The Access To Care Approach

Access to Care | Right Care | Right Time | Right Place

VOLUME: 2, ISSUE: 1, DATE: 13/02/01

In This Issue

Experience Based Design Workshop, January 8-9 , 2013

The ebd approach (experience based design) is a method of designing better experiences for patients, carers and staff. The approach captures the experiences of those involved in healthcare services. It involves looking at the care journey and in addition the emotional journey people experience when they come into contact with a particular pathway or part of the service. Staff work together with patients and carers to firstly understand these experiences and then to improve them.

"I've never been asked as a caregiver, 'What's convenient for you?' Or 'How would this work in your family?' Instead it's 'This is what we're going to do for you.' There's no discussion of collaboration."

Members of the Access to Care team were privileged to attend the Experience Based Design Workshop hosted by the South West LHIN. Leading the workshop were Paula Blackstien-Hirsch and Dr. Lynn Maher who engaged and challenged participants over two full days to leave with concrete plans to build Experience Based Design into their work.

Team Members collaborating to build in more opportunities for patients/clients to contribute their wisdom and experience to the project.

For the Access to Care team, it was a timely topic as the Home First philosophy of care continues to spread across the South West and many recommendations from the AL/SH/ADP and CCC/ Rehab reports are being implemented, while others are under consideration by the South West LHIN. Team members left the workshop enthusiastic and with concrete plans to "build-in" more opportunities for patients, clients, consumers and residents to contribute their wisdom and experience to the Access to Care initiative.

At the workshop, the Assisted Living, Supportive Housing team identified the importance of strong communication between caregivers and seniors/ adults with complex needs after experiencing care in an Emergency Department. To further investigate opportunities at this transition point, the Assisted Living, Supportive Housing team have begun to ask people about their emotions during their Emergency Department visits using an Experience Based Questionnaire. Upon return home, willing participants are interviewed to gain a deeper understanding of the process and possible solutions from their perspective.

CCC/Rehab team members are in the planning process to coordinate access to these services through the Care Coordinators at South West CCAC. To ensure the patient voice is embedded in the design and implementation of the new Coordinated Access process, interviews are taking place with patients who have recently experienced the current process.

QUESTIONS TO PONDER

Access to Care is a large system change and will have mutual impact in many areas of the health care system including areas not directly linked to this project.

Seniors and adults with complex needs require care from other areas of health care such as mental health and primary care.

What strategies would facilitate seamless care from the patient, client or consumer perspective?

Consider testing your answer by asking a person who is served by your organization.

FEEDBACK

To receive future issues of the Access to Care eNewsletter, click here.

Access to Care
356 Oxford Street West
London, Ontario N6H 1T3
519-474-5693
Sue.McCutcheon@sw.ccac-ont.ca

Check us out at www.southwestlhin.on.ca
> Current Initiatives > Access to Care for current news and resources

Ontario
South West Local Health Integration Network

Connecting you with care / Votre lien aux soins
South West CCAC / CASC
Community Care Access Centre / Centre d'accès aux soins communautaires du Sud-Ouest

Understanding Patient/Client Journeys

A key success factor in the implementation of Home First in the South West is the high priority that has been placed on truly understanding patient journeys by all team members, through data collection, investigations, and through patient/client experiences.

Monthly and Weekly Home First Reports are monitored closely, enabling the Home First teams to quickly identify issues, investigate causes and to develop solutions with a solid understanding of the issues as they arise. The data is collected from hospitals, CCAC and Community Support Service Agencies and are shared with all participants so that each organization can understand their contribution to the Home First success.

ALC Reviews at London Health Sciences Centre (LHSC) in October/November 2012; a full scale review of all ALC designated patients was booked for both University Hospital and Victoria Hospital. Participants included: Home First Co-Leads, LHSC Managers and Coordinators, Social Workers, CCAC Managers and Care Coordinators. Each patient, in hospital with an ALC designation was reviewed and the following questions were considered:

1. Is this ALC designation/destination correct?
2. What are the barriers keeping patients in hospital?
3. What do we need to do as a system to move people to the next care destination?

Through this review, several emerging themes were identified and recommendations were developed to address these themes. As a result of the ALC review, hospital teams will be completing these reviews on a monthly basis to contribute to the sustainability of the Home First philosophy.

Thanks to Sarah for sharing her experiences from the perspective of an adult with complex needs.

Patient/Client Experiences The people who are impacted most significantly by the Home First philosophy of care are the people we serve. The Home First team is committed to actively working with patients and clients to understand their perspectives, challenges and values. Qualitative interviews with patients/ clients continue to take place, during which the participant is encouraged to share his/her greatest enablers, obstacles and solutions.

To achieve this level of understanding takes time and an investment of resources, among each organization but the insights gained from this work have been invaluable as the Access to Care work continues. Moving forward, the lessons learned through Home First will be applied to new initiatives.

Woodstock General Hospital's Home First and Coordinated Access Team!

On January 14, 2013 an interdisciplinary team of employees came together to launch both Home First and Coordinated Access at Woodstock General Hospital (WGH). Team members discussed the Home First philosophy and considered how to best roll out this approach at WGH. Having been the early adopted site for the Coordinated Access process, WGH Rehabilitation team members were able to provide a unique perspective with regards to implementing this process in the Complex Continuing Care Unit.

WGH's first patient to be discharged home using the Home First philosophy with an Intensive Service Plan in their home left WGH during the week of January 28th. *Congratulations on a great start!*

Reports In Development

As the Access to Care teams were studying and preparing recommendations for the Assisted Living/Supportive Housing/Adult Day Program (AL/SH/ADP) report and the Complex Continuing Care and Rehabilitation (CCC/Rehab) report they determined that each of these initiatives required further study to effectively achieve the goals laid out in the Access to Care initiative.

As recommendations from these two reports are moving forward, additional studies **AL/SH/ADP - Special Populations** and **CCC/Rehab - Restorative Care and Convalescent Care** are underway. During the coming weeks, the co-leads will be engaging with patients, clients, and health care professionals to gain insight to these areas of study and to develop recommendations to improve upon patient/client experiences. For more information about these reports, please contact:

Sue McCutcheon, ATC Lead
sue.mccutcheon@sw.ccac-ont.ca

Mary Jo Dunlop, AL/SH/ADP - Special Populations
maryjo.dunlop@cheshirelondon.ca

Mary Lynn Priestap, CCC/Rehab - Restorative Care/Convalescent Care
marylynn.priestap@sw.ccac-ont.ca

Introducing...

Michele Pegg, Co-lead, AL/SH/ADP

Excited to work towards creating a more effective, sustainable health care system that will achieve positive change for clients, Michele has held a variety of leadership roles in both the Long Term Care and Community Support Sectors in London and Elgin over the past seven years. Michele graduated with her Bachelor's degree in Finance and Economics from UWO and her MBA from the Richard Ivey School of Business. She worked in the financial services sector before finding her passion in health care.

Amber Alpaugh-Bishop, Project Manager, Access to Care

Amber, a certified ergonomist, has over 13 years of experience developing, implementing and improving health and safety programs in multiple industries, inclusive of health care. Having had responsibility for many projects over the years, Amber finds project management and the chance to collaborate with diverse partners exciting. Amber is looking forward to the unique opportunities that the Access to Care project offers.

South West LHIN 3rd Annual Quality Symposium

Location: Stratford Rotary Complex
353 McCarthy Road, Stratford ON

Date: Thursday, June 6, 2013

Time: 8:30 am – 4:00 pm

South West LHIN Quality Awards Program

The Quality Awards program first launched at the South West LHIN 2011 Quality Symposium to recognize organizations that have implemented a sustainable quality improvement initiative to achieve performance excellence. The first award recipients were announced at the 2012 Symposium.

It's now time to think of award-worthy initiatives in your organization, with this year's recipients to be announced at the 2013 Quality Symposium on June 6, in Stratford. (Click here for videos of 2012 award recipients). To be eligible for an award, the initiative must demonstrate sustainable system change and involve two or more organizations or agencies, at least one of which is LHIN-funded. Cross-continuum collaboration is encouraged.

There are two categories, with one award for each. These two categories match the strategic directions described in our Blueprint - Vision 2022.

- **Population-based Integrated Health Services:** *Integrating systems of care to help people manage their health and maintain their independence.*
- **Centrally Coordinated Resource Capacity:** *Integrating systems of care across the continuum to optimize the use of resources to improve flow of patients through the system.*

To learn more about the awards and how to submit a nomination, click here.