EASTERN 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**
• What is the issue and where is the breakdown? • Client focused! Information follows client • Enhance communication Sharing of information-being open/honest. -Support admissions -return from hospital to NH. Circle of care Don't get "MH" background on clients families arranging care-and facilities not informed. Only doing discharge with facilities b/w the zone communication and understanding of processes and consistency Understanding needs of providers to help support efficiency • Promote collaboration between the sectors Connect agencies and services and facilities a central point to access and for information on client electronic file for easy access central point to offer suggestion or input to address sector concerns • Focus on client's needs (not wants) • Develop a tool to share information • Fulfill ideas raised and implement. Focus on outcome • Navigator-[?], Alderwood, Foyer, PHNH, St. Martha's, CBRH, Home Care clinical based -social workers, RN Builds relationships. Do this work in a year 1! • Opportunity to collaborate on complex cases	• Palliative care, Primary Care, Adult protection. Eastern zone leadership meetings because everyone is at the table and we can discuss • LTC, Primary Care Provider • LTC providers, HC provider, Primary Care, Client and Family advisors Red Cross? • Rep from LTC and Home Care • Adult Protection, Palliative Care • Client/family membership, community rehab, service providers, red cross, housing authority?, palliative care, should include front line workers • Physical rep, family rep, palliative care rep • Home Support, LTC, CBRC, OT/PT, Palliative Care, CC, Intake • LTC/HC, Primary Care Physician/NP, Pharmacy Services, Other Clinicians (OT/PT/Dietician) Transitional units (Marie) DR. Seniors and Rest. Care, Family or PT rep from person who receives care • First Nation rep, Mix of front lone who manage transfer of info complimented by admin rep from province and zone levels • NSHA and DHW sponsor to be able to give direction/buy in	• Area based – [??] are individual Care needs to meet client Avoid boundaries-clients on borders, "my" client, case load complete electronic health records to assist with this communication who needs to be informed of issues? Ex. Community (OT, DOT) Community stakeholders • Commitment to attend meetings-this could be built into the TOR Frequency of x number of face to face meetings (tbd) General enough topics to appeal to all partners-engaging Planning to start right from the beg. Committee to facilitate this Enhancement of direct communication with all providers Help to understand impact of services/care on province • Strategic committee-Adhoc committees for specific aspects Communicate what is already available. Inventory of services, organization, support networks, shared services, expertise in specific areas Recruitment strategy for all professional to nova scotia • [Interdisciplinary] rounds-some at the table, not all. Zone is large-how to operationalize. Even

• Help with plans of action to work through challenges • Identify barrier and take action and identify resources and challenges and then identify members • Enhance collaboration amongst all key stakeholders (include pt/family) • Define/disseminate best practices for the actual transfer of information • Research and define standards for intersectoral transfers of information • Define minimum of 3 indicator to measure level of system integration across sectors in managing intersectoral transfer • Improve client care by developing goals and objectives to be achieved over a 3 year transfer time • Regular reporting back to stakeholders in regards to progress, goals/objectives • Barriers to care, appreciate strengths and challenges		former DHA-Large. Local consideration in more zonal approach. Key would be membership. Have resources available to work through specific issues with broader lens • Some may need to be zonal based to access specific resources and support • Groups/orgs who face similar challenges may need to collaborate as not everyone faces similar challenges (area based) ie CEOqrp/DRCqrd? • Smaller Focus groups with a rep from each group bring forth ideas/etc. to larger working groups • Need to have reliable data collection process missing minimal data set for transfers • Resident satisfaction/engagement feedback mechanisms-is it asked, how do we collect?

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?**
NSHA	Bring stakeholders together	ASAP
Partners-Leadership Level (buy in)	Buy In to the ability of the "committee" to improve communication and collaboration	within 6mths
DHW	Provide funding, policy support	ongoing
Need a catalyst CC? DHW? To send out the initial invite to come together	Identify who (what level) needs to attend from each group	

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Need willingness to come to the table (partners)	Respectful and frank conversation… maintained -ground rules/ TOR What do we need to do to ensure best client care is delivered-guiding principle) Develop initial meeting Draft TOR /team charter, ground rules Meeting frequency/venues decided	
Lead identified		
Working together LTC/Community/Acute Care Understanding barriers for communication having access to information re: client (1 record) shore information ie Care Plans Up-to-date information		
Zonal Committee		
Cont. Care Director be the lead		
Sponsor-NSHA/DHW-Susan Stevens		

Anything Else?
• Spreadsheet of what currently exists r/t committees and what their roles are? • Information sharing critical to success of care provision ex. Client is cared for at home by home care then moves to LTC. Home care do not share any info direct to LTC. This is imperative as they know the client best -triggers, likes, dislikes, etc. If committee can achieve this it would be most beneficial to the client served • If the committee doesn't get off the ground can we continue efforts through the spring and fall forums??