Implementation of Transitional Discharge Model (TDM) ARTIC Project

Participant Information Package 2012
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Introduction

Thank you for agreeing to participate in the implementation of the CAHO Transitional Discharge Model (TDM) ARTIC Project. TDM was developed from a participatory action research project in Hamilton, Ontario. The team was led by nurse researchers and included public health nurses, in-patient schizophrenia program nurses, and mental health consumers. The model is based on therapeutic relationships and supports the successful community integration of people with mental health challenges. This model has been shown to reduce length of stay and readmission rates for people being discharged from psychiatric beds. It is already being successfully implemented at sites such as St. Joseph’s Healthcare London.

This model will be implemented in acute as well as tertiary psychiatric wards in nine participating CAHO hospitals across Ontario. Ontario Peer Development Initiative (OPDI) along with mental health Consumer/Survivor Initiatives (CSIs) will be partnering with the hospitals to provide peer support. Hospital wards and peer support volunteers from CSIs will work closely with each other to ensure a seamless safety net exists for patients throughout the discharge and community reintegration processes.

The purpose of this participant information package is to help orient participating hospitals and CSI groups to the project, to help identify local resources for the project and to allow each hospital an opportunity to envision how the TDM may be incorporated onto their specific ward. TDM can be modified on each ward depending on the unique context of the patient population and the community.

We look forward to working with you as we help you implement the CAHO Transitional Discharge Model (TDM) ARTIC Project.

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There are nine CAHO hospitals participating in this project:

Baycrest
Centre for Addiction and Mental Health
Health Sciences North
Hôpital Montfort
London Health Sciences Centre

Providence Care
St. Joseph’s Healthcare, Hamilton
St. Joseph’s Healthcare, London
Thunder Bay Regional Health Science Centre
Council of Academic Hospitals of Ontario

The Council of Academic Hospitals of Ontario (CAHO) is the non-profit association of Ontario’s 24 academic hospitals and their research institutes. CAHO provides a focal point for strategic initiatives on behalf of these academic hospitals.

As research intensive hospitals, CAHO member hospitals are fully affiliated with a university medical or health sciences faculty. Our hospitals provide the most complex and urgent care, teach the next generation of health care providers, and foster health care innovation through research and discovery.

Across the province, CAHO hospitals are inventing the future of health care by developing new standards of patient care, evolving models of health care education, and conducting world-class health research.

Adopting Research to Improve Care (ARTIC) Program

CAHO launched the Adopting Research to Improve Care (ARTIC) program in 2010 with the objective of moving research evidence into practice from one hospital across the CAHO community to another, in order to drive quality improvement and benefit the health care system as a whole. The goal is to learn from this experience in order to help build a systematic and sustainable implementation pathway for evidence adoption across the province.

CAHO is committed to continuing our journey of learning through the ARTIC Program. CAHO believes the development of this knowledge should not be experienced by our community alone. Working with the Ministry of Health and Long-Term Care (MOHLTC), Health Quality Ontario (HQO) and world-renowned experts in knowledge translation, we aspire to build a sustainable pathway for implementing evidence that can improve quality patient care and Ontario’s health care system.

Collectively, the CAHO community, in partnership with the Ministry of Health and Long Term Care has funded six ARTIC Projects:

**HandyAudit™ ARTIC Project:** is an innovative auditing tool that measures hand hygiene compliance in a more effective and efficient way.

**Canadian C-Spine Rule ARTIC Project:** through the use of a clinical decision tool for ED nurses this project aims to reduce ED wait times and increase patient satisfaction by quickly identifying patients who do not require immobilization.

**CAHO Antimicrobial Stewardship Program in ICU Project:** aims to optimize the use of antimicrobials in intensive care units.

**Mobilization of the Vulnerable Elderly in Ontario ARTIC Project:** uses an interprofessional approach that focuses on early and consistent mobilization of older patients through their hospital stay.

**Transitional Discharge Model ARTIC Project:** supports the successful transition from hospital to the community for people diagnosed with a mental illness.

**Enhanced Recovery After Surgery Guideline ARTIC Project:** uses an innovative knowledge translation strategy to implement a range of interventions for patients undergoing colorectal surgery.

Michelle Grouchy, Program Manager, Adopting Research to Improve Care (ARTIC) Council of Academic Hospitals of Ontario 200 Front Street West, Suite 2501 Toronto, ON M5V 3L1 416-205-1567 Email: mgrouchy@caho-hospitals.com www.caho-hospitals.com
Ontario Peer Development Initiative and Peer Support

Ontario Peer Development Initiative (OPDI) is an organization of organizations; mental health Consumer/Survivor Initiatives (CSIs) and Peer Support Organizations (PSOs) across Ontario. These organizations are run by and for people with lived experience of a mental health and/or addiction issue. CSIs and PSOs provide a wide range of services and activities within their communities. No two are the same, but all approach their activities from the common understanding that people can and do recover with the proper supports in place, and that peer support is integral to successful recovery. Most CSIs and PSOs collaborate within local mental health systems to bring the consumer voice to service planning, delivery and evaluation, and provide direct informal or formal peer support and self-advocacy support to individuals. A listing of OPDI member organizations can be found at http://opdi.org/members.html. These organizations, together and individually, comprise Ontario’s developers, thought leaders and experts on the subject of peer support.

OPDI will be providing the qualified training and materials for the Peer Support Coordinators involved in this project. Participating CSIs and PSOs will be coordinating the Peer Support Volunteers who will be matched with the patients being discharged. The Peer Support Coordinators will have access to OPDI materials and trainer training to train the Peer Support Volunteers.

Some CSIs that are contemplating participation in this project include:

- Canvoice
- SWAN (South Western Alliance Network)
- Mental Health Rights Coalition
- HOPE Brantford (Helping Ourselves through Peer Support and Empowerment)
- Mental Health Support Network South East Ontario
- Northern Initiative for Social Action

• Council of Consumer/Survivor, Family Initiatives Algoma Consumer Survivor Network
• People Advocating for Change through Empowerment
• Sunset Country Psychiatric Survivors
• Psychiatric Survivors of Ottawa

OPDI defines peer support as follows:

Peer Support is a naturally occurring, mutually beneficial support process, where people who share a common experience meet as equals, sharing skills, strengths and hope; learning from each other how to cope, thrive and flourish.

Formalized Peer Support begins when persons with lived experience who have received specialized training, assume unique, designated roles within the mental health system, to support an individual’s expressed wishes.

Specialized Peer Support training is Peer developed, delivered and endorsed by Consumer/Survivor Initiatives*, Peer Support Organizations* and Patient Councils, and is rooted in principles of recovery, hope and individual empowerment.

* Consumer Survivor Initiatives and Peer Support Organizations are community-based, self-help organizations run by and for consumer/survivors. This definition of peer support was developed through the focus group/workshop/piloting process of creating the OPDI Peer Support Core Essentials™ Program. A draft was workshopped in a member consultation in 2010, further refined by a member working group, then adopted by electronic vote of the membership. We welcome and encourage you to use or reference this definition or provide links to this page, providing that OPDI is credited and the definition is provided unedited and in its entirety.
What is the purpose of the CAHO TDM project?

The purpose of this project is to implement the Transitional Discharge Model (TDM) at nine CAHO hospitals across Ontario. The TDM supports the successful community integration of people diagnosed with a mental illness and aims to reduce length of stay, readmission rate and improve the quality of care for this population. The TDM is based on the provision of therapeutic relationships to ensure a seamless safety net exists for patients throughout the discharge and community reintegration processes. The TDM has two components to assist patients in the transition from hospital to community:

• Peer Support: Support from a person who has experienced a mental illness, is living successfully in the community, and has completed a peer training program. This includes regular contact on a schedule that suits both parties, for the purpose of providing social support and shared learning from the experience of someone who has lived through a similar transition; and
• Staff Support: Continued support from a staff person from the hospital program, or a community program (the patient identifies the staff person as someone who they have a therapeutic relationship with) until a therapeutic relationship has been established or re-established with a community mental health care provider.

The three basic assumptions of the TDM are:

• People heal in relationships (including staff and peer relationships);
• Transitions in care are vulnerable periods for individuals with mental illness; and
• A network of relationships provided during transitional periods assists in recovery.

The TDM employs a groundbreaking, collaborative, relationship-focused approach to discharging patients that has the potential to revolutionize care at CAHO hospitals across Ontario.

Why is this important?

The transition from hospital to community is complex and can be challenging for many patients. For example, a study of 85 long-term psychiatric patients showed that 25% met the criterion for relocation trauma when moved from hospital to community (Farhall, Trauer, Newton, & Cheung, 2003). Recent research also shows that the first days and weeks following discharge are particularly high-risk periods, with 43% of psychiatric patient suicides occurring within the first month post-discharge (Hunt et al., 2009).

The period following discharge is also a particularly vulnerable period for readmission. With usual care, there can be a significant gap between the discharge date and the time individuals are seen by community agencies. As well, some psychiatric patients are discharged to emergency shelters or no fixed address; these environments do not tend to facilitate recovery from mental illness (Forchuk, Russell et al., 2006). In order to successfully move the focus of care to the community, effective care models of collaborative support are required. The TDM is one such model, and supports the successful community integration of people with mental health challenges, thus decreasing unnecessary in-patient and emergency room hospital visits for this population.
What is the evidence?

In 1992, a Canadian participatory action project called the Bridge to Discharge project (Forchuk, Chan et al., 1998; Forchuk, Jewell et al., 1998) designed and implemented TDM on a long-term ward that was part of the schizophrenia service at the former Hamilton Psychiatric Hospital in Ontario. All 38 pilot participants were successfully “bridged” to the community. In the first year, this resulted in in-patient savings of almost $500,000 while improving patients’ quality of life (Forchuk, Chan et al., 1998).

The pilot project’s success was replicated in other studies. Reynolds et al. (2004) introduced the model in Scotland, UK to four acute care programs. Psychiatric patients were randomized on the day of discharge into an intervention group that employed the TDM or a usual care control group. In this study the control group was more than twice as likely to be readmitted in the 5 months following discharge compared to the TDM group.

Forchuk, Martin, Chan and Jensen (2005) also demonstrated the effectiveness of the TDM in 26 Ontario tertiary care psychiatric wards at four geographic locations. The length of stay for participants on the intervention wards was reduced by an average of 116 days, freeing up 12 million dollars worth of beds. The intervention group also consumed on average $4,400 less hospital and emergency room services per person in the year after discharge compared to the control group. Recent studies (described below) have also identified facilitators and barriers to TDM implementation (Forchuk, Martin et al., in press-a; in press-b).

What are the facilitators and barriers to implementing the TDM?

Despite the strong evidence supporting the TDM, there are several barriers that may disrupt implementation. Throughout this project, the project team will assist in identifying and addressing these potential barriers with you.

Forchuk, Martin et al. (in press-a; in press-b) implemented the TDM on 40 psychiatric wards in three different waves. The researchers compared three groups of wards; Group A wards had already adopted the TDM, Group B wards implemented the TDM in year one, and Group C wards implemented the TDM in year two. Strategies were suggested by the A and B wards to enhance implementation on the B and C wards, respectively. This research revealed that the most commonly cited barriers to adoption of the TDM are:

1) Resistance to procedural changes (e.g. hospital staff feeling swamped with new information and processes)
2) Team dynamics (e.g. some hospital staff being supportive of TDM, while others resist; collaborating successfully with CSI groups)
3) Changes in ward champions, which can disrupt the implementation process

The implementation strategies developed for this project are a direct reflection on the known barriers and were created to mitigate them. According to Forchuk, Martin et al. (in press-a; in press-b), specific strategies that aid in the implementation of TDM include:

1) The use of educational modules for on-ward hospital staff training and peer support training
2) Presence of on-site champions
3) Supportive documentation systems.

All of these best practices will be used in the current implementation.
What activities are included in this project?

The TDM can be implemented in a variety of ways, as long as the basic principles of the intervention are kept intact. These principles include:

• Person-centered care. By placing patients at the centre of care; and
• Continuity of therapeutic relationships. By ensuring a continuity of therapeutic relationships (both hospital staff and peer) as patients are discharged or move between settings.

Before the TDM is implemented at each participating hospital, the project team will assess what type(s) of therapeutic support are available at each setting and in the surrounding community. Each hospital will identify an internal Site Lead who is responsible for the local implementation of the TDM and each geographic site will have a Peer Support Coordinator based in the community and working with the hospital to facilitate matching between peer support volunteers and patients after discharge.

Implementing the TDM in tertiary care psychiatric wards involves having a clinical hospital staff member who has a therapeutic relationship with the patient remain involved following hospital discharge, until the patient establishes a therapeutic relationship with a peer support volunteer.

On acute care wards, there might be less time for the patient to develop a therapeutic relationship with a hospital staff member, in which case a transitional team may be more appropriate, an approach that has worked well in several prior TDM implementations.

In all cases, peer support is offered from a consumer of mental health services who is currently living in the community and who has specialized training in peer support. The Ontario Peer Development Initiative (OPDI) has member organizations that provide peer support services across the province.

Each peer support volunteer will receive specialized training from the Peer Support Coordinator. OPDI will provide training to each Peer Support Coordinator so they are able to train the peer support volunteers who will be supporting patients from the hospital.

OPDI Peer Support Core Essentials™ Program is a training that OPDI developed through a two-year process of consultation and collaboration with its membership, and an independent evaluation, all funded by the Ontario Trillium Foundation. This training involves five full days in class plus several pre-requisite introductory webinars. On the trainer’s recommendation, successful classroom participants may opt to perform an internship in order to become a certified OPDI Peer Supporter. This internship consists of providing a documented 50 hours of individual support to peers in a mental health program or CSI/PSO setting. Participants in training can use the hours that they accumulate from providing peer support with the TDM project towards this internship, hence benefiting both the training participant and the implementation of the project. For more information on the training program, see http://opdi.org/training.html.

Please be advised this training program is the intellectual property of OPDI and is copyrighted with trademark pending. Participants or graduates of OPDI Peer Support Core Essentials™ Program are not qualified or permitted to use OPDI materials to train others, nor to copy or alter them by any means.

The project team will work with the Site Leads, Ward Champions and local peer support groups to ensure that the TDM is implemented in a way that best suits the needs of each hospital. Appendix A provides a sample of the TDM workflow at a tertiary care psychiatric ward.
## Implementation Timeline

<table>
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<tr>
<th>Preparation</th>
<th>Preimplementation &amp; Training</th>
<th>Implementation and Maintenance</th>
<th>Analysis &amp; Sustainability</th>
</tr>
</thead>
</table>

### Project Team

- Conference calls with stakeholders at all sites
- Initial Research Ethics submission
- Identify community partners/service providers

### Preimplementation & Training

- Identify therapeutic supports available at each hospital
- Begin weekly teleconference meetings between hospital staff & CSI groups
- Recruit & hire Peer Support Coordinators
- PI (Cheryl Forchuk) to visit hospital sites to begin relationship building and project planning with each hospital
- 5-Day TDM Orientation Workshop in London, Ontario for Site Leads & Peer Support Coordinators

### Implementation and Maintenance

- Facilitate hospital staff and peer support focus groups
- Use information gathered from status update meetings and focus groups to make site-specific adjustments as needed

### Analysis & Sustainability

- ICES run on readmission rates & ER use
- Data analysis
- Sustainability meetings with CSI groups & hospitals to discuss long-term sustainability plans
- Develop strategies to sustain TDM

### Hospital Team

- Provide information about participating wards
- Identify temporary Site Leads

### Peer Support Team

- Peer Support Coordinator matches and introduces peer support volunteers with patients who are about to be discharged
- Peer support volunteers and patients meet regularly post-discharge (regularity to be mutually determined).

### Hospital, Project & Peer Support Teams

- Status update meetings (Site Leads & Peer Support Coordinators across sites):
  - June 2013: teleconference
  - September 2013: in-person
  - December 2013: teleconference
  - March 2014: teleconference
  - June 2014: in-person
  - October 2014: teleconference
  - January 2015: in-person

- Monitor TDM implementation
- Collect data (Site Leads interview patients at discharge)
- Site Leads facilitate patient focus groups

### Develop strategies to sustain TDM

- 5-Day TDM Orientation Workshop in London, Ontario for Site Leads & Peer Support Coordinators
- Recruit & hire Site Leads and Ward Champions
- Site Leads train hospital staff on the TDM in a 1-day on-site workshop
- Assess and implement documentation & referral systems

- Develop strategies to sustain TDM
Your investment in this project

As a participating hospital, you have agreed to provide the following in-kind support to this project:

• 1 Site Lead (1 FTE)
• 1 Ward Champion (0.25 FTE) per participating ward
• Access to patient records/administrative data (length of stay, readmission rates)
• Two working spaces (including desk, computer and phone) for the Site Lead and Peer Support Coordinator
• Travel support costs for Site Lead and staff to engage in community follow-up
• Dedicated time for Site Lead to participate in 5-day TDM Orientation Workshop in London, Ontario
• Protected time to allow all hospital staff to receive TDM Training

A key component of implementation success will be for the Site Lead, Ward Champion(s) and Peer Support Coordinator(s) to work as a team throughout the patient discharge process. This will ensure that patients are provided with the necessary support as they re-enter the community. This will be facilitated by weekly teleconference meetings between hospital site leads, peer support coordinators, staff and research staff (these meetings will become bi-weekly once the program is up and running).

Effective implementation will thus be accomplished by:

• Creation of a community of practice between the Site Lead, Ward Champion(s) and Peer Support Coordinator(s)
• Developing strategies to address barriers to implementation
• Liaise with the project team through regular communications and updates at regular intervals

More specifically, the responsibilities for the hospital, site lead, peer support coordinator and peer support volunteers are as follows:
Ward Champion (0.25 FTE per ward)

- Serves as a mentor to colleagues on his/her ward and is responsible for providing immediate support to other staff.
- Support could include accompanying staff on an initial home visit if the staff member requires, problem solving approaches with other staff members, and ensuring documentation and scheduling processes are in place on the ward to support TDM.
- Participates in a one day on-site TDM training session.
- This person is an opinion leader on the ward and should be comfortable in a community role.
- This person will require a slightly reduced caseload to allow time to provide support to others.

Site Lead (1 FTE)

- Responsible for the local implementation of the TDM.
- Liaise regularly with the central project team.
- Attend five-day TDM Orientation Workshop in London, Ontario.
- Conduct staff training at the local site.
- Partner with the local peer support coordinator(s).
- Collect evaluation data (administrative data, patient interviews & patient focus groups).
- Prepare local reports for project team.

Peer Support Coordinator (0.5 - 2 FTEs depending on ward discharge rates)

- Attend OPDI training (if necessary).
- Provide training to local peer support volunteers who commit to the project.
- Match peer support volunteers with patients.
- Provide ongoing supervision and support for the peer support volunteers.
- Visit the involved wards at least twice a week to meet with patients prior to discharge to assist in making appropriate matches with local peer support volunteers.

Peer Support Volunteers (approximately 100 volunteers for acute wards, 50 for tertiary wards, in Year 1)

- Complete OPDI training (facilitated by Peer Support Coordinator plus one other OPDI trainer).
- Communicate with Peer Support Coordinator regarding matching with interested patients.
- Meet with patient(s) regularly post-discharge (either one-on-one, or as part of a group, depending on patient and project needs).
- Leverage these hours toward the OPDI internship requirements and complete necessary OPDI paperwork to receive OPDI-Certified Peer Supporter certificate.
- Receive direct supervision and support from the Peer Support Coordinator and complete any reporting required by the project or the workplace.
Pre-Implementation: What we need from you

The project is currently in the early planning stages, however we will be in touch soon to discuss the next steps for your hospital or organization. Each hospital has provided us with a temporary Site Lead who will help navigate the initial phases of the project until a permanent Site Lead is identified. Each hospital has also provided us with a list of the ward(s) that would like to participate in the project, as well as the number of beds per ward, length of stay, and current discharge rates. We are working with members of the Ontario Peer Development Initiative (OPDI) to identify existing peer support groups in your area.

We are holding TDM orientation teleconferences with key stakeholders at each hospital and CSI groups. Once we have a better idea of each hospital’s and CSI’s unique needs, we will begin to work with you to identify the optimal TDM implementation method for your hospital. Over the next few months, we will work closely to ensure that the following pre-implementation requisites are met:

- Nomination of Ward Champion(s)
- Identify a 1 FTE Site Lead
- Identify participating CSI groups in your area and select the most logical site for the Peer Support Coordinator
- Identify Peer Support Coordinator(s) (in collaboration with CSI group(s))
- Site visits by the Principle Investigator to further assess your needs
- Facilitate dialogue between your hospital and local CSI group(s)
- Secure a location/work space for Site Lead and Peer Support Coordinator(s)

What you can expect from us

Our central project team will oversee the project at all participating hospitals. The central project team consists of experienced researchers and clinical staff, peer support specialists, a Research Coordinator – Hospital Liaison and Research Coordinator – CSI Liaison. We will be available to assist you in every stage of the project.

More specifically, we will:

- Assist you in submitting and receiving approval from the Research Ethics Board (REB) at your hospital
- Analyze data and provide interim and final reports
- Lead staff and peer support focus groups
- Develop educational and promotional materials
- Provide implementation tools
- Lead TDM orientation session for Site Leads and Peer Support Coordinators
- Provide OPDI training for Peer Support Coordinators
- Host regular conference calls and meetings with the Site Leads, Ward Champions and Peer Support Coordinators
- Regularly communicate and share best practices
- Make site visits at start up
- Assist with hiring Site Leads and Peer Support Coordinators

Moving Forward: What will we accomplish together?

- Improve outcomes for psychiatric patients, such as increased quality of life, fewer hospital visits and the sense of personal empowerment that comes from being supported by (& supporting) peers who have lived with mental illness
- Facilitate more successful and satisfying community integration for persons with mental illness
- Develop collaborations among the academic hospitals of Ontario
- Improve collaborative relationships between in-hospital mental health care workers and community care providers by linking and integrating psychiatric services with community resources
- Improve collaborative relationships between mental health care workers and consumer/survivor groups by working collaboratively on implementing the model
- Improve collaborative relationships between in-hospital mental health care workers, community care providers, peer support workers and psychiatric patients
Outcomes

Anticipated outcomes of this project

If implemented effectively, the TDM is expected to:

1. Reduce Readmission Rates, Emergency Department Use, Length of Stay, and Hospital Costs
   • Hospitals that have implemented the TDM have freed up to 12 million dollars worth of bedspace in one year among approximately 200 patients, based on shorter patient stays (Forchuk et al., 2005)
   • At four Ontario psychiatric facilities, patient length of stay was reduced by an average 116 days per patient on wards implementing the TDM (Forchuk et al., 2005)
   • TDM intervention groups have been found to consume on average $4,400 less hospital and emergency room services per person in the year after discharge (Forchuk et al., 2005)
   • Usual care control groups were more than twice as likely to be readmitted in the 5 months following discharge compared to TDM intervention groups (Reynolds et al., 2004)

2. Improve Patient Care
   • The TDM improves the quality of patient care by providing ongoing collaborative relationship-based support for psychiatric patients as they recover and transition back into the community
   • The TDM offers patients a sense of belonging, enhanced resources and renewed hope as they recover and integrate back into the community

3. Increase Communication and Collaboration among Hospital Staff and Community Support Groups
   • The TDM allows hospital staff to work in close collaboration with community support groups throughout the discharge process, thus enhancing these crucial relationships

Ultimately, it is our goal to provide your staff and patients with a discharge process that will help patients integrate smoothly and effectively into the community. While it’s true that implementing the TDM will involve an initial learning curve and some procedural changes, the results will be well worth it by reducing patient length of stay and readmission rates.
Appendix A – TDM Workflow

The chart below summarizes the post-implementation TDM workflow on a tertiary care ward:

<table>
<thead>
<tr>
<th>Event</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient is admitted to inpatient mental health unit.</td>
<td>The Inter-disciplinary team and patient identify a staff member who will take on the transitioning role.</td>
</tr>
<tr>
<td></td>
<td>During hospitalization, the transitioning staff member continues to assess the relationship with the patient. This staff member has the potential to change, in the event that the patient has a better therapeutic relationship with another staff member later in the admission. The patient and inpatient team determine this.</td>
</tr>
<tr>
<td></td>
<td>The transitioning staff member and inpatient team collaboratively work with the patient to formalize an Individualized Discharge Plan of Care</td>
</tr>
<tr>
<td>The transitioning staff member and the inpatient team identify whether the patient has peer support services in place</td>
<td>Is the patient receptive to transitioning support?</td>
</tr>
<tr>
<td>NO</td>
<td>Introduce the idea of peer support and discuss the roles and benefits</td>
</tr>
<tr>
<td></td>
<td>Is patient receptive to peer support?</td>
</tr>
<tr>
<td>YES</td>
<td>Explore and facilitate the patient's needs and wishes around the role of the peer supporter during hospitalization.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>Based on patients perceived needs, goals and preferences, the discharge specialist on the unit initiates a referral to a community care provider. (The Discharge Specialist could be the transitioning staff member OR other team member)</td>
</tr>
<tr>
<td></td>
<td>YES</td>
</tr>
<tr>
<td>YES</td>
<td>Initiate referral to peer support services. Facilitate initial meeting with peer support coordinator/Volunteer.</td>
</tr>
<tr>
<td></td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>The transitioning staff member continues the therapeutic relationship while the patient is in transition from hospital to community and encourages the patient to utilize his/her community care provider when requiring support.</td>
</tr>
<tr>
<td></td>
<td>The transitioning staff member maintains contact with the patient to help facilitate a therapeutic relationship with the community care provider. This can be completed via 1) telecommunications, 2) face-to-face contact in community, &amp; 3) when patient accesses outpatient services in hospital. This is then documented in the progress notes and sent down to clinical records.</td>
</tr>
<tr>
<td></td>
<td>Transitioning staff member will begin the termination phase of the therapeutic relationship when the patient establishes a therapeutic working relationship with Community Care Partner or goals of the discharge plan have been met. The transitioning staff member documents a final discharge summary note in the progress notes indicating the relationship has terminated.</td>
</tr>
</tbody>
</table>


Forchuk, C., Martin, M., Jensen, E., Ouseley, S., Sealy, P., Beal, G., Reynolds, W., & Sharkey, S.


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