Home-Based Hospital Mental Health Service

Information for Community Partners

NEW service name

BC Children's Hospital

A home-based hospital mental health service design is underway at BC Children's Hospital (BCCH). Through the provision of virtual multidisciplinary assessment and treatment, our aim is to improve access to specialty mental health care for children, youth, and families across the province. Care pathways will be tailored on a case-by-case basis and have typically involved a combination of virtual and onsite care. As such, each patient journey is individualized and the length of stay is based on the unique needs of the patient and family. Moreover, the model of care being developed and tested is built on principles of Shared Mental Health Care, and expands beyond primary care physicians and psychiatrists to include community care providers and families themselves.

Service Model Components

GOALS-ORIENTED ASSESSMENT

An assessment completed by members of allied, nursing and medical team, combined with patient-reported outcomes.

COLLABORATIVE CARE PLANNING AND IMPLEMENTATION

A care planning and implementation process done in partnership with patients, families and community services.

MEASUREMENT-BASED CARE

Patient-reported outcomes and objective data used in dialogue between patient and provider to establish and re-evaluate treatment goals, recommendations, and plans.

COMMUNITY PARTNERSHIP AND KNOWLEDGE EXCHANGE

Engagement with community partners in the process of virtual care through shared initiatives.

Patient Journey

	Referral	Consultation	Pre-Admission (child psych only)	Admission	Discharge	Post-Discharge Follow-up
Expected level of community partner involvement:		One meeting	One or two meetings	One meeting/wk over 4-6 weeks	One meeting	One meeting (only if necessary)
	Receive referral and review with our team	Talk with patient/family and community provider about goals and the best way that we can help through our programs.	We work with patient/family and community providers to review care goals and provide psychoeducation for families.	We work with patient/family and community providers to implement virtual and/or onsite elements of the care plan.	We discuss readiness for discharge with patient/family and community, including what follow-up care is needed and when.	We work with patient/family and community to continue with post-discharge goals.

FAQ's

As a community partner, what is expected of me in this model of care?
It is hoped that community partners are involved early and consistently in the patient's journey (during consultation and throughout admission) to allow for seamless transition into and out of the hospital service. It is encouraged for community partners to attend virtual Zoom meetings together with the hospital team and patient/family.

Who from the community is expected to be involved?
The primary clinical contact within the community is encouraged to attend meetings throughout the patient's journey in the service.

How do I refer to this service and are there any special considerations to be aware of?
Referrals to this service are received in the same way that any mental health patient would be referred to the hospital. The appropriateness for virtual or onsite care is determined by the hospital team after the referral is made, and doesn't require any special considerations by the referring community provider.

Who is the "Most Responsible Provider/Physician" (MRP) in this model of care?
The BCCH overseeing psychiatrist has been deemed the MRP once the patient is formally admitted into the service. The community clinician holds the primary responsibility for the patient throughout the referral, consultation, pre-admission stage (if applicable), and once again after discharge.

How are challenges/differences in interventions managed? For example, if BCCH makes a recommendation that the community doesn't have capacity to implement, how will this be managed/addressed?
BCCH will make recommendations tailored to the patient's needs and available community resources. The hospital and community will work together using the following strategies:

- The completion of the *"Understanding your Community's Capacity for Child Mental Health Care Providers"* (child psychiatry) form upon referral to the service. This inventory form will help the hospital team understand the resources available in each patient's community.
- Involvement of the community provider consistently throughout the patient's journey to help brainstorm what the transition back into the community might look like.
- Involvement of the community provider in the discharge conference to help match community supports with hospital recommendations.

How is the BCCH Home-Based Mental Health Service changing?
Between October 2020 and March 2021 the project team will be implementing "Plan Do Study Act" (PDSA) cycles (one per month) to monitor implementation and suggest improvements. These cycles will be reviewed with a subset of the hospital teams on each unit, in conjunction with community partner and patient/family partner representatives.

Questions? Please contact Interim Program Director, Child & Adolescent Psychiatry at BCCH:
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