Transforming Community Access Services through Client- and Family-Centred Homecare Transitions

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**Abstract**  
This article describes how one provincial health region adopted a client- and family-centred approach to improve access to community health services. Transition best practices and the “Triple Aim” supplied a framework for the transformation of transition of clients needing home healthcare services (Berwick et al. 2008). The need to improve the patient and family experience, establish and streamline professional practice standards, strengthen interprofessional collaborations, increase efficiency, create a critical mass of experts in the clinical domain of care transitions and program access, and evaluate customer experience were the organizational drivers for this transformation. The new framework identifies clients’ needs and assigns a priority code. It also identifies which family member provides what support to the client and offers a one-stop service number staffed by individuals trained to provide client- and family-centred homecare services. This transformation of home healthcare transitions has improved the client and family experience, strengthened service provider satisfaction and generated efficiencies in prioritizing and delivering community healthcare services.
Introduction
It is well-known that healthcare clients prefer to remain at home rather than be institutionalized. Virtually every health authority in Canada and internationally is struggling with the challenge of providing high-quality patient- and family-centred homecare services to an aging population.

The Innovation
Home healthcare emphasizes medically required services that are provided in response to clients’ and families’ stated needs. A health region in British Columbia streamlined community transition services while strengthening interprofessional collaborations, service provider satisfaction and the client and family’s experience. Transition services provide continuity of healthcare for patients transferring from one location to another or from different levels of care (Coleman and Berenson 2004). Building on transition services’ transformation of the home healthcare liaison role (Meadows et al. 2014), this health region standardized and centralized the role of the clinician at the point of access into home health services. A project team was established with a mix of administrative, clinical and technical representation. The project team’s interprofessional nature is consistent with quality improvement initiatives and interprofessional councils established to enhance quality and patient safe care delivery (Burkoski and Yoon 2013). The team drew on the Structure, Tools, Environment and People methodology to establish the framework to transform the home health service line (Friedman and Herman 1998). Implementation of the framework resulted in the amalgamation of eight home healthcare access systems into one centralized department.

Review of the Literature
The transformation began with a review of the literature and national practices, as well as key informant interviews. The review emphasized streamlined, one-stop services for clients, standardized work processes and a mix of clinical and clerical team members. Seven practices were identified that would benefit homecare clients in the health region: (1) centralization of service with the co-location of staff; (2) a single call number with a person answering calls; (3) a mix of clinical and clerical staff; (4) standardization of processes and team management; (5) an education and training program; (6) triage and appointment scheduling; and (7) use of an electronic health record (Riggs 2011, Service Coordination Industry Consultant (Community Health), 2006).

The majority of jurisdictions contacted in the national review identified centralization of service as a critical success factor that facilitates standardization of processes and integration of best practices related to transitional care (Early Childhood Iowa – Quality Services and Programs Component Group 2011; Sobolewski 2011). Ease of entry, opportunity to streamline recruitment and
orientation, creation of efficiencies with staffing models and enhanced data collection and evaluation were the key identified benefits (Gardner 2009). Contact via a single, staffed phone number was identified as a best practice. Establishment of a diverse team that includes clerical staff with enhanced competencies and professionals with a variety of designations emerged as a trend (Humphrey 2002; Zuber 2002). Commitment to a quality improvement process and a program of education and training were also highlighted as essential to a successful transformation (Sobolewski 2011). Triage and appointment scheduling were synergistic to complementing the work of a home health access service (Zuber). Electronic records were found to support the use of consistent assessment/screening tools and the consistent data collection for evaluation of all aspects of the triple aim (Coleman 2007).

The regional team integrated recommendations from the review into their service delivery and project planning. They implemented best practices to transform the home health service line by standardizing and streamlining practice standards, building an interprofessional collaboration, increasing productivity and efficiency, creating a critical mass of experts in the clinical domain of access and addressing customer experience. They situated clients and their families at the centre of the Interprofessional Care Team Model and emphasized the need to improve the client’s experience (Figure 1).

In Figure 1, the client and client’s family is at the heart of the transition to home healthcare. The outer ring identifies those who may form part of the interprofessional team collaborating to ensure the successful transition. The model shows two-way communications between interprofessional team members and the client and client’s family so that team members know and are responsive to the client’s stated needs and goals as well as clinical needs. Strengthened communication and collaboration among members of the interprofessional team contribute to the patient experience and can reduce costs by eliminating duplication of effort and maximizing efficiency.

**Adoption of the Triple Aim Framework**

The Institute for Healthcare Improvement (IHI) implemented the Triple Aim model of care in 2007 in an effort to provide cost-effective patient-centred healthcare in a complex and fragmented healthcare system. IHI identified three objectives for improving healthcare delivery: (1) improving population health; (2) strengthening the patient experience; and (3) controlling per capita care costs (Berwick et al. 2008). The Triple Aim is patient- and family-centred, emphasizes primary care services to improve population health while controlling costs and identifies the benefits of system integration. The healthcare region used the Triple Aim to establish a client-centred framework for transitional care.
The project team redesigned service delivery to focus on the needs of the patient and the patient’s family. The team identified the client population, built a transition plan, and developed and implemented a priority system for service referrals. Care providers received customer service training. Roles and responsibilities, workflow and service delivery were standardized. The design and implementation of a new interprofessional role strengthened interprofessional collaboration. Clients are asked what are their goals, and this information is invaluable for planning the best and most appropriate home healthcare. Family members are asked what roles they play with reference to providing support for the client in recognition of family members having different roles and responsibilities within support structures. This knowledge ensures timely interactions with the appropriate family member and improves patient safety by reducing miscommunications during the transition (Joint Commission Center for Transforming Healthcare 2015).

In a healthcare system that is experiencing human resource shortages, escalating cost and increasingly complex healthcare needs, interprofessional healthcare
professionals must work collaboratively to ensure consistent, continuous and reliable care (College of Health Disciplines 2013). Effective collaboration between healthcare professionals is key to successful health promotion in community-based care to improve population health and ensure an efficient healthcare system.

A survey undertaken as part of the preliminary project work identified that both clinical and clerical staff who supported access were duplicating activities, including screening, registration, client contact and documentation. To eliminate work duplication, the project team defined clerical functions as those that included the collection of any information, including first-hand client narratives, collateral information and any function that included providing general, non-clinical information. The clerical role was identified as the fundamental first interface for any

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<thead>
<tr>
<th>Table 1.</th>
<th>Setting priorities for a new service referral to home healthcare services</th>
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<tr>
<td>Priority 1: Service within 24 hours</td>
<td>Clinical decision that there is high probability of immediate negative outcome to health, safety of client/family and/or the development of primary and/or secondary complications if not contacted within 12–24 hours</td>
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<td>Priority 1a: Service/Visit within 12 hours (same-day service)</td>
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<td>Priority 1b: Service/Visit within 12–24 hours</td>
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<tr>
<td>Priority 2: Service within 48 hours</td>
<td>Clinical decision that there is a high probability of negative outcome to health, safety of client/family and/or the development of primary and/or secondary complications if situation persists over 48 hours</td>
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<td>Priority 3: Service within 5 days</td>
<td>Clinical decision that there is a high probability of negative outcome to health, safety of client/family and/or the development of primary and/or secondary complications if situation persists over 5 days</td>
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<tr>
<td>Priority 4: Service within 7 days</td>
<td>Clinical decision that there is a moderate probability of negative outcome to health, safety of client/family and/or the development of primary and/or secondary complications if situation persists over 7 days</td>
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<tr>
<td>Priority 5: Service within 14 days</td>
<td>Clinical decision that there is a minimal probability of a negative outcome to health, safety of client/family and/or the development of primary and/or secondary complications if contact occurs after a 14-day time frame, or pre-scheduled visit/interventions that can occur within a variable time frame</td>
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<tr>
<td>Priority 6: Pending service need, no date specified. Contact client within 2 weeks to confirm that the referral was received, to mitigate risk and discuss next contact.</td>
<td>Pending referral (date not yet specified), client’s referral to the service is delayed</td>
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Source: Guy, S. and J. Fraser. 2013. Table 1, Setting Priorities for a New Service Referral to Home Healthcare Services. Adapted from GUIDELINE: Determining Priority of Visit for a New Service Referral to Home Health. Fraser Health Authority: Surrey, BC.
new referral to home healthcare through the home health access service or Home Health Service Line (HHSL).

The clinical role was defined as any function that required clinical judgment and clinical decision-making. A job description and a workflow were developed based on these distinctions. Clinical competencies identified similarities and differences with the home healthcare liaison role in transition services. The project team also developed a priority tool with standardized definitions to facilitate referral decisions based on clinical judgment.

Development of a Priority Tool for a New Service Referral
The HHSL steering committee developed a priority tool based on clinicians’ assessments of the clients’ needs. The priority tool outlines seven priority levels. Each level provides a time frame for the first in-person visit. The tool reflects clinicians’ judgments based on the information they have about the potential client (Table 1.)

The project team’s review of the tool identified needed changes. These included: shifting language of “tolerable risk” to consideration of clients’ needs; clarification of the definitions of the terms “priority,” “service” and “visit” (i.e., in person and by phone); and promising minimum contact within two weeks. The new priority tool promotes a standardized approach to priority setting within the new HHSL and a strengthened collective meaning across the region. For example, when home healthcare offices talk about a Priority 2 client, there is now a universal understanding of what accountabilities and responsibilities are required within 48 hours, as well as an understanding of what type of client profile fits the priority. This work helped inform the access referral and leads into the work around the transition plan.

Development of the Transition Plan
As patients in transition are particularly vulnerable to unplanned readmission to hospital and other adverse events, continuity of information is critical to a successful transition (Dhalla et al. 2012). The health region’s transition plan highlights five innovative patient-focused practices demonstrated to improve the quality and safety of home healthcare transitions to clients: (1) essential clinical handover information; (2) consistent client-centred contact with the client and/or family/support person; (3) stated needs and goals of the client or referral source; (4) caregivers’ roles in supporting clients, using the Financial, Advocacy, Care Coordination, Emotional and Direct Care Provision methodology (FACED) framework; and (5) population identification. Each of these practices contributes to continuity of care.
An interdisciplinary shared work team identified necessary components for a transition plan electronic record. The driver for this record included dissatisfaction with a hybrid electronic and paper clinical chart that made it difficult to quickly locate the key information for the first in-person visit. The second driver was inconsistent completion of the current clinical assessment tool. The tool exceeded 20 pages, too long for many users. The lead of the shared work team consulted with clinical practice committees (CPCs) to identify required information for different types of referrals to ensure a safe and high-quality first in-person visit. This approach was inspired by Coleman’s work suggesting that there are key approaches that support safe transitions (Rutherford et al. 2013).

The “consistent client-centred contact” approach acknowledges the health literacy of the individuals who call the access clinicians. Education and practice scripts were provided to clinicians to strengthen communication with clients in plain language, as well as value the client’s perspective of care needs. The client’s stated goals were invaluable, painting a whole picture for the client and providing a necessary picture of the client’s home for the first clinician. The benefits of the first transition plans were seen early. For example, where a reason for referral and diagnosis may have been a postsurgical hip wound from the referral source, the client would suggest that his/her goals were to be able to play card games at the community centre and be able to physically get there. The consistent client-centred contact enabled the clinician to focus on the client’s needs and wants, while the homecare clinician assessed and managed wound care within the context of the client’s goals.

Introduction of the FACED framework recognizes that families and support systems include many roles and responsibilities within support structures (Gibson et al. 2012). For example, with an older adult, one family member may manage the financial details. Another member may manage the care coordination from hospital. Thus, the framework provides the clinician with information on who is the family contact person, depending on the client’s stated needs. This information is helpful because it provides clarity with the different roles of the family and provides the conditions for a positive first home visit for the clinician with the client and/or family.

The transition plan also includes the identification of five client populations: (1) developmentally delayed; (2) end-of-life/palliative; (3) frail older adult; (4) interventional; and (5) neurological. Identifying the population is a preliminary step for focusing care on clients’ needs versus the types of services provided. Although this categorization was introduced to assess the accuracy of predicting who are our clients, post analysis revealed that the populations were accurate 85% of the
time based on an audit of 20 charts. The transition plan was one of the most successful elements of the HHSL transformation and replaces what was previously a clinical assessment. The transition plan, in conjunction with the priority tool, provides the necessary information for the first home visit.

**Customer Service Training**

Healthcare customer service training is another successful element of the HHSL transformation. Healthcare is publically funded in the region where this transformation took place. Our customers have sometimes been left with the perception that they should feel grateful for receiving any publically funded services. In home healthcare, the notion of customer service training is almost non-existent. The HHSL project team included front-line staff and customers. All team members identified improved client experience as a high priority. Documented workflow processes provided a framework for the development of customer service training and education. Scripts for staff were developed based on HHSL workflow processes. As part of an initiative to build sustainability, the project team identified key behavioural components for HHSL staff having direct phone contact with customers. These components included managing calls with a customer focus, using words that are helpful when interviewing over the phone and applying strategies to calm angry customers. As implementation of the HHSL has proven to be so successful, customer training is being incorporated into core orientation for all new homecare staff.

**Lessons Learned**

Knowing what can be transitioned over time and what has to be completed before a restructuring or transformation of existing organizational structures can occur is a critical success factor. The lessons learned from the transition of the home healthcare liaison role in the hospital system (Meadows et al. 2014) contributed to the success of the current transition. One lesson learned in the earlier transition emphasized the importance of local home healthcare office leadership and front-line representation at the project team level. As a result of this learning, the project structure included feedback loops with the management team and front-line staff, with representatives at the office level. These “Change Leads” exchanged information on a bi-weekly basis.

The importance of understanding quantitative numbers when dealing with any type of service that involves volumes as a basis for restructuring is another lesson learned. Accurate counts are essential for ensuring efficiency. The absence of information management systems to count calls and referrals made it hard to quantify calls received. Our local manual audits and interviews with managers provided a count of 45,000 calls. This estimate misrepresented the true magnitude of the work involving community access. We built a system to manage 45,000 calls and ended up with a system receiving over 65,000 calls.
Transitioning home healthcare offices’ systems and staff into one centrally located office structure went well, with a few notable bumps. Our transitioning of the offices on different weeks and with a series of “must do” actions completed prior to the transition was successful. The team’s use of the Plan, Do, Study, Act (PDSA) quality improvement method helped identify the impact of small changes on the transition (Langley et al. 2009). This method was selected because its widespread use in healthcare means that many nurses are familiar with it and can use it to improve work processes. The PDSA cycles enabled the project team to manoeuvre quickly to change plan and course to overcome small hurdles. Use of PDSA cycles prompted the team to delay the transitioning of an office by one week. This bump forced the delay of our public launch but ensured its success, and was one of the key success factors for the transition.

Another area of success was the identification of processes that benefited from using the “Big Bang” approach to one-step implementation and those that benefited from a phased approach (Eason 1988). The Big Bang approach requires that everyone transition to a new approach at the same time. The transition plan was implemented using the Big Bang model. In preparation, half of the offices had already been transitioned into the new model because the Big Bang implementation would affect all the home healthcare liaison offices downstream. At the same time, a phased approach was used for practice guidelines that were in development and which evolved throughout the project’s implementation phase.

The importance of a clinical practice committee (CPC) structure to support new and emerging practice is another lesson learned. Prior to this transformation, the access role was neither clearly understood nor standardized. As a result, clinical practice was inconsistent and, at times, non-existent. For example, there were no clinical standards on documentation. The CPC identified clinical practice gaps and established shared work teams to address these gaps. We are now able to discuss clinical practice for access clinicians within a formalized CPC structure. Since being implemented, the CPC has developed key documents to further support the clinicians’ professional practice: a policy outlining the elements of the referral package; a protocol outlining the processes for contacting clients and declining referrals; and revision of the transition plan guidelines and the required clinical information summary document.

Identifying a lack of standardization downstream at local offices was an unexpected consequence resulting from centralizing access to the regional home healthcare program. Although identified with earlier transition initiatives, the current transition is unique because of its focus on consistent client-centred contact.
The emphasis on client-focused services to facilitate transition of clients to home healthcare provided the health region with an opportunity to strengthen interprofessional collaborations, clarify scopes of practice, reduce duplication of work and generate efficiencies, increase staff satisfaction, create a priority setting tool, strengthen the patient experience and ensure successful homecare transitions.

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Reference

