Enhancing Concurrent Capability Toolkit
Transitions in Care
Quick Reference Sheet

What makes transitions successful?

Seamless transitions in care

A successful transition may include no interruptions in care and that the person exits treatment or is not readmitted to that level of care.

Successful transitions in care require:

- Timely and accurate communication between healthcare providers, services, and clients to minimize misunderstandings or gaps in service.
- Including the client, their family, their care team, and the new service provider in the transition planning.
- Comprehensive planning for the transition that allows enough time for a warm handoff.
- Standardized procedures and forms for transition.
- Timely follow-up with everyone involved after the transition.

One person leads transition

One person should lead the transition and ensure planning, information transfer and follow-up are all completed. Lead role includes:

- Communicating correct and appropriate information with the right people.
- Sharing accountability and responsibilities among all team members, including the person receiving care, family members as appropriate, health care providers, and new members of the care team.
- Developing a written plan, with copies for each member of the care team, family members as appropriate, and the team members to which the care is being transitioned.
- Assessing the readiness of the person receiving treatment to transition, including screening for risk of self-harm.
- Allowing enough time to plan the transition.
- Using volunteer or peer support workers to help people and their families navigate various systems and ensure they are connected with appropriate community services (such as housing, finance, legal, education, recreation).

Risk of poor transitions

If transitions in care are not well planned or have poor communication, the client may not receive the care they need, or may receive unnecessary duplication of care.

This may lead to poor outcomes, including:

- Early withdrawal from services and programs.
- Frequent readmission to residential or inpatient services.
- Poor care coordination or lack of resources.
- Increased likelihood of suicidality, destabilization, and substance use.
- Poor use of health care resources and personnel.

Excerpt from: Enhancing Concurrent Capability Toolkit: Transitions in Care

Alberta Health Services