WESTERN 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**
• monitor progress/evaluation • centered around client rather than services • Public awareness of services available, rehab, mental health, social • services-who are partners, what are their roles • Goal 1: needs to be effective, remove barriers/solution focused, timely/flexible, conclusion, resource mapping, planning transition among all partners, family included • Grand rounds model • Continuing Care navigator role get as liaison to access resources etc. • One electronic record for patient/clients, organized in some manner that only specific information is seen by appropriate HCP within legislation • Review and propose changes to curriculum. Share info on other activities. • Get LTC on same page • Service Review Eligibility • Action Teams • need solution oriented focus • Team size needs to be relevant and manageable	• volunteers, representative of all areas (region) • team leads, OT, PT, Dietitians, MD, Palliative care, pharmacists, LTC -Director of Care, Home care-senior manager or regional ED-actual decision makers who can implement • EHS, LTC-nursing facilities (local), client/family advocate, caregivers ns, RCMP seniors safety office • EHS, Home support, Social Workers, Primary Care, Navigator - education to the public, Volunteer Associations someone with a sense of overall services • LTC, AP, HC, Housing NS, PHC • Open-who is interested can participate • LTC, Home Care Providers and Care Coordinator • Continuing Care-need front line staff not only senior mgmt • CC-Home Support, VON, LTC • Service Delivery and quality and risk (licensing) • Front line staff from all sectors • RN/LPN/CCA, Clinical OT/PT/SW/DT, family/clients, Caregivers NS, Rep for family med, Home support, C-CANs, CGO, HANS • Directory of local contacts across the sector/zones when looking at reaching out • Primary health care • Service providers	• Are there existing committees vs forming a new committee i.e. zone meetings • options for virtual attendance, collaboration, participation • if by zone (b/c difference issues/resources) then an option for the groups to communicate provincially • ongoing communication strategy to the people it impacts (ie on cont. care websites and option for people impacted to ask questions • clear direction, committee and accountability (accountability for progress and deliverable) • not too large of a committee • zone based • Sub-committee. Local more focused at home level • local committee to bring things forward • Responsible timelines/allowing for info exchanges and info processing • Managing waitlists • Topics can vary, complex cases can be reviewed-what went wrong/what worked/ how can it be improved for next time • The zone could provide the overall structure yet each area could have their own committee, as it is important to have the conversations at the local level. Build from what is presently working-if LTC transitions forum in South Shore-

• Identify key partners. Broader perspective of community and health resources	• Department of Housing, EHS, Seniors RCMP programs, ad hoc membership for some?, adult protection, NP/physician	can we change the format and structure of a present committee to fulfil this mandate • zone based in person • needs to be local with option to feed to a larger team for decision making

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?**
DHW, representation	identify gaps in resources and from current state to ideal state -LEAN six sigma methodology	90 day start date
Who initiates? DHW?	find representation from all sectors	Step 1 after this can identify quick wins (low handing fruits) and medium to longer term problems and solutions
Each partner identify who is attending	meet to develop goals and TOR	ASAP, new year
membership	set goals-meet them	
Love the idea of Grand Rounds?	undertake committee	immediately by Spring March 31/19
Access and Flow person in the community. This would be excellent!	mapping for who does what and at what level	
Acute needs to show up at the table-unit managers and /or social ??/ team lead etc.	local partner	Spring
Adult mental health	TOR	after meeting
Membership	find appropriate advocate	within first few months
NSHA contracts services "the group"	Find out what works well/doesn't work well from different perspectives. Build on what works well. Find gaps (table top exercise with all partners involved)	early 2019 -before spring forum
	Convene group	
	Continuum of care. Process map defining the transitions and what different players need at each point	
	when pull the sections apart have those impacted help to define issues and opps	

Establish a provincial committee. This group will look at a provincial model of engagement ie what teams in what area? From here establish membership and goals then there is a consistent model across province and this will formulate basis for moving forward and must be a solution-orientated group. At the same time, if this group can't solve the problem or need a higher level of approval there needs to be a clear avenue to feed issues with an expected response in an established time frame.		

Anything Else?

- One adult protection social worker in one area has been a barrier when service provide concerned about MH/safety issues in home
- We've been told AP only gets involved when client is not competent. Access to competency assessments in a timely manner is a barrier prior to a "crisis" situation.
- Staffing in both the community and LTC continue to be a significant challenge
- NSHA to be leader/ask for reps/ with DHW and licensing. Define scope and team charter. State expectations
- Commitment on resources -i.e. to resource actions
- CC flow person-is this not what placement does?