The context: Northern British Columbia

The area of Northern Health Authority represents two-thirds of the geography of British Columbia. A key service delivery challenge is the small size of communities as many have 50-200 persons.

The context: Northern Communities

- 10,000+ persons
- 1000-10,000 persons
- Predominantly First Nations Community
So what IS Care North?

- A **STRATEGY** co-developed by Northern Health and Northern physicians
- A **STRATEGY** that will further engage communities
- A **STRATEGY** to improve the health system through the creation of a more effective and robust Primary Health Care system.
- A **STRATEGY** that supports Northern Health’s Vision of an organization that is ‘known for our strong primary health care system where people experience seamless and coordinated service’.3

How is this different than other health initiatives?

- This is a way of working; not a pilot project
- There is an opportunity for changes to be made from the ground up – decisions and processes can be changed mid-stream
- Evaluation and change is an ongoing process – what works best for the patient, provider and community
- Involvement of all individuals in healthcare – it belongs to all of us
- Involves a systems approach – highlighting that various service providers do not function in a vacuum but need to consider how actions in one area affect those in other areas
- Quality improvement methodology is utilized

Care North – A Few Key Principles

- We will use the best available evidence to guide our decisions
- Since “patients as partners” is a foundational element of our Care North strategy, we will work in partnership with patients and communities in making decisions – respecting the choices that are made
- We believe that long term partnerships between patients and care providers are important to achieving quality in our care
- We will be open to new roles and responsibilities for all care providers
Way of working.....

- Positioned in the Physicians’ practices – co-located
- Respond to emergencies immediately within the physician practice and the emergency department
- Utilized by emergency RN’s to completed assessments before physician is called.
- Liaise with community counseling, RCMP, and MCFD
- Speak to community groups about Mental Health
- Provide “in-house” training to hospital nursing staff, long-term care staff and the college programs about MH

Way of working

- Physicians MOA’s book directly into clinicians calendar for intakes – clients are seen within one week
- Crisis clients are seen same day
- Refer directly to Psychiatrists
- Meet monthly with GPs concerning “high-need, crisis” patients, coordinate the Psychiatrist debriefing with GP’s, developed templates to assist GPs to complete the necessary governmental documentation for CPP and Disability for patients – this is a fill in the blank for physician.

Way of working

- All Plan G [free psychiatric medication for patients] form are completed on site rather than faxed to larger community hospital
- Discharge planning with the Regional hospital
- Liaise with Probation Services and the Court system
- Liaise with community pharmacists’ to ensure continuity of pharmacological services for community patients
- Oh yeah, I also provide direct patient care……..
**Why is it working...**

- GPs do not have time
- GP queries' regarding underlying MH issues are dealt with
- GP is aware of client progress and are aware of any non-compliance with medication and or treatment
- GPs are now aware of recommendations from Psychiatry regarding medication and discharge
- GPs are feeling more supported and confident when addressing MH concerns within their practice as they have quick access to a clinician to field questions – true collaboration and shared happens at this level
- GP is made aware by clinician of patients issues in the monthly meeting
- MOAs have access to clinicians schedule

**Acute Care Reduction**

- Typically all psychiatric emergencies would have been sent to Prince George, regional psychiatric unit
- However since August 1 – January 1 the statistics have drastically changed
- August 1 – 2008 - December 31st
  - 39 emergencies
  - 7 patients transported to Prince George

RESULT: 32 patients kept in community not utilizing acute care, receiving coordinated shared care