CENTRAL ZONE – ACCESS AND FLOW ENGAGEMENT RESULTS, Fall Forum 2018

STEP 1 – Proposed Action

Create an intersectoral committee with representation from all points in the care journey with the purpose of improving care to individuals who transition across the continuum.

Potential Mandate	Membership	Additional Considerations

• Open & transparent communication
• Identify & map process
  o Root cause analysis
  o Identify bottlenecks
  o Transition points & what we can learn at each stage
  o Feedback data
• Wonder if a committee meeting will be able to effect change – perhaps a table top exercise of each transition point, would help identify policy or systemic barriers that need to be changed and inform areas of focus for committee.
• Would be great to have a member of the public to co-chair – would help challenge assumptions.
• Improve info transfer
• Opportunity to foster healthy working relationships – partnerships
• Networking
• Improve Patient flow
• Decision making body??
• Different members at the table bring/research information re: what happens at transitions
• Develop & Share common language
  o More objective, less subjective e.g. 2 hours of clinical care vs. easily managed – What care by whom?
• Improve patient flow
• Patient flow
• Model what a continuum of care looks like for a client/patient
	• PT/OT
	• Home Oxygen
	• Cultural/Diversity rep
	• Community/Public representative
	• *Can this information be gathered by groups already organized?*
	  o *Alzheimer Society*
	  o *Caregivers Nova Scotia*
	  o *CGO CC Council*
	• Spring and Fall forums could provide opportunity for input – Put aside one hour like an ad hoc committee
	• Family/patient advocate
	• Palliative care
	• First Nations program reps
	• Patient navigator
	• Service providers/agencies
	• Community member as co-chair
	• LTC facilities
	  o By zone?
	  o Or Provincial?
	• Client rep / patient rep
	• Community health boards
	• Primary Care
	• Workplace safety
	• Risk Management
	• What is a “good experience” at each touch point
	• Continuing Care – placement & Care Coordinators, Facility representation from Continuing Care
	• EMC
	• ECP
	• Marginalized persons / representation
	• Urban/rural representations
	• Pharmacy representations
	• Client/Family/Care Provider (individual)
		• Community Health Boards?
		• Need an overall steering committee & then subcommittees
		  o Broken down by segment
		  o By cohort
		  ▪ Chronic
		  ▪ Acute
		• Need project manager for total oversight
		• The update or objectives of the committee are too general. The proposed actions should be more focused and achievable and focused on the transition points. It is not only important to communicate information accurately at transition points, accurate and complete information must be obtained during assessments. More leading questions must be asked and, if permitted, family members should be consulted.
		• Continuing Care Council
		• Provincial work Health Force Planning
		• Overwhelming to think one group can do it all
		• Immediate focus area
		  o Convalescent care
		  o Behavioral stabilization unit (additional/separate from Willow)
		• Area based due to expansive geography
		• Something exists at the Director & Senior Leadership level, not really at the manager/front line level
		• This used to happen prior to the change from DHAs to NSHA, Facility partner feels

• Develop and improve action plans based on discussions and knowledge sharing • Report back in a timely manner to sector that they are representing • Be a liaison – two way to communicate information from sector to committee and committee to sector	• Front line service providers (CCAs) in LTC • EHS • Care Coordinator • Adult Protection – Judy Young • Continuing Care/Home Support (?) • Care Coordinators • Adult Protection • EHS • Patient Family Representative (what is the client experience) • Department of Justice – to help with issues related to family dynamics • Social workers – to provide a front line perspective on how to navigate the system • Lunch & Learn sessions • Education platforms • *Standardized checklist/flow chart for all transitions – computerized would help • *Electronic referral • Home Care Agencies • LTC • Patient Advocate • Seniors Mental Health • Research knowledge translation	this is missing, was more prevalent when we were CDHA. • Memberships shouldn't be appointed (members need to want to be there) • Need role clarification • Different experiences/realities within a zone • Clear visual/implementation plan that enables consistency in applications • Provincial • Rural verses urban • Cultural Diversity on the Team • Frontline and management representation • Resources to facilitate the working group

STEP 2 – Next Steps

What are the necessary next steps to move toward this action? **Please be as specific as possible.**

Who	Needs to do WHAT	by WHEN?
The memberships listed on page 1 [Q1 above] – Department Health & Wellness as lead	Develop checklist	April of 2020
Senior Leadership	Develop electronic referrals with built in flow chart/decision tree	New Year Jan 2019
NSHA	Make it so	2019- June
	Form a steering committee	

Anything Else?

- Checklists, help people change behaviour
- Provide feedback prior to next forum