North Bay Regional Health Centre
Centre régional de santé de North Bay

NBRHC Regional Programs

Navigating Tertiary Care in the North East

June 2016

Tertiary Care

- North Bay Regional Health Centre Mental Health Programs offer a continuum of care from crisis and acute to highly specialized and comprehensive specialized tertiary programs for both in and outpatients.

Inpatient Programs – 18+

Unit	Description
Dual Diagnosis Unit (DDU) *Birch/Maple Lodges* 14 beds	Developmental/intellectual disability plus mental health concerns/behavioural challenges with focus on the specialized needs of those functioning in the moderate to profound range of developmental disabilities. Services include providing assessment, stabilization, rehabilitation, and transitional support to return “home”
Specialized Rehabilitation and Transitional Unit *Nickel Lodge** 16 beds	Specialized Adult Rehabilitation and Transitional Service providing care/support to those with severe mental illness/co-morbid conditions
Clinical Rehabilitation and Evaluation Unit *Northern Lights Lodge* 16 beds	Provides assessment and treatment and rehabilitation for individuals with complex and refractory mental illness
Transitional Unit *Osprey Lodge* 8 beds	Provides ongoing rehabilitation for individuals who require a supportive environment to transition towards a community reintegration

Inpatient Programs – 65+

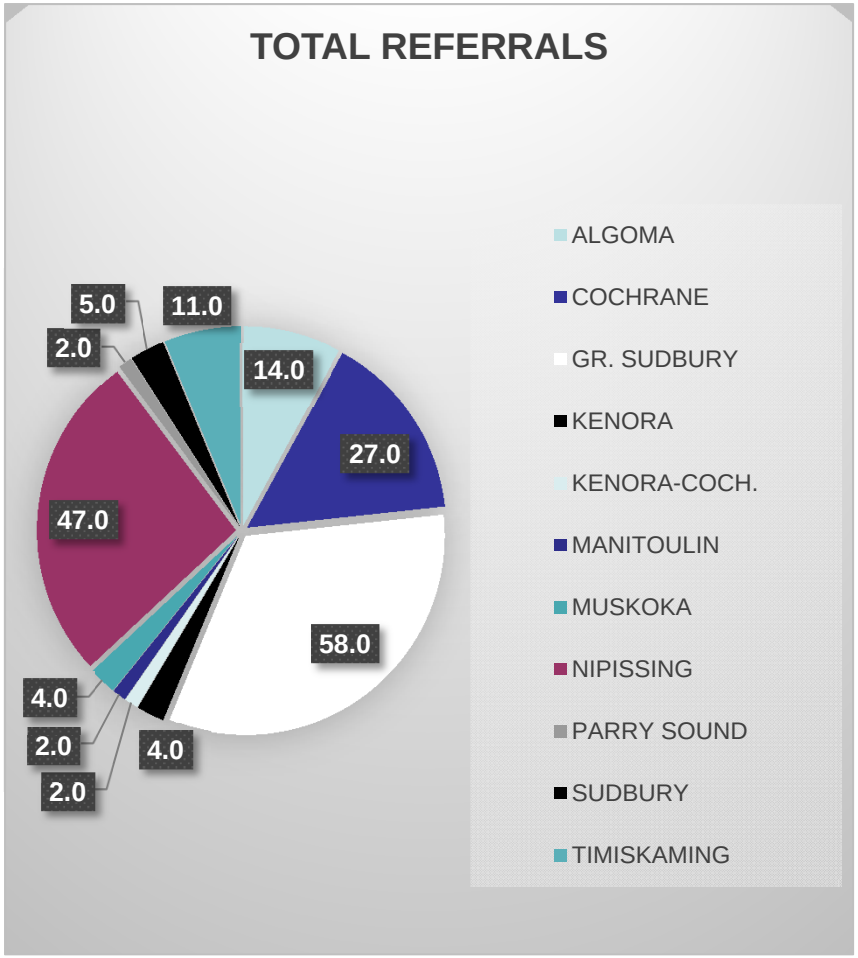
Unit	Description
Geriatric Assessment and Treatment Unit *Evergreen Lodge* 15 beds	Provides specialized assessment and treatment for older adults with complex age related psychiatric needs which are complicated by behavioural and psychological symptoms, and/or medical comorbidities Examples include: Late-life mood disorders (e.g. depression, anxiety, mania) Late-life psychotic disorders (e.g. delusional disorder, schizophrenia) Psychiatric disorders and behavioural symptoms associated with complex medical co-morbidities and functional impairment (e.g. Parkinson's disease)
Dementia Care Program *Oak Lodge** 15 beds	Provides specialized assessment/treatment of older adults and/or adults with an age related dementia complicated by behavioural, psychological and/or neurocognitive impairments Potential diagnoses include: Alzheimer's disease Vascular dementia Mixed dementia Frontotemporal dementia Lewy Body dementia

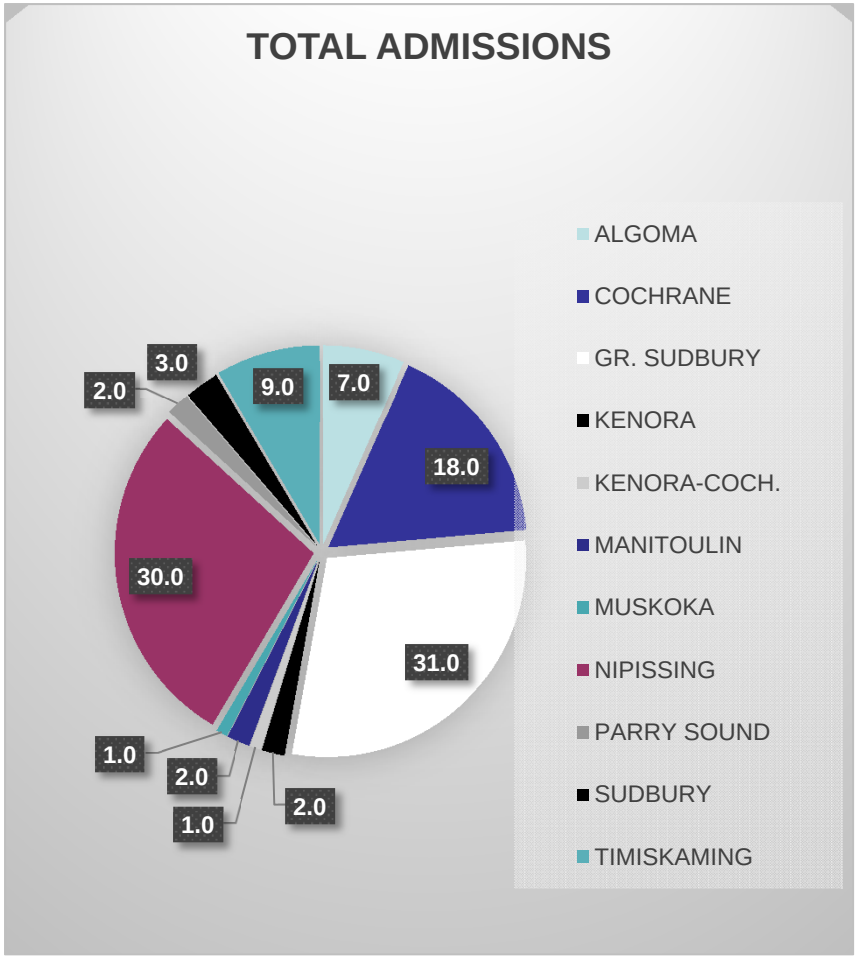
**Located at Kirkwood site in Sudbury*

Central Referral

- Improves patient flow and starts prior to individuals' accessing our programs
- Improves communication of programs and services to assist patients/care partners to navigate a sometimes complex system
- Improves wait times
- Improves access to care

2015/16 Central Data





Our Mission

- Our mission: As partners in care we restore and maintain health for mind and body
- We identify communication between partners is key to reducing the system gaps to ensure the delivery of services to our patients at the right time every time

Shared Goals

- Improve access to care for mental health patients requiring non-urgent to urgent care
- Improve knowledge of how to refer by offering a brief description of our programs and services
- Identify referral requirements to improve communication with our partners
- Identify pre-admission goals to help us better serve our patients with the most effective interventions
- Listen to our patients and partners to understand the gap and how to improve

Central Referral

- A single point of access for regional inpatient units, outreach services
- Allows referring sources to access the right care in a time sensitive manner
- Phone: (705) 495-7841
- Fax: (705) 495-7843
- http://www.nbrhc.on.ca/health-care-provider-forms/

Intake Process

- Upon receipt of referral, Clinical Intake team will:
  - Screen for eligibility
  - Provide a recommendation and triage the referral to the most appropriate regional program
- The process will include the following:
  - Review of regional outreach services and availability
  - Access to local/district outreach services

Admission Criteria

- Clients must meet mandate of regional program
- Copies of recent consultations and assessments of psychiatry and physician that includes: preliminary diagnosis, treatment and interventions
- Ensure community based services have been explored and exhausted prior to referral
- Prior to admission, psychiatric recommendations should be implemented and evaluated (where possible without compromising client and/or staff safety)

Intake Process con't

- The program team will review the referral and meet with patient/SDM/referring agency to establish goals for admission
- If the client is accepted to the Program a letter is sent to the referring source to confirm and identify an admission date when possible
- If the client is declined, the Intake team will identify reasons for the decline and offer assistance with system navigation and recommendations for follow-up in the community where possible

Appeal Process

- In the event the referral is declined there is an appeal process
- If you do not agree with the reasons for decline outlined in the letter, we encourage you to contact the Intake team or Manager of the program for further discussion

Admission Goals

- SMART – specific, measurable, agreed upon, realistic, time-based
- Linked to Clinical Assessment Protocols (CAP) from the MH RAI
- For example:
  - *General Goal:* decrease frequency or severity of challenging/responsive behaviour
  - *Smart Goal:* (name)…will physically act out less than three times a week
  - *Measure:* # of times target behaviour occurred
  - *CAP:* Harm to others

Waitlist Management

- Once accepted the individual is placed on a waitlist for the regional program identified
- Referring sources are contacted when a bed becomes available
- Admission dates are planned with the referring source to assist with transition to hospital

Admission

- All admissions to regional programs are *planned* admissions
- Urgent requests for admission may need to be referred to an acute setting
- Once the date for admission is determined, the referring source is contacted and a one page update will be completed to ensure client is:
  - Medically stable
  - Still requires admission to the tertiary program
  - Pre-admission goals are reviewed and repatriation agreed upon
  - Re-evaluate client/family readiness to participate in treatment goals where possible

Approach to Care

- Interdisciplinary team focus to address the causes of the complex presentation and responsive behaviours
- Holistic approach using evidenced-informed practices in the use of environmental, behavioural and pharmacological interventions

Shared Care Goal

- Facilitate quality care, change and improvement to:
  - Improve the patient's overall quality of life by enhancing/retaining patient abilities;
  - Promote patient, family and care partner engagement;
  - Provide learning opportunities for increased community capacity;
  - Successfully transition the patient to the most appropriate community discharge destination

Shared Care Plan

- Throughout the admission community partners are encouraged to attend prescheduled One Patient One Plan (OPOP) meetings with the patient
- OPOP meetings:
  - Engage the patient to communicate with the team about their personal recovery goals
  - Engage community partners to prepare a successful transition plan with the patient and care team
  - Supports continuity of care between formal community supports and inpatient care providers

Discharge process

- A detailed patient Shared Care Plan will be provided to the patient/family and community partners as patient returns to their community setting
- To ensure successful transition to the community:
  - Engage patient/family and community partners in a crisis plan. This allows information to be shared at service entry points such as ED, crisis intervention lines, mobile crisis, doctor office or at a time when patients are unable to share
  - Hospitals and community partners have made a commitment to our patients to improve communication and ensure successful transitions for every patient

Partnering with stakeholders

- With effective transitional discharge planning our patients have a safety net of supportive relationships to be successful in the community setting
- It is our collaborative vision and values that will help support and focus on improving patient flow and ensure that our community and regional patients receive the right care, in the right place, every time