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Implementing the Transitional Discharge Model

**Final Report –Prepared for the Council of
Academic Hospitals of Ontario (CAHO)
Adopting Research to Improve Care (ARTIC)
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TABLE OF CONTENTS

EXECUTIVE SUMMARY	5
The Model	5
Background	5
Implementation of CAHO TDM ARTIC project	5
Table 1- Participating Hospitals and CSIs/Peer Support Programs	6
Purpose	6
Project Evaluation	7
Description of Client Population	7
KEY FINDINGS	8
Sustainability	9
Spread	10
FULL REPORT	11
NEED/CHALLENGE THAT PROJECT ADDRESSES	11, 12
PROJECT DESCRIPTION	13
EVIDENCE	14
IMPLEMENTATION STRATEGY	15
Peer Support	15
Table 2- Site Variations- Peer Support	16
Table 3 - Initial implementation plan for Peer Support	17
Hospital Sites	17
Table 4 - Site Variations- Hospital Sites	18
Table 5 - Implementation plan utilized by bridging staff	19
Table 6 - General implementation strategies for hospital and peer support sites	20
Table 7 - Continued sources of TDM funding	21
RESULTS AND INTERPRETATIONS	22
Project Evaluation	22
Focus Groups	22
Table 8 - Sample characteristics (Client Focus Groups)	23
Interviews with Clients at Discharge	24
Table 9 - Sample characteristics (Client Interviews)	25
Current Level of Social Support including friends and family support	26
Figure 1. Histogram of total scores from the Personal Resource Questionnaire	27
IMPLEMENTATION EFFECTIVENESS	27
Satisfaction with Service	27
Degree of TDM Implementation	27
Table 10 - Degree of implementation across all sites	28
Quality of Life	28
Table 11- Average scores across all domains of the Quality of Life Inventory	29
Client use of services	29
Readmission Rates Results	30
Average Length of Stay Results	31

Table 12 - Average Length of Stay _____	31
Emergency Department Usage Results _____	32
Cost Effectiveness of the Intervention _____	32
Table 13- Cost of TDM implementation and expected savings _____	33
IMPLEMENTATION STRATEGIES & LESSONS LEARNED _____	34
Pre-Implementation Strategies _____	34
Hospital specific strategies _____	34
Peer support specific strategies _____	35
Hospital and peer support specific strategies _____	36
Implementation Strategies _____	37
Hospital specific strategies _____	37, 38
Peer support specific strategies _____	39, 40
KEY SUCCESSES AND ACCCOMPLISHMENTS _____	41, 42
PROJECT MILESTONES AND ACTIVITIES _____	43
CONCLUSION _____	43
Discussion _____	43
Reflection _____	43
Future plans _____	44
Next steps _____	45
References _____	46, 47, 48

EXECUTIVE SUMMARY

In 2013, The Council of Academic Hospital of Ontario (CAHO) awarded funding to *Implementing the Transitional Discharge Model (TDM)* as part of their Adopting Research to Improve Care (ARTIC) program. Principal Investigator, Dr. Cheryl Forchuk, based out of Lawson Health Research Institute in London, Ontario, led this two year-project.

The Model

The purpose of TDM is to support the successful discharge and community re-integration of people diagnosed with a mental illness discharged from psychiatric facilities. The principles of the model are based on the provision of therapeutic relationships to ensure a safety net exists for clients throughout the discharge and community reintegration processes.

TDM has two components:

- 1) an overlap of hospital and community staff until a therapeutic relationship is established with the community care provider
- 2) peer support from someone with the lived experience of mental illness who has successfully made the transition to community

Background

Developed through a participatory action project started in 1992, this made in Ontario model has already been proven in Canadian and International contexts to significantly improve the discharge process. Published results from previous Ontario TDM projects found: 116 day average reduction in length of stay resulting in savings of 12 million dollars, an average savings of \$4,400 in usage of emergency room services per person in the year after discharge for those receiving the TDM compared to those not receiving the TDM (Forchuk, Martin, Chan & Jensen, 2005), and improved quality of life and social relations (Forchuk et al., 1998). Internationally, Scottish parliament declared TDM a best practice after demonstrating a significant reduction in readmission rates (Reynolds et al., 2004).

Implementation of CAHO ARTIC TDM ARTIC project

TDM was implemented at 9 hospitals across Ontario. A key partnership was with the Ontario Peer Development Initiative (OPDI). OPDI acts as a provincial voice for 48 Consumer/Survivor Initiatives and Peer Support Programs across Ontario. Hospital staff and peer supporters worked together to implement TDM on both acute and tertiary care wards. Implementation strategies varied across all sites; however, the principles of the model focusing on relationships to bridge the discharge process remained the same. Table 1 outlines the participating hospitals and partnering Consumer/Survivor Initiative or Peer Support Program.

Table 1- Participating Hospitals and CSIs/Peer Support Programs

Participating Hospitals	Participating Consumer/Survivor Initiative Organizations/Peer Support Programs
Centre for Addiction and Mental Health	Centre for Addiction and Mental Health Internal Peer Support (Toronto)
Hôpital Montfort	Psychiatric Survivors of Ottawa
London Health Sciences Centre	Connect for Mental Health Inc. (London)
Providence Care	Mental Health Support Network South East Ontario
Baycrest	Krasman Centre (Richmond Hill)
St. Joseph’s Healthcare Hamilton (SJHH)	Patient and Family Collaborative Support Services (SJHH), Hamilton
St. Joseph’s Health Care London	Can-Voice (London)
Thunder Bay Regional Health Sciences Centre	People Advocating for Change through Empowerment (Thunder Bay)
Ontario Shores (Non-CAHO hospital)	CMHA Durham (Oshawa)

Purpose

The purpose of the current CAHO ARTIC TDM project was to examine the effectiveness and sustainability of implementing TDM at 9 hospitals across Ontario. The TDM project provided an opportunity to understand and refine implementation strategies for the model.

CAHO TDM ARTIC project specifically assessed the following:

- Description of client population
- Client use of services including readmission rates and length of stay
- Cost effectiveness of intervention
- Implementation effectiveness of TDM specifically assessing the enablers and barriers to implementation.

Project Evaluation

In order to test the effectiveness and sustainability of the TDM, the project team gathered data through four main sources:

Data Sources

1. Focus groups with clients, hospital staff, and peer supporters at six months and one year post-implementation. This included:
 - 87 clients
 - 216 hospital staff
 - 66 peer supporters
2. Interviews with 370 clients at discharge
3. Hospital administrative data
4. ICES data

A 4th data source, provincial administrative data held at the Institute for Clinical Evaluative Sciences (ICES), will also be analyzed to capture individual participants' use of health services (readmissions, emergency room visits, outpatient visits). This data will also be used to determine the cost effectiveness of the intervention by calculating the change in readmissions, emergency room visits, and physician visits for the six months period prior to implementation and post-implementation.

Description of Client Population

Among the 370 individual clients who were interviewed, and the 81 clients who filled out a demographic form during focus groups, key demographic information is summarized:

Description of Client Population (includes interviews and focus groups)

- Average age was middle aged for both (interview: 42.2 years, focus groups: 44.2 years)
- Roughly equal distribution of males and females for both interviews and groups
- Majority were Caucasian descent for both (interview: 76.9%, focus groups: 62.0%)
- For interviews, almost half had completed high school (43.6%), with slightly less (39.5%) having completed community college or university
- For focus groups, more than half had completed community college or university (60.0%), with less having completed high school as their highest level of education (27.6%)
- The prevalent psychiatric diagnoses for both interviews and focus groups were consistent: mood disorders (interview: 52.2%, focus groups: 54.3%); anxiety disorders (interview: 24.6%, focus groups: 38.3%); and schizophrenia or schizoaffective disorders (interview: 22.4%, focus groups: 25.9%).

KEY FINDINGS

TDM provided appropriate supports to help keep clients in the community and out of hospital.

Specifically:

- Reduced average length of stay by 9.8 days.
- This amounts to a potential savings in hospital days of **\$31,360,000** if TDM remains on participating wards
- This amounts to a potential savings in hospital days of **\$632,201,920** if TDM were implemented province-wide.
- Reduced readmission rates (based on qualitative data)
- Savings of TDM implementation amounts to **\$2,907,416** per Site, Annually (based on cost of intervention and savings from reduced length of stay)

The cost effectiveness of the implementation was assessed by comparing the cost of implementing the intervention to any changes in hospital spending based on reduced length of stay. When available, ICES data will be used to also calculate change in readmissions, emergency room visits, and outpatient visits. Associated costs of this health service utilization will be calculated and compared against the cost of implementing the TDM. At present time the reduction in length of stay alone suggests a cost savings however with the future inclusion of readmission rates and emergency room visits we anticipate that the savings will likely be even greater than those presently reported. These savings significantly outweigh the cost of intervention which includes training, a peer support coordinator/volunteer support and staff time for bridging clients to the community.

Better integration of care between hospital and community.

- Increased communication/collaboration among hospital staff, community staff, peer supporters
- Integration of peer support into hospital and follow-up care
- Increased staff/client comfort and sense of security with discharge process due to provision of support.

Best hospital specific implementation strategies included:

- For tertiary care wards, any clinical ward staff might participate in continuing to see clients after discharge to bridge to community care providers
- For acute care wards, a specific multi-disciplinary transition team generally provides bridging. For select client situations there may be occasion for other ward staff to participate in bridging
- Assignment of a "site lead" to lead implementation of TDM and serve as a point person for staff questions and support
- Standardized in-depth TDM training for site lead to learn how to train staff for TDM, and strategies for implementation
- TDM training for all hospital staff on participating wards
- Access to a community of practice through regular discussions with other wards and programs implementing the model

- Engagement of hospital leadership. Active, hands on senior leadership support/interest is key

Best peer support specific implementation strategies included:

- Standardized training for peer supporters (through OPDI Peer Support Core Essentials Training Program or equivalent training)
- Association of peer support with a community peer run group
- Paid Peer Coordinator whose role includes on-ward peer support presence with activities and interaction with clients on ward, recruiting of peer supporters, training of peer supporters, matching of clients and peer supporters, and support of peer supporters
- The TDM peer support uses a friendship model. People providing peer support could be paid or volunteers, but capacity to include those wanting to provide occasional volunteer work is needed. For paid peer support consider whether a sufficient caseload is possible and whether paid peer supporters should provide support where a more intensive level of support is needed
- Include support for peer supporters including things such as volunteer recognition activities, travel costs and support for shared activities
- The availability of a variety of peer support opportunities. This includes 1:1 matching, peer support groups on the ward and in the community, and informal activity based groups
- A community of practice including regular discussions with other programs and peer supporters using the model
- A diverse pool of peer supporters; both males and females, peer supporters with a variety of interests and with diverse backgrounds and educational levels.

Sustainability

A challenge with the TDM model is that while changing staff roles to accommodate bridging clients to community care can be done within the hospital budget, the peer support generally requires collaboration with, and funding for, an external community group. Thus, the primary challenge for sustainability is to ensure ongoing funding of peer support coordinators/staff and their activities. A variety of strategies were employed to address the sustainability of peer support, and some strategies are stop-gap measures while longer term solutions are sought.

In addition, strategies are needed to continue support of the bridging staff component of TDM. These include:

- Continuation of a site lead/ward champion role which includes orientation of new staff and being a resource for the model
- Continued support for bridging staff including scheduling, and transportation costs as required

Spread

Given the success of the implementation of TDM at these hospitals the issue of spread needs to be addressed.

The goal

That TDM be the standard of care and available at all Ontario mental health wards.

Priority consideration should be given to spreading the TDM to specialized mental health hospitals on mental health wards that have experience in implementing the model and trained trainers.

Where additional hospital sites are interested in implementing the TDM, priority should be given to adding some nonacademic hospitals and smaller communities.

Funding should be sought to strategically add sites so that all LHINs have at least one TDM program.

Funding for Community Organizations providing peer support.

Funding is foundational for the implementation, sustainability and spread of TDM.

Linkage to programs that also provide informal peer support and activity based peer support

These allow for greater choice to support increasing social support through peer support.

Providing continuity of staff support in combination with peer support is an innovation to be spread beyond mental health settings.

Given the success of TDM in mental health consideration to testing the model with other long-term chronic conditions is appropriate.

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IMPLEMENTING THE TRANSITIONAL DISCHARGE MODEL FINAL REPORT

Prepared for the Council of Academic Hospitals of Ontario (CAHO)
Adopting Research to Improve Care (ARTIC) Program

NEED/CHALLENGE THAT PROJECT ADDRESSES

In Ontario, as elsewhere, mental health initiatives have increasingly moved from hospital settings to community-based care. This led to a trend referred to as the ‘dehospitalization’ (rather than deinstitutionalization) (Sussman, 1998) of mental health clients. This trend resulted in a reduction of the number of psychiatric hospital beds that were available for clients and often led to poorly supported discharges. This result is worrisome, because the discharge process is challenging for mental health clients. For example, a study of 85 long-term clients showed that 25% experienced relocation trauma when moved from the hospital to the community (Farhall, Trauer, Newtown, & Cheung, 2003). Standard discharge practices from psychiatric wards often leave clients with a gap in care. This disrupts the continuity of services and supports available to clients during their transition, before they are seen by community agencies. In the time immediately following discharge clients are vulnerable and are at risk of readmission (Madi, Zhao & Fang Li, 2007). Given that clients also face a heightened risk of suicide at this time, preventing gaps in care is essential (Bickley et al., 2013).

The TDM was developed to address this need. In 1992, a Canadian participatory action project called the *Bridge to Discharge* developed and piloted the TDM (Forchuk, Jewell, Schofield, Sircelj, & Valledor, 1998). Not only were all 38 pilot participants successfully “bridged,” to the community but TDM implementation also resulted in nearly \$500,000 of in-patient savings while improving patients’ quality of life (Forchuk et al., 1998). The pilot project’s success was replicated in other studies. Reynolds et al. (2004) introduced the model in Scotland to four acute care programs. In this study the participants who did not undergo a TDM were more than twice as likely to be readmitted in the 5 months following their discharge. In yet another study, the length of stay for participants receiving TDM discharges was reduced by an average of 116 days, resulting in a savings of \$12,000,000 in freed bed-space (Forchuk, Martin, Chan, & Jensen, 2005). 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 (Forchuk et al, 2005). Interventions such as the TDM are related to several positive outcomes, such as reducing re-hospitalization rates and improving adherence to after-care programs (Curran & Brooker, 2007; Steffen, Kösters, Becker, & Puschner, 2009). In their comprehensive review of the research on

organizational interventions for patients with severe mental illness, Franx et al. (2008) found that, compared to conventional services, multidisciplinary teams and integrated care changes had beneficial effects on several patient outcomes such as symptom severity, functioning and employment.

The TDM has been accepted in both research and health care communities. However the implementation of the TDM is not always implemented in a standardized manner when not part of a research project. Many hospitals appear to adopt some aspects of the intervention (e.g. providing bridging/transition staff) but do not adopt other parts (e.g. connecting with consumer groups). As an example, the schizophrenia program at the Centre for Addiction and Mental Health (CAMH) in Toronto has been implementing a “from hospital to home” initiative. This initiative has several components that are similar to the TDM proposed here, such as collaborative partnerships with housing providers and maintaining relationships during transition. Given the importance of supporting clients throughout the discharge process and the potential value of the complete TDM, comprehensive and consistent implementations will be required. Supporting and understanding the process of TDM implementation will be essential for successfully spreading the TDM across Ontario.

PROJECT DESCRIPTION

The Transitional Discharge Model was created to guide and support the effective and safe discharge of mental health clients from psychiatric hospitals to the community. In order to successfully move the focus of care to the community, effective models of collaborative support were required. TDM, one such model was based on the theoretical concept of therapeutic relationships. Therapeutic relationships are formed in the context of care, and have been shown to support clients and care providers in a variety of health care settings (Forchuk, 1993; Forchuk, 1994; Forchuk & Reynolds, 2001). A variety of relationships can be therapeutic such as care providers but also family and friends. Applying this theoretical innovation ensured that a safety net exists for clients throughout the discharge and community reintegration processes.

TDM has two components to assist clients in the transition from hospital to community:

1. Peer support from a person who has experienced a mental illness, is living successfully in the community, and has completed a peer training program. Peer support includes regular scheduled contact that suits both parties, for the purpose of social support and learning from the experience of someone who lived through a similar transition.
2. Continued support from hospital staff. These individuals were identified by the client as someone with whom they have a therapeutic relationship. The therapeutic relationship with hospital staff was continued until a new therapeutic relationship was established with a community mental health care provider.

The three basic assumptions of TDM are:

1. People heal in relationships (including relationships with staff and peers).
2. Transitions in care are vulnerable periods for individuals with mental illness.
3. A network of therapeutic relationships during transitional periods assists in recovery.

EVIDENCE

The TDM has been evaluated using a variety of well-established research methods. These studies have unanimously found that TDM provides high quality mental health care by supporting recovery. These studies also confirm that effective TDM implementation reduces length of stay and readmission rates.

Initially developed through a participatory action design, TDM successfully “bridged” 38 long-term in-patients to the community through ongoing staff and peer support. By implementing TDM \$500,000 was saved in the first year alone. This was done while also improving clients’ quality of life (Forchuk et al., 1998). On a larger scale, TDM was implemented using a randomized cluster design in 26 Ontario tertiary care psychiatric wards. In this study, 13 wards were randomized to receive the intervention (TDM implementation), and 13 wards were randomized as control wards (the control wards received usual care). Hospital wards in the intervention group were partnered with 17 CSIs to provide peer support. The length of stay for participants on the intervention wards (TDM) was reduced by an average of 116 days, resulting in savings of over 12 million dollars. The TDM 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 (Forchuk, Martin, Chan, & Jensen, 2005). Internationally, the Scottish parliament declared TDM a best practice after demonstrating a significant reduction in readmission rates in a 2001 randomized control trial (Reynolds et al., 2004).

Following the positive results achieved by the early TDM studies, a delayed implementation control group design study was conducted to examine implementation barriers and facilitators to assist with knowledge integration. This involved implementing TDM on 40 psychiatric wards in 3 waves (Groups A, B and C), with the partnership of 24 Consumer/Survivor Initiatives who provided the peer support. Each wave of wards used strategies recommended by the prior wards. Group C implemented TDM most effectively and efficiently by using best practices identified by Groups A and B. Best practices included; compact TDM educational modules, having on-ward champions/site lead and supportive documentation systems (Forchuk et al., 2012).

Overall, TDM was well accepted by hospitals and community organizations in the initial and current TDM studies. This combination of evidence demonstrates that TDM provides high quality care, and supports recovery. Through these studies, TDM was shown to be a best practice for knowledge integration and implementation. As a result, TDM was well-suited for partnership with ARTIC program in collaboration with the Council of Academic Hospitals of Ontario (CAHO).

By adopting TDM in hospitals across Ontario, the province has the potential to save millions of dollars. When appropriate supports are not in place for individuals experiencing mental illness the healthcare system will remain more expensive than necessary. Beyond the enormous financial value that TDM brings to the province of Ontario, it is important to

emphasize the immense personal and psychological benefits that individuals suffering with mental illness stand to gain. By providing collaborative, relationship-centered support to psychiatric inpatients, TDM offers a sense of belonging, important resources and hope. Each of these is necessary to support recovery and community integration.

IMPLEMENTATION STRATEGY

TDM includes both peer support and bridging hospital and community care. Therefore strategies are needed to ensure each of these two components are supported

Peer Support:

The Ontario Peer Development Initiative (OPDI) was a key partner in this 2 year project. OPDI is funded by Ontario Ministry of Health and Long-Term Care (MOHLTC) to act as a voice for 48 Consumer/Survivor Initiatives (CSIs) and peer support programs across Ontario. Deb Sherman, the Executive Director of OPDI was a co-investigator on the project, attended weekly TDM meetings, and was a key resource when liaising with CSIs and peer support programs.

During the pre-implementation stage, the project team organized teleconferences with each site to discuss local peer support implementation strategies. Discussing the local context was key, as it allowed the team to enhance or develop strategies that would respect each site's existing peer support program. This localized approach supported the sustainability of each implementation.

The original peer support plans were to develop peer support with an OPDI member organization that partnered with participating hospitals. Most sites continued to use this approach. We recommended that each site have a .5 FTE peer support coordinator for up to 50 referrals per year and one FTE peer support coordinator for up to 100 referrals. The peer support coordinator oversaw the recruitment of peer supporters, conducted their training, matched supporters and clients (peer matching), and provided ongoing support for each peer supporter. This person visited the wards regularly (e.g. twice a week) to meet with clients prior to discharge, to assist in peer matching and to run ward peer groups.

Due to existing in-hospital peer support programs, two sites decided that peer support would be offered by hospital based peer support workers. These peer supporters met clients on the ward and bridged them into the community themselves. In these cases clients were not matched with peer supporters in the community. These paid peer supporters usually offered, in other programs, a more intensive form of peer support than the friendship model and were more a part of the clinical programming.

Table 2- below is a visual representation of the variations of peer support:

SITE VARIATIONS-PEER SUPPORT					
Site	Coordinator	Workers	Volunteers	Hospital Based	Community Based
CONNECT (London)	✓		✓		✓
Can-Voice (London)	✓		✓		✓
Canadian Mental Health Association Durham	✓		✓		✓
Krasman Centre (Toronto)	✓		✓	✓	✓
Mental Health Support Network (South East)	✓	✓			✓
Psychiatric Survivors of Ottawa	✓		✓		✓
People Advocating for Change through Empowerment (Thunder Bay)	✓		✓		✓
Centre For Addiction & Mental Health (Toronto)		✓		✓	
St. Joseph's Healthcare Hamilton		✓		✓	

Original peer support project milestones were based on an early assumption that sites would implement peer support through a Consumer/Survivor Initiative, and used language reflecting a coordinator and volunteer’s strategy.

Table 3- below summarizes the initial implementation plan for peer support.

MILESTONE	TIMELINE	
Identify if there is an existing OPDI training group in the area. If not, the site can be matched up with another area to receive training.	Months 1-3	Completed
Psychiatric survivor group members complete OPDI training.	Months 1-6 for initial cohort and continued training of new peers as needed	Completed
If necessary, train additional OPDI trainers.	Assess Months 2, 6 & 12	Completed
Hire peer support coordinator (.3 FTE for up to 50 referrals/year and one FTE for up to 100 referrals/year). <u>Note:</u> the original milestone suggested .3FTE, however, given the responsibilities of the peer support coordinator & the importance of having a ward presence, this was later suggested to be .25 FTE until they received 12 referrals, in which case, they would be bumped up to .5FTE	Months 1-3 for initial hire and maintained throughout	Completed
Create individualized training programs (webinars, etc.) based on specific site needs.	Months 2-6 and maintained throughout	Completed
Match and introduce peer support volunteers with clients who are about to be discharged.	Beginning by Month 3	Completed
Peer support volunteer and client meet regularly post-discharge. This includes support from consumer organizations to facilitate shared activities (e.g. Tim Horton’s gift certificates, etc.).	Beginning by Month 3	Completed

Hospital Sites

Each site identified a site lead and a ward champion for each participating ward.

Site leads: Most site lead positions were incorporated into existing advanced practice and/or leadership roles. Site leads worked closely with the Central Project Team and peer support coordinator in ensuring successful implementation of the TDM. Site leads collected evaluation data, provided guidance, gave ongoing support, and maintained ongoing communication with the ward champions and staff. This process occurred throughout TDM implementation on each ward.

Ward champion: The ward champion served as a mentor and guide. This person provided ongoing support to colleagues on his/her ward at each hospital setting. Support included developing problem solving approaches with staff members or accompanying staff on an initial home visits. Site with no more than 30 beds per ward combined the **site lead** and **ward champions**.

The TDM was implemented on a variety of psychiatric wards at the 9 participating hospitals. This study did not include a control group, as all 9 hospitals received the intervention. The team worked with each site to ensure that TDM was adapted to each hospital’s unique context. Overall, TDM was implemented within 14 different psychiatric wards. Half of the wards provided acute-care the other half were tertiary. Sites were both unionized and non-unionized. Ontario Shores was the only non-CAHO hospital. Staff support was provided by either clinical staff, an internal transitional team or community transitional team.

Table 4- Below is a visual representation of site variations:

SITE VARIATIONS-HOSPITAL SITES				
Site	Acute Care	Tertiary Care	Ward Staff Bridging	Bridging Team
London Health Sciences Centre	✓			✓
St. Joseph’s Health Care, London		✓	✓	
Ontario Shores (Whitby)		✓	✓	
Baycrest (Toronto)		✓	✓	
Providence Care (Kingston)		✓	✓	
Montfort (Ottawa)	✓			✓
Thunder Bay Regional Health Sciences Centre	✓			✓
Centre for Addiction & Mental Health (Toronto)	✓			✓
St. Joseph’s Healthcare Hamilton	✓	✓	✓	✓

Table 5 - below outlines implementation plan utilized by bridging staff

MILESTONE	TIMELINE	
Identify specific wards that will be involved in the implementation as well as specific staff members.	Months 1-3	Completed
Recruit and select the transition team.	Months 1-3	Completed
Confirm position support.	Initially Month 1 with ongoing dialogue	Completed
Confirm physician support.	Initially Month 1 with ongoing dialogue	Completed
Train staff on TDM through full or half-day workshop (Local leads with support from research team and research coordinator).	Months 1-3	Completed
Establish clear start date for implementation.	By Month 2	Completed
Implement documentation systems.	By Month 3	Completed
Implement referral systems.	By Month 3	Completed
Identify site coordinator/champions for each participating ward.	By Month 1	Completed
Staff begin providing bridged support (includes post-discharge follow-up visits).	By Month 3	Completed

Table 6 - below outlines general implementation strategies for hospital and peer support sites

GENERAL MILESTONE	TIMELINE	
Identify each hospital's ability to allocate resources to TDM.	Month 1	Completed
Identify community partners/service providers.	Month 1-3 initially and throughout	Completed
Establish referral process between hospitals and peer support groups.	Month 2-3	Completed
Develop relationships between hospital and peer support groups (minimum weekly meetings).	Beginning Month 1 and continuing throughout	Completed
Create clear role statements for peer supporters and staff.	Months 1-3	Completed
Ensure agreement exists on the evaluation strategy.	By Month 3	Completed
Secure a location/working space for team (both peer supporters and staff).	By Month 3	Completed
Review patient target group and establish systems to triage patients based on readiness to engage with bridging staff.	Months 3, reviewed month 6, 9, 12, 15	Completed
Recruit and hire a site lead at each hospital who will be in charge of local implementation.	Month 1-2	Completed
Recruit and hire a research coordinator to help with data	Month 1-2	Completed

collection/analysis, staff training and peer training/matching. This research coordinator will work out of the Lawson Health Research Institute in London.		
Bring all site leads together for orientation session on TDM for at least a week. Also pull peer coordinators together at the same time.	Month 1-2	Completed
Open dialogue with local peer support group.	Ongoing	Completed
Build and promote collaboration between peer support workers and bridging staff.	Ongoing	Completed
Interview patients at discharge and 3 months post-discharge. <u>Note:</u> the original milestone indicated patient interviews would take place 3 months post-discharge, however, that was later changed to interviews only at discharge.	Ongoing	Completed
Identify strategies for sustainability of the intervention. This will involve collecting feedback during implementation to create a feedback loop. This can also involve bringing consumer groups and hospital groups together to provide feedback (e.g. focus groups and interviews at 6 months and 1 year post-implementation).	Months 1, 6, 12 & 18	Completed
Survey participating hospitals to assess the degree to which TDM is being implemented across Ontario (both pre- and post-implementation).	Months 1 & 19	Completed

The project team worked with all sites to identify strategies for sustainability of the TDM intervention. All sites have continued with the clinical staff bridging component of the model and have identified a site lead. The biggest challenge of sustainability, however, was securing funding for the peer support coordinator position, as this was funded through the current project. The most ideal strategy was for the CSI to secure funding through their Local Health Integration Network (LHIN) so that peer support would be seen as a regional resource. Some sites were able to secure this or are in the process of securing this funding through their LHIN. Where this was not possible, alternative sources were pursued. The table below summarizes the status of each site’s sustainable funding for the peer support position.

Table 7- Continued sources of TDM funding

Site	Secured Funding	Type of Funding
Psychiatric Survivors Ottawa- Montfort	yes	LHIN funding
CMHA Durham- Ontario Shores	yes	Hospital funding, peer support coordinator remains based out of CMHA
Krasman -Centre Baycrest	No	LHIN funding – denied Federal grant – to hear back in March 2015 Interim Plan: Peer support coordinated by trained peer support volunteer under volunteer services at hospital
Mental Health Support Network – Providence Care	yes	LHIN funding
Internal Peer Support (Patient and Family Collaborative Support Services) – St. Joseph’s Healthcare Hamilton.	yes	Hospital funding
CONNECT- London Health Sciences Centre	yes	LHIN funding – denied (LHIN in process of reviewing peer support) Interim Plan: Funding through LHSC until March 31, 2015 with further funding under discussion
PACE- Thunder Bay Regional Health Sciences Centre	yes	LHIN funding
CAMH –Internal Peer Support	no	Have not secured funding through hospital budget
Can-Voice – St. Joseph’s Health Care London	yes	LHIN funding – denied (LHIN in process of reviewing peer support) Interim Plan: Funding through St. Joseph’s Health Care London (SJHC-L) until June 30, 2015. CONNECT to partner with SJHC-L.

RESULTS & INTERPRETATIONS

Project Evaluation

In order to test the effectiveness and sustainability of the TDM, data was gathered through four main sources:

1. Focus groups with clients, hospital staff, and peer supporters at six months and one year post-implementation.
2. Interviews with clients at discharge.
3. Hospital administrative data (for client demographics, discharge rates, readmission rates, cost effectiveness).
4. ICES data analysis on readmission rates, emergency room visits, and physician visits.

Focus Groups

Focus groups were held with clients, hospital staff, and peer supporters at six months and one year post-implementation. The purpose of groups was to explore people's experiences related to using TDM. Suggestions were sought regarding what was working related to the model as well as necessary recommendations and strategies required to enhance the current model.

The inclusion criteria for care providers were as follows:

- a. Qualified psychiatric/mental health staff
- b. Work in mental health setting that implemented TDM
- c. Responded to poster to attend focus group

The inclusion criteria for clients were as follows

- a. Have been hospitalized
- b. Are able to understand English to the extent necessary to participate
- c. Competent to sign consent
- d. Are being discharged from a unit participating in the study

The inclusion criteria for peer supporters were as follows

- a. Have participated in OPDI training and matching program (or an equivalent peer support training program).
- b. Provide peer support or other community support for hospital/ward that implemented TDM and/or completed training for TDM
- c. Responded to poster

Inclusion Criteria for all participants was 18-85

Below is a table summarizing sample characteristics for Client Focus Groups

Table 8- Sample characteristics (Focus Groups; n=81)

DEMOGRAPHICS – FOCUS GROUPS	
Characteristic	n(%)
Age [Mean (SD)]	44.2 (14.5)
Sex	
Male	37 (45.7%)
Female	43 (53.1%)
Declined	1 (1.2%)
Ethnic Group (n=79)	
European Origins (Caucasian)	49 (62.0%)
Visible Minority	5 (6.3%)
Aboriginal	12 (15.2%)
Other	13 (16.5%)
Highest Level of Education Achieved (n=80)	
Grade School	9 (11.3%)
High School	22 (27.6%)
Community College/University	48 (60.0%)
Other	1 (1.3%)
Psychiatric Diagnoses	
Mood Disorder	44 (54.3%)
Anxiety Disorder	31 (38.3%)
Schizophrenia/Schizoaffective Disorder	21 (25.9%)
Diagnosis Type Unknown	9 (11.1%)
Personality Disorder	8 (9.9%)
Substance-Related Disorder	7 (8.6%)
Other*	7 (8.6%)
Disorder of Childhood/Adolescence	7 (8.6%)
Psychosis	2 (2.5%)
Organic Disorder	1 (1.2%)
Developmental Handicap	1 (1.2%)
Has had Contact with Staff since Discharge (n=64)	49 (75.4%)
Has had Contact with Peer since Discharge (n=68)	48 (70.6%)

**Includes: seizures, Parkinson's, stress*

The average of focus group participants was similar to that of the client interviews (44.2 years vs. 42.2 years) and was also almost evenly split among males and females (53.1% and 45.7%, respectively). Compared with the client interview sample, the focus group sample was comprised of fewer individuals of European Origins (62.0% vs. 76.9%), with more individuals of

Aboriginal descent (15.2% vs. 8.7%) and “Other” ethnicities (16.5% vs. 4.9%). Individuals in the focus group sample were also more likely to have a community college or university degree (60.0% vs. 39.5%). With respect to psychiatric diagnoses, mood disorders, anxiety disorders, and schizophrenia/schizoaffective disorders were most prevalent in both samples, however, there was a higher prevalence of anxiety disorders among the focus group participants than those who completed the client interviews (38.3% vs. 24.6%). In terms of supports following discharge, roughly three-quarters (75.4%) of focus group participants indicated they had been in contact with staff from their inpatient ward following discharge, with slightly less indicating they had been in contact with a peer following discharge (70.6%).

Interviews with Clients at Discharge

A maximum of 10 clients each month on participating wards were given the option of participating in an interview before they were discharged. The site lead at each hospital conducted these approximately 30 minute interviews.

Below are the measures included in these interviews:

- Demographic Questionnaire
- Personal Resource Questionnaire
- Client Satisfaction with Service
- Discharge Process of Follow-Up Questionnaire
- The Degree of (TDM) Implementation Scale
- Quality of Life

Demographic data (at discharge): Demographic measures were collected before the clients were discharged, including: age; gender; ethnicity; diagnosis; contact with family; level of education; length of stay and number of hospitalizations; discharge destination; housing status; and employment status.

Below is a table summarizing sample characteristics for client interviews at discharge.

Table 9- Sample characteristics (client interviews; n=370)

DEMOGRAPHICS – CLIENT INTERVIEWS	
Characteristic	n(%)
Age [Mean (SD)]	42.2 (16.8)
Sex	
Male	185 (50%)
Female	185 (50%)
Ethnic Group (n=368)	
European Origins (Caucasian)	283 (76.9%)
Visible Minority	35 (9.5%)
Aboriginal	32 (8.7%)
Other	18 (4.9%)
Marital Status (n=366)	
Single/Never Married	220 (60.1%)
Married/Common-Law/Engaged	74 (20.2%)
Separated/Divorced	58 (15.8%)
Widowed	12 (3.3%)
Declined/Don't Know	2 (0.6%)
Has Children (n=363)	143 (39.4%)
Has Contact with Family (n=357)	329 (92.2%)
Highest Level of Education Achieved (n=365)	
Grade School	56 (15.3%)
High School	159 (43.6%)
Community College/University	144 (39.5%)
Graduate School	4 (1.1%)
Declined/Don't Know	2 (0.6%)
Psychiatric Diagnoses	
Mood Disorder	193 (52.2%)
Anxiety Disorder	91 (24.6%)
Schizophrenia/Schizo affective Disorder	83 (22.4%)
Personality Disorder	33 (8.9%)
Substance-Related Disorder	23 (6.2%)
Diagnosis Type Unknown	18 (4.9%)
Psychosis	17 (4.6%)
PTSD	13 (3.5%)
Other*	10 (2.7%)
Disorder of Childhood/Adolescence	9 (2.4%)

Developmental Handicap	3 (0.8%)
Number of Psychiatric Hospitalizations in the Previous Year [Mean (SD)]	1.5 (1.7)
Duration of the Most Recent Hospitalization (Days) [Mean (SD)]	41.6 (130.8)
Total Number of Psychiatric Hospitalizations [Mean (SD)]	4.6 (8.1)

**Includes: eating disorders, brain injuries, Parkinson's*

Among the 370 individuals who were interviewed, the average age was 42.2 years and the sample was split evenly between males and females. The majority of the sample was of Caucasian descent (76.9%) and currently single (60.1%). Almost forty percent (39.4%) had children, and almost the entire sample (92.2%) was in contact with a family member. Almost half the sample had completed high school (43.6%), with slightly less (39.5%) having completed community college or university. The most prevalent psychiatric diagnoses were: mood disorders (52.2%); anxiety disorders (24.6%); and schizophrenia or schizoaffective disorders (22.4%). On average, individuals had been hospitalized for psychiatric reasons 1.5 times in the previous year, with the duration of the most recent hospitalization lasting 41.6 days on average. In total, individuals had been hospitalized for psychiatric reasons an average of 4.6 times in their lifetime.

Current Level of Social Support including friends and family support

The client's level of social support was measured at discharge using part 2 of the Personal Resource Questionnaire (PRQ) (Brandt & Weinert, 1981). Part 2 of this questionnaire consists of a 25 item scale based on 5 dimensions; worth, social integration, intimacy, nurturance and assistance. Responses were based on a 7-point likert scale, with higher scores indicating higher levels of perceived social support. A total score is created by summing the responses with possible scores ranging from 25 to 175.

Across the 345 individuals who had complete data for the PRQ, the minimum score was 44 and the maximum was 175. Figure 1 below contains a histogram of the total scores from the PRQ. From this figure, it appears the responses skewed towards the higher end of the scale. Overall, the average PRQ score was 127.5 (SD: 23.9), which indicates on average, individuals in this sample tended to have a moderate level of social support.

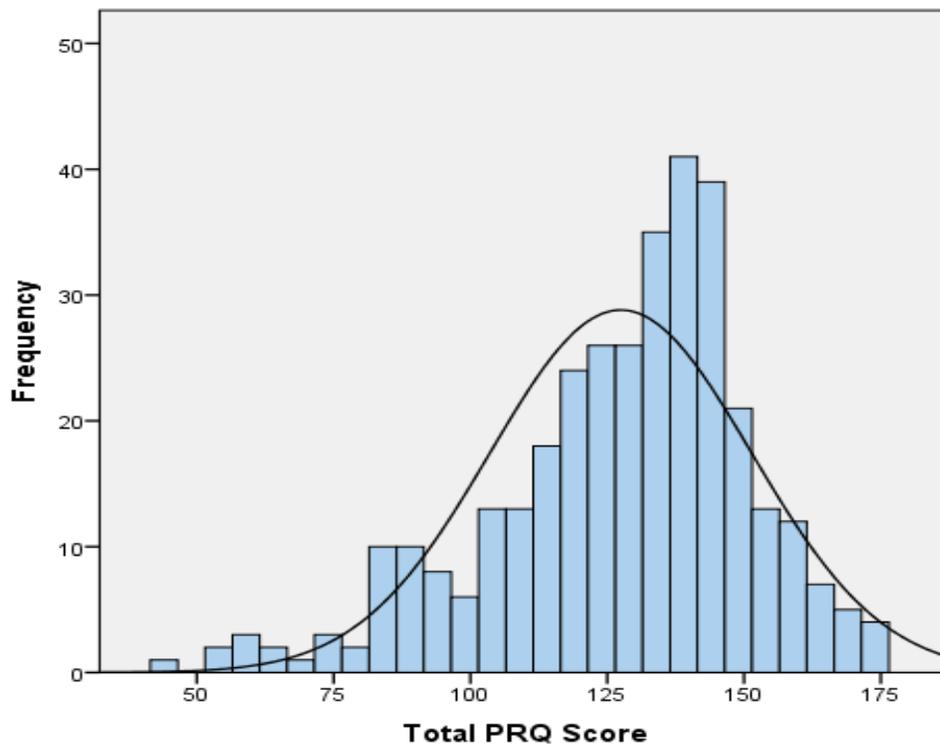


Figure 1. Histogram of total scores from the Personal Resource Questionnaire.

IMPLEMENTATION EFFECTIVENESS

The following implementation information was also gathered at discharge during client interviews

Satisfaction with Service

Client satisfaction with the team’s services was measured at discharge using the following question "If you needed treatment again would you choose to come back to this hospital?" Yes/No.

Of the 359 individuals who responded to the question around satisfaction with service, 317 (88.3%) indicated they would choose to come back to the hospital if they needed treatment. This suggests a high degree of satisfaction with services among this sample of individuals.

Degree of TDM Implementation

The Discharge Process of Follow-up Questionnaire (DPFQ; Forchuk et al., 2005) was used to evaluate implementation effectiveness. This scale consisted of six open-ended questions that explored the discharge plan, description of activities/issues that may help or hinder the

process, and anticipated support from hospital staff as well as peer support following discharge. The qualitative responses to these questions was used to generate a numeric score that measured the degree of implementation of the intervention, as experienced by the study participant, on the *Degree of Implementation Scale*

The Degree of Implementation Scale (Forchuk et al., 2002) was used to measure the extent to which TDM is anticipated to be implemented on the wards. This scale was crucial because it is impossible to evaluate the outcomes of the model unless fidelity in implementing the model can be demonstrated. The scale is based on an interview with the client as to what services they are anticipating receiving. The two parts of the TDM, peer support and continued support from in-patient staff, are rated on 4-point scales and then totaled for the total implementation score. For each ward, the mean scores were calculated every month.

Table 10. Degree of implementation across all sites.

DEGREE OF IMPLEMENTATION				
Type of Ward	n	0 to 6 Months [Mean (SD)]	7 to 11 Months [Mean (SD)]	12+ Months [Mean (SD)]
Acute	248	2.6 (1.9)	2.9 (2.1)	2.9 (1.9)
Tertiary	42	1.6 (2.2)	1.8 (1.9)	2.6 (2.4)
Total	290	2.5 (1.9)	2.8 (2.1)	2.8 (2.0)

Degree of implementation was originally to be analyzed by month and by ward. However, due to the small amount of data available on degree of implementation from several of the wards, data was combined across the sites and categorized by ward type (acute vs. tertiary) and by time since implementation (0 to 6 months, 7 to 11 months, and 12 months and beyond). Among the acute wards, the average degree of implementation started at 2.6 and increased in the 7 to 11 month period to 2.9. This then plateaued at the 12 month mark. Among the tertiary wards, the degree of implementation was smaller than in the acute wards at the start (1.6 vs. 2.6) but steadily increased until a similar degree of implementation was achieved after the 12 months mark (2.6 vs. 2.9). From this appears the tertiary wards took longer to fully implement TDM, but were able to match the degree of implementation found in acute wards after one year.

Quality of Life

Client quality of life was measured at discharge using *The Quality of Life Inventory 20 (QOLI-20)*, which is the subjective measure of the Lehman Quality of Life Inventory Brief Version. This scale was derived from the QOLI-Full Version (Lehman, 1988; Lehman, Kernan, & Postrado, 1994). This specific version contains 21 items measuring subjective quality of life and was used to

describe our sample. Table 11 below displays the average scores across all of the domains of the QOLI-20. The average scores across the domains ranged from 3.9 to 5.3, with the most positive feelings being associated with legal and safety issues (mean=5.3), social relations (mean=5.0), and family relations (mean=4.9). With the exception of finances, the average score of all domains fell above the neutral point indicating the majority of the sample felt satisfied in these areas of their lives.

Table 11. Average scores across all domains of the Quality of Life Inventory 20.

Domain	Mean (SD)
Global Life Satisfaction	4.7 (1.7)
Satisfaction with Family Relations	4.9 (1.5)
Satisfaction with Finances	3.9 (1.7)
Satisfaction with Leisure Activities	4.6 (1.3)
Satisfaction with Living Situation	4.7 (1.7)
Satisfaction with Social Relations	5.0 (1.3)
Satisfaction with Legal and Safety Issues	5.3 (1.2)

Client use of services

Data for the evaluation of TDM came from several sources: individuals, wards, and provincial administrative data. Individual level data came from interviews with clients as they were discharged, which was subsequently entered into a database at each site and sent to the research team. Hospital administrative data was also collected from each participating ward on a monthly basis and sent on to the research team. Finally, provincial administrative data held at the Institute for Clinical Evaluative Sciences (ICES) was also identified as a data source to capture individual participants' use of health services (readmissions, emergency room visits, outpatient visits) before and after enrollment in TDM. To that end, OHIP numbers were collected in order to link ward-level data on use of hospital services with provincial data from The Institute for Clinical Evaluative Sciences (ICES). If OHIP number was not available, surname and date of birth was collected in order for ICES to run a probabilistic match. The OHIP number, surname and date of birth number was recorded on a separate piece of paper and kept separate from the participant's interview responses. Unfortunately, due to the delayed implementation of a number of the wards and the amount of time needed to collect, clean, and link administrative data at ICES, post-implementation data will not be available until at least October 2015. This impacts the ability to conduct some of the analyses, as indicated below.

Readmission Rates Results

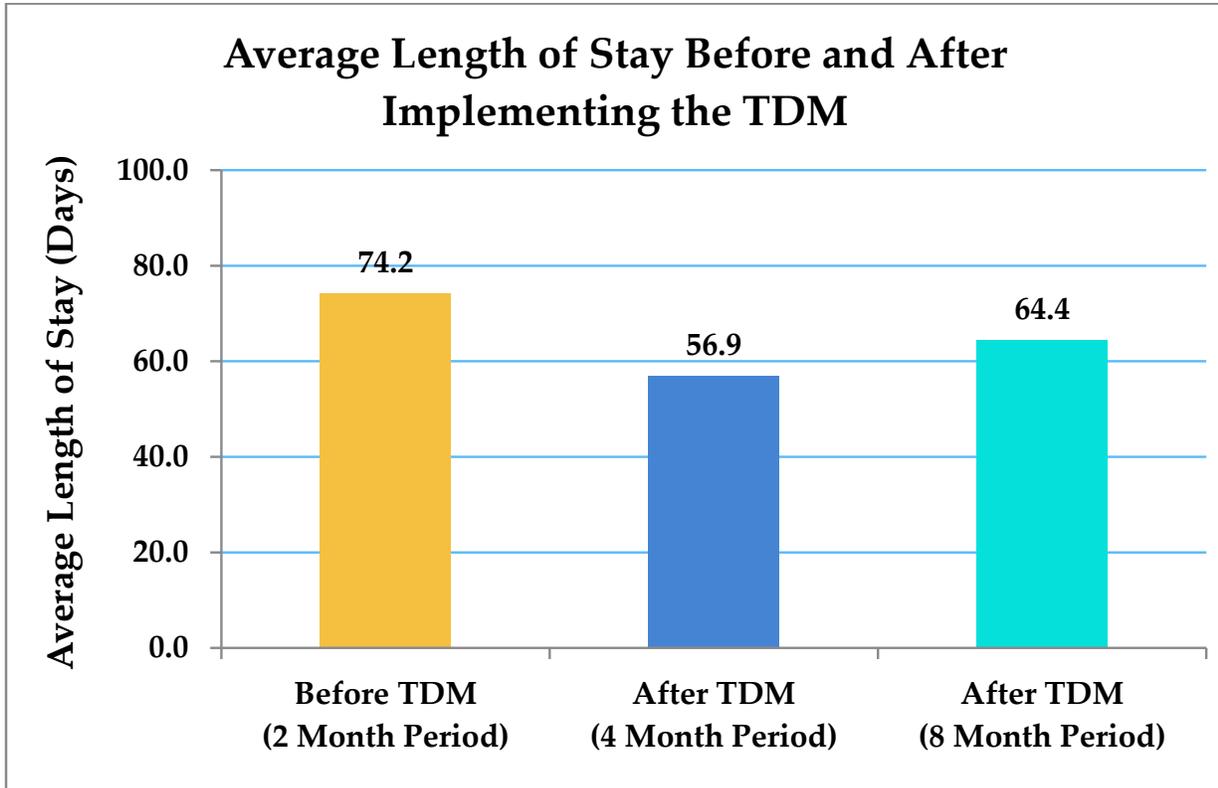
Originally, an analysis of readmission rates was planned using administrative data provided by the individual sites. However, two situations arose through the course of the study which hindered this plan. First, several of the sites experienced very few discharges in the months leading up to implementation of the TDM. This in turn meant that there were no readmissions in the two months prior to TDM implementation. In these cases sites would have been subject to a ceiling (or floor) effect where any readmissions post implementation would have given the appearance of a negative result while it was actually due to chance.

Second, for various reasons (often related to computer glitches) sites were occasionally unable to provide their monthly administrative data. This impacted both the pre and post implementation data as sites required data from both pre implementation months and at least 75% of the post implementation months (6 of the 8 months) in order to calculate the average readmissions with a reasonable amount of accuracy.

Due to these two situations, very few sites had complete data for the comparison of readmission data pre and post implementation and it is highly unlikely that any comparison done on these sites would be generalizable to other sites or hospitals. As a result, an analysis at the individual level is being planned using ICES data once it's available.

Average Length of Stay Results

Table 12. Average Length of Stay



In total, 10 of the wards had complete data on length of stay before and after implementation of TDM. Again, the issue of some tertiary care wards having very few discharges played a role. Length of stay is determined at point of discharge. Therefore if there are no, or few, discharges there is very little length of stay data. In the two months prior to implementing TDM the average length of stay across these 10 wards was 74.2 days. Across the four months following implementation the average length of stay was 56.9 days, a decrease of 17.3 days from pre-implementation. Across the eight months following implementation, the average length of stay was 64.4 days, a decrease of 9.8 days from pre-implementation. At this time period, more discharges were coming from the tertiary care wards, and these stays were longer. Therefore, although the length of stay appears to rebound slightly as time progresses, this may not indicate the effectiveness of the TDM is decreasing. In fact, it may indicate that the TDM is impacting the more long-term patients and is assisting in getting these patients discharged.

Emergency Department Usage Results

As noted above, emergency room usage will be examined using ICES data once it is available for the time period following TDM implementation at all sites. This analysis is currently planned for late 2015 or early 2016.

Cost Effectiveness of the Intervention

The cost effectiveness of the implementation was assessed by comparing the cost of implementing the intervention to any changes in hospital spending based on reduced length of stay. When available, ICES data will be used to also calculate changes in readmissions, emergency room visits, and outpatient visits. Associated costs of this health service utilization will be calculated and compared against the cost of implementing the TDM. Including readmission rates and emergency room visits in future calculations will be an added value to the present report and such will be available in February 2016.

At present time the reduction in length of stay alone suggests a cost savings. Given the average cost for 1 day of hospitalization is conservatively estimated around \$800 (Department of Justice Canada, 2008) a reduction of 9.8 days in length of stay per discharge translates to a savings of \$7,840 per discharge. The average number of discharges per year from all 9 sites' participating wards was collected pre-implementation TDM. Given this was calculated to be, on average, a total of approximately 4000 discharges per year for the participating wards, this amounts to a potential savings in hospital days of \$31,360,000 per year if TDM remains implemented solely on the participating wards. Given the most recent data at the provincial level (from 2012) calculates the number of psychiatric discharges per year at 80,638 (Canadian Institute for Health Information, 2015), this amounts to a potential savings in hospital days of \$632,201,920 if TDM were implemented province-wide. These savings significantly outweigh the cost of intervention which includes training, a peer support coordinator/volunteer support and staff time for bridging clients to the community. Table 13, demonstrates expected total savings based on cost of intervention and reduced length of stay.

Table 13. Cost of TDM implementation and expected savings

Costs for TDM Implementation (per Site, Annually)		
Item	Description	Amount
Peer Support Coordinator Salary	1 FTE (37.5 hours per week for 52 weeks) \$25.45/hour + benefits = \$30.73/hour	\$59,924
Peer Support Coordinator Training	\$1,000 honorarium per trainer \$1,200 for trainee for 5 days of training	\$2,200
Peer Support Mileage	\$500/month for travel to clients and volunteers	\$6,000
Volunteer Training	50 volunteers for 5 days of training \$30 materials + \$20 food/person/day = \$130 per volunteer	\$6,500
Volunteer Recognition Activities & Activities with Patients	Includes gift certificates, etc. so that support works and patients can do activities together	\$5,000
TOTAL COSTS		\$79,624
Savings from TDM (per Site, Annually)		
Item	Description	Amount
Reduction in Length of Stay	Reduction in LOS = 9.8 Days/Discharge Cost of Stay in Hospital = \$800/Day Average Discharges Across All Sites = 381 Savings = Reduction in LOS X Cost per Day X No. of Discharges	\$2,987,040
TOTAL SAVINGS		\$2,987,040
RETURN ON INVESTMENT (TOTAL SAVINGS – TOTAL COSTS)		<u>\$2,907,416</u>

IMPLEMENTATION STRATEGIES & LESSONS LEARNED

Assessing various implementation strategies informs best practices for implementation assists the implementation. TDM was developed, and now implemented using participatory-action research principles, including the inclusion of all stakeholders throughout the process. There were regular opportunities for dialogue that resulted in changes to practice. Participatory methodologies are responsive to the needs of the community; providing the opportunity for participants to take an active role in the research process. Participatory action research acknowledges the need to include participants throughout the project; accepting that each person has valuable knowledge and that all participants can learn from each other (Conder, Milner & Mirfin-Vietch, 2011).

In accordance with participatory action principles, lessons learned were derived from multiple sources and included feedback from all key stakeholders. Qualitative data also served as a feedback loop to improve the TDM intervention over time and are listed below:

- Focus groups with clients, hospital staff and peer support volunteers/workers conducted at six months and one year post-implementation at each site
- Focus group with site leads and peer support coordinators/workers
- Bi-weekly calls with project team
- Face to face meetings and ongoing communication with site leads, peer support coordinators/workers and key stakeholders.

Pre-Implementation Strategies

HOSPITAL SPECIFIC STRATEGIES

Engagement of Hospital Leaders

It was imperative to engage hospital leaders at the onset. Active, hands-on support and interest from senior leadership was essential throughout the project. Sites that had visible support from hospital leadership were able to overcome implementation challenges more swiftly and had more buy-in from front line staff. It was helpful when senior leaders had the same view and communicated consistent messages about the model. Prior to introducing the model to staff, comprehensive communication between the central team and senior leaders at the onset addressed glitches.

Inclusion and Acknowledgment of Site Leads and Ward Champions

Site leads and ward champions were instrumental to successful implementation. At the onset, site leads engaged in ongoing communication with the central project team and participated in bi-weekly calls with site leads and ward champions at other sites. Available and consistent levels of support from the central project team and communication from other hospitals

helped wards stay on-track. Overall, ensuring that champions were acknowledged and celebrated in their role as well as allowing dedicated times for the completion of their duties was critical to successful implementation. Most of the project site leads juggled dual roles; TDM specific duties were combined with their usual responsibilities. Many site leads reported that they would have benefited from having more time allocated in their schedules to attend to TDM responsibilities. Most site leads underestimated how long it would take for them to set up staff training, become familiar with data collection, arrange for client interviews and complete the required documentation. Site leads reported that they benefitted from having a ward champion or another staff member who was invested in TDM. Ward champions assisted site leads with aspects of staff training, data entry and in setting up client interviews. Site leads also benefited from speaking directly to their managers and by identifying when they needed additional support to successfully fulfill both of their roles.

Proactive Communication with Unions

Within sites where unions were present, proactive communication with unions prior to introducing TDM to staff helped allay concerns and gain the support of these key partners.

Knowledge of Hospital Infrastructure

It was easier to implement TDM at hospitals where existing practices and services were aligned with components of the TDM. For instance at sites that:

- already used peer support,
- had formal discharge planning,
- adhered to some principles of TDM (such as consistent nurse assignment or consistent scheduling to aid in development of therapeutic relationships).

PEER SUPPORT SPECIFIC STRATEGIES

Inclusion of Peer Support Coordinator

Most sites identified a peer support coordinator based out of a community peer-run group who worked with the hospital to facilitate matching between peer support volunteers/workers and clients after discharge. Training was provided to each of the peer support coordinators so that they could train the peer support volunteers/workers who would be supporting the clients from the hospital. Each paid peer support coordinator had a higher skill that went beyond the direct provision of peer support. The responsibilities of peer support coordinators included: recruitment, training, peer matching, and supporting and supervising volunteers/workers. Peer support coordinators were encouraged to have a presence on the participating ward as well as to maintain linkages in the community. Peer support coordinators worked closely with hospital staff and had planned on-ward activities. Hospital sites that associated peer support with a community peer-run group had more success. Making linkages to a Consumer/Survivor Initiative aided transitions and decreased dependence on the hospital.

Proactive Communication

It was vital to initiate discussions early and frequently with key individuals at each site to develop unique and specific implementation plans. Each site has a unique local context in which many discussions needed to take place to develop a TDM implementation strategy that worked for both the hospital staff and the peer supporters. No two sites implemented the TDM in the same way due to the specific needs of both acute care and tertiary care wards, as well as the need to partner with a variety of peer support organizations and CSIs.

Collaborative Relationships

It was important to facilitate a relationship between peer supporters/CSIs, hospital staff, and hospital leadership from the beginning. Open communication between peer supporters, hospital staff and hospital leadership was key in outlining expectations and implementation strategies. These discussions took place early and addressed the following questions:

- What strategies will be used to integrate peer support on the ward?
- Is hospital orientation required for peer support coordinators?
- Can peer support volunteers visit the wards?
- How can all of this be facilitated?
- Where will the peer support coordinator's office be?
- Where can peer support groups be located?

Training

Training was vital for all participants since it decreased staff confusion and assisted with staff buy-in. All site leads and peer support coordinators received standardized, in-depth TDM training and participated in a 5-day TDM orientation workshop in London, Ontario. Standardized training was also available for peer support coordinators and peer support volunteers/workers. Participants had a choice between OPDI's *Peer Support Core Essentials Training Program* or their own CSI training. Every staff member on the site-wards also participated in either a full- or half-day training session. Site leads were responsible for delivering TDM training to orient staff regarding their hospital's participation.

Strategies for including a research component

Sites considering including a research component as part of their TDM implementation should take into account some of the implications listed below:

Ethics

Submitting ethics applications and receiving research ethics board (REB) approval for this project took longer than expected. Ethics application and procedures varied extensively from site to site. Staff resources dedicated towards the completion of REB approval was extensive due to the unique and rigorous processes required by each of the hospitals. Sites should anticipate longer timelines for completion of REB protocol

within each site and should advocate for streamlined processes for all sites to avoid unnecessary expenditure of resources.

Data Collection

Collecting administrative data from each of the participating sites also took longer than expected as all participating hospitals had diverse procedures for collecting ward-level data. Some of the site leads experienced difficulty in obtaining this data from their respective departments. Sites should initiate data collection processes early to allow for the timely delivery of requested data. Sites should also anticipate that each hospital may not be able to provide this information on a monthly basis.

Sensitivity to Staff's Qualifications and Experience

A majority of the site leads participating in the current project possessed clinical background, as opposed to a research background. This limited the staff's level of familiarity with research procedures and thus their comfort with various research tasks such as data collection and entry. For sites that chose to include a research component data collection was required. It is advisable to support these new researchers by offering additional staff training on research related tasks at different intervals throughout the project's implementation. Furthermore, creating a database-collection manual clearly outlining all required documentation, data collection and research procedures is helpful as was identified as an important resource in current project.

Implementation Strategies

HOSPITAL SPECIFIC STRATEGIES

Sensitivity to unique context

The exact way in which each hospital implemented TDM depended on that hospital's and community's unique features and settings. Care delivery systems should be modified in a way that respects the unique context of the client population, the hospital ward and the community. Thus, one of the first steps of the current TDM implementation plan involved assessing what type(s) of therapeutic supports were available at each hospital setting and in their community. Additionally, each client's need for transitional care was identified. For example, if a client was about to be discharged and already had a therapeutic relationship with a community care provider, then that client did not usually need to be paired with transitioning staff. On acute care wards, less time was available for the client to develop a therapeutic relationship with a hospital staff member, so a transitional team member (TDM team) was often an ideal match. Due to high volume of discharges on the acute care wards, the transition team was an important asset, because it was difficult to have large numbers of staff providing both hospital and community care.

Bridging Teams

Bridging teams work in acute care wards to support a client's transition into the community when ward-staff may not be able to do so. TDM bridging teams are enhanced when they include members that are multidisciplinary and when the option exists for occasional ward-staff bridging. After staff experienced the positive outcomes of the model, they incorporated it into discussions with clients. By implementing a "feed-back loop" to share success stories and encouraging staff's involvement, these experiences can be better supported. This should also include those who are not on the bridging team. For tertiary care wards, having a site lead or ward champion accompany bridging staff and clients on initial visits may assist with the staff's initial anxieties. This is especially true when the staff member is not used to working with clients in the community.

Integrating TDM into Hospital Processes

Implementation effectiveness was more visible when TDM was integrated across all hospital processes. This was achieved by including TDM in regular staff discussions such as: rounds, meetings, staff orientations and ongoing education. Formalized documentation processes such as check lists for staff, clear referral processes, assessment systems and guidelines around roles were also found to be helpful.

Clarity of Roles and Timelines

Having a clear idea of roles, responsibilities and processes significantly aids in implementation. Staff, peer supporters and clients need to clearly understand the roles of everyone involved. This is particularly important with regard to ensuring that everyone involved understands the difference between the support offered by a peer supporter and that offered by a clinical staff member. Sites that had clearly defined roles had better outcomes in client and staff satisfaction. Setting out clear, specific goals and timelines was also appreciated by clients and staff when implementing the model.

Visible Inclusion of Peer Support Coordinator

Integrating the peer support coordinator role onto the ward is important to ensure successful implementation. Wards had more implementation successes when they included a peer support coordinator in TDM staff training and when the peer support coordinators attended rounds. Success was also promoted when wards provided an onsite workspace such as desk, computer and phone and provided consistent space for the peer support coordinator to organize peer support groups. On-ward visibility was important especially for acute care wards. Such help ensured that the peer support coordinator met clients prior to discharge and assisted with client-staff relationship building.

PEER SUPPORT SPECIFIC STRATEGIES

Peer Support Strategies

It is imperative to offer a variety of peer support strategies. In previous TDM studies the focus on the number of matches made was emphasized, but in this project clients discussed peer support in a variety of ways beyond matching. In this TDM implementation we learned that peer support can be offered in many ways, and cannot solely be measured by number of matches. Although the opportunity for formal matching is important some people prefer more informal processes. The basic principle of the TDM is that individuals are not discharged without a safety net of relationships, and this principle can be met in a variety of ways by each site. Peer support groups may be held either on or off of the ward, 1:1 peer support may be offered, drop-in peer support organizations may be used and these services may be offered by peer support coordinators, volunteers or workers.

Paid & Volunteer Positions

Having a combination of paid and volunteer supports helped to build community capacity and prevented the formation of waiting lists. At sites that relied exclusively on paid peer supporters, there were more waitlists and capacity issues were frequent. The peer support facilitated by TDM uses a friendship model. People providing peer support could be paid or volunteers. When volunteers are used, the program will have to accommodate those wanting to provide only occasional volunteer work. Advantages of volunteers include: having an increased pool of available people for matching, being an appropriate friendship model, and involving a minimal time commitment (which is ideal for students). Volunteering offers the opportunity for consumer survivors to volunteer 1 hour per week and may even function as a stepping stone to employment. Paid positions have a higher level of responsibility. That role's responsibilities include: providing an on-ward peer support presence, organizing activities and interaction with clients on the ward, recruiting peer supporters, training peer supporters, matching clients and peer supporters, and supporting the peer supporters. For paid peer supports, it is important to first consider whether it is possible to provide a sufficient caseload and ensure that there is ample support for paid peer supporters to prevent capacity issues.

Police Record Checks

Most of the CSIs required a police record check from their volunteers (and staff) prior to providing peer support. The peer support coordinators cited delays in volunteers requesting the check and a delay in the police station processing the request. Police checks for new volunteers and workers should be requested as early as the CSI feels comfortable. Identifying this issue early and discussing the associated processes with the police can promote timely completions. Additionally, police checks need careful examination since some events that occurred may be related to experiences of mental illness (e.g. a suicide attempt) and would not necessarily reflect a current risk posed by the potential volunteer or worker.

Diversity of Peer Supporters and matching

To effectively meet the needs of a variety of clients, it is important to have a diverse pool of peer supporters, including: both women and men, peer supporters with a variety of interests, those with diverse backgrounds as well as those with different educational levels. Feedback from clients indicates more satisfaction with matches when peer supporters are matched based on sameness of age, gender and interests (as oppose to diagnosis). CSI organizations that had peer support matching forms available and encouraged them be filled out by both clients and peer supporters aided significantly in this process. Additionally client's satisfaction was increased when matching and initial meetings between clients and peer supporters occurred prior to discharge.

Support for Peer Supporters

Ensuring that peer supporters received support was imperative. Holding peer supporter groups is one way this support could be offered, although it does not need to be limited to groups. When offering peer support, flexibility of location and manner of support should be individualized to account for diverse needs of clients. Support should be varied according to the needs of the client and should include phone calls, home visits, and meetings in either the community or the hospital.

Community of Practice

Establishing a community of practice is key to successful implementation. For the current project, implementing TDM along other sites was motivating and inspired sites to stay on track. Scheduled bi-weekly phone meetings and in person meetings held once a year with site leads, peer support coordinators and project teams were instrumental in providing updates on the sites' progress and their challenges. These meetings were also seen as a valuable opportunity for all those involved to pose questions and brainstorm solutions.

KEY SUCCESSES AND ACCCOMPLISHMENTS

TDM Launch and Orientation- TDM Project Team and CAHO hosted a successful Launch, orientation and training workshop week of April 8th in London, ON for all hospital site leads and representatives from the Consumer/Survivor Initiatives (CSI) peer support programs.

Status Update Meetings -The TDM team and CAHO hosted two successful status update meetings (September 10, 2013) and (June 24, 2014) for all hospitals site leads and representatives from the Consumer/Survivor Initiatives/peer support programs.

Bi-weekly Teleconferences -In addition to in person status update meetings, project team offered support to all hospitals and CSI's in the form of regular bi-weekly teleconference calls with all participating members (hospital, CSI groups and project team).

Project Tools –Some of the following documents were developed to assist Hospital and CSI's in TDM implementation: TDM Data Collection Manual, Revised TDM Power point learning slides, TDM Tool Kit for staff, Referral Forms, TDM Advertisements and pamphlets, TDM Binders for staff with all essential documents and TDM articles. TDM website was created to provide an overall overview of the model.

Ethics –9 very diverse applications and REB procedures were filled out and submitted by the project team. Research Ethics Board approval was received for all 9 participating sites.

Translation of Project Documents – Project Team had all vital TDM project materials translated into French. Some of these documents included: advertisements, all data collection instruments, focus group guides and some CSI material. As a result, TDM can now be successfully implemented within Francophone sites.

Media – TDM attracted local media to both the TDM Launch and Final Results Conference. Local media was also engaged at many local sites.

Local Disseminations- Presentations were held at each of the sites. This was an opportunity to provide results of the project locally to each of the participating sites.

Conference Presentations - TDM was presented at several national and international conferences throughout 2013, 2014 and is scheduled to be presented at several more conferences this year.

Conference	Type	Location	Date
Conference of Addictions & Mental Health Ontario	Oral	Toronto, Canada.	May 28/13
Mobilizing Peer Support in Ontario: <i>OPDI & AGM Conference.</i>	Oral	Toronto, Canada.	Oct 4/13
Arthur Labatt Family School of Nursing Western University, 27 th Annual Research Conference- <i>Reorienting the Health System to What Truly Matters: Values of Health Care.</i>	Oral	London, Canada.	May 9/14
Regional Mental Health Care London and Southwest Centre for Forensic Mental Health Care, 15 th Annual Research Half Day.	Oral	London, Canada.	May 14/14
2014 Annual Addictions and Mental Health Conference.	Panel	Toronto, Canada.	May 27/14
3 rd European Conference on Mental Health.	Oral	Tallinn, Estonia.	Sept 10-12/14.
3 rd Horatio European Festival of Psychiatric Nursing. <i>Creativity in Care</i>	Oral	St. George's Bay, Malta.	Nov 6-9/14
Health Quality Transformations 2014. <i>Partnering to accelerate best care, best health, best value.</i>	Poster	Toronto, Canada.	Nov 20/14

Conference	Type	Location	Date 2015
Ontario Shores, 4 th Annual Research Day. <i>Advancing Recovery Research: Patients, Partnerships and Peers</i>	Oral	Toronto, Canada.	Feb 24/15
4 th Global Congress for Qualitative Health Research. <i>"Dialogues and Bridges for Intercultural Health"</i>	Oral	Yucatan, Mexico.	Mar 18-20/15
Nursing Leaders Network of Ontario. Annual Health Care Leaders Conference. <i>Transitions, Partnership, Integration.</i>	Oral	Toronto, Canada.	Mar 26-27/15
International Council of Nurses Conference and Council of National Representatives. <i>Global Citizen, Global Nursing.</i>	Oral	Seoul, Korea.	Jun 19-23/15

PROJECT MILESTONES AND ACTIVITIES

- 9 Hospitals have successfully launched TDM
- All sites met their milestones.
- To date over 350 clinical hospital staff and 400 peer supporters across all sites received training on the model. Additional staff and peer supporters continue to receive training.
- A total of 738 research participants were recruited
- Site visits and dissemination conferences were scheduled at each of the 9 participating sites.

CONCLUSION

Discussion

This project sought to understand the best practices associated with TDM implementation. The study identified both barriers and enablers to successful implementation. Prior research already demonstrated the effectiveness of the TDM. However, those same studies showed that the TDM is most successful when it is leveraged in the favor of all parties. That is, it must be (it must and be perceived to be) a benefit to the clients, the hospital staff and community peer supporters. When these groups work together to successfully implement the TDM, both the local hospital and the health care system as a whole will benefit. Given the past success of the TDM, confirming the effectiveness of the TDM was a secondary goal of this study. As a result, this project sought to move the TDM from theory into practice by studying its implementation, use, and continuing potential in a variety of settings across Ontario.

This project implemented the TDM in 9 sites across Ontario. Using previous research on the TDM as a starting point, the research team and research staff developed the initial tools and strategies used in the first round of TDM implementations. Those strategies and tools were revised in consultation with clients, care providers, peer supporters and stakeholders. Revisions were then applied in further implementations. Throughout the project, this high-level of collaboration created a set of implementation strategies, rooted in practice, in order to help clients transition into the community. Successive implementation allowed each set of strategies to be tested and refined, positioning the results of this project to be implemented in other sites.

Reflection

By partnering with ARTIC, this project was able to spread and implement TDM in 9 sites across Ontario. Indeed, this project saws several “firsts” throughout. Spreading TDM to a non-CAHO hospital gave researchers some preliminary insight into how the model might be successfully used outside of the academic hospital context. By including a non-CAHO hospital, this pilot has contributed to ARTIC’S goals – promoting the rapid adoption of evidence into practice. Further, this study oversaw the first TDM implementation in acute care mental health wards in Canada. This also supported ARTIC’S mission as it will allow for the rapid adoption of TDM in a variety of clinical settings.

The findings of this study indicate that there are several areas that will require continued support. Bridging a client's transition from the hospital into the community is the hallmark of TDM. In order to achieve this result, the research team and research staff worked closely with each site through their workshops, status update meetings, and bi-weekly teleconferences. Within each site, communication was found to be essential. Hospital leadership needed to be engaged in the implementation process from the outset and communicate effectively with front-line staff.

Site leads and ward champions benefited from mutual support following TDM implementation, and the value of their roles also needed to be acknowledged from the outset. This is especially important because their roles required a significant time commitment. Proactive communication with unions was also important because it allayed labor concerns and avoided potential problems. When existing hospital infrastructure could be leveraged to support TDM implementation (e.g., support from existing peer support programs, formal discharge planning, and the use of consistent nurse scheduling in order to foster the development of therapeutic relationships), the transition into a TDM ward became smooth and efficient.

Future Plans

TDM is poised to be spread beyond the 9 sites involved in the current study. Several sites have already contacted the research team, and are interested in bringing TDM to their mental health wards. In order to support these hospitals and spread TDM, new types of sites should be included and studied in the next phases of TDM implementation. In particular, non-academic hospitals and hospitals in rural communities will require further study in order to understand how the TDM implementation strategy used in this study might be applied to those contexts. In Ontario, hospitals are regionally organized into LHINs. So, to spread TDM at the macro-level of health care, at least one hospital in every LHIN should implement TDM. Funding will have to be strategically sought in order to address this goal. These long-term strategies will allow for the spread of TDM within diverse regional contexts and will ensure that the unique needs of those contexts are addressed. This information is essential to achieve successful TDM implementation at all mental health wards in Ontario.

Given the success of TDM in the mental health context, consideration to testing the model with other long term-chronic conditions is appropriate. Peer Support exists and has been showed to be effective in other health-fields such as: cancer care (Campbell et al., 2004; Docherty, 2004; Rankin et al., 2004; Usher et al., 2006) , dialysis (Hughes et al., 2009; Sattoe et al., 2014) cardiac care (Riegel & Carlson, 2004) and eldercare (Bury, 2007). The reputation of peer support is spreading and its positive results noted whenever there is chronic and or acute life altering illnesses (Dennis, 2003; Heisler, 2006). As well, continuity of care has been explored in contexts such as: in seniors care after complex surgeries (Naylor et al., 1999), with elders hospitalized with heart failures (Naylor et al., 2004) and common medical and surgical conditions (Naylor and McCauley, 1999). As the Literature on therapeutic relationships indicates, providing

continuity of staff support in combination with peer support is an innovation that should be spread beyond the mental health setting.

Next Steps

Rapid spread and implementation can be achieved in specialized mental health hospitals that have already implemented TDM on at least one ward. Given that these hospitals have experience implementing the model and trained local staff, spreading the TDM to additional wards within these hospitals may be done quickly and with the required level of support. In order to continue to support site leads, ward champions, and peer support coordinators throughout the bridging process, additional funding will be required. This is because changing staff roles must be accommodated within hospital budgets. Peer support, a key aspect of successful TDM implementation, generally requires collaboration with and funding for an external community group. This funding will also have to be actively pursued by all stakeholders to continually support transitional discharges. To ensure long-term sustainability, special attention must be paid to accessing and maintaining ongoing funding for peer support coordinators, staff, and their activities. Due to the important role played by these organizations, linkages must be maintained, supported, and built upon.

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