# FOR MORE INFORMATION

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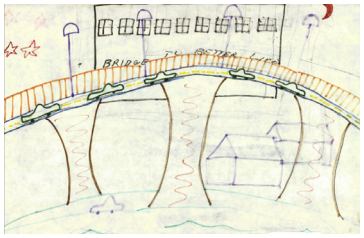


**PSSEO/020/2015-07**


# Transitional Discharge

# Model

***Core Purpose***
***"to be with people living with addiction and/or mental health challenges and to support them in being as well as they can be."***

***Our Vision***
**"Providence Care will lead the way in compassion and discovery"**

# Transitional Discharge Planning

- Supports participants during the transition from hospital to community
- Develops a plan to strengthen existing relationships and build new ones that support the participant during the transition period
- Participant, staff and peer supporters are active partners
- Builds a “safety net” of relationships for participant
- Hospital in-patient staff continues to have an established therapeutic relationship with the participant after the participant leaves hospital
- Hospital in-patient and community services overlap until the participant has established a working relationship with the community care provider
- Peer support after the participant leaves hospital

# Roles in Transitional Discharge Planning

### Participant

A partner with health care providers and peer support worker(s) who actively contributes to his/her transitional discharge planning, and guides and utilizes supportive relationships to meet identified goals.

### Bridging Staff

The inpatient health care provider who has the best therapeutic relationship with the participant and continues to see the participant after discharge from hospital.

### Community Care Provider

The community-based health care provider who will be providing primary mental health care.

### Peer Support Worker

The Peer from Peer Support South East Ontario who is trained to provide informal/social support to the participant leaving hospital.