their staff to help them manage their health care needs (e.g., medication administration, using medical equipment, behaviour management).

Ensure that information and training are accessible and culturally appropriate.

Recognize that some approaches used in hospitals may not be possible in community settings.

Offer information and support to the community health providers who will care for the patient in the community after discharge.

Resources: [ECHO Ontario: Adult Intellectual & Developmental Disabilities](#); [The Nuts & Bolts of Healthcare for Direct Support Professionals Toolkit](#); [Tools for the Primary Care of Adults With Intellectual and Developmental Disabilities](#)

Preparing for Transitions

QS 5: Transition Plans

People transitioning from hospital to home are given a written transition plan, developed by and agreed upon in partnership with the person, any involved care partners, the hospital team, the primary care clinician, and home and community care providers before leaving hospital. Transition plans are shared with the person's primary care clinician, home and community care providers, and relevant specialist clinicians within 48 hours of discharge.

Ensure that the transition and community support plan is:

- Developed and agreed upon in partnership with the patient, any involved care partners, the hospital team, and community health and developmental service providers
- Provided in a format accessible to everyone involved before the patient leaves hospital
- Updated regularly throughout the transition period

Resource: [Patient-Oriented Discharge Summary](#)

QS 6: Coordinated Transitions

People admitted to hospital have a named clinician who is responsible for timely transition planning, coordination, and communication. Before people leave hospital, this person ensures an effective transfer of transition plans and information related to people's care.

Identify leads from the hospital and the community who will be jointly responsible for transition planning and coordination.

Ensure that the transition process and time frame are tailored to the needs of the patient and can be

adjusted as needed, depending on how the patient responds.

Provide an opportunity for community health providers to meet and engage with the patient before discharge.

Offer ongoing support for a defined period after discharge as the person and their care team adjust.

QS 7: Medication Review and Support

People transitioning from hospital to home have structured medication reviews on admission, before returning home, and once they are home. These reviews include information regarding medication reconciliation, adherence, and optimization, as well as how to use their medications and how to access their medications in the community. People's ability to afford out-of-pocket medication costs are considered, and options are provided for those unable to afford these costs.

Provide regular structured medication reviews, including at hospital admission and before discharge.

Before discharge, identify a prescriber who can provide ongoing medication management in the community.

Ensure that reviews include information about medication reconciliation, adherence, optimization, and use. They should also indicate who will support administration and ongoing monitoring.

Consider the patient's ability to afford out-of-pocket medication costs and provide options for those unable to afford these costs.

Resource: [Patient-Oriented Medication Tools](#)

QS 8: Coordinated Follow-Up Medical Care

People transitioning from hospital to home have follow-up medical care with their primary care clinician and/or a specialist clinician coordinated and booked before leaving hospital. People with no primary care clinician are provided with assistance to find one.

Before the patient is discharged, identify providers who can provide ongoing medical and clinical care, and ensure that initial appointments are scheduled.

Ensure that all patients have a primary care clinician, as well as a psychiatrist and other specialist clinicians as needed.

For people with complex needs, ensure that care is provided by multidisciplinary teams.

Ensure that the transition plan and relevant medical information are shared among clinicians and providers.

Resource: [Tools for the Primary Care of Adults With Intellectual and Developmental Disabilities](#)

Transition Home

QS 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 support services they and their care partners need. When these services are needed, they are arranged before people leave hospital and are in place when they return home.

Identify housing and community supports that meet the patient's needs and preferences, promote a sense of belonging, and support them in feeling safe and comfortable, considering:

- The person's daily support needs
- The person's sensory, social, and functional needs
- Proximity to family, services, and activities
- The physical environment
- Cultural appropriateness

Ensure that patients meet their new staff and visit their new home before discharge.

Resource: [Successful Housing Elements & Developmental Disabilities \(SHEDD\) tool](#)

QS 10: Out-of-Pocket Costs and Limits of Funded Services

People transitioning from hospital to home have their ability to pay for any out-of-pocket health care costs considered by the health care team, and information and alternatives for unaffordable costs are included in transition plans. The health care team explains to people what publicly funded services are available to them and what services they will need to pay for.

Ensure that the hospital team is familiar with the funding sources available for patients with a dual diagnosis.

Identify community partners who can support the funding application process. Before discharge, help the patient and their care partners apply for and secure funding for support in the community.

Resource: [Developmental Services Ontario](#)

Definitions

- **Alternate level of care:** This is a term used in hospitals to describe patients who no longer require the level of care that hospitals provide. Typically, patients are labelled as alternate level of care because there is nowhere appropriate for them to be discharged to, so they remain in hospital
- **Community health and developmental service providers:** This group includes health care providers outside the hospital inpatient unit (e.g., primary care clinicians, psychiatrists, other specialist clinicians, psychologists, behaviour therapists, social workers, nurses, occupational therapists, speech–language pathologists) and service providers funded in the developmental sector (e.g., direct support professionals, day programs, vocational support programs, residential providers)
- **Developmental Services Ontario:** This is the access point for all adult developmental services in Ontario that are funded by the Ministry of Children, Community and Social Services
- **Dual diagnosis:** According to the [Joint Policy Guideline for the Provision of Community Mental Health and Developmental Services for Adults With a Dual Diagnosis](#), this refers to people who have “both a developmental disability and mental health needs”

Resources

- [About My Health](#): A tool to communicate the needs and preferences of people with developmental disabilities
- [HELP With Emotional and Behavioural Concerns in Adults With Intellectual and Developmental Disabilities](#): This tool reviews the biopsychosocial circumstances that might contribute to emotional distress and behaviours of concern
- [Communicate CARE](#): This tool offers guidance to providers on conducting person-centred assessments of adults with developmental disabilities
- [Decision Making in Health Care of Adults With Intellectual and Developmental Disabilities](#): This tool provides practical guidance to respect the decision-making rights of people with developmental disabilities
- [ECHO Ontario: Adult Intellectual & Developmental Disabilities](#): This program provides virtual education and a community of practice for health and developmental service providers to learn about this population together
- [The Nuts & Bolts of Healthcare for Direct Support Professionals Toolkit](#): This toolkit includes information and resources to help staff support the health care of people with developmental disabilities
- [Tools for the Primary Care of Adults With Intellectual and Developmental Disabilities](#): This resource contains a range of tools for primary care clinicians to support the care of adults with intellectual and developmental disabilities

- [*Patient-Oriented Discharge Summary*](#) and [*Patient-Oriented Medication Tools*](#): These are patient-oriented tools that have been implemented in hospitals across Ontario and can be adapted to different settings and populations
- [*Successful Housing Elements & Developmental Disabilities \(SHEDD\) tool*](#): This tool can be used to identify an appropriate home for people with developmental disabilities and complex needs

Additional tools and resources are on [Quorum](#).

Need this information in an accessible format? 1-877-280-8538,
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Document disponible en français en contactant info@OntarioHealth.ca

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